

Handbook for
ABORIGINAL ALCOHOL
and **DRUG WORK**

Kylie Lee
Bradley Freeburn
Steve Ella
Warren Miller
Jimmy Perry
Kate Conigrave

Handbook for

ABORIGINAL ALCOHOL

and **DRUG WORK**

Kylie Lee

Sydney Medical School,
University of Sydney

Bradley Freeburn

Drug and Alcohol Unit,
Aboriginal Medical Service
Co-op Limited Redfern

Steve Ella

Aboriginal Drug and
Alcohol Consultancy and
Counselling Portfolio,
Drug and Alcohol Service,
Central Coast Local
Health District

Warren Miller

Makin' Tracks Project,
Aboriginal Drug and
Alcohol Council SA Inc.

Jimmy Perry

Makin' Tracks Project,
Aboriginal Drug and
Alcohol Council SA Inc.

Kate Conigrave

Drug Health Services,
Royal Prince Alfred Hospital,
Sydney Local Health District;
Sydney Medical School,
University of Sydney

Published in Australia by the University of Sydney

© University of Sydney, Discipline of Addiction Medicine, Sydney Medical School, 2012

This work is copyright. The information has been prepared by the editors, contributing authors and reviewers for people doing Aboriginal alcohol and drug work in Australia. Written permission is needed to reproduce, store, transmit or translate any sections of the handbook. If permission is granted, any use of information needs to include an acknowledgment of the University of Sydney and the editors as the source. If a particular chapter is cited, the relevant chapter name and contributing author should also be cited. Where there is no author name listed for a particular chapter, the editors should be listed as the author. This book may not be used for commercial uses or sale. The mention of specific companies or of certain medicines or other equipment does not imply that they are endorsed or recommended by the University of Sydney or by the editors in preference to others of a similar nature that are not mentioned. Unless there has been human error or if something has been left out, the names of commercially sold products or programs are distinguished by initial capital letters.

Production advice: Jamie Ferguson

Graphic design: Kyle Walker

Typeset by: Melinda McFadden

Printed in Australia by: Bluestar Print

ISBN: 978-1-74210 267-2 (hard copy) 978-1-74210-268-9 (online)

The authors and editors have taken all care to present accurate and up to date information. However, if the reader finds the information presented conflicts with their workplace or government guidelines, they should check with an independent experienced clinician. The reader should also take great care in working with pregnant women or people with major physical or mental illnesses, and seek medical advice if in any doubt. The phone numbers of state and territory specialist advisory services are provided on p. 435.

Suggested citation (for the whole book): Lee K, Freeburn B, Ella S, Miller W, Perry J, Conigrave K [editors] (2012). *Handbook for Aboriginal Alcohol and Drug Work*. Sydney: University of Sydney, p. 446.

Suggested citation (for a chapter in the book): Heffernan E, Andersen K & Whitton G (2012). Prison populations. In: Lee K, Freeburn B, Ella S, Miller W, Perry J, Conigrave K [editors] *Handbook for Aboriginal Alcohol and Drug Work*. Sydney: University of Sydney, p. 385-397.

Further copies of this handbook can be downloaded from the University of Sydney website sydney.edu.au/medicine/addiction/indigenous



Foreword

Alcohol and drugs impose a threat to the very soul of Aboriginal Australia. There are more Aboriginal people working in this field today and along with our colleagues the hope is always that we can minimise and negate this threat. This handbook is an excellent and valuable addition to the knowledge base and to the resources required to do this.

Aboriginal people working in alcohol and drugs need to keep up with the times. The contemporary use of alcohol and drugs within Aboriginal Australia is not static. New drugs emerge and yesterday's habits need to be rearranged to suit today's lifestyle. This handbook is respectful of both the clinical and cultural domains that prevail throughout Aboriginal Australia.

While the handbook is designed specifically for Aboriginal health professionals, no doubt it will be of value across a broader spectrum of people including those in workforce development, academia and policy. It will be able to be used well into our future to help make our knowledge base more practical and useable. Alcohol and drug interventions must work to an evidence base. It is clear that the authors have looked at the available evidence regarding prevention and treatment. Not one size fits all, what might be good in a particular Aboriginal setting may not be so elsewhere. However the fundamentals remain constant.

The authors are to be congratulated for producing this handbook. Persistence and patience are virtues required for producing quality information in any format. It is apparent that this team of Aboriginal and non-Aboriginal colleagues working together have produced a resource that is compatible with Aboriginal people's desire to participate and influence the ways forward.

Associate Professor Ted Wilkes

Aboriginal Research Programs,
National Drug Research Institute,
Curtin University, WA; and Chair, of the
National Indigenous Drug and
Alcohol Committee (NIDAC)

Introduction and how to use this book

Aboriginal and Torres Strait Islander alcohol and drug work happens all over Australia. So, too, the people who helped to write this book come from a range of backgrounds and experiences, from cities through to small isolated communities. The editors come from New South Wales, South Australia and the Northern Territory, and the authors and reviewers are from a range of states and territories including Queensland (including the Torres Strait), Western Australia, and the Australian Capital Territory. This section talks about why and how the book was written, and how you might be able to use it.

A practical tool

This book has been written as a practical tool to use in your everyday work, and to be combined with your skills and local knowledge. It offers a detailed look at alcohol and drug work from clinical, through to prevention, early intervention and harm reduction. This handbook is also likely to help people working to improve policy and those advocating for change. The idea for it came from workers all over Australia. They told us that they needed an easy to use handbook that can help them respond to the range of alcohol and drug issues they face every day. They also told us that such a book needs to take into account the complex challenges facing workers when helping clients, their families and, sometimes, whole communities.

Where the information in the book comes from

This book is based on clinical and cultural experience, as well as on the available evidence about what works to prevent and treat alcohol and drug problems. Where possible we have tried to match national guidelines. Sometimes national and state guidelines differ slightly. So, if at any point you find the book differs from guidelines used in your local area, then seek guidance from your manager or an expert clinician. If there is any part of the book that you disagree with, we would be keen to know about it, as we hope to continue to improve the content.

How it has been written

This book has been written by a number of contributing authors. Each section has been edited and checked by our editors, and in many cases also reviewed by an expert in the relevant field. For space, the term 'Aboriginal' has been used throughout this book to refer to Aboriginal and Torres Strait Islander Australians. This is using the word 'Aboriginal' in its broad sense, for people who have been in this country for many thousands of years.

We hope you enjoy this book and that it helps you in the important work you do.

Contents

<u>Foreword</u>	i
<u>Introduction and how to use this book</u>	ii
<u>Acknowledgements</u>	iv
<u>Authors and editors</u>	v
<u>Contributing authors</u>	vi
<u>Reviewers</u>	x
<u>Images</u>	xi
<u>Abbreviations</u>	xii
<u>1 General principles</u>	1
<u>2 Alcohol</u>	65
<u>3 Tobacco</u>	105
<u>4 Cannabis</u>	127
<u>5 Opioids</u>	139
<u>6 Stimulants</u>	159
<u>7 Benzodiazepines</u>	173
<u>8 Pharmacy and supermarket drugs</u>	185
<u>9 Petrol, paint and other inhalants</u>	207
<u>10 Other drugs</u>	217
<u>11 Polydrug use</u>	237
<u>12 Mental health and substance use</u>	247
<u>13 Reducing the harms from substance misuse</u>	283
<u>14 Legal issues</u>	317
<u>15 Community-wide approaches to substance misuse</u>	331
<u>16 Special situations, settings and groups</u>	343
<u>17 Tips for workers</u>	405
<u>Appendix</u>	419
<u>Index</u>	437

Acknowledgements

We would like to acknowledge elders, past and present, and our colleagues who have provided so much advice along the way.

Thanks to all of the contributing authors and expert reviewers for their time and for putting up with many drafts of each chapter.

For funding and other resource support, we would like to thank the Foundation for Alcohol Research and Education (FARE), New South Wales Ministry of Health, the University of Sydney and Sydney Local Health District.

Lastly, particular thanks to the Aboriginal Drug and Alcohol Network (ADAN) Leadership Group in New South Wales, Coralie Ober, Ralph Moore, our families and the many others who remain anonymous.

Authors and editors

Kylie Lee is from Darwin. She trained as a music therapist and then did her PhD in substance use and mental health disorders in remote Arnhem Land communities. She now holds an NHMRC postdoctoral fellowship in Aboriginal and Torres Strait Islander Health. She is joint coordinator of the Graduate Diploma of Indigenous Health (Substance Use) at the University of Sydney and the matching Masters course. She has produced films about tobacco, cannabis and alcohol and other health issues with the Anindilyakwa people and The Perfect World Production Company.

Bradley Freeburn is a Bundjalung man from the mid-north coast of NSW. He is the manager of the Drug and Alcohol Unit of the Aboriginal Medical Service Co-op Ltd Redfern. This unit was the first opioid treatment unit in an Aboriginal Medical Service in Australia. He is a member of the National Indigenous Drug and Alcohol Committee (NIDAC), the NSW Aboriginal Drug and Alcohol Network (ADAN) Leadership Group, and the NSW Health Aboriginal Alcohol and other Drugs Sub-Committee; and a board member of the National Aboriginal Torres Strait Islander Health Worker Association (NATSIHWA).

Steve Ella coordinates the NSW Aboriginal Drug and Alcohol Traineeship Program for NSW Health. He is seconded to that position from his usual role as an Aboriginal drug and alcohol worker and team leader of Counselling at the Drug and Alcohol Service, Central Coast Local Health District. Steve brings to this work his past experience as an Aboriginal drug and alcohol worker, and his work in developing the NSW Aboriginal workforce, which has included teaching the Certificate III and IV in Alcohol and Other Drugs at the Aboriginal Health College (NSW).

Warren Miller is from the Ceduna and Nullarbor regions (Wirangu and Kokatha ties). He works for the Aboriginal Drug and Alcohol Council SA Inc. on the Makin' Tracks project. Together with Jimmy Perry he provides support for communities and Aboriginal health professionals around drug and alcohol issues across the whole of SA and also in NT, Qld, NSW and WA. He has extensive experience in remote and regional communities and in prevention as well as clinical management approaches.

Jimmy Perry is from the Coorong region south-east of Adelaide. For the last 10 years he has worked for the Aboriginal Drug and Alcohol Council SA Inc. on the Makin' Tracks project. Together with Warren Miller he provides support for communities and Aboriginal health professionals around drug and alcohol issues across the whole of SA and also in NT, Qld, NSW and WA. He has extensive experience in remote and regional communities and in prevention as well as clinical management approaches.

Kate Conigrave is a medical doctor and professor who has specialised in addiction medicine and public health. Together with Kylie Lee she coordinates the Graduate Diploma Indigenous Health (Substance Use) at the University of Sydney and the matching Masters course. Kate works with Aboriginal clients in inner Sydney, and collaborates with Aboriginal communities and agencies in urban and remote settings. She has co-authored a handbook for doctors on Addiction Medicine published internationally.

Associate editors

Toby Lea

Kirsten Taylor

Contributing authors

Darri Adamson

Registered Nurse, Drug Health Services,
Royal Prince Alfred Hospital, NSW
Chapter 16: Aggressive clients

Georgina Anderson

Senior Psychologist, Cannabis Clinic,
Central Coast Local Health District, NSW
Chapter 4: Cannabis

Kimina Andersen

Social Worker & Acting State-wide
Coordinator, Aboriginal & Torres Strait
Islander Mental Health, Forensic Mental
Health Service, Queensland Health, Qld
Chapter 16: Prison populations

Robert Assan

Indigenous Risk Impact Screen
(IRIS) Project, Queensland Health, Qld
Chapter 2: Alcohol brief intervention

Kirsten Black

Clinical Academic Gynaecologist and
Senior Lecturer, Discipline of Obstetrics,
Gynaecology & Neonatology,
University of Sydney, NSW
Chapter 16: Contraception

Maggie Brady

Research Fellow, Centre for Aboriginal
Economic Policy Research (CAEPR),
Australian National University, ACT
*Chapter 2: History of drinking in Aboriginal
and Torres Strait Islander communities*

Lynette Bullen

Smoking Cessation Coordinator, Training and Support Unit for Aboriginal Mothers, Babies and Children, Clinical Education Training Institute – Rural Directorate (CETI-RD), NSW

Chapter 1: Case management

Wendy Casey and the Strong Spirit Strong Mind team

Wendy is the Manager, Aboriginal Alcohol and Other Drugs Program, Drug and Alcohol Office, WA

Chapter 1: Counselling

Steve Childs

Assistant Director, Counselling and Psychological Services, North Sydney Central Coast Local Health District, NSW

Chapter 1: Counselling

Ken Curry

Senior Staff Specialist and Medical Director, Drug Health Services, Canterbury Hospital; and Clinical Senior Lecturer, Addiction Medicine, Sydney Medical School, University of Sydney, NSW

Chapter 2: Alcohol withdrawal

Apo Demirkol

Staff Specialist, Drug and Alcohol Services, South Eastern Sydney Local Health District; and Clinical Lecturer, Addiction Medicine, Sydney Medical School, University of Sydney, NSW

Chapter 2: Alcohol: background, assessment, relapse prevention, Chapter 7: Benzodiazepines, Chapter 17: Using research to help you work with clients: 'Evidence-based practice' (overview)

Brian Doyle

Aboriginal Project Officer, Kirketon Road Centre, South Eastern Sydney Local Health District, NSW

Chapter 13: Needle and syringe programs

Adrian Dunlop

Senior Staff Specialist and Area Director, Drug and Alcohol Clinical Services, Hunter New England Local Health District; and Associate Professor, University of Newcastle, NSW

Chapter 11: Polydrug use

Elizabeth Elliott

Professor of Paediatrics and Child Health, Children's Hospital, Westmead and University of Sydney, NSW

Chapter 16: Alcohol use in pregnancy and Foetal Alcohol Spectrum Disorders

Joanne Ferguson

Staff Specialist, Drug Health Services, Sydney and South Western Sydney Local Health Districts; and Clinical Associate Lecturer, Addiction Medicine, Sydney Medical School, University of Sydney, NSW

Chapter 1: Residential rehabilitation

Roger Garsia

Senior Staff Specialist and Director, Clinical AIDS Services, Sydney Local Health District; and Clinical Senior Lecturer, Immunology and Infectious Diseases, Sydney Medical School, University of Sydney, NSW

Chapter 13: HIV/AIDS

Anthony (Tony) Gill

Senior Staff Specialist, Drug and Alcohol Clinical Services, Hunter New England Local Health District Newcastle, NSW

Chapter 5: Opioids

Sarah Gobbert

Manager, Tobacco, Alcohol and other Drugs Clinical Services, NT Government, NT

Chapter 9: Petrol, paint and other inhalants

Dennis Gray

Deputy Director, Professor and Leader, Indigenous Australian Research Team, National Drug Research Institute (NDRI), Curtin University, WA; and member of the National Indigenous Drug and Alcohol Committee (NIDAC)

Chapter 15: What communities can do to prevent or limit drinking problems

Paul Haber

Medical Director, Drug Health Services, Sydney and South Western Sydney Local Health Districts; and Professor, Addiction Medicine, Sydney Medical School, University of Sydney, NSW

Chapter 13: Hepatitis C and B

Michelle Harrison

Faculty Liaison Librarian, supporting the School of Public Health, University of Sydney, NSW

Chapter 17: Using research to help you work with clients: 'Evidence-based practice'

Ann Harwood

Juvenile Justice Counsellor, Gosford Juvenile Justice, Department of Attorney-General and Justice, NSW

Chapter 16: Working with young people with alcohol or drug issues

Alison Healy

Psychologist, Cannabis Clinic, Central Coast Local Health District, NSW

Chapter 4: Cannabis

Edward Heffernan

Psychiatrist and Director, Queensland Forensic Mental Health Services, Queensland Health, Qld

Chapter 16: Prison populations

Susan Hill

Child Protection Educator, NSW

Chapter 16: Protecting and supporting families at risk

Ernest Hunter

Regional Psychiatrist, Remote Area Mental Health Service, Queensland Health; and Adjunct Professor, James Cook University, Qld

Chapter 12: Anxiety and stress

Peter Jack

Aboriginal Drug and Alcohol Worker, Kalparrin Community Inc., SA

Chapter 1: Mutual support groups (Aboriginal men's groups)

Jaime Key

Aboriginal Drug and Alcohol Clinician, Shoalhaven Magistrate's Early Referral into Treatment (MERIT) and Diversion Service, Illawarra Shoalhaven Local Health District, NSW

Chapter 14: Programs to reduce re-offending or avoid prison

Julian Keats

Senior Addiction Medicine Registrar, Drug and Alcohol Clinical Services, Hunter New England Local Health District; and Advanced Physician Trainee, Chapter of Addiction Medicine, Royal Australasian College of Physicians, NSW

Chapter 1: The role of medicines
Chapter 11: Polydrug use

Julie Keech

Clinical Nurse Consultant, Volatile Substance Abuse, NT Government, NT

Chapter 9: Petrol, paint and other inhalants

Christine Kelly

Clinical Nurse Consultant, Volatile Substance Abuse, NT Government, NT

Chapter 9: Petrol, paint and other inhalants

Joseph Lawler

Gastroenterologist, Royal Prince Alfred Hospital, Sydney Local Health District, NSW
Chapter 13: Hepatitis C and B

Toby Lea

Research Associate/PhD Candidate, National Centre in HIV Social Research, University of New South Wales, NSW
Chapter 10: GHB, ketamine, hallucinogens, other sedatives (barbiturates), betel nut, khat, anabolic steroids

Lana Miller

Outreach Coordinator, Council for Aboriginal Alcohol Program Services (CAAPS) Inc., NT
Chapter 1: What is alcohol and drug work? (Strong relationships)

Jeannie Minnis

Clinical Nurse Consultant (Perinatal and Family), Drug Health Services, Royal Prince Alfred Hospital, NSW
Chapter 16: Pregnancy, breastfeeding & early childhood

Bridin Murnion

Staff Specialist, Drug Health Services, Sydney Local Health District; and Clinical Senior Lecturer, Addiction Medicine, Sydney Medical School, University of Sydney, NSW
Chapter 8: Pharmacy and supermarket drugs

Oriel Murray

Project Officer, Cape York Family Centre, Congress Community Development Education Unit, Qld
Chapter 17: Looking after yourself

Catherine O'Connor

Director of Sexual Health, Assistant Director of Women's Health and Executive Clinical Director of Community Health, Sydney and South West Sydney Local Health Districts; and Associate Professor, Sydney Medical School, University of Sydney, NSW
Chapter 13: Sexually transmissible infections in the setting of substance use

Jude Page

Project Manager, Aboriginal Health, Justice Health and Forensic Mental Health Network (NSW)
Chapter 14: Programs to reduce re-offending or avoid prison

Louise Ross

Project Officer, Tobacco Cessation, Drug Health Services, Sydney and South West Sydney Local Health Districts, NSW; and member of the Australian Association of Smoking Cessation Professionals and of the Association for the Treatment of Tobacco Use and Dependence
Chapter 3: Tobacco

Robyn Shields

Psychiatric Registrar, Sydney Local Health District, NSW
Chapter 12: Mental health and substance use: Introduction

Lynette Simpson

Project Officer, Aboriginal Health, Drug Health Services, Sydney Local Health District, NSW
Chapter 1: Mutual support groups (Aboriginal women's groups)

Darren Smyth

Clinical Nurse Consultant, Drug Health Services, Royal Prince Alfred Hospital, NSW
Chapter 14: Guardianship

Elizabeth Stubbs

Volatile Substance Abuse Worker,
NT Government, NT
Chapter 9: Petrol, paint and other inhalants

Kelly Trowbridge

Clinical Nurse Consultant, Volatile
Substance Abuse, NT Government, NT
Chapter 9: Petrol, paint and other inhalants

Ingrid van Beek

Director, Kirketon Road Centre, South
Eastern Sydney Local Health District, NSW
Chapter 13: Needle syringe programs

Emily Walker

Registered Nurse (Consult and Liaison),
Drug Health Services, Royal Prince Alfred
Hospital, NSW
*Chapter 1: Mutual support groups
(overview, 12-steps, SMART)*

Anne Wand

Staff Specialist Psychiatrist, Sydney
Local Health Network; and Clinical
Lecturer, Sydney Medical School,
University of Sydney, NSW
Chapter 12: Depression and suicide, Psychosis

Ann White

Clinical Nurse Consultant, Harm
Minimisation Drug Health Services,
Sydney Local Health District, NSW
*Chapter 13: Harms from injecting drug
use and safer injecting*

Gilbert Whitton

Senior Staff Specialist, Drug Health, South
Western Sydney Local Health District and
Southern NSW and Murrumbidgee Local
Health Districts, NSW
Chapter 16: Prison populations

Scott Wilson

Director, Aboriginal Drug and Alcohol
Council Inc., SA; and member of the
National Indigenous Drug and Alcohol
Committee (NIDAC)
Chapter 17: Keeping up your skills

Adam Winstock

Consultant Addiction Psychiatrist, South
London and Maudsley NHS Trust; and
Honorary Senior Lecturer, Institute of
Psychiatry, Kings College London
*Chapter 1: Why people become dependent
on drugs, Chapter 6: Stimulants*

Julie Woods

Comorbidity Officer, Ngnowar Aerwah
Aboriginal Corporation, Wyndham, WA
Chapter 1: What can families do?

Reviewers

Jeanette Callaghan

NT Early Intervention Pilot Program
Coordinator, Police Prosecutions Division,
NT Police Youth Services, NT
*Chapter 14: Programs to reduce
re-offending or avoid prison*

MacDonald Christie

Professor of Pharmacology, Discipline of
Pharmacology, Sydney Medical School,
University of Sydney, NSW
Diagrams

Russell Freeburn

Chief Executive Officer, Buyinbin
Aboriginal Corporation, Casino, NSW
*Chapter 16: Protecting and supporting
families at risk*

Bev Grant-Lipscomb

Clinical Nurse, Aboriginal Children's Services; and Indigenous Counsellor, TAFE NSW

Chapter 16: Protecting and supporting families at risk

Rowena Ivers

Clinical Associate Professor, Graduate School of Medicine, University of Wollongong; and GP, Illawarra Aboriginal Medical Service, NSW

Chapter 3: Tobacco

Marianne Jauncey

Medical Director, Sydney Medically Supervised Injecting Centre, NSW

Chapter 13: Harms from injecting drug use and safer injecting

Vanessa Lee

Senior Lecturer, Indigenous Health, Faculty of Health Sciences, University of Sydney, NSW

Chapter 16: Torres Strait Islanders

Petah Martin

Psychiatrist, Aboriginal Mental Health Unit, Sydney Local Health District, NSW

Chapter 12: Anxiety and stress

Charlie McHughes

Drug and Alcohol worker, Orana Haven, NSW

Chapter 1: Residential rehabilitation

Martin O'Donnell

MERIT (Magistrates Early Referral into Treatment) Clinician, Drug Health Services, Sydney Local Health District, NSW

Chapter 14: Programs to reduce re-offending or avoid prison

Emily Walker

Registered Nurse (Consult and Liaison), Drug Health Services, Royal Prince Alfred Hospital, NSW

Chapter 1: Alcohol, Chapter 16: Pregnancy, breastfeeding and early childhood

Images

James Conigrave

Graduate of Bachelors of Psychology and of Health and of the Master of Public Health

Diagrams

Craig Rodgers

Staff Specialist and Medical Unit Manager, Kirketon Road Centre, South Eastern Sydney Local Health District, NSW

Clinical photographs

Simone Strasser

Hepatologist, AW Morrow Gastroenterology and Liver Centre, Royal Prince Alfred Hospital; and Clinical Associate Professor, Sydney Medical School, University of Sydney, NSW

Clinical photographs

Adam Winstock

Consultant Addiction Psychiatrist, South London and Maudsley NHS Trust; and Honorary Senior Lecturer, Institute of Psychiatry, Kings College London

Clinical photographs

Abbreviations

Aboriginal	Aboriginal and or Torres Strait Islander
AIDS	Acquired Immune Deficiency Syndrome (a severe illness that can develop when a person has been infected with the HIV virus)
ADHD	Attention Deficit Hyperactivity Disorder
AWS	Alcohol Withdrawal Scale
CBT	cognitive behavioural therapy
COPD	Chronic Obstructive Pulmonary Disease
CPR	cardiopulmonary resuscitation
Detox	detoxification
ECT	electroconvulsive therapy (for depression)
FAS	Foetal Alcohol Syndrome
FASD	Foetal Alcohol Spectrum Disorders
GHB	gamma-hydroxybutyrate
Hepatitis B	Hep B
Hepatitis C	Hep C
HIV	Human Immunodeficiency Virus
MDMA	ecstasy
NSP	Needle and Syringe Program

NAS	Neonatal Abstinence Syndrome
NRT	nicotine replacement therapy (e.g. nicotine patches or nicotine gum)
OST	opioid substitution therapy (e.g. methadone or buprenorphine)
PNG	Papua New Guinea
Rehab or Resi rehab	residential rehabilitation
SIDS	Sudden Infant Death Syndrome

1

General principles

<u>What is Aboriginal alcohol and drug work?</u>	2
<u>Why people become dependent on alcohol or drugs</u>	4
<u>What type of drug is it?</u>	10
<u>Assessment</u>	11
<u>Overview of ways to help</u>	17
<u>Getting a person thinking about their substance use</u>	19
<u>Counselling</u>	20
<u>Case management</u>	43
<u>The role of medicines</u>	50
<u>Mutual support groups</u>	54
<u>Residential rehabilitation</u>	58
<u>What can families do?</u>	62

What is Aboriginal alcohol and drug work?

OVERVIEW

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

TEAMWORK

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

CONFIDENTIALITY

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

STRONG RELATIONSHIPS

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

KNOWING THE SCOPE OF THE ROLE

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

KEEPING SAFE

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

Why people become dependent on alcohol or drugs

OVERVIEW

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

WHO DEVELOPS DEPENDENCE AND WHO IS AT RISK?

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

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

Things that put us at risk

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

Things that protect us

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

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

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

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

Mental illness

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

Dependence on one drug can lead to dependence on another

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

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

Some drugs are more addictive than others

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

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

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

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

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

THE PLEASURE/REWARD PATHWAY IN THE BRAIN

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

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

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

How chemicals transmit messages between nerve cells in our brain

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

TOLERANCE AND WITHDRAWAL

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

What happens in the brain in dependence?

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

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

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

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

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

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

What type of drug is it?

OVERVIEW

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

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

‘Downers’

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

‘Uppers’

- Amphetamines
- Ecstasy
- Cocaine
- Nicotine

‘Sideways’

- Cannabis
- LSD and ‘magic mushrooms’

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

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

Assessment

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

YOUR APPROACH IN ASSESSING THE CLIENT

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

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

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

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

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

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



Confidentiality

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

What is the problem right now?

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

The alcohol and drug use history

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

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

Is the client dependent on that substance?

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

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

When is a person dependent on a drug?

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

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

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

Overview of a client's lifetime substance use

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

Consider local culture and views on causes of sickness

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

How ready is your client to change right now?

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

Other drug use

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

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

General health and other issues

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

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

Seeking extra information from family or others

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

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

Your observations

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

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

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

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

Summing up after your assessment

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

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

Overviews of ways to help

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

ENGAGING THE CLIENT

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

MANAGING ANY WITHDRAWAL

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

HELPING THE PERSON STAY DRY OR CLEAN (ABSTINENT)

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

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

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

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

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

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

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

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

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

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

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

Counselling

OVERVIEW

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

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

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

HOW YOU APPROACH COUNSELLING

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

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

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

Some of the skills of counselling involve working out:

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

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

Remember the 'circle of change'

When working with clients it is important to remember:

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

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

Trying to change thinking as well as behaviour

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

WORKING WITH A PERSON WHO IS STILL USING ALCOHOL OR DRUGS

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

Assessment as a way to help bring about change

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

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

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

Trying to engage the person with the idea of change

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

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

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

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



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

Working with someone who is prepared to think about change

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

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

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

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

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

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

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

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

BUILDING A CLIENT'S MOTIVATION (MOTIVATIONAL INTERVIEWING)

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

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

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

Ways to approach motivational interviewing

There are six basic principles:

1 *Express empathy*

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

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

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

3 *Avoid arguments*

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

4 *Work with resistance*

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

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

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

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

6 *View life as a whole (holistically)*

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

Adapted from Strong Spirit Strong Mind

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

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

Using visual aids when talking with your client

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

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

SUPPORTING CHANGE

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

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

WORKING WITH A CLIENT WHO HAS MANAGED TO CHANGE

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

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

RELAPSE PREVENTION

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

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

Things that help prevent relapse include:

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

Coping with cravings

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



The 3Ds approach can help clients manage cravings

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

Identifying and tracking high-risk situations and triggers

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

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

Tips to identify high-risk situations and triggers

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

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

Dealing with high-risk situations and triggers

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

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

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

Working with the client to develop coping strategies

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

Adapted from Strong Spirit Strong Mind

WORKING WITH CLIENTS WHO HAVE HAD A LAPSE OR RELAPSE

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

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

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

Lapse versus Relapse

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

Understanding cultural aspects of a situation

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

PLANNING WHAT YOU WILL COVER IN COUNSELLING SESSIONS

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

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

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

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

Engaging the client in planning and reviewing how counselling is going

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

SOME SKILLS THAT YOU CAN HELP YOUR CLIENT LEARN

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

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

Problem solving

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

Seven steps to problem solving

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

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

Step 2: Identify the problem

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

Step 3: Brainstorming ideas to address the problem

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

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

Step 4: Select the best idea (decision making)

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

Step 5: Develop an action plan

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

Step 6: Try it out

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

Step 7: Evaluate and review how it went

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

Adapted from Strong Spirit Strong Mind

Helping a client to set short-term goals

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

Here are some tips for helping a client set goals:

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

Questions your client can work through in goal setting

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

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

Adapted from Strong Spirit Strong Mind

Forming an action plan

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

How to set an action plan

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

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

Adapted from Strong Spirit Strong Mind

COUNSELLING APPROACHES TO HELP THE CLIENT CHANGE THEIR THINKING

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

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

Challenging irrational thinking – an example

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

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

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

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

What is CBT?

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

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

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

CLIENTS THAT ARE HARD TO GET ALONG WITH

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

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

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

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

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

Some tips to developing a harm reduction plan:

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

WORKING WITH FAMILY

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

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

If the person is still trying to change:

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

If the person has made a change:

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

If the person has relapsed:

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

If the person does not want to or cannot change:

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

Adapted from Strong Spirit Strong Mind

WHEN TO REFER

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

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

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

It is important to recognise your strengths and limitations

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

Working in partnership with mental health professionals or other specialised counsellors

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

Explaining the role of different mental health professionals to your client

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

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

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

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

CONTINUING TO DEVELOP YOUR COUNSELLING SKILLS

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

FURTHER READING

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

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

Case management

OVERVIEW

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

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

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

ASSESSING YOUR CLIENT'S NEEDS

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

Forming a treatment plan

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

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



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

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

COORDINATING AND SUPPORTING TREATMENT

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

ADVOCATING FOR YOUR CLIENT

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

If your client is dealing with Centrelink

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

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

Birth certificate

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

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

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

If your client does not have stable housing

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

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

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



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

If your client is going to court

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

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

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

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

If your client is dealing with child protection services

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

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

If your client needs food or money urgently

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

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

- *Budgeting*

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

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

FURTHER READING

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

Substance and Mental Health Services Administration (SAMHSA) (1998).

Applying case management to substance abuse treatment. Available from: www.ncbi.nlm.nih.gov/books/NBK64857.

The role of medicines

OVERVIEW

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

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

REDUCE CRAVINGS

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

BLOCK THE EFFECTS OF DRUGS OR ALCOHOL (‘ANTAGONIST’)

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

Medicines that block the effects of opioids

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

Medicines that block the effects of alcohol

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

MAKES TAKING ALCOHOL VERY UNPLEASANT ('AVERSIVE AGENT')

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

REPLACEMENT MEDICINES

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

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

Opioid substitution treatment

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

Only available on prescription, methadone and buprenorphine also:

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

Nicotine replacement therapy (NRT)

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

RELIEVE SYMPTOMS OF ALCOHOL OR DRUG WITHDRAWAL

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

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



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

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

TREATMENT OF RELATED MENTAL OR PHYSICAL HEALTH PROBLEMS

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

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

FURTHER READING

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

Mutual support groups

OVERVIEW

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

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

What is recovery?

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

12-STEP GROUPS

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

Alcoholics Anonymous (AA)

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

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

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

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

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

Narcotics Anonymous (NA)

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

Marijuana Anonymous (MA)

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

Family and friends (Al Anon, Al Teen)

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

SMART RECOVERY

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

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

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

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

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

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

ABORIGINAL MEN'S GROUPS

What does a men's group offer?

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

How to start a men's group in your area

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

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

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

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

ABORIGINAL WOMEN'S GROUPS

What does a women's group offer?

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

Where are groups typically held?

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

How to start a women's group in your area

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

HELPING YOUR CLIENTS ACCESS MUTUAL SUPPORT GROUPS

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

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

Residential rehabilitation

WHAT IS RESIDENTIAL REHABILITATION?

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

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

WHEN CAN A CLIENT BENEFIT FROM REHAB?

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

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

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

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

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

WHAT DO REHABS OFFER?

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

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

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

Aboriginal-specific rehabs

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

HOW TO HELP YOUR CLIENT CHOOSE A REHAB CENTRE

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

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

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

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

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

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

How do I refer a client to rehab?

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

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

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



Organising transport to rehab

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

FURTHER READING

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

What can families do?

OVERVIEW

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

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

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

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



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

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

SUPPORTING A FAMILY MEMBER TO STAY IN TREATMENT

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



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

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

SUPPORTING A FAMILY MEMBER WHO CANNOT OR WILL NOT STOP USING

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

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

PREVENTING FAMILY MEMBERS FROM STARTING ALCOHOL OR DRUG USE

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

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

Where to find educational resources for young people

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

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

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

2

Alcohol

<u>Overview</u>	66
<u>What happens in intoxication?</u>	68
<u>When is drinking a problem?</u>	70
<u>Harms from drinking</u>	71
<u>Screening for alcohol problems</u>	76
<u>How to assess a client who drinks alcohol</u>	77
<u>How to help people who want to stop drinking</u>	86
<u>Assessing and planning for alcohol withdrawal</u>	86
<u>What you can do to help someone in alcohol withdrawal</u>	90
<u>Helping a person stay dry</u>	98
<u>Community action to reduce the harms from alcohol</u>	104
<u>Further reading</u>	104

OVERVIEW

As well as harming family and community, alcohol can harm almost every system in the drinker's body. Many mental health problems can also be caused or made worse by drinking.

When someone is hooked on alcohol ('alcohol dependence' or alcoholism) they usually need a lot of support to get on top of it. They often need help with withdrawal and most need help to stay 'dry'. A range of approaches is available including counselling, mutual support groups, rehab and medicines. You can help clients choose which ones suit them best, and they can make use of several different approaches.

This chapter looks at the nature and causes of alcohol problems, how to recognise alcohol problems and give help earlier, and the range of approaches to help someone with alcohol dependence.

History of drinking in Aboriginal and Torres Strait Islander communities

- Traditionally Aboriginal people in some regions made mild alcoholic drinks by fermenting plant products (e.g. sap from 'cider gum' in Tasmania, or crushed pandanus nuts in Borroloola).
- Aboriginal people learned about stronger forms of alcohol and new ways of drinking from outsiders.
- Makassan fishermen (from Indonesia) sailed to northern Australia every year in December, from 1720 or earlier up to around 1907. These fisherman brought strong alcoholic spirits with them, called *arrack*. This drink was introduced to Aboriginal people along a large area of the Northern Territory coastline, and perhaps the Kimberley coast.
- While in Australia, the Makassans would drink until they were drunk. But when they returned home each April, Aboriginal people were alcohol-free again.
- The English and Irish who came with the First Fleet brought rum and brandy. They also often drank until they were drunk.
- Aboriginal people watched the colonists and tried out their drinking styles. Aboriginal people were also encouraged to get drunk and even fight to amuse the audience – some acted drunk when they were not, for fun.

- The authorities issued licences to control the number of hotels, and passed laws to stop the supply of alcohol to Aboriginal people, but these policies were not successful. Aboriginal people experienced many problems in the 1800s because of alcohol.
- Banning the drinking of alcohol by Aboriginal people (and later Torres Strait and Pacific Islanders) started in the 1830s to protect them from being exploited. It was also to 'protect' colonists from drunken Aboriginal people. It was impossible to stop 'sly grogging' though and Aboriginal people then drank in secret, often in the open air. Because they were banned from hotels, Aboriginal people could not access beer, so they drank spirits or port. They were kept out of mainstream social drinking. Aboriginal people often drank quickly so as not to get caught.
- Laws banning Aboriginal people from drinking alcohol were lifted by different states and territories, between 1957 and 1972. There was no planning or training for Aboriginal people to help manage these new drinking rights.
- Since then, communities and governments have (separately or together) tried different ways to reduce the health and social troubles caused by alcohol.

How common are drinking or drinking problems?

Aboriginal Australians are less likely to drink alcohol in any one year than other Australians. We do not have good information on drinking patterns, but we know that many Aboriginal drinkers drink on one day a week rather than every day. In one city-based survey, two out of every five Aboriginal men and one out of every five women drank at least 13 drinks whenever they consumed alcohol.

WHAT HAPPENS IN INTOXICATION?

In small amounts, alcohol makes people feel more relaxed and often slightly 'high'. In larger amounts alcohol affects coordination, decision-making and problem solving skills. So people may have accidents and falls, or get into fights. People may say or do things they regret and act on the spur of the moment (i.e. they are more impulsive or have less inhibitions). In severe intoxication, alcohol can slow down or stop breathing, and cause death (alcohol poisoning).

What happens inside your body when you drink?

There are many types of alcohol, but all contain the active ingredient of ethanol (ethyl alcohol).

Ethanol mixes easily in water, and so travels easily through the body. When a person drinks, it passes from the mouth to the stomach, and then on to the small intestine. From the moment alcohol touches the inside of the mouth a small amount enters the bloodstream (is absorbed). Some more is absorbed from the stomach. However, most is absorbed in the small intestine.

When people eat food their stomach empties into the small intestine more slowly, and this slows down how alcohol is absorbed in the body. So it is good for people to eat while drinking. On the other hand, smoking tobacco or mixing a soft drink with alcohol speeds up the stomach's emptying, so alcohol is absorbed more quickly and the person feels more intoxicated.

Once alcohol is in the bloodstream, it moves around the body and into the brain very quickly.

Women have less water in their bodies because they are smaller and have less muscle. So women generally get a higher blood alcohol level after the same amount of alcohol.

Only a small percentage of alcohol leaves the body through sweat, urine or breath.

Most of the alcohol that enters the bloodstream is broken down into smaller parts (molecules) in the liver. But the liver can only break down alcohol at the same steady rate – about one standard drink per hour. If a person drinks more than one small drink each hour the alcohol can remain in the body, or start to build up. So they stay intoxicated.

What is happening inside the brain when a person gets drunk?

Alcohol turns down activity in the brain, so it is called a 'depressant'.

When a person has just had a little to drink, many people become more confident and talkative, and may do the first thing that comes into their mind (they have less inhibitions). This is because alcohol damps down the parts of the brain that help us stay calm and that control our behaviour.

One way alcohol turns down the brain's activity is by boosting the effect of a brain chemical called GABA (gamma amino butyric acid). GABA's main job is to make the brain slow down. So, because of this effect, small amounts of alcohol are relaxing, but large amounts cause people to lose their balance, see double and not remember things (see *Alcohol and the brain*, p. 200). If people drink far too much on one occasion their breathing may slow down and stop.

Alcohol also works on various feel good chemicals in the 'reward centre' of the brain; this includes the same receptors that heroin works on (opiate receptors), as well as serotonin and dopamine.

WHEN IS DRINKING A PROBLEM?

There are different ways of drinking too much:

- *Risky drinking*: some people may not have had any problems but the way they drink may mean they have a greater chance of injury or long-term harms to their body.
- *Harmful drinking (or alcohol abuse)*: alcohol has already caused harms to the drinker or those around them. Harms can be to the body, mind, family or community. But the person drinks by choice, not because they are hooked on alcohol.
- *Dependence on alcohol (alcoholism)*: this is the most severe type of alcohol problem. The drinker usually has lost some control over drinking.

How much alcohol is too much?

The more a person drinks the greater their risk of running into problems. For example, drinking:

- More than two 'standard' drinks most days means more chance of long-term health problems such as diabetes, cancer or high blood pressure.
- More than four standard drinks on any occasion increases the chance of injury.

A 'standard drink' is a small drink; for example:

- A glass (285ml) of full strength beer, which is less than one can
- A small glass (100ml) of wine
- A standard nip (30ml) of spirits.

In pregnancy: alcohol can harm unborn babies (see FASD, p. 364 and p. 206), so women who are pregnant are best to drink nothing at all. Also, younger woman who might become pregnant should avoid alcohol.

Young people: the younger a person starts drinking the more likely they are to run into problems from alcohol in later life. So it is best for young people (less than 18) to stay away from alcohol altogether. If they drink they should have as little as possible.

HARMS FROM DRINKING

Drinking can cause harms to family and community, to mental health and to nearly every part of the body. For example, harms may be to:

- Family and community: drinkers may lose their jobs, marriages or families because of alcohol. Family violence may happen when people drink too much in one sitting, not just when they are hooked on alcohol (dependent).
- Physical health: people with alcohol problems may come to the GP or clinic with injuries or various health problems from alcohol. Health professionals may not always realise that alcohol is the cause.
- Mental health: alcohol tends to make any mental health problem worse; and regular use can cause disorders like depression or anxiety.

Harms can be:

- Short-term: from even one occasion of drinking, or
- Long-term: from regular and ongoing drinking. These long-term effects on the body are most often seen after years of drinking.

Short-term harms from drinking

Even a single occasion of drinking can cause short-term harms like:

- Injuries
- Violence
- Suicide
- Relationships problems (that can go on long after the drinking stops)
- Drownings
- Burns
- Having sex that was not planned or protected (leading to unwanted pregnancies, infections, and relationship and cultural problems)
- Money problems (including gambling)
- Alcohol poisoning (loss of consciousness and risk of death).

Alcohol's effect on behaviour and the body depends on

- How much alcohol the person drinks
- How long a person has been drinking that day and how quickly: six drinks over one hour will make a person more intoxicated than six drinks over 12 hours. But, even having six drinks spread over every day can still cause long-term harms to the body.
- Other drugs used: some drugs increase the effect of alcohol and can cause overdose (e.g. benzos, heroin, and painkillers containing codeine or morphine).
- How many months or years the person has been drinking: regular drinkers find they need more alcohol to feel its effects. These 'tolerant' drinkers may not appear drunk, but are more likely to get long-term harms from alcohol such as diabetes, or brain damage.
- Physical health: alcohol can make other major health problems worse (e.g. liver disease, heart disease, high blood pressure or diabetes). Their diet also makes a difference, as alcohol can cause the body to be short of vital vitamins (especially thiamine – vitamin B1).
- Mental health: when drunk, alcohol makes any feelings stronger (e.g. makes a person feel even more sad, or more angry). When used regularly, alcohol can also cause anxiety and depression. This is a trap, as drinking may make a person feel better, but all the while it is quietly making things worse.
- A person's body make-up (biological reasons): women generally feel the effects more than men from the same amount of alcohol. Also, some families have a greater chance of alcohol problems than others. This is partly because of the genes we inherit, and partly because of what each person is exposed to in life (e.g. traumas, or lots of drinkers around them). People sometimes say that Aboriginal people's bodies handle alcohol differently from non-Aboriginal people, but there is no evidence for that.

Long-term harms from drinking

Alcohol can cause long-term harms in nearly every system of the body:

System	Problem
<i>Mental health</i>	• Sleep problems • Anxiety • Depression • Makes any existing mental health problem worse
<i>Brain and nerves</i>	• Alcohol withdrawal • Confusion and/or staggering: Wernicke's Syndrome – a brain disease from not having enough thiamine (vitamin B1) • Loss of memory: from mild to very severe (e.g. in Korsakoff's Syndrome) • Dementia • Numbness/tingling from damage to nerves in arms and legs (peripheral neuropathy)
<i>Stomach, gut, pancreas</i>	• Heartburn (gastro-oesophageal reflux) • Nausea, pain from inflamed lining of the stomach (gastritis) • Pain from pancreatitis: irritated pancreas from heavy drinking. The pancreas is a small organ that helps with digestion and controls the release of hormones such as insulin. The pain can be sudden and severe then settle (acute) or it can stay around for a long time (chronic).
<i>Liver</i>	• Fatty liver – where the liver is enlarged • Alcoholic hepatitis: inflamed liver from heavy drinking – may have some pain, and liver may feel larger than normal and tender; may have yellow 'whites' of the eyes ('jaundice') and yellow skin (in clients with lighter skin; see Jaundice, p. 202) • Cirrhosis: scarred liver from long-term drinking (see Cirrhotic liver, p. 202). Scar tissue starts to block the normal blood flow through the liver. This can lead to bulging blood vessels in the oesophagus or fluid in the belly (ascites) and legs (oedema). If bulging blood vessels (varices) in the oesophagus burst, then the person can vomit very large amounts of blood quickly.

System	Problem
<i>Bones</i>	• Bones become less dense (less solid) and break easily (osteoporosis). They also heal more slowly after breaks.
<i>Blood</i>	• Tiredness or shortness of breath from effects on red blood cells ('anaemia') • Bleeding or bruising: alcohol or liver damage can make it harder for blood to clot properly.
<i>Heart</i>	• High blood pressure • Abnormal heart rhythm (fast and irregular) • Weak heart muscle (cardiomyopathy)
<i>Lungs</i>	• Increased chance of developing severe chest infections, including pneumonia and tuberculosis
<i>Kidney</i>	• Alcohol can hurt weak kidneys in two ways: by causing high blood pressure, or by making people 'wee' (pass urine) more and get dehydrated (loss of fluid) mainly in hot climates. • If someone has kidney failure, they cannot clear away all the fluid from alcohol and it can build up.
<i>Body chemistry (metabolism)</i>	• Vitamin deficiency (especially thiamine), e.g. causing confusion (Wernicke's Syndrome) • Shortages of other important vitamins or of healthy food, causing sickness • Very overweight (obese) • More likely to develop diabetes; more problems getting diabetes under control (high or low sugars) • Natural salts out of balance (e.g. low magnesium causes seizures; low sodium can cause confusion or severe illness)
<i>Joints</i>	• Gout: joint pain due to build-up of crystals in the joint tissues
<i>Hormones and sexual function</i>	• Sexual problems: impotence from low levels of male hormone (testosterone) • Breast enlargement in men ('man boobs'): from changes in the balance of female and male hormones because of liver problems.

Why does alcohol cause long-term harms to the body?

If a person regularly drinks too much (e.g. above recommended limits), they can develop long-term harms to many parts of their body. One reason for this is because alcohol is broken down in the body, by steps. Along the way, alcohol is changed into various other chemicals. One of these chemicals (acetaldehyde) is very harmful to the body. It causes cancers and causes damage known as ‘oxidative stress’. In the brain, damage is made worse by a shortage of thiamine (Vitamin B).

How to recognise alcohol dependence

If a person drinks at a risky level regularly over months or years they may become dependent on alcohol. Sometimes it is very obvious when someone is dependent on alcohol; they may be drinking very large amounts, and their life or health may be falling apart because of their drinking. Or the person may have very clear alcohol withdrawals when they stop. But other times the picture is not as clear. The person may drink a lot, but you are not clear whether this is by choice or whether they are losing control over their drinking. They may not drink every day and there may not be any withdrawal symptoms when they stop. For people like this, you need to ask specific questions to check for the presence of dependence (Assessing dependence, see p. 78).

How to recognise alcohol withdrawal

Some (but not all) dependent drinkers feel tense or uncomfortable when they stop drinking and have poor sleep. Others also experience ‘the shakes’, sweating, vomiting and diarrhoea. Severe withdrawal can be a life threatening sickness, and the person may be confused, paranoid, and see things that are not there. Alcohol withdrawal and how to manage it are described in more detail on p. 86.

How common is alcohol dependence and withdrawal?

Around one in 20 people in Australia (4%) are dependent on alcohol, and may be at risk of alcohol withdrawal. Some Aboriginal Australians do not have daily access to alcohol (e.g. because they run out of money or live in a ‘dry community’), and these individuals may get less severe withdrawals or no withdrawals when they stop.

SCREENING FOR ALCOHOL PROBLEMS

It is often easy to detect a severe drinking problem, but milder problems can be missed. It is important to ask every person coming to a health service (and to settings like corrections) about their alcohol use so that they can be given a chance to think and talk about their drinking. Then help can be offered, where needed.

You can quickly screen for a drinking problem by asking 2–3 simple questions as part of an adult health check:

- How often do you drink?
- How many drinks do you have on a day when you are drinking?
- And (if it is not already clear): How often do you have six or more drinks on one day?

You can change how you ask these questions to suit your own setting and style. For example, instead of the third question (above), some people ask: “What about pay day or funerals?” This is to get a feel for the drinking on possible heavy days.

Tools to help you screen for an alcohol problem

There are tools available to help you quickly check for an alcohol problem. These are used as part of a routine health check. If there is any hint of an alcohol problem, you then assess the drinking more fully to work out how severe it is.

- *AUDIT-C*: three simple questions on how much and how often people drink (see *AUDIT-C*, p. 426).
- *AUDIT*: 10 questions that ask about alcohol use, symptoms of dependence and related harms (developed by the World Health Organization; see *AUDIT*, p. 424).
- *IRIS (Indigenous Risk Impact Screen)*: a brief questionnaire that asks about alcohol, drug and mental health problems; developed by and for Indigenous Australians (see *IRIS*, p. 427).

The aim of these screening questions is to pick up a problem that you might not know about or that the client may not be aware of.

HOW TO ASSESS A CLIENT WHO DRINKS ALCOHOL

If a client comes to you for help with drinking, or you suspect they have a problem with alcohol, you need to assess their drinking carefully. How you do this will depend on your setting.

Often it works best to start with just hearing the client's story. After getting a feel for what is going on and what are your client's main concerns, you can find out about specific points. Try to avoid writing at first, so the client can see that you are really listening.

Taking a drinking history in a remote setting

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

Drinking history

An important step is to find out about the client's pattern of drinking. You can ask:

- How much do you drink?
 - How big is the glass? Drinks poured at home are usually bigger than 'standard' drinks.
 - If the client cannot give you the number of glasses, ask: "How many people were sharing the cask?" Or, for people who drink alone: "How long does it take you to go through a case of beer?"
 - Some people might tell you the amount that the group drinks, not what they drink themselves. Try to find out how many people usually share the cask of wine, and roughly how much your client drinks.
 - Ask what type of alcohol the client drinks. If they tell you (for example) about beer, also ask about wine and spirits.
 - Sometimes you can make the client more comfortable to admit to heavy drinking if you suggest a high amount, e.g. "How many cases do you get through in a day?"

- How often do you drink (and how)?
 - Do you drink with friends or family? For daily drinkers, ask: “What time of the day do you start drinking?”, “Do you drink with food?”, “Do you have any days off, when you are not drinking?”
- About withdrawal:
 - Ask: “What happens if you stop drinking? Do you become unwell or uncomfortable; do you feel uptight (anxious), get the shakes (tremor), or have problems with your sleep?”
 - If the person has not stopped drinking, ask: “What are you like in the morning, before your first drink?” Or are they drinking to avoid getting withdrawals? (see Assessment of withdrawal, p. 86).
- About dependence on alcohol
 - You need to find out if the person is dependent on alcohol because, for dependent drinkers, stopping drinking is usually the only option that will work. Knowing this will also help you work out how much support the client might need.

How to assess if your client is dependent on alcohol

If a person gets alcohol withdrawal, then it is clear that they are physically dependent. But some dependent drinkers do not get withdrawal. You can find out if a drinker is psychologically dependent by checking if they have three or more of the following features:

- *A strong desire to drink (craving) or has to drink (compulsion)*: ask, “If there is no alcohol around, do you think about it a lot? How much do you miss it?”, “Do you feel you drink because you want to, or because you need to?”
- *It is hard to control drinking*: ask, “Have you tried to cut down or stop?” Their answer will show if they found they could not. You can also ask: “How easy would it be to stop?” and “Do you find you drink more than you plan to?”
- *The person needs more alcohol just to feel its effects (tolerance)*: are they drinking a large amount and can still walk and talk normally? Or you can ask: “How much do you need to drink to get the effect you are after? Did you always need that much?”
- *Withdrawal (see above)*.
- *Alcohol becomes ‘number one’*: is the person still able to do other activities they used to do (e.g. work, sport, music, spending time with family and friends)? Or are they doing these less because of drinking, or have they stopped doing them altogether? You can ask the client to describe their typical day and see if most of their time is spent drinking.
- *Keeps drinking in the face of clear harms*.

Try to get an overview of the person's lifetime drinking history. You can ask:

- What age did you start?
- Roughly, how much of your life have you been drinking, and how much have you been 'dry'?
- What are the major harms that drinking has caused (e.g. to physical or mental health, family and community)?

Consider local culture and views on causes of sickness

In some communities, traditional beliefs may lead people to think that alcohol-related sickness and death (even alcohol-related road accidents) are not caused by drinking but happen because of sorcery and black magic.

Past treatment or approaches to stopping:

- In the past, have you managed to stop drinking? If so, what worked to achieve this; what did not work?

How ready is your client to change right now?

- If the client is not yet ready to change, you may be able to get them thinking about change (see Stages of change, p. 199 and p. 423; Brief intervention, p. 82).

Other drug use

Ask the client about their other drug use, including benzos (see Benzos, p. 173).

Alcohol and other sedative drug use

If a person is withdrawing from benzos and alcohol at the same time, withdrawal can be more severe. Also, being intoxicated from benzos or heroin at the same time as drinking can increase the chance of overdose (see Alcohol overdose, p. 103).

General health and other issues

Are there major issues going on right now that will affect the client's drinking, or that the drinking will affect (e.g. physical or mental health, family, community, cultural or legal issues)?

Seek extra information from family or others

Some drinkers report their drinking as less than what it really is. The most common reason for this is shame, though other people may be worried about getting into trouble with the law or with child protection agencies. Also, some people with alcohol problems can have memory problems or can be too drunk to remember what they drank. It can be useful to get extra information from family and friends, but only if your client says that this is okay. Talking to family members is also important because often the client's drinking impacts on them, and they may need your support. Family may also be able to support the drinker to make a change.

Your observations

What you notice tells you some more about your client's drinking. Is your client:

- Intoxicated (slurred speech, unsteady, smells of alcohol)?
- In withdrawals (restless, tremor, sweaty palm of hands)?
- Showing signs of liver damage (yellow 'whites' of the eyes, swollen legs or belly, many bruises)?
- Staggering even while sober (this damage to the part of the brain that controls balance; or could mean there is Wernicke's Syndrome)?
- Confused or seeing things that are not there?
- Does what the client says match how they look? For example, if they say they are ready to change, do they appear convinced of this, or are they still not sure?

If you are trained to do a physical examination, is:

- The liver enlarged?
- Blood pressure, pulse or temperature raised (as in withdrawal)?

Summing up after your assessment

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

- Whether their drinking is:
 - At a level that could give them problems in the future (risky or hazardous drinking)
 - Is already causing significant harms (harmful drinking), or
 - Is dependent, and, if so, will they need help with managing withdrawal
- What sorts of help they have tried in the past
- What are their other key health issues (physical and mental)
- What are the other key family, community or cultural issues that are relevant to their drinking.

Getting a person thinking about their drinking (brief intervention)

Sometimes a person may not realise that their drinking is putting them at risk of future problems. Or they may already be having difficulties in their life, or be causing problems to others, but they have not linked these in their mind to their drinking. Other people may know they are drinking too much, but are not yet ready for change. When health clinics, hospitals or other settings ask everyone about alcohol use, this can allow a drinking problem to be picked up earlier, and the drinker can have a chance to step back and think about change. Even a brief conversation with a person can be a chance to get them thinking. This short conversation on alcohol is often known as ‘brief intervention’.

Picking up an alcohol problem when someone is there for something else

When a client has come to a health clinic for some other reason (e.g. for a chest infection) or is in a setting like corrections or probation, it is a chance to find out about their drinking. For example, services can include three quick screening questions on alcohol in the adult health check or they can use another short screening tool (see Screening, p. 76). Every client is asked these questions, so no one has to feel they are being shamed or singled out. If an alcohol problem seems likely, you can then ask a few more questions to see if the client is dependent on alcohol and to work out if they have already started to think about changing their drinking (see Assessment, p. 78).

Getting your client thinking about their drinking

Whether this is the first time your client has tried to change their drinking, or if they have tried many times before, a short conversation can help get them thinking about their drinking. It may help get them more ready for change.

Some points to remember:

- It is your client's right to choose if they drink. Your job is not to tell the client what to do, but to use every chance to get them thinking about their drinking. If you give them a plan to stop drinking, it is your plan. If they come up with a plan to stop drinking, then it is their plan, and is much more likely to work. You can also help the client make sure that their plan for change is achievable.
- Alcohol does not just harm the client. Remember that the client's drinking is like a stone being thrown into a pond. The ripples can go out and affect their family, their friends and the whole community.
- Try to step in your client's shoes. Work out what matters to them, and what factors might make them want to change their drinking. If family, community, land and culture are important to them, then try to help the client think about how drinking affects these.

The steps of brief intervention can be summarised by the word 'FLAGS'

F

Feedback

Listening to the client's story, and reflecting back with them, on what harms alcohol or drug use might be causing.

L

Listen

What stage of change are they at?

A

Advise/assist

Share information that you have which might help your client make a decision about their substance use.

G

Goals

What goals is your client prepared to accept? Cutting down? Stopping? Having someone care for the kids when they're using?

S

Strategy

Help your client identify steps or strategies to reach this goal. Is further support or treatment needed?

Feedback

- Feed back to the client parts of the story that they tell you ('reflective listening'). This can help them step back and understand their drinking better. It can make a clearer link in their mind between their drinking and the problems it is causing them, their family and community. For example: "You mentioned that it bothers you that your kids are scared when you've been drinking?"
- Try to give this feedback in a gentle way, like you are 'standing in their shoes' (i.e. with empathy). For example, you might say: "That was a tough time for you, those problems with the cops, last time you were drinking". Feedback should never be judgemental.
- Feedback can be a good way of starting a conversation about drinking. For example: "You know that screening test you filled in on drinking? Can I tell you about your results?"
- Feedback on raised blood tests for the liver can also help start this conversation (see Blood and other tests to assess drinking, p. 430).
- Help the client weigh up the good and not-so-good things about drinking (see Motivational interviewing, p. 24).

Listening

Showing that you are listening to the client is important. You should be able to pick up how ready they are to change. The Stages of Change picture can help you (or your client) think through where they are at in terms of changing their drinking (see Stages of change, p. 199 and p. 423).

If someone is happy with their drinking, then your conversation might help them get them to the point of thinking about change. However, if they are just thinking about change, you might be able to support them get to the point of taking action. Any progress is good.

Advise/assist

Sometimes the client may not realise that a particular problem is linked to alcohol. For example, they might have sleep problems and feel stressed every morning. You may be able to share with them what you know. For example, that sleep problems and anxiety in people can often start to get better a few weeks after stopping drinking. Try to be familiar with health problems that can be linked to alcohol, or get a resource to explain these (see Alcohol and the body, p. 201; Short-term harms, p. 71; Long-term harms, p. 73).

Sharing what you know about how much simpler life can be when alcohol is under control can be powerful.

If the person is drinking just a little over the recommended limits, but not experiencing any harms, they may be interested to see a chart of the health guidelines about drinking levels. This can show them how to reduce their chance of developing health problems like diabetes or cancers.

Sometimes, culturally, you may have the right to tell a client what to do. Or sometimes as a health professional you will have the authority to recommend a change. But most often your role is to help the person reach a decision themselves. Always respect the client's right to choose if they drink.

Goals

What goals is your client prepared to accept? Do they want to stop drinking, cut down, or reduce the harms of drinking? Or are they not ready to make any change yet?

Strategies

If your client is ready to make a change in their drinking, help them think through how they will reach their goals. Thinking about some practical strategies can make change more likely.

Tips for drinkers who would like to cut down

- Avoid friends when they are drinking or limit the time spent with them
- If being asked to drink, have an excuse ready: e.g. "I'm getting fit" or "My doctor has told me to cut back" or "It makes my sugars go out of whack"
- Drink only with food
- Have water when thirsty and between drinks
- Choose low alcohol beer
- Switch to a smaller size glass.

There are a number of visual aids available to help you give brief intervention. You can choose what best meets your needs or create your own resource (see Further reading, p. 104).

People who are dependent on alcohol usually find it impossible to cut down. For them, stopping is usually the only option. The following sections deal with strategies to help a dependent drinker stop drinking and stay dry.

HOW TO HELP PEOPLE WHO WANT TO STOP DRINKING: OVERVIEW

People with more severe problems may need a lot of help and support, including treatment of withdrawal and approaches to help them stay dry.

Deciding on a plan to tackle alcohol

The information you put together from your assessment of the client's drinking will help you and your client come up with a safe and sensible plan for stopping drinking. For most clients there are two main elements to this plan:

- *How to manage withdrawal:* Try to work out whether your client will go through withdrawal. If withdrawal is expected you can help them choose the right place for it to be safely completed. Also, if a person knows that they can get help for their withdrawal symptoms, this can give them the confidence to stop drinking.
- *How to stay dry:* Stopping drinking is only the first step, and staying dry is usually the bigger challenge. Once the client's withdrawal is under control, they can be offered support to help stay dry, such as counselling, group support and/or medicines. Other clients may prefer or need to go to a rehab.

ASSESSING AND PLANNING FOR ALCOHOL WITHDRAWAL

Alcohol withdrawal can vary from being very mild and hard to notice, through to being a severe life threatening illness. Withdrawal usually starts within a day of stopping drinking and lasts less than a week. It is important to be sure that the client is safe during withdrawal.

The most common symptoms of withdrawal are:

- Sleep problems (insomnia)
- Anxiety
- Tremor
- Sweating
- A strong desire to drink (craving).

The more severe the withdrawal, the longer it lasts:

- *Mild*: poor sleep for a few nights, a bit stressed by day, feels anxious or mildly restless. Typically lasts 1–3 days.
- *Moderate*: tremor, anxiety, sweating, diarrhoea and vomiting, fast heart rate, raised blood pressure and temperature. Finishes within a week.
- *Severe*: may include hallucinations and confusion, as well as the other features of withdrawal. This type of confusion is called 'delirium tremens' (DTs) and needs urgent medical treatment (see DTs, p. 96). People with DTs can die if not treated quickly. DTs can last up to 10 days.
- *Seizure (fit)*: a seizure can be life threatening; it may also be a warning sign of a more serious withdrawal that is still developing. It is most common on the first day after stopping drinking.

How soon after drinking is withdrawal at its worst?

- *Moderate withdrawal*: usually peaks at 48 hours and finishes within a week.
- *Severe withdrawal*: can continue to get worse for longer, peaking at day 4; it also lasts longer (up to 10 days).
- *Seizure*: if it occurs, is often in the first 24 hours after stopping drinking.

Will your client experience a withdrawal?

When a person plans to stop drinking it is important to try to work out if they will experience withdrawal, and how severe it will be. This helps you to discuss with the client the best place to stop drinking (e.g. at home, 'out bush' away from their community, or in a detox unit or hospital). It also helps you work out if the client needs a medical assessment before stopping drinking.

Find out about your client's past withdrawal experience:

- What happened when they have stopped or cut down before?
- Have they had withdrawal symptoms? If so, what? "Do you have sleep problems, or feel tense, or get the shakes?" Your client may not realise that these symptoms are part of withdrawal.
- If the client has never tried to stop drinking, ask what they feel like each morning before their first drink. "Do you feel tense or bad tempered? Do you get tremors (the shakes)?"
- Have they ever had severe withdrawal symptoms like seizures or DTs?

Withdrawal is likely to be more severe in a person who:

- Drinks more alcohol on a drinking day
- Drinks often
- Has been drinking for longer (e.g. more weeks or months) during this latest period of drinking
- Has been drinking for several years altogether
- Is dependent on alcohol (see Assessing dependence, p. 78)
- Has had significant withdrawals in the past.

Severity of withdrawal varies from person to person

- Not all drinkers who are hooked on alcohol (dependent) get physical withdrawal symptoms.
- Sometimes a person who has been drinking heavily for many years can stop without much withdrawal. This may be due to differences in a person's make-up (i.e. genetic factors).

Where should withdrawal take place?

You can help a client choose the best place to go through alcohol withdrawal. If there is any doubt on the best setting, talk with the client and an experienced doctor or specialist advisory service. In general if you are expecting a:

- *Mild withdrawal (e.g. sleep problems, anxiety only)*: many people can stop drinking at home (or 'out bush') without medical help.
- *Moderate withdrawal (e.g. tremor, sleep problems)*:
 - This can sometimes be managed at home with the help of a doctor. It is best if the drinker sees the doctor before stopping drinking.
 - Other clients need to go into a detox unit (or hospital) because their home environment is not suitable or because they have trouble stopping drinking, or for medical reasons.
 - Valium (diazepam) can be prescribed by the doctor and given during the withdrawal (for 1–7 days) to relieve symptoms and to prevent complications such as seizures or DTs.
- *Past seizure or severe withdrawal (e.g. seeing things that are not there, very unwell during past withdrawal)*: it is best if the client can go into a hospital or detox unit where they can be given diazepam and be monitored carefully.

Wherever the withdrawal is managed, clients will benefit from knowing they are in a safe environment, and from support and reassurance.

Clients who may be suitable for home detox:

- Have never had seizures or a severe withdrawal (for example, with hallucinations)
- Are relatively healthy (mentally and physically)
- Have support people around who do not drink. If others around them are drinking, it may be better for the client to go to a household with non-drinkers or to a dry community or other dry place to go through withdrawal.

Getting remote clients to a safe spot

If the client has had severe withdrawals in the past, and lives in a remote community with no medical help, it is better if they plan to go through withdrawal somewhere where medical help is available.

Clients who are best going through withdrawal in a detox unit or hospital include those who:

- Have had seizures or severe withdrawals in the past (including DTs). Their next withdrawal can be severe even if they have only restarted drinking a short time ago.
- Have another serious illness (e.g. pneumonia, unstable diabetes, kidney failure, epilepsy). These clients are more likely to get severe withdrawal symptoms and are better managed in a detox unit that can give diazepam or hospital.
- Have serious mental health problems (e.g. very depressed, suicidal or psychotic).
- May withdraw from another drug (benzo withdrawal is particularly risky when happening at the same time as alcohol withdrawal).

WHAT YOU CAN DO TO HELP SOMEONE IN ALCOHOL WITHDRAWAL

The health worker has an important role in making sure the client is safe and in supporting the client and their family. For example:

In mild withdrawal (e.g. anxiety, sleep problems), if this is managed at home, then family members or other support people should be told:

- The person will need plenty of fluids, encouragement and reassurance
- What withdrawal symptoms to expect
- What to do if things go wrong. Call for medical or nursing help if:
 - Someone has a seizure: first lie them on their side in the coma position (see CPR guide, p. 436); call for an ambulance if available.
 - Withdrawal symptoms get worse.

If the client's withdrawal is moderate (e.g. tremor, anxiety):

- Support them to see a doctor who can arrange diazepam to help with withdrawals. For a home detox, diazepam is given to the client daily. Usually only a nurse, doctor or pharmacist can give it out.
- Monitor how the client is feeling during the withdrawal. An alcohol withdrawal scale is a good way of keeping track of the client's progress.
- If the withdrawal is not well controlled, arrange to transfer the client to a detox unit or from the detox unit or hospital.

If the client has a seizure or more severe withdrawal (including DTs, severe vomiting, agitation):

- Transfer them to a hospital (or if not available to a detox unit that can offer diazepam). In DTs, withdrawal symptoms need to be monitored every hour until they come under control.

How to monitor alcohol withdrawal

It is important to monitor withdrawal carefully to check that it is staying under control and that treatment is right. For a home detox a daily check is usually enough. Sometimes the client is asked to come into the clinic daily (this is known as 'ambulatory detox'). If a trained nurse is available for home visits, they can check the client and they can also give them diazepam for that day if needed. In a detox unit or hospital, if a more severe withdrawal is expected, the client may be monitored every four hours or more often.

These are the withdrawal signs that are usually monitored:

- Sweating
- Tremor
- Anxiety
- Agitation/restlessness
- Hallucinations – does the client appear to be seeing or hearing things that are not there?
- Temperature
- Orientation (e.g. does the person know what day it is and where they are?).

Using an alcohol withdrawal scale

Alcohol withdrawal scales are useful to assess and monitor alcohol withdrawal (e.g. see AWS, p. 432). These can help monitor whether the client is getting better or worse. They can also help clinicians decide how much diazepam is needed.

Some tips for using a withdrawal scale:

- Score the signs of withdrawal that can be seen, from 0 (when not present at all) through to the top score, when there are severe signs.
- If the score is getting higher the withdrawal is probably getting worse and more diazepam and/or a review by a doctor is needed.
- Conditions like chest infections, anxiety or other mental disorders can also raise the score on a withdrawal scale. If someone has a problem like that, get a medical review:
 - Sometimes the doctor will tell you to take less notice of some items in the scale, e.g. if a person is always anxious even when sober for months, you may take less notice of the anxiety score. Or if they have a fever from a chest infection, you may ignore the temperature item.

Use of diazepam in alcohol withdrawal

Diazepam (e.g. Valium) controls the symptoms of alcohol withdrawal and makes seizures and more severe withdrawal less likely. If it is given daily, with careful supervision, it can be life saving. If a person has a history of seizures or severe withdrawal it is important for them to see a doctor before stopping drinking if possible, or if not as early as possible. The doctor can then organise for diazepam to be given soon after the person stops drinking to prevent these problems. Seizures can occur on the first day after stopping drinking. Sometimes the seizure happens before there are other signs of withdrawal.

There are risks in using diazepam:

- Too much can make a person too sleepy or even become unconscious and stop them breathing.
- If a person keeps taking the diazepam for six weeks or more, they may become dependent on it.

Because of these risks, only certain health professionals (e.g. doctor, nurse or pharmacist) are allowed to give the client diazepam.



Tips for using diazepam safely

- Careful supervision by a health professional and/or family member is needed.
- If the person is going through withdrawal at home, arrange for the diazepam to be given out daily (this also allows for daily monitoring of the withdrawal).
- The client needs to avoid driving and take care when crossing roads.
- Stop the diazepam if the person starts drinking again or if they seem sleepy.
- Take special care in clients with bad livers, who are older, or who have lung problems; a doctor will sometimes advise a shorter acting benzo (like Serepax, which is oxazepam) for these clients.
- Use diazepam no more than one week (except up to 10 days for DTs).

Diazepam can be prescribed for alcohol withdrawal in three ways:

- A fixed dose regime
- As needed, where the dose given varies according to the client's score on a withdrawal scale
- A loading regime (higher doses early on).

The doctor decides which regime will work best for the client and their setting.

Fixed diazepam regimes

Fixed regimes are often used during home detox (outpatient or ambulatory withdrawal). They are also sometimes used in detox units or hospitals.

- If a person has a history of withdrawal seizures but cannot be managed in hospital, this regime can help prevent seizures.
- A typical regime for mild to moderate withdrawal is shown below. Up to eight (5mg) tablets (i.e. 40mg in total) are given daily for the first two or three days. Then the dose is gradually cut down to nothing within a week.
- If a person is expected to have a milder withdrawal, lower doses may be enough.
- The regime can be adapted to fit how the withdrawal is going.

Adjusting the diazepam regime to fit the client's needs

- Extra diazepam may be prescribed to keep withdrawal symptoms under control (e.g. to keep the alcohol withdrawal scale score below the recommended cut off (e.g. below 4 for AWS, or below 10 for CIWA-AR).
- If the client needs more than 12 (5mg) tablets (i.e. 60mg in total) of diazepam in one day, then they may need to be moved to a detox unit that can provide diazepam or a hospital, as this means that they are having a severe withdrawal.
- If the person is sleepy during the day the diazepam dose may be too strong for them. They should talk to a doctor or nurse before taking any more.

'As needed' diazepam regime

This method is often used in hospital or detox units if it is not clear if the person will experience an alcohol withdrawal.

- The withdrawal scale is measured every four hours (or more often if a severe withdrawal is expected), and the amount of diazepam is adjusted to fit how severe the withdrawal symptoms are.

Diazepam loading regime

This 'upfront loading' regime is sometimes used in 'inpatient' (live in) detox units. Up to four (5mg) diazepam tablets are given every two hours, until the client is mildly sleepy, then less is given on later days. This regime is not used for home withdrawal, as the person will usually become sedated.

Further information on the different diazepam regimes to manage withdrawal can be found in the National Guidelines for Treatment of Alcohol problems (see Further reading, p. 104).

Tips for managing withdrawal

- Monitor the withdrawal regularly.
- Diazepam (or other benzos) need to be used very carefully (see Diazepam tips, p. 92) and should be stopped within 7–10 days.
- Seek review by a doctor (or if not available, an experienced nurse) if the withdrawal does not behave as you expect:
 - If withdrawal is still not under control after 12 tablets (60mg) for a home withdrawal or 18 tablets (i.e. 80mg) of diazepam in a detox unit, the doctor can check if there is another health problem going on, or see if benzos are needed through a drip. A number of serious medical conditions can have symptoms that can look like withdrawal.
 - If the client becomes confused, it could be that they are getting the DTs and need more diazepam, or it could be they had too much diazepam. Also a number of serious medical conditions can cause confusion, including shortage of thiamine or low or high blood sugars.
- Make sure the person has plenty of fluids. People in withdrawal may get too dry (dehydrated) because of fever, sweating, vomiting or diarrhoea. They should drink more water than usual or if they are vomiting they may need intravenous fluids (through a 'drip' into the vein).
- Give thiamine to prevent brain damage from vitamin shortage.

Other problems that can look like withdrawal

Sometimes it can be hard to know if what the client is going through is caused by withdrawal or by another health problem. Several health problems can give a raised score on a withdrawal scale; for example:

- A fever from any infection can make a person sweaty and their heart beat fast.
- If a person is anxious for any reason, they may have a tremor or be sweaty.
- A severe chest infection with shortness of breath can make a person anxious, make their heart beat faster and give them a raised temperature.
- A head injury or abnormal blood sugars in diabetes or vitamin B shortage can cause confusion.

If the person stopped drinking more than 10 days ago, then any sickness they are experiencing is *not* linked to alcohol withdrawal. There must be another reason for it.

If you think that something else could be going on, ask for a skilled doctor or nurse to assess the client as soon as possible. If there is no doctor or nurse available, get phone guidance from a specialist advisory service (see Specialist advice, p. 435).

Thiamine (vitamin B1)

People who are dependent on alcohol may become short on essential vitamins and minerals because:

- They may not be eating properly.
- Their stomach lining may be irritated and swollen (inflamed) which makes it hard to absorb some of these nutrients.
- Alcohol can make it hard for the body to make use of thiamine (vitamin B1).

A shortage of thiamine is common in people with alcohol dependence. This can lead to a sickness called Wernicke's Syndrome, which can cause severe and permanent brain damage (see p. 97).

All people going through alcohol withdrawal should have extra thiamine to prevent this:

- Tablets may be enough if the client has been eating a healthy diet, and alcohol dependence is not severe. Give 100mg tablet, three times each day for the first five days.
- Injection into the muscle (intramuscular or IM) is safest if there is vomiting or stomach pain, if the person has not been eating well, or if alcohol dependence is severe.
- Injection into the vein (intravenously or IV) is needed if the client is confused, or if there is any other reason to suspect Wernicke's Syndrome.
- The client can continue thiamine tablets (1–3 times each day) for a few weeks.



Give thiamine as soon as possible for very heavy drinkers

Try to give thiamine as soon as a heavy drinker comes into detox and before they have sugary drinks or sweet food. Giving sugary drinks or food (or glucose in a drip) first can trigger Wernicke's Syndrome and lead to permanent memory loss.

Always have some thiamine on hand. If you are caught out without thiamine, toast and vegemite is safer than sweet foods.

The one exception to this rule is when a person has diabetes. If their blood sugar might be low (e.g. they had their insulin or diabetes tablet, then missed a meal), they may need sugar urgently.

Managing the complications of withdrawal

Delirium tremens (DTs)

As described above, DTs are a severe form of alcohol withdrawal and a life threatening condition. The client needs to be urgently transferred to a high dependency unit (or ‘intensive care unit’) in hospital. In remote areas a medivac is usually needed.

The features of DTs usually include:

- Confusion
- Not knowing when or where you are (disorientation)
- Seeing, hearing or feeling things that are not there (hallucinations)
- Severe fear of things that are not real (paranoia).

These features occur along with the other symptoms and signs of withdrawal, such as sweating, diarrhoea, vomiting, rapid pulse and high blood pressure.



Medical treatment is needed urgently in DTs to avoid death from dehydration, heart attack, stroke or suicide. Without medical treatment, up to one in every six individuals with DTs may die. DTs can be prevented if withdrawal is treated well from the start.

There is a higher chance of severe withdrawal and DTs if your client:

- Has more severe alcohol dependence and over a longer period of time
- Has had severe alcohol withdrawals in the past
- Has any recent onset (acute) and/or severe medical conditions
- Has had recent surgery (an operation)
- Is older.

The prompt treatment for DTs is needed, for example:

- Diazepam or related medicine (midazolam) is usually injected into the vein by a doctor or nurse. This is done carefully, in small doses at a time, to prevent breathing problems. Sometimes midazolam is given constantly and slowly through a 'drip'.
- An anti-psychotic drug may be given to help with hallucinations or agitation (e.g. olanzapine).
- The fluid balance is monitored (i.e. the amount of fluids taken in compared with the amount of urine) and the client usually needs a drip (intravenous fluids).
- Thiamine is given direct into the vein or through the drip.
- A calm environment helps to reduce anxiety and agitation.

Wernicke's Syndrome

As explained earlier, Wernicke's is a serious brain sickness (encephalopathy) that is caused by a lack of thiamine in the body. Wernicke's can happen in alcohol withdrawal or while your client is still drinking. Without treatment Wernicke's can lead to coma and death or to permanent, severe memory loss.

Signs of Wernicke's can include:

- Staggering and being unbalanced when trying to walk (ataxia), even when sober
- 'Eye signs' – jerking, flickering movements of the eye (nystagmus) or paralysed eye muscles (i.e. not being able to move the eyes from side to side). The client may have double vision
- Confusion or short-term memory loss.

If you suspect Wernicke's, a thiamine injection (if possible into the vein) is given straight away and in high doses for at least three days. Urgent review by a doctor is needed.



If you do not have someone to give a thiamine injection to your client, give thiamine by mouth while you transfer the client urgently to a clinic or hospital.

If not treated, Wernicke's Encephalopathy can lead to life-long and profound memory loss. This is known as Korsakoff's Syndrome. Memories of the distant past (e.g. youth) are kept, but no new memories can be laid down. So the person cannot remember what happened five minutes earlier and will often make up the details they have forgotten ('confabulation').

Wernicke's Syndrome can be prevented by eating healthy food and taking thiamine tablets, or, in sick clients or dependent drinkers, by arranging a thiamine injection.



Your client or their family can get thiamine tablets at the chemist.
No script is needed.

Preventing complications by early treatment of withdrawal

- Help your client plan for stopping drinking and to talk to a doctor about withdrawal.
- If your client has a hospital admission coming up for a medical or surgical condition:
 - The doctors and nurses need to know that alcohol withdrawal may happen, so they can monitor the client and give early treatment for it.
 - Even better, if the client can stop drinking a month before planned surgery they may have less complications and quicker healing.

HELPING A PERSON STAY DRY

Once the client has safely stopped drinking, and any withdrawal is over, they should be offered some form of support to help them stay dry. This can include counselling (psychosocial intervention), group support (which may include AA or SMART Recovery) and medicines. Other clients may prefer or need to go to a rehab. Often clients need more than one type of treatment at the same time to help them avoid relapse.

Case management and support

The care and support you provide can be very important in helping your client stay dry. Clients also often need support with practical problems such as housing or training. Help with these issues can assist your client to stay dry (see Case management, p. 43).

Counselling

Every client should be offered some form of psychosocial treatment such as motivational interviewing and cognitive behavioural therapy (CBT). Counselling can increase the chance of staying dry (see Counselling, p. 27).

Medicines to help prevent relapse

Suggest to your client that they see their doctor for a medical check-up and to ask about medicines to help prevent relapse. These medicines should be considered for all clients with alcohol dependence. They can start once withdrawal is nearly over.

There are three medicines approved for the treatment of alcohol dependence: naltrexone (Revia), acamprosate (Campral) and disulfiram (Antabuse; see p. 99). The GP can help advise which medicine will be best for your client. For example:

- Revia makes it a bit easier for the client to stay dry. It does this by slightly reducing their strong desire (craving) for alcohol; also, if they slip up, the drinker get less 'high' from alcohol.
- Campral can help make the craving for alcohol less and can also help with the anxiety that some clients feel in the early months after coming off alcohol.
- Antabuse 'punishes' drinking because the client gets a severe reaction if they drink even a small amount of alcohol. Drinking alcohol while on Antabuse causes headache, heart pounding (palpitations) and vomiting. It works best for clients who have someone to watch them taking the medicine each day. It can only be used in clients who are relatively healthy. People with major health problems like diabetes, heart disease and kidney failure cannot usually take Antabuse.

Note: these medicines can be combined (e.g. one medicine to reduce craving, used together with Antabuse to 'scare' people off drinking). Clients should have a say in choosing the best medicine for them.

Cost of relapse prevention medicines

Revia and Campral are subsidised by the PBS when part of a comprehensive treatment program (i.e. when the client has been offered counselling and measures such as AA, and when the GP monitors their progress). This means they are cheaper for clients or free under CTG (Close the Gap).

Antabuse is not currently subsidised by the PBS, which makes it more expensive (at least \$70 per month). But Antabuse can be very effective and some clients point out that it costs a lot less than drinking.

Pros and cons of medicines used to prevent relapse

	<i>Campral</i>	<i>Revia</i>	<i>Antabuse</i>
Once a day	✗	✓	✓
Reduces cravings	✓	✓	✗
Helps stop a slip-up becoming an all-out relapse	✗	✓	✓
Can help with anxiety/sleep problems	✓	✗	✗

How alcohol relapse prevention medicines work

- Campral (acamprosate): helps the brain adapt more quickly to not having alcohol there. It does this by helping set the brain’s natural stimulation back towards normal. At a chemical level this is turning down the NMDA/glutamate system.
- Revia (naltrexone): stops some of the ‘high’ (euphoria) from drinking. It does this by blocking alcohol’s effect on the opiate receptor. It also reduces craving.
- Antabuse (disulfiram): blocks the normal breakdown of alcohol. Because of this, there is a build-up of a very unpleasant chemical called acetaldehyde. It is acetaldehyde that gives a person a bad reaction to drinking.

Mutual support groups

Some clients find mutual help groups such as Alcoholics Anonymous (AA) or SMART Recovery helpful when trying to stay dry (see Mutual support groups, p. 54).

Rehab

If a client has already either tried (or is not suited to) the approaches described above and continues to drink heavily, spending time at a residential rehabilitation (rehab) may be helpful. Rehabs offer intensive programs to clients, it gives them time to feel more stable, and helps to make them stronger (build resilience) to prevent relapse. Programs can last from weeks to months.

Many rehabs need clients to detox first (i.e. to finish their 5–7 day withdrawal, either at home or in a detox unit) before entering the rehab (see Resi rehab, p. 59). This can be a challenge if you cannot get the client straight from the detox to the rehab. Sometimes there is a gap of a week or more, when you might be left trying to support the client to stay dry.

Coping with relapses in alcohol dependence

People who are trying to stop drinking because they are dependent often need a lot of support. In some cases, helping a drinker can be very rewarding and they can turn their life around. Other times it can be disappointing and frustrating, for the drinker and for everyone around them.

It is important for the worker, the family and the client to remember that the person may not stop drinking forever straight away. Some drinkers cycle through the different stages of change many times (see Stages of change p. 199 and p. 423). If this happens, the drinker will stay dry for a while, then will slip up, but then later may become dry again. Every time they are dry, their body is having a break, and their family and community is having a break from their drinking.

If a client relapses to drinking, the worker and family can encourage the client to start thinking about change again. They may do this, for example, by helping the drinker balance up the good and not-so-good parts of drinking. They can also remind the drinker about how good things were last time they were dry. Once the drinker has become dry again, they can look back and learn from their slip-up. Understanding why the drinker slipped up can help keep them safer in the future when they might be tempted to drink.

Reducing harms to drinkers who cannot or will not stop

There will always be clients who will continue to drink – some because they cannot stop and some because they do not want to. Even if they continue drinking, you can still provide ongoing advice and support. Every time you meet with the client you can sensitively bring up the issues around the harms from their drinking, and the benefits of changing the way they drink.

Some tips you can offer clients to reduce the harms of alcohol use:

- Taking thiamine tablets may reduce the risk of developing memory loss but it cannot stop all the harm from alcohol to the brain (or other parts of the body).
- Leave the car keys at home if the client knows that they are going to drink heavily (see Alcohol, drugs and driving, p. 322). If you know your client is continuing to drive while drunk, discuss this with another senior clinician to help you decide whether you need to report their drink driving to the drivers' licensing authority.
- Consider the safety of any children in your client's care. They should organise care for their children if they are planning to drink. If the client is unable to arrange support and safety for the children and continues to drink, in a way that puts them at risk, discuss this with a senior clinician. You may need to notify the child protection authority (see Protecting and supporting families, p. 370).
- Living with a dependent drinker is not easy and families are often distressed. Family members may be able to get some extra help from Al Anon (a mutual support group for families of alcoholics) or from other family focused services such as Family Drug Support.

Managing emergencies in drinkers

A number of situations can need urgent medical care. These include:

- Severe alcohol withdrawal, which can be life threatening
- Seizures: the client's first seizure, or seizures that go on for a long time, or keep happening often
- Confusion or unexplained sleepiness: if someone becomes confused (e.g. does not know who, when and where they are), they could either be entering DTs or have Wernicke's Syndrome, both of which need urgent medical treatment (see DTs, p. 96; Wernicke's, p. 97). The person can be given thiamine (by injection if possible) even while waiting for other treatment.

Managing alcohol poisoning (alcohol overdose)

Because alcohol is a depressant, if a person drinks enough it can make them unconscious and can even stop their breathing. This is a particular risk for young people who are not yet tolerant to alcohol or for people who combine alcohol with other depressants like benzos or heroin. The person can die from alcohol poisoning alone, or from breathing in their vomit while unconscious ('drowning in their vomit' or 'aspiration').

For this reason it is very important:

- To put an unconscious person on their side, in the recovery position (see CPR guide, p. 436)
- For overdose, if breathing is very slow, get medical help quickly (e.g. calling 000 for an ambulance).
- If the person may have used opioids like heroin or strong painkillers, then the opioid antidote, Narcan (naloxone), can be life saving.

Alcohol use in pregnancy and FASD (Foetal Alcohol Spectrum Disorders)

Alcohol is a poison in pregnancy (a 'teratogen') that may damage an unborn child (foetus). It particularly affects the brain. The more a woman drinks, the higher the chance of damage to the unborn child. The range of problems in the child caused by the mother's drinking during pregnancy is described by the term Foetal Alcohol Spectrum Disorders (FASD; see p. 364 and p. 206).

COMMUNITY ACTION TO REDUCE THE HARMS FROM ALCOHOL

At a community level, if there are many drinking problems, people can work together to try to reduce alcohol-related harms. To do so, some communities might start with a community meeting to discuss possible solutions. Many work with the licensing commission in their state or territory to try to reduce the supply of alcohol (see p. 337). This can be done in cities as well as in regional and remote areas.

These measures often take time and effort. The alcohol and hotels industry will often oppose these changes strongly because they do not want to lose money. However, there are many examples where communities have succeeded. Bringing agencies and community members to work together is important, so that you can show the licensing commission that there is strong support in the community for action. Some communities are able to get help from a 'pro bono' lawyer if required (i.e. for free).

In addition to controlling the supply of alcohol, communities and households can look to create alcohol-free zones to ensure a safe space for the whole community. Some households have also got support from the housing department to make their house alcohol-free. This can help a person tell relatives that they cannot drink in the house.

FURTHER READING

For a short overview of treatment of alcohol problems:

Haber P, Lintzeris N, Proude E & Lopatko O (2009). *Quick reference guide to the treatment of alcohol problems: Companion document to the guidelines for the treatment of alcohol problems*. Canberra: Prepared for the Australian Government Commonwealth Department of Health and Ageing. Available from: www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/treat-quick.

For the fuller version of how to treat alcohol problems:

Haber P, Lintzeris N, Proude E & Lopatko O (2009). *Guidelines for the treatment of alcohol problems*. Canberra: Prepared for the Australian Government Commonwealth Department of Health and Ageing. Available from: www.nhmrc.gov.au/your-health/alcohol-guidelines.

Find out about blood tests to assess drinkers on p. 430.

Go to the Indigenous HealthInfoNet website and type alcohol in the search box: www.healthinfonet.ecu.edu.au.

3

Tobacco

<u>Overview</u>	106
<u>Effects on the body</u>	107
<u>How to recognise nicotine dependence</u>	111
<u>How to recognise nicotine withdrawal</u>	112
<u>How to assess a client who smokes tobacco</u>	113
<u>How to help a client tackle their smoking</u>	114
<u>What medicines are there to help people quit smoking?</u>	118
<u>Using a carbon monoxide monitor when helping clients to quit smoking</u>	125
<u>How to reduce the harms of passive smoking</u>	125
<u>Further reading</u>	126

OVERVIEW

Nicotine is a chemical found in the tobacco plant. When people smoke, nicotine is the drug that can make the brain hooked on cigarettes (dependent). But there are many other chemicals in cigarette smoke, and some of these can cause cancer. Tobacco smoking also causes heart and blood vessel disease.

There are many ways to help clients quit smoking or cut down. These include: counselling and support, using nicotine replacement therapies (NRT) like patches or gum, and using prescription medicines (Champix or Zyban). What works for one client may not work for another, but you can help your client find the best way for them to quit. If they are not ready to quit, you can help them find ways to reduce the harms of their smoking on themselves and on people around them.

About the tobacco plant

Most tobacco comes from the *Nicotiana tabacum* plant, but many other plants contain nicotine. Nineteen of these plants are native to Australia and at least five of these were used by Aboriginal communities before contact with European people.

History of tobacco smoking in Aboriginal communities

Traditionally, Aboriginal people used the dry leaves of pituri (*Duboisia hopwoodii*) and other native 'tobacco' plants. The leaves were powdered, often mixed with ash and chewed. Nicotine helped people stay awake and reduced hunger during long journeys. Some Aboriginal people still use pituri and other native 'tobacco' plants today.

When Europeans came to Australia they brought commercial tobacco. This was stronger and more addictive than the chemicals in Australian plants. Settlers paid Aboriginal workers with rations, including tobacco, in exchange for their labour. Missionaries also gave tobacco as a reward for going to church.

How common is smoking?

On average nearly half of Aboriginal Australians smoke, compared to less than one in five non-Indigenous Australians. The number of people smoking is even higher in some remote Aboriginal communities, where up to 8 in 10 people smoke. In general, Aboriginal people start smoking at an earlier age, smoke more each day, and smoke for more years than non-Indigenous Australians.

Smoking is the biggest contributor to the 'gap' in life expectancy between Aboriginal Australians and non-Indigenous Australians. If we are to close the gap in health and length of life, tackling smoking will be vital. There are some signs that smoking rates in Aboriginal Australians are starting to go down, as people hear the message about the health effects of smoking.

Smoking is very common among people who are risky drinkers or who use illegal drugs. Clients in alcohol and drug treatment programs tend to smoke more cigarettes each day, inhale more deeply, and spend about one-third of their income on cigarettes. Smoking may be more likely to kill your clients than alcohol or illegal drug use. So when their alcohol or drug use settles down, it is good to start a conversation about smoking.

EFFECTS ON THE BODY

Why does tobacco cause sickness?

While nicotine gets people addicted to tobacco, it is not usually the nicotine that causes sickness. The harms from smoking come from breathing in smoke from a burning cigarette. Along with nicotine, there are over 4,000 chemicals in cigarette smoke and at least 60 of these cause cancer. Smoking also produces carbon monoxide, which is the same poison in car exhaust fumes. Carbon monoxide causes damage to small blood vessels and leads to heart disease and stroke.

Why tobacco can make you feel good

Nicotine is the drug in tobacco that makes you want to smoke more. When a person smokes, the nicotine goes into the blood and up to the brain, where ‘feel good’ chemicals (like dopamine) are released. This makes a person feel calm, reduces hunger and helps them concentrate.

Chemicals found in tobacco smoke

<i>Chemical</i>	<i>Commonly found in</i>
Acetone	Nail polish remover
Ammonia	Toilet cleaner
Arsenic	Insecticide, pesticide, herbicide
Benzene	Petrol
Butane	Lighter fluid
Cadmium	Batteries
Carbon monoxide	Car exhaust
DDT/Dieldrin	Insecticide
Formaldehyde	Fluid for embalming dead bodies
Hexamine	Lighter fluid
Hydrogen cyanide	Rat and insect poison
Methane	Natural gas
Naphthalene	Mothballs
Stearic acid	Candle wax
Vinyl chloride	Plastic pipes

Why is carbon monoxide bad for us?

When we breathe in carbon monoxide it enters our bloodstream, sits on red blood cells and stops oxygen from getting into the blood. Smokers have less oxygen in their blood than non-smokers. To increase the amount of oxygen, the body makes more red blood cells. However, too many red blood cells can lead to blood clots forming, and this can lead to a heart attack or stroke.

What sickness does smoking cause?

Smoking causes lots of sickness in Aboriginal Australians. The damage occurs on the inside and often cannot be seen. Smoking causes harm to almost every organ in the body. The younger a person starts and the more years they smoke, the greater the health risks. However, stopping smoking at any age can improve health.

Cancer

Smoking greatly increases the risk of getting cancer of the lungs, mouth, lip, throat, stomach, liver, pancreas, kidney and bladder.

When a person smokes and also drinks alcohol in a risky way, they have a much higher risk of some health problems (e.g. cancers of the mouth and throat).

Heart and blood vessel disease (cardiovascular disease)

Smoking narrows the blood vessels that take oxygen to the heart and to other parts of the body. Once narrowed, these blood vessels can easily get blocked. When a blockage happens, parts of the body can be damaged or die because of a lack of oxygen. For example, a person can have a stroke because of an area of brain damage, or a heart attack when an area of heart muscle is damaged. After a stroke, a person can be paralysed for the rest of their life. If the arteries that take oxygen to the legs and feet are affected, a person can get pain in their calves when walking, or when a blockage happens they can get gangrene, where part of their foot goes black and dies.

Lung disease

Smoking is the main cause of long-term (chronic) lung diseases like bronchitis and emphysema. Together these are known as Chronic Obstructive Pulmonary Disease (COPD). COPD makes people short of breath, causes a cough or wheeze, and makes the airways produce large amounts of mucus (a slimy or sticky substance, also called phlegm). Over time, even everyday activities become hard to do, like having a shower or going shopping. Once a person has COPD, their lungs do not usually return to normal.

Quitting smoking can stop a client's COPD getting worse and can reduce the number of chest infections they get.

Diabetes

Smoking increases the chance of developing diabetes (type II). It also increases the risk of sickness from diabetes such as heart or blood vessel disease.

If a person has diabetes and they smoke, damage to the blood vessels can happen more quickly. Helping them to stop smoking is important to prevent these problems.

Pregnant women and harm to the baby

Smoking when pregnant is dangerous as the poisons in tobacco can be passed onto the baby.

Women who smoke while pregnant may have more problems during pregnancy and labour, and the baby may:

- Be born too early (premature)
- Have a greater risk of cot death
- Be born too small (low birth weight). This is linked to poor health, even into adulthood (e.g. heart disease, stroke, high blood pressure, being overweight and diabetes).
- Have an increased risk of deformities, such as cleft palate and cleft lip.

It is best if mothers can stop smoking before getting pregnant, but the earlier they stop during pregnancy the better. It is also better for pregnant women to try to avoid being around smokers altogether.

Passive smoking

Breathing in smoke from someone else's cigarette is called 'passive smoking'. Non-smokers can get sick from this (e.g. heart disease and breathing problems).

The effects of passive smoking on children include:

- More ear infections
- More coughs, colds and asthma
- More likely to take up smoking because they copy their parents or other family members or friends who smoke.

Risks of black market tobacco

'Chop chop' (black market tobacco) may contain chemicals, cotton plant waste, fungi and bacteria that can cause severe breathing problems and lung disease.

Death

Smoking is the leading cause of death in Aboriginal Australians. It causes one in every five deaths (many more deaths than alcohol or drug use cause). But tobacco is a 'silent killer'. You often do not see the harms until the illness is already severe. The three most common causes of death from smoking for Aboriginal Australians are heart and blood vessel disease (including strokes), lung disease and cancers. Nearly all lung cancer deaths (9 out of 10) are caused by smoking.

Consider local culture and views on causes of sickness

In some Aboriginal communities, commonly held beliefs may lead people to think that tobacco-related sickness (e.g. lung cancer, heart attack and stroke) happens because of sorcery and black magic. In these cases, it can be useful to work with community leaders, agencies and other community members to raise awareness that sickness such as lung cancer, heart attack and stroke can be caused by smoking. If the community speaks their own language, it can be useful to give messages about tobacco-related sickness in the local language and using local concepts. Ask local Aboriginal people to help you to explain it better.

HOW TO RECOGNISE NICOTINE DEPENDENCE

Some people only smoke tobacco occasionally (e.g. at a party) and they do not miss it if they do not have it. But most people who smoke daily or almost daily are dependent on nicotine (addicted) and find it hard to stop. They get strong cravings for cigarettes if they do not have one. They may also feel edgy or cranky if they cannot smoke. People who are highly dependent usually have their first cigarette within 30 minutes of waking. If they try to stop, they experience withdrawal symptoms. Dependent smokers are more successful at quitting if they get help.

A person is more likely to become dependent on cigarettes if they have:

- A parent or grandparent who was or is a smoker
- Grown up in a household where most people smoke
- Experienced trauma and high levels of stress in childhood
- Mental health issues
- Peer pressure to smoke or if many of their peers smoke
- Other drug and alcohol use.

HOW TO RECOGNISE NICOTINE WITHDRAWAL

Nicotine withdrawal happens when a dependent smoker stops smoking. It usually starts within an hour after the last cigarette and can include:

- Craving
- Feeling anxious
- Feeling cranky or irritable
- Trouble concentrating, or being forgetful
- Feeling tense and frustrated
- Increased hunger, especially for sweet foods
- Headaches
- Feeling dizzy
- Feeling constipated
- Feeling depressed.

Symptoms get stronger and usually peak around 1–3 days after the last cigarette. They then get weaker and usually settle down within 10–14 days. Because of these withdrawals, stopping smoking can be hard.

If your client gets strong withdrawal symptoms for most of the day, they are more likely to relapse and start smoking again. There are medicines to help reduce these withdrawal symptoms (see p. 118).

The 5 ‘As’ of smoking cessation can remind you of the steps in helping clients to cut down or stop smoking:

1. *Ask* all clients if they smoke tobacco.
2. *Assess* your client’s smoking (e.g. dependence, readiness to change).
3. *Advise* all clients who smoke that quitting would be the best thing that they could do for their health. This can be done in a clear and supportive way that is not judgemental.
4. *Assist*: offer smokers advice on quitting or cutting down. You can tell them about medicines available to help them. If your client cannot or will not stop smoking, you can discuss ways to reduce the harms from smoking.
5. *Arrange* a follow-up session with clients who are trying to quit. Even clients who are not ready to quit can be encouraged to come back and talk anytime about their smoking.

HOW TO ASSESS A CLIENT WHO SMOKES TOBACCO

Ask all clients if they smoke (if you do not already know). You can then find out:

- How ready they are to change. Ask: “Have you ever thought about stopping smoking?”
- How dependent they are on nicotine. Ask: “How soon after waking do you smoke your first cigarette?”

Finding out about your client’s past experience of quitting can help you decide what might be most helpful for them now.

- Ask: “Have you ever tried to quit in the past?”

If they say yes, ask them:

- “What withdrawal symptoms did you get?”
- “Have you tried any medicines to help you quit?” If yes, “Did you have any problems with them?”

HOW TO HELP A CLIENT TACKLE THEIR SMOKING

Sometimes just asking questions can be a powerful way of getting a person to think about their smoking. You can also use motivational interviewing to help the person weigh up what they like and what they do not like about smoking. For example, you can ask:

- What do you like about smoking?
 - They might say that it: calms you down, stops boredom, can be shared with friends, and is nice smoking with family and friends.
- What do you not like about smoking?
 - They might say that it: costs a lot, makes it harder to run or play sport, makes you cough, makes your chest feel tight and makes you short of breath, causes sickness. Also, people say that they do not like it when everyone asks for cigarettes (humbug), when they run out of smokes and want more, and that their kids do not like it.

The type of help you give will depend on:

- How ready the client is to tackle smoking
- The goals they want to aim for (e.g. trying to quit now, coming back to discuss quitting, cutting down, trying to avoid smoking near children)
- Which treatments the client prefers, if any (e.g. nicotine gum, Champix)
- What training and experience you have had in helping clients to cut down or quit smoking
- Whether you have a skilled smoking cessation worker available to help your client.

How to help a client who wants to cut down (but not quit)

Of course the best thing for your client's health is to stop smoking altogether. But not everyone is ready or able to quit right away. After talking about their smoking, your client may decide that they are prepared to cut down but are not ready to quit.

If your client is just an occasional smoker, and is not dependent, they may be able to cut down on their own (see Tips to cut down or quit, p. 115).

But if your client is dependent on cigarettes (e.g. they smoke as soon as they wake up, or get cranky when they run out of cigarettes), cutting down can be a problem. Your client may find that they drag more deeply on each cigarette because they are 'desperate for a smoke'. This can be particularly bad for the lungs, as the poisons get right out to the small airways at the edges of the lungs. If a dependent smoker wants to cut down, NRT can make it easier.

Invite the client to come back and let you know how they are going with their smoking.

How to help a client who is ready to quit

- Some people can quit smoking without any help, but support, counselling and medicines have shown to help dependent smokers. Offer to see the client regularly while they are trying to stop.
- Many smokers take several attempts to quit.
- What works to help one smoker quit may not work for someone else. Your client can try a different approach if they do not succeed at first.
- Discuss support options including QuitLine (phone: 131 848).
- Discuss NRT and other medicines.
- Consider getting help from a GP. In particular, get advice from a GP if your client is pregnant, taking other medicines, is less than 18 years old, has a serious health problem, or if they want a script for NRT or other medicines.
- For most people (more than nine out of 10), even a single puff on a cigarette can lead to relapse. It is important that once a person has stopped smoking, they avoid cigarettes altogether.
- Often clients with drug and alcohol, mental health or physical health issues have complex histories and may be very dependent on nicotine. More support may be needed to help them stop smoking.

Tips to help your client cut down or quit smoking

Tip 1: Stay away from other smokers

Try to avoid being around other smokers during the first few weeks of quitting, although this will be very hard to do in some communities. Breathing in other people's smoke and spending too much time around smokers will make cravings stronger and is the biggest cause of relapse.

Tip 2: Do not make the mistake of having 'just one' cigarette

For most people who quit smoking, just one puff on a cigarette can lead them back to smoking all the time.

Tip 3: Avoid drinking alcohol during the first few weeks of quitting

Alcohol increases cravings for nicotine. Drinking alcohol can increase the chance of starting up smoking again and can make you feel less determined to want to stop smoking. Smokers who have quit are more likely to ask for a cigarette if they drink alcohol during the first few weeks of quitting.

Tip 4: Reduce caffeine but do not stop

Drinking less coffee, cola and other caffeinated drinks when trying to quit smoking can help people feel less agitated and anxious. Reducing the amount of caffeine by about half each day can help, but stopping altogether can lead to caffeine withdrawal.

Tip 5: Citrus helps (lemons, limes, oranges, grapefruit and native or 'wild' limes)

Citrus and nicotine do not go together very well. Rubbing a lemon wedge on the tongue is a natural way to reduce nicotine cravings. Or your client can eat or drink citrus fruit.

Tip 6: Eat breakfast

Eating breakfast can help reduce nicotine cravings. Sometimes smokers mistake feeling hungry for nicotine cravings.

Tip 7: Distract yourself

Most cigarette cravings last about 3–5 minutes, but it can feel much longer. Distraction can help to manage the craving until it passes (e.g. do the washing up, sweep the floor, go into another room, go for a short walk, brush your teeth, or have a shower).

Tip 8: Glucose helps

Having something sweet like a glucose lolly or a jellybean when craving a cigarette can help reduce cravings during the first few weeks of quitting.

Tip 9: Do some exercise

Regular exercise for short periods of time can help when trying to quit smoking. Exercise helps the brain release 'feel good' chemicals (e.g. dopamine) that can help when trying to quit smoking.

Tip 10: Everyone smokes outside the house or car

Advise your client to make their house and car a smoke-free zone before trying to quit. Allowing people to smoke inside the house and/or car when trying to quit makes it difficult to stop. If your client lives with other smokers, advise them to talk to these people about smoking outside before making a quit attempt. They should try not to go outside when other people are smoking.

Things to consider if your client uses caffeine, alcohol or certain prescribed medicines

Smoking can affect how the body processes (metabolises) other drugs such as caffeine, alcohol, paracetamol and some psychiatric medicines.

Caffeine and nicotine

Most smokers drink more tea, coffee and cola than non-smokers. This is because caffeine breaks down faster in smokers. When quitting smoking your client's caffeine levels may build up. Having too much caffeine can make them feel anxious and can cause sleep problems. This can make the withdrawal worse. This is why smokers should reduce their caffeine intake by half when quitting smoking.

Alcohol and nicotine

Smokers also process alcohol faster than a non-smoker and so tend to drink more to get the same effect from alcohol. Nicotine and alcohol strengthen each other's 'high' – that is why they are so often used together. Added to this is that alcohol can take away the will to say no.

Medicines and nicotine

Smoking can speed up the way the body processes certain medicines such as insulin, warfarin (a blood thinner) and clozapine (an anti-psychotic drug). These medicines can sometimes build up in the body when a person stops smoking. Your client should see their doctor while they are quitting to check that these medicines do not become too strong.

WHAT MEDICINES ARE THERE TO HELP PEOPLE QUIT SMOKING?

There are two types of medicine available that can help people to quit smoking. These are most often used if the person is dependent on nicotine (addicted). These are:

- Nicotine replacement therapy (NRT): patches, nicotine gum, lozenges, mini-lozenges, microtabs, inhaler
- Prescription medicines: Champix (varenicline tartrate) and Zyban (bupropion).

How do quitting medicines help?

Quitting medicines reduce withdrawal symptoms such as cravings, feeling cranky and irritable, mood swings and feeling anxious. They usually do not stop withdrawal symptoms altogether. Most clients will still get some cravings in situations where they usually smoke.

The tablets, Champix or Zyban, are started while a person is still smoking. They can reduce the desire to smoke.

Using nicotine replacement therapy (NRT)

NRT is much safer than smoking tobacco because it does not contain the cancer-causing chemicals found in tobacco smoke. NRT helps to reduce cravings and withdrawal symptoms.

Your client should speak to their doctor or pharmacist before using NRT if they are:

- Pregnant
- Have a major illness (e.g. recent heart disease)
- Taking strong medicines such as insulin, warfarin (a blood thinner), or medicines for schizophrenia
- Less than 18 years old.

Patches

A patch is placed on the skin and slowly releases nicotine through the skin and into the blood, giving the body a steady dose of nicotine. This takes the edge off cravings throughout the day but may not take them away altogether. If a client does not smoke every day and does not get withdrawals, a patch may be too strong and may make them feel sick in the stomach. If the client feels sick, they may do better using short-acting NRT instead (e.g. gum or lozenges).

Tips for using nicotine patches

What strength patch should be used?

- Most smokers who are heavily dependent or smoke 15 or more cigarettes a day should start with a 21mg patch. If they get withdrawals they may need to increase to two patches.
- Less dependent smokers who smoke less than 15 cigarettes a day should start with a 14mg or 7mg patch (designed as a 16-hour patch).

When to use a 24-hour patch?

- Clients should use a 24-hour patch if they smoke soon after waking.
- To reduce the chance of sleep problems (e.g. vivid dreams), put the patch on late at night (e.g. 11pm or later). This allows the body's nicotine levels to build up slowly overnight ready to help with the morning craving.

When to use a 16-hour patch?

- Clients should use a 16-hour patch if they do not smoke until later in the day – at least a couple of hours after waking.
- Clients who have sleep problems (e.g. vivid dreams) with a 24-hour patch (even when they put it on late at night), or clients who want to go to bed early, should use a 16-hour patch.
- Put the 16-hour patch on first thing in the morning and take it off before bed.

How and where to put on a patch?

- Shower before putting the patch on (patches can come off when they get wet).
- Apply to clean, dry and hairless skin on the upper body.
- Hold the patch down for 10 seconds.
- Remember to put the patch in a different spot every day.
- In hot, humid climates, your client may need to use some tape (e.g. 'micropore' tape) to keep the patch in place, against the skin.

What if the patch is not strong enough?

Highly dependent smokers may end up smoking while wearing the patch because it is not strong enough. If this happens, they may need to add short-acting NRT (e.g. gum, lozenge, microtab, inhaler). Specialist smoking cessation clinics also often add a second patch. You can get advice on this from the Quitline or a specialist smoking cessation worker.

What if the patch is too strong?

If the patch is too strong, your client may feel like a young person who has smoked too many cigarettes (e.g. dizzy, sick in the stomach). If this happens, they can use a weaker patch or switch to short-acting NRT instead.

What if people smoke while using a patch?

If a person smokes while using a patch, this usually just means that they need a higher dose of NRT (see above). It is not a reason to stop using patches.

Short-acting NRT

- People who are nicotine dependent often need to use both a patch and also a short-acting form of NRT (such as gum, lozenges, mini-lozenges, microtabs, or an inhaler). The short-acting NRT helps cope with occasional cravings during the day.
- Occasional smokers, or people who often run out of cigarettes, may not be physically dependent on nicotine. For them, short-acting NRT alone may be enough.
- It is absorbed through the lining of the mouth.
- It gives a quick hit of NRT (within 2–3 minutes).
- It should be used quickly, as soon as the client thinks about smoking (do not let the craving build).

Tips for using short-acting NRT*What strength should be used (for gum and lozenges)?*

If your client is very dependent, they should probably start on the stronger form (4mg). If you are not sure, your client can start with the lower strength (2mg), and, if needed, use two pieces at once.

Choosing a short-acting NRT

- Gum: people with many missing teeth or with false teeth should not use gum.
- Mini-lozenges: can taste better than lozenges, but may be a little more expensive.
- Microtabs: more expensive than gum and lozenges.
- Inhaler: the inhaler gives the quickest hit of nicotine and is most like a cigarette. It can also help replace the ‘ritual’ of smoking.

What flavour?

The flavoured gum, lozenges and microtabs (e.g. mint, citrus) taste better than the standard variety.

How do you use it?

- Gum: put gum in mouth and chew a few times, until a tingling or peppery taste is felt. Then 'park it' between the cheek and gums. Every now and then, chew a few times to release more nicotine. Throw the gum away after 30 minutes.
- Lozenges/mini-lozenges: move around the mouth and let dissolve.
- Microtabs: leave the tablet under the tongue until it dissolves.
- Inhaler: the smoker puffs on a plastic tube that contains a cartridge of nicotine (called an inhaler).

How often?

Your client can use short-acting NRT as often as they need it, whenever they feel like smoking. Tell them not to let the craving build. However, if they use it too much, they may feel dizzy, sick in the stomach or get a sore mouth.

What to do if it's not strong enough

- If your client still has cravings, they may need a patch as well (or instead).
- Your client may need to use the short-acting NRT more often, or use a higher strength (4mg instead of 2mg).
- Different kinds of short-acting NRT can be mixed (e.g. inhaler and gum).
- If your client is using an inhaler and it does not seem to be working, make sure they are puffing on the inhaler rather than just taking deep breaths.

Can your client get hooked on short-acting NRT?

Short-acting NRT gives a much quicker hit of nicotine than patches, so occasionally a person can become dependent on it, and find it hard to stop. These people can be weaned off short-acting NRT (using lower strength, or less often), or they can use a patch to allow them to stop.

Warning: 'e-cigarettes' are sometimes bought on the internet, but are not recommended, as they may contain cancer-causing agents.

NRT and pregnancy

Pregnant women could try going 'cold turkey' first, but pregnant women who are more dependent can use short-acting NRT. Patches are generally not recommended for pregnant women. Sometimes a specialist may approve them.

NRT and illness

Patches should not be used if the person has had a heart attack in the last 24 hours or recent onset heart pain (angina) in the past month.

Using NRT to reduce the harms from smoking

Your client can use NRT if they are ever in a place where they cannot smoke (e.g. airport, train, hospital).

There is evidence that NRT helps people smoke less. This is because when a person uses NRT they are less 'desperate' for a cigarette and draw back less, so less poison from the cigarette enters their body.

How your client can get NRT

- NRT is available at most chemists, and at big supermarkets and petrol stations in cities and towns. Any adult can buy them. If your client needs extra advice on how to use them, they can ask the chemist or call the Quitline (phone: 131 848).
- Free or discounted nicotine patches are available on prescription from a GP.

**Free nicotine patches for Aboriginal Australians**

Aboriginal Australians can receive up to two courses of free nicotine patches a year by getting a script from their doctor. Each course is for 12 weeks.

Discount nicotine patches for all Australians

Your Aboriginal client may have a non-Aboriginal partner who smokes. At the time of writing, any Australian who wants to quit smoking can ask their GP for a script for nicotine patches. This makes the patches the same cost as other medicines on the PBS, and a lot cheaper than full price patches at the chemist.

Using prescription medicines

Champix (varenicline tartrate) and Zyban (bupropion) are two medicines available on a script from a doctor to help people stop smoking. The client starts taking the medicine while they are still smoking and it may reduce the desire to smoke. These medicines are not suitable for all clients.

Champix and Zyban are both listed on the PBS to make them less expensive.

Champix

- Champix partly blocks the effect of nicotine on the brain, so that smoking loses its reward or 'feel good' effect. People lose interest in smoking. It also has a very small nicotine-like effect, and because of this the client does not get withdrawals.
- Tablets are taken twice a day following the instructions on the box.
- If a client has cut down but not stopped smoking after one month on Champix, they can add NRT (short-acting NRT or patches) and continue for another two months.
- If there is no reduction in smoking after one month, the client should stop taking Champix and switch to NRT.

Possible side effects of Champix:

- Nausea: can be reduced by taking Champix with food
- Sleep problems: to avoid sleep problems, take the Champix at 7am and 3pm. Taking the second dose of Champix any later in the day can increase the risk of sleep problems. However, there needs to be eight hours between the first and second dose.
- Depressed and suicidal thoughts: ask family or a health professional to keep an eye out for any mood changes
- Aggressive or strange behaviour
- Can increase the risk of heart attack.

Champix should not be used if your client:

- Is pregnant
- Has kidney problems
- Has a history of seizures
- Has a history of suicidal thoughts or severe depression
- Shows aggressive behaviour when not intoxicated.

Within one month of taking Champix, almost half of smokers (4 in 10 people) will stop smoking or greatly reduce how much they smoke. However, we do not know why this medicine works for some people and not others.

Zyban

Zyban is an anti-depressant medicine that helps reduce nicotine withdrawal symptoms. Tablets are taken twice a day for 12 weeks. The full course of treatment should be taken to increase the chance of successfully quitting.

- If a client has cut down their smoking after two weeks but not stopped, they can use NRT (any type) together with Zyban for the rest of the 12 weeks.
- If after two weeks there is no reduction in smoking, the client should stop taking Zyban and talk to their doctor about using Champix or NRT.

Possible side effects of Zyban:

- Sleep problems: can be helped by taking the night-time dose as early as possible before going to sleep. But remember that there needs to be around eight hours between taking the first and second dose.
- Seizures: these are not common.

Zyban should not be used if your client:

- Is pregnant
- Could be at risk of seizures because of withdrawal from alcohol or benzos, a brain tumour, or past serious head injury
- Has a history of eating disorders (e.g. anorexia nervosa, bulimia nervosa).

Within two weeks of taking Zyban, 1 in 3 smokers will stop smoking. However, we do not know why this medicine works for some people and not others.

USING A CARBON MONOXIDE MONITOR WHEN HELPING CLIENTS TO QUIT SMOKING

Carbon monoxide is a poisonous gas found in cigarette smoke, cannabis smoke and car exhaust fumes. It is a major cause of the damage to blood vessels that happens in smokers.

What is a carbon monoxide monitor?

A carbon monoxide monitor (usually called a ‘smokerlyser’) looks a bit like a breathalyser. It is used to show clients how much carbon monoxide is in their breath and how smoking less can help reduce this.

The client blows into the smokerlyser and gets a reading of the amount of carbon monoxide in their breath. High readings tell us that the client draws in deeply when they smoke and has a greater risk of harm.

Within 2–3 days of stopping smoking, carbon monoxide levels will drop to that of a non-smoker. Cutting down by using NRT can greatly reduce the level of carbon monoxide in the body. Seeing carbon monoxide levels drop can help motivate clients to keep trying to quit.

HOW TO REDUCE THE HARMS OF PASSIVE SMOKING

If your client is not ready to quit, you can talk about things that they can do to reduce the risks of smoking to the people around them. Your client can:

- Smoke outside
- Make their house and car a smoke-free zone. Remove all ashtrays from inside the home and perhaps create a special outside area where people can smoke.
- Avoid smoking around babies, children or older people, and ask others to do the same
- Wear a shirt for smoking and leave it outside. Take it off before cuddling babies and children.

FURTHER READING

The Centre for Excellence in Indigenous Tobacco Control (CEITC) has information and resources. See www.ceitc.org.au.

Zwar N, Richmond R, Borland R, Peters M, Stillman S, Litt J, Bell J, Caldwell B. (2007). *Smoking cessation pharmacotherapy: An update for health professionals*. Melbourne: The Royal Australian College of General Practitioners. Available from: www.racgp.org.au/Content/NavigationMenu/ClinicalResources/RACGPGuidelines/smoking/Smoking_Cessation_Update09.pdf.

4

Cannabis

<u>Overview</u>	128
<u>What does cannabis look like and how is it used?</u>	128
<u>Effects on the body</u>	130
<u>How to recognise harms from cannabis</u>	131
<u>How to recognise cannabis dependence</u>	134
<u>How to recognise cannabis withdrawal</u>	135
<u>How to assess a client who uses cannabis</u>	135
<u>How to help a client who uses cannabis</u>	136
<u>Reducing the harms if a client cannot or will not stop</u>	137
<u>Preventing cannabis use from ever starting</u>	138
<u>Further reading</u>	138

OVERVIEW

The cannabis plant has been used throughout the world for centuries. Cannabis is an addictive drug that changes how people feel ('mind-altering'). In Australia cannabis is known by many names including: marijuana, gunja, yarndi, hemp, hash, amarda, skunk, grass, weed, pot and mull.

It is illegal to buy, grow or supply cannabis in Australia; however, the penalties for this differ across the country (see Cannabis and the law, p. 133).

Most often cannabis is mixed with tobacco and smoked in a water pipe (bong) or rolled into a cigarette (joint). It can also be baked and eaten in cakes and biscuits. Cannabis users can become strongly attached to the tools and equipment that they use to smoke.

How common is cannabis use and how does it affect communities?

Cannabis is the most commonly used illegal drug in the world. Over 1 in 3 Australians have tried cannabis and over 1 in 10 people have used it in the last year. Typically more males than females use it, and people aged 18 to 29 have the highest rates of use (2 in 10 people in the past year). Cannabis is the second most common reason people access alcohol or drug treatment in Australia.

Overall, across Australia cannabis use has reduced in recent years, but among some Aboriginal communities it has increased. Over 2 in 10 Aboriginal Australians report using cannabis in the past year in surveys, but some communities have very high levels of cannabis use – with up to 6 in every 10 people smoking every day if they can. Some communities report problems, like fights or other violence when cannabis is in short supply or runs out. They also report money problems, mental health problems (like psychosis and sometimes depression) and fewer people working.

WHAT DOES CANNABIS LOOK LIKE AND HOW IS IT USED?

Types of cannabis

For the purpose of smoking, the cannabis plant is broken down into two parts: the leaves and stems, and the buds or heads. As a general rule the leaves and stems contain less of the active THC component and therefore give less of a 'stoned effect'. The buds or heads have a stronger concentration of THC.

Types of cannabis that are used

- Resin extracted from the flowers of the female plant is referred to as 'hash', which can be chewed or smoked; it is less common in Australia.
- Hash oil is the strongest of the concentrated extract of the plant; it is also less common in Australia.
- Cannabis plants grown indoors (hydroponic) are generally stronger than cannabis grown naturally outdoors; it is the genetic make-up of the seeds, which has the biggest impact on its strength. 'Skunk' is one type of hydroponic cannabis used in Australia.
- Other synthetic types of cannabis include Kronik, Spice, Karma and Voodoo. These products are banned in many parts of Australia. They contain a blend of dried herbal plants mixed with chemicals similar to THC and are sometimes sold as 'fake weed' in small bags of various colours. The short and long-term effects of synthetic cannabis are still largely unknown.

Typical equipment for using cannabis

Cannabis smokers usually have a preferred way of smoking.

- The 'joint' or 'spliff' is similar to a large rolled cigarette, often mixed with tobacco, and is often passed around in a group.
- A bong is usually a homemade water pipe; the smoke is bubbled through water, which cools and filters the smoke; the smoke is often taken deep into the lungs. As the cannabis is placed into a cone, which is inserted into the bong, users may describe how many 'bongs' they smoke a day.
- A vaporiser acts by heating the cannabis so that the active ingredients rise off as a vapour that is then inhaled via a pipe. As there is no actual burning there is no smoke or tar and there are likely to be less toxic gases.

EFFECTS ON THE BODY

The main active chemical in cannabis is THC (delta-9 tetrahydrocannabinol). When THC enters the bloodstream the person feels ‘chilled out’, ‘stoned’ or ‘high’.

The effect that THC has depends on:

- How tolerant the person is to it – if they are new to cannabis, they will be more affected; if they are a long-term or dependent user, they may be affected less.
- The method of use (e.g. bongs or cookies)
- The strength of the cannabis. The cannabis available in some communities has become twice as strong in the past 10 years. If this stronger type of cannabis is available, it is often called ‘hydro’ (hydroponic cannabis).
- Any other physical or mental health issues.

Short-term effects

Smaller amounts of cannabis

Effects typically last two to four hours and can include:

- Feeling happy
- Feeling relaxed and sleepy
- Problems with concentration and remembering things
- Distorted sense of time and place
- Feeling less inhibited – may do or say things they would not usually do or say
- Problems with coordination
- Hungry (‘munchies’)
- Red eyes
- Dry mouth and throat
- Increased heart rate.

Larger amounts of cannabis

This can cause more problems, including:

- Vomiting
- Being isolated from family and friends (withdrawn)
- Poor judgement and decision making
- Being anxious or paranoid, sometimes with panic or aggression
- Slower reactions (e.g. when driving, slower to respond to a problem) and problems with coordination
- Triggering a mental illness: hallucinations, paranoia and removed from reality (drug-induced psychosis).

HOW TO RECOGNISE HARMS FROM CANNABIS

What are the physical harms of chronic cannabis use?

Long-term ('chronic') cannabis use can lead to serious physical problems including:

- Lung disease, coughing, chronic bronchitis, and difficulty breathing. This is caused by deeply inhaling the smoke – and can lead to tar and other poisons entering the lungs. We do not yet know if cannabis may be linked to lung cancer.
- Smoking any substance is often also bad for the heart. Cannabis increases the heart rate so may put strain on the heart in a person who is already at risk of a heart attack (for example, if they are overweight or also smoke tobacco).
- Effects on fertility (the ability to have children): cannabis causes lower sperm quality and levels of testosterone (the male hormone) in men; and, for women, periods that are not regular.
- Cannabis use may weaken the immune system (i.e. the 'system' that fights off illnesses), leaving the person with a higher chance of infections and colds.
- Tooth decay, gum disease caused by dry mouth.
- Effects on the developing baby (foetus): smoking any substance can reduce the amount of oxygen that reaches the foetus. Also, cannabis crosses from the woman into the developing baby. We still need more research, but it seems likely that cannabis can harm the developing baby. Babies may be at risk of low birth weight, infections and breathing problems if their mother uses cannabis.
- Cannabis can be found in breast milk of women who smoke it.
- Nausea, uncontrollable vomiting and abdominal pain (known as 'cannabinoid hyperemesis') can occur. Hot showers may provide some temporary relief. Some people may need to be admitted to hospital if they are unable to hold down any fluids.

What are the psychological harms of chronic cannabis use?

Short-term harms

- One distressing effect of smoking cannabis is that a person can experience anxiety and have paranoid thoughts. Sometimes, it can become hard for them to work out what is real and what is not, and they may even hear or see things that are not real (psychosis and hallucinations). These experiences are more common in people who have not smoked much cannabis before or in those who smoke more than they usually do. Whilst distressing at the time, for the smoker and for those observing, these symptoms are usually short term and stop when the cannabis wears off.

Long-term harms

Long-term chronic cannabis use can lead to serious psychological harm including:

- Anxiety and panic (symptoms include: feeling worried and fearful, racing thoughts, awareness of paranoid thinking, shortness of breath, and increased heart rate). While the person may be using cannabis to calm them down, it may be, bit by bit, making their anxiety worse.
- Depression (feelings of worthlessness, hopelessness and loss of interest in activities, low energy and possible suicidal thinking). There is growing evidence that cannabis may make depression worse.
- Psychosis (paranoid thinking, confused and jumbled thoughts, changes in sense of reality, hallucinations and aggression). The person may not be aware of their symptoms. Drug-induced psychosis is short term and can last from one to four weeks after stopping cannabis use; the symptoms develop during, or within one month of cannabis use. Using cannabis with a family history of schizophrenia, particularly in adolescence, may increase a person's vulnerability to longer-term psychotic disorders such as schizophrenia.
- Loss of self-esteem (changes in how the person views themselves).
- Poorer memory, attention and organisation skills. This can lead to poor ability to learn new things. Research into whether these effects are reversible is ongoing; however, there is more concern for people who use cannabis during their adolescent years while their brain is still developing.
- Decreased motivation and energy. This can lead to a loss of desire to carry out plans, to work or be productive.
- Disturbed sleep patterns (unable to sleep without cannabis).
- Pre-existing mental health disorders such as anxiety, depression or schizophrenia can be made worse or be triggered by the use of cannabis. Cannabis use can also impact on the treatment of such disorders, impacting on the effectiveness of anti-depressant medicine and engagement in counselling.
- Cannabis can trigger a first episode of schizophrenia in someone who is naturally at increased risk of developing this illness (e.g. if they have a family history of schizophrenia).

What are the social harms of cannabis use?

Long-term chronic cannabis use can lead to serious social harms, including:

- Poor school attendance
- Risky sexual activity that can lead to sexually transmissible infections (STIs) and unplanned pregnancy (see STIs, p. 284)
- Other illegal drug use and dependence: of course not all cannabis users go on to use other drugs, but some get to know people who sell illegal drugs; some also get bored of using cannabis and want to try something new.
- Higher unemployment (difficulties keeping a job)
- Financial problems (from the cost of cannabis, fines or unemployment)
- Relationship problems (communication problems, domestic violence)
- Parenting problems (e.g. difficulty making an emotional connection and attending to the needs of the children)
- Sometimes communities might think it is better to smoke cannabis than use other drugs
- Sometimes if people who use cannabis cannot get any supply, they might get violent or aggressive
- Legal issues (e.g. criminal charges, family law and children's court).

Cannabis and the law in Australia

In some parts of Australia, a person can get a small fine (instead of a criminal charge) for possessing small amounts of cannabis and cannabis plants ('decriminalisation'). States and territories that have decriminalised some cannabis offences include: the ACT, NT, SA and WA.

In the other states (NSW, Qld, Tas and Vic), cannabis is not decriminalised. This means that people caught with cannabis or cannabis plants can get a criminal charge, which may involve a large fine, going to jail, and getting a criminal record. However, people caught with small amounts of cannabis in these states are often given a 'caution' from police. A caution usually involves being given information about the harms of cannabis use, and may include drug assessment and referral. There is a limit to the number of cautions a person can have. For more information, contact the police in your local area.

Note: this information was correct at the time of writing.

What are the harms of using cannabis with other drugs?

- It is potentially dangerous to mix cannabis with other drugs including alcohol and prescribed medicines.
- It is important that doctors know if a client is taking medicines for mental illness (for example, anti-depressants or anti-psychotics) and also using cannabis. The cannabis may interfere with how well the medicines work, or the cannabis effects may be confused with side effects of these medicines.
- Most cannabis users also smoke tobacco, either as 'spin' in their cannabis or as a stand-alone drug. Those cannabis users who use tobacco increase their risk of cardiovascular disease and lung damage. People who smoke tobacco and cannabis tend to inhale more deeply and for longer, and they hold more smoke than tobacco smokers who do not smoke cannabis.
- It is especially risky to combine alcohol with cannabis. Alcohol may increase the speed with which your body absorbs cannabis. Both can affect driving and control of impulses. The combined impact can lead to poorer decision making, greater risk taking, and more negative health outcomes. If a person is trying to reduce their cannabis use, it is important that they do not increase their alcohol consumption to replace the cannabis.

HOW TO RECOGNISE CANNABIS DEPENDENCE

Around 1 in 10 people who use cannabis become dependent. Up to half of daily smokers can be dependent. When dependence happens, cannabis becomes something that the person needs and feels they cannot live without.

People who are dependent on cannabis may:

- Feel a strong desire to use ('cravings')
- Want to stop or reduce their cannabis use but find that they are not able to do so
- Become anxious or agitated when they run out or stop using cannabis (i.e. go through withdrawal)
- Need to use more cannabis to get the same effect (tolerance)
- See cannabis as more important than most other things, so they may not take part in other activities that are important to them; they may spend a great deal of time obtaining, using and getting over cannabis use.
- Continue to use cannabis even though they can clearly see the harms that it is causing them or their family.

The time and amount of cannabis used before a person becomes dependent varies. Past and present stress and social supports can also affect the chance of becoming dependent on cannabis.

HOW TO RECOGNISE CANNABIS WITHDRAWAL

People who are dependent on cannabis may experience some withdrawal symptoms when they stop. Withdrawal may occur in half or more of dependent users. Withdrawal signs can start within six hours of stopping cannabis. People often feel at their worst 2–3 days after stopping, and feel much better after six days. Some symptoms can last for a few weeks, but they gradually improve over that time. Cannabis withdrawal is uncomfortable but not physically dangerous.

Symptoms of cannabis withdrawal

- Irritability, anger, aggression
- Anxiety or nervousness
- Restlessness
- Sleep difficulties, strange dreams
- Cravings
- Weight loss or decreased appetite.

Less commonly, people may experience:

- Depressed mood
- Physical discomfort: stomach pain, chills, sweating, shakiness.

HOW TO ASSESS A CLIENT WHO USES CANNABIS

People who use cannabis often do not access treatment and may attend health services for another reason (e.g. for anxiety, depression, chest infections, other drug use). As with any drug and alcohol assessment, use a positive style when you look at what is going on. Consider their cannabis use in the setting of their other substance use, their health, and family and community. The assessment should also look at the person's strengths and the resources they can access to help them cut down or quit cannabis.

Questions you can ask about cannabis use

- How much do you use? (e.g. grams, cones, joints or money spent)
- How long have you been smoking cannabis?
- How old were you when you first used cannabis?
- Have you ever tried to stop using before? Were you able to quit previously? If so, how did you do this? (e.g. What help did you receive?)
- How does cannabis help you? What are the good things about smoking cannabis?
- What are the not-so-good things about smoking cannabis?
- Do you want to change your cannabis use?

Other questions to ask your client

- Do you use any other drugs or alcohol?
- Do you have any mental health concerns? (e.g. anxiety, depression, strange experiences/psychotic symptoms)
- Are you having thoughts about suicide or planning to harm yourself?
- Do you have any physical health problems? Have you had a recent health check?
- Are you having any problems with relationships, money, the law, or employment?
- What supports do you have? (e.g. family, friends, employment, other health workers)
- Are there children at risk when people are smoking cannabis? (safety: are there care givers who do not use drugs?)
- Are you safe at home? (e.g. is there any violence in the home?)

HOW TO HELP A CLIENT WHO USES CANNABIS

Counselling

Counselling is the best available treatment for people who are dependent on cannabis (see Counselling, p.20). Services that provide counselling support to cannabis users include:

- Drug and alcohol services (government or non-government)
- Aboriginal medical services
- Youth counselling services
- Medicare approved private counsellors (psychologists, social workers and occupational therapists). Your client can get a referral from their GP.
- Support groups such as Marijuana Anonymous, Narcotics Anonymous, SMART Recovery and relapse prevention groups (see Mutual support groups, p. 54).

Counselling usually focuses on the following areas:

- Education on the harms of cannabis can help raise their awareness of bad aspects of use.
- Increasing or maintaining motivation for change – you can help them weigh up the good and the bad aspects of their cannabis use.
- Problem solving and goal setting
- Developing coping skills, including stress management and relaxation, assertiveness and communication skills, drug refusal skills, and self-care
- ‘Mindfulness’, including recognising triggers for cannabis use
- Strategies for a healthier lifestyle (e.g. sleep, diet and exercise).

Managing cannabis withdrawal

For most clients, cannabis withdrawal can be managed at home and many people do not need any medicines. If there are concerns about the client's mental or physical health, or if they feel they are unable to stop while in the community, an inpatient detox or residential rehabilitation program ('rehab') can be considered.

People who are particularly at risk (e.g. mental health problems, major social stress) may need longer periods within a safe environment to gain skills to help them to make long-term changes. For these people, rehab programs may be better.

If a client is having (or expects to have) problems with withdrawal symptoms (e.g. sleep problems, depression, anxiety) they could see their doctor. Sometimes low dose Valium (diazepam) is prescribed; for example, 1 tablet 3 times a day, reducing to nothing by the 5th day. Daily dispensing of Diazepam (e.g. from the chemist) reduces the risk of misuse.

If a person mixes tobacco with cannabis they may also get nicotine withdrawal when they cease cannabis. Nicotine gum or another short-acting nicotine replacement therapy (NRT) may help (see p. 118).

Medicines for relapse prevention?

There are no medicines that are approved to prevent people relapsing to cannabis dependence. Many medicines have been trialled, but none have been effective enough to be used all the time.

REDUCING THE HARMS IF A CLIENT CANNOT OR WILL NOT STOP

If a client cannot or will not stop using cannabis, they could try:

- Smoke a joint instead of using a bong. Joints take more time to prepare and may be less damaging to the lungs as more smoke is lost compared to using a bong. People also may inhale less deeply with a joint.
- Increase the time between smoking sessions.
- Do not mix tobacco with cannabis to avoid or reduce tobacco dependence and also to avoid the harms of smoking tobacco.
- Do not mix cannabis with alcohol or other drugs.
- Do not drive while stoned due to slower reaction time, and reduced concentration and coordination (see Alcohol, drugs and driving, p. 322).
- Do not smoke near children and other people.
- Do not breastfeed if smoking cannabis.
- Spend more time with people who do not use cannabis.
- Get outdoors and exercise more.

PREVENTING CANNABIS USE FROM EVER STARTING

Cannabis use often begins in adolescence. Problematic cannabis use is more common in young people who experience peer pressure, stressful life events, low self-esteem and have easy access to cannabis. Parents, caregivers and other family are best placed to help young people through adolescence. When young people do experiment it is important that adults offer support by talking to them in a non-judgemental way and provide them with accurate information.

Keeping young people connected (e.g. to school, family, community and/or culture) can help make them stronger and less likely to develop cannabis and other drug problems.

FURTHER READING

National Cannabis Prevention and Information Centre's cannabis fact sheets: ncpic.org.au/workforce/alcohol-and-other-drug-workers/cannabis-information/factsheets/.

Copeland J, Frewen A & Elkin K (2009). *Management of cannabis use disorder and related issues: A clinician's guide*. Sydney: National Cannabis Prevention and Information Centre, University of New South Wales. See: ncpic.org.au/ncpic/news/ncpic-news/pdf/management-of-cannabis-use-disorder-and-related-issues-a-clinicians-guide.

5

Opioids

<u>Overview</u>	140
<u>What are some commonly used opioids?</u>	140
<u>Effects of opioids on the body</u>	141
<u>How to recognise harms from opioid use</u>	142
<u>How to recognise opioid dependence</u>	144
<u>How to recognise opioid withdrawal</u>	145
<u>How to assess a client who uses opioids</u>	146
<u>How to help a person who uses opioids</u>	149
<u>Opioid overdose</u>	155
<u>Reducing the harms if a client cannot or will not stop</u>	156
<u>Preventing opioid use from ever starting</u>	157
<u>Further reading</u>	158

OVERVIEW

Opioids are medicines that reduce pain, and also make people feel sleepy and calm ('sedated'), or a strong sense of happiness ('euphoria'). Opioids occur in plants and can be found in opium poppies (e.g. morphine, codeine). Opioids are also made in laboratories. For example, some are naturally occurring opioids that have been altered (e.g. heroin), while others are made from chemicals only (e.g. methadone, oxycodone, buprenorphine). The body also produces its own opioids (endorphins).

Opioids are used as a treatment for pain, but also to treat coughs and diarrhoea. The sedation and euphoria that opioids provide are the effects particularly sought after by opioid users.

Whether the opioids are legal (like oxycontin) or illegal (like heroin), misuse can lead to severe health and social problems, and a much higher chance of death at a young age. Daily or almost daily use of illegal opioids often becomes a long-term problem in which people become dependent on the drug, have withdrawals when they stop, and frequently relapse back to use after stopping. There are treatment programs (e.g. opioid substitution treatment), which can reduce the harms of illegal opioid use.

WHAT ARE SOME COMMONLY USED OPIOIDS?

- *Heroin*: is mostly injected, but sometimes smoked. It has very strong effects and is obtained illegally. Heroin is mixed with other substances such as quinine, lactose and starch to reduce its purity.
- *Oxycontin*, *MS Contin*: are typically injected or swallowed. They have strong effects, and last for up to 12 hours when taken by mouth. When injected the effects are stronger but shorter acting. These drugs can be prescribed by a doctor for pain relief, given by a friend or relative, or bought illegally from others.
- *Endone*: is mostly swallowed. It is shorter acting (lasting up to six hours) and has fairly strong effects. It can be prescribed by a doctor for pain relief, given by a friend or family, or bought illegally.
- *Codeine*: is mostly swallowed. It is short acting (lasting up to six hours) and has mild effects. It can be prescribed by a doctor in higher doses for pain relief (e.g. Panadeine Forte), or bought over-the-counter at pharmacies.

How common is opioid use?

About 1 in 70 Australians have ever used heroin, and between 1 in 250 and 1 in 500 people have used heroin in the past 12 months. We do not have good data on how common heroin use is among Aboriginal Australians.

Among people who have problems with illegal (illicit) opioids like heroin or street Oxycontin, it is thought that up to 1 in 7 are Aboriginal.

Around 1 in 15 Aboriginal people have ever used painkillers for non-medical reasons, and, in the past 12 months, 1 in 24 had used them. This is about two times higher than in non-Indigenous people.

Prescription opioid use has increased a lot since 2001. For example, the number of prescriptions for oxycodone (Oxycontin) grew by more than 10 times between 2001 and 2007.

People who use opioids often use other drugs as well. Drugs commonly used by opioid users include tobacco, cannabis, alcohol, methamphetamine, and benzos.

EFFECTS OF OPIOIDS ON THE BODY

Opioids act on the body by attaching to specific parts of the body called ‘opioid receptors’. When opioids attach to these receptors (e.g. in the brain, in the spine, and in other parts of the body), they cause the opioid effects including pain relief, sleepiness, and a pleasant feeling. Opioids that cause strong effects at the opioid receptors (e.g. pain relief, sleepiness and a pleasant feeling) are called ‘full agonists’. Morphine, heroin, codeine, methadone, and hydromorphone all have strong opioid effects and are examples of full agonists. Some opioids, like buprenorphine, cause much less opioid effect. These are called ‘partial agonists’, meaning they cause only a part of the opioid effects. Partial agonists cause less sleepiness and less of a pleasant feeling compared to full agonists (see Opioid receptors, p. 203).

Main effects of occasional use of opioids on the body

- Less pain
- Sleepiness (sedation) and relaxation, calming
- Strong sense of happiness (euphoria)
- Small pupils ('pinned')
- Slowed breathing
- Decreased blood pressure
- Increased sweating
- Less bowel activity.

Long-term daily use of opioids

With long-term use of opioids, there is less pain killing effects over time, less sedation, less drop in blood pressure, less slowing of breathing and less euphoria. Pupils remain small even with very long-term opioid use.

Other common side effects from long-term opioid use are:

- Constipation
- Hormonal changes which can cause reduced sexual desire and problems with sexual function (e.g. impotence in men)
- Lots of sweating
- Sleep problems.

HOW TO RECOGNISE HARMS FROM OPIOID USE

Physical harms

- Overdose: Overdose is common in opioid users. Overdose happens when the opioid dose is too strong for that person. People in overdose will have slowed breath that can stop and lead to death, and they may be sleepy or unconscious ('on the nod'). People who are newer to using opioids, or use low amounts or less often are more likely to overdose, as they have not yet adapted to using opioids (i.e. they have low tolerance). Overdose is not related to the person's size. Death from overdose can happen within minutes.



In case of overdose the following steps are vital

- Put the person in the recovery position
- Call for help – ambulance if the person has very slow breathing
- If breathing stops, clear the mouth and throat and give CPR (see p. 436)
- The antidote, Narcan, can be lifesaving.

- Harms from injecting
 - Injecting any drug can lead to infection with blood-borne viruses like hep C and hep B. HIV is not common in people who inject drugs in Australia, but can still be spread by sharing needles, syringes and other injecting equipment.
- Injuries and infections from injecting are common in people who inject opioids. This can include skin infections (e.g. cellulitis), and abscesses or infections in the blood and heart, which can lead to death (see Harms from injecting, p. 289).

Using opioids and the chance of becoming infected with hep C

Out of 10 injecting opioid users who have been injecting for four years or more, up to seven of them will become infected with hep C (see Hep C and hep B, p. 302).

- Harms from smoking: Some people think that smoking opioids reduces the chance of overdose and does not lead to dependence, but overdose and dependence can happen when smoking opioids.
- Dental problems: Taking opioids long-term can cause teeth decay as opioids dry the mouth and reduce saliva (spit). Saliva helps kill bacteria so is important in protecting teeth. Heroin, Oxycontin, methadone and most other opioids have the same effect on teeth (see Opioids and teeth, p. 204). People on methadone can reduce dental problems by cleaning their teeth regularly, seeing a dentist and chewing sugar-free gum to increase saliva flow.

Psychological harms

The main psychological harms of heroin use happen because it is illegal and there is a lot of stigma around use. When people become dependent on heroin, life becomes very complex which can lead to anxiety and depression.

Social harms

- Buying opioids, such as heroin or Oxycontin 'on the street' is expensive. People who are dependent usually need a lot of money to maintain their opioid use and avoid withdrawal (e.g. people dependent on heroin usually use between \$50 and \$200 worth of heroin a day).
- Because of this, the person's finances, employment, and relationships with their partner and family are often destroyed.
- People dependent on opioids may turn to crime or sex work to raise money to continue using opioids. This can lead to a loss of respect in their community, and many people end up spending time in jail.

HOW TO RECOGNISE OPIOID DEPENDENCE

When a person is dependent on opioids their drug use becomes more important for them than most other things. For example, drug use may take priority over work, relationships, finances, health, family and community.

A person can become dependent on opioids very quickly. Others may continue with occasional use for a long time. On average, people become dependent after one to two years of opioid use.

Opioid dependence is said to be present if three or more of the following have been happening (together at some time) during the previous year:

- A strong desire (craving) or need for opioids (compulsion); for example, if trying to stop or cut down
- Hard to control opioid-taking behaviour
- Physical withdrawal when opioids are stopped or reduced, or using an opioid (or other drug) to relieve or avoid withdrawal symptoms
- Needs to use more opioids just to feel its affects (tolerance; i.e. higher doses are needed to get the same effects that were originally experienced by lower doses)
- Opioids become number one in the person's life. Family, work and everything else becomes secondary. More and more time is taken up getting and using opioids.
- Keeps using opioids despite clear signs of harms. You could check that the client is aware that this harm is linked to their opioid use.

If the person returns to opioid use after a period of not using (abstinence), these features may very rapidly reappear.

A clear sign of opioid dependence is when a person goes into opioid withdrawal when they cannot obtain the drug, or when they intentionally stop using.

Opioid dependence, if severe, will often be a chronic relapsing condition. It is not unusual for people to struggle with this condition for 10 to 20 years. We know now that opioid dependence is a complex condition. People can be more at risk of becoming dependent due to their genes (make-up), early development and social supports. Once dependent, they have problems with finances, work, health, and social networks, which can make life difficult and make it harder to stop using. Also, there are changes that happen in the brains of people who are dependent that make it more difficult to stop using. This does not mean people cannot overcome opioid dependence, but stopping use can be a long-term struggle. Health workers need to be realistic about what can be achieved by dependent people at particular times.

HOW TO RECOGNISE OPIOID WITHDRAWAL

Opioid withdrawal is usually not medically dangerous. It does not cause hallucinations (seeing and hearing things that are not there) or seizures, and people do not become very confused. Opioid withdrawal usually starts within about 24 hours of the last use of short-acting opioids like heroin. Symptoms can be very unpleasant, and are similar to a bad case of the flu.

Opioid withdrawal mostly takes the following course:

Day 1 (first 24 hours): increased sweating, runny eyes, runny nose, loose bowel motions, aches and pains, sleep problems, craving for opioids.

Days 2 to 4: diarrhoea, feeling sick in the stomach (nausea) and vomiting, stomach cramps, worsening aches and pains, headache, passing urine more often, 'goose bumps', small increase in heart rate and blood pressure, anxiety, low mood, sleep problems get worse, and strong cravings for opioids.

Day 5: withdrawal symptoms fade away over the day, except for some persisting sleep problems and moodiness. Cravings can continue for a number of weeks, though they tend to slowly go away over that time.

However, if your client has been using longer-acting opioids like methadone, then withdrawal will come on more slowly, and last longer before it fades away. Methadone withdrawal can last three to four weeks for clients who have been taking methadone for many years (see Opioid substitution treatment, p. 150).

While opioid withdrawal is usually not a medically serious or dangerous condition, it can sometimes be dangerous. For example:

- In pregnant women: withdrawal can cause miscarriage, early labour, or other risks to the health of the baby or mother.
- When withdrawal is brought on suddenly by taking an opioid blocker drug like naltrexone (oral tablet) or Narcan (naloxone injection). This can cause severe vomiting and diarrhoea, and mental confusion (delirium) where clients may hallucinate and not know where they are. If this happens, clients can be at risk of harm to themselves or others.
- In people who are already very sick.

HOW TO ASSESS A CLIENT WHO USES OPIOIDS

Encouraging your client to talk about their opioid use

Clients may have many reasons why they will not talk about their opioid use.

They may be:

- Worried about getting into trouble with the law
- Embarrassed or ashamed because of stigma about opioid use
- Worried you will tell people who they do not wish to know
- Worried about having their children removed if they talk about drug use.

Ask about opioid use in a non-judgmental way, using non-threatening language, so the client feels more comfortable talking to you about their use. You could say:

- “A lot of people take painkillers or use stronger drugs like heroin. They can be really tough to get off. Do you use heroin or other painkillers? Have you used them in the past?”

Finding out more about your client’s opioid use

If the client says that opioid use has become more important than other aspects of their life, this is the key sign of dependence. Of course, describing withdrawals when they stop, and using to avoid going into withdrawal are also sure signs of opioid dependence. It is important to work out whether the client is likely to have withdrawals if they stop, or if they are at risk of serious problems from ongoing use if they do not stop.

In order to do this, you need to ask the client:

- Which opioids they use
- How much they are now using, how often they use, and by what route (e.g. inject, smoke, swallow)
- How long their use has been at that level
- When they first used opioids, when they started to use them regularly, and when it became daily use
- If their patterns of use have changed over the years (e.g. have they had periods off opioids, how they achieved that, and what led up to them returning to opioid use)
- When they last used, as that will help in working out if withdrawals could be an issue right now.

Talking with your client about what to do about their opioid use

Once you have found out about the client's opioid use, you should talk about what they want to do about their opioid use. If the client is undecided, take a motivational approach where you help the client think about the good and bad things about opioid use, provide information about the harms from opioid use, and what the benefits of stopping might be. This can help the client to make up their mind about what to do about their drug use.

For clients who are taking opioids for chronic pain (that is not caused by cancer or terminal illness), it is important to give information about opioids and long-term pain. There is not good evidence for the use of opioids to treat long-term pain. It seems that opioids will only reduce pain levels in up to 3 in every 10 people with chronic pain. Over time, people become tolerant to opioids (their bodies get used to them and they do not work as well) and they can get caught up wanting more and more opioids. But often all they get is more side effects and no real change to their pain levels.

If a client is interested in help, it is important to give them information about what helpful options are available, and explore any worries that they have. The client might be worried about how sick they will get in withdrawal, spending time away from their family or community, going to a detox unit, or side effects of treatment. By talking about their fears and giving accurate information, clients can become more willing to accept the help they would benefit from.

It is important to ask people who use opioids about their use of other drugs, and take their other drug use into consideration when planning how to help the person.

What you observe

Indications that people might be using opioids can also be found from observing people closely. For example:

- Look at their eyes to see if their pupils are very small, even in poor light
- Sleepiness or drooping eyelids
- Track marks on arms or needle marks running along veins are evidence of injecting drug use – a common way opioids are used.

Urine testing

Urine testing is another way to find out whether a client is using opioids, and which one(s) they are using. Sometimes it can help start a conversation about their recent drug use. Urine testing will usually show traces of opioids for 48 to 72 hours after a person has used. Long-acting opioids like methadone will be in the urine for longer. It is important to remember that a client's urine test results can be subpoenaed by courts or child protection agencies (i.e. you have to give the court or other agency the test results).

Urine test results

When looking at urine test results, the break-down products of the drug may show in the urine test. For example, heroin will show up as acetyl morphine or morphine. Morphine will show up as morphine and codeine. Codeine may show up as codeine and traces of morphine. It is best to check with labs when results are confusing, rather than jump to conclusions about the meaning of 'positive' urine tests. Also, many labs do not routinely test for some opioids including Oxycontin (oxycodone) or buprenorphine unless you ask them to.

HOW TO HELP A PERSON WHO USES OPIOIDS

The following treatments are usually available to help people who have problems with opioid use:

Detox or withdrawal treatment

As opioid withdrawal is mostly not dangerous, treatment can be provided while the client remains in the community, or can happen in an inpatient detox unit or a hospital ward.

No medicine will completely take away the withdrawal symptoms. People detoxing need to be prepared for some discomfort. The best medicine to help reduce withdrawal symptoms is buprenorphine. Clients withdrawing in the community are detoxed over about five days, where they are given a dose once a day with smaller doses each day until the dose reduces to nothing. In inpatient settings, buprenorphine is given in smaller doses throughout the day as needed to help reduce the symptoms, again with doses reduced to nothing over about five days. Buprenorphine prescribed in the community needs to come from an accredited prescriber (the doctor does a short course).

If buprenorphine is not available, clients are given medicines that target their symptoms (e.g. medicines to reduce diarrhoea, nausea, aches and pains, sleep problems, and agitation). The medicines (e.g. clonidine, Buscopan, Diazepam) are given for no more than five days so the client does not switch their dependence to these drugs.

Clonidine is a blood pressure medicine that can help reduce some of the opioid withdrawal symptoms. But this medicine can cause drops in blood pressure and pulse, so should only be used under close medical supervision (e.g. observe the person in the clinic for half an hour after their first dose).

The support of counsellors, nurses, family and friends is important to help clients to get through opioid withdrawal. It is best if support and professional help are available when a client detoxes to help them get through.

However, opioid withdrawal is often not successful in the long-term. Relapse rates back to opioid use after detox are very high (e.g. up to 9 out of 10 people may relapse within a year). Despite this, opioid withdrawal is often the necessary first step before starting a program that can provide further support. For example, to go into rehab, clients usually have to detox before entry. Clients who do an inpatient detox may be more likely to complete withdrawal and go onto to another form of treatment.

Rehab

Residential rehab programs are mostly for clients who have been opioid dependent for a long time and have suffered major life problems because of their drug use. Rehab programs require a strong commitment to making changes. Clients leave their home and family and friends for a long time, often between three months and two years. During that time they have to attend groups and counselling in the rehab, and follow the rules of the rehab. Because of this, most opioid dependent people do not decide to go into a rehab program. Also, many people drop out of rehab within the first three months (around 6 in 10 people leave within three months). On the other hand, we know that for those who stay longer, the outcomes are better (see Resi rehab, p. 58).

Opioid substitution treatment

Opioid substitution treatment (OST) is the main treatment for opioid dependence in Australia. This treatment works by providing opioid dependent people with a prescribed opioid drug that stops withdrawals and cravings for opioids, and helps clients to get their drug use and other parts of their lives under control. These treatments help to reduce the health and social problems caused by opioid dependence.

The main types of OST are:

- Methadone
- Buprenorphine (Subutex), which is buprenorphine alone
- Buprenorphine-naloxone (Suboxone), which is a combination of buprenorphine and naloxone (an opioid blocker).

If Suboxone is injected, the naloxone can cause unpleasant withdrawal symptoms. Suboxone was designed to stop people from injecting their buprenorphine.

- Methadone and buprenorphine are long-acting medicines that need to be taken every day (or every second or third day for some people on buprenorphine).
- Methadone is a liquid that is swallowed, and buprenorphine is a tablet which is placed under the tongue. Suboxone is available as a film that looks like a small piece of plastic that dissolves under the tongue. Suboxone tablets may be phased out as they take longer to dissolve and so there may be more risk of clients diverting their dose (i.e. removing it from the dosing site before it has been absorbed).
- Because these medicines are not supposed to be injected, if taken correctly they reduce the risk of infections like hep C, hep B and HIV.

Supervised dosing of methadone or buprenorphine

Clients on methadone or buprenorphine (as Subutex or Suboxone) treatment usually have to come to a clinic or pharmacy every day or almost every day for supervised dosing. Sometimes clients on buprenorphine can have a higher dose that lasts two or even three days, so they do not have to come as often.

Clients who are stable after three months on methadone or Suboxone treatment can usually start to have some takeaway doses (where they take the medicine themselves at home). For Suboxone, stable clients can build up the number of takeaways over time, until they are receiving 30 takeaway doses at a time (picking up their medicine just once a month).

It is often difficult to access OST in rural and remote areas.

Methadone and buprenorphine are prescribed in doses that stop withdrawal symptoms and stop craving for opioids, so that if clients use opioids like heroin on top of them they do not get much of an extra effect. The actual dose to help someone become stable will be different for each client. The key is not the actual dose, but how it is affecting the client. An effective dose will stop the client from using other opioids, is not so large that it is sedating, and is not too small that the client experiences withdrawal symptoms before their next dose. An effective dose will also help the client function better in the community. Usually an effective dose of methadone will be somewhere between 60 and 120mg daily, and an effective dose of buprenorphine will be between 12 and 24mg. We know that you need a high enough dose to do well in treatment, as low doses are a common reason for treatment to fail.

OST also brings opioid dependent people into contact with doctors who can treat other physical or mental health conditions they have. It also brings clients into contact with counsellors or caseworkers who can help them sort out issues with drug use and in other areas of their lives.

Some clients may do better on methadone, while others do better on buprenorphine. There is no clear way to work out which treatment is better for different clients. Methadone may have lower rates of treatment drop-out. On the other hand, buprenorphine is less likely to cause dangerous overdose in the early part of treatment.

How long does treatment last?

Clients typically do better the longer they stay on treatment. Because of this, people are not reduced off their program if they are not ready to stop, unless their behaviour is unacceptable (e.g. aggression) or they are clearly not benefitting from treatment (e.g. using other drugs like alcohol and benzos in a dangerous way). If a client continues to use heroin while on OST they need a medical review to see if their dose is high enough.

How long treatment lasts for each client will vary. Clients who have been using heroin for many years may need several years of treatment. When a client reduces off methadone or buprenorphine, it needs to be done slowly (several months for methadone). Clients on OST have a better chance of doing well after they stop treatment if they reduce off their medicine at a time when both they and their case worker/prescriber agree that they are ready. Relapse back to opioid use is very common after stopping OST – around 8 in 10 clients relapse within 12 months of stopping the program. Sometimes people relapse because they have come off treatment too soon, or tried to come off too quickly.

What are some day-to-day problems clients have with treatment?

OST can also be difficult for clients, which can often make clients feel their life would be better without OST. For example:

- Family, friends or others may have negative attitudes about a person being on OST.
- Treatment can be expensive. Often pharmacies or private clinics will charge clients between \$5 and \$8 per day. Then there is the cost of seeing the prescriber regularly, which may be an issue if the doctor does not work in a public clinic or does not bulk bill.
- Being on OST means that organising trips and holidays can be difficult. There may be no dosing for the client where they want to go, and it will always need to be organised in advance.

Gaining and keeping a job can be hard when a client is on OST if they are dosing daily or almost daily at a clinic or at a time or place that does not suit their work.

People for whom access to an OST is a priority

There are some groups of people who can get on OST more quickly. These are:

- Aboriginal and Torres Strait Islander people: you should advise your client to mention that they are Indigenous as this may help them get on a program more quickly.
- Pregnant women who are opioid dependent, and their opioid using partners: this is because of the risk of complications from opioid use during pregnancy. Methadone is the treatment of choice for opioid-dependent pregnant women, as it is important to avoid opioid withdrawal because of the problems this can cause during pregnancy (e.g. early labour, miscarriage, death of the baby in the womb, womb infections).
- People with HIV and their opioid using partners: people with HIV who continue to inject opioids can place other people at risk of becoming infected with HIV through sharing of needles, syringes and other injecting equipment. Also, people with HIV with problem opioid use have trouble sticking to their HIV treatment and their health suffers.
- People with life-threatening problems from injecting opioids such as heart infections (infective endocarditis).
- Other priority groups are people with hep B, leaving jail or on court diversion programs.

If you do not know where to find a local methadone or buprenorphine prescriber, try calling any local drug and alcohol unit or the Alcohol and Drug Information Service (ADIS) in your state or territory (see p. 435).

Naltrexone

Naltrexone is an opioid blocking drug that is taken in tablet form. It has no opioid effects itself. If taken as prescribed, which is usually one tablet a day, it will block the effects of opioids for 48 hours. This means that if the person uses opioids while naltrexone is in their body, the opioids will have no effect. This sounds like a good treatment, but many clients do not take naltrexone as prescribed, and after three months only about 1 in 16 people who started treatment will still be taking it. Because of this, naltrexone is not subsidised on the PBS for the treatment of opioid dependence, so people have to pay around \$140 or more per month. If a person plans to start naltrexone treatment, they have to be sure they have all opioids out of their system to avoid a severe withdrawal ('precipitated withdrawal').

Naltrexone and naloxone (Narcan, another opioid blocking drug) are used for rapid opioid detox. These drugs are given under medical supervision to a client who is opioid dependent, so that they go into severe opioid withdrawal. This is much more severe than the usual opioid withdrawal but shorter in duration. This treatment can be dangerous if not done under proper medical supervision. Even with medical supervision there are risks. Rapid detox can help people to get onto naltrexone more quickly. But the problem remains that people do not keep taking the naltrexone and usually relapse to opioid use.

There is research being conducted into forms of naltrexone that can be inserted under the skin as implants, which releases naltrexone for many months, or given as injections that work for about one month. While these are promising ideas, the treatments are still being tested and are not available in Australia at this time.

Counselling

People who use opioids, but are not dependent on them, can benefit from counselling where they learn about the risks of using these drugs. They can also learn about ways to avoid becoming dependent. This includes skills on how to refuse drugs, how to cope with urges to use, how to avoid situations where using is more likely, and how to seek help if they are slipping into dependent use.

A motivational interviewing approach can assist people to make their own decision to get help if undecided. CBT (cognitive behavioural therapy) involves helping a client to change the thinking that leads them to drug use.

For people who are dependent, counselling can help people find out about treatments that work, and how to access those treatments.

Relapse prevention counselling after withdrawal from opioids can assist to reduce the risk of returning to opioid use. As noted above, severe opioid dependence is a chronic relapsing condition, so even with counselling relapse rates are very high (see Counselling, p. 27).

Mutual support groups

Mutual support groups are meetings where people share stories of how their lives have been affected by drug use to support each other to stay 'clean'. Many people have found them helpful in maintaining abstinence from opioids. Some people do not choose these options if they do not feel comfortable talking in front of a group. Also, some Narcotics Anonymous (NA) groups do not support people staying on methadone or buprenorphine treatment and this may upset some clients (see Mutual support groups, p. 54).

OPIOID OVERDOSE

Overdose on opioids is life threatening, and may need urgent cardiopulmonary resuscitation (CPR) and medical attention. The risk of overdose is greater when opioids are taken with other depressants like alcohol and benzos (e.g. Diazepam, Rivotril, Xanax, Serepax).

Overdose is also more common when people use opioids after a period of being off them. In this situation, their body is no longer used to the effects of opioids, and a dose which may not have been dangerous when they were using regularly can all of a sudden be life threatening (i.e. their tolerance has gone down). This can happen after people are released from jail, after leaving detox or rehab, or after stopping naltrexone.

Recognising overdose

When someone is in opioid overdose, here are the signs you will see:

- The client will look very 'drugged', unsteady on their feet, drowsy and then can be seen to be 'nodding off'.
- Snoring can be heard sometimes, and this does not mean they are okay.
- Breathing becomes slowed and sometimes laboured. Breathing can stop, as can their heart.
- Heartbeat can become slow and blood pressure may drop quite low.
- The client may be confused and clouded in their thinking.
- The pupils in their eyes will be very small (pinpoint pupils).
- They may become unable to be woken up (unrousable).
- Lips and fingernails may turn blue. Their skin may become very pale and clammy.

What to do about overdose

If you are with a client who has signs of overdose, you should do the following:



Call 000 for an ambulance, and try to describe to the operator what you know about what the person has taken, and what condition they are in.

- Call for help from people nearby.
- If the client looks like they are about to vomit, lie them on their side and try to make sure they do not inhale the vomit.
- Do not let the person fall asleep – keep them moving and awake if possible.
- Do not give drinks or other drugs to ‘wake them up’ like coffee, water, or stimulants.
- Start CPR if they stop breathing, and make sure an ambulance is coming urgently (see p. 436).
- Note: Narcan only lasts for half an hour, but overdose can last much longer.

REDUCING THE HARMS IF A CLIENT CANNOT OR WILL NOT STOP

There will be some clients you see who continue to use opioids even though they are experiencing problems, and others who wish to stop but cannot. For these clients, it is important to provide information to reduce the harms from opioid use. This includes information about:

- Needle and Syringe Programs and where to find one (see NSPs, p. 298)
- Safer injecting, including using clean needles and syringes and other injecting equipment, and not sharing any injecting equipment with another person. This can help reduce the spread of diseases like hep C, hep B and HIV (see Safer injecting, p. 296).
- Testing the strength of the opioid, by first using a small amount to make sure they do not overdose
- Avoiding combining opioids with other depressants (benzos and alcohol). These can increase the risk of overdose.
- The risks of driving (and operating machinery) when using drugs. People who misuse opioids have more car accidents and other injuries. Driving should be avoided by people who are intoxicated with opioids. Note: it is okay to drive on prescribed methadone or buprenorphine if the person does not feel drowsy.

- The risks of using drugs when there are children around. For example, you should talk to your client about whether they have trouble caring for their children when they are intoxicated. Also talk to your client about avoiding sleeping in a bed with babies when they are intoxicated.
- Unsafe sex that can happen after using drugs, which may lead to unplanned pregnancies and STIs.

PREVENTING OPIOID USE FROM EVER STARTING

Reducing the supply of opioids and reducing demand for opioids can help prevent problems with opioid use.

Reducing supply

Reducing supply means making opioids less available. For drugs like opioids this can be done by reducing the amount of opium poppies that are grown, and reducing the amount of opioids that are illegally brought into Australia. There is debate over how effective these approaches are, and how costly they are.

In recent years, the use of prescription opioids has increased (e.g. Oxycontin, Endone and morphine), which also increases the number of people who have problems with their use of these drugs. There are a number of ways to prevent problems from prescription opioid use, including:

- Making it harder to get a prescription. This means that doctors have to show authorities that clients really need the opioids.
- Educating doctors about the overuse of opioids
- Letting clients know that opioids do not always work well for long-term pain except in people with cancer.

Reducing demand

A number of things make a person more likely to become dependent on opioids. These include: growing up in a disadvantaged family environment, family problems, lack of supervision and discipline, and drug and alcohol use by parents and siblings. Also, earlier use of drugs and alcohol, being impulsive while growing up, and having drug-using peers also increase the chance of starting opioid use.

Reducing these risk factors may prevent opioid use problems developing in some people. Also, making young people stronger (more resilient) through programs that increase self-confidence and provide skills to live without drugs may also help prevent opioid use from starting.

FURTHER READING

NSW Health (2006). *New South Wales Opioid Treatment Program: Clinical guidelines for methadone and buprenorphine treatment of opioid dependence*. North Sydney: Mental Health and Drug & Alcohol Office, NSW Department of Health. Available from: www.health.nsw.gov.au/policies/gl/2006/pdf/GL2006_019.pdf.

Access All Areas: Making treatment transparent. This series of short videos provides information about treatment for people who inject drugs. There is a list of video topics and links to view these on YouTube. See www.anex.org.au/new/publications/reports.

The National Drug Strategy has separate guidelines for the use of methadone and buprenorphine, and other publications. You can find these by googling for *national drug strategy publications*, then choosing *illicit drugs*. Or use this link:

www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/resources-menu

6

Stimulants

<u>Overview</u>	160
<u>What are some commonly used stimulants?</u>	162
<u>Effects on the body</u>	163
<u>How to recognise harms from stimulants</u>	165
<u>How to recognise stimulant dependence</u>	167
<u>How to recognise stimulant withdrawal</u>	168
<u>How to assess a client who uses stimulants</u>	168
<u>How to help a person who uses stimulants</u>	169
<u>Stimulant overdose</u>	171
<u>Reducing the harms if a person cannot or will not stop</u>	172
<u>Preventing stimulant use from ever starting</u>	172
<u>Further reading</u>	172

OVERVIEW

Stimulants are the class of drugs that include ‘uppers’ such as: MDMA (known as *ecstasy*), methamphetamine powder (known as *speed*), crystalline methamphetamine (known as *ice*, *crystal*, *shabu* or *crystal meth*) and cocaine (also known as *coke*). When methamphetamine is discussed in this handbook it includes amphetamine, as almost all amphetamine sold in Australia is actually methamphetamine.

All stimulant drugs cause an increase in mood, stamina, energy and concentration; and a reduction in appetite and the need for sleep. The more you take, the stronger the effect and the more likely you are to experience physical and mental health problems.

People can become dependent on stimulants. When they stop using they can feel depressed, but do not experience a dangerous physical withdrawal. The main treatment is counselling.

How common is stimulant use?

Stimulants are the second most commonly used type of illegal drug after cannabis in Australia. Around one in 40 Australians currently use stimulants. Most people do not use often and do not have problems with their use.

Ecstasy is most commonly used (around 1 in 25 Australians have used in the past 12 months), followed by methamphetamine (around 1 in 50 Australians). New stimulants regularly emerge, often legal at first and sold on the internet, before authorities catch on and prohibit their use. For example, mephedrone (also known by the street names *meow meow* and MCAT) has begun to be used in recent years.

History of stimulant use

Naturally occurring plant-based stimulants have been used by many cultures for thousands of years. Often used for their healing effects, stimulants were typically used for specific purposes at specific times. Examples include coca leaves and areca nut (also known as betel nut). Areca nut was chewed in a similar way to how some Aboriginal people chew pituri.

Problems were uncommon because stimulants were usually swallowed or chewed, so the effect came on slowly. Also, the amount of stimulant absorbed into the body from the plant was quite small (i.e. not enough of the drug could get into the body to cause a 'high').

About 100 years ago things changed. Cocaine was made from coca leaf and scientists first made amphetamine and methamphetamine. All of these are much stronger than natural stimulants. At first these drugs were used as medicines: cocaine was used for toothache; and amphetamines were used to stop blocked noses, to help people lose weight and to help with tiredness and sleepiness.

As these new stimulant drugs were much stronger than naturally occurring plant-based stimulants, only small amounts were needed to get a big effect. Made into crystals and powders, these drugs could be smoked, snorted and injected, meaning that big amounts could get into the body very quickly. Instead of feeling a bit brighter, having a bit more energy and not needing as much sleep, these drugs were taken in doses that meant you felt 'on top of the world' and could go without sleep for days.

WHAT ARE SOME COMMONLY USED STIMULANTS?

All illegally made stimulants can be ‘cut’ or diluted with various other substances, such as sugar, baking soda, or cheaper drugs. This is done to maximise profit. The following list shows the usual characteristics of the main stimulants sold in Australia.

- *Ecstasy (MDMA)*: usually comes as tablets but also in capsules or powder. The colour of the powder ranges from white to yellow to brown. Ecstasy tablets are made illegally and come in different sizes and colours. They often include a symbol stamped on the tablet (e.g. star, love heart) or a brand name logo (e.g. Mitsubishi, Calvin Klein). The main ingredient in Ecstasy is meant to be MDMA but the amount of MDMA in each tablet varies and some tablets contain none at all. In addition to MDMA, ecstasy tablets may contain methamphetamine, caffeine, ephedrine or hallucinogens. Ecstasy is usually swallowed, but is sometimes snorted. Some people inject ecstasy, or insert it into their vagina (known as shelving) or anus (known as shafting).
- *‘Amphetamine’ powder (speed)*: is usually white or yellow in colour and is usually not very pure (around 5% methamphetamine). It is the most common form of methamphetamine in Australia, and is usually snorted but can also be swallowed or injected.
- *Crystalline methamphetamine (ice, crystal, crystal meth)*: looks like slivers of glass or crystal-like white, beige or yellow powder and can be very pure (up to 80%). However, more commonly it is heavily ‘cut’ (i.e. mixed with other things) so this purity is often much lower (10–20%). It is usually smoked or injected.
- *Base methamphetamine (paste)*: is an oily, waxy product made during the process of making crystal methamphetamine. It is usually white, yellow or brown. Base is less pure (40–50%) than crystal. It is usually injected but can be swallowed.
- *Dexamphetamine (Ritalin) tablets*: are intended for the treatment of ADHD (Attention Deficit Hyperactivity Disorder) but are sometimes misused for the high they produce.
- *Cocaine (‘coke’)*: usually comes as a white powder (cocaine hydrochloride). It is mostly snorted, but it is sometimes injected or swallowed. Cocaine powder cannot be smoked because its melting point is too high so it does not turn into vapours (fumes).
- *Freebase*: is another form of powder cocaine (that has had the hydrochloride removed). It is more pure than regular cocaine, and can be smoked.
- *Crack cocaine*: is a crystalline form of cocaine that is usually smoked. It is more pure than cocaine powder or freebase powder. It usually looks like small yellowish-white crystal rocks. It is rarely used in Australia. Crack cocaine can be smoked because it has a lower melting point than cocaine powder.

EFFECTS ON THE BODY

The length of time that a user will feel 'high' after taking a single dose of stimulants depends on:

- Tolerance (when more of the drug is needed to get the same effect)
- Amount used
- Purity of the drug
- How it is used (e.g. swallow, snort, inject)
- How often it is used
- What other drugs are used at the same time.

Infrequent users may take one or two doses over a session lasting 8–12 hours; heavier dependent users may use every couple of hours for 3–4 days continuously.

Some of the physical effects common to all stimulants

- Increased movement, restlessness, muscle twitching, tremors – i.e. shaky hands
- Increased body temperature, sweating and dry mouth
- Big pupils (dilated), wide-open eyes, blurred vision
- Breathing faster
- Have more energy, strength and reflexes
- Do not need to eat as much
- Do not need to sleep as much
- Enhanced awareness of the senses, e.g. sounds seem louder and lights and colours look brighter
- Increased pulse and blood pressure.

Some psychological effects common to all stimulants

- Having more energy
- A strong sense of happiness (euphoria)
- Being more alert and able to concentrate, heightened awareness
- Being more confident, impulsive behaviour (disinhibition)
- Excitable and very talkative, talking loudly and quickly.

Some effects specific to ecstasy

- Ecstasy enhances the user's interactions with others. They become more understanding of others (empathy) and are less likely to be hostile, argumentative or aggressive than people using cocaine or methamphetamine.

Some effects specific to methamphetamine

- Methamphetamine use is associated with aggression or violence more often than other stimulants.

Some effects specific to cocaine

- People describe feelings of a greater sense of confidence and elation when using cocaine than for other stimulants.

How do stimulants work?

- All stimulant drugs increase the amount of chemical messengers in the brain (called monoamines). The most common monoamines are dopamine, noradrenaline and serotonin. These chemicals are important in the reward centre of the brain, i.e. the part of the brain that makes you feel good. The brain works best when it has the right balance of monoamines. Too many monoamines makes you overexcited, restless and agitated and can lead to feeling very agitated and paranoid. This is because too many monoamines cause the sympathetic nervous system to overwork.
- The sympathetic nervous system is a primitive system in the body that works to get you out of trouble when threatened, excited, frightened or anxious. However, stimulant drugs switch on the sympathetic nervous system chemically. They make you feel high (euphoric), with increased alertness and energy, and you feel like moving around quickly. You feel more confident because the body is in overdrive and the brain is very alert and working quickly.
- While too many monoamines make you over-excited, too few monoamines make you feel depressed, tired and low in energy. After using stimulants for many days in a row (binge), the brain has no monoamines left to release. This is why after taking stimulants for more than two or three days, people complain of hardly getting any effect. This is also why many users binge for a few days and then stop and sleep before bingeing again after their brain has refilled its supply of monoamines.

The ‘come down’ or ‘crash’ after stimulant use

After being ‘high’ from stimulants, the user can experience a ‘come down’ or ‘crash’ where they can feel down and need a lot of sleep.

The more stimulants a person uses each time and the longer each session is, the worse and longer lasting the ‘come down’ or ‘crash’ will be. Without food or sleep for 2–3 days, the person will collapse and go to sleep (i.e. they will ‘crash’). After sleeping for 24 hours or more, the person will be very hungry when they wake up. The crash and come down period can last for between 2–7 days, when the person feels tired, moody and unable to concentrate.

Although people can use stimulants for days and days, eventually the chemical transmitters in the brain cells are unable to keep making the person feel high. In order to get high again, the brain needs time to recharge.

HOW TO RECOGNISE HARMS FROM STIMULANTS

Who gets harms from stimulants?

- The more you take and the longer you take it for, the more likely you are to run into physical or mental health problems. People can become stimulant dependent when larger amounts are used over longer periods of time.
- Problems are also more likely when stimulants are taken with other drugs (polydrug use), especially alcohol, and the risk of physical problems and risk behaviours (such as violence) goes up.
- Mental health problems are commonly seen from stimulant use, and stimulant use can make most mental health problems worse.
- Stimulant use is particularly risky for people with heart problems, or a history of fits (seizures).
- For methamphetamine users, smoking (rather than injecting) does not protect you from trouble – people can still become dependent, and become psychotic and depressed.
- Smoking methamphetamine is also bad for your lungs. Tobacco smokers can be more at risk of lung problems.

Clients with a mental illness who use stimulants

- Are more likely to experience hallucinations, violence, suicide attempts, and be admitted to hospital
- May find that their psychiatric medicine does not work as well
- May become more violent or aggressive if they have a history of violence or aggression.

What are some of the physical harms of stimulants?

- Chest pain, abnormal heart rhythms, heart attack (especially for cocaine users)
- Risk of stroke
- Feeling unpleasantly agitated and restless
- Fits (seizures)
- Dangerously increased body temperature and dehydration – that can lead to collapse
- Jaw clenching, teeth grinding
- Dental problems – as a result of teeth grinding, as well as poor diet and not looking after teeth
- Weight loss
- Feeling tired with no energy (fatigue)
- Staggering (ataxia)
- Feeling like you want to vomit (nausea), vomiting, and ulcers
- For people who inject – becoming infected with blood-borne viruses (hepatitis C, hepatitis B, HIV), developing abscesses, and inflammation inside the heart (endocarditis).

What are some of the psychological harms of stimulants?

- Depression
- Anxiety
- Panic
- Paranoia
- Seeing or hearing things that are not there (hallucinations).

Stimulant-induced psychosis

Using large amounts of methamphetamine or cocaine can lead to temporary psychosis that may look the same as paranoid schizophrenia. People with stimulant-induced psychosis usually feel suspicious about other people, have unusual thoughts, and can experience delusions and hallucinations. With these delusions and hallucinations, people can hear things that are not there but can also see things or feel things that are not there (e.g. bugs crawling under the skin).

Stimulant-induced psychosis typically goes away within a few days, or at most a few weeks. People who have experienced stimulant-induced psychosis are more likely than other people to experience it again.

Stimulant-induced psychosis occurs in up to 1 in 7 users (10–15%), and is more common in dependent users, men, people who inject or smoke methamphetamine, polydrug users, and following a binge when the person has had no sleep.

What are some of the social harms of stimulants?

- Aggression and violence can lead to arguments and community disruption.
- As with all illegal drugs, users can get into trouble with the law.
- People who are dependent on stimulants can spend large amounts of money on them. This takes away from money that the family could use. Some people turn to crime or sex work to pay for their drugs.

HOW TO RECOGNISE STIMULANT DEPENDENCE

People who are dependent on stimulants often use for 3–4 days followed by a break (although some people may have longer periods of daily use). Because cocaine is a short acting drug (the effects drop to half in four hours), people may use many times a day, and, if they inject, their arms can be covered in track marks.

As with any substance, people who are dependent on stimulants can show:

- Strong desire (craving) or need to use (compulsion)
- Hard to control use (wanting to stop or having trouble stopping)
- Some may experience withdrawal symptoms
- Needing more of the drug to feel its effects (tolerance)
- Stimulant use starts taking over their life and becomes more important than everything else
- Continued use in the face of clear harms.

Your client may be at particular risk of stimulant dependence if they:

- Use methamphetamine. People can become addicted to methamphetamine more quickly than cocaine. People are less likely to become dependent on ecstasy.
- Have a family history of dependence
- Have used other drugs from a young age
- Have a mental illness or behavioural disorder
- Are male and use heavily
- Smoke or inject rather than those who snort or swallow the drug
- Were brought up in a disadvantaged neighbourhood or had a traumatic upbringing
- Had Attention Deficit Hyperactivity Disorder (ADHD) as a child.

HOW TO RECOGNISE STIMULANT WITHDRAWAL

If stimulant use is stopped for more than a few days (abstinence) and not started up again, then the body starts to adjust to life without stimulants and 'withdrawal' may be experienced. This withdrawal is not life threatening and the types of severe physical problems typically seen with alcohol or heroin withdrawal are not seen with stimulant withdrawal.

- Stimulant withdrawal can last for several weeks, and includes symptoms of depression.
- Over 3–4 weeks, there should be a gradual improvement in mood and functioning. However, low mood, irritability and craving typically last for up to 10 weeks.
- As with other drug withdrawals, withdrawal will be worse in heavier users, polydrug users and people with physical and mental health problems.

How to tell stimulant withdrawal and depression apart

Stimulant withdrawal

Lasts for weeks
Low mood, tearful, irritable
Sleep a lot
Increased appetite/weight increases
No energy, fatigued, moody
Craving for drugs

Depression

Lasts for months and years
Low mood, tearful, irritable
Sleep less
Reduced appetite/weight decreases
No energy, fatigued, moody
Low libido

HOW TO ASSESS A CLIENT WHO USES STIMULANTS

In order to manage any drug problem you need to know what someone has taken. You can ask the client what they have used and also look at them for signs of intoxication (e.g. sweaty, tremor, big pupils, teeth grinding). You can also do a urine drug screen. People will usually give a positive urine test for stimulant drugs for up to two to three days after their last use.

People may come and ask for support with their stimulant use. However, just as commonly, stimulant use will be identified as part of an assessment for another problem, often another drug-related problem. Any of the complications already discussed may be the primary concern of the person. Most often people want help to reduce or stop their use because of the problems it has caused them. Those problems may be related to:

- Mental health and the effect stimulants have had on their mood (e.g. depression, suicidal thoughts, psychotic episodes)
- Problems with relationships
- Physical problems with their heart or loss of weight
- Unable to cope with things
- Behaviours such as violence and high-risk sexual practices that place vulnerable people at even more risk.

Whatever the presenting problem, it is likely that after an assessment you will find a lot more problems. What is important is that you make sure the person knows you are focused on helping them deal with what they consider to be the biggest problem.

What you observe

- The client's behaviour may show that they are intoxicated
- Or they may be down and appear to be in withdrawal
- You may see track marks if they inject
- You may see poor self-care, particularly if they are dependent on stimulants.

Stimulants and ADHD

Most people say taking stimulants speeds them up, makes them talk a lot and do lots of things. But, in people with ADHD, stimulants may make them feel calmer and able to focus and settle – remember the treatment for ADHD is with stimulant medicine such as Ritalin (methylphenidate) or dexamphetamine. People with ADHD may have been fidgety, restless, and impulsive as a child. If you are worried about ADHD or other mental health problems in your client, they may benefit from an assessment by a psychiatrist.

HOW TO HELP A PERSON WHO USES STIMULANTS

Often your client will have many social and health issues when they first come for help. Dealing with all of these at once can be overwhelming for the client. In most cases, using drugs less often or stopping use altogether will reduce their problems.

Counselling

Psychosocial interventions (e.g. counselling) are the best available treatment for stimulant abuse and dependence. Cognitive behavioural therapy (CBT) and motivational interviewing can help people to stop or reduce stimulant use. A CBT manual has been developed specifically for use with stimulant users (see Further reading, p. 172). These treatments can be delivered in both outpatient and residential services.

Rewarding people for stopping stimulants

Contingency management (CM) is when vouchers, tokens or other incentives are used to help people stay on treatment or complete their treatment program. In practice, ways to use CM can be found everywhere, especially if there is local support from shops, sports clubs, cinemas and sports centres. Write to these places in your area and ask for some free passes or vouchers for a project you are running (for example: to help mums and kids stay off drugs). The two important aspects of CM are:

- Immediate reward for good progress
- Bigger rewards for more time off drugs.

As soon as the client has shown that they have not used that day or week (for example: a clean urine result or no injecting sites) they are given a voucher or cinema pass. The more weeks they show they are not using, the bigger the reward gets.

Managing or preventing stimulant withdrawal

Management of withdrawal is largely supportive and usually the client can be managed at home. The client should be in quiet surroundings for several days and allowed to sleep and eat as much as is needed. Benzos (e.g. diazepam) may be prescribed on a short-term basis to reduce agitation. If the client is very depressed, a suicide assessment may be needed.

Symptoms of depression are highest during the withdrawal period. Therefore, it is useful to wait until after they have stopped using for four weeks to reassess depressive symptoms. The advantages of waiting are so a more accurate diagnosis can be made and to prevent unnecessary medicines from being prescribed.

However, depressive symptoms that last more than four weeks after stopping stimulant use may mean that there is underlying depression, which should be treated. There is a high risk of relapse if lasting depression is left untreated. So, severe and persistent depression will require anti-depressants. Remember that these medicines will not reduce stimulant use itself, but can help to manage major depressive episodes linked with their use.

How to help a person going through stimulant-induced psychosis

The best approach to managing stimulant-induced psychosis is stopping the drug and providing sedation. However, clients are often hostile and violent because of delusions or hallucinations where the person thinks they are being persecuted (made to suffer or harassed). Because of this, safely containing and managing the client can be difficult.

They may need to be physically restrained and given medicine. Benzodiazepines (e.g. diazepam) are usually the first-line medicine, with anti-psychotics (e.g. Zyprexa) used only if additional sedation is needed. The doctor should not make a final diagnosis until the person is in a drug-free state.

Medicines to prevent relapse

There are no routinely used medicines to help treat stimulant dependence. Many have been trialled, but none have been shown to be effective enough for widespread use.

STIMULANT OVERDOSE

Recognising stimulant overdose

People who have overdosed on stimulants:

- Are usually very agitated, restless and over-aroused
- Can also be unpredictable, and likely to lash out, often because they are frightened
- May have collapsed because they are dehydrated and are overheated
- Can have chest pain and what looks like a heart attack
- Can have fits (seizures).

Overdose on stimulants can be frightening and places the stimulant user as well as other people at risk, mainly because of violence.

What to do about stimulant overdose

The most important thing is to keep the client and other people safe.

Call an ambulance if:

- You are worried someone is unable to control themselves if they are threatening or not able to move without risk of injury. While you wait, remember to stay a safe distance from the person and talk slowly and calmly. Reassure them by saying something like: “You are safe, we are getting help, no one wants to hurt you”. Try not to shout, make rapid movements or shine lights in their eyes, as this can be frightening.
- A person has collapsed from stimulant overdose: while you wait, move them into the shade, take off any heavy clothes, try and get them to drink some cold water, pour water over them and try to keep them from moving too much.
- The person has seizures or chest pain.
- Remember that there are other life-threatening medical conditions (e.g. head injury, infection) that can look like drug intoxication. If you are not sure, call an ambulance.

REDUCING THE HARMS IF A PERSON CANNOT OR WILL NOT STOP

Tips for your client:

- Avoid drinking lots of alcohol when you use stimulants
- Avoid taking too much at a time and avoid regular use with the build-up of tolerance
- Avoid injecting
- Remember to drink water to stay hydrated.

People who are on medicines for psychiatric conditions, heart conditions or epilepsy are best to avoid taking stimulants. People who have recently had a bad experience when using a particular stimulant should avoid taking that drug.

PREVENTING STIMULANT USE FROM EVER STARTING

- Working with communities to make young people and whole communities more resilient should help protect young people from ever starting stimulants (see Young people, p. 332).
- It is not clear if school education about stimulants helps young people avoid using. There have been some studies from overseas where students just got more interested in drugs when they heard about them.
- Practical advice for young people to help keep them safe could be to let them know that a pill sold as ecstasy may not always contain ecstasy, and drugs can affect people differently.

FURTHER READING

Baker A, Kay-Lambkin F, Lee NK, Claire M & Jenner L (2003). *A brief cognitive behavioural intervention for regular amphetamine users*. Canberra: Australian Government Department of Health and Ageing.

Australian General Practice Network (2007). *Management of patients with psycho-stimulant use problems: Guidelines for general practitioners*. Canberra: Australian Government Department of Health and Ageing. See: www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/psychostimulant-gp

7

Benzodiazepines

<u>Overview</u>	174
<u>Why do people misuse benzos?</u>	174
<u>Effects on the body</u>	175
<u>How to recognise benzo misuse</u>	177
<u>How to recognise benzo dependence</u>	177
<u>How to recognise benzo withdrawal</u>	178
<u>How to assess a client who uses benzos</u>	179
<u>How to help a person who misuses benzos</u>	180
<u>Reducing the harms if a client cannot or will not stop</u>	183
<u>Benzo overdose</u>	183
<u>Preventing benzo misuse from ever starting</u>	184
<u>Further reading</u>	184

OVERVIEW

Benzodiazepines ('benzos') are a class of drug commonly used as sleeping pills or to calm people down when they are anxious (tranquillisers). These medicines are available only on prescription in Australia.

When people use benzos too often or too long they can become dependent. If they try to stop they can have withdrawal symptoms. These can range from mild (problem sleeping) through to severe (seizures).

Sometimes people become dependent on benzos without meaning to, but sometimes benzos are deliberately misused to get their sedative effect. When a person who is addicted to benzos wants to stop, they may need to be slowly weaned off, with a doctor's help. This is to avoid them having seizures.

How common is benzo use and dependence?

Around 1 in 50 Australians have been taking benzos longer than six months. Women are prescribed benzos twice as often as men.

WHY DO PEOPLE MISUSE BENZOS?

People may misuse benzos for different reasons:

- To get intoxicated
- To escape from stress
- If they are a heroin user, to enhance the effects of heroin or to use when they run out of heroin.
- To help with the 'coming off' effects of stimulants, i.e. amphetamine-like drugs (speed, ice, base etc.), ecstasy or cocaine
- To help with withdrawal from other substances, e.g. heroin, alcohol.

Although benzos are mostly in tablet form, some people inject them to get a quicker 'hit'.

EFFECTS ON THE BODY

Benzos make you feel sleepy, relaxed and less anxious. How long this effect lasts varies. Benzos, like any other medicines, are made by different drug companies. As a result they can have different brand names. See page 176 for a list of the most commonly used benzos in Australia and how short or long their effects last.

Effects of benzos on the brain

Benzos are brain (central nervous system) depressants. They increase the effects of a natural brain chemical called GABA (gamma-aminobutyric acid). GABA's main role is to transmit messages from one brain cell to another. The message GABA passes on tells the brain cells to slow down (an 'inhibitory' message). As a result, GABA's natural effect is to make you feel calm like you have been 'tranquilised'. Benzos increase this sedating effect of GABA and as a result make you feel sleepy, relaxed and less anxious.

The benzos that have an effect that comes on quickly (e.g. Xanax) are particularly addictive. These benzos are also often the ones that wear off more quickly, so the person keeps cycling between being intoxicated and withdrawing.

Names of some commonly used benzos in Australia

<i>Chemical Name</i>	<i>Other (brand names</i>	<i>Some street names</i>	<i>The strength of tablet that is typically misused</i>	<i>How many Valium tablets does that equal?</i>
Alprazolam	Xanax, Kalma, Alprax, Ralozam, Zamhexal	X, Xannies	2mg	4
Temazepam	Normison, Tameze, Temtabs	Normies, Temaze	10mg	1
Oxazepam	Serepax, Murelax, Alepam	Sarah's	30mg	2
Lorazepam	Ativan		2.5mg	5
Diazepam	Valium, Ducene, Antenex, Valpam, Ranzepam		5mg	(1)
Clonazepam	Rivotril, Paxam	Rivies	2mg	4
Nitrazepam	Mogadon, Alodorm	Moggies	5mg	1
Flunitrazepam	Hypnodorm, Rohypnol	Rohies, Roofies	1mg	1

HOW TO RECOGNISE BENZO MISUSE

Your client may be buying benzos off the street (as single tablets or packets) or they may be using prescribed benzos in a risky way, e.g. using them with alcohol, taking more than the prescribed dose. They may experience withdrawals when they stop, or may be experiencing harms from their use.

Harms from benzo misuse

Benzos misuse can cause significant problems such as:

- Impulsive behaviour: taking more risks like having unprotected sex, driving while intoxicated or being involved in criminal activity
- Poor memory of what happened while intoxicated. This increases the chance of family and work problems and relationship breakdowns.
- If used long-term, benzos may cause confusion and ‘short-term’ memory problems (difficulty remembering what happened recently).
- Dependence and withdrawal.

Harms from injecting benzos

Injecting benzos can cause significant harm because they are not designed for that use. These harms include: tissue and vein damage or organ damage. Also, if using shared needles, syringes and other injecting equipment, the person can get blood-borne viruses such as HIV or hepatitis C. Dirty equipment or bad injecting techniques can also cause skin or heart infections (see Harms from injecting, p. 289; Safer injecting, p. 296).

HOW TO RECOGNISE BENZO DEPENDENCE

Benzos are addictive if used for long periods of time. The body and brain get used to the action of these drugs, which is called ‘tolerance’. When this happens, more of the benzo is needed to achieve the same effect. Usually, daily use of benzos for more than four to six weeks is associated with some dependence.

It can be hard for a person to recognise that they are dependent on benzos while they are still taking them. But they may notice they are using up their benzo script faster than before or needing to see more than one doctor to get enough scripts (‘doctor shopping’). They may be topping up by buying benzos off the street. If the person stops using benzos, the withdrawal causes sleep problems or anxiety, which may be similar to the problems that first led them to take benzos. Sometimes the withdrawal anxiety is worse than the anxiety they had to start with.

How long does it take to become dependent on benzos?

The time it takes to form a physical dependence on a given benzo varies. The size of the dose as well as the frequency of use influences whether a person becomes dependent. Rarely, people can develop dependence after only two weeks of regular use at the prescribed dose. Usually, daily use of benzos for more than four to six weeks is associated with some dependence.

HOW TO RECOGNISE BENZO WITHDRAWAL

If a person develops dependence to benzos and then stops taking them for any reason, they can experience withdrawal symptoms as their body adjusts or reacts to being without benzos. Withdrawal symptoms are not the same for everybody and can range from mild (sleep problems and anxiety) to very severe (e.g. seizures).

Physical withdrawal symptoms

The most common ones are:

- Shaking/tremors – usually in the hands
- Muscle twitching – anywhere in the body
- Fitting/seizures.

Other physical withdrawal symptoms

People may also experience:

- Sensitivity to loud noise or bright light
- Pain in the joints
- Headache
- Irregular heart rhythm (palpitations)
- Itchy skin
- Electric shock sensation
- Numbness and pins and needles.

Psychological withdrawal symptoms

- Anxiety
- Trouble sleeping
- Nightmares
- Rapid mood swings
- Trouble concentrating
- Craving benzos
- Feelings of unreality / detached from self ('out of self')
- Thinking negative thoughts a lot of the time (obsessive negative thoughts).

How long does withdrawal last?

The length of time (duration) of the withdrawal symptoms varies as well. Many people feel better in a couple of weeks but some people may need as long as a year to feel completely better. The important thing for your client to know is that these withdrawal symptoms will come and go but will permanently disappear as their body gets used to being without benzos.

HOW TO ASSESS A CLIENT WHO USES BENZOS

Assessment of a client who uses benzos should be done as part of a full assessment about the person's substance use. This should include:

- What type of benzo is used? You can remind the client of the common brand names.
- How long has the benzo been used?
- How often is it used each time (frequency of use); e.g. daily, three times a day, every second day or three times a week?
- How much is used each time? (If more than one type of medicine is used, record each of them.)
- Details of the last use; e.g. What was the medicine? How was it taken? When was it taken?
- What happens when you stop using or run out? (Any withdrawals? What is sleep like?)

Also, ask about:

- Alcohol use history
- Other drug use history
- Medicines prescribed for other medical or psychiatric problems
- Any major co-existing medical problems.

HOW TO HELP A PERSON WHO MISUSES BENZOS



If your client thinks they are dependent on benzos or you think they are dependent, you can support them to see a GP or an addictions doctor. The doctor may need to slowly wean them off benzos to prevent seizures.

What to do about benzo misuse in a person who is not yet dependent (brief intervention)

If this is the first time your client has been using benzos, they have never been dependent on benzos in the past, and they have been using them for less than a month, it is usually safe for them to stop the benzos straight away. But getting a doctor to check this can be useful. It is dangerous for a person who is dependent on benzos to stop straight away.

You can give your client some education about benzos, the risk of overdose, how addictive they are, and the risk of seizures once dependent. You can explore the reason why they are using (Is it for stress? Is it for sleep problems?) and see if they can find another, safer way of coping with this problem. Sometimes counselling or group support may help (see Counselling, p. 20; Mutual support groups, p. 54).

How to help a person who is dependent on benzos

Increasing motivation to change

As with the management of any other substance use problem, the first step is to make sure that the client wants to stop using and is ready for change. If they are not ready to quit, the client needs to be educated in a non-judgemental way about the risks of using benzos. You can also help the client weigh up the good and the bad of using benzos (motivational interviewing).

Managing or preventing withdrawal symptoms

Once a client who is dependent on benzos decides to stop using them, they need to be weaned off in a safe and secure way. To do this, you need to support your client to see a doctor (a GP, or addictions doctor, or at a medicated detox unit). The treating doctor will usually swap the client over to a long-acting benzo (e.g. Diazepam), and then slowly reduce the dose over days or weeks. This is known as a reducing regime, and helps prevent significant benzo withdrawal.

Should my client come off benzos at home or in a detox unit?

The weaning off can either be done at home or in a detox unit or hospital depending on your client's history, their circumstances and the services available. In general, people using higher doses of benzos, or for a longer time, or with other substance use problems (e.g. alcohol dependence) are more likely to need a residential, medicated detox.

Organising a home detox

If the client's doctor agrees that your client is suitable for a home detox, the weaning off process has to be organised carefully. It is not wise to give large amounts of benzos to a client who is already struggling with them. A firm arrangement should be put into place for clients to pick up their medicine (i.e. daily or second daily pick-ups from the chemist). Sometimes a family member can keep their benzos, and give them out one day at a time. But that person has to be very responsible and has to be able to cope if the client becomes demanding, upset or unwell.

Your client should have only one prescriber and have regular reviews by the doctor. Sometimes the prescriber can ask the client to regularly sign a PBS (Pharmaceutical Benefits Scheme) release of information form. This releases information to the doctor about any other benzos the client may be given by other doctors.

Counselling and referral

It is also important to address underlying physical or social and emotional problems. You may need to make referrals to other relevant services.

Psychological treatments such as cognitive behavioural therapy can be effective in managing benzo misuse. Relapse prevention counselling in a group or one-to-one can support the client while they are trying to stop using (see Counselling, p. 20).

Improving sleep without benzos

You can help your client work on better sleeping practices, such as: not drinking tea or coffee six hours before going to bed, exercising during the day, avoiding day time naps, not watching TV in bed, not eating food in bed, going to bed just before feeling ready to sleep, and thinking about ways to try to relax or 'unwind'. Some people relax best by listening to music, going fishing or other activities, other people can learn special breathing techniques or other techniques to help them relax from a counsellor.

Some clients try herbal products like Valerian to help them sleep. We do not know a lot about herbal remedies, but it does not seem that people become dependent on Valerian. If a person has a severe sleep problem, some doctors will prescribe a non-addictive medicine to help. Examples are mirtazapine (Avanza), which is usually used for depression, but is sometimes used in half dose for sleep (even when there is no depression). Also anti-psychotics (medicines more often used for conditions like schizophrenia), such as Seroquel (quetiapine) are sometimes used in very low doses to help with severe sleep and anxiety problems.

Getting other support for your client

Your client can often get support from family or friends. Also, support groups such as Narcotics Anonymous (NA) or SMART Recovery, or men's and women's support groups can be effective.

Follow-up

After detox, it is important for your client to have follow-up. This can be with you and/or with a counsellor, and sometimes also with the prescribing doctor.

REDUCING THE HARMS IF A CLIENT CANNOT OR WILL NOT STOP

Tips for your client:

- Avoid using benzos with other sedating substances (e.g. alcohol, heroin) because of the high risk of overdose.
- Avoid using the very rapid onset benzos like Xanax (alprazolam) as they are more addictive. If you must use benzos, choose slower onset ones such as Valium (diazepam). These also last longer, so they can 'hold' you for longer during the day.
- If you are not yet dependent on benzos, try to use no more than three times a week.
- If you are already dependent on benzos (e.g. you get shakes when you stop), you can try spreading the tablets more evenly though the day.
 - So, instead of taking a handful every morning, and feeling terrible every night, the same amount can be evenly split into a morning, lunch and bedtime dose.
 - Avoid taking the tablets at times of stress. Instead take the benzos 'by the clock' at set times, and build up your other skills of coping with stress.
 - See if you can use a little bit less each week, or at least try not to let the amount creep up.
- Have someone trustworthy (e.g. chemist, family member) keep your tablets and just give them to you a day at a time.

BENZO OVERDOSE

Recognising benzo overdose

Benzo overdose is a serious problem and can happen with either benzos alone or combined with other depressants (e.g. alcohol or opioids such as heroin, methadone or strong pain killers). The symptoms of overdose are similar to that of a heroin overdose – the blood pressure drops and oxygen does not get to vital organs like the brain. The breathing slows down and eventually will stop as the body shuts down. People may make snoring-like sounds as their breathing slows down. This can mean that something may be blocking their airways (breathing).

What to do about benzo overdose

If a person has taken large amounts of benzos (alone or with alcohol or heroin), and is conscious but cannot move or speak, someone should stay with them and someone should call an ambulance. If they are unconscious, place them in a coma position on their side. If they have stopped breathing, CPR (cardiopulmonary resuscitation) should be given and an ambulance called urgently.

PREVENTING BENZO MISUSE FROM EVER STARTING

Benzos are usually meant to be used for short periods of time (less than a month), and when needed, rather than regular daily use. This is because they only treat the symptoms and not the underlying causes of sleep problems or anxiety. It is also to avoid the risk of becoming dependent.

Wherever possible use natural (and non-addictive) approaches to help with sleep and anxiety (see above).

FURTHER READING

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

Sleep habits: www.cci.health.wa.gov.au/docs/Info-sleep%20hygiene.pdf.

8

Pharmacy and supermarket drugs

<u>Overview</u>	186
<u>Over-the-counter medicines</u>	186
<u>Prescribed medicines that are misused or sold on the streets</u>	190
<u>Alcohol-based products in supermarkets</u>	192
<u>Energy and cola drinks</u>	193
<u>Inhalants</u>	194
<u>Further reading</u>	194

OVERVIEW

Many medicines can be bought without a prescription from pharmacies and supermarkets. Some of these medicines can be misused and may lead to dependence. Examples include painkillers, antihistamines, and cough, cold and flu medicines. High doses can also cause serious damage to different parts of the body (e.g. heart, liver or kidneys).

Prescription medicines (including benzos or opioids) are also misused or sold on the street. These medicines -often have a smaller difference between a safe and a dangerous dose than over-the-counter medicines (i.e. a lower safety margin). That is why they should only be used if prescribed by a doctor. If people without a prescription use them, they can cause serious damage.

There are also a number of common household and supermarket items that can be misused (e.g. methylated spirits, vanilla essence). Use of these products can also lead to dependence and damage to the body.

This chapter describes: reasons for misuse of these medicines and products, the harms from misuse, and treatments to help people cut down or stop.

OVER-THE-COUNTER MEDICINES

Painkillers

A number of painkillers are available 'over-the-counter'. Many of these painkillers contain low doses of codeine (an opioid that is a distant cousin of heroin). The codeine is combined with paracetamol or ibuprofen. Some common examples are Panadeine Plus (with paracetamol), and Nurofen Plus and ProVen (with ibuprofen).

'Dextropropoxyphene' is another opioid available in some over-the-counter combination tablets in Australia. Capadex (with paracetamol) and Di-gesic (with paracetamol) are some common brand names. Dextropropoxyphene is currently being phased out in Australia because of safety concerns.

Why do people misuse painkillers?

Some people take these medicines for pain, but painkillers with codeine may not be any better for pain relief than simple paracetamol or ibuprofen. But these medicines can make people feel less anxious or agitated, or make them feel a strong sense of happiness (euphoria).

What are the harms?

People who regularly take high doses of painkillers may become dependent on the codeine. Once dependent, a large number of tablets are needed to get the same opioid effect, and to stop withdrawals. Large doses of paracetamol or ibuprofen can damage the body. For example, too much paracetamol can cause liver failure, and too much ibuprofen can cause bleeding in the gut, kidney failure and fluid build-up (fluid retention). If a person uses a very large amount, the codeine can lead to coma and stopped breathing.

Dextropropoxyphene can cause irregular heart rhythms. It can also cause slowed breathing, and sometimes stopped breathing.

Taking opioid painkillers with other depressants such as alcohol or sleeping tablets can make the person more likely to overdose. It can also make the person drowsy when driving.

What treatments are available?

Many people only need a brief intervention to warn them of the risks of codeine misuse. Some people who are dependent on the codeine (or other opioid) can be switched to a safer opioid pain medicine such as a buprenorphine (Norspan) patch. If the person is highly dependent on codeine, then they sometimes need a buprenorphine or methadone maintenance program.

You may also be able to help your client get assessed and receive treatment for their pain problem that started the cycle of painkiller misuse (e.g. from a pain clinic, GP or hospital; see Opioids, p. 139).

Preventing problems and reducing the harms

Wherever possible clients should use 'simple' painkillers that do not contain codeine (e.g. use paracetamol or ibuprofen on their own). Because paracetamol and ibuprofen work in different ways to tackle pain, a person can alternate them (e.g. take ibuprofen with meals and paracetamol if needed between meals). It is very important that only the recommended daily dose is taken, whether or not the medicine contains codeine.

Supporting your client to get treatment for problems like tooth decay as soon as possible may reduce their need for painkillers. Some people may be able to organise free or cheaper dental treatment through their GP, Aboriginal Medical Service or hospital.

Antihistamines

Antihistamines are over-the-counter medicines used for travel sickness and hay fever. They may also be found in some combination painkillers, and cough and cold remedies.

Why do people misuse antihistamines?

Some antihistamines can make you feel really tired (sedated), and people may misuse them to get to sleep, to calm down or get 'stoned'. Some antihistamines can make you see and hear things that are not there (hallucinations), and people sometimes misuse them for this effect.

What are the harms?

Some people may become dependent on antihistamines, but we do not know how common this is. Withdrawal symptoms are very uncommon.

Even if taken in the way they are supposed to be taken, antihistamines can cause a dry mouth. When higher doses are taken (more than is prescribed by a doctor or advised by the pharmacist), the heart rate can become fast and irregular. Confusion and disorientation (delirium), coma and seizures can also happen, but usually only after very high doses.

What treatments are available?

There are no specific treatments for antihistamine misuse. Brief intervention and counselling approaches can be used.

Preventing problems and reducing the harms

Supporting your client to get help for any underlying sleep or anxiety problems may be helpful. Avoid mixing antihistamines with alcohol or other drugs as using these together increases the risk of overdose and other problems.

Cough, cold and flu medicines

Cough, cold and flu medicines often contain combinations of:

- Paracetamol
- Drugs that reduce inflammation (such as ibuprofen)
- Opioids (codeine and dextromethorphan – 'DXM')
- Antihistamines
- Drugs that dry out the nose (decongestants, e.g. pseudoephedrine).

These medicines are taken when someone has a cough, cold or flu. They do not make the underlying illness any better – they just reduce the symptoms.

Why do people misuse cough, cold and flu medicines?

People misuse medicines that contain pseudoephedrine because they cause a stimulant effect that is like amphetamines if used in high doses (see Stimulants, p. 159). Because pseudoephedrine is also used to make amphetamines, the Australian Government has put restrictions on the sale of this product (people have to provide their name and address at the pharmacy when they buy medicines that contain pseudoephedrine).

Other people use cough medicines because they like the opioid effect (it makes them feel calmer or 'high'). DXM can cause hallucinations in higher doses (makes a person see and hear things that are not there). Some cough medicines also contain alcohol.

Sometimes people combine these medicines with alcohol or other drugs to get more of a 'high'.

What are the harms?

If people overuse nasal decongestants, when they stop their runny nose comes back as bad or worse than before ('rebound' in the symptoms). Because of this, nasal decongestants should only be taken short-term. These drugs should not be taken by people with severe heart disease or high blood pressure (hypertension), as they can make these illnesses worse.

People taking certain types of anti-depressants should also avoid cold and flu medicines containing pseudoephedrine. Examples include monoamine oxidase inhibitors (e.g. tranylcypamine) or tricyclic anti-depressants (e.g. amitriptyline).

It can be dangerous to take pseudoephedrine with amphetamines or cocaine because these drugs have similar effects on the body that increases the chances of problems. It can lead to high blood pressure and heart attack.

Some cough, cold and flu remedies contain large amounts of sugars like sorbitol. This can cause diarrhoea if high doses are used.

What treatments are available?

There are no specific treatments for misuse of cough, cold and flu medicines. Usual brief intervention and counselling approaches can be used.

Preventing problems and reducing the harms

Inform clients that using these medicines does not make them get better more quickly, and that they should only use them for a short time and only take the recommended dose. If your client uses these medicines, advise them not to mix them with alcohol or other sedatives (e.g. benzos). The client should also avoid driving because these medicines can make people drowsy.

PRESCRIBED MEDICINES THAT ARE MISUSED OR SOLD ON THE STREETS

Prescription opioids

Prescription opioids include strong painkillers such as oxycodone (e.g. Endone, OxyContin), morphine (e.g. Kapanol, MS Contin), and higher doses of codeine (e.g. in Panadeine Forte), as well as methadone and buprenorphine, which are prescribed for opioid dependence.

Why do people misuse prescription opioids?

Prescription opioids may be misused because they make people feel less agitated or anxious, and they may feel a strong sense of happiness (euphoria) when they take them, or because they help people get to sleep.

People may misuse prescription opioids because heroin is not available, or because they have become dependent after taking them for pain relief, particularly with chronic pain. Some people use prescription opioids if they cannot get on methadone or buprenorphine maintenance treatment.

What are the harms?

If prescription opioids are used in a way other than prescribed, overdose can cause coma, reduced breathing and death. All opioids can cause dependence.

What treatments are available?

Treatment focuses on getting the client's opioid use under control. This can be done by arranging for clients to pick their medicines up more regularly from the pharmacy (e.g. every day). Another way is to arrange for family or a responsible person in the community to look after the medicines and hand them to the client one day at a time. Some clients may need to go on methadone or buprenorphine maintenance treatment, in the same way as people who are heroin dependent (see Opioids, p. 150).

Preventing problems and reducing the harms

People with chronic pain may get relief from physiotherapy with exercise plans. Counselling can also help people manage their pain. Sometimes people have to come to terms with the fact that they cannot totally get rid of the pain, which can be hard. As with heroin, if someone is injecting prescription opioids, they should use clean fits, use a filter, not use alone and call an ambulance if someone drops. But injecting crushed tablets is particularly risky, because tiny particles can get lodged in different parts of the body, including the lungs (see Harms of injecting, p. 289).

Benzos

Why do people misuse benzos?

Benzos are medicines such as Valium (diazepam), Serepax (oxazepam) and Normison (temazepam). They are sometimes prescribed for sleep problems or anxiety. People may abuse benzos because it makes them feel calmer, more relaxed, or helps them get to sleep.

What are the harms?

In the long-term, benzos often increase anxiety and disrupt the body's normal sleep-wake cycle. Misuse can also lead people to lose control of what they say and do, and say and do things they would not normally do ('disinhibition'). There is also an increased risk of overdose if benzos are combined with alcohol or other sedating drugs such as opioids.

What treatments are available?

Treatment of benzo dependence is to wean the dose down to zero over a period of time, and use other treatments to manage sleep and anxiety (see Benzos, p. 180). This may include psychological treatments like relaxation and medicines such as anti-depressants.

Medicines intended for treating mental illness

Why do people misuse medicines intended for treating mental illness?

Medicines for treating depression (anti-depressants) or psychosis (anti-psychotics) change the chemistry in the brain. There are many different types of these medicines including Zyprexa (olanzapine) and Seroquel (quetiapine). People may misuse them because they can make the person feel very relaxed (sedated). We do not know how often these medicines are misused.

What are the harms?

Anti-depressants and anti-psychotics can cause heart problems if taken in large doses. In large enough doses they can even cause the heart to stop. Long-term misuse over months to years can cause weight gain and diabetes. People should not take medicines that have been prescribed for someone else.

Viagra

Viagra (sildenafil) is marketed for treatment of erection problems in men. It acts by relaxing the blood vessels.

Why do people misuse Viagra?

Viagra is used to help men get an erection. Some people use Viagra with alcohol or other drugs (e.g. ecstasy, amphetamines). This is because those drugs may increase sexual desire but can make it difficult to get an erection.

What are the harms?

Viagra can be dangerous if taken by someone who has heart problems, if taken in high doses, or if taken with other medicines or recreational drugs. In these cases it can cause blood pressure to drop to dangerous levels. This reduces the delivery of oxygen and nutrients to different parts of the body, which can damage the body's organs such as liver and kidneys.

ALCOHOL-BASED PRODUCTS IN SUPERMARKETS

A number of products contain quite high concentrations of alcohol (e.g. mouth wash, vanilla essence, methylated spirits). Some mouthwashes, for example, contain 20% alcohol, which is more alcohol than in most wines. Methylated spirits is almost 100% alcohol.

Why do people misuse alcohol-based products?

People misuse alcohol-based products from supermarkets and other shops because it can be cheaper than buying alcohol. Young people sometimes choose this form of alcohol because they are not allowed to buy alcohol from bottle shops.

What are the harms?

People can become dependent on the alcohol in products like mouthwash, vanilla essence and methylated spirits. Some of the non-alcoholic parts of these products can also cause health problems (e.g. too much of sugars like sorbitol can cause diarrhoea). Methylated spirits is very 'rough' on the stomach and many people develop pain in the belly and vomiting.

For information on preventing problems, treatment and reducing the harms from alcohol-based products bought in supermarkets.

ENERGY AND COLA DRINKS

Energy and cola drinks contain large amounts of caffeine and sugar. Some energy drinks contain guarana, which itself has high levels of caffeine. Popular energy drinks include V, Red Bull and Mother.

Why do people misuse energy and cola drinks?

People may drink energy and cola drinks because they are thirsty, or because they want to stay awake. Some people mix highly caffeinated drinks with alcohol so they can feel more alert and keep drinking more alcohol and not get too sleepy. Young people are using these drinks with alcohol because they taste like soft drinks and hide the taste of the alcohol.

What are the harms?

Too much caffeine can cause agitation, sleep problems, tremor, nausea/vomiting and heart pounding or racing (palpitations). Even larger doses can cause confusion, seizures, very fast heart rate, and altered heart rhythm. When caffeine is stopped suddenly, a person can get a headache (rebound headache) and poor concentration. The person may feel less drunk if they mix these drinks with alcohol and so may drink more. This can increase risky behaviours like having car accidents, getting into fights and having unprotected sex.

These drinks contain lots of sugar, which can contribute to obesity and problems with teeth. Diet drinks may be very acidic, and this can still cause teeth damage even though they have no sugar.

Because caffeine and other stimulant drugs (e.g. amphetamines) have similar effects on the body, taking them together can increase the chance of problems, such as rapid heart rate and poor sleep.

What treatments are available?

There are no specific treatments for people who misuse energy and cola drinks. Brief interventions and counselling could be used.

Preventing problems and reducing the harms

If people cannot stop drinking energy and cola drinks, they should try not to drink them after midday so that they have less sleep problems. They can try to have fewer drinks in one session; replacing every second drink with water can help to reduce the amount consumed.

INHALANTS

Inhalants are products like petrol, paint, glue and cleaning products that give off vapours (fumes that may be invisible) at room temperature (see Petrol, paint and other inhalants, p. 207).

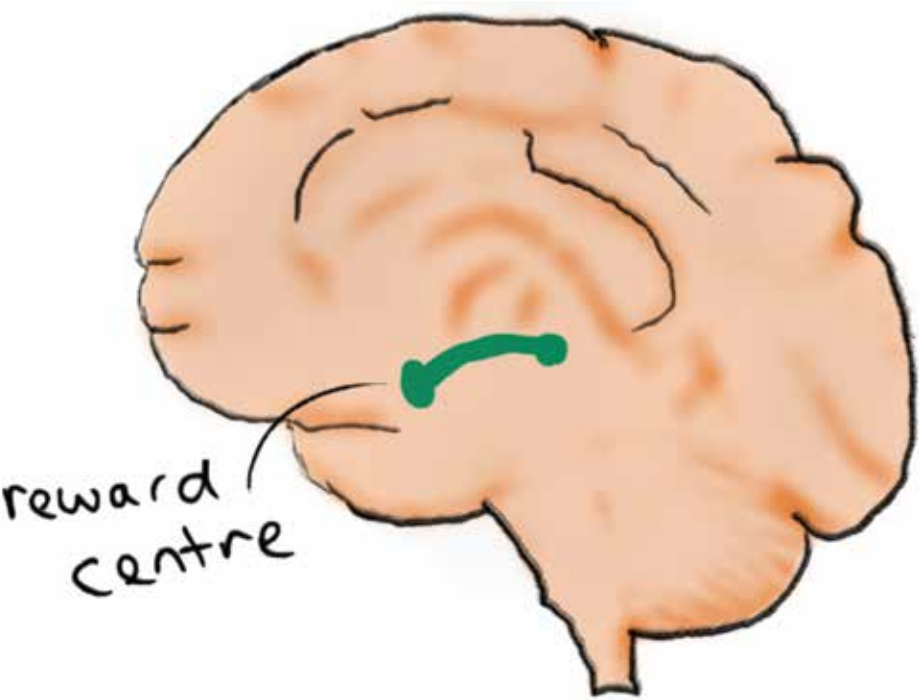
Many of these products are available in supermarkets. Inhalant misuse occurs when the vapours from these products are deliberately breathed in to get 'high'. Heavy intoxication with inhalants can be very damaging to the body and may require an emergency response (e.g. calling an ambulance, resuscitation). Counselling is the best available treatment to help people reduce or stop using inhalants. There are no medicines currently available for the treatment of inhalant dependence, although some medicines are used to treat individual symptoms.

FURTHER READING

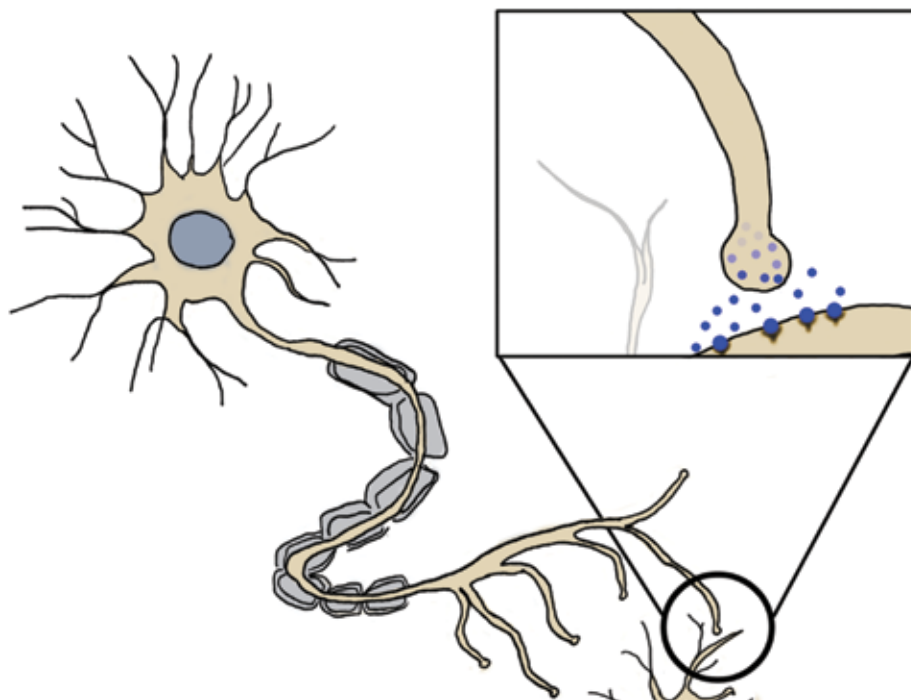
The National Prescribing Service has free information for clients and health professionals on pharmacy and supermarket drugs. See: www.nps.org.au.



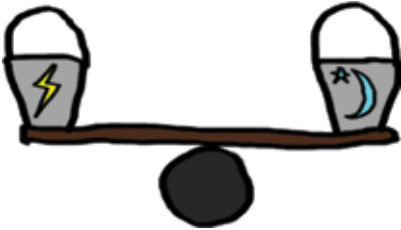
Editors (from left to right): Kate Conigrave, Jimmy Perry, Warren Miller, Kylie Lee, Bradley Freeburn, Steve Ella



The reward centre of the brain.



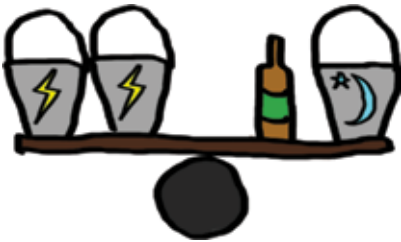
A nerve cell. The zoom shows how one cell talks to another using chemical transmitters to cross the gap (the synapse).



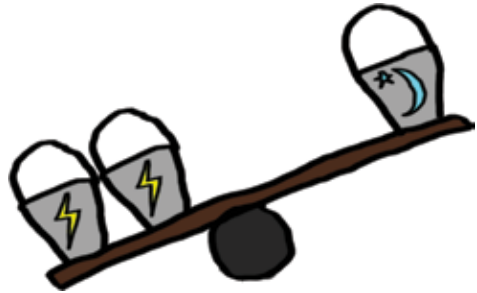
Our brains are naturally held in balance: we have natural 'uppers' that keep us awake and natural 'downers' that calm us down.



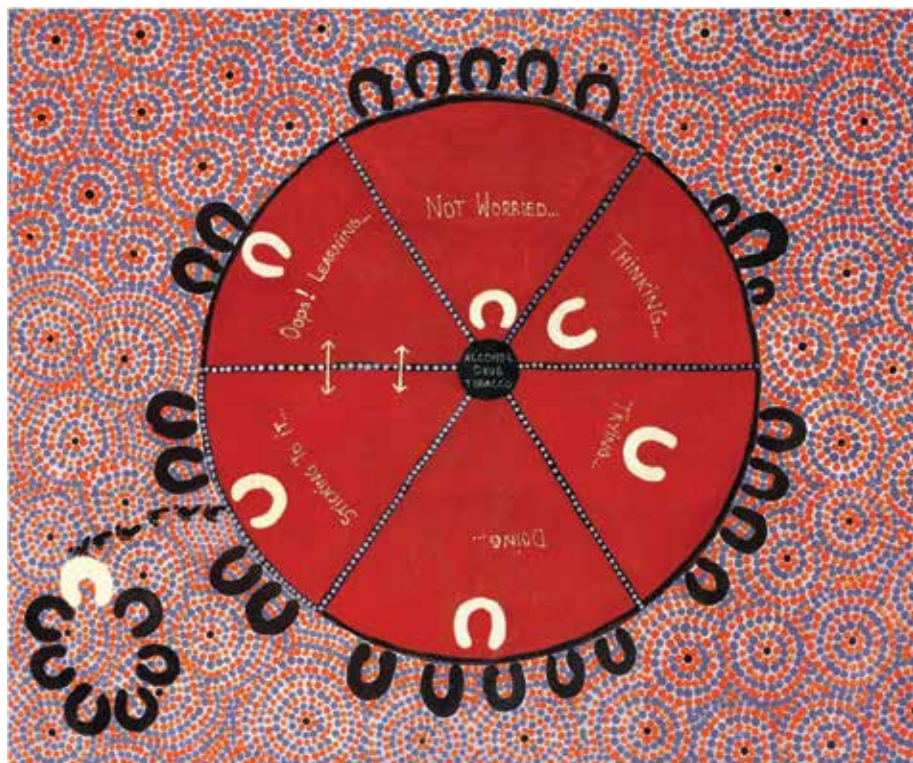
When a person who is not used to alcohol drinks far too much, it can make them so sleepy they become unconscious.



If a person keeps drinking often, their brain gradually adapts (tolerance). They can stay awake after drinking a lot, because they have increased their natural uppers.



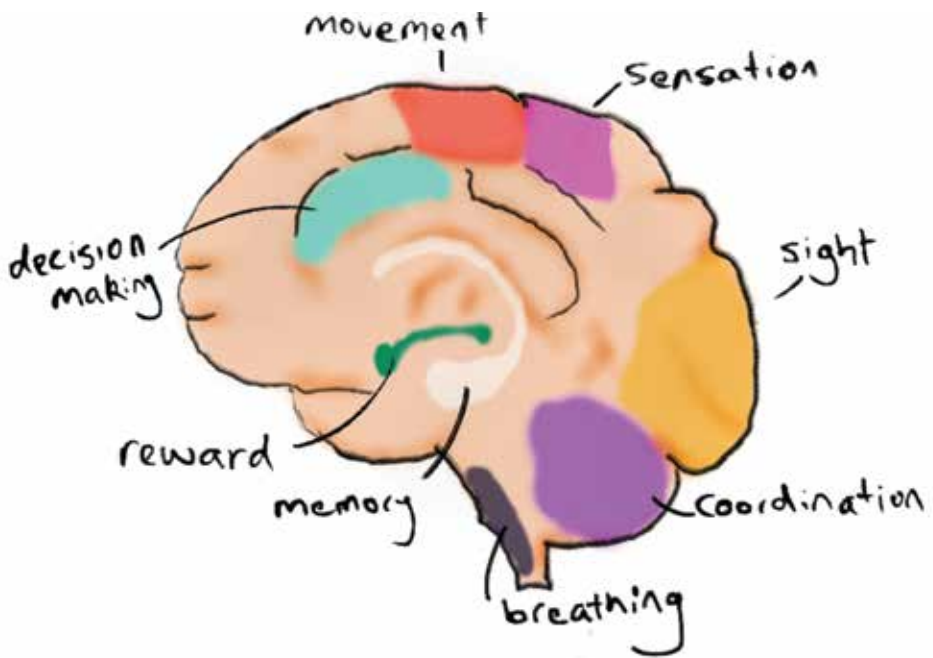
When alcohol is stopped, the natural uppers are then too strong. The person is left jumpy, anxious and cannot sleep (withdrawal). It takes time for this to settle back to normal.



Artists: Terry Simmons and Sophia Conway from Titjikala Community

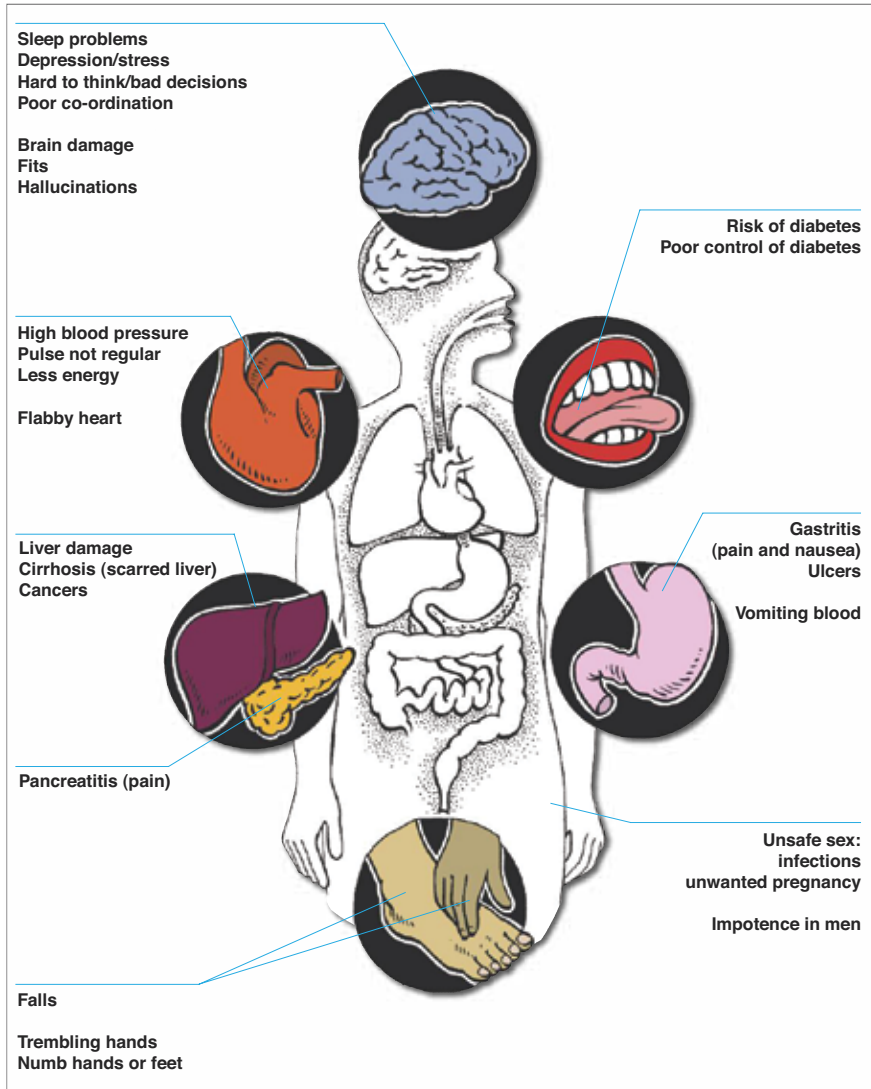
Stages of Change: change often happens as part of a cycle.
See p. 423 for the story of this cycle.

Art reproduced with permission of Batchelor Institute of Indigenous Tertiary Education.



Alcohol intoxication affects many different parts of the brain.

Alcohol and your body



Copyright University of Sydney and Sydney South West Area Health Service

AVS 98030

Alcohol use can affect nearly every part of the body. See p. 73 for more detail.



Liver problems can cause the whites of the eyes to turn yellow (jaundice).



A liver that has been severely scarred (cirrhosis). This can happen with years of alcohol use, and or after years of hepatitis C infection.



An empty opioid receptor, before the drug has been taken. It is ready to be switched on by a person's natural opioids (endorphins).



Drugs like heroin fit neatly into the opioid receptor and switch on chemical reactions in the nerve cell. These make the person feel good or high. Drugs like heroin or methadone are called 'full agonists', because they fully act on the receptor.



Buprenorphine is a medicine that is a cousin of heroin. It fits tightly into the receptor, but does not switch it on as much as heroin. It sits there so tightly that drugs like heroin cannot get onto the receptor. So if the person takes heroin, they do not get a high.



A drug like naloxone (Narcan) or naltrexone fits neatly into the receptor, but does not turn it on at all. It just sits there blocking any opioids from working. So heroin cannot have any effect while it is still present. It is called an antagonist because it works against (or 'anti') the agonists like heroin.

See Opioids, p. 141.



Any opioids, including heroin and codeine dry out the mouth and this can end up in tooth decay. This is because saliva kills germs that cause this decay and also heroin users may not clean their teeth well.



Ecstasy tablets can come in many different forms. They often have a symbol stamped on them. Often the tablet contains other drugs as well as (or instead of) ecstasy.



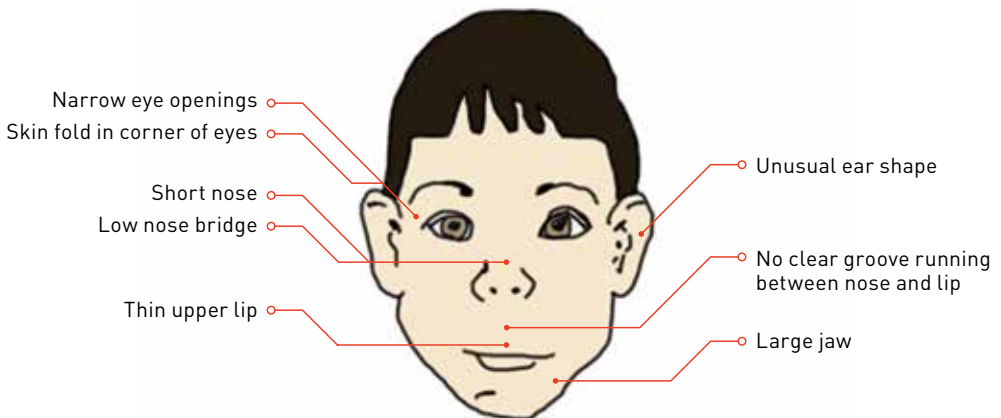
Scarring (track marks) from injecting. Old track marks look white or bluey-grey. Fresh track marks look red, like someone has recently had a blood test.



An infection has led to a build up of pus under the skin of the arm (an abscess). This usually needs surgery to drain and antibiotics.



This person has an area of infection in the skin. It has probably been caused by germs entering the skin while injecting. This is known as cellulitis.



This is what the face often looks like if a person has foetal alcohol syndrome (FAS).

Adapted from: Alcohol and Pregnancy and Fetal Alcohol Spectrum Disorder (2009).
Telethon Institute for Child Health Research.

9

Petrol, paint and other inhalants

<u>Overview</u>	208
What are some commonly used inhalants?	208
<u>What are some common ways to use inhalants?</u>	209
<u>Effects on the body</u>	210
<u>How to recognise harms from inhalants</u>	211
<u>How to recognise inhalant dependence and withdrawal</u>	213
<u>How to help a client who misuses inhalants</u>	213
<u>What treatments are available?</u>	214
<u>Reducing the harms if a client cannot or will not stop using</u>	215
<u>Preventing inhalant use from ever starting</u>	216
<u>Further reading</u>	216

OVERVIEW

Inhalants (also known as volatile substances and solvents) are products like petrol, paint and glue that give off vapours (fumes that may be invisible) at room temperature. Inhalant use occurs when these vapours are deliberately breathed in to get ‘high’. Most inhalants have a depressant effect on the body (e.g. petrol, paint, glue), which means that they slow down a person’s brain and nervous system, but others have a stimulant effect (e.g. amyl nitrate).

There are many products available at supermarkets, newsagents, hardware stores and petrol stations that can be inhaled and cause intoxication.

Counselling is the best available treatment to help people reduce or stop using inhalants. There are no medicines currently available for the treatment of inhalant dependence, although some medicines are used to treat individual symptoms. Heavy intoxication with inhalants can be very dangerous and may require an emergency response (e.g. calling an ambulance, resuscitation).

WHAT ARE SOME COMMONLY USED INHALANTS?

The inhalant	Some of the chemical(s) it contains
<i>Petrol</i>	Toluene and benzene
<i>Glues and resins</i>	Toluene, benzene, n-hexane, xylene, or ethyl acetate depending on the product
<i>Air fresheners, hair spray, deodorants, fly spray or refrigerants</i>	Butane and freon
<i>Paint, paint thinners and stripper, varnish</i>	Toluene, butane, dichloromethane and methylene chloride
<i>Cleaning fluids (e.g. stain removers); liquid paper</i>	Trichloroethylene or trichloroethane
<i>Lighter fluid</i>	Butane
<i>Amyl nitrate (also called ‘poppers’)</i>	Amyl nitrate
<i>Soda bulbs</i>	Nitrous oxide

WHAT ARE SOME COMMON WAYS TO USE INHALANTS?

- Breathing in vapours directly from a container ('sniffing')
- Breathing in vapours from a plastic bag or a paper bag ('bagging')
- Spraying chrome-based paint from an aerosol can into a plastic bag and breathing in the vapours ('chroming')
- Wetting a piece of material (usually clothing) with an inhalant, and then holding it against the mouth or nose ('huffing')
- Spraying straight into the mouth.

How common is inhalant use?

There is little information about how common inhalant use is in Australia. Around 1 in 30 Australians have ever used inhalants. The number could be as high as 1 in 15 for Indigenous Australians.

Petrol is the most commonly used inhalant in remote Aboriginal communities. It tends to start at a young age and is more likely to become a problem over time. The age of people who sniff petrol ranges from 8 to 30 years, with most users aged 12 to 19 years. In many remote communities, Opal fuel has been introduced to replace regular petrol. Opal fuel has less of the chemicals ('aromatics') that make the sniffer intoxicated, and in some communities Opal has greatly reduced the number of sniffers, particularly in remote and isolated areas.

Chroming (i.e. paint sniffing) is the most common form of inhalant use among Aboriginal people in urban and rural areas. In urban areas, inhalants tend to be used for a shorter length of time, and use is most common among 12 to 14 year olds.

EFFECTS ON THE BODY

Inhalants are quickly absorbed into the body through the lungs. It takes only 3–5 minutes to become intoxicated after breathing in the vapours of most inhalants (from around 10–15 breaths). The effects are greatest after 15–30 minutes and can last for about 3–6 hours.

Most inhalants have similar effects on the body to other depressant drugs such as alcohol and cannabis and include:

- Strong sense of happiness and excitement (euphoria and exhilaration)
- Feeling tired or drowsy
- Loss of inhibitions (resulting in: increased risk of unwanted and unprotected sex, violence, feeling anxious or irritable, and involvement in crime)
- Loss of appetite (note: sometimes people sniff petrol to cope with hunger)
- Agitation and irritability
- Dizziness and giddiness
- Confusion and disorientation (not knowing where you are)
- Slurred speech, poor muscle coordination and staggering (ataxia)
- Sneezing, coughing, glazed eyes or runny nose
- Widening of the pupils of the eye (dilated pupils), blurred vision, bloodshot eyes
- Nosebleeds and sores around the mouth and nose
- Headaches
- Nausea and vomiting, general stomach pain
- Hearing problems from ringing in the ears.

While most inhalants are depressants, amyl nitrate ('poppers') is a stimulant or 'upper'. It is often used to increase sexual desire.

HOW TO RECOGNISE HARMS FROM INHALANTS



There are no safe levels of inhalant use. Death caused by a heart attack (cardiac arrest) can happen if a person has a sudden fright or if they exercise after using inhalants. This is known as 'sudden sniffing death'. It is not known exactly how many people die from sudden sniffing death, but it is thought to be uncommon.

Short-term harms

Problems can result from using inhalants even once:

- Injury or accidents (including drowning and road accidents) to the user or others. These are often due to poor physical coordination or because feeling high makes them say or do things they normally would not do (disinhibition).
- Violence and involvement in crime
- Burns – because inhalants can catch fire easily (i.e. are flammable)
- Breathing problems, suffocation, choking, cough and irritated lungs
- Abnormal heart rhythm (cardiac arrhythmia) and chest pain
- Temporary psychotic symptoms such as:
 - Beliefs which are not true or not reality-based (delusions)
 - Seeing or hearing things that are not there (hallucinations)
 - 'Ideas of reference' (e.g. believing that a TV show is sending a secret message to you)
 - Paranoia (wrongly thinking that people are 'out to get you')
- High doses of xylene (e.g. in bicycle tyre repair glue) can cause loss of consciousness, stopping of breathing (respiratory failure) and death
- High doses of ethyl acetate (e.g. in wood cement) can lead to coma and death
- Lack of oxygen due to sniffing can put a client into cardiac arrest, especially if they are being chased, or if they do other exercise while sniffing
- Sudden sniffing death.

Long-term harms

Problems that can result from using inhalants long-term:

- Damage to the brain (e.g. memory loss, not able to think things through or make decisions as well)
- Loss of hearing, vision or sense of smell
- Abnormal flickering eye movements (nystagmus)
- Feeling numb in the hands and feet due to nerve damage in the arms and legs (peripheral nerve damage)
- Difficulty walking, loss of coordination/poor balance, arm and leg spasms
- Poor immunity, so the person catches more infections
- Liver and kidney damage
- Injury to bone marrow, which is where blood cells are made – this can lead to increased risk of leukaemia (cancer of the blood)
- In pregnant women, damage to the unborn baby
- Sudden sniffing death.

Look out for physical clues of inhalant use

- Strong smell on the client's clothes or breath
- Looks drunk, dazed, or is staggering
- Sores around face and mouth
- Weight loss
- Client is carrying items used for sniffing (e.g. empty tins or cut down plastic bottles, plastic bag sprayed with paint or material soaked with inhalant).

HOW TO RECOGNISE INHALANT DEPENDENCE AND WITHDRAWAL

Regular inhalant use can lead to the client becoming psychologically dependent. They may feel a powerful desire to sniff (craving). They may sniff because they need to and not just because they want to (loss of control). They may continue using despite experiencing harms from use, and find that inhalant use is becoming more important than other things in life.

In a small number of people there can also be physical dependence, where more drug is needed to feel the desired effects ('tolerance') and withdrawal symptoms happen when sniffing stops. Dependence is more common for inhalants containing toluene (e.g. petrol, spray paint, glue and paint thinner).

Withdrawal symptoms can include:

- Loss of appetite
- Irritability or aggression
- Feeling lightheaded (dizziness)
- Tremors (usually of the hands)
- Upset stomach with an urge to vomit (nausea)
- Depression
- Anxiety.

HOW TO HELP A CLIENT WHO MISUSES INHALANTS

If your client is intoxicated

- Remain calm. Never chase or frighten someone who has been using inhalants as this may lead to sudden sniffing death.
- Keep other people who are near the client calm. Talk quietly and use simple commands.
- Seek help (e.g. family, friends, other community members, ambulance, police if necessary).
- Make sure there is good airflow so the vapours from the inhalant can escape the area.
- Contact the National Poisons Information Centre (Telephone: 131 126) for advice on the particular inhalant that has been sniffed.
- If you are seeing a client indoors who can be aggressive, make sure you are in between the person and the door. Remove anything that could be used as a weapon and get help (see Aggressive clients, p. 398).

If your client is heavily intoxicated

When a client is heavily intoxicated (i.e. when they show many of the signs of intoxication described in ‘effects on the body’), a standard emergency response approach can be used:

- Resuscitation (see CPR guide, p. 436)
- Call an ambulance
- Remain with the person until medical assistance arrives
- Look out for and treat physical illnesses, injuries or burns particularly lung/airway disorders, head injuries and seizures.

If your client uses inhalants but is not currently intoxicated

If a client is not intoxicated but does currently use inhalants, a full drug and alcohol assessment should be conducted.

- Inhalant use: what substances they use, how often, where, who with, why they use, and any harm they have experienced from use
- Alcohol and other drug use: tobacco, alcohol and illegal drugs
- Physical health: prescribed medicines, medical conditions and allergies
- Psychological health: mental health, involvement with mental health service
- Social factors (e.g. legal, employment, family, housing, any current crisis)
- Risk behaviours (e.g. risk of suicide, self-harm, harm to others and harm from others).

WHAT TREATMENTS ARE AVAILABLE?

Counselling

Counselling can include brief intervention, motivational interviewing, and general relapse prevention counselling. This may include building up skills in goal setting, self-monitoring, managing emotions, decision-making and communication. Counselling can happen in different settings: in a clinic, an outreach service (i.e. in the community), or in a residential treatment or rehabilitation service.

It can be helpful to include families or other support people in counselling. An outreach approach, rather than waiting for the client to come to the clinic, is an advantage. Providing alternative activities to inhalant use (e.g. recreational and cultural activities, and training opportunities) can be important.

Intensive follow-up and counselling is important after release from a residential program (known as aftercare). Aftercare is often provided through an outreach model, and focuses on monitoring for any sign of relapse and reinforcing skills learned in treatment.

Medicines

No medicines are yet available to treat inhalant dependence. Anti-depressant or anti-psychotic medicines can be used to treat co-occurring mental health concerns. Medicines are sometimes used to relieve individual symptoms (e.g. diazepam for agitation).

REDUCING THE HARMS IF A CLIENT CANNOT OR WILL NOT STOP USING

Some individuals are not yet ready to stop sniffing. It is important to try to keep them as safe as possible until they are ready to change. You can:

- Encourage the client to use in a safer setting; for example:
 - Away from fires to prevent burns
 - Away from roads or rivers to prevent injuries
 - Not sniffing in closed areas like cupboards but in outside areas where the client can get clean oxygen and where communities can see if help is needed
 - Sniffing with just the mouth or the nose so the client can get clean oxygen
 - Sniffing with other non-sniffers so that if anything happens when client is intoxicated, help can be called
- Keep spray paints or other commonly used inhalants locked away (in shops, at work or in personal houses)
- In working with a client who sniffs, remember that what is important to you as a clinician (e.g. for the client to stop sniffing) could be different to the client's needs (e.g. finding a place to sleep, getting some food or money and feeling a sense of belonging)
- Communities in remote areas can apply to the Australian Government for a subsidy to use Opal fuel instead of regular petrol supply. This can greatly reduce sniffing, or even stop it.

PREVENTING INHALANT USE FROM EVER STARTING

If you are in a remote setting, your community can approach the Australian Government for a subsidy for Opal fuel. In communities where common household products (such as paint) are being inhaled, shop owners and community members can be asked to lock these products away. Many communities try to work broadly to engage with people who might otherwise use inhalants. Creating opportunities for recreation, cultural, work and other activities that are meaningful alternatives to using inhalants, could do this. These positive opportunities can also help make stronger communities.

FURTHER READING

Aboriginal Drug and Alcohol Council SA Inc. (2000). *Petrol sniffing and other solvents – a resource kit for Aboriginal communities*. Adelaide: ADAC SA Inc., SA Department of Human Services and the Commonwealth Department of Health and Aged Care.

Central Australian Rural Practitioners Association 2009, *CARPA standard treatment manual*, 5th edition, Central Australian Rural Practitioners Association, Alice Springs.

National Health and Medical Research Council (2011). *Caring for people who sniff petrol or other volatile substances: A quick reference guide for health workers*. Canberra: Commonwealth of Australia. See: www.nhmrc.gov.au/_files_nhmrc/publications/attachments/cp136a_volatile_substance_use_quick_reference_guide.pdf

10

Other drugs

<u>Kava</u>	218
<u>GHB</u>	220
<u>Ketamine</u>	223
<u>Hallucinogens (magic mushrooms and LSD)</u>	226
<u>Other sedatives</u>	231
<u>Betel nut ('areca nut')</u>	232
<u>Khat</u>	234
<u>Steroids (i.e. anabolic steroids)</u>	236

Kava

OVERVIEW

Kava is a depressant drug that can make you feel sleepy and calm (sedated). It is commonly used during ceremonies in the Pacific Islands and is used in some countries as a medicine. Kava is known by names including: wati (PNG); kawa, waka, lewena, grog (Fiji); ava (Samoa).

Harms from regular long-term use can include: scaly skin, weight loss and spending a lot of time using it. It is not clear if people become hooked on kava (dependent). Counselling is the best available treatment for people with problems with kava use.

History of kava use

Kava was introduced to some Aboriginal communities in northern Australia as a safer alternative to alcohol. In some of these communities, kava continues to be used today. Among some Pacific Islanders who live in Australia, kava is used as a tradition. Some other Australians also drink kava, though we do not know how many people use and about their patterns of use.

The law and kava use

Kava can be imported into Australia only for medical or other scientific purposes. When travelling to Australia, people aged 18 years or older are allowed to bring up to 2kg of kava in their luggage. Check with the police in your state or territory for more details on the law and kava.

WHAT DOES KAVA LOOK LIKE AND HOW IS IT USED?

Kava looks like brown ‘muddy’ water and is made from the roots of a type of pepper plant called *Piper methysticum*. The roots are ground up or crushed, added to water and then drunk.

EFFECTS ON THE BODY

The effects from kava on the body depend on the individual and how the drink is prepared (e.g. how much kava powder is added to water). Some effects from lower doses include: feeling relaxed, sleepy and happy. Some effects from higher doses include: nausea and being unstable on your feet (e.g. staggering).

Harms from using too much kava may include:

Physical

- Dry and scaly skin (sometimes called ‘crocodile skin’)
- Loss of appetite that may lead to the person not getting the vitamins and nutrients they need (malnutrition) and eventually weight loss.

It may also cause:

- Sore and red eyes
- Loss of sexual drive
- Blood tests that show abnormal cholesterol or liver results.

Psychological

- Loss of motivation and drive (apathy).

Social

- Person may spend too much time drinking kava and not enough time doing the things they usually do in life (e.g. work, sport, music, spending time with family or friends)
- Spending too much of the family’s money on buying kava.

Can kava use lead to dependence and withdrawal?

It is not clear if people get hooked (dependent) on kava, or if people experience withdrawal, though some communities report some people spending a lot of time using.

HOW TO HELP A CLIENT WHO USES KAVA

There is no specific treatment for clients who may have problems from kava use or be hooked on it (dependent). Standard brief intervention and counselling approaches can be used.

REDUCING THE HARMS IF A CLIENT CANNOT OR WILL NOT STOP

If the client cannot cut down or stop using kava, they should:

- Not mix kava with alcohol or other drugs
- Try to eat food that is well balanced in vitamins and nutrients
- Monitor the amount being used in each session, and wait until the effects start to wear off before using more
- Avoid driving or using work machinery after drinking kava
- Get help from a health professional if they are feeling bad effects from using.

GHB

OVERVIEW

GHB (gamma-hydroxybutyrate) is a depressant drug, also known by the street names GBH, grievous bodily harm, liquid E, liquid ecstasy and fantasy. One of the main harms of GHB use is the small difference in dose that can lead to overdose and unconsciousness. If a person overdoses on GHB, medical help should be sought straight away. People can become dependent on GHB and may experience withdrawal symptoms when they stop using. There are no routinely used medicines for GHB dependence. Counselling may help people with problems with GHB.

History of GHB use

GHB was developed in the 1960s for use in surgery, but was stopped because of its side effects. In the 1980s it was used to help people sleep and also as a dietary supplement for body builders. GHB started to appear in Australian nightclubs in the mid-1990s. It was banned shortly after this.

How common is GHB use?

Compared to other drugs, GHB use is not very common in Australia. Around 1 in 1,000 people have used GHB in the past year. GHB use is often used at nightclubs, 'raves' and other dance parties.

WHAT DOES GHB LOOK LIKE AND HOW IS IT USED?

GHB usually comes as a bitter or salty-tasting liquid and is often sold in small vials (e.g. in small soy sauce containers shaped like fish). It is most commonly sold as a clear liquid, but food colouring is often added so it is not confused with water. Sometimes it is sold as a white powder, or as a capsule or tablet. People often mix GHB into an alcoholic drink or other drink (soft drink, juice etc.). Injecting has been reported.

EFFECTS ON THE BODY

Only a small dose of GHB is needed to feel the effects. The effects come on quickly (5 to 20 minutes after taking it) and last for 1½ to 3 hours. Sometimes similar drugs are sold as GHB (e.g. GBL; 1,4-BD). These drugs convert to GHB in the body and the effects come on more slowly and last longer than GHB.

People report taking GHB because it:

- Is relaxing
- Makes you more sociable and confident
- Increases sex drive
- Can help ease the 'comedown' from stimulant drugs like ecstasy.

Other short-term effects include:

- Memory lapses
- Drowsiness
- Sleeping
- Headache
- Dizziness
- Tremor
- Feeling like you need to vomit (nausea)
- Diarrhoea.

HOW TO RECOGNISE HARMS FROM GHB

High doses of GHB can be dangerous and can quickly cause overdose. Large doses can lead to:

- Hallucinations (e.g. hearing or seeing things that other people cannot hear or see)
- Blackouts
- Seizures
- Unconsciousness (coma)
- Stopping breathing (respiratory arrest).

There is only a small difference between the amount of GHB that is taken to make a user 'high' and a dose that causes overdose. Overdose is quite common. Among Australians who had used GHB more than 15 times in their lifetime, three out of four had overdosed at least once. Mixing GHB with alcohol or other depressant drugs (e.g. opioids, benzos) increases the risk of overdose.

Someone who has overdosed on GHB will look asleep, but they cannot be woken (they are in a coma). If they are awake, they may sweat a lot, vomit, or have irregular or shallow breathing. They may also find it hard to stand up or have muscle spasms.

Not much is known about the long-term harms of GHB use.

HOW TO RECOGNISE GHB DEPENDENCE AND WITHDRAWAL

People can become physically and psychologically dependent on GHB. Tolerance to GHB can develop, so that larger doses are needed to get the same effect.

GHB withdrawal symptoms are similar to alcohol withdrawal. Withdrawal usually starts two to 12 hours after the last time it is used, and lasts from three to 15 days.

HOW TO HELP A CLIENT WHO MISUSES GHB

Standard brief intervention and counselling approaches can be used.

There is no routinely used medicine for GHB detox:

- Benzos (e.g. diazepam) are often used to manage some of the symptoms of GHB withdrawal, anti-psychotic or anti-convulsant medicines are also used.
- If delirium occurs the client may need supervised care in a hospital or clinic.

GHB overdose

- If someone has overdosed on GHB and is unconscious, get medical help straight away by calling 000 or other local emergency contacts.
- While waiting for the ambulance or other medical help, put the person on their left side (the recovery position) so that if they vomit they do not choke and stop breathing. Also, check that their airway is clear and that their chin is not touching their chest (see CPR guide, p. 436).

REDUCING THE HARMS IF A CLIENT CANNOT OR WILL NOT STOP

If the client cannot cut down or stop using GHB, they can try to reduce the risk of overdose by:

- Not mixing GHB with alcohol and other depressant drugs such as benzos and opioids
- Monitoring the amount of GHB they are using in a session, and wait for the effects of the GHB they have taken to reduce before taking any more
- Avoiding driving after taking GHB.

Ketamine

OVERVIEW

Ketamine (ketamine hydrochloride) is an anaesthetic drug that can make you feel like you are outside of yourself (a dissociative anaesthetic). It is also known by the street names: 'K', 'special K', 'cat tranquiliser' and 'vitamin K'. Harms from ketamine use include anxiety, paranoia, hallucinations, and falling unconscious. Ketamine dependence and withdrawal are not common. Counselling is the best available treatment for people with problems with their ketamine use.

The law on ketamine use

Ketamine is used legally as an anaesthetic in animals. It used to be an anaesthetic for humans but it is rarely used for that purpose now because it can cause bad dreams. It is still sometimes used for pain relief or other reasons in hospitals. It is illegal to use ketamine recreationally.

WHAT DOES KETAMINE LOOK LIKE AND HOW IS IT USED?

Ketamine is a white powder that looks like crystals. It can also come as tablets or be dissolved into a liquid.

Ketamine is usually snorted in small amounts ('bumps'), rather than in larger 'lines'. Other ways it is taken include swallowing, or by injecting into veins or muscles.

EFFECTS ON THE BODY

The effects usually last for around one hour if snorted or injected and up to two hours if swallowed. The mind-altering ('psychedelic') effects of ketamine usually stop within one hour, and so people may take repeated doses throughout a session.

People report using ketamine to:

- Feel relaxed
- Feel a 'rush' or 'high' (euphoria)
- Have their senses altered
- Get hallucinations
- 'See' sounds and 'hear' colours
- Feel like they are floating outside your body ('out-of-body experiences')
- Bring on the effects of other drugs faster or more intensely
- Stay up all night dancing.

Other short-term effects of ketamine include:

- Blurred vision and/or smaller pupils (constriction)
- Slurred speech
- Poor muscle coordination
- Numbness (especially in hands and feet)
- Unable to move (temporary paralysis) and/or speak
- Anxiety, agitation and/or panic
- Paranoia
- Increased heart rate and blood pressure
- Faster breathing
- Feeling like you need to vomit (nausea) or vomiting
- Sweating.

Users sometimes fall into a 'k-hole'. Usually involves the feeling of being outside your body, and can include hallucinations, and not being able to move or speak. Sometimes it is likened to a near-death experience.

HOW TO RECOGNISE HARMS FROM KETAMINE USE

Harms from high doses

The harms of high doses of ketamine include:

- Agitation
- Panic or terror
- Paranoia
- Depression
- Memory loss or memory disturbance (amnesia)
- Convulsions
- Abnormal heart rhythms (cardiac arrhythmia)
- Overdose.

Harms from long-term use

Regular heavy use can result in problems with mood (e.g. feeling depressed or paranoid) as well as memory and reasoning. 'Flashbacks' have been reported, where an experience on the drug is strongly experienced again, after the drug was taken.

Can ketamine use lead to dependence and withdrawal?

Tolerance to ketamine can develop quickly, so that people need larger doses to get the same effect. Regular use of ketamine can lead to psychological dependence, but this is not common. Withdrawal symptoms are not usually experienced.

HOW TO HELP A CLIENT WHO USES KETAMINE

Ketamine users may need to go to a hospital emergency department if they feel very anxious, agitated, or have chest pain or palpitations. Most of the time these problems will go away without medical help because ketamine wears off quickly.

Standard brief intervention and counselling approaches can be used. Sometimes benzos are used to treat symptoms like anxiety and agitation (on the one day only).

Overdose

- Ketamine users can become unconscious if larger doses are taken. There is also a risk of stopping breathing (respiratory arrest) or heart failure.
- Because ketamine numbs feelings of pain and can lead to hallucinations, people may accidentally injure themselves.
- Eating or drinking before taking ketamine can cause vomiting, and there is a risk of choking if the person vomits and falls unconscious.
- Very few people have died from ketamine overdose alone and deaths have almost always involved another drug.
- Mixing ketamine with depressant drugs such as alcohol, benzos (e.g. diazepam), opioids (e.g. heroin) or GHB can increase the risk of overdose.
- If someone has overdosed on ketamine and is unconscious, get medical help by calling 000 e.g. after overdose a person may have kidney problems because of a breakdown of muscle fibres ('rhabdomyolysis').
- While waiting for the ambulance or other medical help, put the person on their left side (the recovery position; see CPR guide, p. 436).

REDUCING THE HARMS IF A CLIENT CANNOT OR WILL NOT STOP

If the client cannot cut down or stop using ketamine, they should:

- Not mix ketamine with alcohol, benzos, opioids or GHB
- Monitor the amount they are using in a session, and wait until the effects reduce before deciding to take any more. This may reduce the risk of unpleasant effects and overdose.
- Use with someone who is sober or not using ketamine
- Avoid driving after taking ketamine.

Hallucinogens (magic mushrooms and LSD)

OVERVIEW

Hallucinogens are drugs that change the way a person perceives and experiences things around them. Hallucinogens affect all the senses, and can make a person see and hear things that are not there (hallucinations), can change the way they experience time, and the way they think about things and experience emotions. ‘Magic mushrooms’ and LSD are the most common hallucinogens in Australia.

People generally do not become dependent on hallucinogens. Some people who use hallucinogens may experience a ‘bad trip’ and become very distressed. Counselling may help people who are having problems with hallucinogen use.

WHAT DO HALLUCINOGENS LOOK LIKE AND HOW ARE THEY USED?

Magic mushrooms

Magic mushrooms contain the hallucinogenic substance ‘psilocybin’. There are more than 12 different types of magic mushroom in Australia. They grow wild, and often appear after heavy rain. While some people pick them wild, they usually are sold as dried mushrooms, and sometimes come as a dried powder or in capsules.

Mushrooms are normally eaten (either on their own or mixed into food) or brewed into a tea. Some people smoke mushrooms, mixing them with cannabis or tobacco. Magic mushrooms are also known as ‘mushies’ and ‘shrooms’, or by the type of mushroom (e.g. gold tops, blue meanies).

LSD

LSD is a man-made hallucinogen that usually comes as small squares of blotting paper that have been soaked in LSD. The small squares usually have a picture printed on them (e.g. a strawberry or a yin yang symbol). LSD can also come as a liquid, a powder (white, if pure), capsules or tablets.

LSD is usually swallowed, but some people may snort or inject. LSD is often known by the street names acid, trips or microdots.

How common is hallucinogen use?

Around 1 in 70 Australians have used hallucinogens in the last year. Use is most common in people aged 20 to 29 years.

EFFECTS ON THE BODY

People typically use hallucinogens for their mind-altering ('psychedelic') effects. These effects include:

- Seeing or hearing things that are not there (hallucinations)
- Distorted sense of time and space
- Experiencing the body and emotions in a different way
- Spiritual experiences (e.g. having new insights about the world and existence).

Other effects include:

- Strong sense of happiness (euphoria)
- Relaxed and sense of wellbeing
- Poor coordination
- Dilated pupils
- Increased body temperature and sweating
- Faster breathing
- Increased heart rate and blood pressure
- Dizziness.

The effects of LSD usually come on in the first half hour but can take up to two hours. The effects are strongest in the first three to eight hours, while reduced effects can be felt for up to 12 hours afterwards.

The effects of hallucinogens can vary greatly in different people. Even if the same person takes the same dose every time they use hallucinogens, the effects can be very different, especially the psychological effects.

Other drugs or alcohol used at the same time can change the way the drugs affect the person and can increase the risk of harm.

HOW TO RECOGNISE HARMS FROM HALLUCINOGEN USE

Bad trips

People who take hallucinogens may sometimes experience what is known as a 'bad trip'. A bad trip normally includes:

- Scary or unpleasant hallucinations
- Anxiety
- Panic
- Paranoia.

Someone who is intoxicated with hallucinogens or is having a bad trip may do things they normally would not do that might lead to accidents and injury (e.g. jumping out of a window, running across a road without looking).

Negative effects may be more likely to happen if hallucinogens are combined with alcohol or other drugs.

Injecting

Injecting LSD can be frightening for users because the hallucinogenic effects come on so fast.

Mushroom poisoning

Magic mushrooms in the wild often look the same as poisonous mushrooms. Accidentally taking a poisonous mushroom can make you very sick and cause kidney failure, permanent liver damage and in some cases death.

Comedown

Sometimes people experience a bad comedown after taking hallucinogens. This can last for several days, and may include:

- Low mood
- Anxiety
- Panic
- Psychosis.

Flashbacks

Flashbacks are when people re-experience parts of their hallucinogen experience, without having taken the drug. They are usually visual (e.g. changed perception, hallucinations) and usually last from a few seconds to a few minutes but may last longer. Flashbacks can happen days, weeks, or even years after the drug was taken. Some flashbacks can make the person very anxious while other flashbacks may be enjoyable. Drugs like cannabis may bring on a flashback. Being stressed, tired or anxious may also increase the chance of a flashback.

Death

There have been very few deaths where hallucinogens overdose has been found to be the cause. Deaths normally occur because other drugs are used with hallucinogens, or because of suicide or accidents that happen when the user is intoxicated.

CAN PEOPLE BECOME DEPENDENT ON HALLUCINOGENS?

There is no physical dependence or withdrawal syndrome associated with magic mushrooms or LSD. However, regular use can lead to a short-term tolerance, where larger doses are needed to feel the effects.

Some people may become psychologically dependent, and find it difficult not to use hallucinogens in some situations, but this is not common.

HOW TO ASSESS A CLIENT WHO USES HALLUCINOGENS

People who are experiencing a bad trip may sometimes attend a hospital emergency department. They may be very distressed and anxious, confused and disoriented. Some people may present with acute psychosis, where they may experience very unpleasant hallucinations, severe paranoia, and a loss of reality ('disassociation'). You can ask which hallucinogens they use, how often they use, what kind of situations they use in, and any problems that they have had with using.

HOW TO HELP A CLIENT WHO USES HALLUCINOGENS

Standard brief intervention and counselling approaches can be used.

People who have taken hallucinogens and are very distressed may be given benzos (e.g. diazepam) to relieve these symptoms. Anti-psychotic medicines are sometimes given to people who are very agitated.

Clients having a bad trip

If your client has taken hallucinogens and is very distressed, it is important to make sure that the environment around them is calm and safe. You can speak calmly and reassure them that everything will be okay. Try not to leave clients in this situation on their own.

You may also need to call an ambulance if they are very distressed, showing signs of acute psychosis, or are at risk of putting themselves or others in danger.

REDUCING THE HARMS IF A CLIENT CANNOT OR WILL NOT STOP

To reduce the harms from hallucinogen use, you can offer your client the following advice:

- Do not use hallucinogens on your own. Always use with people you trust, and preferably with someone who is not using hallucinogens at the same time as you.
- Do not mix hallucinogens with alcohol or other drugs.
- Try not to use hallucinogens when you are unhappy or going through a difficult time. Using hallucinogens at such times can increase negative feelings.
- People who have underlying mental health problems or a family history of mental health problems are best to avoid using hallucinogens.
- Driving after taking hallucinogens is not safe as the senses are not operating as they normally do.

Other sedatives

BARBITURATES

Barbiturates are depressant drugs that cause people to become sleepy and relaxed (sedated). They are misused for these effects, and ongoing use can lead to dependence and withdrawal. Overdose is common and can lead to death.

‘Z DRUGS’

‘Z drugs’ (e.g. ‘Stilnox’ or zolpidem, zopiclone) are sedative drugs that cause people to become sleepy and relaxed. They can also cause strange behaviour, confusion, sleep driving, sleep walking and for people to be more forward than they usually would in a sexual way (disinhibited). When these drugs first came out, people thought they were not addictive, but alcohol and drug treatment units all over the world report seeing clients who are addicted. Treatment of dependence is usually for a doctor to swap the client onto diazepam (e.g. Valium) instead. This is handed daily to the client and then they are slowly weaned off.

Betel nut ('areca nut')

WHAT IS BETEL NUT AND HOW IS IT USED?

Betel nut (or areca nut) is the seed from the fruit of a type of palm. The nut is usually sliced into thin pieces and wrapped in a betel leaf with slaked lime (a white powder) and flavourings. This mix is known as 'betel quid', and it is chewed. In some places, tobacco is added to the mix.

How common is use?

Betel nut is commonly used in Papua New Guinea, Indonesia, India and other parts of Asia. It is not known how common betel nut use is in Aboriginal Australians. It is more commonly used in Torres Strait Islander people because of their closeness to Papua New Guinea. In Papua New Guinea, around 4 in 5 people who live on the coast chew betel nut.

EFFECTS ON THE BODY

People chew betel nut for its stimulant effects. Common effects include:

- Feeling relaxed
- Feeling of happiness and wellbeing (mild euphoria)
- Better concentration
- Increased satisfaction after eating.

Other effects include raised skin temperature, faster pulse, and sweating. The effects normally start within a few minutes and last for a few hours.

WHAT ARE THE HARMS OF BETEL NUT USE?

- Regular use of betel nut stains the mouth, teeth, and gums a deep red colour. Long-term use can lead to mouth (e.g. tongue, lips, inside mouth), teeth, and gum damage. There is an increased chance of getting mouth cancer.
- Chewing betel nut with tobacco can lead to mouth and throat cancer (pharynx and oesophagus).
- High doses can cause an upset stomach (nausea), vomiting, diarrhoea, and dizziness.
- Pregnant women should avoid using betel nut as it may harm the unborn baby.

DOES BETEL NUT USE LEAD TO DEPENDENCE AND WITHDRAWAL?

Regular, ongoing use can lead to tolerance (needing more drug to get the desired effect) and dependence.

Withdrawal symptoms are often reported, but are usually mild. They include:

- Craving
- Anxiety
- Irritability
- Dry mouth
- Low mood
- Difficulty concentrating
- Sleep problems.

HOW TO HELP A CLIENT WHO WANTS TO STOP

There are no specific treatments for people who would like to stop using betel nut. Counselling (e.g. motivational interviewing, cognitive behavioural therapy) may help some clients to reduce or stop using.

Khat

WHAT IS KHAT AND HOW IS IT USED?

Khat (qat, qad) is a plant whose fresh leaves are chewed for their mild stimulant effect. The active ingredient in khat is cathinone, which is structurally similar to amphetamine. The plant comes from the Middle East and East Africa, where it has been used for centuries. In NSW, Victoria and Tasmania, individuals can obtain a permit to import 5kg per month for personal use. Khat is illegal in the other states and territories.

How common is use?

Khat use in Australia is most common among people who have immigrated from north east Africa and the Middle East.

EFFECTS ON THE BODY

Common effects include:

- Feel more alert, have more energy, feel excited
- Feel happier (mild euphoria)
- More talkative
- Better concentration
- Less appetite.

Other effects include raised body temperature, faster pulse and breathing, and sweating.

WHAT ARE THE HARMS OF KHAT USE?

Some of the harms from use include:

- Dental problems
- Mouth cancer
- Trouble sleeping
- Constipation
- Existing heart problems can get worse
- Psychosis.

People often smoke more tobacco than they usually would when chewing khat, which can increase the harms from tobacco. Some people use alcohol after using khat to calm themselves down and get to sleep.

Pregnant women should avoid khat as it may harm their unborn baby.

DOES KHAT USE LEAD TO DEPENDENCE AND WITHDRAWAL?

People who use khat every day may become dependent. Mild withdrawal symptoms may happen after stopping regular use. Symptoms include anxiety, low mood, feeling tired with no energy (fatigue), and sleep problems.

WHAT TREATMENTS ARE AVAILABLE?

There are no specific treatments for people who would like to stop using khat. Counseling may help some clients reduce or stop using. Khat users experiencing psychosis may be given anti-psychotic medicines. Khat users experiencing withdrawal symptoms like anxiety and sleep problems may be given benzos (e.g. diazepam).

Steroids (i.e. anabolic steroids)

Anabolic steroids work in the same way as the male hormone 'testosterone'. They are often used illegally by bodybuilders and athletes to gain muscle and improve performance. They are sold as tablets or a liquid, which is injected into muscle.

Injecting increases the risk of becoming infected with a blood-borne virus (e.g. hep C, hep B, HIV) if injecting equipment is shared (see Safer injecting, p. 296). There is also an increased risk of liver damage, liver cancer and heart problems.

Psychological effects of steroid use include aggression ('roid rage') and depression. People who regularly use steroids may become psychologically dependent and may get distressed when they stop using.

There are no standard treatments for anabolic steroid misuse, although medicines may be used to relieve some symptoms. Counselling may help clients reduce or stop using.

FURTHER READING

NSW Health (1999). *Anabolic steroids: Let's get the facts right*. Available from: www.druginfo.nsw.gov.au/__data/page/1228/anabolic-steroids_handout.pdf.

11

Polydrug use

<u>Overview</u>	238
<u>What is polydrug use?</u>	238
<u>Reasons for polydrug use</u>	239
<u>What are the harms of polydrug use?</u>	240
<u>How to assess a person who uses several drugs</u>	242
<u>How to help a person who uses several drugs</u>	244
<u>Reducing the harms if a client cannot or will not stop</u>	245
<u>Preventing polydrug use from starting</u>	246
<u>Further reading</u>	246

OVERVIEW

Polydrug use is when a person uses more than one type of drug, either at the same time or at different times. Polydrug use can lead to more problems than using just one type of drug. For example, it can increase the chances of overdose, mental health problems, risky behaviours and accidents.

There are no specific treatments for polydrug use. Instead, the approach to treatment is similar to what is used for other drug and alcohol problems (e.g. counselling and medicines).

WHAT IS POLYDRUG USE?

Polydrug use can include alcohol, illegal drugs, prescription drugs, over-the-counter medicines, and petrol, paint and other inhalants. Cigarettes and coffee are usually not included in this definition. The terms ‘polydrug use’ and ‘polysubstance use’ mean the same thing.



When the terms ‘drugs’, ‘drug use’ or ‘polydrug use’ are used in this chapter they include illegal drugs, alcohol, medicines, and petrol, paint and other inhalants.

With polydrug use, the drugs may be used together at the same time, or they may be used at different times in a day, week, month or year (without necessarily being used at the same occasion).

Different examples of polydrug use

A person may use drugs at the same or different times; for example:

- Alcohol and cannabis together at the same time
- Alcohol at different times or places than when they use cannabis
- Alcohol only when cannabis is not available.

A person may be dependent on none, one or several drugs. They may:

- Be dependent on several drugs at once
- Be dependent on one drug but use others from time to time
- Use various drugs from time to time but not be dependent on any.

How common is polydrug use?

It is difficult to know exactly how common polydrug use is, but we do know that it occurs often. Most people who use illegal drugs, for example, report that they have also used other drugs or alcohol as well in the last 12 months. Looking at everyone in Australia, Aboriginal people are more likely to have used illegal drugs in the last 12 months than non-Aboriginal people.

REASONS FOR POLYDRUG USE

There are many reasons why people may use more than one type of drug:

- *To increase the 'high'*: this happens when drugs that have similar effects are used together (e.g. using heroin and benzos together to get more 'stoned') but may also include using drugs from different classes (e.g. using heroin and cocaine together in the one shot, known as 'speed-balling').
- *To reduce unwanted side effects*: to reduce side effects during drug use (e.g. using alcohol to reduce anxiety and agitation caused by cocaine), or to reduce the after effects of use (e.g. using cannabis when 'coming down' from ecstasy).
- *To relieve withdrawal symptoms*: this usually occurs when a person is dependent on a drug and experiences withdrawal symptoms when their use stops or is interrupted (e.g. people dependent on heroin may use benzos (such as diazepam) to reduce withdrawal symptoms when they run out of heroin).
- *Because of chronic pain*: prescribed drugs may be used in combination with non-prescribed drugs (e.g. a person who is prescribed morphine for pain may also use over-the-counter medicines and alcohol to manage their pain). Some people may use combinations of illegal drugs to manage pain (e.g. heroin and cannabis), especially if the person cannot get pain relief through medical sources.
- *Because of sleep problems*: sleep problems are common and can lead to polydrug use to help the person get to sleep (e.g. alcohol, cannabis and benzos may be used to achieve sedation and sleep, although in the long-term this can make sleep problems worse).

- *Because of mental health problems:* people with mental health problems may try to make themselves feel better ('self-medicate') with a number of drugs (e.g. a depressed and shy person may use amphetamines and alcohol to lift their mood and feel more confident, or a person who hears voices may use a number of drugs to try and block out the voices).
- *Because people around them use multiple drugs:* in some groups or with certain friends and families, polydrug use may be expected or considered 'normal' (e.g. at dance parties or raves, people may use ecstasy, cocaine and/or amphetamines in combination with alcohol, and may use benzos or cannabis to 'come down' after the event).
- *Because of availability:* using one drug instead of another when the preferred drug is not available is very common (e.g. when heroin is not available, injecting drug users often inject amphetamines or prescribed opioids).

WHAT ARE THE HARMS OF POLYDRUG USE?

The effects of alcohol or drug use are different from person to person. The effects can also vary from occasion to occasion in the same person depending on the strength and how much of the drug is used. Each additional drug used adds to these effects and to the possible harms. This may increase the chance of serious problems, especially if the different drugs have similar harms.

Ways that the effects of more than one drug combine

The effects of using multiple drugs can add up (called *additive effects*); such as when someone uses heroin and benzos together, both drugs have a calming effect and effect of the benzos is added on top of the effect of the heroin.

Sometimes using some drugs together can lead to greater effects than would be expected from simply adding up the effects of each drug. This is called *synergism*. It happens when one drug actually makes the other drug work more strongly. For example, a person may be able to handle alcohol when no cannabis is smoked, or may be able to handle cannabis when no alcohol is drunk, but when they drink alcohol and smoke cannabis at the same time it becomes too much, and they become very heavily intoxicated. How much greater the effects are varies from person to person and between occasions. As a result, the effects of combined drug use can be very unpredictable and dangerous.

Because of combined effects, polydrug use can cause an increased chance of:

- Intoxication (being more ‘high’)
- Worse hangovers
- Risky behaviour (such as driving under the influence of alcohol or drugs)
- Accidents and other injuries (like falls)
- Getting into fights and other violent behaviour
- Becoming dependent on one or more drugs
- Problems getting on with family and friends
- Mental health problems (such as depression or paranoia)
- Medical problems (such as liver disease or heart disease)
- Overdose.

Harms from common drug combinations

Some examples of common hazardous drug combinations are:

Alcohol and cannabis

Drinking and smoking cannabis at the same occasion can lead to people getting more intoxicated than if they used either drug on its own. It can also lead to a greater chance of risky behaviour like accidents, falls, fights, other violence and stronger paranoia (particularly if a lot of cannabis is used). Using alcohol and cannabis at different times and in different places can still lead to problems (see Alcohol harms, p. 71–74; Cannabis harms, p. 131).

Heroin and benzos

People dependent on heroin will often use benzos to increase the ‘downer’ effects of heroin, either by swallowing benzos around the time of heroin use, or by injecting them at the same time as heroin, morphine, methadone or buprenorphine. As both heroin and benzos slow down breathing, there is a high risk of overdose – and even stopping breathing completely and dying from lack of oxygen (see Opioids, p. 142; Benzos, p. 177).

Alcohol and stimulants

The use of stimulant drugs like amphetamines and cocaine can mask the effects of alcohol because the drinker can stay more alert. People who mix alcohol and stimulants often drink more and for much longer periods of time than if only alcohol was being used. The effects can cause people to feel over-confident and to have poor judgement, which may lead to risky behaviour such as unprotected sex, violence and driving under the influence of alcohol or drugs (see Alcohol harms, p. 71; Stimulant harms, p. 165).

Amphetamines and ecstasy

These drugs are often used together by young people at raves, dance parties, or in bars or nightclubs. Used together, amphetamines and ecstasy can cause people to be over-stimulated. They may overheat, and become dehydrated and exhausted from dancing for long periods. This can place strain on the heart and can cause muscles to overheat ('muscle meltdown') and kidney failure, both of which can lead to death (see Stimulant harms, p. 165).

HOW TO ASSESS A PERSON WHO USES SEVERAL DRUGS

A full drug and alcohol history should be taken (see Assessment, p. 11), paying attention separately to each drug. This requires patience and attention to detail and may be challenging if the person has memory problems caused by their polydrug use.



A full drug and alcohol history should be taken for each drug, including:

- How the drug is taken (e.g. swallowed, smoked, snorted, injected)
- Patterns of use (e.g. every day, weekends, paydays only or special occasions)
- Reasons for use
- Relationship to other drug use (e.g. is one drug only used when the other runs out, or are they used at the same time?)
- Risky behaviours that happen when the person is high
- Any problems resulting from their alcohol or drug use.

A full medical, psychiatric and psychosocial history should be taken. Also, look for evidence of drug use, signs of intoxication or withdrawal, and signs of drug use complications (both physical and psychological/psychiatric). If possible, a full medical examination should be arranged.

The role of urine drug screen and breathalyser

A urine drug screen can confirm what the client says about their polydrug use. It may also show drug use that was not mentioned by the client that needs to be explored further. Some drugs that are only used occasionally may not show up in a urine drug screen, but still may be causing significant problems to the person. A breath or blood alcohol reading may also be useful.

At the end of the history, you should be able to write a brief summary statement about which drugs are used and the pattern of use of each, i.e. occasional, regular or dependent (usually daily). Where there is occasional drug use, this should be described as low risk, hazardous, or harmful. If the person is dependent on any particular drugs, these should be listed. In most cases either the client or the clinician can work out that one or two drugs are the main problem, and other drug use is a lesser issue. But sometimes, if no one drug outweighs the others, and if the client is not dependent on any one particular class of drug, their use is described as 'polydrug dependent'.

When is a client diagnosed as polydrug dependent?

While many clients use more than one drug, the formal diagnosis of being *polydrug dependent* is usually only made when:

- There is no drug of choice (preferred or main drug)
- Multiple drugs are used within the same 12 month period without the use of one being more than the others
- There is no clear dependence on one drug class (such as alcohol, cannabis, benzos, opioids or stimulants)
- All of the drugs being used together amounts to a pattern of dependent use.

HOW TO HELP A PERSON WHO USES SEVERAL DRUGS

Counselling

The approach to polydrug use is similar to that used in all drug and alcohol treatment. An honest, open and supportive relationship with the client is important, as polydrug use often requires long-term management. It is important to build motivation by helping the client to recognise the problems caused by their drug use, and reinforce the reasons they want to change (see Brief intervention, p. 19).

Identify with the client which drugs are causing them the most problems (both the most pressing problems – i.e. those that need attending to right now – and the most severe problems, even if the effects might not be felt for a few years) and which drugs the client is willing to stop using. Some clients may wish to address all drug use at once but it is more common for one drug problem to be dealt with at a time. Generally, those drugs causing the most pressing or most severe harms should be looked at first.

Once any withdrawal is over, and life is a little more stable, the client needs to deal with the reasons for their use – whether it is chronic pain, sleep problems, mental health symptoms, relationship issues, other reasons, or a combination of reasons. This is important to maintain any reduction in alcohol and other drug use. This may involve a specific talking therapy (e.g. CBT for depression; relaxation training for anxiety) or it may involve more general support and counselling. Specific drug and alcohol counselling (e.g. CBT to help cope with cravings or other triggers to drug use) can also help prevent a return to harmful use. It should be arranged for ongoing follow-up (see Counselling, p. 27).

Medicines

For some substances, specific medicines are available to help maintain reduced drug use or to avoid relapse to drug use (e.g. methadone or buprenorphine for opioid dependence; Antabuse, Campral or naltrexone (Revia) for alcohol dependence).

Detox and withdrawal management may be required for clients who wish to stop dependent drug use. Whether this is undertaken in a live-in detox unit or hospital or whether this can be done at home should be decided based on the person's wishes, their situation at home, and how severe a withdrawal is expected.

Referral to other services

Consider early referral to specialist drug and alcohol services for people using a number of drugs. Where necessary, also refer to other services for physical or mental health care. Referral for social services such as housing assistance may also be needed.

REDUCING THE HARMS IF A CLIENT CANNOT OR WILL NOT STOP

If a client is not ready to stop polydrug use, they can be given advice on ways to reduce the problems or harms they encounter (this is called harm minimisation):

- If multiple drugs are going to be used, it may be wise to first use a small amount of just one drug and wait and see how that affects them before adding in other drugs. Much smaller amounts of each drug should be used if they are being combined than if the drugs were used on their own.
- Changing to less harmful ways of using drugs (e.g. using drugs by mouth instead of injecting them) may reduce the chances of other health problems.
- Driving or operating heavy machinery should be avoided completely when under the influence of alcohol or other drugs (see Alcohol, drugs and driving, p. 322). Drugs should only be used in safe places and if possible a trusted friend or family member who is not using drugs should be present so they can get help if something goes wrong.
- Plenty of time should be allowed for recovery between occasions of drug use. Getting enough sleep or rest, eating healthy foods and drinking plenty of water can help with recovery. Clients should be discouraged from using one drug to cope with the after-effects or withdrawal symptoms of another drug.
- Encouraging clients to remain involved with their family, friends and workplace is important to help them stay connected with their community and meet their responsibilities, such as raising children and paying bills.

Offering non-judgemental support is sometimes all that can be offered, so that when a person is ready to make a change they feel comfortable asking for help.

PREVENTING POLYDRUG USE FROM STARTING

Educating people about the risks of polydrug use can reduce the chance they will start in the first place. Helping people with chronic pain, sleep problems, mental health problems, relationship problems or drug dependence to get appropriate treatment may help stop polydrug use from happening. Trying to make sure that people using drugs or alcohol dangerously are not prescribed other drugs of abuse or dependence is also important.

Reducing drug use and drug availability in the wider community means that there is less drug use around a person, which might encourage them to not take up polydrug use.

FURTHER READING

National Centre for Education and Training on Addiction (NCETA) (2004). *Polydrug use, part B3.9. Resource kit for GP trainers on illegal drug issues*. Canberra: Department of Health and Ageing. Available from: www.nceta.flinders.edu.au/workforce/publications_and_resources/nceta-workforce-development-resources/gp_trainers_kit/section_b3_9/.

12

Mental health and substance use

<u>Introduction: Mental health and substance use</u>	248
<u>Depression and suicide</u>	249
<u>Anxiety and stress</u>	261
<u>Psychosis</u>	275

Introduction: Mental health and substance use

Many Australian Aboriginal people are no longer the proud hunter-gatherers of this land. Instead, we are recognised as one of the most disadvantaged groups in modern Australia. A history of colonisation and disruption has had many negative impacts. Active separation of families has contributed to the disruption of Aboriginal society. A loss of the respected position in a once ordered society has led to disharmony in our communities and degradation of culture. All of these are reflected in and are linked to the development of poor health and mental health in our people.

What this has meant is that generations of our people are at risk and vulnerable to developing mental health problems. This may or may not be related to alcohol or drug use. When this does happen, some individuals or families seek help from Aboriginal health professionals or others. The help that we can offer needs to be well thought out and may rely on both knowledge of cultural understanding in addition to Western approaches. In some more serious cases, we may be called on to help people who are losing touch with reality or becoming depressed or even suicidal.

This is why a chapter on mental health has been included in this handbook. It is not only to provide knowledge to those working in Aboriginal alcohol and drug work, but also as a resource to people who are helping particularly vulnerable members of our communities. This chapter explores some mental health conditions (e.g. depression and suicide; anxiety and stress; and psychosis) in the context of substance use.

Depression and suicide

OVERVIEW

All of us experience grief at some point in our lives. With sickness and deaths and separations, Aboriginal communities can experience grief more often than other Australians. But when a person has a sadness that they cannot shake, or that goes on much longer than normal grief, and stops them moving on with life, then they may be suffering from depression. There are different types of depression, including depression that can occur after a baby is born (postnatal depression). For milder forms of depression, simple measures such as walking outdoors and talking therapies may help. For more severe forms of depression, medicines can be very important. Assessing the risk from depression and from suicidal thinking is very important. All clinicians need to know what professionals in their area can help assess or arrange treatment for a depressed or suicidal patient.

WHAT IS DEPRESSION?

Major depression, also known as clinical depression, is a serious illness. It is a collection of symptoms such as feeling low most of the time, losing interest or motivation to do things, having no energy, and difficulty sleeping and eating.

How common is depression?

Around 1 in 20 Australians will have depression at any one time. Across a lifetime, up to 1 in 4 women and up to 1 in 8 men will experience depression. Overall, younger people have a higher chance of being depressed than the elderly.

Among Aboriginal people, depression is also a widespread problem. It is the most common mental health problem in people seeing their general practitioner (GP). It is hard to know the real number of Aboriginal people who have depression, and many people do not seek help.

WHY DO PEOPLE GET DEPRESSION?

A number of different factors may contribute to a person being depressed. Most often depression occurs because of a combination of these reasons and not just one cause. Personality and life circumstance can also affect why some people become depressed.

Physical or biological reasons

Depression may:

- Run in the family (hereditary)
- Be the result of problems with the body's system for managing stress (the stress-hormone system)
- Be caused by changes to chemicals in the brain. These include changes in the emotional centre (limbic system) to chemicals like serotonin.
- Be caused by other health problems (e.g. anaemia, stroke, heart attack, cancer).

Psychological reasons

Depression may occur because of:

- Bad childhood experiences
- Negative thinking, e.g. if someone always expects the worst or feels like they are a failure or that they are unlovable. This pattern of thinking may come about because of early bad experiences with caregivers.
- Feeling powerless, e.g. where there is domestic violence or loss of control over life
- Certain personality styles, e.g. people who are introverted (who naturally turn inwards and think a lot), who worry a lot, are too dependent on others, or are very sensitive.

Social reasons

- Social factors can make people more likely to develop depression, such as:
 - Not having a close relationship, e.g. with family or partners or being single
 - Being unemployed or doing unpaid work at home only
 - Major life events, which lead to loss, change or other long-term stress.
- In Aboriginal people, depression may be a response to experiencing racism, dispossession and disadvantage.

Cultural reasons for depression and understandings of depression

It is important to consider cultural and spiritual factors when assessing and treating depression.

In traditional communities, people understand depression as something that happens if a person has done something wrong culturally. A person may also become depressed because of 'longing for land'.

HOW TO RECOGNISE IF SOMEONE HAS DEPRESSION

Everyone feels sad or unhappy at times, but these feelings are usually short-lived and gradually go away, and the person can still go on with their life. Clinical (or major) depression is different to these normal changes in mood. People with depression typically feel 'low' in mood most of the time (for at least for two weeks or more), and are unable to enjoy things that would normally give them pleasure. They often have trouble doing things they normally do (e.g. work or looking after their children).

What problems (symptoms) do people report?

- Feel cranky (irritable)
- Sadness
- Not much energy
- Poor memory and concentration, hard to make decisions (indecisive)
- Sleep problems
- Eating less or more than normal
- Weight gain or loss
- Loss of pleasure or interest in things that normally make them happy
- Less interest in sex
- Suicidal ideas, thoughts about death (see Suicide, p. 257).

What might you see in a person with depression (signs)?

- Cries a lot
- Does not look after themselves
- Too much movement (restless, jumpy) or barely moves at all
- Does not speak unless spoken to, or speaks very softly and does not say much
- Cranky (irritable) or sad
- Has negative thoughts about themselves and the future, feels guilty, hopeless or worthless
- Talks about wanting to die and has a plan to hurt themselves
- Seems withdrawn from others and life (e.g. no eye contact, not wanting to talk, or not going out).

Sicknesses often seen in people with depression (comorbidity)

It is very common for people with depression to be facing other health problems at the same time, such as:

- Anxiety disorders
- Medical illnesses (e.g. heart disease, cancer, dementia)
- Substance use problems (especially alcohol – people who are dependent on alcohol have high rates of depression. This may be a result of alcohol being a ‘depressant drug’. However, the person’s depression may also have led to their drinking problem).
- Difficulties relating to other people. These are sometimes described as personality disorders when the way a person interacts with other people is disturbed, unhelpful and does not adapt to different circumstances (‘maladaptive’). These sorts of behaviours can lead to much distress, including depression, and can get in the way of their ability to cope with life, stress, and relationships.

When a client has one sickness (e.g. alcohol problems) at the same time as another sickness (e.g. depression), this is known as comorbidity.



Common illnesses that get confused with depression

Sometimes the symptoms of depression are actually being caused by another illness. That illness may be able to be treated so it is important for the depressed client to have a medical assessment. All these illnesses can cause symptoms that can look like depression:

- An underactive thyroid
- Anaemia, kidney failure
- Dementia
- Withdrawal from drugs like alcohol, heroin and other opioids, stimulants and benzos
- Other health problems (e.g. dementia, personality problems and reactions to grief and other stressful events).

HOW TO ASSESS A CLIENT WHO MAY HAVE DEPRESSION

The most useful part of an assessment for depression is to give the client an opportunity to tell their story and explain how they feel. They might talk about what problems they are having and how what they are feeling now is different to how they usually feel.

Questions to ask your client

- What symptoms they are experiencing
 - It may be helpful first to talk a bit and to ask some more general questions to get your client feeling comfortable, such as:
 - “How are you?” or “What have you been doing lately?”
 - If they do not talk much you may then need to ask more specific questions. For example: “Have you been feeling sad or weak?”, “Does it feel like you have lost interest in things you like?” or “Are you having trouble with sleep or eating?”
- If they use drugs or alcohol. If so, how much and how often.
- If they have other mental health problems, now or in the past, and what treatment was provided
- If they have any other health problems and if they take any medicine for these health problems
- If they are feeling suicidal. If they are, find out if they have a plan and what this plan is.
- Ask about other risk factors for depression and suicide (see p. 250, p. 258).

What you observe

Write down some notes about how your client looks, behaves, speaks and relates to you. For example:

- Do they look sad? How do they express their emotional state in their face and body language? (this is called their ‘affect’)
- Do they appear to have trouble concentrating and with short-term memory? (‘cognitive’ problems)
- If the client consents, it is also helpful to speak with their family and any other health professionals who they have seen (e.g. health worker, GP). This gives you the chance to see what behaviour changes people around them have seen.

Consider local culture and views when assessing depression

It is important to work out if cultural reasons may be affecting how the client is feeling. Having an experienced Aboriginal mental health or other Aboriginal health professional (or traditional healer) working with the client's GP or psychiatrist can be important to get the best outcome for the client.

Different types of depression

Many different disorders can cause a depressed mood; for example:

- *Major depression* (also sometimes called clinical depression)
- *Psychotic depression*: the person has beliefs and experiences that are not based in reality (e.g. hallucinations, delusions).
- *'Atypical' depression*: the person sleeps and eats too much. This is the opposite of what usually happens in depression where people often sleep or eat less than usual.
- *Postnatal depression*: this develops during pregnancy or after childbirth.
- *Depression as part of bipolar disorder*: the person may have periods of depression as well as other times when they feel really high (also known as 'mania'; or a manic phase). Each mood swing may last from weeks to months, or longer if not treated.
- *Mood disorders as a result of alcohol or drug use (substance-induced mood disorders)*: some drugs have a depressant effect, such as alcohol and benzos. In other drug use, such as with amphetamines, the person may feel depressed when they first stop using the drug. Usually the person's mood improves when they stop using the substance for a while. This can take about a month after alcohol dependence, for example.
- *Long-term sadness (chronic dysthymia)*: the person feels sad, but only has a few other symptoms of depression, and the low mood is there most of the time for two years or more.

WHEN TO GET HELP IF YOU THINK A CLIENT HAS DEPRESSION

Get help from a GP, psychiatrist or mental health team if:

- You are not confident or trained to assess their level of risk
- You think a client has major depression and may need treatment
- The client is reluctant to talk and has isolated themselves from their family and friends
- The client's families and friends are worried
- You feel that the person may be at risk (e.g. because of community reasons, or lack of resources or experience). This is particularly important if someone has a clear plan to hurt themselves or has already tried to hurt themselves.
- The person is at risk of harming themselves or someone else – they may need treatment for depression, even against their wishes (using the Mental Health Act). Families and carers are typically involved in this process.



If someone needs treatment for depression, even against their wishes

- Usually the clinic nurse or GP can arrange to have the person transferred to a hospital.
- This may mean involving the police to help keep someone safe (and contained) if they do not want to go to hospital.
- Clinic staff sometimes may need to use medicines to help the person calm down, especially if they are angry or aggressive. This may also help keep the client safe while arrangements are made with the hospital and during the transfer.
- The person may feel a little better if they have a trusted relative with them throughout this process.
- The police or clinic staff fill out a schedule (Form 1 of the Mental Health Act), which allows the person with the mental illness to be taken to a mental health hospital for assessment and treatment against their wishes.

WHAT TREATMENTS ARE AVAILABLE FOR DEPRESSION?

For mild to moderate depression, some types of talking therapy (such as CBT – cognitive behavioural therapy – and interpersonal therapy) are just as effective as anti-depressant medicines. They can also have an important role in more severe depression, together with other approaches such as medicines.

Talking therapies

Skilled therapy, with specific treatments such as CBT, is an effective way to treat depression.

In cities or regional areas, psychologists can be accessed through GPs or the local drug and alcohol or mental health service (often paid for by Medicare). In rural and remote settings, they can be harder to find. There are still not many Aboriginal psychologists in Australia. Aboriginal mental health workers may also provide some counselling in your community.

Medicines

In a more severe depression, medicines can have a very important role. Anti-depressants can be used to treat depression together with lifestyle changes (such as exercise and being involved in positive enjoyable activities). There are many different types, each with different doses and side effects. The client's doctor can help them choose the medicine best suited for them. Anti-depressants take a few weeks to work. Most people (around two out of three people) will improve on the first anti-depressant they try. Some people may not want to take tablets or may experience side effects. It is important that they discuss these concerns with their doctor. Anti-depressants must be taken every day to be effective. The GP or psychiatrist can help assess whether an anti-depressant might be helpful for your client.

Electroconvulsive therapy (ECT)

Shock treatment (electroconvulsive therapy, ECT) has got a bad name from movies and because of the way it was used in past times, but these days ECT is an effective, safe and life-saving treatment in severe cases of depression. ECT is a painless procedure that is performed by a medical team while the client is under anaesthetic (i.e. is kept asleep by strong medicines). Some side effects, such as confusion and headaches, only last a few hours. Others such as problems with short-term memory may last 3–6 months. ECT does not cause brain damage. It is used in severe cases of depression where it would be dangerous or cruel to leave the client suffering while waiting for medicines to start working. It can also be useful if the person cannot take anti-depressant medicines.

SELF-HARM

When a person has depression or other problems (e.g. health, family, money worries), they may want to physically harm themselves ('self-harm').

Some common reasons for why people self-harm are:

- To block out emotional distress
- To release tension and stress
- Because they want to 'feel' something, as they feel so out of touch with reality.

Clients who harm themselves may also later attempt suicide so it is important to assess the client each time they are seen. Clients who self-harm can be challenging to care for. Seek advice from their psychiatrist on the best way to respond if they harm themselves. If a client tells you they feel like hurting themselves or have already harmed themselves, it is important to have them assessed (e.g. by a GP, clinic nurse or mental health worker).

For some traditional communities, ritual self-harm may be part of a ceremony. This should not be misinterpreted as a suicidal gesture. If you are not sure if this is appropriate cultural behaviour, seek advice from an experienced local Aboriginal health worker or community member.

Suicide

Some people who have depression wish that they were dead and think about killing themselves ('suicidal ideation'). It is important that risk of suicide be assessed properly.

How common is attempted suicide and suicide?

We do not know enough about suicide in Aboriginal people, but we do know that it is common. In some studies, up to 1 in 6 people have attempted suicide (15%), and in any one year, 1 in 50 (2%). The suicide rate in Aboriginal communities is double that of other Australians. Suicide is often impulsive and young Aboriginal men have the highest rates of suicide. Most deaths occur between ages 15–30 and from violent methods (e.g. hanging, gunshot wounds).

What makes some people more likely to attempt suicide? (risk factors)

- Experience of grief and loss (deaths, loss of culture)
- Experience of trauma
- Having a mental illness (half of all people who commit suicide have depression)
- Using alcohol and other drugs
- Being single, divorced, separated or widowed
- Having a medical illness
- Family history of suicide
- Being sexually abused as a child
- Someone who worries, has low self-esteem or takes lots of risks
- Problems connecting with others
- Poor achievement at school.

HOW TO ASSESS A CLIENT WHO MAY BE AT RISK OF SELF-HARM OR SUICIDE

Risk is assessed in a number of ways:

- Taking a history from the person and their relatives
- Talking with health staff who have helped the client in the past
- Asking the client directly whether they have been thinking about suicide or self-harm.

Find out about any factors that may place a client at risk of self-harm or suicide

Do not be afraid to ask lots of questions; for example:

- Have you thought about hurting yourself?
 - If you have, do you have a plan?
 - Have you acted on this plan in any way?
- How often do you think about suicide or self-harm?
- Do you have access to things to harm yourself with (e.g. medicines to overdose on, a weapon to harm themselves with)?
- Have you tried to hurt yourself in the past?
- What situations make you think about hurting yourself (e.g. when drinking)?
- Have you decided when you will hurt yourself?
- What stops you from hurting yourself?

Also, try to work out:

- Has the client been looking after themselves and their family as usual?
- Has the client been aggressive, violent or neglectful? If so, in which circumstances?

Think about any factors that may help protect the person

- Supportive family
- Their spiritual beliefs
- An important role (such as being a parent).

Work out what practical help or supervision can be provided

It may not be possible to care for the person at home. The person may have to be cared for by relatives/friends, be seen at a health clinic or admitted to hospital.



Who should you refer the client to?

If you have a client who you think might be at risk of harming themselves or harming someone else, tell their local doctor, nurse, mental health service or the police. It may be that your client needs urgent protection, even if they do not want help. They need an assessment and may need to talk to someone and have treatment. They could also call Lifeline (131 114) or Kids Helpline (1800 55 1800). These services are free from landlines, payphones and mobiles across Australia, although people with a Telstra mobile cannot access Kids Helpline for free. Kids Helpline also offers web counselling and email counselling (www.kidshelp.com.au).

HOW TO PREVENT DEPRESSION AND SUICIDE FROM HAPPENING

Finding ways to improve a person's social and emotional wellbeing may help to prevent depression and suicide. Exercise and good experiences (e.g. going fishing, going to the movies) can help, as well as connecting with family and culture.

Where to get more information

- Beyondblue: www.beyondblue.org.au or www.youthbeyondblue.org.au
- Lifeline: www.lifeline.org.au or 131 114
- Kids Helpline: www.kidshelp.com.au or 1800 55 1800
- Sane Australia: www.sane.org
- Reach Out: www.reachout.com

FURTHER READING

See more information on the Beyondblue website: www.beyondblue.org.au.

See the Indigenous Risk Impact Screen (IRIS; p. 427).

See a resource for Indigenous Social and Emotional Wellbeing work:
www.healthinfontet.ecu.edu.au/sewbworkers.

Anxiety and stress

OVERVIEW

We all experience anxiety at some point in life when coping with stressful events. But the word ‘anxiety’ is also used to describe a mental disorder in which the experience is too severe, it goes on for too long, or where there is no obvious cause. This chapter will look at what is anxiety, what causes it, when does it become a ‘disorder’, and what kinds of anxiety disorders are there. It will also talk about how to help someone with anxiety.

WHAT IS ANXIETY?

Anxiety is a condition that may be serious and affects behaviour, emotions and thoughts (i.e. it is both physical and psychological). We can think of the physical elements as ‘tension’ (or agitation) and the psychological elements as ‘apprehension’ (an unpleasant feeling that something is wrong or something bad may happen).

What is happening in anxiety?

The physical parts of anxiety, i.e. tension, are like the ‘fight, flight or freeze’ response that most animals (including humans) have in dangerous situations. As the brain signals ‘danger’, the body gets ready to respond. The body sets itself to ‘high alert’ with increased activity of the nervous system and the body produces ‘stress hormones’ (steroids and adrenaline-like substances) that prime us for action. In response, heart and breathing speed up, muscles tense, arms and legs may become shaky (tremulous), mouth becomes dry, sweating may increase, and there may be ‘a knot’ (discomfort) in the stomach as the body gets ready for ‘action’. In anxiety, these changes may be minor and brief, or they may be intense and/or long lasting.

The psychological element of anxiety, i.e. apprehension, is a sense of foreboding (that something bad is going to happen). This feeling can vary from feeling emotionally ‘keyed up’ and ready to react (excited expectation) or crippling dread. The causes of this thinking may be obvious to the person (e.g. many past bad experiences) or the person may not understand why they feel this way.

These experiences of tension and apprehension are usually present to some extent when people talk of being anxious or stressed.

How common is anxiety?

Anxiety disorders are common and affect around one in 10 Australians. Anxiety is more often seen in women than men. Aboriginal Australians are more at risk of developing an anxiety disorder than many other Australian groups because of greater exposure to 'risk factors' throughout life, i.e. experiences that can occur while the baby is developing in pregnancy, in childhood or in later life.

WHY DO PEOPLE GET ANXIETY?

Most often anxiety occurs because of a combination of factors and not just from one cause. Both personality and life circumstances can affect why some people have anxiety.

Physical or biological reasons

A range of physical or biological reasons can make a person more at risk of developing anxiety:

- *Family history:* anxiety is linked with the natural level of activity in the brain. While levels of anxiety can be positively or negatively affected by past experience, there are enormous differences in how people respond to stress and how they experience anxiety. Our genes (inherited factors) can influence our brain's make-up.
- *Changes to chemicals in the brain:* the brain can be 'short circuited', for example, by alcohol or drugs or by an illness such as an overactive thyroid gland.
- *Problems during pregnancy can make a person at risk of later anxiety:* this can happen, for example, from stress in the mother, alcohol, tobacco and other drug use, or poor nutrition.

Social and psychological reasons

How likely a person is to get anxiety is influenced by their family and community setting. These may have a positive effect or a negative effect:

- *Problems during infancy:* e.g. illness, separations from parents, poor growth, and unstable homes can place a person at risk of problems with anxiety.
- *How safe and adequate the family environment is:* this influences emotional development of the infant and child.
 - A good environment helps a person develop trust in others and a sense that the future will turn out well (optimism). It also can offer healthy lifestyle options.
 - Experience of major life difficulties like traumas (e.g. deaths, or abuse as a child) can increase the risk of later anxiety. Sometimes, after childhood traumas, distress linked to those traumas may be triggered again by quite minor events, e.g. people who were removed as children from their families may suffer from severe anxiety if they face an event or situation that triggers the bad memories.
 - A sense of control over their environment and confidence as they grow up that they can get along with people and play a part in society: if the infant or growing child develops this sense of control and ability, they are less likely to develop anxiety disorders.
- *Experience of trauma and stress throughout life:* Aboriginal Australians are more likely to experience situations and events that are stressful (such as death, loss, separation, unemployment, money worries, poor health, poor living conditions) and are less likely to have access to resources and services to help them during times of need. All these traumas and stresses may place people at risk of anxiety disorders.
- *Experience of racism, dispossession and other disadvantage:* these can put a person at greater risk of anxiety.
- *How stable the community is:* even if a person does not use any drug, if the community around them is unstable, or uses a lot of alcohol or cannabis, they can face constant demands for money, and sometimes have violence around them. This creates stress, which puts them at risk of anxiety.

The difference between just feeling anxious and an anxiety disorder

Understanding anxiety as a ‘normal’ reaction helps us to understand when anxiety becomes a problem in someone’s life. Performing in front of an audience is an example of a situation where it is normal to feel anxious. If you are well prepared, you may feel very alert and your body may feel slightly on edge. These sensations usually disappear once the performance is over and you feel a sense of relief.

You get less anxious before a performance once you have done it many times before (i.e. you have repeated that sort of performance). Also you feel less stressed if you have practiced (rehearsed) the performance successfully, either out loud or in your mind. The repeated success gives you a sense that you are ‘in control’ and of ‘mastery’. This is because each time a stressful experience is successfully completed (resolved), your brain adjusts, to help you deal with the next stressful situation.

In life, as children grow up they repeatedly end up practising how to cope with stressful events. A supportive, stable family or community can help children get through stress successfully (i.e. to resolve this stress). The young person learns that they can cope with stress and their brain learns ‘success’.

Other people never get the sense that stress can be managed or that things will settle down. They may have experienced so many pressures and traumas that stress seems overwhelming. They never get that feeling that stress can successfully settle down (be resolved). The brain still adapts and learns from past experiences, but in this case the brain learns ‘failure’ instead of success. Instead of imagining successfully coping with stress, without planning to, the individual begins to repeatedly ‘rehearse’ in their mind the experience of failure or stress, along with all the uncomfortable feelings that go with it. Expecting a bad outcome, the anxiety becomes dread and the brain signals ‘flight or freeze’.

HOW TO RECOGNISE IF SOMEONE HAS ANXIETY

Sometimes there are clear signs a person is anxious (e.g. trembling, restlessness or fidgety, or the person looks like they are worrying about something). But other times, there may be no outward signs that the person is feeling anxious. Their anxiety may come out in things they say, or you may need to ask some questions to find out if they are anxious.

Anxiety is considered a disorder when responses to stressful events are either:

- Excessive (too much)
- Persistent (too long)
- Disabling (the response to stress interferes with the person socially, emotionally and with their ability to do the work or other activities they normally would do).

These responses to stress may be physical and/or psychological (i.e. of the body or of the mind).

HOW TO ASSESS A CLIENT WHO MAY HAVE ANXIETY

There are questions you can ask to find out if your client has anxiety, and how severe that anxiety is. Whether you assess a client yourself, or whether you refer them to a mental health team will depend on how severe their anxiety is, and on your training.

If a client has experienced major traumas in the past, and finds it very difficult to talk about these events, you should respect this. It is not a good idea to push a person to talk about these events when they are not ready. It can be very distressing, and sometimes can put them at risk of self-harm. Such a client can be offered specialist mental health support.

For most clients with anxiety, getting a better understanding of what they are experiencing now can help you find ways to support them.

What problems (symptoms) do people report?

- Stress
- Cannot relax
- Cannot eat
- Cannot stay still
- Feeling tense
- Heart beats fast
- Trouble getting to sleep.

Questions to ask your client

You can check for anxiety by asking your client:

- Do you feel 'keyed up' or on edge?
- Do you worry a lot?
- Have you been irritable or cranky?
- Do you have trouble relaxing?
- Do you have trouble sleeping? (i.e. trouble falling or staying asleep, waking up early, or have vivid dreams or nightmares)
- Have you had any headaches or neck aches?
- Have you experienced any of the following: trembling, tingling, dizzy spells, sweating, going to the toilet a lot to 'wee' (i.e. pass urine), diarrhoea?
- Have you been worried about your health?
- Do they describe anxiety-related behaviours (e.g. trying to avoid certain activities or places, doing things in very particular and unusual ways)?
- Ask about their substance use, general mental health and physical health:
 - Do they use drugs or alcohol? If so, how much and how often, and has their use changed recently?
 - Do they have other mental health problems, now or in the past, and, if so, what treatment was provided and/or how did they cope or make it better?
 - Do they have other health problems, and, if so, do they take any medicine for these health problems?
 - Do they worry about recent health problems, and, if so, what are the symptoms of these (e.g. feeling tense, heart beating fast, poor sleep)?

What might you look for in a person with anxiety (signs)?

- Breathing fast
- Being cranky or irritable
- Being sad
- Sweating
- Fidgeting behaviour
- Pacing
- Being 'jumpy'
- Trembling (tremor).

Sicknesses often seen in people with anxiety (comorbidity)

It is very common for people with anxiety to be facing other health problems at the same time, such as:

- Depressive disorders
- Medical illnesses
- Substance use issues.

Other conditions where anxiety can be just one symptom

As well as being a disorder of its own, anxiety can be a symptom of a wide range of other physical and mental illnesses:

- Depression
- Conditions where the client believes what they are feeling is part of a serious medical illness but there is no evidence of this. The most common example is hypochondriasis (the person is sometimes described as a 'hypochondriac').
- Some personality disorders (e.g. borderline personality disorder): there is usually a lifelong history of problems with relationships and with self-image. Clients may have impulsive and self-defeating behaviours such as self-harm and substance misuse.
- Substance misuse is commonly linked with anxiety:
 - Intoxication: stimulants like amphetamines can cause all the symptoms of anxiety (and, if used repeatedly, can cause paranoia with intense fearfulness about imagined harm).
 - Withdrawal: anxiety can be part of withdrawal symptoms when the drug is not available (e.g. for alcohol, cannabis, opioids, petrol sniffing).
- Physical illnesses: such as an overactive thyroid or as a side effect of a medicine (e.g. some anti-depressants).

Tools to help screen for anxiety or to assess it

Many questionnaires have been developed as tools to identify anxiety. Some are 'screening tools' that are used to pick up people with possible anxiety disorders (e.g. in a general health clinic). The others are 'diagnostic tools' to confirm that the person who is anxious really does have an anxiety disorder. Examples can be found in Mental Health First Aid.

Consider local culture and views when assessing anxiety

It is important to work out if cultural reasons may be affecting how the client is feeling. Having an experienced Aboriginal health professional (or traditional healer) working with the client's GP or psychiatrist can be important to get the best outcome.

Individuals from traditional areas may more easily talk about physical anxiety experiences than about their emotions. Also, there may be issues that they will not mention unless asked about, especially if the person asking is not from that community. For example:

- Beliefs in sorcery are very common.
- Fears may also be associated with worry about payback, sometimes without any idea about why.
- 'Jealousing' needs to be asked about – for men and women, both for the jealous person and the person exposed to it.

DIFFERENT MENTAL DISORDERS WHERE ANXIETY IS A CORE FEATURE

Anxiety is the core symptom for many different mental disorders, including:

- *Generalised anxiety disorder*: the person has long-standing and excessive worries about issues such as money, family, work, with many of the physical experiences described earlier.
- *Social phobia*: the person is fearful of and tries to avoid social situations. This is more commonly seen in people who were obviously shy as children.
- *Panic disorder*: the person has repeated, intense but short-lived 'attacks' of acute anxiety with such strong physical symptoms that the person fears for their life.
- *Agoraphobia*: the person is worried about experiencing repeat panic attacks and this leads to increasing social withdrawal until they feel unable to leave their house.
- *Post-traumatic stress disorder (PTSD)*: the person has experienced intense trauma(s) that leads to intense and often long lasting anxiety symptoms. They have particular psychological and behavioural reactions that relate to the trauma, and PTSD is often associated with depression and substance use.
- *Obsessive compulsive disorder*: the person experiences repeating and worrying thoughts (obsessions) and feels pressure to perform particular behaviours or rituals that they recognise as unnecessary or 'silly' but cannot resist (compulsions).
- *Reactive or adjustment disorders*: the person experiences marked anxiety or distress for a period of time, often after a life event. They may find their own ways to deal with this and their anxiety settles. If it does not, support and simple measures are usually enough to help them feel back in control of their life.

HOW TO HELP SOMEONE WITH ANXIETY

Helping someone who is experiencing anxiety is an important role for all health and alcohol and drug workers. With awareness and understanding you can help someone be better able to cope with the symptoms of anxiety. You can also help them find approaches to tackle the causes of anxiety. Finally, you can help a distressed person to consult a doctor or mental health professional if the problem gets worse or keeps going on.

The first step in helping someone with anxiety is to show concern and to develop a trusting relationship with them to find what is going on.

The word ‘ANXIETY’ can help you remember how to assess and manage a client’s anxiety

A	Ask	About physical and psychological symptoms.
N	Note	Appearance and behaviour.
X	(e)Xplore	Stressful life situations – e.g. relationships, money, legal.
I	Intake of drugs	Alcohol, tobacco, cannabis, caffeine, others.
E	Everyday	Approaches to managing stress – e.g. exercise, talking, music.
T	Traditional issues	Think about sorcery, payback, jealousy, and traditional practices.
Y	Yesteryear	Be alert to the person’s past and issues such as health, trauma, childhood.

Choosing the right time, place and approach to talk about anxiety

Helping usually starts with communication. An anxious person will often begin to experience relief when they start talking. You can help this process by being tuned in to that person's preferences:

- Where: they may be keen to talk but there may be a better place (i.e. where they can be more relaxed or away from someone who is causing them stress).
- When: they may be keen to talk but not able to right now (i.e. they may start to feel more settled when they know that you will be available later).
- How: they may also need:
 - Assurance (e.g. about confidentiality, which can be a tricky issue, for instance, when there is concern about abuse)
 - A support person (e.g. family member) with them
 - Simple things that show them that you care (e.g. getting them a glass of water or cup of tea; avoid giving lots of coffee to people who are acutely anxious; offering something simple to eat can also help as some people develop symptoms that look like anxiety if they have not eaten and their blood sugar falls).



Dealing with acute anxiety or panic

If the person looks tense and is breathing rapidly it can be useful to take some time to focus on their physical symptoms. Do this by:

- Trying to get them into an appropriate space (where they feel safe and there are not too many distractions), and into a comfortable position (usually sitting in a relaxing armchair)
- Helping them clear their mind of thoughts that are tormenting them by focusing on their breathing, i.e. help them to breath slowly and calmly
- Relaxation exercises – you can learn effective relaxation exercises (see Relaxation exercise, p. 272).

If someone is so distressed that they are confused (i.e. they do not know where they are or what is going on), agitated (i.e. they are unpredictable and potentially harmful to themselves or others) or they have severe physical symptoms (such as breathing difficulties or chest pain), then the first thing to do is to make sure they are seen by a doctor or nurse.

When the acute situation has settled, then you can look at lifestyle and other coping strategies.

A relaxation exercise (PMR – progressive muscular relaxation)

- First explain what you are going to do (“I’m just going to show you something simple that will help you relax your body”).
- Give clear instructions (“I want you to listen to me and to breath slowly, I am going to count to four slowly and I want you to breathe in, and then I’ll count to four again as you breath out – you just keep in time with me”).
- Talk in a reassuring way (let them know that they are doing well, that their breathing is settling).
- Sometimes people find this easier with their eyes closed – but that should be left up to that person to decide.
- When breathing is regular you can stop counting and just talk reassuringly for a few minutes, encouraging them to continue; then point out that they have been able to do something that has helped make a difference, i.e. to get back in control.

Key steps

After choosing the right time, place and approach, these three steps will often be enough to help someone feel that they are beginning to get things under control:

- Simply talking things through: allow people to express their distress and the issues behind it (a chance to ‘vent’).
- Let them know that help is available (reassure the person).
- Begin to discuss options and strategies (problem solving).

Everyday strategies to manage stress

You can help a client develop lifestyle strategies to reduce stress. The basics can be discussed straight away, but it is helpful to follow up on this through a number of meetings.

The word ‘STRESS’ can help you remember strategies that your client can use to reduce stress in their life

S	<i>Substance use (alcohol and drugs)</i>	Can be part of the problem, not the solution; reducing caffeine, e.g. less coffee, tea and soft drinks (particularly Coke) can help; reducing stimulant use (e.g. ice), and reducing alcohol and benzos, as withdrawal can cause anxiety.
T	<i>Talking with others</i>	Developing social relationships.
R	<i>Relaxation exercises, meditation or other mindfulness approaches can also be effective</i>	These approaches have been successfully used in Aboriginal populations (e.g. with children from primary school in the Townsville region). It is worth learning some basic relaxation exercises (such as the exercise described in the box above).
E	<i>Exercise</i>	Exercise (regular, aerobic, low intensity), such as walking, effectively reduces stress.
S	<i>Sleep routine and ways to improve sleep</i>	For example, avoid coffee or Coke after 4pm, and have a calming routine before bed, and avoid daytime naps.
S	<i>Sensible diet and possibly supplements like fish oil</i>	There is now evidence that fish oil supplements are useful in preventing a number of mental and physical health problems. They are natural, harmless and cheap. For people who are vegetarian or allergic to fish, linseed oil may help.

Getting someone to think about these issues can offer them a sense of direction and of regaining control in their life.

There are tools available for health workers to provide information about exercise, tips for good sleep habits and nutrition, and most clinics have brochures that are useful to give to clients.

When to refer?

Health workers and alcohol and drug workers can do a lot to help people who are experiencing anxiety. However, it is important to be aware of your limits and to know when to seek help. There are now effective treatments for anxiety disorders, and helping the client get a referral to a qualified mental health practitioner is an important intervention in itself. In general, talking therapies are better than drug use. Occasionally, if talking therapies fail, then a doctor can recommend a non-addictive medicine to help, e.g. an anti-depressant that also works on anxiety.



Note: some clients will be using benzos to deal with long-term anxiety. This is a very risky solution for anyone with an alcohol or drug problem as benzos are addictive. Also the person becomes tolerant to their effects if used regularly, so they work less well.

HOW TO PREVENT ANXIETY FROM HAPPENING

The strategies listed on p. 273 are also useful to prevent anxiety. Exercise and good experiences (e.g. going fishing, going to the movies) are also important, as is connecting with family and culture. As a health professional, you can also help others through the example you provide. So, the messages about managing stress and living a healthy lifestyle are as relevant for the health professionals as they are well for the patient. Take care of yourself so you can better help others.

Where to get more information

- *Beyondblue:* www.beyondblue.org.au or www.youthbeyondblue.org.au
- *Lifeline:* www.lifeline.org.au or 131 114
- *Kids Helpline:* www.kidshelp.org.au or 1800 55 1800
- *Sane Australia:* www.sane.org
- *Reach Out:* www.reachout.com
- *Mental Health First Aid:* www.mhfa.com.au/cms/

FURTHER READING

See the Indigenous HealthInfoNet website and type *anxiety* in the search box: www.healthinfo.net.ecu.edu.au.

See a resource for Indigenous Social and Emotional Wellbeing workers: www.healthinfo.net.ecu.edu.au/sewbworkers.

Psychosis

OVERVIEW

Sometimes a person may become out of touch with reality; for example, hearing voices or thinking people are ‘out to get them’ or are controlling them. This state of mind is known as psychosis. Psychosis may occur as part of schizophrenia, bipolar disorder or severe depression occurring after childbirth. In some people, the use of alcohol or certain drugs may cause psychosis (e.g. ‘drug-induced psychosis’). On the other hand, people with psychosis may turn to alcohol or other drugs to relieve the symptoms of psychosis.

When psychosis occurs, it is usually distressing to the client, their family and the community. Treatment for psychosis usually involves anti-psychotic medicines, counselling and relapse prevention for substance misuse.

How common is it?

We do not know how common psychosis is among Aboriginal people. In some parts of Australia with high levels of cannabis use, health professionals report that many Aboriginal people are admitted to hospital with drug-induced psychosis.

HOW DO YOU KNOW IF SOMEONE HAS PSYCHOSIS?

What problems people report (symptoms)

When a person develops psychosis there is a change in their thinking and behaviour that involves:

- A set of beliefs that is not true and not based in reality (delusions). These beliefs cannot be shaken, even when you talk to the person. Examples include: the false belief that someone is wanting to hurt you, or believing that someone is able to control your thoughts.
- Hearing voices that other people do not hear (auditory hallucinations). Sometimes people may see things that are not there, or experience changes in smell, taste or touch that are not real (these are also hallucinations).

It is important to look at any client in the context of their culture. For example, if a client says they are seeing a person who has recently died, check with a local person (if you are not from the client's country) whether these experiences are considered culturally 'normal'.

What you might see in a person with psychosis (signs)

- What they say does not make sense (disturbed thought process)
- Lack of expression on their face (flattened affect)
- Disorganised or unusual behaviour – this may include unusual rituals such as holding their body in an unusual position (posture) for no reason and for long periods
- Not talking much or not starting conversations, when they normally would (lack of spontaneous speech)
- Lack of motivation or the ability to start things (apathy)
- Not able to do their usual tasks at home, work or school. For example, cannot look after themselves, isolates themselves from friends or family, do not want to engage with people (emotionally detached).
- May be suspicious of other people even when there is no real reason for this (paranoid).

It is important to try to help a person to get treatment early and to prevent relapse – as the more times a person experiences psychosis the more problems can grow.

WHAT TYPES OF PSYCHOSIS ARE THERE?

Psychosis may only last a short period of time like hours or days (transient psychosis), or it may continue for six months or more (sustained or chronic psychosis). Short-term psychosis often happens because of drug use. Short-term psychosis can also happen in someone with a personality disorder who is in crisis (e.g. when going through a relationship breakup they may develop paranoid ideas like everyone is looking at them and laughing about them, or they might hear voices saying things like: ‘you are a bad person’, ‘you are ugly’, ‘who would want you?’). Longer-term psychosis is often part of a mental illness like schizophrenia.

There are several different types of psychosis, and they can be hard to tell apart:

- *Drug-induced psychosis*: happens after using amphetamines, cocaine or cannabis.
- *Schizophrenia*: this is one of the most common illnesses that cause chronic psychosis. A doctor (where possible a psychiatrist) makes the diagnosis of schizophrenia. Before making a diagnosis of schizophrenia, the doctor will check if the client has other medical problems that could be their psychotic symptoms, e.g. head injury or thyroid problems. The doctor will usually wait until the client has stopped using drugs like cannabis or stimulants before making a diagnosis.
- *Bipolar disorder*: in this illness, a person typically has a history of ‘manic’ episodes or depressive episodes. In the manic episodes people sleep very little, may feel really happy, have far too much energy, and make bad decisions, such as spending very large amounts of money in a way that is not normal for them. The highs and the lows of bipolar disorder typically last weeks to months (longer if not untreated). Of course, it is normal for healthy people to experience a variety of mood changes throughout the day depending on their circumstances and thoughts.
- *Schizoaffective disorder*: where a person has problems with their mood (mania or depression) and also psychotic symptoms.

Common health problems associated with psychosis (comorbidity)

- Drug and alcohol problems, including tobacco
- Greater chance of developing other mental health problems such as:
 - Depression
 - Suicide
 - Anxiety (e.g. feeling worried, loss of self-confidence and difficulties returning to social situations).

WHY DOES PSYCHOSIS DEVELOP?

Many different factors may put a person at risk of developing psychosis.

Their 'make-up' (or biological reasons)

- Psychosis may be caused by changes to chemicals in the brain. We do not know exactly why this happens, but brain chemicals like dopamine and serotonin are involved.
- The chance of developing schizophrenia is greater if a close relative has it (i.e. schizophrenia is carried in their 'genes'); schizophrenia is also more common if the client had problems with how their brain developed when they were young.

Psychological and social reasons

- Psychosis is more likely to develop in people who experience stressful events in their life (e.g. separation or divorce from a partner, death of a partner, loss of employment). Stressful life events may increase the risk of relapse of psychosis, but may or may not be a cause of schizophrenia.

Drugs such as cannabis and amphetamines can cause psychosis

- *Cannabis and psychosis*: if a person uses cannabis when they are young (especially under the age of 15) they are more likely to develop psychosis later in life than if they had never used it. The more cannabis they use, the greater the chance of developing psychosis. If someone has a family history of psychosis, cannabis use can increase their chance of getting psychosis.
- *Stimulants and psychosis*: after taking large doses of amphetamines or other stimulants, people can develop a psychosis with confusion, which goes away quickly as the drug leaves the body. Long-term (chronic) stimulant use can cause a long-term psychosis (similar to schizophrenia) in some people, even after use of the drug has stopped.

Culture and psychosis

Some Aboriginal people may also believe a serious sickness like psychosis happens for cultural reasons; for example, because the person did something wrong.

How long does psychosis last?

A period of psychosis can affect a person once, or may come back again and again throughout their life, like in bipolar disorder or schizophrenia.

Does schizophrenia get better?

If a client has schizophrenia:

- Up to 1 in 3 will completely recover
- Up to 1 in 3 will continue to have moderate symptoms
- About half will continue to be significantly affected
- Up to 4 in 10 may try to hurt themselves (attempt suicide).

Clients may experience less problems with schizophrenia if:

- Psychosis develops very quickly (not slowly over many months)
- There is an obvious trigger for the psychosis (e.g. a period of cannabis use)
- Schizophrenia develops at a later age (e.g. after age 25, because by this time many people will have finished school, met a partner, started work, which are all things that reduce the chance of developing schizophrenia).

A drug-induced psychosis tends to gradually disappear within days to months after a person stops using the drug. If it is still present after more than three months of abstinence, the doctor will usually review the diagnosis and there could be something else going on.

HOW TO HELP SOMEONE WHO EXPERIENCES PSYCHOSIS

A person with psychosis usually needs medical treatment. It can sometimes be difficult and frustrating trying to convince them to access a doctor. Occasionally, if they are a risk to themselves or others, they can be forced to have treatment. For any psychosis, stopping using drugs such as cannabis and amphetamines is important. This is particularly important for drug-induced psychosis.

Medicines

Anti-psychotic medicines, such as olanzapine (Zyprexa) or quetiapine (Seroquel), can relieve symptoms of psychosis such as paranoia and thought disorder. They usually start to work after 10 days, but may take a couple of weeks. Some people do not like taking this medicine because of the side effects. There are many different anti-psychotic drugs, each with different side effects.

Some common side effects are:

- Putting on weight
- Diabetes
- Drowsiness
- A drop in blood pressure when standing up, which can cause dizziness (postural hypotension)
- Stiffness or trembling in muscles
- Feeling restless inside ('akathisia').

Because of these side effects, people on anti-psychotics should have regular check-ups with their doctor to make sure they do not have any problems with their weight, heart, body movement, and cholesterol. Also, they should be checked for diabetes.

If your client is experiencing side effects, you can support them to talk to their GP or psychiatrist. Their doctor may know another medicine that could work better for them. Some people with psychosis also experience depression. A GP or psychiatrist can assess whether the person may also need an anti-depressant medicine.

Psychological treatments

There are a number of 'talking' therapies (psychological therapies) used to help treat psychosis. These are not enough on their own, but may increase the effectiveness of medicines. These psychological treatments may also help a client cope with any symptoms that cannot be fixed by medicines.

The types of therapies used are:

- *Cognitive behavioural therapy (CBT)*: where the client is taught to understand how their thoughts affect their feelings and actions, and to learn new ways of thinking
- *Social skills training*: where the client is taught social skills such as how to start and hold conversations, how to develop friendships, find a job, and find some hobbies
- *Family therapy*: where the client and their family are provided with information and education about psychosis and learn problem-solving skills. This can help to improve communication, reduce stress and reduce feeling socially isolated.

Other coping strategies

- For hearing voices: encourage the client to keep busy (walk, exercise, play music), spend more time with family or friends and keep busy (TV, music, humming, earplugs, any other activity they enjoy).
- For delusions: the client can learn to test the reality of their thoughts (this also can be part of CBT).
- For drug and alcohol problems: it may be helpful for the client to talk with a mentor, e.g. an older person in the community who has successfully ceased using drugs or alcohol; they can try to avoid particularly stressful situations or situations where they will be very tempted to use alcohol or drugs.
- Check that your client knows where to get help if they are at risk of hurting themselves. This may be through the local mental health team, the clinic, a helpline or a responsible community member.
- For sleeping problems: you can teach the client ways to try to sleep better (see Further reading, p. 282).

Helplines to provide information and support to your client

Lifeline (24 hours, 7 days)

Ph: 131 114

www.lifeline.org.au

Kids Helpline (24 hours, 7 days)

Ph: 1800 55 1800

www.kidshelp.com.au

Sane Australia (9am to 5pm weekdays)

Ph: 1800 18 7263

www.sane.org

Relapse prevention

Trying to prevent relapse of psychotic episodes is an important part of treatment. Along with the mental health team, you can help your client by doing these things:

- Establish and maintain a good relationship with the client.
- Help them find out more about psychosis.
- Look out for the early warning signs that your client may be getting unwell (e.g. signs that they are staying in their room or withdrawing from family or friends, feeling nervous or cranky, and finding it hard to concentrate). The client's family may also be able to help look out for the early warning signs of psychosis.
- Encourage them to seek help early if they become unwell.

- Support them to have more contact with their mental health worker or GP, who will monitor their symptoms and review their medicines. Talk with the client about how to cope with stress better. For example:
 - Relaxation techniques like controlled breathing, meditation and progressive muscle relaxation may be helpful.
 - ‘Step by step’ problem solving may also help. This is a way of working through a problem one step at a time, which can make people more aware of lots of possible solutions and feel more in control of their problem (see Further reading, p. 282).

HOW TO PREVENT PSYCHOSIS FROM EVER HAPPENING

Avoiding cannabis and amphetamine use can reduce the risk of psychosis. This is particularly important if a person has a family history of psychosis.

FURTHER READING

Sleep habits: www.cci.health.wa.gov.au/docs/Info-sleep%20hygiene.pdf.

Relaxation techniques: www.gpcare.org/evidence%20based%20psychological/relaxationstrategies.htm.

Problem solving: www.reachout.com/find/articles/problem-solving.

Mills KL, Deady M, Proudfoot H, Sannibale C, Teesson M, Mattick R, Burns, L (2010). *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*. University of New South Wales, Sydney. See: [www.med.unsw.edu.au/NDARCWeb.nsf/resources/Guidelines1/\\$file/Comorbidity+Guidelines.pdf](http://www.med.unsw.edu.au/NDARCWeb.nsf/resources/Guidelines1/$file/Comorbidity+Guidelines.pdf).

Hunter E (1993). Aboriginal mental health awareness. An overview: Mental status examination. *Aboriginal and Islander Health Worker Journal*. 17, 14-20.

See a resource for Indigenous Social and Emotional Wellbeing workers: www.healthinfonet.ecu.edu.au/sewbworkers.

13

Reducing the harms from substance misuse

<u>Sexually transmissible infections in the setting of substance use</u>	284
<u>Harms from injecting drug use and safer injecting</u>	289
<u>Needle and Syringe Programs</u>	298
<u>Hepatitis C and B</u>	302
<u>HIV/AIDS</u>	311

Sexually transmissible infections in the setting of substance use

OVERVIEW

Sexually transmissible infections (STIs) are infections that are spread through sexual contact. They are sometimes also spread from mother to child during pregnancy or childbirth. Common STIs include gonorrhoea, chlamydia, syphilis, genital warts and herpes.

Most STIs do not cause major symptoms until after a long time (weeks or even years), so a person can have an STI without knowing and then pass it on to someone else. People who drink to intoxication or who use drugs are more at risk of being infected with a STI, due to the risky behaviour associated with alcohol and drugs, and should be regularly tested. Testing is usually easy to organise and varies according to the type of STI, e.g. urine tests, swab tests or blood tests (a swab is like a large cotton bud, used to collect samples of fluid). Most STIs are easy to treat and this usually involves taking tablets or having an injection.

Encouraging regular condom use, regular testing, and trying to limit the number of sexual partners can help reduce the spread of STIs.

How common are STIs in Australia?

STIs are very common in Australia and Aboriginal people tend to have higher rates of STIs than the wider community. Chlamydia is particularly common, and rates are rising among young people (under 25 years).

Herpes is very common in Australia. This is because once a person is infected they are infected for life, even if they do not have any symptoms. People with multiple sexual partners are more likely to be infected with herpes.

Men who have sex with men are more likely to become infected with certain STIs – gonorrhoea, syphilis, and herpes.

STIs AND SUBSTANCE USE

People who drink or use drugs to the point of intoxication are more at risk of STIs. This may be because they have less inhibition or because they are less able to make clear decisions. They may be more likely to have sex to begin with, and also more likely to have unprotected sex. Also, people may be heavily sedated and have unwanted sex.

They may also not remember if condoms were used. Some drugs (e.g. amphetamines) may increase sexual desire.

HOW ARE STIs SPREAD?

STIs are usually spread ('transmitted') from person-to-person during sexual contact. Most infections are carried in the body fluids of the man or the woman. That is, they are spread from the penis, vagina, or anus, and sometimes from the mouth in oral sex. Genital warts are spread during sexual contact by infected skin coming into contact with the skin of another person. What part of the body gets infected will depend on the way that the person has sex.

If someone is infected with an STI, there is a high chance that they will pass it on to another person during unprotected sexual contact.

Some STIs can be spread from mother to child during pregnancy or childbirth; for example, gonorrhoea, chlamydia and syphilis. So women should be tested before or during pregnancy so they can be offered treatment. Genital warts can also be transmitted from mother to child but this is rare.

WHAT ARE THE SYMPTOMS OF STIs?

Most STIs can cause sores or discharges (i.e. abnormal fluids) from the penis, vagina and anus. But most people who are infected with an STI do not show any symptoms (they are 'asymptomatic'). Some common symptoms of STIs include:

Symptom	Possible cause
Ulcer/blisters on the genitals. With herpes, these sores can recur (happen regularly). The first time there are lots of painful ulcers/blisters but when they recur they are usually much less painful and there are only a few ulcers/blisters.	<i>Syphilis, herpes</i>
Lumps on genitals or anus or around this area. Genital warts look like warts that you would find on other parts of the body.	<i>Genital warts, syphilis</i>

Symptom	Possible cause
Discharge from penis or vagina	<i>Gonorrhoea, chlamydia</i>
Sore throat	<i>Rarely syphilis, herpes, chlamydia, gonorrhoea</i>
Anal symptoms other than warts (e.g. very sore bottom, continual need to pass a bowel motion, discharge)	<i>Syphilis, herpes, chlamydia, gonorrhoea</i>
Often show no symptoms	<i>Chlamydia, gonorrhoea, syphilis, herpes</i>

Symptoms of syphilis

After being infected with syphilis, at first sores or ulcers can happen where the person was infected, usually the genitals, anus or mouth (‘primary syphilis’). After four to 10 weeks it spreads through the body and causes a rash, fever and enlarged glands (‘secondary syphilis’). After a few weeks all the symptoms go away but blood tests are still positive (‘latent syphilis’). Many years later people can get severe heart, brain and nerve disease (‘tertiary syphilis’). Many people infected with syphilis do not realise they are infected and think their symptoms are because of another illness.

HOW TO TEST FOR A STI

Clients can access free testing for STIs through their local doctor or clinic, sexual health centre, and through many drug treatment centres.

Testing for gonorrhoea and chlamydia involves a first-catch urine sample (i.e. it is first part of the urine sample after one hour of not passing urine). For gonorrhoea, swab samples are also taken from the throat and anus. For chlamydia, swab samples are taken from the vagina, cervix (the opening of the woman’s womb), and anus. Testing for syphilis involves a blood sample. Testing for herpes involves a swab sample from the ulcer/blisters or sores.

Results may take up to a week for some tests.

There are no urine or blood tests for genital warts. They are diagnosed only by visual inspection.

WHAT TREATMENTS ARE AVAILABLE

Treatment for STIs usually involves injections, tablets or creams. Most people with an STI should not have sex until after the treatment is completed and their partners are also treated.

Treatment for STIs is normally received at the same place where the person is tested. For example: through their local doctor or clinic, sexual health centre, or through a drug treatment centre.

The following list has information about the treatment of some common STIs:

Gonorrhoea

- A single injection of antibiotics (Ceftriaxone) is given to stop discharge from the penis, vagina or anus.
- The client should not have sex for the next seven days.
- Contact tracing should happen. This means contacting sexual partners from the previous two months and getting them tested and treated.
- The client should be re-tested in three months to make sure they are no longer infected.

Chlamydia

- A single dose of antibiotic tablets (azithromycin 1g = two tablets) is given to stop discharge or burning sensation from the penis and discharge from vagina or anus.
- The client should not have sex for the next seven days.
- Contact tracing should happen. For chlamydia this means contacting partners from the previous six months and getting them tested and treated.
- The client should be re-tested in three months to make sure they are no longer infected.

Syphilis

- Weekly injections of penicillin are given to treat syphilis. How many injections the client needs depends on what stage of infection they are at. For early infections (primary or secondary), only one injection is needed. For late infections (after one year), three injections are needed.
- Contact tracing should happen and partners should be tested and treated. For primary syphilis this means partners from the previous three months before symptoms started. For secondary syphilis this means partners from the six months before symptoms started. For early latent syphilis – partners from the previous 12 months before symptoms started.
- The client should not have sex until one week after treatment ends.
- The client should have follow-up blood tests to make sure they are no longer infected.

Genital warts

- Warty lumps on penis, around anus or around entrance to vagina can be frozen off (cryotherapy) or burned off (cauterising).
- The client can also use Podophlotoxin paint or cream and apply it themselves. (This paint should not be used by women who could be pregnant.)

Herpes

- Anti-viral tablets (Valacyclovir, Famciclovir, Acyclovir) can be taken for around two to five days when the client has symptoms. This can reduce the number of ulcers/blisters on the penis, inside and around the anus, or around the entrance to the vagina. The client should not have sex when they have symptoms, although herpes can be spread even when there are no symptoms.
- Anti-viral tablets can also be taken long-term to help to prevent spreading herpes to sexual partners. This treatment is listed on the Pharmaceutical Benefits Scheme (PBS) so is cheap for Aboriginal clients under Close the Gap.

WHAT HAPPENS IF STIs ARE NOT TREATED?

If STIs are untreated, they can cause problems with getting pregnant for both men and women. Untreated STIs can also spread from mother to baby during pregnancy.

STIs can also cause a lot of worry and distress as you can easily spread STIs to sexual partners.

PREVENTING THE SPREAD OF STIS

Regular use of condoms and having fewer sexual partners are the best ways to prevent the spread of STIs. Making people aware of the ways people can get STIs is also important. It can also be useful to consider local language and cultural concepts when providing this information.

To prevent genital warts, a free vaccine (gardasil injection) is available to school-aged girls (usually Grade 7) through the National Immunisation Program. Adults can get the vaccine by prescription but it is expensive (around \$145). If young teenage women miss getting this vaccine, they should go to their GP to ask about getting a dose.

Harms from injecting drug use and safer injecting

OVERVIEW

There are a number of ways that people can be harmed from injecting drugs. There are social harms, such as those related to drug use being illegal, being dependent on a drug, or things a person does to raise money for drugs. There are also physical harms of injecting like: the direct effects of the drug itself (such as overdose), and harms from poor injecting technique and from sharing injecting equipment. Health workers can help reduce a client's harms from injecting drug use by encouraging them to stop using, by supporting them to attend drug treatment, or to use safer injecting practices for those who continue to inject. Getting the person to change how they inject can reduce many of the physical harms from injecting. Harm reduction forms the basis of Australia's national health policy on drugs.

WHAT ARE THE PHYSICAL HARMS OF INJECTING?

The physical harms of injecting drugs generally include:

- Injuries related to the process of injecting
- Infections related to poor injection technique
- Blood-borne virus infections from sharing injecting equipment
- Injuries related to other substances mixed with drug/s
- Injury related to direct effects of the drug/s injected (such as overdose).

These problems can occur:

- Near the site of injecting (local)
- In other body parts well away from the injecting site (distant)
- In the whole body (systemic).

Injecting can carry germs or particles to a different part of the body

Normally drugs are injected into veins, which carry blood back to the heart and through the lungs, before going out into the rest of the body, including the brain. Any germs or small particles from the drug can get stuck in the lungs, brain or other parts of the body.

Sometimes drugs are accidentally injected into arteries, which carry blood away from the heart to the rest of the body. If particles from the drugs lodge in a finger or toe, for example, they can block the blood supply and cause the finger or toe to go black and die (gangrene).

Injuries related to the process of injecting

Physical injuries from injecting are common, and include:

- *Bruising*: this happens when blood leaks out from the vein through the hole made by the needle, into the surrounding tissue under the skin.
- *Track marks (scarring)*: these are scars along the skin caused by repeated injecting into the same spot on the body (injecting site).
- *Swelling or inflammation*: redness or swelling around the injection site can happen if the vein is missed and the drug is injected into the flesh near the vein.
- *Vein damage*: this can happen at (or near) the site of injecting when someone:
 - Uses the same spot to inject many times
 - Has repeated infections from injecting
 - Where the drug contains a contaminant like bleach or dirt
 - When the drug itself (e.g. methadone) irritates the vein, or the substances used to ‘cut’ the drug irritate the vein
 - A damaged (e.g. barbed) or blunt needle is used
 - A vein becomes inflamed and sore (phlebitis) or blocked off.
- *Artery damage*: this happens when someone accidentally injects into an artery. It is more common when injecting in the groin because the artery and vein sit close together. It can also happen when injecting in the arm and neck.
 - In arteries, blood is under higher pressure and can spurt out.
 - Major bruising can happen unless firm pressure is applied for 15 minutes.
 - If small particles are injected, these can get stuck further along an artery, in another part of the body. This can block off the blood supply to that part of the body, and cause that body part to die. For example, if an artery supplying blood to the fingers is blocked off, the fingers can turn black and die.

- *Embolism*: sometimes a bit of drug, a piece of a blood clot, or other particles fly off through the veins and get stuck somewhere else in the body (e.g. lungs, brain, fingers). If this happens in the lung (pulmonary embolism) it can cause chest pain, shortness of breath and coughing up blood. This is serious and means a person should be admitted to hospital for treatment. This can happen when injecting any illegal drug. It can be even more likely when people inject crushed tablets.

Infections related to poor injection technique

Infections from poor injecting technique can happen if:

- People do not wash their hands or clean their skin properly (with an alcohol wipe) before injecting
- The needle becomes contaminated before injecting, such as from licking the tip, or from using in a dirty environment. Germs can get onto the equipment, even if using a new 'fit'
- Someone reuses their own injecting equipment
- People share injecting equipment. Infections, including blood-borne viruses, can pass from one person to another when different people share the same equipment. Reused needles and syringes are known as 'dirty fits'.
- The person has a 'dirty hit' by injecting bacteria that was mixed in with the drug itself
- There is a lot of vein damage.

Infections may be in the same area as the injection (local) or occur where germs/particles lodge downstream (distant). A systemic infection is serious and happens when an infection spreads to the bloodstream.

Some common infections that can happen after injecting drugs are:

- *Local infections (at the injecting site)*
 - Cellulitis: an infection underneath the skin that causes redness, pain, inflammation and heat to the area. If not treated it can cause an abscess or systemic infection or blood poisoning (see Cellulitis, p.206).
 - Abscess: a collection of pus (white blood cells and dead tissue) under the skin that is caused by an infection that has been 'walled off' by the body. Abscesses usually need to be drained by a doctor and treated with antibiotics (see Abscess, p.205).

- *Infection in a distant body part*: when bacteria travel through the bloodstream they can set up an infection somewhere else.
 - Bacteria can get stuck in a small blood vessel in another part of the body (embolism). So people who inject drugs can get infections in unusual places. These can be hard for the doctor to diagnose, especially if the doctor does not know the person injects drugs. Examples are a brain abscess, an infection in a bone (osteomyelitis), or in a joint (septic arthritis). These infections can be very serious and usually need antibiotics through a drip in hospital.
 - Heart valve infection (endocarditis): this is a life-threatening illness that makes it difficult for the heart to pump blood. Symptoms may just be fever, chills, and feeling unwell. In other cases there may be weakness, cough, difficulty breathing, headaches and aching joints. People can get very sick and can die if treatment is not received quickly. Anyone who has recently injected drugs and is unwell with a fever with no clear cause needs to have blood taken to test for endocarditis (including 'blood cultures'). If the doctor suspects endocarditis, he/she will usually start antibiotics through a drip, and transfer the person to hospital.
- *Systemic infection or blood poisoning*: this is a serious condition known as 'septicaemia'. It may occur when a localised infection is not treated and spreads to the blood. It may also occur when germs (bacteria) enter the blood with injecting and then multiply. It causes high fever (more than 38.5°C) and often chills and shaking. Blood poisoning can be fatal if not treated quickly with antibiotics, usually given through a drip in hospital.
- *Blood-borne viruses (hep C, hep B, HIV) from sharing injecting equipment*
 - Blood-borne viruses (BBVs) like hep C, hep B and HIV can be passed from one person's blood to another's when people use injecting equipment after another person has already injected with it. The risks are highest when someone shares a needle or syringe. However, BBVs (hep C in particular) may be transmitted when other injecting equipment is shared, such as spoons, water or tourniquets.
 - There are several different strains of these viruses, so a person infected with one can still catch another strain.
 - Often people do not know that they are infected with a BBV, so it is important for people who inject drugs to regularly get tested. This is important, as treatment is available. People can get tested (usually for free) through their GP or clinic, and through many sexual health or drug treatment clinics (see Hep C and hep B, p. 305, 308; HIV p. 315).

Injuries related to other substances mixed with the drug/s

Illegal drugs are expensive so dealers often mix in other substances so that it looks (or weighs) more when they sell it. This is called ‘cutting’ the drug. A wide range of substances can be used and include:

- A powder that looks like the drug (e.g. talcum powder, corn starch, cellulose)
- Other cheaper drugs (illegal or prescription drugs).

Sometimes chemicals used to make or purify the drug are left behind in the drug. This could include acids like vinegar or lemon juice, and even hydrochloric or sulphuric acid. These chemicals can cause damage to the body at the site of injecting or sickness.

Harms related to direct effects of the drug/s injecting (such as overdose)

There is a higher chance of having an overdose after injecting a drug than when it is taken by mouth or smoked. This is because a large quantity of the drug reaches the brain very quickly. The most common type of overdose is from opioids, but overdose can occur with all types of drugs. For example, overdose from sedating drugs (e.g. opioids, benzos) can result in loss of consciousness and slowed or stopped breathing. When too much cocaine or amphetamines are used, a person may become very agitated, paranoid and/or psychotic.

Opioid overdose is more likely to happen when a person:

- Injects alone
- Uses more than one sedating drug (e.g. heroin used with alcohol or benzos or other opioids such as oxycodone or morphine)
- Has not used for a while and their tolerance is down. This could happen after someone leaves detox or rehab, if they come off methadone or buprenorphine treatment, or if they have recently come out of jail (see Opioids, p. 155; Benzos, p. 183).

How to recognise an overdose

The person is likely to be having an overdose if they:

- Have very slow, and/or very shallow breathing. If you count more than fifteen or twenty seconds without a single breath, it is likely they are overdosing.
- Are not responding in any way when you shake them or talk loudly to them (i.e. they are unconscious)
- Are turning blue (lips, finger tips).

What to do if someone overdoses

If the client is unconscious but is still breathing:

- Place the person on their side.
- Ask someone to call 000 for help.
- Make sure their airway is clear so they can breathe (check that there is nothing blocking their mouth or throat, and put their head in a good position; see CPR guide, p. 436).
- Watch them to make sure they do not get worse. This is very important, as an overdose may become more severe in a matter of minutes. Continue to check their breathing until the ambulance arrives.

If the client is not breathing:

- Check that their airway is clear.
- Ask someone to call 000 for assistance.
- Start cardiopulmonary resuscitation (CPR; see p. 436). If you are not sure how to do CPR, the 000 operator will help you with step-by-step instructions until the ambulance arrives. Breathing for the person ('the kiss of life') is often the most important part, as in a sedative overdose (e.g. heroin, alcohol or benzos) the person's breathing may stop before their heart does.

Many people think that if they call an ambulance when somebody overdoses the police will also be involved. Police do not usually attend overdoses unless someone has died.

WHAT ARE THE PSYCHOLOGICAL HARMS OF INJECTING?

Because you get a strong 'hit' from injecting, there is a greater risk of becoming dependent.

WHAT ARE THE SOCIAL HARMS OF INJECTING?

Some social harms of injecting include:

- *Stigma and discrimination:* people who inject drugs often experience discrimination, including in the health care system. As a result, clients may not seek help because they do not want to be judged.
- *Money problems:* because of the high cost of illegal drugs and because they are particularly addictive when injected, money problems often happen (e.g. being unable to pay bills, difficulty finding or keeping a job, or becoming homeless).
- *Family and community problems:* people who inject drugs and are dependent may have trouble caring properly for themselves or their families. They may also be isolated or disconnected from their community and feel shame. This can lead to sadness, depression or even suicide.
- *Criminal behaviour:* people who inject drugs often become involved with the police and criminal justice system. This is not only because drug use is illegal, but also because many of the activities that people are engaged in (to afford the drugs) brings them into contact with the law.

REDUCING OR PREVENTING THE HARMS FROM INJECTING

Clearly, if a person agrees to stop injecting or accepts treatment to help them stop, this is a big step to reducing the harms from injecting. However, many people take some time, or multiple attempts, before they are able to stop. Some people may stop completely, others may reduce how often they use, or how much. Other people do not want to stop using a drug, but may be prepared to swap from injecting to another method, such as swallowing, smoking, snorting, or shelving (putting it up into their anus). There will always be some people who do not want or are unable to stop injecting. Because of this, it is important to think about ways of reducing the harms from injecting. This can keep the user safe, but can also reduce the harms that are passed on to people in their family and in their community.

SAFER INJECTING

While our goal as health professionals may be to help people stop using drugs, we have to be practical and realistic. We know that not everyone wants to stop and not everyone is able to stop as soon as they decide to. It is essential that we try to keep people healthy for as long as possible. It may be that they then live long enough to stop their drug use. It is also important that they stay healthy so that infections and other harms of injecting do not hurt them or family and community around them.

It is uncommon for an established injecting drug user to change their method of drug use to swallowing or smoking. Many continue injecting because they are dependent, and want the stronger, faster effect. Other methods of using drugs like taking by mouth or smoking generally do not give as strong an effect, so the person would need to use more of the drug and spend more money to do so. For others the ritual of injecting can be very difficult to stop. So it is essential to be able to advise people who inject drugs on how to make injecting as safe as possible.

Why do people share injecting equipment?

There are many reasons why people will reuse a 'fit' (i.e. their needle and syringe) or use another person's dirty fit: for some it is because they are 'hanging out' for the drug so are in a hurry; others are unable to find a source of new clean fits. This can be a big problem in rural and remote areas as there are fewer Needle and Syringe Programs (NSPs) and they may be far away. Some other reasons why people share equipment is because of group pressure, being physically dependent, confusion or making a mistake, or not realising that sharing equipment can cause health problems.

Sharing is an important part of Aboriginal culture, but injecting equipment is one thing that should not be shared. Sharing a 'dirty fit' is one of the main causes of health complications and deaths in people who inject drugs.

SAFER INJECTING PRACTICE

If a person is injecting drugs, even sometimes, it is good to talk with them about how they do it (their injecting technique). For example, you can ask:

- How hard is it to get clean fits (injecting equipment)?
- Do you ever share injecting equipment, and, if so, in what circumstances?
- Is anyone injecting near you when you are injecting? Or in the same house?

You may find you need to give advice on how to make injecting safer. Here are some tips you can share with your client:

- Wash hands and fingers, and if water is unavailable clean fingers with alcohol wipes
- Find a clean area to prepare and wash it down if possible
- Use new fits (i.e. new needle and syringe)
- Use clean injecting equipment (including water, spoon, filter, alcohol wipe, tourniquet) and do not share
- Find a vein (use a different site every time if possible)

- Clean the injection site with an alcohol wipe
- Put on the tourniquet – not too tight
- Inject with the needle at a 45 degree angle to the skin (i.e. pointing towards the heart, with the needle on a slant compared to the skin)
- Pull back the plunger a little way – blood should appear
- If possible, release the tourniquet before slowly pushing in the plunger
- Be sure the tourniquet is off before removing the needle
- Apply pressure at the injecting site using clean cotton wool or tissue (for at least one minute)
- When finished, clean area and dispose of all equipment safely
- Wash hands; if water is unavailable clean fingers with an alcohol wipe.

Things people do to clean fits when new equipment is not available

- Washing a fit is never as safe as using a new fit. Some people use bleach to clean used injecting equipment if they cannot get fresh fits. They flush out the syringe first with water, then bleach, then with water again. Fresh bleach does kill the HIV virus, but the bleach does not work as well if it is out of date, or stored in the sun. Sometimes bleach is not fully washed out of the syringe and a small quantity may be injected into the person. Hep C is harder to kill with bleach.
- Sometimes people try to clean their used injecting equipment by flushing out with only clean or sterile water. While this is better than doing nothing, viruses, especially hep C, can stay behind even after any visible traces of blood are gone.

Where your client can get clean injecting equipment

There are Needle and Syringe Programs (NSPs) in many cities and regional centres (see NSPs, p. 298). Some of these will have vending machines for injecting equipment or outreach services. Also, people can usually buy needles and syringes from local pharmacies. Some drug and alcohol treatment units also dispense free injecting equipment.

FURTHER READING

See the Indigenous HealthInfoNet website and type *harms from injecting* in the search box: www.healthinfonet.ecu.edu.au.

See the NSW Users and AIDS Association Inc. www.nuaa.org.au/index.php.

See the Aboriginal Drug and Alcohol Council Inc. SA website and click on *resources*: www.adac.org.au.

Needle and Syringe Programs

WHAT IS A NEEDLE AND SYRINGE PROGRAM?

Needle and Syringe Programs (NSPs) provide clean injecting equipment to people who inject drugs, which may include needles and syringes, swabs, water, spoons, filters and tourniquets. This equipment usually comes in a black plastic case known as a Fitpack, which can also be used as a container for used equipment. Some NSPs also provide larger yellow plastic containers for the safe disposal of used equipment. NSP staff also offer information and advice to clients such as:

- How to reduce the risks associated with injecting drugs, like becoming dependent, overdosing, or infections such as HIV, hep B and hep C
- The types of treatment and rehabilitation programs available to help reduce or stop using drugs, also helping clients get in contact with these programs
- How to get in contact with other services like Legal Aid and Centrelink.

WHY ARE NEEDLE AND SYRINGE PROGRAMS IMPORTANT?

The main idea behind NSPs is to prevent infections such as HIV (that causes AIDS), hep C and hep B. These viruses are carried in blood (blood-borne) and can be spread among people who inject drugs into their veins. Blood-borne viruses can be prevented by making sure that needles, syringes and other injecting equipment that have infected blood on them are not used by someone else to inject drugs. That way, people are less likely to become infected by injecting these viruses into their blood. Making sure that clean needles, syringes and other injecting equipment is available to people who inject drugs helps to lower the spread of HIV (see, p. 311), hep C and hep B (see p. 302).

WHERE TO FIND A NSP IN YOUR AREA

Across Australia, NSPs can be found in a range of different places:

- Some are stand-alone, where the NSP is the main service provided.
- Others are part of a larger health service like a hospital or primary health care clinic.
- Some operate from drug and alcohol clinics, sexual health clinics or community health centres.
- Many local chemists sell injecting equipment.
- In some communities, automatic vending machines provide injecting equipment for a small fee (around \$3) or for free. These are usually found outside hospitals, drug and alcohol clinics, sexual health clinics or community health centres.

HOW DO PEOPLE GET IN TOUCH WITH AN NSP?

People do not need a referral or an appointment to go to a NSP. They can walk in off the street at any time during the NSP's opening hours. People of all ages can access an NSP, recognising that younger people are particularly at risk of blood-borne viruses like HIV.

WHAT IF PEOPLE FEEL SHAME ABOUT INJECTING DRUGS?

Injecting drug use can be a source of shame, and people who inject drugs often report experiencing discrimination in the healthcare system. To make sure that people are comfortable about getting clean injecting equipment from NSPs, NSP staff provide a non-judgemental, confidential and anonymous service (as much as anonymity is possible). In smaller and remote communities it is harder to remain anonymous when someone walks into a NSP, and special efforts may need to be made. For example, NSP staff may be able to arrange delivery of injecting equipment to a convenient location, which is more discreet.

A sample case from Brian, a Koori man who works in an urban NSP in inner Sydney

As a Harm Minimisation worker I deal with people who are injecting drug users as well as the wider community. Here is a story about a client who comes to the NSP.

A young Koori man comes into the NSP. The first thing I do is greet him with a smile and make some casual small talk like: *"How's it going brother?"*

This is to acknowledge and show respect and also helps create a two-way yarn, which can give a young person a sense of empowerment, not to mention making him feel welcome.

I then let the young person guide the conversation. He might ask: *"What do you mob do here?"*

I would usually respond by saying: *"We look after the community."* I would then tell him about the NSP, what else we offer and ask him if he needs anything. The conversation will go one of two ways:

He might say *"F*** that!! You help those dirty junkies?"*

I would then respond by saying something like: *"They are still our mob and if we don't look after each other then who will?"*

Or alternatively he might say: *"Give us a few darts [needles], bro."*

This is the crucial opportunity to engage the client. I would provide what he was asking for (some needles) and start a yarn about health-related things. I might mention where to get help at night (like accommodation or food), advise him never to mix drugs (including alcohol), and to try to take it easy. I would also advise him not to share needles, syringes and other injecting equipment when injecting with someone else and then finish with: “*Hey, if you have any problems, come back. Come back anyway!*”

NSPs are part of Australia’s harm minimisation approach to alcohol and other drug use, which has formed the basis of Australia’s National Drug Strategy since 1985.

Harm minimisation includes a range of approaches under three pillars that work together “to build safe and healthy communities by minimising alcohol, tobacco and other drug-related health, social and economic harms among individuals, families and communities” (*The National Drug Strategy 2010–2015: A framework for action on alcohol, tobacco and other drugs*, see: www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/home).

These three pillars include:

1. *Demand reduction*: to prevent people taking up drugs in the first place, or to reduce drug use among people who have already started using drugs. When last estimated, about 40% of all government drug and alcohol funding went towards this.
2. *Supply reduction*: to reduce the production and supply of illegal drugs, and control the supply of legal substances such as alcohol and tobacco. These approaches have received just over half of all government funding to address drug and alcohol issues in Australia.
3. *Harm reduction*: to prevent drug-related harms like HIV, hep C and hep B among people who for whatever reason are unable to cut down or stop injecting drugs. NSPs are a key harm reduction strategy. These approaches have only received a small amount (less than 5%) of all drug and alcohol funding to date.

FURTHER READING

The National Drug Strategy 2010–2015: A framework for action on alcohol, tobacco and other drugs. See: www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/home

National Centre in HIV Epidemiology and Clinical Research and Commonwealth Department of Health and Ageing (2009). *Return on investment 2: Evaluating the cost effectiveness of needle and syringe programs in Australia.* Sydney: National Centre in HIV Epidemiology and Clinical Research, UNSW. Canberra: Commonwealth Department of Health and Ageing.

Hepatitis C and B

OVERVIEW

Hepatitis C and hepatitis B (known as hep C and hep B) are viruses that can harm the liver. The viruses infect and live in the liver cells. These cells are ‘attacked’ by the virus and this attack can cause scarring in the liver. Hep C is very common among injecting drug users. For many people hep C does not cause problems, but for one in six people it can lead to serious liver damage. The risk of this is much greater if the person drinks alcohol above the recommended levels. Hep B is less common in injecting drug users than hep C, and you can protect against it with vaccination. Some Indigenous communities have high rates of hep B.

HOW ARE BLOOD-BORNE VIRUSES SPREAD?

Viruses like hep C and hep B are ‘blood-borne’. This means that an infected person’s blood needs to come in direct contact with a non-infected person’s blood for the infection to be passed on. The most common way of getting hep C is when people inject drugs and share needles or injecting equipment (see Safer injecting, p. 296).

Occasionally, a person can catch hep C by sharing a toothbrush or razor. The virus stays on the used razor in tiny invisible spots of blood and the virus then enters the second person’s blood through tiny cuts. A much less common way of becoming infected is by coming into contact with tattooing needles or medical equipment that is not sterilised. Blood transfusions in Australia are now considered safe.

What is a virus?

Viruses are tiny particles, much smaller than bacteria. They cannot survive on their own. They depend on other living things, such as humans, to survive. Viruses are passed from one person to another (‘transmission’) in different ways. The flu virus, for example, can be transmitted when a sick person coughs or sneezes the virus into the air. A person can get this infection if they breathe in droplets containing the virus. That is why the flu virus is so easy to catch, and one of the reasons so many people get this virus every year. You cannot catch hep C or B from someone coughing or sneezing on you.

How people become infected with hep C or hep B

	Hep C	Hep B
How is it transmitted?	• From blood to blood (It is more uncommon to become infected through unprotected sex, but it can happen)	• From blood to blood • Through unprotected sex
Risky situations	• Unsafe injecting • Unsterile tattooing • Prisons (because of unsafe injecting and tattooing) • From mother to baby (around 1 in 20 babies are born to mothers with hep C)	• Unsafe injecting • Unsterile tattooing • Prisons (because of unsafe injecting and tattooing) • From mother to baby (up to 1 in 10 babies born to mothers with hep B can get this virus)

HEP C: WHAT HAPPENS WHEN A PERSON BECOMES INFECTED?



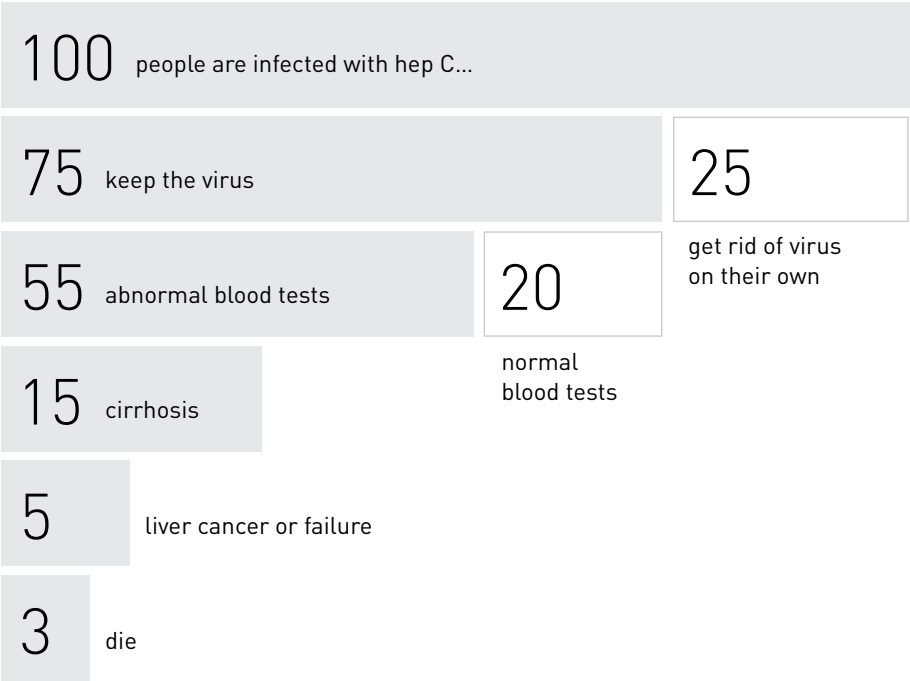
One in four people will get rid of the hep C virus on their own within six months of being infected.

If a person clears the virus, they do not become immune and can be infected again. This is a key difference to hep B. For 3 in 4 people, the hep C virus will stay in their body. This is known as chronic hep C.

The hep C virus infects the liver cells. Liver damage comes from a person’s immune system recognising the virus in their liver cell and attacking that infected cell. This ‘attack’ scars the liver over time. Chronic infection often develops without the client knowing it, as many people do not feel sick. It takes time for the liver to be damaged. It can be 20 years before you can see signs of illness from liver scarring or cirrhosis (see Cirrhotic liver, p. 202). This is why it is important to screen for hep C in people who are at risk, such as people who inject drugs, to catch them before serious damage is done.

What happens to people who are infected with hep C?

If 100 people get infected with hep C, this drawing shows what will usually happen in people who avoid drinking alcohol but do not get treatment.



Hep C and alcohol

If someone has chronic hep C and they drink a lot of alcohol, they can develop cirrhosis and get sick much more quickly than someone that does not drink. That is why it is so important to get people with chronic hep C to stop drinking alcohol or, at the very least, cut down to a tiny amount (e.g. no more than one drink per occasion, and not every day). If the client has cirrhosis, it is best for them to drink no alcohol at all.

HEP C: HOW DO YOU WORK OUT IF SOMEONE HAS IT?

The first test for hep C is a blood test called the hep C antibody. The antibody is a weapon that the body makes to fight against hep C. If this test is positive, this means the person has been infected with the hep C virus at some point. A second test is then done to check if the person still has the virus (called HCV RNA or HCV PCR). If the test is positive, the person has chronic hep C. If the test is negative, the client has cleared the virus and does not have chronic hep C.

If the person still has the virus, their blood may be tested to find out which type of hep C virus the person has. This is the hep C strain ('genotype') (genotypes 1, 2, 3 and 4 are the most common). The genotypes of hep C are like brothers and sisters from the same 'family' of hep C. Different genotypes respond differently to treatment. It is important to know what genotype a person has to work out how long treatment should go for. All of these tests are done on blood. The tests do not cost the client anything as long as certain Medicare rules are met. People can get tested through their GP or clinic, and through many sexual health or drug treatment clinics.

Privacy and discrimination

It is illegal to discriminate against a person (to harass or treat them unfairly) who has hep C or hep B. Discrimination usually occurs when people are scared of getting hep C or hep B or have negative attitudes towards injecting drug use.

In a few cases the law requires a person to say if they have hep C or B:

- When donating blood or sperm
- If they are a health professional who as part of their job comes into contact with blood and body fluids
- If they are in the armed forces
- When filling out some insurance papers.

In most situations, it is up to the client to decide whether to tell someone they have hep C or B (e.g. an employer, landlord or other person who looks after your housing).

For information about privacy and rights around hep C and hep B, contact the hepatitis organisation in your state or territory (see Contacts, p. 306).

Hepatitis organisations in each state and territory

Australian Capital Territory

ACT Hepatitis Resource Centre

Ph: 02 6282 2611

www.hepatitisresourcecentre.com.au

New South Wales

Hepatitis NSW

Ph: 02 9332 1853

www.hep.org.au

Northern Territory

Northern Territory AIDS and

Hepatitis C Council

Ph: 08 8944 7777

www.ntahc.org.au

Queensland

Hepatitis Queensland

Ph: 07 3846 0020

www.hepqld.asn.au

South Australia

Hepatitis C Council of South

Australia

Ph: 08 8362 8443

www.hepcouncilsa.asn.au

Tasmania

Tasmanian Council on AIDS,

Hepatitis and Related Diseases

Ph: 03 6234 1242

www.tascahrd.org.au

Victoria

Hepatitis C Victoria

Ph: 03 9380 4644

www.hepcvic.org.au

Western Australia

Hepatitis WA

Ph: 08 9227 9800

www.hepatitiswa.com.au

You can also call the National Hepatitis Infoline on 1300 HEP ABC (1300 437 222)

HEP C: HOW DO YOU TREAT IT?

If someone has hep C, they can ask their GP for a referral to a specialist (gastroenterologist or infectious diseases specialist) or the hep C team. Some hep C clinics have a 'drop in' service, so a person can then find out more about treatment and decide if it is right for them. Anyone with chronic hep C is eligible for treatment. A liver biopsy is not needed. The government pays for the treatment, so there are no costs for the client.

The treatment for hep C consists of ‘ribavirin’ tablets taken twice a day, and a weekly injection of ‘pegylated interferon’. Ribavirin works against the virus. Interferon helps the immune system fight the virus. The length of time that a person needs to be treated depends on the genotype of hep C they have. People with genotypes 2 and 3 are generally treated for six months. Treatment is most successful in this group. Around 4 in 5 people (80%) with genotype 2 or 3 will get rid of the virus with six months of treatment. People with genotypes 1 and 4 are generally treated for one year. Treatment is successful in about half (50%) of these clients.

In 2013 or 2014, a new class of drug, protease inhibitors (e.g. telaprevir, boceprevir), will be made available to treat hep C. These tablets act directly against the virus. They will be given in combination with ribavirin and pegylated interferon as a ‘triple’ treatment.

Hep C treatment can be tough because of the side effects, but if it can clear the virus the person can stay healthy for life. Remember, people can get hep C again even after the virus has been cleared with treatment. It is not possible to have treatment during pregnancy as the medicines can affect the growing baby. Reliable contraception is very important before and during treatment to avoid this situation (see Contraception, p. 344).

Are there any side effects of treatment?

Some side effects of hep C treatment include:

- Flu-like symptoms that tend to get better with time (fever, lack of energy, muscle and joint aches, headaches). These symptoms improve with paracetamol or anti-inflammatory drugs like ibuprofen (Nurofen).
- Poor appetite
- Hair falling out (alopecia). This is not common and it gets better after stopping treatment.
- For some people, the treatment can affect their blood and cause problems like:
 - Tiredness from low red blood cells (anaemia)
 - Infections from low white blood cells (leucopenia)
 - Easy bruising from low platelets (thrombocytopenia)

If these problems occur, the medicine doses may need to change or the treatment even stopped for a time.

- If a person already has a mood disorder, like depression, treatment can make this worse. Once mental health is stable, treatment can usually be given with some monitoring of mood.

LIVING WITH HEP C

If your client is living with hep C, there are some simple things they can do to try to stay healthy:

- blood tests 1–2 times per year to monitor progress
- an ultrasound, or (where available) fibroscan to check progress
- get the vaccination against hep B, and if available, hep A
- minimise alcohol use
- avoid weight gain as a fatty liver can cause liver damage.

Women who have hep C can still become pregnant and breastfeed their infants. Pregnant women should let their doctor know that they have hep C.

HEP B

Hep B is a blood-borne virus like hep C. Hep B is not as common in people who inject drugs. But, like hep C, hep B can live in the body without people knowing it. Over a long period of time, hep B can cause damage to the liver.

Hep B vaccination

The good thing about hep B is that it can be prevented. A vaccine, given as three separate injections, is available to protect against getting hep B. The vaccine gives you immunity, which means that you cannot get the virus even if you are exposed. In adults, one injection is given, followed by another one a month later, and a final injection three months later.

Since 2000, all babies born in Australia are vaccinated for hep B. It is important to protect children from this virus, as children are more likely to develop chronic hep B. Most adults that get infected with hep B get rid of the virus without treatment. If a person gets hep B and then ‘clears’ the virus, they cannot be infected again because they are immune.

Hep B testing

A simple blood test can check if someone has hep B (this is called the HBsAg). The test is free. If someone develops chronic hep B infection, they are at increased risk of liver scarring, cirrhosis, and liver cancer. Chronic hep B can also flare up at different times and make people very sick.

There is also a blood test to check if the vaccine has been successful (called HBsAb). A repeat course of vaccination may be needed in some cases.

Hep B treatment

The approach to treatment of chronic hep B is complex. Treatment may be weekly interferon injections for one year, or oral medicines taken every day for the rest of the person's life. This treatment is covered by Medicare, so people with chronic hep B should see a liver specialist.

CIRRHOSIS AND LIVER CANCER

Cirrhosis and liver cancer can develop in people who have had hep C or hep B over many years.

What is cirrhosis?

Chronic hep C and hep B infection causes irritation and inflammation of the liver. Over time, this irritation causes scarring of the liver. When this scarring becomes severe, it is known as cirrhosis.

Cirrhosis affects the liver's ability to filter toxins from the blood and affects its ability to build proteins that we need. It also makes the liver 'stiff' and this stops blood from draining freely from the gut and through the liver. This then increases the pressure in these blood vessels that drain the gut. This can cause bleeding in the gut, which can show up as vomiting of blood. Cirrhosis occurs in about 1 in 5 people with chronic hep C or hep B.

Early on, many people have no symptoms so they may not realise they have cirrhosis. The symptoms and signs of cirrhosis include:

- Loss of energy
- Yellow discolouration of the skin and eyes (jaundice)
- Swollen belly (ascites)
- Legs swollen with fluid (oedema)
- Poor concentration or confusion (encephalopathy)
- Bruising
- Gut bleeding (portal hypertension and varices)
- Enlarged spleen (splenomegaly) that can be felt by the doctor (for a fuller description of cirrhosis, see Alcohol, p. 73).

Liver cancer

People with cirrhosis are at risk of developing liver cancer (called hepatocellular carcinoma). Hep B is a bit different. People with chronic hep B are at risk of liver cancer even when they do not have cirrhosis. People with cirrhosis or chronic hep B need to start screening for liver cancer when they are about 40 years old. Every six months, they have a blood test (alpha-fetoprotein) and a liver ultrasound. If a liver cancer is found, they need to see a liver specialist.

Liver transplant

Liver transplant is a surgical procedure that involves removing a sick person's liver and replacing it with a liver that someone has donated after they have died. Transplant is an option in clients that are too sick from their own failing liver or in clients with early liver cancer. In Australia, liver disease due to chronic hep C infection is the most common reason for liver transplant. Getting a liver transplant is very difficult. Clients undergo many assessments before going on a waiting list for the surgery. Once the transplant has been performed, the client has to be on medicine for the rest of their life to stop their body rejecting the new liver. Only a few hospitals around Australia provide this type of treatment; it is very specialised.

FURTHER READING

For factsheets and other information about hep C and B see the Hepatitis NSW website. See: www.hep.org.au/.

Aboriginal Health and Medical Research Council of NSW (2008). *Hep C and us mob: A handbook for Aboriginal people about hepatitis C*. Sydney: Aboriginal Health and Medical Research Council. See: www.hep.org.au/documents/Us-Mob-4MB.pdf.

HIV/AIDS

OVERVIEW

AIDS is a severe illness that can develop when a person has been infected with the HIV virus (Human Immunodeficiency Virus). AIDS stands for Acquired Immune Deficiency Syndrome. That means it is an illness that people pick up (or acquire) which interferes with the body's ability to fight off illness. The normal system that defends the body, the immune system, is impaired by the infection. Because of this, illnesses that otherwise would be quite mild can become life threatening. Simple coughs can develop more easily into dangerous pneumonia, and people can get other less common illnesses, with germs that do not usually harm humans. It may take many years for the HIV infection to cause the disease of AIDS. These days there are very good treatments available if a person catches the HIV virus or develops AIDS, so it is important to detect HIV infection early and have good monitoring to see if treatment is needed.

HIV is a virus – What does that mean?

HIV (Human Immunodeficiency Virus) is the virus that causes AIDS. All viruses, including HIV, are so small that you cannot see them unless you look through a very strong microscope. Viruses make the infected person's body produce more copies of the virus. These copies can then be spread to other people, making them infected with the virus too.

Viruses are not easily killed and HIV is no exception. HIV is very different from most other viruses because it can survive in the infected person for a very long time, silently damaging the body's natural defence system against sickness (the immune system). HIV is also very good at escaping the body's natural defences. The immune system rarely, if ever, succeeds at removing the virus from the body (clearing the virus). Because of this, developing good treatments has taken a long time and even better ones may still emerge in the future. At the moment there is no vaccine or cure for HIV.

WHAT HAPPENS TO SOMEONE WITH HIV IF IT IS NOT TREATED?

People living with HIV will eventually get very sick if they do not get treatment. On average it takes about 10 years for the immune system to be weakened so much that it can no longer protect the person from infections. Some people get sick much quicker than that, while some people may still be feeling well more than 20 years after being infected. Because of this, most of the time someone is infected they will look and feel normal. Until they are diagnosed, people will usually not be aware of their infection but they can still be infecting others during unprotected sex or by blood-to-blood contact.

If HIV is left untreated or if treatment is not used properly (e.g. not taking all doses or not staying on treatment) the virus can continue to damage the immune system leading to other infections being able to grow quickly. In that situation the person with HIV can develop pneumonia (lung infection with cough, chest pain, fever and difficulty breathing), thrush (a mouth infection), brain abscess (collection of pus in the brain) and skin infections. People with HIV may also develop lymphoma (a type of immune system cancer), Kaposi's sarcoma (a cancerous tumour with bluish-red or purple bumps on the skin) and anal cancer. Some people just show extreme weight loss as the only sign their immune system is damaged. Although these are severe problems, all of these are treatable and some are curable.

When HIV has progressed to a severe stage, the person is classified as having AIDS.

HOW IS HIV SPREAD FROM PERSON TO PERSON?

HIV stays in an infected person all their life. HIV can then be spread to other people through contact with that person's blood (e.g. through shared needles) or through unprotected sex. You cannot get HIV by just touching. Kissing is a very low risk activity for HIV transmission. But if someone has recently brushed or flossed their teeth or used mouthwash and has open cuts in their mouth, there is a possible risk of HIV transmission. In these cases, kissing should be avoided until the bleeding stops. This may be particularly important in communities where people have poor dental health.

When a man has HIV, the virus is present in the fluids that come from his penis during sex (semen). These can infect the person he is having sex with. The risk of HIV infecting the second person is greater if that person has a STI (sexually transmissible infection), as this can damage their body's surface protection (similar to broken skin but on the inside – this is known as the mucous membrane). In the same way, if the second person has any small cuts or grazes inside their body, the HIV virus can enter more easily.

When a woman has HIV it is less often passed on to her partner. However, if she and a male partner have a STI it is more likely for HIV to be transmitted to this partner.

HIV can also be transmitted from mother to child at the time of birth if the mother is HIV positive. If there were 10 pregnant women with HIV and none were on treatment, around two or three of these women would have their baby born with HIV.

How common is HIV in Australia?

In Australia, most HIV cases are found in men who have unprotected sex with other men. A smaller number of people get HIV through sexual contact with someone of the opposite sex. However, among Aboriginal people, more heterosexuals live with HIV than in the wider community.

For people who inject drugs, sharing injecting equipment increases the risk of being infected with HIV. Fortunately, less than one in 50 injecting drug users have HIV in Australia. Our rates of HIV infection in injecting drug users are far lower than in countries like the USA because Australia provides clean needles to injectors (see NSPs, p. 298).

There is a fear that HIV will affect more Aboriginal injecting drug users because Aboriginal Australians are more likely to share injecting equipment. Also there is a concern that, as Torres Strait Islanders are often in contact with people from Papua New Guinea, the high rates of HIV in Papua New Guinea will start to be seen in the Torres Straits and Cape York.

WHAT YOUR CLIENTS CAN DO TO REDUCE THE SPREAD OF HIV

Reducing the spread through sex

- Condoms are the best way to reduce the transmission of HIV during sex. They are effective in preventing transmission if used properly and used every time.
- As well as the usual ‘male’ condom, there is a ‘female condom’ that women can use. This is inserted inside their vagina, but unfortunately most pharmacies and supermarkets don’t stock them, though they can be brought in if ordered. Condoms should never be re-used and they should be used with a water-based lubricant that is suitable for their type.
- The prevention or treatment of other sexually transmissible infections (STIs) can also reduce the risk of catching or spreading HIV. So it is important that your clients are tested and receive treatment where needed. Condoms will prevent most STIs.

- People living with HIV need to be aware that they carry the virus, so that if there is an accidental break to a condom or if they have unprotected sex, their partner can receive treatment right away. In this case, their partner would receive antiretroviral medicines for a short period to kill off any virus that may have entered their body before they have a full-blown infection. This treatment is given as a precaution after the person is exposed to the virus and is known as ‘post exposure prophylaxis’ (PEP).
- Using a water-based lubricant or ‘lube’ during sex can help reduce the risk of the condom breaking. It can also help avoid too much rubbing, which can break the partner’s surface protection and let the HIV virus in.
- Some sexual practices are more risky than others. If you are not comfortable discussing safer sex in detail with your client, you can mention the importance of using condoms, and then help them access a sexual health worker. You can mention how important it is to know about safer sexual practices.
- The withdrawal or ‘pulling out’ approach, where a man tries to avoid leaving semen inside his partner, is not reliable as semen starts coming out before climax.

Reducing the spread through injecting drug use

- People who inject drugs need to avoid sharing injecting equipment like needles, syringes, spoons, filters, swabs and tourniquets. As well as the risk of catching or spreading HIV, you can also be infected with hep C or hep B if you share injecting equipment (see Hep C and hep B, p. 302; Harms from injecting and safer injecting, p. 289). Tell clients that, as well as not using other people’s injecting equipment, they should also not pass on their own injecting equipment for others to use. You can give them clean injecting equipment if this is offered at your service, or you can direct them to the nearest Needle and Syringe Program (if available), or to a local chemist that provides equipment (see NSPs, p. 298).

Reducing the spread through pregnancy

- Women who may be infected with HIV should be tested early, so they can receive treatment in pregnancy to protect their baby.
- Occasionally they may need to have the baby delivered by ‘Caesar’ (caesarean section) to protect the baby from becoming infected with HIV. The baby will also receive a brief course of prevention treatment for the first 4–6 weeks of life (in the form of a syrup to drink).

HOW ARE PEOPLE TESTED FOR HIV?

Testing for HIV involves a blood test that looks for the body's attempt to fight off the virus (the specific antibody to the HIV virus). The tests are very reliable. They can detect HIV within the first month of infection in most cases, and within three months of infection in almost all cases. If a test comes back positive, a new test is usually done to make sure the first test was not a mistake.

If your client is HIV positive, how are they monitored?

If your client is HIV positive, they need to be regularly monitored with blood tests (at least four times each year). Two types of tests are done. One measures how much HIV there is in the blood (the viral load). The other is a measure of the number of (good) immune cells still there in the body – known as 'CD4 T-cells'. These tests help doctors choose the right time to recommend starting treatment.

HOW IS HIV TREATED AND HOW CAN PEOPLE GET TREATMENT?

Antiretroviral drugs are the main treatment for HIV. These drugs stop HIV from making more copies of itself or stop it from entering other cells in the body. Many different medicines are used. A combination of three or four medicines is taken each day and treatment needs to be kept up continuously. Some drug companies combine up to three drugs into the same pill to make it easier for people to take. A doctor monitors the person's blood tests to see how the medicines are working. When these medicines work, the HIV viral load usually falls to very low levels and the immune system begins to recover.

The main side effects of treatment depend on the exact drugs given but are usually quite mild. Mild nausea is the most common side effect and generally it settles in the first few weeks of treatment. Those starting medicines for the first time are strongly encouraged to talk with their doctor if they are getting unpleasant side effects from their treatment. If one combination is causing side effects, the doctor will advise a different set of medicines.

Because the treatments are effective and expensive for the government (but not for the patients), prescriptions can only be made by specially trained doctors based in hospital clinics, Aboriginal medical services, general practices (some) and sexual health clinics (most). Medicines are available on the PBS and are free for Aboriginal clients as part of the 'close the gap' initiative.

People with HIV can access mainstream services for support but also many health services have specialised support staff that know a lot about supporting people with HIV. There are specialised services for children through children's hospitals and also information is freely available through the internet (www.ashm.org.au).

Because people with HIV can get other severe infections (e.g. in the lungs or brain), sometimes other medicines (e.g. antibiotics) are recommended on a daily basis to prevent these.

Why HIV is not a 'death sentence' any more

When HIV was first discovered in the early 1980s it looked like it would lead to an early death for almost everyone infected. With the success of new treatments, it seems that people who use the best treatments and stay on treatment probably only lose a few years of life. But, for a small number of people, the disease will still progress even if they are treated.

WHAT ABOUT LEGAL ISSUES AND HIV?

HIV testing can only be done if your client consents to being tested. People living with HIV are required by law to tell their sexual partners that they are HIV positive before they have sex. They must allow the other person to decide whether they still want to have sex and under what conditions (e.g. only with a condom). People living with HIV do not legally have to tell anybody else that they are HIV positive. They do not have to tell their employer.

It is illegal to discriminate on the basis of HIV infection, so people with HIV do not lose their rights to care, employment and other benefits. Health care workers need to make sure that they protect the privacy of people living with HIV and that they do not accidentally reveal a person's HIV status to their family, friends or other agencies.

If you as a health care worker have HIV, check the procedures in each state and territory guiding health care workers who are HIV positive. The national registration body for health care workers is updating its guidelines in 2011 (Australian Health Practitioner Regulation Agency – AHPRA). In the meantime, state-based guidelines apply. It is important to make sure that any invasive procedures (e.g. like taking blood) are not risky for clients.

FURTHER READING

See The Australasian Society for HIV Medicine for resources: www.ashm.org.au.

14

Legal issues

Guardianship 318

Alcohol, drugs and driving 322

Programs to reduce re-offending or avoid prison 325

Guardianship: when a person can no longer look after their own affairs

WHAT IS GUARDIANSHIP?

If an adult is unable to look after their own affairs, there are laws that can sometimes give someone else the power to help them. This most often happens when a client is unable to make decisions for themselves because of a disability (e.g. brain damage from alcohol or from drug overdose). Sometimes a relative or other adult can be made the client's guardian. This guardian is given the right to look after the person's affairs, including their health and welfare. In other cases a 'public guardian' or 'public advocate' is appointed. This is someone outside the family, who might do this as part of their job. Rules about guardianship will vary in each state and territory. This section gives an overview of some common features.

WHEN MIGHT A GUARDIAN BE NEEDED?

Use of alcohol or other drugs can damage a person's brain, which may result in them acting in ways that place them at risk. This can happen when they are intoxicated, but the harms from alcohol or drug use can continue long after becoming sober.

Guardianship may be needed when a person has:

- Brain damage, from alcohol, drugs or other causes
- A severe psychiatric disorder, that leaves them unable to care for themselves
- A developmental delay that has been present from birth (e.g. Down's Syndrome). This may have led them to use alcohol or drugs, and they may now be at major risk (e.g. of physical or sexual abuse).
- A severe alcohol and/or drug problem that regularly exposes them to major risks (e.g. they are in hospital a lot, or they regularly put their life at risk through suicide attempts)
- Been neglected, exploited and or abused by someone because of their drinking or drug use. The person's family or friends are also unable to prevent this harm.

ARE ALL GUARDIANSHIP ORDERS THE SAME?

All guardianship orders give someone else control over a person's affairs. But there are different types of orders. Sometimes a guardianship order:

- Is lifelong ('continuing')
- Gives control over just part of a person's affairs (e.g. their money, or one aspect of their treatment). This is called a 'limited order'
- Is for a set period of time (a 'temporary order').

WHO CAN BE A GUARDIAN?

A guardian must be 18 years or older. Often the guardian is a family member, but other responsible adults can be the guardian. The guardian cannot be arguing or fighting with the person who needs a guardianship order. The guardian must be able and willing to complete the tasks set out in the order (e.g. manage the money, decide on housing). If a person has no family or friends who are able to act as their guardian, a public guardian can be appointed.

WHAT DOES A GUARDIAN DO?

The guardian may have the power to decide over aspects of a person's day-to-day life; for example:

- *Accommodation*: the person can be told to live in a certain place (e.g. in a supported hostel).
- *Health care*: the person can be made to attend certain treatment (e.g. see a doctor, have surgery for a badly broken arm, attend drug and alcohol treatment (note: some rehabs may not take clients who have not chosen to be there – 'coerced clients').
 - *Note*: the guardian may need to consent to any health care (e.g. you may need to get a guardian's consent to have a tooth extracted, or to transfer a client to a rehabilitation unit).
 - *Note*: in an emergency, treatment may need to go ahead, even while you wait for consent.
- *Finances*: the person's money can be looked after, and bills paid for them. The person may be given some spending money for other expenses.
- *What education and training they should do*
- *What work they should do* (e.g. someone with brain damage can be supported to work in a sheltered workshop).

HOW TO ORGANISE A GUARDIANSHIP ORDER?

When you request a guardianship order the government will want to know why, and they will need to have the facts well documented. You will need to be able to satisfy the panel (or tribunal or court) that the person you are concerned about has major problems with making decisions and cannot manage their life.

Finding someone who understands the system and has successfully organised a guardianship order before can be a big help. Usually you will need to have your client's level of disability clearly documented (e.g. with a report from a doctor or psychologist on their level of brain damage). Sometimes specialist doctors (e.g. brain doctor or 'neurologist') or psychologists are required for assessment and reports.

It can be challenging and time consuming to obtain a guardianship order. But in the long run it can save a lot of time and, most importantly, sometimes it is the only way to keep the person safe.

Sometimes you can suggest to the person's family that they consider a guardianship order, and you can support them in starting the process. If the individual has no family involved, you can try to start the process of organising a public guardian yourself.

WHERE TO FIND OUT ABOUT GUARDIANSHIP IN YOUR STATE OR TERRITORY

A useful place to find out more information about guardianship is the Public Guardianship Board in your state or territory.

State and Territory Public Guardianship Boards

Australian Capital Territory

Office of the Community Advocate

Phone (02) 6207 0707

www.publicadvocate.act.gov.au

New South Wales

The NSW Public Guardian

Phone (02) 9265 3184 (Sydney)

(02) 9671 9800 (Blacktown)

(02) 4320 4888 (Gosford)

www.lawlink.nsw.gov.au/opg

Northern Territory

Office of Adult Guardianship

Phone (08) 8922 7116 (Darwin)

(08) 8951 6739 (Alice Springs)

www.health.nt.gov.au/Aged_and_Disability/Adult_Guardianship/index.aspx

Queensland

The Adult Guardian

Phone (07) 3234 0870

www.justice.qld.gov.au/91.htm

South Australia

Office of the public advocate

Phone (08) 8269 7575

www.opa.sa.gov.au

Tasmania

Office of the Public Guardian

Phone (03) 6233 7608

www.publicguardian.tas.gov.au

Victoria

Office of the Public Advocate

Phone (03) 9603 9500

www.publicadvocate.vic.gov.au

Western Australia

The Public Advocate

Phone (08) 9278 7300

www.publicadvocate.wa.gov.au

FURTHER READING

Fogerty B (2009). *Guardianship and administration laws across Australia*. Sydney: Intellectual Disability Rights Service. See: www.idrs.org.au/_pdf/Guardianship_and_administration_laws_across_Australia_by_Ben_Fogarty.pdf.

Alcohol, drugs and driving

OVERVIEW

Alcohol and drugs affect people's driving skills, making it harder to drive safely. Driving under the influence of alcohol or drugs increases the chances of having accidents and of getting into trouble with the law. To avoid problems with drink or drug driving, people should avoid using or stay under the limit when they plan to drive, or make other plans such as public transport, have a designated driver, or stay with a friend or family member when intending to use.

How many people drink or drug drive in Australia?

Among people who have had any alcohol in the past 12 months, around 1 in 6 men and 1 in 11 women report drink driving. Among people who have used illegal drugs, around 1 in 5 men and 1 in 8 women report drug driving, mostly after using cannabis. Young people are almost twice as likely as older adults to drive after using drugs.

In Australia, alcohol is involved in a quarter of the car crashes where someone dies. However, among Aboriginal people, alcohol is involved in up to 8 in every 10 crashes where someone dies. In these cases, usually a lot of alcohol is found in the driver's blood (often up to four times the legal limit).

WHAT ARE THE LAWS AROUND DRINK AND DRUG DRIVING?

Alcohol

All Australian drivers have to follow the same rules about how much alcohol can be in their blood when driving:

- 'Full' licence drivers can have up to 0.05% (g/100ml) of alcohol in their blood.
- 'Provisional' (P Plate) or 'learner' drivers can have no alcohol in their blood while driving.
- People who drive for a living (e.g. bus, taxi and truck drivers; police) can have no alcohol in their blood when driving work vehicles.

The general rule to help stay below the blood alcohol limit of 0.05% is:

- For women, no more than one standard (small) drink each hour
- For men, no more than two standard (small) drinks in the first hour, then no more than one standard (small) drink each hour after that.

How alcohol is broken down in the body varies from person to person. So, for one person, drinking no more than one standard (small) drink each hour may be too much, while for someone else it keeps them under the 0.05% limit.

Remember, this is the legal limit, not the health limit (see Alcohol, p. 70).

Drugs

It is an offence to drive under the influence of drugs in Australia. There are some differences across Australia, so check with the police in your state or territory.

Roadside testing

Roadside alcohol and drug testing is conducted by police around Australia and includes breath and saliva tests and sometimes blood tests. Anyone who is driving or attempting to drive can be tested. If a person gets caught drink driving, they may have to go to court, pay a fine, or lose their licence or demerit points (see your state or territory road authority for more information on penalties).

WHAT HAPPENS TO DRIVING SKILLS WHEN YOU DRINK OR DRUG DRIVE?

Driving requires lots of skills like: being able to focus, making judgements and decisions, and doing things with hands and feet while keeping your eyes on the road. These skills get worse when people use alcohol, illegal drugs, or prescribed medicines.

- The driver may: have a slower reaction time (e.g. is slower to put on the brakes), have poorer vision, be less focused, have trouble judging distance and speed, have trouble staying in their lane and take more risks while driving.
- Mixing alcohol with other drugs or taking different drugs together can also make driving skills even worse.
- Being intoxicated with alcohol or drugs increases the chance of being in an accident and of injuries caused to the driver and others.

How long does it take for alcohol or drug levels in the body to go down?

The only way to make the level of alcohol or drugs in the body go down is with time. For example, with alcohol, the liver takes about one hour to break down one standard drink. Nothing can make these levels go down faster. Drinking coffee, sucking on a lozenge, taking a shower and getting some fresh air all do not help the body break down alcohol or drugs faster.

Is it okay to drive on methadone or buprenorphine treatment?

If your client is on methadone or buprenorphine treatment, it is safe to drive if they are on a stable dose. If their dose is being increased or if they feel sleepy after their dose, then they should not drive. Of course if they are using alcohol or other drugs, then they also should not drive.

TIPS FOR STAYING SAFE

- Talk to your client about the risks of drink and drug driving (e.g. causing accidents, getting a fine, losing their licence).
- Encourage your client not to drink or use drugs if they are going to drive.
- If your client is going out in a group, encourage them to have one person be the designated driver who will have no alcohol or drugs, or to keep their alcohol use under the limit.
- Encourage your client to use public transport, taxis, courtesy buses, or to stay at a friend's or family member's house rather than drive home after using.
- If your client is taking prescribed medicines (e.g. anti-depressants, benzos) and is worried about driving safely, they should stop driving and talk to their doctor or pharmacist about the side effects of this medicine and whether they should change to a different medicine.

FURTHER READING

For more information on road safety in Aboriginal people: www.healthinonet.edu.au/related-issues/road-safety.

Programs to reduce re-offending or avoid prison

OVERVIEW

Sometimes going to prison can pull up an episode of using alcohol or drug problems. But drug use can also continue or even increase while a person is in custody, putting them at risk of problems from using including hep C or HIV. Because of the harms that may come from being in prison, each state and territory has a range of programs to try to keep people out of court and out of the prison system.

These approaches can include conditional bail, diversion, and court ordered programs to encourage the offender to address the underlying causes of their offending behaviour, such as alcohol or drug use. Sometimes the offender will be asked to complete a diversion program instead of going to court. There are also options that can happen before or after sentencing, and which are aimed at changing offending behaviour.

This section gives an overview of the range of options to help reduce re-offending and to offer alternatives to punishment such as prison. Note: programs to reduce offending or avoid prison are different in each state and territory. Therefore this section provides a broad overview of the types of options available, along with some examples.



If a person has a mental illness and they commit an offence

Each state and territory's Mental Health Act allows offenders with serious mental illness to get treatment rather than be automatically sent to prison. How this happens varies across Australia. For example: a person may be ordered to attend treatment instead of going to court; a psychiatrist report may be made to the court; and/or the magistrate might give a compulsory treatment order instead of punishment. Check with the mental health team, Department of Justice or Attorney-General's Office in your area for details.

PROGRAMS THAT REPLACE COURT

Cautions or ‘expiation notices’

In some states and territories, offences such as possession of cannabis can be dealt with by giving the person a caution or a fine, instead of having to go to court. This means the offence has been decriminalised, i.e. even though the possession of cannabis is still against the law (illegal) it is not classed as a criminal offence, so police can deal with the issue instead of the courts.

Juvenile diversion

In some states or territories police can refer certain offenders to diversion programs instead of to court. An example of this is the Northern Territory Police’s Youth Diversion Scheme.

Juvenile diversion programs vary, but may involve:

- Education and treatment about drugs and alcohol
- Doing something to make up for the crime (restitution), e.g. doing volunteer work in the shop where the offence happened
- Community service
- The victim meeting the offender in a neutral safe environment (‘victim offender conference’) to try to give the offender a better understanding of the impact of their actions and to address the hurt they caused to the victim (and others).

Diversion often works best when there are suitable community-based programs available in the local area, such as alcohol and drug programs and youth services. However, informal programs or activities that also meet the offender’s (and perhaps victim’s) needs can also work well.

Note: there may be fewer options for formal diversion programs in smaller communities. If you work in a more isolated area, contact your local Department of Justice to ask about the possibility of increasing the diversion options available to your clients.

ALTERNATIVE SENTENCING

Courts that use alternative sentencing have the full sentencing powers of a 'regular' court. To be eligible for alternative sentencing programs, the offender often needs to plead guilty (but not always; check the details in your state or territory). Most offences can be heard in these courts, with the exception in some instances of particularly serious crimes such as murder, family violence and sexual offences. Some types of alternative sentencing options include 'problem solving' and 'culturally appropriate' courts.

Problem solving courts

These are special courts that offenders can be referred to depending on the type of crime and how severe it is. Examples include the Drug Court (NSW), Victorian problem solving courts, Family Violence Court (Vic) and the (NT) Substance Misuse Assessment and Referral for Treatment (SMART) court.

For example, the Drug Court (NSW) is a specialist court for offenders who are dependent on drugs. In this 12-month program, the magistrate can order treatment and urine drug screens three times a week. In this court and others like it, the magistrate plays an active role in regularly reviewing what progress the offender is making. A point demerit system is used to 'punish' the offender if they run into trouble while on their program. The number of points that are deducted depends on how severe the trouble is. For example, if drugs are detected in the offender's urine, a point may be taken away for every illegal (illicit) drug found. Drug Court users start with 28 points, and when they reach 0 they are sent back to prison.

Culturally appropriate courts

These courts try to provide a more culturally appropriate way of sentencing in a less 'formal' court setting. People who care for the offender (e.g. family, elders, mentors) are actively involved in the court process. Respected community members such as elders who understand the issues assist in agreeing on a sentence and can set bail conditions more suited to the offender's rehabilitation options and their community. They can also help explain the process and consequences to the offender and their family. These courts may also help strengthen the authority of elders and other responsible family members.

The family of the offender or of the victim, and the victim themselves, may also be invited to take part in the court proceedings. This can provide opportunities for the offender to be more aware of the harms they have caused to the victim, their family, their community and themselves. It is hoped that involving family and others in this way will help reduce re-offending. Examples include: Koori Courts (Vic), Murri Courts (Qld), Circle Sentencing (NSW) and Community Court (NT). Most programs are similar in that they want the offender to take responsibility for their criminal behaviour and to play an active role in their recovery.

PROGRAMS THAT HAPPEN BEFORE SENTENCING

Programs are available to offenders of minor offences before they go to court (pre-sentence programs). Taking part in a program can help a person to get treatment or education sooner, and to encourage them to change their behaviour. It may also help them get a better outcome when they go to court, e.g. a reduced sentence. Most programs aim to tackle the underlying problem that has caused the offending behaviour.

A number of states and territories have programs that bring the offender together with victim(s) of the crime and other people affected. Examples include Forum Sentencing (NSW) or Family and Victim Offender Conferencing (NT). This provides the victim and other people affected by the crime an opportunity to meet face-to-face and to tell the offender about the harm that the crime has had on their lives. It also provides the offender with an opportunity to learn about the harm their behaviour had on the victim and other people.

Across Australia there are also various problem-solving courts that look at releasing an offender on bail to undertake treatment and other programs prior to final sentencing (described above in 'problem-solving courts'). Some of these require the offender to admit they have broken the law and to agree to address their issues. In NSW, offenders can be referred by the court, before they enter a plea, to the MERIT program (Magistrate's Early Referral into Treatment). This provides intensive counselling support and case management for three months.

PROGRAMS THAT HAPPEN AFTER SENTENCING

The magistrate or judge has many options to order treatment or another option instead of sending the offender to prison, or as well as prison. Again, such programs aim to tackle the underlying issues that contribute to the offence, such as alcohol, drug or mental health issues. One example is treatment orders where the magistrate may order the offender to enter a rehab or other alcohol and drug treatment instead of going to prison. If the offender does not follow this order and take part in the program, then they can be sent to prison. The offender's lawyer (solicitor) can ask the court for a treatment order (like going to rehab) instead of the client having to go to prison.

Some challenges with treatment orders

- Magistrates may not always be aware of the full range of options, including the range of treatment approaches or which treatment is better than another. As professionals we need to try to keep magistrates up to date.
- Sometimes the magistrate may order the offender to attend rehab, but the offender is unable to get a place in a rehab. With the client's permission, it is important to talk to the offender's legal representative about this to explore other options.



For information on how your client can access programs after they have committed an offence, contact your local Department of Justice or Attorney-General's Department, Legal Aid office or your client's lawyer (solicitor).

HOW CAN A CLIENT ACCESS PROGRAMS TO REDUCE RE-OFFENDING OR AVOID PRISON?

The availability of these programs and the rules varies around Australia.

- Many programs are only available for less serious offences.
- Referrals are sometimes made by the police, or by the prosecution or the court magistrate.
- Sometimes the offender's lawyer can request access to these programs.
- To be eligible, defendants usually (but not always) need to plead guilty.
- Contact the office of your local legal service (or your Department of Justice or Attorney-General) to check what options are available in your area and which offences are eligible.

FURTHER READING

Go to the Indigenous HealthInfoNet website and type *diversion programs or alternative sentencing* in the search box: www.healthinfonet.ecu.edu.au.

15

Community-wide approaches to substance misuse

Engaging with communities to address drug and alcohol issues 332

What communities can do to prevent or limit drinking problems 337

Engaging with communities to address drug and alcohol issues

OVERVIEW

Most health workers or drug and alcohol workers in communities have the respect of that community, and knowledge about drug and alcohol issues, but they may not have the skills or training to engage or educate community members.

A worker may be stuck at their desk, either swamped with work, or sitting there with nothing to do. Particularly if they are not from that community, they may find it challenging to work out how to engage with that community.

This section gives an overview of ways a person can work with and support the community to prevent drug and alcohol problems, or reduce their harms. This section focuses on community-based efforts. Work with individuals and families are covered in other sections (e.g. Counselling, p. 20; What families can do, p. 62).

LETTING COMMUNITIES KNOW ABOUT THE ROLE OF THE WORKER

Even though the drug and alcohol worker is there in the clinic or other centre, the community may not know that this worker can help with drug and alcohol issues. Workers often have broad roles (e.g. men's health), and the community may see them driving cars, cooking barbeques, and not realise that they can offer counselling or can link people to drug and alcohol treatment. Also, communities may not know about the full range of treatments available – for example, they may believe that live-in rehab is the only treatment possible; and they may not know about the possibility of home detox (see Home detox, p. 88).

It is the responsibility of the worker to build a strong relationship with the community. This can be done through information days, barbeques and community events and meeting with key agencies (e.g. hospitals, schools, youth services, police). The worker can also provide training at 'in-services' for local agencies.

Community events, such as drug- and alcohol-free entertainment, can be timed to link with drug action week, youth week or other key dates. Sometimes a visiting event or program, such as 'Vibe 3-on-3' or another sporting or cultural occasion can provide the focus.

If the worker is not from the community, they need to understand the local cultural protocol, which is different from area to area. Working with a local person is a good way to learn about this. Also, talking to senior groups is helpful. In general you should ask permission from relevant community leaders before running a community event. There may be something else important planned for that date. You should also consult with community members on how to run a culturally-specific community event. There may be gender-based barriers; for example, a male drug and alcohol worker may not be able to talk about Foetal Alcohol Spectrum Disorders, while sometimes community leaders may give permission for a male to talk about women's issues. Always seek local advice.

These issues are important, even in the city, but are particularly important in a rural and remote setting. If you are seen to be doing the right thing and respecting community, you are much more likely to get community support.

Getting to know the community

If you are new to a remote community, you should go out and speak with local elders or leaders of each clan group (male and female). Introduce yourself, say where you are from, a bit about yourself and who invited you, and ask permission to offer to give some education or to plan an event on drug and alcohol issues. They will tell you what you can talk about and what you cannot, and also advise on any other cultural barriers you may face.

You can also ask community leaders: "Is there anything else you want us to talk about?" This way, the leaders can advise on particular local issues. What is important to you as a drug and alcohol worker may not be important to the community – so it is important to line up your efforts with community priorities.

GETTING COMMUNITIES THINKING AND ACTING

How to prevent drug and alcohol problems from ever starting

You may be able to help provide support to programs that are already running; for example, camps, disco nights, competitions, sports days and other activities. These activities are alternatives to substance use and can help address boredom and isolation, and also help bring communities together. Cultural activities (including painting, dance, fishing, hunting) also play an important role and can help to make individuals and communities stronger. Sometimes the most valuable education opportunities

happen in a more informal setting when people are relaxed. Other times, if you are new to the community or the role, you may not do any education, but merely let the community have time to get to know who you are and what your role is.

Communities need holistic support, not just education on facts about drug and alcohol issues. Many communities are well aware of the harms of drugs or alcohol, and in some communities education has been 'done to death'. Practical support, like helping people get to a camp, can help. Actually being in the community, and taking the opportunities that arise to offer support or to provide education, can often be more important than a formal education session, particularly in remote settings. In cities, because of the larger population, more structured approaches may also be needed; for example, holding an event at a set time.

If education is to be given around drugs and alcohol, it should be tailored to that community. In a rural setting, you can seek advice on the best setting (e.g. camp, community meeting room).

You need to carefully think about what type of education is offered; for example, what gender and age groups will be invited to attend, and whether you will be speaking to groups who already have problems (sometimes or all the time), or to groups with a mix of people. There is a risk that if you just tell young people about the harms of drugs, they may get curious and want to try them. However, if a person is already using drugs or alcohol, then education to reduce the harms is very important. If you are not sure about these issues, seek advice and training from someone trained in health promotion.

It is also important to be sure that your knowledge is up to date (see *Keeping up your skills*, p. 406).

How to help people or communities with drug and alcohol issues

Sometimes the person's alcohol or drug issues may be not their main concern, but a symptom of other major problems, such as overcrowded housing, family violence, lack of employment or money problems. Tackling those underlying problems, for the individual and the community, can be the key to moving forward.

Some communities may decide that there are so many alcohol problems that they would like to restrict access to alcohol, either for the whole community or certain areas (dry areas). This chapter also talks about how this can be done, and what communities can do about clubs, bottle shops or other locations that are not responsible in how they sell alcohol.

Cultural reasons why some staff may not be able to work with other staff

Be aware that some workers may not be able to talk to particular people because of family relationships (kinship), e.g. they cannot talk to their cousin or father-in-law because of cultural reasons. Do not assume that the worker is 'not doing their job' as there may be other reasons why they appear to not want to talk to a particular community member.

Working with the shopkeeper or other supply source can also be important in addressing issues such as glue, other inhalants and tobacco. Simple measures like keeping glue out of reach (e.g. up high on a shelf) or behind the counter can make a difference.

The role of locally developed messages about alcohol or drugs

It can be useful to work with community leaders, other community members and agencies (such as health and education) to raise awareness that sickness can be caused by alcohol or drugs. If the community speaks their own language, it can be useful to use messages about sickness in the local language and building on local understandings and concepts.

To address their own drug and alcohol use

In some Aboriginal communities, non-drinkers may be concerned if a worker drinks at all, even if that worker only drinks a small amount. Workers need to be aware that drugs and alcohol are sensitive areas. In a small community, the worker should try to be discreet. For example, if the worker is seen every night at the pub drinking until closing time, they may lose credibility when working with their community to address alcohol issues. On the other hand, if they have a quiet drink at home (only if they do not live in a dry community!) this may not be an issue for the community.

Where the health worker is a smoker, and needs to do community education around smoking, this can be challenging. Both discretion and honesty are needed, but key information can still be provided to the community on how to access support to cut down and quit cigarettes.

The community's strengths and barriers to address drug and alcohol issues

Every community has its own priorities, and also its own strengths and barriers to address drug and alcohol issues. It is important to understand these, and also any specific challenges that the community may have to tackle.

How to reduce the harms of drug and alcohol issues even if the user does not want to change

Even if a community cannot change the level of alcohol or drug use right now, there may be things that they can do to reduce the harms from alcohol, tobacco or other drug use. Work with the community to help identify measures that could work (e.g. night patrol).

You may also need to work with the community sensitively if there is concern about harm reduction measures such as Needle and Syringe Programs.

Providing alternative night-time activities can help to reduce harms among young people and young adults. Simple measures like turning off the lights at the basketball courts at 10pm could be tried to encourage people to go home. Having well lit streets can also discourage dangerous or illegal activities.

Ideally police would also work with communities to tackle drug and alcohol issues, and to respect community priorities and ways of working within local cultural protocols. There are examples of police officers who do this very well, and others who struggle.

Working between agencies (e.g. schools, sport and rec, health, family support agencies; in both government and non-government agencies) can greatly increase your chance of a community-wide effect.

As a drug and alcohol worker there are a lot of challenges; however, your work with community can make a big difference. There are many examples where communities have made big changes, when they are supported by key agencies.

What communities can do to prevent or limit drinking problems

STOPPING ALCOHOL PROBLEMS BEFORE THEY START (PREVENTION)

Keeping communities and families strong and connected can help reduce the chance of young people ever developing alcohol problems. Increasing the opportunities for young people and all community members to be involved with culture, education and training, jobs, and sport and recreation are important.

As well as this, communities can try to either lessen people's interest in alcohol (demand reduction) or they can try to reduce its supply (supply reduction). Education about the harms of alcohol has a useful role, but of course many families already know many of the harms of alcohol all too well. They often have seen these harms first-hand. But families may not be aware of the silent harms from alcohol (e.g. that alcohol makes them more likely to develop diabetes or high blood pressure, that it interferes with sleep and causes depression and anxiety). Education programs that help give young people the skills to say 'no' to alcohol when others around them are drinking can also be useful.

It can be a challenge to get a community to change how they think about drinking, so that more people can stop at one or two drinks, and not put themselves at risk by drinking to intoxication.

We know that limiting the supply of alcohol (including the number of pubs, and the times they open) is more effective than education in reducing the harms from alcohol. This can include trying to keep children or young people under 18 years of age from having access to alcohol.

Having good treatment available for parents and friends with alcohol and drug or mental health problems will help make life easier for their children, and so help prevent alcohol problems being passed on from one generation to the next.

LIMITING THE SUPPLY OF ALCOHOL

The more alcohol that a community drinks, the more chance of short-term harms like fights and assaults, car accidents and other injuries. Also, there is more chance of long-term harms like brain damage and liver cirrhosis. The amount of alcohol that is consumed in a community depends on how much is made available by those who sell it (supply), and how much community members want to drink (demand). To reduce the harms from drinking too much, we need to: reduce the 'supply', reduce the 'demand'

for alcohol and use strategies to reduce immediate harms from drinking (e.g. using community patrols and sobering-up shelters). This section talks about some ways to limit the supply of alcohol in communities to help reduce harms seen from drinking.

Existing liquor licensing laws

In Australia, to address the problems seen from drinking, all states and territories have liquor laws, which restrict the supply of alcohol. This includes:

- Restricting who can sell alcohol, i.e. can only be sold by people who have a license (known as ‘licensees’) and their employees.
- Alcohol can only be sold from venues that have a liquor license (‘licensed venues’), e.g. hotels, taverns, nightclubs and restaurants.
- Making sure that the way alcohol is sold in licensed venues is responsible (‘responsible service of alcohol’), i.e. not serving to people who are drunk.
- Restricting who is allowed to buy alcohol or who alcohol can be sold to, e.g. young people aged 17 years or younger (‘minors’) or people who are intoxicated are not allowed to buy or be supplied with alcohol.
- Restricting the days or times during the day when alcohol can be sold.

It is important that these laws are enforced to help reduce the harms from problem drinking. Any breaches of these laws should be reported to liquor licensing authorities or to the police.

Some situations when liquor licensing laws are used

- *If a new venue wants to sell alcohol:* an application to sell alcohol needs to be made to the liquor licensing office in your state or territory. Individuals or communities can object to applications being made to grant new licenses by contacting the same liquor licensing office.
- *If an existing venue wants to change when and how they are allowed to sell alcohol:* the person or people who have a liquor license (‘licensees’) are allowed to apply to change the conditions under which their original license was granted. For example, they may want to increase the sales of alcohol by extending their trading hours or expanding the size of their premises. But licensing laws also allow for individuals or communities to object to any proposed changes if they believe the changes are likely to increase alcohol-related harm.
- *If communities or individuals want to object to how alcohol is being sold from a particular venue:* liquor licensing laws allow for individuals or communities to object to how alcohol is sold if they believe the licensee is not following the conditions of their liquor license and/or if they are worried about alcohol-related harm occurring as a result of drinking at a particular venue or in the community generally.

Liquor licensing offices in each state and territory

<i>Australian Capital Territory</i> www.ors.act.gov.au/community/liquor	<i>South Australia</i> www.olgc.sa.gov.au
<i>New South Wales</i> www.olgr.nsw.gov.au	<i>Tasmania</i> www.gaming.tas.gov.au
<i>Northern Territory</i> www.nt.gov.au/justice/commission	<i>Victoria</i> www.responsiblealcohol.vic.gov.au
<i>Queensland</i> www.olgr.qld.gov.au	<i>Western Australia</i> www.rgl.wa.gov.au

OTHER LIQUOR RESTRICTIONS

The licensing laws discussed above may differ between individual states or territories. In addition to these general restrictions, licensing laws also allow people to apply for additional restrictions in particular towns or on particular licensed premises. Some of these other ways that supply of alcohol can be restricted to help communities address drinking are discussed below. Communities should contact the liquor licensing office in their state or territory to talk about how they can apply for additional restrictions on alcohol supply.

Restrictions on trading hours

Efforts to reduce trading hours for drinking in a venue ('on-premises consumption') and to reduce when people can buy alcohol to drink at home ('takeaways') can help address problem drinking and related harms. In Australia, some community groups have successfully lobbied for reductions in trading hours in towns such as Alice Springs and Tennant Creek. At one time in Tennant Creek, there was a complete ban on takeaway sales on Thursdays (sometimes known as 'thirsty Thursday').

Restrictions on the sale of low-cost beverages

The cheaper alcoholic drinks are, the more alcohol is consumed. The cost of a 'standard drink' – a drink containing 10g of pure alcohol – varies considerably because of the costs of making, packaging and distributing it and also because of the tax on alcohol. In many communities, bans have been placed on the sale of cask wine in containers of more than two litres – as alcohol sold in this way is usually cheaper and gives drinkers 'more bang for their buck'. Limiting the availability of low-cost drinks has shown to be an effective way to help reduce problem drinking.

Other price controls

Another effective way to reduce how much people drink is to make alcohol more expensive. This has been shown to help reduce how much alcohol is consumed by heavier as well as the more moderate drinkers. As we have seen, banning low-cost drinks such as cask wine can be effective at the local level. One of the most effective ways to reduce the availability of cheap alcohol more broadly is to increase the tax on alcohol. Unfortunately, successive Commonwealth Governments – which have responsibility for alcohol taxation – have been reluctant to make the necessary changes, but several groups around the country continue to lobby for changes to be made in relation to tax on alcohol.

Another way to increase the cost of alcohol is to set a minimum price below which a standard drink cannot be sold. This is sometimes called a ‘floor price’ (e.g. prohibiting the sale of alcohol below the price of a middy or pot of beer). This has not been tried in Australia, but state or territory governments are able to implement it, and groups in the NT have been strongly lobbying the NT Government to do this.

Reducing the number of licensed premises

The level of drinking is related to the number and types of licensed premises. As far back as the Royal Commission into Aboriginal Deaths in Custody, there have been calls for governments to reduce the number of licensed premises in some towns. Governments have generally been reluctant to do this, but in Alice Springs community lobbying has led to the ‘buy-back’ of three liquor licenses.

Dry community declarations

Depending on the state or territory, under either liquor licensing laws or Aboriginal land legislation, it is possible for some discrete Aboriginal communities to declare their communities ‘dry’ – that is, to prohibit the sale or consumption of alcohol within their boundaries. These bans have generally proven to be effective in reducing both the health and social problems associated with alcohol consumption.

Local dry areas

In some areas, local or state/territory governments have banned the consumption of alcohol in certain public areas within towns (such as in Adelaide or Port Augusta) or within a certain radius of licensed premises (as under the ‘Two Kilometre Law’ in the NT). Unlike ‘dry community declarations’, these have not shown to be effective. They simply move public drinking to other areas – often where there are fewer controls over drunken behaviour.

Liquor licensing accords

In some places, local licensees have agreements or ‘accords’ among themselves to impose voluntary restrictions on the sale of alcohol. These accords can have some benefits, but unlike the restrictions discussed above – which are imposed (often as a result of community lobbying) by licensing authorities or other government agencies – these accords cannot be enforced by law. This, along with the commercial self-interest of licensees, can limit their effectiveness.

Prohibiting sales to Aboriginal people

While some of the restrictions discussed above may be implicitly targeted at Aboriginal people, they do not discriminate in that they apply to all citizens within the set areas. However, in some places (such as Curtin Springs in the NT) Aboriginal communities have applied for the prohibition of sales to local Aboriginal residents. This requires application for a special exemption under the Racial Discrimination Act. Without such an exemption, this restriction is illegal.

Evasion of restrictions

Wherever restrictions on the supply of alcohol exist, there will be some people who try to get around them; for example, by ‘sly-grogging’ or by buying alcohol to drink from other towns. However, despite these attempts to get around restrictions, most communities and experts find that the benefits of restricting the supply of alcohol outweigh the harms.

SUMMARY

As well as the liquor licensing laws that apply generally across states and territories, there are additional restrictions on the supply of alcohol that communities can lobby for. The evidence shows that where restrictions are enforced (in a culturally sensitive manner), most are effective. However, restrictions on supply are not a simple solution. They need to be used alongside measures such as treatment, education and strengthening communities and young people (to reduce the demand for alcohol). They also need to be combined with measures to address the harms here and now, using approaches such as community patrols and sobering-up shelters (harm reduction).

FURTHER READING

Go to the Indigenous HealthInfoNet website and type *alcohol restrictions* in the search box: www.healthinfonet.ecu.edu.au.

16

Special situations, settings and groups

<u>Contraception</u>	344
<u>Pregnancy, breastfeeding and early childhood</u>	349
<u>Alcohol use in pregnancy and Foetal Alcohol Spectrum Disorders</u>	364
<u>Protecting and supporting families at risk</u>	369
<u>Preventing alcohol or drug issues among young people</u>	378
<u>Working with young people with alcohol or drug issues</u>	381
<u>Prison populations</u>	385
<u>Aggressive clients</u>	398
<u>Torres Strait Islanders</u>	403

Contraception

OVERVIEW

Choosing when and if to have children is an important decision. In Australia, different ways to prevent pregnancy are available and this is known as 'contraception'. Each type has advantages and disadvantages. Contraception may also have other health benefits. This section describes different contraception options available in Australia for men and women.

COMBINED ORAL CONTRACEPTIVE PILLS

The tablet is taken by women, and is simply known as 'the pill'. It contains small amounts of two hormones – progestogen and oestrogen.

How reliable are combined oral contraceptive pills?

Out of every 100 women using the pill, one or two might get pregnant in a year.

Key tips about the pill

- Needs to be taken every day (one tablet)
- Sometimes may cause: irregular bleeding, headache, feeling sick in the stomach (nausea), sore breasts, mood changes and pimples
- Cannot usually be used by women who:
 - Have had liver disease
 - Have high blood pressure
 - Smoke
 - Are over 35 years of age
 - Have had a blood clot or stroke
 - Have had breast cancer
 - Have had diabetes for many years
 - Who take some medicines for epilepsy
 - Have severe migraine with loss of sight
 - Are breastfeeding
- Health benefits include: more regular, lighter and less painful periods.

PROGESTOGEN ONLY PILLS

Progestogen only pills contain only one hormone and are used when women are breast-feeding or for women who are unable to take the combined oral contraceptive pill.

How reliable are progestogen only pills?

Progestogen only pills are not as reliable as the combined oral contraceptive pill. But they are still reliable if taken using the instructions from your doctor. Out of every 100 women using this method, two or three might get pregnant in a year.

Key tips about progestogen only pills

- Needs to be taken every day and at the same time (one tablet)
- Bleeding changes are common
- Safe to use when breastfeeding.

INJECTABLES ('DEPO')

Contraceptives that can be injected contain the progestogen hormone and are known as 'Depo' (Depoprovera). Depo is injected into muscles (most often on the bottom) every 12 weeks.

How reliable are injectables ('Depo')?

Because a woman does not need to remember to take a tablet, Depo is very reliable. Out of 100 women using this method, less than one might get pregnant in a year.

Key tips about Depo

- Injection needs to be made every 12 weeks.
- Bleeding changes are common, especially after the first injection.
- May cause: weight gain, mood changes and headaches. These side effects may take a while to settle down.
- Women may not be able to get pregnant straight away after stopping.

IMPLANTS

Implants contain the progestogen hormone. They are plastic rods about 4cm long that are put under the skin, often in the upper arm. In Australia, 'Implanon' is the available implant. Implants can be felt under the skin and are easily removed by a trained health professional.

How reliable are implants ('Implanon')?

Out of 100 women using this method, less than one will get pregnant in a year.

Key tips about implants

- Last for three years
- Bleeding changes are common
- May cause: weight gain, mood changes and headaches
- Needs to be inserted under the skin by a trained health professional.

INTRAUTERINE DEVICES (IUDS)

Intrauterine devices are placed inside the woman's uterus. There are two types: the copper type that lasts for 5–10 years (depending on the type) and the hormone IUDs that last for 5 years and contain progestogen.

How reliable are intrauterine devices (IUDs)?

They are one of the most effective forms of contraception. Out of 100 women using this method, less than one will get pregnant in a year.

Key tips about IUDs

- Needs to be inserted into the uterus by a specifically trained health professional
- Can last 5–10 years depending on the type
- May cause bleeding problems: copper IUDs can make periods heavier and hormone IUDs can make the periods irregular.

CONDOMS

Male condoms

Male condoms are usually made of latex rubber and stop the sperm from the man meeting the egg in the woman. They also help protect against sexually transmissible infections (STIs) (see STIs, p. 284). Condoms need to be put on the penis before any sexual contact is made. They are cheap and widely available to buy. Some men believe that they have less sensation during sex when using condoms but for most men this is not a problem.

Female condoms

Female condoms are made of plastic and sit inside the vagina. They have a ring at the top, which is placed inside and a ring at the bottom, which holds the condom outside the vagina. They prevent pregnancy by stopping the sperm meeting the egg, and also protect against STIs (see STIs, p. 284). Female condoms are available at chemists, but are more expensive than male condoms and not as easy to use or buy.

How reliable are male and female condoms?

Male and female condoms are not as reliable as pills, implants or IUDs.

Male condoms: out of 100 women, 15 will get pregnant in a year. If this method is used perfectly every time, two women will get pregnant.

Female condoms: out of 100 women, 5–15 will get pregnant in a year.

Key tips about male and female condoms

- Need to be used every time and in the correct way following the instructions
- Need male and/or female partners to work together to use them properly
- Helps to protect against getting STIs, including HIV.

EMERGENCY CONTRACEPTION (THE MORNING AFTER PILL)

If a woman has sex without protection, emergency contraception is available to help prevent pregnancy. Two options are available:

- Taking a pill called ‘Postinor’ – contains a progestogen hormone and can be bought from a chemist
- Getting a copper intrauterine device inserted by a doctor.

How reliable is emergency contraception?

Emergency contraception is not as reliable as using condoms, pills or other methods described above. The morning after pill will prevent about 3 in 4 pregnancies.

Key tips about emergency contraception

- Taken after sex to prevent pregnancy
- Should be taken as soon as possible after sex and within five days
- Copper IUDs need to be inserted by a doctor within five days of sex.

STERILISATION

Female sterilisation

Women who are sure that they do not ever want to get pregnant can be sterilised using a procedure called a 'laparoscopy'. In this procedure, a camera is put into the woman's belly – and then clips are used to block the tubes, which carry the women's egg to her uterus. This prevents the sperm meeting the egg.

Male sterilisation

Men who are sure that they do not ever want to have children can be sterilised using a procedure called a 'vasectomy'. In this procedure, the tube that carries the sperm out of the scrotum is blocked. Vasectomies are usually done under a local anaesthetic. Three months after the operation the man needs to check that no sperm is able to get through the blockage to be sure that the operation has been successful.

Key tips about female and male sterilisation

- They are permanent options – as it is not usually possible to reverse either procedure.
- Both procedures involve surgery but male sterilisation can be done under a local anaesthetic.
- Neither method affects the ability to enjoy sex.
- There are no other side effects.

FURTHER READING

For fact sheets for clients and information for health professionals, see: www.fpnsw.org.au.
For other information see: www.fsrh.org.

Pregnancy, breastfeeding and early childhood

OVERVIEW

It is particularly important to understand substance use in pregnancy, because it can harm the unborn baby. It is even more important to know when to organise medical care to help a woman who is dependent on alcohol, opioids or benzos to stop safely. If the woman goes through withdrawals, this can harm the developing baby. Treatment can prevent withdrawals.

Sometimes if a mother is dependent on alcohol or a drug, the newborn baby may go through withdrawals. This is known as Neonatal Abstinence Syndrome (NAS) and can usually be treated.

It is also important to be able to advise a woman who uses alcohol or drugs on how to reduce the risks to her baby, when she is breastfeeding.

This section also has some tips to support families with young children to bring up strong children.

PREGNANCY

Pregnancy is a time when a woman needs to be encouraged to look at her substance use and make positive changes. During this time, problems can happen with the unborn baby (foetus) because of alcohol or drugs. The harms may be due to:

- The drug itself: different problems happen depending on when and what drugs the woman uses during pregnancy. For example, alcohol or other substance use early in pregnancy may be more likely to result in miscarriage or physical abnormalities, while later in pregnancy the risk may result in slowed growth of the foetus or even death of the unborn baby.
- Other substances mixed in with the drugs: illegal drugs are not chemically pure and may be cut with other unknown and toxic substances. These substances can be dangerous to an unborn baby.
- Withdrawal: the stress of the mother's withdrawal can be harmful to the baby.
- Neglecting care of oneself and from the risks typically seen with a lifestyle of using alcohol or drugs: women who are dependent on a drug may not eat a good diet and may be exposed to risky situations including violence.
- Where the mother is physically dependent on alcohol, or some other drugs (particularly benzos and opioids), the baby may go through withdrawal when born (Neonatal Abstinence Syndrome).

Alcohol and pregnancy

Drinking alcohol during pregnancy can lead to the following problems in the baby:

- Miscarriage, stillbirth, and premature birth
- Foetal Alcohol Spectrum Disorders (FASD), which can include problems with brain development, behaviour and abnormalities of the face (see FASD, p. 364 and p. 206)
- Babies who do not develop as well as others (e.g. slowed growth).

The safest option for pregnant women and women who are planning to have a baby is not to drink at all.

Tobacco and pregnancy

Carbon monoxide in cigarettes reduces the amount of oxygen getting to the baby, and increases the chances of the following problems:

- Miscarriage, stillbirth, and premature birth
- Problems with the placenta getting nutrients and oxygen to the foetus (placental insufficiency)
- Breathing problems and infections in the newborn baby
- Sudden Infant Death Syndrome (SIDS or 'cot death')
- Middle ear infections which can lead to hearing loss (otitis media)
- Babies born too small.

There is no safe level of smoking in pregnancy. The more cigarettes smoked the more likely the chance of problems. Even passive smoking in pregnancy and after birth increases the risk of SIDS (cot death), breathing problems, and chest infections in the baby.

Caffeine and pregnancy

Drinking large amounts of caffeine (600mg or more a day) during pregnancy may lead to the following problems in the baby:

- Miscarriage and stillbirths
- Lower birth weights.

Pregnant women should keep their caffeine down to 200mg daily (i.e. this is no more than one large cup of drip coffee or espresso; and this is the same as two cups of instant coffee, 3–4 cups of tea or cocoa, or three cans of cola).

Cannabis and pregnancy

There is not a lot of information about the effects of cannabis use in pregnancy. However, THC (the active ingredient in cannabis) can cross from the mother to the developing baby.

Cannabis use in pregnancy may lead to the following problems in the baby:

- They grow less well (e.g. weight and length)
- Birth defects
- Sleep problems
- Later problems with short-term memory and concentration.

People often mix cannabis with tobacco, which can further increase the harms. Any smoking can reduce the amount of oxygen and nutrients going to the foetus.

Opioids and pregnancy

Opioids (e.g. heroin, Oxycontin, codeine, morphine, fentanyl) are not linked to birth defects but the ‘highs and lows’ of intoxication and withdrawal can be harmful to the unborn baby. Withdrawal between doses can lead to miscarriage or a premature baby. It is important not to go ‘cold turkey’ in pregnancy. If a pregnant woman is in withdrawal (‘hanging out’), her unborn baby will also be hanging out and will not grow well.

Heroin and other opioid use may lead to the following problems in the baby:

- Miscarriage, stillbirth, and premature birth (particularly if opioid use is stopped suddenly)
- Infections from injecting which can harm the mother and the baby
- Poor growth before birth (i.e. the baby is small for how many weeks it has been growing)
- SIDS.

Methadone is safer for a pregnant woman than heroin because the woman is no longer cycling between intoxication and withdrawal. Her life is more stable and she can eat a proper diet. Also, while the woman is coming to get her methadone, the treatment team can help link her with health care for her pregnancy.

Stimulant use and pregnancy

Cocaine and amphetamines make the heart rate in the mother and foetus go up. The blood vessels in the mother and in the placenta get smaller (constrict), which then reduces the blood supply to the baby. This means that the baby then gets less oxygen and nutrients than are needed for healthy growth and it may be born small. If cocaine causes a blood vessel in the baby's brain to spasm, an area of brain can die, and this can lead to stroke (i.e. like in an adult). Cocaine and amphetamines may cause the placenta to break away from the wall of the womb (placental abruption). This is life threatening for the mother and baby.

We do not know a lot about the effects of ecstasy (MDMA) use in pregnancy. But because it is a stimulant it may cause harm. Ecstasy tablets also often contain other drugs that are more risky such as methamphetamine.

Stimulant use in pregnancy may lead to the following problems in the baby:

- Miscarriage, premature birth
- Slow growth (small for how many weeks the baby has been growing)
- Stroke or heart failure
- Deformities (heart, face, kidneys, arms, legs)
- Damage to baby's brain.

Benzos and pregnancy

Benzos cross the placenta and are passed from the woman to the developing baby. However, the risk to the baby is thought to be low. There may be a slight increase in the risk of cleft lip or cleft palate. This could depend on the amount of benzos used and at what time during pregnancy they are used. Benzo withdrawal can lead to miscarriage or premature birth, so it is important not to suddenly stop benzo use while pregnant.

Inhalants and pregnancy

Inhalants contain many toxic substances, which are harmful to both mother and baby. It is believed that nearly all inhalants cross the placenta and enter the baby's bloodstream. For this reason, it is important to stop using inhalants during pregnancy.

Inhalants can lead to the following problems in the baby:

- Premature birth
- Problems with brain development and later learning ability
- Breathing problems
- Increased risk of infection
- Neonatal Abstinence Syndrome (NAS).

Vitamins and medicines in pregnancy

Women with alcohol and other drug use issues may have lower levels of some vitamins and minerals. It is good for the woman to have a medical check-up when they find they are pregnant and to have some blood tests.

Vitamin supplements

- Folic acid is recommended before pregnancy and in first three months to prevent serious problems with the brain and spine (e.g. spina bifida). It is okay to take folic acid (also known as folate) throughout pregnancy.
- Other vitamin supplements may be needed if blood tests suggest levels are low (e.g. iron, vitamin D).

A woman should talk to a doctor about any medicines she is taking to check they are safe to take during pregnancy. Sometimes another medicine might be safer.

Tips for discussing substance use with pregnant women

- Shame and stigma might make it difficult for pregnant women to talk about their substance use.
- Avoid focusing on the substance use issues right away – get to know the woman first.
- Be positive when delivering messages about substance use and about any treatment options.
- It is important to look at what is happening in a woman's life and to look at the social or mental health issues related to her substance use.
- Partners and other family members are important to consider – including what alcohol or drugs they might be using.

Some of the following tips may help pregnant women give up or cut down on harmful substance use

- Talk about stressful issues with trusted women (e.g. aunties, sisters, grandmothers).
- Encourage other family members to give up or cut down their substance use.
- Try to 'get in touch' with her unborn child; for example:
 - Talk to the unborn baby and count their kicks.
 - Get copies of the baby's ultrasound images.
- Offer the pregnant woman encouragement for any changes they are able to make.

Antenatal care and child protection services

It is important that a woman see her doctor or midwife (i.e. to book in for antenatal care) as soon as they learn they are pregnant. This can help ensure the baby is as healthy as possible. It is also important that a woman sees her doctor if she has any unexpected symptoms during pregnancy or if she thinks the baby is not moving or not moving as much.

Some women attending drug treatment may worry about seeking regular help for themselves and their unborn baby (antenatal care) because they are afraid that their baby might be taken away by child protection services (see Protecting and supporting families, p. 369). However, if they do not enrol in antenatal care, then child protection services may be involved anyway. Therefore, it is important for mothers to get antenatal care.

HOW TO HELP A PREGNANT CLIENT WHO USES ALCOHOL OR DRUGS

Standard brief intervention and counselling approaches can be used (see Counselling, p. 20).

Treatments for alcohol

- Women who get withdrawals when they stop drinking (e.g. feel sick, get the shakes, feel jittery, sweaty and anxious) may be alcohol dependent. Pregnant women who get withdrawals when they stop drinking should seek medical help to stop drinking. This is especially important if the woman usually has seizures when she stops.
- Sometimes alcohol detox can be undertaken at home or as an outpatient in a clinic. It is better for pregnant women to detox in a hospital or detox centre. This usually takes about a week (see Alcohol withdrawal, p. 87).
- Relapse prevention medicines cannot be used during pregnancy because we do not yet know how safe they are (e.g. Campral, naltrexone, Antabuse).
- Other treatments can still be used, such as counselling and mutual support groups (e.g. Alcoholics Anonymous).

Treatments for smoking

- As well as standard brief intervention and counselling approaches, referral to smoking cessation groups or support options like Quitline (phone: 131 848) may also be helpful.
- Because pregnant women often feel guilty about their smoking, it is important to point out that every cigarette cut down is helping the mother and the baby. Stopping late in pregnancy is better than not stopping at all.

- Smokerlysers are expensive; however, if available they can help show a woman how much carbon monoxide she has in her body and how much the baby will be getting from her smoking.
- Pregnant women could try going ‘cold turkey’ first, but those with higher levels of dependence can use short-acting NRT like gum, lozenges, microtabs and inhalers. Patches are generally not suitable for pregnant women, although sometimes a specialist may recommend them. If in doubt, you or the woman can ask her obstetrician for advice. Champix and Zyban are not used in pregnancy.

What to do if the woman cannot or will not stop smoking

- Women with babies need to be advised to go outside to smoke, to avoid smoking in cars and avoid smoke-filled places.
- Women with babies can put a jacket on over their clothes when they smoke and remove it before touching the baby.

Treatments for caffeine

Women who drink large amounts of caffeine may have withdrawal symptoms such as severe headaches and irritability if they suddenly stop. They should cut down gradually and can have decaf (decaffeinated) tea or coffee instead. Check with one of the agencies (p. 363) before using herbal teas (apart from chamomile or lemongrass which are fine to drink), because some herbal teas can be harmful during pregnancy.

Treatments for cannabis

- Counselling is the best available treatment for people who are dependent on cannabis. Finding new and healthier ways to deal with stress or boredom is important.
- A supervised medical withdrawal may help some women with withdrawal symptoms such as nausea and vomiting, anxiety, sleep problems and depression. Medicines to relieve these symptoms (e.g. Maxolon to reduce vomiting and diazepam to help with anxiety and sleep) are safe for short-term use in pregnancy (3–7 days).

Treatments for opioids

Pregnant women should not stop opioids (e.g. heroin or methadone) suddenly. Medical supervision is essential for the safety of the growing baby. Methadone is the best treatment for pregnant women who are dependent on opioids.

Methadone treatment

- Sometimes it takes a while for a woman to become stable on methadone and she might use heroin on top of her methadone. If this happens, encourage your client to smoke heroin rather than inject to reduce the risk of infections (e.g. endocarditis, blood infections). These infections are very serious in pregnancy.
- It is possible for women to be admitted to hospital for a few days to stabilise on methadone more quickly. If her partner or others living with her use heroin, they should also be offered methadone or buprenorphine because it is hard to stay clean if others around you are using.
- Some pregnant women worry about methadone treatment because it takes a long time to reduce off. But methadone is considered the safest treatment for opioid dependence in pregnancy.
- Clients may also have heard that pregnant women on methadone are automatically reported to the child protection agency. However, being on methadone does not mean an automatic report to the child protection agency; in fact it can show the agency the client is trying to get her drug use under control. If a woman feels pressured by the child protection agency to stop methadone, she can ask her doctor to ring her child protection caseworker.
- Women on methadone should sip their dose slowly and wait for 20 minutes before leaving the clinic or chemist. This may reduce the chance of vomiting in women with morning sickness. Your client can also get tips from their midwife about dealing with nausea.
- Pregnant women often have to increase their methadone dose because of changes to the body during pregnancy. You can reassure your client that withdrawal in the baby is not related to the mother's methadone dose.

Buprenorphine treatment

Because buprenorphine is a newer medicine, we still do not know a lot about how it affects the developing baby. Because of this, there are warnings about the safety of buprenorphine in pregnancy and some women switch to methadone. But some women stay on buprenorphine without any problems. It is best for the client to make the decision with her prescriber.

Treatments for benzos

Pregnant women should not stop taking benzos suddenly and should get medical advice. Benzo withdrawal in pregnancy needs to happen very gradually to avoid distressing symptoms for the mother and her unborn baby.

Some women can be weaned off benzos while still staying at home (in an outpatient setting) with medical supervision and counselling. But some women need the support and supervision of inpatient withdrawal.

Some women cannot manage to stop benzos completely before the birth; however, it is important to reduce down to the lowest possible dose. The baby's withdrawal is usually less complicated if the mother's benzo use is very low.

NEONATAL ABSTINENCE SYNDROME (NAS)

When a mother is dependent on alcohol or drugs and uses during pregnancy, the baby may go into withdrawal when they are born. This is known as Neonatal Abstinence Syndrome (NAS). NAS happens because the baby is no longer exposed to the substances taken during pregnancy. NAS can cause the baby to be unsettled and can affect feeding.

NAS may occur in babies when the mother has used opioids, benzos, alcohol, tobacco, inhalants, stimulants, and caffeine.

It is hard to predict whether or not a baby will get NAS. Reducing or stopping drugs other than methadone will help reduce the chance of the baby getting NAS and may reduce the severity of withdrawal symptoms in babies who get NAS.

What are the signs of NAS?

- High-pitched cry
- Irritability
- Tremors and jittering
- Sleep problems
- Stuffy nose
- Sneezing (this is a sign of NAS but can also be normal baby behaviour)
- Feeding difficulties (due to sucking problems)
- Tense arms, legs and back
- Poor weight gain
- Vomiting and diarrhoea
- Faster breathing
- Convulsions
- Skin irritation
- Raised temperature, sweating.

Most babies who experience NAS show signs 1–3 days after birth. But sometimes these signs do not appear until 5–7 days after the baby is born. The time it takes for NAS to show depends on the combination of substances used in pregnancy, particularly those used in the last three days before the birth.

NAS can last from one week to six months. The length of withdrawal also depends on the amount and type of drugs the baby has been exposed to.

How is NAS assessed?

Women who use substances during pregnancy, are on methadone or buprenorphine treatment, or are on benzo treatment may need to stay in hospital for 5–7 days after birth so that the baby can be monitored for NAS.

The baby is monitored every four hours and given a score for each symptom (using the Modified Finnegan Score). Babies may also experience these signs for other reasons, so the baby needs to be closely monitored, e.g. to make sure they do not have a fever. The baby is examined after a feed because false high scores can occur if the baby is hungry. Every baby will have an unsettled period each day. We need to keep this in mind so that normal newborn behaviour is not confused with NAS.

How is NAS treated?

If a baby has significant NAS (3 Modified Finnegan Scores of 8 or more in a row in 24 hours) they are given medicine, usually morphine and/or phenobarbitone (phenobarb). These medicines can be used separately or together depending on what substance(s) the baby has been exposed to during pregnancy.

Babies receiving NAS treatment are admitted to a nursery in hospital. Most babies respond quickly to treatment but it can take a few days for the baby to be well enough to be discharged or to be returned to the mother in the hospital ward. The medicine is usually reduced on a weekly basis until the baby is completely weaned off it. This can take quite a few weeks. Many parents are taught how to administer the medicine and how to continue giving it to the baby while at home.

NAS can make the baby very warm, so parents need to try not to use too many blankets or clothes on the baby. If a baby has a temperature over 37.5 degrees, seek medical help.

Medicines for the treatment of NAS

Morphine is an opiate medicine. Morphine is prescribed to treat the baby for opioid withdrawal, for example, if the baby has been exposed to methadone, heroin, morphine, codeine etc.

Phenobarb is an anti-convulsant and a barbiturate. Phenobarb is prescribed to babies who are withdrawing from substances such as benzos and alcohol.

Parents' feelings when their baby has NAS

It can be very distressing for the parent when their baby has NAS. They can feel a lot of guilt. These feelings are even stronger when parents are separated from their baby. One of your roles as a worker will be to support the parents through the baby's withdrawal.

BREASTFEEDING

General tips: breastfeeding and using alcohol or drugs

- Most substances pass into the breast milk. When a breastfeeding woman is prescribed any medicine it is essential to check that it is safe for use while breastfeeding. Contact the clinic, hospital or one of the agencies below if you are not sure about a particular medicine being taken and its effects on breastfeeding (see Further information, p. 363).
- If a breastfeeding woman uses cannabis, heroin, cocaine, amphetamines or inhalants, her breast milk needs to be expressed into a bottle for 24 hours and thrown away. During this time, the baby can feed on breast milk that has been previously frozen or on formula.
- If your client is intoxicated with alcohol or drugs it is important that they have someone who is not intoxicated to help them care for and feed the baby.
- It is important that someone who is sedated from alcohol or drugs does not sleep with the baby, in case they roll on the baby.
- For more information about breastfeeding, seek advice from a baby nurse or breastfeeding nurse, or from a baby or child health service.

Alcohol and breastfeeding

- The alcohol level in the mother's blood will be about the same as the baby gets in the breast milk.
- Drinking alcohol while breastfeeding can affect the baby's behaviour and development, and can cause problems with the baby's sleep.
- Drinking more than two standard drinks each day during breastfeeding can lead to less milk being produced, so the baby does not get as much milk as it needs.
- The safest option is for the woman to not drink alcohol during breastfeeding. In particular, women should avoid alcohol in the first month after delivery until breastfeeding is well established. If a woman does want to drink, she should:
 - Have no more than two standard drinks a day
 - Avoid drinking immediately before breastfeeding
 - Consider expressing milk before drinking.

Tobacco and breastfeeding

Nicotine can reduce the amount of breast milk that is produced and also change the taste of breast milk. Babies may fuss, struggle or refuse the breast because they do not like the taste. If the mother smokes more than 15 cigarettes a day, the baby can show signs of nicotine toxicity (e.g. vomiting after a feed, 'grey' skin colour, loose stools, increased heart rate and restlessness).

Caffeine and breastfeeding

Breastfeeding mothers who drink a lot of caffeine may report that their baby is jittery, colicky, constipated and generally unsettled. Caffeine may also reduce the milk supply and may contribute to an area of the woman's breasts being inflamed (mastitis). Heavy caffeine use can reduce the amount of iron in breast milk, which can then lead to the baby having a lack of iron and being anaemic.

Methadone or buprenorphine and breastfeeding

Methadone

Women can breastfeed when on methadone. A very small amount of methadone crosses into the milk; but the benefit of breastfeeding is better than a small amount of methadone getting into the breast milk. If the baby is being treated for NAS, the small amount of methadone in breast milk can help relieve the baby's symptoms. If the woman decides to wean suddenly, the baby's NAS medicine dose may need to change. The woman should let the baby's doctor know if she is planning to wean-off feeding the baby by breast.

Buprenorphine

There are warnings about buprenorphine use when breastfeeding; however, many women are breastfeeding on buprenorphine without any problems. The woman can discuss this with her prescriber or the baby's doctor.

Benzos and breastfeeding

Benzos cross into the breast milk; however, women on very low doses of benzos can breastfeed safely. It is important to talk with a baby doctor (paediatrician) about the mother's benzo dose while breastfeeding.

HEP C**Can hep C be passed onto babies from the mother?**

- Babies born to women who have hep C need to have follow-up blood tests when they are four months old and again at 18 months. The mother's antibodies to hep C will disappear from the child's blood by about 18 months; so then an accurate 'antibody test' can be done to find out if the baby has hep C.
- Children who have hep C at 18 months of age are referred to a specialist for follow-up. They may need monitoring or treatment.

Around 1 in 15 babies born to mothers with hep C have hep C passed onto them.

Can women with hep C breastfeed?

Women who have hep C can safely breastfeed. But if the nipples become cracked and bleed it is best to express the milk and discard it until the nipples have healed.

PREPARING FOR GOING HOME WITH A NEW BABY

When a woman and her baby are getting ready to go home, it is important to check that the parents understand:

- How to access family support programs and other community resources
- The importance of the baby's health record
- When to come back to the doctor or go to the early childhood centre
- How to give the baby medicine for NAS (if needed)
- How to register the baby for Medicare, birth certificate and Centrelink
- Safe sleeping for babies
- Emergency contact phone numbers (e.g. hospital, clinic or baby health centre).

EFFECTS OF ALCOHOL AND DRUGS ON PARENTING

Being intoxicated on alcohol or drugs can interfere with parenting. This can be a particular problem with alcohol and benzos, as these substances cause loss of inhibitions, and so loss of temper. Stimulants can also cause problems with anger management. It is not possible to provide safe parenting to children when a parent is intoxicated. If they cannot stop using, it is vital to get someone to care for their children while intoxicated. Withdrawal can also interfere with parenting; for example, causing the parents to be irritable (with alcohol or benzos) or have depression (with stimulants or cannabis). It is important to discuss these issues with the parents.

Safe sleeping for babies and children under the age of two-years

It is important that the newborn baby has a safe place to sleep. Bed sharing with the baby or nursing the baby in the parent's arms while affected by any substance could put the baby at risk of dying from either suffocation or overheating. It is important to have a cot for the baby to sleep in to prevent the risk of Sudden Infant Death Syndrome (SIDS).

To further reduce the risk of SIDS:

- Place the baby on their back to sleep
- Do not smoke around the baby
- Position the baby at the base of the cot
- Put the baby in clothes that may prevent overheating, like cotton
- Do not cover the baby's head.

If your client has any further questions on how to reduce SIDS, suggest that they ask their midwife or doctor or contact the SIDS foundation on 1300 308 307, or from the local clinic in smaller communities. Brochures about SIDS can be found at: www.sidsandkids.org/safe-sleeping/.

Supporting a family to care for a baby or young child

Early in life is when a child's sense of emotional wellbeing is strongly shaped. So supporting families with young children is an important way to help bring up strong children, and end up with young people who are able to cope with the stresses of life. People who have had a supportive and loving home life are less likely to run into problems with alcohol or drugs later in life (see Protecting and supporting families, p. 369).

Further information on drugs in pregnancy and breastfeeding

Australian Capital Territory

ACT Drug Information Service

Canberra Hospital

Ph: 02 6244 3333

New South Wales

Mothersafe

Ph: 9382 6539 (Sydney)

Ph: 1800 647 848 (Rest of NSW)

Northern Territory

NT Department of Children and Families

Web: www.childrenandfamilies.nt.gov.au/Families/

Queensland

Queensland Government Community

Child Health Service

Web: <http://www.health.qld.gov.au/cchs/default.asp>

South Australia

Women's and Children's Hospital

Ph: (08) 8161 7222

Victoria

Royal Women's Hospital

Ph: 03 8345 3190

Monash Medical Centre

Ph: 03 9594 2361

Western Australia

Women's and Children's

Health Services

Ph: 08 9340 2723

All states and territories

NPS Medicines Line

Ph: 1300 MEDICINE (1300 633 424)

FURTHER READING

For resources for health care workers and parents about Foetal Alcohol Spectrum Disorders: www.nofasard.org.

Information about SIDS and kids: www.sidsandkids.org.

Alcohol use in pregnancy and Foetal Alcohol Spectrum Disorders

OVERVIEW

Alcohol is a poison in pregnancy (a 'teratogen') that may damage an unborn child (foetus). It particularly affects the brain. When a woman drinks while pregnant, alcohol moves through her body ('circulates') in the bloodstream, and also enters the baby's bloodstream in the same concentration. So, the more a woman drinks, the higher the chance of damage to the unborn child. The range of clinical problems caused by drinking during pregnancy is described by the term Foetal Alcohol Spectrum Disorders (FASD). We need to do more to prevent FASD and also to support the families who are already caring for individuals with FASD.

How common is alcohol use during pregnancy?

In Australia, more and more women are drinking alcohol at risky levels. During pregnancy, drinking by women is also common – up to 7 in 10 women in some studies. About the same numbers of Indigenous and non-Indigenous women drink during pregnancy, but Indigenous women are more likely to 'binge' ('i.e. have five or more drinks in a single drinking occasion). Because up to half of all pregnancies are not planned, many women may expose their unborn child to alcohol even before they realise they are pregnant.

HOW CAN ALCOHOL HARM AN UNBORN CHILD?

When pregnant women drink too much alcohol it can cause:

- Miscarriage, or for the baby to be born early (premature) or stillborn
- Damage to the developing brain of the child. This means that the child may have problems as they grow up with their learning, speech and language, school performance, behaviour and mental health.
- Problems with how well various organs in the body form and grow (including the heart, kidney, eyes and ears). This can cause poor health and problems with hearing and vision.

- Changes in the face: features such as small eyes, thin upper lip and a long, flat area between the upper lip and the bottom of the nose ('philtrum'). Note: birth defects and abnormalities of the face only result from exposure to alcohol during the first 12 weeks (trimester) of pregnancy, when body parts are forming (see FASD, p. 206).
- Damage to the brain – this damage may not be visible to health professionals even on brain scans, but changes to the cells and chemicals in the brain may cause problems with how the brain works.
- Poor growth before and after birth.



Note: the baby's brain grows rapidly throughout pregnancy and may be damaged by being exposed to alcohol any time during pregnancy.

HOW MUCH ALCOHOL IS HARMFUL TO THE UNBORN CHILD?

Not all women who drink alcohol during pregnancy will have an abnormal child. The likely damage depends on:

- The amount of alcohol the mother drinks
- How often she drinks
- The strength of the alcohol
- When the mother drinks during her pregnancy
- Whether the mother drinks throughout her pregnancy.

Damage can occur at any time in pregnancy

Drinking in the first three months of pregnancy can cause birth defects, altered appearance of the face (abnormal facial features) or damage to the developing brain of the unborn child. Although drinking in the last six months of pregnancy will not cause birth defects or alter how the child looks physically (their facial appearance), it may still damage the developing brain and result in problems with development and learning.

Certain factors in the mother determine how high a level of alcohol is reached in her blood, and therefore into the baby's blood. These factors include the mother's:

- Age
- General health
- Body make-up (its composition: fat, muscle)
- Liver function
- Genes (inherited traits can determine how alcohol is broken down in the body).

These factors make it hard to predict the harm that might be caused to the unborn child – so it is impossible to work out a safe level of drinking during pregnancy and we cannot experiment on pregnant women. The best advice is for women to avoid drinking during pregnancy.



Women should not drink alcohol during pregnancy or while breastfeeding – as recommended by the national alcohol guidelines published by the National Health and Medical Research Council of Australia.

WHAT ARE FOETAL ALCOHOL SPECTRUM DISORDERS?

The range of clinical problems that may be caused by drinking during pregnancy can be grouped using the term FASD. This includes three main clusters of problems:

Foetal Alcohol Syndrome (FAS)

Children with Foetal Alcohol Syndrome:

- Have abnormal facial features (small eye openings, thin upper lip and a flat area between the upper lip and the bottom of the nose)
- Are born small and may have poor growth in childhood
- Have a small head or problems with how their brain works (including problems with learning, movement, hearing or vision, behaviour or school performance).

Alcohol-Related Neurodevelopmental Disorder (ARND)

Children with alcohol-related neurodevelopmental disorder do not have the facial features described above for Foetal Alcohol Syndrome, but they have:

- Problems with how their brain works (such as problems with: lower intelligence, speech and language, academic achievement, memory, the ability to plan and carry out complex tasks – also known as 'executive functioning', attention deficit or hyperactivity, behaviour and social skills).

Alcohol-related birth defects (ARBD)

Alcohol use in pregnancy can result in problems with the development and growth of one or more of the body's organs (e.g. heart, lungs, kidneys).

What do we know about FASD in Australia?

We do not know how often FASD occurs in Australia because of under-diagnosis and under-reporting. Some Aboriginal workers report that many children are affected in certain communities.

What is the long-term outlook for children with FASD?

The damage caused by alcohol does not go away. Although we can help affected children to reach their potential, long-term studies show that many young people and adults with FASD will have problems with education, employment, drugs and alcohol, and mental health. Early diagnosis and assessment gives affected children the chance to access health and education programs.

HOW TO PREVENT FOETAL ALCOHOL SPECTRUM DISORDERS

What you can do for a pregnant client

When seeing a pregnant woman, health professionals should try to help women become aware of the harms of drinking during pregnancy, to themselves and their unborn child.

- *Ask* about their alcohol use.
- *Assess* and record the amount of alcohol they use .
- *Advise* that no alcohol is the safest choice in pregnancy. This is because we do not know what level of drinking is safe, that risk to the unborn child is hard to predict, and that alcohol may harm the unborn child.
- *Assist* women to stop drinking by offering positive reinforcement of their efforts to stop drinking, offering a brief intervention and advising that alcohol may harm the unborn child.
- *Arrange* further support or treatment if needed.
- *Note:* remember that there may be many reasons why a client drinks during pregnancy. You may be able to help lessen stresses, or help the woman find some other way to cope with them. It is important not to judge the woman because she may already feel shame or guilt about drinking in pregnancy.



Early diagnosis of FASD will enable the right help to be given to the child straight away and lessen the chance of problems later in life. It will also enable the mother to get help and may prevent the birth of another child with FASD.

Working with communities to prevent FASD

FASD does not occur in children whose mothers do not drink in pregnancy. However, it can be hard to start up efforts to get women to not drink during pregnancy. Some remote communities have asked their clubs not to serve alcohol to an obviously pregnant woman. Other communities have lobbied for alcohol restrictions or have become totally 'dry' communities. There are also education programs for teenage girls, older women and men to warn them about the dangers of drinking during pregnancy. Efforts to work with communities to change attitudes to drinking alcohol during pregnancy are needed – as is more education about the potential harms of alcohol to the unborn child.

FURTHER READING

Alcohol and Pregnancy Project (2009). *Alcohol and Pregnancy and Fetal Alcohol Spectrum Disorder: A resource for health professionals (1st revision)*. Perth: Telethon Institute for Child Health Research. See: www.ichr.uwa.edu.au/files/user5/2009_Revised_Core_web.pdf.

Protecting and supporting families at risk

OVERVIEW

Alcohol or drug misuse in parents can put children at risk. On the other hand, some parents are careful that their children are well looked after if and when they use alcohol or drugs. As health professionals, we need to be aware of what we can do to support families at risk. We also need to be aware of what the law and our workplace say we need to do to protect children.

In our work with families, we are also responsible for the safety of their children. This includes being alert to the needs of the children, and supporting parents to care for their children, e.g. helping parents work out how their behaviour may affect their children, and what they could do to make sure that their children's physical and emotional needs are met. In more extreme cases we may need to report concerns about a child's safety to the child protection agency. This chapter looks at how we can protect and support families at risk from alcohol or drugs.

TIPS FOR PARENTS ON HOW TO KEEP THEIR CHILDREN SAFE

As health professionals, we should aim to provide help earlier (early intervention) to make sure children are safe and to support families better.

A number of practical ideas can help keep kids safe if their parents use alcohol or drugs.

- Someone to look after the children: suggest that if the client is going to use alcohol or drugs that they ask someone they trust to look after their children.
- Parenting skills: some clients may have been exposed to poor parenting themselves (i.e. when they were children) or they may have been brought up in an institution. Other parents may have trouble looking after children who are more challenging. Try to link the client into a parenting program in your area. Sometimes these are informally offered (e.g. by cultural leaders or other strong parents) or as formal programs (e.g. like the Triple P Parenting Program). Ask your baby health centre or child health service what programs are available.
- If a parent is feeling stressed from looking after their children: they may be able to find a reliable relative or close friend to look after the child for a short time each week. This can stop pressures from building up.
- If the parent is ever in a crisis situation where they feel so stressed (e.g. because of a screaming child) that they feel at risk of hurting the child, they should leave the child in a safe place (e.g. in a cot or with a trusted adult) and step out of the room.

- If you are able to see the client in their own home, it can be easier to discuss practical ideas with parents on ways to look after their children. If you are not confident to do this, then perhaps another person from your team or region may offer this support with the family's consent.
- In some regions, there are services or programs to help couples or families under pressure, e.g. Brighter Futures in NSW, or Relationships Australia. Ask your baby health centre or child health service what programs are available.
- If a lot of the client's money is being spent on alcohol or drugs: help the client make sure that bills are paid automatically, either:
 - Direct from their Centrelink benefits (a free service called 'Centrepay'), or
 - As an automatic deduction from the client's bank account.
- If a lot of the client's money is being spent on alcohol or drugs: you can give them advice on how to budget and manage their money better. If there is a particular risk on payday, you might suggest that they give their key card to someone they trust. Or they could arrange for someone they trust to be with them to make sure money is spent on the family's needs first before being spent on alcohol or drugs.



Where to get help for parents in your area

Work out what supports are available for parents and families in your area. Larger cities may have a dedicated 'drugs in pregnancy' service. Ask your baby health centre or child health service what programs are available.

THE DIFFICULT QUESTION: WHEN TO DISCUSS A CLIENT WITH A CHILD PROTECTION AGENCY

All health workers have a role to play in protecting children from abuse and neglect. This means thinking about how a client's alcohol or drug use may affect their children's wellbeing or safety and it could mean looking out for obvious signs of abuse or neglect in a client's children.

Sometimes if health workers have concerns for a child's welfare, they may need to notify the child protection agency. Many years ago, reporting to a child protection agency was often done in secret without talking to the client. Now, where possible, health workers talk with clients about:

- The effect that the client's behaviour may be having on their children
- Whether the child protection agency needs to be involved.

It is important to remember that you would not talk with the client about your concerns if you thought it would put the child or yourself at risk. In this situation, you may find it helpful to talk first with your manager or supervisor before reporting to the child protection agency.

Child protection and the law

Child protection laws are different in each state and territory. In most states and territories, health workers are compulsory (mandatory) reporters. This means that health workers legally have to report to their local child protection agency if they believe a child is at risk of abuse or neglect. Note that a child usually means a person up to 18 years of age.

It is important to be aware of your legal responsibilities as a health worker. Talk to your manager or supervisor about how to find out what is needed to make a report, or what training is available to learn more about child protection issues. You can also contact your local child protection agency about training (see Contacts, p. 375).

What do I need to report?

Child protection laws generally cover cases about:

- Sexual abuse
- Physical abuse
- Neglect (physical or psychological)
- Emotional or psychological abuse
- Family or domestic violence.

If you have concerns about a pregnant woman and her unborn baby, it may be appropriate to discuss these with the local child protection agency. The aim of making a report would be to get early support and help for the woman to make sure the baby is safe when born. You may wish to talk to your manager or supervisor before making a report about a pregnant woman.

Am I breaking client confidentiality if I make a report to a child protection agency?

Some health workers may worry that they are breaking client confidentiality if they make a report to the child protection agency. However, health workers who report possible child protection issues are not breaking confidentiality, and are protected by the law. It is good to inform clients that you have a mandatory reporting responsibility so they know where they stand.

In some cases, the law says that health workers must share information with the child protection agency to help with their investigations. Talk with your manager or supervisor about what to do if you are asked to provide confidential information about a client in a child protection investigation.



For clients seeking help about alcohol and drug issues, it can sometimes be hard to work out whether you need to make a report to the local child protection agency. Ask your manager or supervisor for advice and more information about when you need to make a report.

DIFFERENT TYPES OF ABUSE

What is child sexual abuse?

Child sexual abuse is any sexual act or sexual threat made to a child or young person that causes them physical or psychological harm, or to be frightened, fearful or upset. It can happen to children of any age and in most cases the offender is known to the child.

There are different types of sexual abuse including those with no physical contact. Victims of child sexual abuse may be physically and/or psychologically pressured into sexual activity. In these situations, the child's young age or dependency on their caregiver or other authority figure is taken advantage of.

What is physical abuse?

Physical abuse is any physical harm made to a child or young person that is not an accident, and is caused by actions of a parent or other caregiver. Physical abuse often results in physical signs or marks. Examples include beating, shaking, biting, kicking, deliberate burning with an object, and attempted strangulation.

What is neglect?

Neglect happens when the parent or caregiver does not look after the child's basic physical needs such as:

- Food
- Clothing
- Keeping them clean and washed
- Having a home to live in
- Safety from harm, including appropriate supervision (e.g. keeping young children safe from roads and other dangers).

Neglect can also happen when a parent or caregiver does not look after a child's emotional needs. For example, the parent or caregiver may not give the attention and stimulation the child needs to thrive; they may not encourage, comfort, reassure, or accept the child. This form of neglect also includes regularly ignoring the child's signals of distress and pleas for help.

Neglect may or may not be done on purpose, but, like abuse, neglect can be serious and can have long-term negative effects on the child as they grow up. It is important to distinguish neglect from simple poverty, when a parent cannot provide for their child, even though they are trying hard to.

What is emotional or psychological abuse?

Serious emotional and psychological harm occurs when the behaviour of the parent or caregiver damages the confidence and self-esteem of a child or young person, resulting in possible trauma, or seriously affecting the child's emotional development. It can include when the only attention a child gets is when they are yelled at, or when the child is totally ignored even if afraid or upset.

This sort of abuse can harm the child's social, emotional, cognitive and intellectual development, as well as how the child relates to other people.

What is family violence?

Family violence (or domestic violence) is when a person uses abusive behaviour to keep control over their partner or other family members (e.g. wife, husband, girlfriend, boyfriend, children). It can include behaviour that makes a person frightened or makes them feel like they have to do something that the person says (intimidating behaviour). Family violence can include physical assault, sexual assault and/or psychological abuse.

Children and young people may experience harm from domestic violence on a number of levels. They may be:

- Direct victims of physical and emotional abuse. Child abuse is common in homes where domestic violence happens.
- Indirect victims (e.g. when trying to protect someone else from family violence or living in the same house where there is domestic violence).

HOW TO RECOGNISE FAMILY VIOLENCE OR ABUSE OF A YOUNG PERSON

Everyone whose work brings them into contact with children, young people and families has an important role to play in child protection. Workers may receive information that a child has been harmed or may be at risk of harm, or may make observations about a child's appearance, behaviour or family circumstances that causes them to be concerned about the child's safety.

Some signs (indicators) of child abuse and neglect may be enough to make workers have concerns, while others might be part of a puzzle that builds a picture of abuse or neglect.

Some general signs of abuse or neglect include:

- A child tells you of their abuse or neglect
- Someone else tells you about the abuse or neglect
- There is a history of abuse or neglect
- Parents appear unable to function well enough to look after their children
- Sometimes a child's behaviour might be unusual – for example, very withdrawn, strangely well behaved, inappropriate sexual talk or behaviour, physical violence towards other children or animals. These behaviours are not always because of abuse or problems in the family, but are a reminder to consider that possibility.

Trying to work out if a child's safety is at risk can be difficult. It can be important to identify appropriate people who you can talk to about these issues. You may be able to get advice from a senior clinician in your service or you may be able to discuss the case with child protection services or another advisor without mentioning the client's name. It is important that you carefully weigh up the desire for confidentiality against the risks to the child.

HOW TO MAKE A REPORT

Making a report to the child protection agency is different in each state and territory. In some parts of Australia there is one central number to call to make a report. In other places there is a local office to call to make a report.

Contact details for child protection agencies in Australia

Australian Capital Territory

Office for Children, Youth and Family Support

Ph: 1300 556 729

For mandatory reporting,

Ph: 1300 556 728

www.dhcs.act.gov.au/ocyfs

New South Wales

Family and Community Services

Ph: 132 111

For mandatory reporting,

Ph: 133 627

www.community.nsw.gov.au/preventing_child_abuse_and_neglect.html

Northern Territory

Department of Children and Families

Ph: 1800 700 250

www.childrenandfamilies.nt.gov.au

Queensland

Child Safety Queensland

Ph: 1800 811 810

www.communities.qld.gov.au/childsafety

South Australia

Department for Education and Child Development, Families SA
Child Abuse Report Line (for

mandatory reporting) Ph: 131 478

Ph: (08) 8226 8800

www.decd.sa.gov.au/speced2/pages/childprotection/

Tasmania

Department of Health and Human Services – Child Protection Services

Ph: 1300 737 639

www.dhhs.tas.gov.au/children/child_protection_services

Victoria

Department of Human Services – Children, Youth and Families

Ph: 131 278

www.dhs.vic.gov.au/for-individuals/child,-youth-and-family-services/child-protection

Western Australia

Department for Child Protection

Ph: 1800 622 258

For mandatory reporting

Ph: 1800 708 704

www.dcp.wa.gov.au

Tips for making a report to child protection

- Be aware of what you legally have to report in your state or territory.
- Prepare the information required by the child protection agency before you call.
For example:
 - The client and child's personal details
 - Your concerns for the child, and what led you to have these concerns, e.g. this might include signs of potential abuse or neglect you have seen, such as: bruising on the child, signs of the child not getting enough nutrients either from not eating enough or not eating good food, or things the client or the child has said.
 - You will also need to say when you saw the things that concern you.
- When making a report it is important to describe why you are concerned that the child is being placed in an unsafe situation, e.g. because of their parents' alcohol or drug issues.
- Talk to your manager or supervisor before calling (where possible or appropriate).
- You will usually need to fill out some forms either to send to the agency or for your own records. Make notes about the report in the client's file.



To find out what information is needed to make a report, contact your local child protection agency or visit the National Child Protection Clearinghouse website which has information sheets for each state and territory (www.aifs.gov.au/nch/pubs/sheets/menu.html).

WHAT HAPPENS AFTER YOU MAKE A NOTIFICATION

The child protection agency will decide whether the matter needs to be investigated. If this happens, the child protection agency may work with the family and other agencies (e.g. schools, health workers) to find out what is happening for the child (or children). Remember that your piece of information may be one piece in a jigsaw puzzle.

The child protection agency may work with the family in order to make the child safe again. The family may also be referred to other agencies for support and help. In extreme situations, children may no longer be able to live with their parents, and alternative caregivers may be found. Ideally these caregivers would be other family members or local community members.

What to do if you do not hear back from the child protection agency

When you make a report to the child protection agency, they may contact you for more information or ask you to attend a case meeting so a plan can be developed with the family to make the children safe. If you do not hear back from the agency, you can call them to ask what progress has been made about your report. If you are concerned about other issues or new incidents that may be affecting the children's safety, it is important to make a new report.

HOW CAN I SUPPORT A CLIENT IF THEY HAVE HAD A CHILD REMOVED?

Sometimes the parents' lifestyle means that they are unable to care for their children into the future and the children need to be placed in the care of someone else on a permanent basis. Where parents have had children removed in the past, in order to get their children back, or to keep looking after a new baby, they may need to demonstrate what is different about their life that means their children will be kept safe.

If a parent wants to have their child or children returned to their care, it is important for them to understand what needs to be different before the child protection agency or court will allow the child to return home. You may be able to help parents work with the child protection agency to get their child returned to them (e.g. by passing on positive information to the agency about things the parents have done to address their children's safety, or by supporting the parents as they seek legal advice or representation in the Children's Court). It is also a good idea to get to know your local child protection agency or workers, so you can work together to protect children and support families.

FURTHER READING

National Child Protection Clearinghouse resource sheets. These provide information about different child protection issues in Australia, as well as for each state and territory. See: www.aifs.gov.au/nch/pubs/sheets/menu.html.

National Association for Prevention of Child Abuse and Neglect (NAPCAN). This website includes brochures that can be downloaded, as well as brochures and other resources that can be ordered for a small fee. See: www.napcan.org.au.

Parentline provides phone counselling, support and parent education at the cost of a local call. See: www.parentline.com.au.

Preventing alcohol or drug issues among young people

OVERVIEW

Prevention typically targets young people who have not yet starting using alcohol or other drugs. Or sometimes it targets groups of young people, where there is a mix of non-users, sometimes users and regular users. Prevention can happen anywhere, in any setting, and is not just provided by health services/staff. It is important to have a range of holistic prevention measures that do not just involve giving facts about alcohol or drugs. Keeping young people, families and communities strong is important. Measures that make alcohol or other drugs less available to young people also have a role.

HOW TO PREVENT SUBSTANCE MISUSE AMONG YOUNG PEOPLE

Prevention can happen in many different settings (e.g. youth groups, youth camps, community), not just in school. Sometimes the young people most at risk of alcohol or drug problems are those who are not attending school or do not like the school setting. Bush camps can provide a setting where young people can receive education about alcohol or drugs in a culturally appropriate setting. Even for young people from cities, the bush provides a peaceful setting, away from distractions. It also provides an opportunity for young people to learn about culture. This can help to give them a stronger sense of who they are and of their belonging. The bush setting also provides the opportunity for relaxed one-on-one talking.

Prevention may not be delivered by alcohol and drug workers or other health workers by themselves, as it is the role of whole communities and a range of services (health, education, law, licensing etc.). Sometimes even punishment and policing can help prevent a person taking up a drug, or can move a 'sometimes' user away from drugs.

Prevention can aim to stop young people ever beginning to use a drug (whether that is tobacco, alcohol or other drugs). It can also aim to stop occasional users ('sometimes mob') becoming regular users ('all-the-time mob'). For young people who already have a substance use problem, any of the measures below may help them shift back to becoming occasional users or non-users.

Prevention can include a range of different approaches

- Education on the harms of alcohol or drugs is useful, but may not always work, especially when education is given on its own. It needs to be part of a holistic approach that also involves other support mechanisms. The value of education also depends on who is providing the education, e.g. how comfortable they are, is there a language barrier, how up-to-date and relevant the information is that is being presented.
 - One of the challenges of education on drugs is to give young people the knowledge they need, but not make them curious about the drug, or ‘glorify’ use. One way to do this is to tailor the education to the needs of different groups of young people. This is easier in a less formal setting like a camp. So, for example, the whole group of young people might receive the basic information. But the ‘all-the-time mob’ that regularly uses alcohol or drugs might receive more detailed education, even one-by-one, away from the main group. The ‘sometimes mob’, who use only occasionally, might receive different information.
 - There are also challenges as to when to start giving education about alcohol or drugs. Because most drugs are illegal, many schools (and some communities) are uncomfortable about starting drug education before the mid-teenage years. However, some young people start using drugs or alcohol at quite a young age. One solution is for education in primary school to focus on general health messages, and to touch on alcohol and smoking. Then, in early secondary school, other substances like inhalants or cannabis can be introduced, in the context of keeping yourself healthy. Then education about other illegal drugs often starts from around Year 9 (about 15 years). Remember that messages need to be regularly reinforced, and be a standard part of the curriculum rather than a one-off add in. Whoever is doing the education (whether teacher or health worker) needs to update their skills and training regularly. If they do not have the required skills or confidence, they may need to seek additional help.
- Families may need education about how to recognise the effects of drugs, and on knowing how to talk to young people about drug use (see What can families do?, p. 62).
 - Keeping kids occupied: the more programs in the community the better to avoid young people getting bored. These could be sport, culture, training, music and art etc. As well as providing an alternative to drug use, these programs help young people feel connected and feel good about themselves (higher self-esteem). However, these programs need to be ongoing – i.e. all through the year, and need to be continued even when the community is doing well.
 - Making families and communities stronger: families and communities need to be involved with keeping young people safe. This might be, for example, taking adults

or senior members of the community on a camp, or it might involve community members in watching or running sport programs or teaching culture. In this way the adults are part of the day-to-day solution to address substance use issues. A holistic approach is needed, so that young people at risk are seen as part of their family or community. So, for example, if a young person is using petrol, their parents or family may need support. On the other hand, if the parents are misusing alcohol or other drugs, their children (and extended family) may need extra support.

- Looking at the mental health needs of young people: some young people may need treatment or extra support because of mental health issues. This may include young people with Foetal Alcohol Syndrome (see FASD, p. 364 and p. 206).
- Trying to keep underage people from accessing tobacco, alcohol, and drugs – if young people have easy access to these substances they are more likely to run into problems.
- Supporting communities' efforts to stamp out alcohol or drug misuse.
- Remember you are a role model.

ENGAGING AND EMPOWERING YOUNG PEOPLE TO PREVENT SUBSTANCE MISUSE

Try to work with the community to get the message to young people to think before they act. These messages might incorporate local Aboriginal concepts and language (if appropriate).

Working with young people with alcohol or drug issues

OVERVIEW

Young people use alcohol and drugs for the same reasons as adults: to have fun, to relax, for an emotional escape, or to block out problems. However, being younger and not having as much life experience can make extra challenges for young people and increase their exposure to alcohol and drugs. Young people are often very influenced by their friends and at a stage where it is normal for them to challenge and be suspicious of adults. This can make them more at risk of falling into alcohol or drug use problems and less aware of the dangers of use. This section describes what is different when working with young people with an alcohol or drug problem, and discusses treatment options available for young people.

How common are alcohol or drug problems among young people?

Many young people in Australia first use alcohol and other drugs during their teenage years. Some young people also grow up in families and communities who often use alcohol or drugs, which makes it more likely that the young person will also use. The earlier a person starts using alcohol or drugs, the more likely they are to use as an adult, and have problems with use. Young people have the added risk that their bodies and brains are still growing, so normal development can be affected by substance use, leading to further problems.



The importance of good relationships

Establishing and maintaining a good relationship with the young person will be key to the help you are able to offer them. Take the time to get to know them and to build rapport before talking about their use of drugs or alcohol.

GENERAL TIPS FOR WORKING WITH YOUNG PEOPLE

- Education on drugs and alcohol should be given as part of a motivational interviewing approach – helping the young person to weigh up the good and not-so-good things about substance use. This can avoid the young person feeling you are telling them what to do. If an adolescent feels they are being ‘pushed around’ they may react by feeling angry or wanting to do the opposite. You can help the young person ‘own’ the decision to change their alcohol or drug use by using open questions, showing you are listening carefully (reflective listening) and by summing up what they have just said to you. This approach can help cut down the young person’s resistance to change and help them find reasons for change.
- Just as working with adults, young people need to feel there is a reason for them to change their behaviour and that they have the necessary skills to attempt this change. Breaking strategies into simple and clear steps will help young people gain confidence. Also reassure them that sometimes it takes many attempts to make change happen.
- You can use a range of approaches such as workbooks, DVDs, group exercises, outings and activities to create an engaging and stimulating opportunity for young people to learn skills to address their drug and alcohol issues.
- Young people who are strongly connected to family and community, who have something to do, such as school or sport, and who have good support networks will be less likely to misuse drugs or alcohol. Feeling good about life is one of the best ways to prevent substance use problems from happening.

HOW TO RECOGNISE WHEN A YOUNG PERSON HAS AN ALCOHOL OR DRUG PROBLEM

Youth is often a time when people experiment with new things, and some young people misuse alcohol or try illegal drugs as part of this process. Talk to the young person and explore their reasons for using and ensure they are aware of the possible harms of their use.

- It is not always easy to recognise if a young person is misusing substances, but engaging with them and talking to them in a non-judgemental way is the best way to find out. Young people expect adults to make judgements about their behaviour but usually respond well to direct questions once a good relationship is established.
- It is important to never assume what the young person is using. If they are willing to engage and to talk about their use, you are best able to try to help them. Some young people will not yet be ready to talk about their alcohol or drug use or to change (see Counselling, p. 22).
- Types of drugs, their names and how they are used change all the time. So if the young person is using names or terms you do not know, ask them – they are a great source of information.

HOW TO HELP YOUNG PEOPLE WITH ALCOHOL OR DRUG PROBLEMS

If a young person is not willing to talk about their alcohol or drug use, you should tell the young person about services that are available if they later decide to make changes. If they are ready to change, support them to change (see Counselling, p. 23) and help them access these services if needed.

Home-based detox

- Some services provide outpatient detox and support where medicine and/or counselling is provided to help the young person at home. This approach suits young people who have less complex issues, and who have good family or other support.
- There are not yet many outpatient detox services available for younger people and you need to check the entry criteria and what type of program it is to see if it suits the young person.

Residential rehabilitation ('rehab')

Rehab programs designed for young people provide drug-free environments where the young person can gain awareness and skills to address their substance misuse. The young person usually leaves their family and community and lives at the rehab centre for 8 to 12 weeks.

- Young people referred to rehab are usually alcohol or drug dependent and need this more intensive treatment.
- Different rehab programs have different treatment approaches. You should be aware of the program's entry criteria and the type of approach it uses before suggesting it to your client (some programs have religious input and this may not suit the client).
- Every young person's needs are different. Matching the young person to the most appropriate service increases the chances of success. The better the program matches the young person's cultural, spiritual and practical needs, the more likely it is to help them.
- Rehabs will conduct a drug and alcohol assessment (usually on the phone and then face to face) before agreeing to take the client. They will also say if detox has to happen before the client enters the rehab centre.

- If the rehab requires the young person to detox before entering their program, detox usually happens at a residential detox unit. There are limited youth detoxes (for under 18 year olds) but some adult detox units accept under 18s in particular situations. Once in detox, the staff will need to be watchful to ensure the young person feels safe and cared for. Staff at rehab and detox programs try to work together so the young person completes their detox and then transfers straight to rehab. However, sometimes this is not possible and a structured support plan should be put in place until they enter rehab. Having a break between detox and rehab usually results in relapse.
- Many rehabs provide outreach support once the young person has finished the program. They will also usually let a young person return if they did not complete the program the first time, as it often takes several attempts to complete. If the rehab does not offer aftercare support, it is important to look at whether you and/or another service can provide aftercare for the young person.
- It can take many weeks or months to access a program, because adolescent detox and rehab services are limited. You can try to help the young person stay safe and sometimes to make small steps in reducing their alcohol or drug use while they wait.
- Sometimes when there is no rehab available, families or communities have been able to create their own safe or healing place for young people. The Mt Theo program is an example of this, which is run by the Warlpiri Youth Development Aboriginal Corporation. It is important to check with a doctor if the young person is safe to detox without medical help. You can help monitor how safe and effective such an approach is.

Prison populations

OVERVIEW

When a person with alcohol or drug issues enters prison it can be a chance for them to 'step back' to decide whether they want to try to stop using. However, it can also be a difficult time because people often come into prison with health issues and many other concerns, and it can be challenging to know what help is available and how to access it. It is also difficult working out how to deal with the drug culture in prison, and how to prepare the person to leave prison and to re-enter the community safely. This is where support from a health worker can be invaluable. Lots of people fail to deal with drug and alcohol issues because they face barriers that could be removed with some helpful guidance.

The criminal justice system can be a confusing place. The easiest way to understand it is that when people are arrested and detained, usually the first place they stay is a watch-house (police cells), and this might be for a few days. If they are detained in custody for a longer period, they go to a prison (it can be called lots of other things, e.g. correctional centre, custodial centre, remand centre). In the case of younger people, it is called a detention centre. However, in this section, we will call everything a prison.

The way that prisons run across Australia varies – the government runs some, while others are private. The types of health services available can also vary. Because of these differences, this chapter offers general advice for working with drug and alcohol clients who are: about to enter prison, currently in prison, and leaving prison to return to their community. Every prison in each state and territory has information about how the prison runs and what services are available. For more information, call the prison or search the internet for more specific information for your client.

WHAT TO DO FOR CLIENTS ABOUT TO ENTER A PRISON

Substance use problems among Indigenous people entering prison are extremely high and may be related to their offending. Programs to avoid being sent to prison once an offence has occurred are available in most states and territories, and may include diversion to rehab services. These are dealt with separately in this book (see Programs to reduce re-offending or avoid prison, p. 325).

Once a client enters prison, the state or territory becomes responsible for their health care. This means that they will have access to health care services and should not lose hope with respect to any progress they have made in addressing their drug and alcohol issues in the community. However, the client will need to adapt to the services that are available in prison and understand what is required to access these.

The following information may help you to prepare your client for entry to prison; it applies equally to men, women and young people.

General advice

- As a health worker you should be able to obtain specific information about the type of health services and drug and alcohol services available in the prison. A good source of information is the Nurse Unit Manager or Nurse in Charge in the prison health centre. This person can usually be contacted on the prison's general phone number.
- Most prisons will also have Indigenous liaison or support officers that may be able to provide information about relevant cultural supports as well as about the health services available inside.
- Check the rules for visiting the prison. Most prisons have particular times and days of the week for personal visits and specific arrangements for professional visits if you, as a worker, want to visit. This information will be very important to your client and their loved ones, as it lets them know what ongoing support and contact they can get.
- Remember, even if visits are not practical, phone calls are available. The usual system is that the inmate must set up an account and provide details of the names and numbers of the people they wish to call. Sometimes this takes a while to set up and can be frustrating, so suggest to your client that they have money ready for their phone account and a list of names and numbers of people they want to contact.
- Prepare the client for some of the realities of prison regarding drug use. Searches for drugs and drug-using equipment, including the use of drug detection dogs, happen regularly, not only for inmates, but also for visitors.
- Being in prison is a stressful time for most people. Your client may be less stressed if they make arrangements for important things before they enter prison (e.g. childcare, finances and care of accommodation and property). Your client may also wish to tell family, friends and employers that they are going to prison, and you may be able to help with this.

Specific advice

For clients with an alcohol or drug issue

- Advise your client that a pre-prison ‘binge’ is likely to cause problems such as: making it more difficult to organise their personal matters before entering prison, facing more charges for things that happen while intoxicated, or facing more alcohol or drug-related harms either while using or when they first enter prison (e.g. going through withdrawal).
- Gradually reducing drug use before entering prison can make withdrawal in prison less difficult. Also, injecting drug use in prison is very risky, so strategies to reduce or stop injecting drug use before entering prison will be helpful.
- At the time of writing, there are no Needle and Syringe Programs (NSPs) in prison to provide clean injecting equipment. In any event, injecting while in prison puts a person at very high risk of health problems.
- For clients with opioid dependence, starting opioid substitution treatment (i.e. methadone or buprenorphine) before custody can avoid withdrawal on entering prison and can reduce problems with access to treatment.
- On arriving in prison, your client will have a health assessment, usually within 24 hours. This is a good time for them to mention any major health issues, including risks of going through alcohol or drug withdrawal. This may be the only chance they get to raise this issue promptly.

For clients with mental health issues

- Most people in prison with a severe substance use issues also have mental health issues. Sometimes this mental health issue is more than just stress, worry, and feeling down and is actually a mental illness such as schizophrenia, bipolar disorder, depression or anxiety disorder.
- If your client has a mental illness, then it is important that the prison health staff know about this when they enter a prison. It is likely that during their initial health screen they will be asked if they have experienced a mental illness, suicidal thoughts or attempts, or any current or past treatment for mental health problems.
- It is very helpful to get a short letter from your client’s doctor or service that states the client’s condition and the required treatment.
- Other things that can provide helpful information to prison health staff include medicine boxes, scripts or discharge summaries. Your client can bring these to prison or you could fax relevant discharge summaries and other relevant information to the prison health centre with your client’s permission.

- Make sure the client has the name and phone number of their doctor, case manager or service written down to provide to prison health staff.
- Taking medicines with them to prison is also a good idea as it alerts health staff to the type and dose of medicine that they need; and it also provides a supply if the health centre does not have the medicine in stock.

WHAT TO DO FOR CLIENTS WHILE THEY ARE IN A PRISON

There are some major differences between approaches taken to drug and alcohol issues in prison compared with services offered in the community. As described above, at the time of writing there are no Needle and Syringe Programs (NSPs) in Australian prisons. There is also likely to be limited access to opioid substitution therapy (methadone or buprenorphine) and to counselling. However, in prison the primary health care services have standard approaches (protocols) to support people going through withdrawal and, there is access to some medicines and/or group programs to help address alcohol and drug problems. What is available will vary by state/territory and prison.

Substance use among adults entering prison

In 2010, one-quarter of all people in prison were Aboriginal Australians. Most Aboriginal people who enter prison smoke tobacco, around two-thirds drink alcohol at risky levels, and more than half have used cannabis. Smaller numbers have used methamphetamine (speed, ice, base), heroin, or ecstasy. One in 10 people will have been on methadone or buprenorphine treatment for opioid dependence. Offending often happens when people are intoxicated.

Substance use among young people entering detention ('juvenile justice centre')

More than half of all young offenders aged 10–17 years are Aboriginal. Young offenders usually start drinking at a young age, and nearly always report getting drunk. Offending often happens when they are drunk. As they may not drink every day, young offenders may not think their alcohol use is harmful, even if it has led them to being in custody. Inhalant use (e.g. petrol, paint, butane) is sometimes reported by young offenders. Young offenders also usually report using cannabis from a young age. Unlike with alcohol, young offenders who use cannabis are usually cannabis dependent. They may smoke cannabis from when they wake up in the morning and use it all day. They may also get stressed if they cannot get any cannabis and may offend to get money to buy cannabis.

General advice

- As mentioned earlier, you can contact the prison (on the general phone number) and speak to the health centre manager to find out which services may be relevant to your client.
- On arriving in prison, your client will have a health assessment, usually within 24 hours. This is a good time for them to mention any major health issues, and whether they expect to go through any alcohol or drug withdrawal. This may be their best chance to get prompt help.
- It may be possible to keep up contact with your client through professional visits if you feel it is needed. Another way to maintain contact is by regular phone calls, and to do this your client needs to add you to their phone list.
- Most clinicians in prison are likely to be non-Indigenous, so if you feel your client will benefit from having an Aboriginal person helping with health assessments, there are usually Indigenous liaison officers or other Indigenous staff who can help. Again, contact the relevant prison to organise this.

Specific advice

For clients with a alcohol or drug issue

- Prisons generally use standard withdrawal management protocols (guidelines) that include medicines. If your client has severe dependence or has had a past complication of withdrawal, like seizures, and you think their treatment needs may not be met, try to discuss this with the prison health centre. Most prisons have doctors who can adapt treatment to your client's needs.
- Young people entering custody are less likely than adults to experience withdrawal symptoms. However, if you believe a young person may experience significant withdrawal symptoms, it is important to tell the health staff as soon as possible.
- It is common for people to be offered drugs while in prison. Using drugs in prison can result in greater legal, physical, emotional and health problems than in the outside world. The drug trade inside prison, like outside, is associated with violence and standover tactics.
- Most large prisons have drug-free units and your client may not be aware of this. They may be able to request to transfer to one of these units.

For clients with a mental health issue

- Entering prison and being separated from family and community can be very stressful; it may increase feelings of hopelessness and helplessness. If your client has a mental illness, it is important that the health service in prison is aware of this so they can continue treatment.
- You can help with coordination and communication in your client's ongoing health care. Sending in letters from their doctor or health service will help their mental health care in prison.
- Sometimes inmates will not mention thoughts about suicide or self-harm to prison staff because they are worried they will be isolated and placed under observation. Encourage them to tell the health staff why they are thinking about suicide (i.e. the context), and also about any factors that would keep them safe (e.g. if they would not hurt themselves because of their children). In that way mental health staff can better assess their risks and find the best way to keep them safe.
- Where prisoners are placed in prison is usually decided based on security concerns, and it may not be flexible. However, prisons will usually try to find ways to help distressed individuals. For example, they may be prepared to place a person in a unit with family and friends from the same community to help keep them safer. This can also help a person find out about the types of services available in prisons.
- Some prisons will have Indigenous-specific programs and activities such as elder visits and art groups. Make sure your client is aware of these (if available) as these may help your client feel less isolated from family and community.
- If you become aware that your client is not coping in prison, or something is affecting their mental wellbeing, contact the prison health service, usually the nurse unit manager, and let them know about your concerns.
- The prison may have Aboriginal staff in counselling or health positions that your client can see.

Substance withdrawal in prison*Alcohol*

Alcohol withdrawal is serious and can be life-threatening but prison health staff are usually experienced in identifying the risk of alcohol withdrawal. It is very important that your client lets staff know if they have an alcohol problem, particularly if they have a history of complicated withdrawals (DTs, seizures) or liver disease. Alcohol withdrawal treatment usually includes Valium (diazepam), thiamine and other medicines to relieve symptoms. Most prisons (that receive people straight from the community) will have a health centre with beds set aside for detox for people who need closer observation (see Alcohol withdrawal, p. 86).

Tobacco

Helping people to stop smoking in prison is not easy. Tobacco is usually sold to inmates, and most smokers say it is harder to quit in prison than outside. NRT is available in prisons in all states and territories for inmates who want to stop smoking. Some prisons are smoke-free, so smokers entering these prisons can be given NRT to help with cravings.

The cost of NRT in prison varies; for example:

- *Qld and SA prisons*: free to prisoners who take part in smoking cessation programs
- *In Tasmania*: half price to clients who take part in smoking cessation programs
- *In NT, ACT and NSW*: at cost price (i.e. a little cheaper than the cost outside prison).

Champix (Varenicline)

- Champix (varenicline) is available for free in prisons in ACT, Qld and SA.

For young offenders, smoking is usually not allowed. NRT is sometimes given to young offenders to manage nicotine withdrawal. For more information about helping people quit smoking, see Tobacco, p. 115.

Cannabis and stimulants

There are no standard medicines used for cannabis withdrawal or stimulant withdrawal in prisons. Your client can talk to the nursing staff in the prison if they are having difficulty coping with cannabis or stimulant withdrawal, including if their mental health is becoming worse during withdrawal (see Cannabis, p. 135; Stimulants, p. 168).

Opioids

Withdrawal from opioids (e.g. heroin, morphine) can be very unpleasant; also if the person uses illegal drugs in prison to cope with withdrawal, this puts them at a major health risk. Most prisons have guidelines to manage withdrawal symptoms and the approach varies depending on what medicines are available, including methadone.

Being on opioid substitution treatment (OST) in prison can relieve withdrawal, and it can also reduce the risk of getting infected with hep C or HIV from sharing needles, syringes and other injecting equipment. OST can also reduce the risk of returning to heroin use, and of overdosing, when an opioid dependent person leaves prison.

The availability of methadone and buprenorphine in prison varies in each state and territory and also within each prison.

- Some prisons only offer methadone to pregnant women who are opioid dependent or to those who were already on treatment before entering prison. Some prisons only offer reducing methadone regimes (to manage withdrawal symptoms), and not maintenance treatment.
- Some prisons do not offer buprenorphine at all because of fears it will be diverted. Suboxone film (which contains buprenorphine combined with naloxone) has recently become available outside prisons. It dissolves very quickly in the mouth and is less likely to be diverted. It is possible it may become approved for use in some prisons.

Which prisons in Australia offer methadone and buprenorphine treatment?

	Methadone		Buprenorphine (with or without naloxone)	
	On a program before prison	Not on a program before prison	On a program before prison	Not on a program before prison
<i>ACT</i>	✓	✓	✗	✗
<i>NSW</i>	✓	✓	✓	✓
<i>NT</i>	✓	✗	✗	✗
<i>Qld</i>	✓	✗	✗	✗
<i>SA</i>	✓	✓	✓	✓
<i>Tas</i>	✓	✗	✗	✗
<i>Vic</i>	✓	✓	✓	✗
<i>WA</i>	✓	✓	✓	✗

Adapted from: AIHW (2011). The health of Australia's prisoners 2010
Note: this information was accurate at the time of writing



Extra note on OST in prisons

- In NT, Qld and Tas, methadone and buprenorphine are only available if the person was already on a program before entering prison.
- In some states (e.g. WA) buprenorphine is only available with naloxone (i.e. as Suboxone), and this is to reduce the risk of ‘medicine diversion’.

Benzos

Benzo withdrawal can be very serious if not identified and treated properly. Make sure your client knows to tell health staff about their benzo use, so that treatment can be provided. Detox usually involves a benzo like diazepam prescribed in gradually reducing doses over time (see Benzos, p. 180).

Injecting drug use in prisons

- Injecting in prisons can be very dangerous as it is difficult to get new or sterile needles, syringes and other injecting equipment. At the time of writing, there are no NSPs in Australian prisons, so injecting equipment used for illegal drugs (‘picks’, ‘fixes’, ‘kits’) is usually makeshift.
- There is a very high chance that needles and syringes used in prison have been used by other people, e.g. one study found that prison needles were shared by up to 100 people. Because of this, injecting in prison carries a very high risk of becoming infected with blood-borne viruses like hep C and hep B, and getting other infections.
- Injecting contaminated drugs (e.g. drugs stored in someone’s mouth or other body cavity) is very risky and can result in life-threatening (or limb-threatening) infections or blood vessel damage.
- Inmates may not know what drug they are getting.
- Some drugs should not be injected. For example, injecting benzos or psychiatric medicines can cause very significant health risks including death; and injecting Suboxone can cause acute withdrawal because it contains naloxone (Narcan).

Medicine diversion in prison

- Medicine diversion is when a client removes (or tries to remove) their medicines (e.g. benzos, methadone, buprenorphine or mental health medicines) from the clinic so they can take it later, or so they can sell it or give it to someone else.
- Medicine diversion does occur in prison, and because of this people may not receive their prescribed treatment.
- There are significant penalties for diverting medicine.
- Sometimes people are pressured by other inmates to divert their medicine, and this can be extremely unpleasant. One way to deal with this is to request a transfer to another unit. If a person is on buprenorphine, they can consider requesting transfer to Suboxone (if available) or methadone, which are harder to divert.

WHAT TO DO FOR CLIENTS ABOUT TO BE RELEASED FROM A PRISON

Supporting people who are about to be released from prison is important because:

- Transition from prison to the community is a high-risk period; drug-related death and suicide in the first few weeks following release is very common.
- People often lose tolerance to drugs while in prison. This means that if they start using the same amount they used before entering prison, they are more likely to overdose (especially if they use opioids or benzos).
- Often people return to the same stressful environment they were in when they entered prison (i.e. limited supports and finances, no accommodation and exposure to drug-using peers).
- The risk of re-offending is high in people who have already been in prison, especially if inmates are not reconnected with their families and communities.

General advice

- The most critical thing about release is preparing for it, so it is important to be aware of a client's release date.
- Some prisons have transitional programs that can help smooth a client's return back to their community. These programs help clients to prepare for release by helping them organise accommodation, finances, social supports, return to work and sometimes health care needs.
- Most people will not have had access to transitional programs and the biggest initial challenges can be accessing finances, gaining accommodation, and accessing continuous health care.
- People who have been in custody for some time may need to get new identification. Assisting your client with these matters can also help them to successfully transition to being out in the community.

- Some people who are in prison get released unexpectedly by a court. This can be extremely challenging. In most states there are non-government organisations that provide short-term assistance to your client (e.g. the Court Network or Salvation Army) while they get organised.
- When a release is planned, clients will usually be given a summary letter about their general health care and several days of prescribed medicine. It is important that they engage with a relevant doctor (or other health care provider) as soon as possible to be sure their treatment continues in the community.
- While many clients will be excited about being released, some people may feel anxious about leaving prison. They might fear returning to old circumstances and habits. This is why it is critical to work with your client to identify challenges they may face and to find realistic short-term goals and plans. The pre-release period is a time for your client to get prepared.
- After release, it is important to find out what health care programs your client has received while in custody, so you can find out if any similar programs are available in their community.
- The Aboriginal staff (either in the prison or other health services) may be aware of particular issues a client could face when returning to their community. Talk with these staff to get their ideas on what can be organised to support your client's transition back to their community.

Specific advice

For clients with a alcohol or drug issue

- It is possible that your client will have accessed an alcohol or drug program or OST (e.g. methadone or buprenorphine) while in prison. Being clear about any treatment they have had in prison will help with planning ongoing care.
- Link your client with the local drug and alcohol services.
- Ensure follow-up plans are made as soon as you become aware your client may be released – as risk of overdose is high if your client is not prepared and supported.
- While most prisons will have either alcohol or drug clinicians or health clinicians with knowledge in this area to help your client prepare, there are often not enough of these staff members and there is a huge demand on their services. Therefore you can play an important role in linking your client to a relevant drug and alcohol (or other) service in the community or with a rehab.

- Transferring methadone and buprenorphine treatment from prison can be difficult because most clients will need daily dosing at a clinic in the community from the day they leave prison. Release dates are not always predictable, and this means that arrangements sometimes have to be made at the last moment. Talk with the prison health staff to support this process. Generally in prison the nurses find a local dosing point as soon as they know a prisoner will be released. The details of the prisoner's last dose, any other identifying documents and a script is then faxed to the new dosing point. But sometimes things do not go to plan, especially approaching weekends. Be sure your client knows where to go to collect their dose.
- Rehab may be good for your client, or it could be part of their parole conditions or release planning. Your knowledge of services that may help your client will be useful in planning for their release.

For clients with a mental health problem

- It is important to arrange ongoing mental health care after your client is released from prison. This can be done, for example, through counselling services, general health services or mental health services.
- Some people may have mental health care as a condition of their release, or be on an involuntary community treatment order. You should be able to find out this information from the client.
- Clients who need to attend community mental health services will usually have arrangements for follow-up made through the specialist mental health services in prison. Your client can get a summary letter from the mental health service in prison, indicating their medicines and doses, to ensure that treatment continues when back in the community.
- As there can be long waiting lists for mental health appointments it is important to book these appointments before release.
- Many families and communities may not have a good understanding of your client's mental health problems and other needs on release. Work with the family, and in some cases the community, to enhance the person's support networks once they are released.
- Some people will be returning to remote areas, so make sure you have an understanding of the local services, as well as the visiting mental health services and the timing of these visits to help coordinate appointments.

WHAT TO DO FOR CLIENTS AFTER RELEASE FROM A PRISON

If your client has been released unexpectedly, or has not had an opportunity to prepare for release, many of the points above may not have been addressed. You may need to help work through all these issues and in particular to arrange aftercare for their drug and alcohol issues, mental health, general health, as well as the practical problems (like lack of identity documents). You may also have an important role in supporting the client and in helping their family come to terms with their release.

If your client is on methadone or buprenorphine and does not know where to collect their dose, you can phone for advice from either the prison health service or a local OST unit. This can be challenging to solve over a weekend, but sometimes you or the local OST can call the on-call doctor at the prison. If a solution is not possible, your client may face an uncomfortable weekend, waiting for a solution on the Monday.

Considering practical issues like establishing contact with a regular GP will be important to ensure regular health and medicines reviews as well as specific issues such as restarting contraception.

In some states and territories there are services to support clients after release from prison (e.g. Connections in NSW, the Catholic Prison Ministry in Queensland); however, there are many different groups and the organisations vary significantly between states and territories, so an internet search of what is available in your state or territory is the best place to start.

FURTHER READING

Australian National Council on Drugs, National Indigenous Drug and Alcohol Committee (2009). *Bridges and barriers: Addressing Indigenous incarceration and health*. Canberra: ANCD. Available from: www.nidac.org.au/images/PDFs/nidac_bridges_and_barriers.pdf.

Australian Indigenous HealthInfoNet (2011). *Health services programs in prison*. See: www.healthinfonet.ecu.edu.au/population-groups/offender-health/programs-and-projects/health-services-programs-in-prisons.

Australian Indigenous HealthInfoNet (2011). *Post-release interventions*. See: www.healthinfonet.ecu.edu.au/population-groups/offender-health/programs-and-projects/post-release-interventions.

Heseltine K, Day A, Sarre R (2011). *Prison based correctional offender rehabilitation programs: The 2009 national picture in Australia*. Research and Public Policy Series No.112, Canberra Australian Institute of Criminology. See: www.aic.gov.au/documents/5/6/4/%7B564B2ECA-4433-4E9B-B4BA-29BD59071E81%7Drpp112.pdf.

Aggressive clients

OVERVIEW

When working in the drug and alcohol field, you often see people who are in an aggressive mood. They may look tense and angry. They may pace around, speak loudly, or even shout. They may throw things or attack people or property.

The first thing to do in any aggressive situation is to keep yourself safe. Next, try to keep others safe. And then, as much as possible try to make sure that the aggressive person is safe as well. But you come first. If you are not safe, you will not be able to help anyone else.

Aggression can have a damaging effect on health workers, causing unhappiness, fear, bad sleep, sick leave, stress leave, or quitting work.

WHY DO PEOPLE GET AGGRESSIVE?

It is important to understand why some clients are behaving in an aggressive way so you can deal with it properly.

Some causes of aggression include:

- Alcohol and other drug use. For example, if a client is:
 - Going through withdrawal from alcohol, inhalants or cannabis
 - Currently intoxicated with alcohol, methamphetamines (ice) or other stimulants, e.g. cocaine, MDMA, 'speed'
 - Heavy use of anabolic steroids
 - Experiencing psychosis because of their drug use (drug-induced psychosis). This can be caused by cannabis, psychostimulants or hallucinogens.
 - Experiencing psychosis because they are withdrawing from alcohol or benzos (e.g. diazepam, oxazepam, alprazolam).
- Mental illness. For example, if a client:
 - has not taken their medicines
 - is having a psychotic episode.

- Other reasons
 - People may be become angry or aggressive if they feel stressed or anxious or are going through other hard times (e.g. worrying about family or friends, having money problems, or grieving for the death of a loved one).
 - Physical problems (including pain) may make people less able to deal with stress and to ‘snap’ more easily.
 - Damage to the brain caused by injuries, lack of oxygen, infections, and epilepsy (after a seizure) may cause aggressive behaviour.
 - Aggression can be a side effect of some medicines, e.g. anti-psychotics, anti-depressants, benzos, Champix (varenicline) and anti-seizure medicines.

HOW CAN AGGRESSION BE PREVENTED?

What can clinicians do?

There are many things that clinicians can do to prevent ‘cranky’ or irritable behaviour from becoming aggression:

- Develop a good relationship with the client from the first time they come to see you for help. The rapport and trust developed with this client will be very helpful if you need to deal with an aggressive situation that they are involved in at a later time.
- Look out for the warning signs of aggression like: raised voices and ‘agitated’ behaviour that is out of the ordinary for that client.
- Listen to the client’s concerns before the problem gets worse:
 - For example, are they upset about waiting? For clients on methadone or buprenorphine, are the dosing queues too long?
 - Consider any changes that could be made to address the client’s concerns and to improve the system. For example, if there are delays that cannot be helped, keep the client up-to-date on how long the wait will be.
- Make sure the client is aware of their treatment choices and is involved in deciding what the best treatment is for them. Where appropriate and with the client’s consent, family members of significant people in the client’s life may also be involved in considering treatment choices.

What can your workplace do?

There are many things that your workplace can do to prevent aggression or to manage it better. This includes:

- Trying to make your service comfortable and welcoming to help prevent clients from getting bored and irritated. For example: having pictures on the walls, toys for the kids, a television and reading material (e.g. magazines, leaflets) in the waiting room.
- Making sure appropriate security measures are in place
- For clients who might be aggressive, try not to see them alone or in an isolated area. Let another staff member know where you will be seeing this client.
 - Carry a security alarm (duress alarm) if your workplace has them.
 - If possible, counselling rooms should have two doors so that clinicians can easily leave the room and clients do not feel trapped. Make sure that there are no objects in the room or on the clinician that could be used as a weapon.
 - If a client is aggressive or has a severe mental illness, try not to see them when they are having a hot drink because it could be thrown at you.
- Attending training on how to cope with aggressive behaviour (if available).
- Reading your workplace's policy on how to manage aggression (if available). Talk to your manager if you have any questions.

HOW TO CALM THINGS DOWN ('DE-ESCALATION TECHNIQUES')

If a client is getting angry, there are things you can do to calm the situation down and stop it from getting worse. For example:

- Talk to the client in a calm voice.
- Ask any extra staff and clients who may be present to leave, as sometimes a situation can get worse if there are a lot of people around and many people are talking all at once.
- If there is someone around who is very familiar with the client (e.g. a relative, friend or other staff member), ask this person to talk to the client.
- Stay calm, introduce yourself (if the client does not know you), be respectful and polite and offer the client a drink or some food (if available).
- Keep things simple when talking with the client: use short sentences, explain things clearly, and make sure the client understands what is being said.

- If a clinician or service has made a mistake, apologise to the client.
- Focus on the current problem and try work out with the client what could be done to help make things a little better now (instead of focusing on the bigger issues that may take more time to organise).
- Do not challenge the person or get caught up in an argument. If you start to feel angry and do not think you can control your reactions, try to get out of the situation as soon as you can. You could ask another staff member for help.
- Try not to take what is happening personally.

WHAT TO DO IF A CLIENT IS BEING AGGRESSIVE

- Do not get too close to the person as this will keep you out of hitting and kicking range. Try not to turn your back to the client.
- If you are inside, try to stay near an exit. But do not block the person from leaving or make them feel like they cannot leave.
- Stand in front and slightly to the side of the person, and try to avoid folding your arms or staring at them (as this could appear like you are trying to intimidate them).
- If the person has a weapon, leave the area as soon as you can and tell other staff or clients who might be present so they do not enter the area. If this happens, inform security or the police.
- If you cannot manage the situation on your own, ask staff (or even call security or the police) for immediate help.
- Sometimes, to protect the person as well as other people, clients may need to be treated against their will ('scheduled'). This is usually organised by a doctor or psychiatrist. Nurses or police may organise this in smaller communities.

WHAT TO DO AFTER A CLIENT HAS BEEN AGGRESSIVE

- Seek help straight away for anyone who has been injured or is feeling upset as a result of the aggressive incident. An ambulance, nurse or doctor may need to be called.
- The staff member should be given the opportunity to sit down with their manager or another staff member to talk about what has happened (this is called *debriefing*).
- If anyone needs more help (e.g. counselling), ask your manager what kind of support is available.
- The manager and team should then discuss how to prevent further aggressive situations from happening with this client. This could involve giving the client a warning or changing the conditions of their visit to the service (e.g. for someone on methadone treatment, this could involve reduced takeaway doses).
 - In cities or towns it may be possible to stop the client's treatment (discharge) or transfer their care to another service for a period of time.
 - In rural or remote regions this may not be possible and, instead, a plan to prevent or manage aggression could be developed with the client. This plan could also involve their family and in some cases the police. Sometimes a client may be asked to always bring a nominated family member with them when attending the service. In more severe cases legal action may be required.
- Talk to your manager to find out what needs to happen after an incident so that it is properly reported (and follow the procedure written in your workplace's aggression policy, if available). Following these procedures is important because it tells management how serious the problem was and can help to work out a plan to prevent incidents from happening again. It also warns other workers about what happened so that they can be careful in similar situations, or when they are dealing with that client in the future.

Torres Strait Islanders

For people living in the Torres Strait there are some particular issues to think about in relation to substance use. This includes where people are living, their history and closeness to Papua New Guinea (PNG), and how these factors relate to alcohol and drug use.

GEOGRAPHY AND HISTORY

The Torres Strait consists of 18 islands and two Northern Peninsula Area communities. The islands are scattered over an area of 48,000 square km, from the tip of Cape York, up north towards the borders of Papua New Guinea (PNG) and west to Indonesia. PNG is a short boat trip away from some of the outer islands and each year thousands of PNG citizens cross the border under the 'free movement' provisions of the Torres Strait Treaty. There are also links in heritage between the Torres Strait, Indonesia, PNG and other Pacific Island communities.

Some issues to consider

- *HIV*: there are many people living with HIV in PNG (nearly 1 in every 100 adults). There is a real chance of the spread of HIV into the Torres Strait, because PNG citizens are able to freely move between PNG and the Torres Strait. Because of this, men and women from PNG and the Torres Strait Islands can form relationships. Substance use, like alcohol, can increase the chance of unprotected sex, and this may increase the spread of HIV (see HIV/AIDS, p. 311).
- *Supply of alcohol*: like other parts of Australia, there are several alcohol outlets in the Torres Straits. We know that the more alcohol outlets you have for a population, the greater the chance of harms from alcohol (see Alcohol harms, p. 71; Preventing and limiting drinking problems, p. 337).
- *Tuberculosis (TB)*: TB is a common disease in PNG and people with HIV have an increased chance of contracting it. TB is also the fourth most common cause of deaths in hospitals in PNG. When left undetected, a person with TB can spread the infection, especially in social settings. The movement of people between PNG and the Torres Strait can spread TB. Alcohol misuse can further increase the spread by interfering with the body's ability to fight off infections (the immune system). Also, a person with an alcohol problem is more likely to drop out of treatment for their TB.

- *Injecting drug use*: if injecting drug use were to become more common in the Torres Straits, this could lead to further spread of HIV (and of other blood-borne viruses like hep C and B). There is also no Needle and Syringe Program in the Torres Straits, so there would be a risk of needle sharing (see NSPs, p. 298; Harms from injecting and safer injecting, p. 289; Hep C and B, p. 302).
- *Cannabis*: cannabis is one of the most commonly used illegal drugs in PNG (see Cannabis, p. 127). It was originally introduced to PNG during the Second World War. Cannabis can also contribute to spread of infectious diseases like TB through sharing of smoking equipment (e.g. bongs, joints).
- *Betel nut*: substances used in PNG like betel nut can be sold, traded or shared with people living in the Torres Strait (see Betel nut, p. 232).

FURTHER READING

ABC (2011). *Island life*. Australian Broadcasting Cooperation. See: www.abc.net.au/nature/island/ep4/default.htm.

The Torres Strait Regional Authority (2007). *The Torres Strait community profile*. Australian Government. See: www.tsra.gov.au/the-torres-strait/community-profiles.aspx.

17

Tips for workers

<u>Keeping up your skills</u>	406
<u>Using research to help you work with clients</u>	409
<u>Looking after yourself</u>	416

Keeping up your skills

OVERVIEW

For many years, there have been limited education opportunities for our drug and alcohol workers to keep up their skills. However, just like how drug and alcohol problems have changed over the years, so too have the needs to develop the skills of our workforce. A range of states and territories now has requirements for drug and alcohol staff to have specific qualifications (i.e. at certificate or university level).

Certificate courses (e.g. offered at TAFE)

Most states and territories have certificate courses on alcohol and other drugs. Many states and territories have Aboriginal-specific courses available.

One example of a certificate course is the 'Strong Spirit Strong Mind' Certificate 3 in Community Services Work. This course is Abstudy funded and students live and work in their own community and travel to do the course for intensive periods of time ('block' study mode). This course is available to workers in NT, Qld, SA, NSW and WA.

In the other states and the ACT, certificate courses in alcohol and other drug work are available for Indigenous workers. Contact your local Aboriginal health college for more information.

University courses

Examples of university courses designed specifically for Indigenous drug and alcohol workers include:

- Bachelor of Health Science (Indigenous Health) at the Aboriginal Health College (NSW) and University of Wollongong
- Graduate Diploma or Master in Indigenous Health (Substance Use) at the University of Sydney
- Bachelor of Health Science (Mental Health) at Charles Sturt University. This course is designed for Indigenous mental health workers, but has some drug and alcohol content.

These courses are Abstudy funded.

More information about courses for Indigenous health workers

Australian Indigenous HealthInfoNet website

www.healthinfolnet.ecu.edu.au

Type 'courses alcohol' into the search box to bring up a list of courses and training available around Australia.

National Centre for Education and Training on Addiction (NCETA)

nceta.flinders.edu.au/workforce/key-workforce-development-issues/training-and-education-1/aod-relevant-training-and-education/training_and_education

Other useful training

Other training is also available to help workers improve their skills, such as short-courses on how to work with aggressive clients, medicines to help prevent relapse, counselling skills and child protection issues. Talk with your manager or supervisor about opportunities to keep updating your skills.

CONFERENCES AND MEETINGS

Conferences can be a great place to get new ideas and meet experts and other workers who may be able to provide advice and support to your local community. They also showcase the latest evidence-based practice in drug and alcohol (see Evidence-based practice, p. 409).

There is a range of conferences that our drug and alcohol workers should attend, including:

- National Indigenous Drug and Alcohol Committee (NIDAC) hosts a conference on Indigenous drug and alcohol issues. It is held in a different city every two years. (www.nidaconference.com.au)
- Australasian Professional Society on Alcohol and other Drugs (APSAD) hosts a conference on drug and alcohol issues. It is held in a different city every year. (www.apsadconference.com.au)
- Australian Winter School is an initiative of the Alcohol and Drug Foundation. It is held in Brisbane every year. (www.winterschool.info)

Going to conferences can be expensive, because of the cost of conference registration, airfares, and accommodation. If your workplace cannot pay for you to attend a conference, you may be able to get funding in other ways. Some conferences have scholarships to help Aboriginal workers attend. If you are interested in attending, give the conference organisers a call and ask if they have scholarships for Aboriginal workers to attend and how you may apply.

BEING LINKED INTO NETWORKS

To keep up to date on new ways to address drug and alcohol problems or for support – look at joining your local, state or national organisations. For example:

- Australasian Professional Society on Alcohol and other Drugs (APSAD).
See: www.apsad.org.au
- Alcohol and Drug Council of Australia (ADCA). See: www.adca.org.au
- Aboriginal Drug and Alcohol Council Inc. SA (ADAC). See: www.adac.org.au
- Aboriginal Drug and Alcohol Network (ADAN) for workers in NSW/ACT.
Phone: 02 9212 4777

Contact your local drug and alcohol organisations to get help with connecting with other clinicians in your state or territory.

SUPERVISION AND MENTORING

Supervision and mentoring is an important part of being a health worker. It gives the health worker an opportunity to talk ('debrief') about any issues that have come up in their work with clients (see *Looking after yourself*, p. 416).

If your workplace cannot provide you with clinical supervision or mentoring, talk with your manager about finding someone from a nearby unit who may be able to help.

FURTHER READING

See: www.easyread.drugabuse.gov/ for easy-to-read drug facts.

See: www.nlm.nih.gov/medlineplus/ for some easy-to-read descriptions about medical terms.

Using research to help you work with clients: 'Evidence-based practice'

OVERVIEW

People working in health and welfare make decisions every day, whether they are clinicians, managers or policy makers. For example, if you have a client who wants to stop drinking alcohol, you need to know what treatment are available, and then make decisions about what might be most helpful. While each clinician brings valuable experiences and knowledge, the decisions that are made are complex, and it is often not possible to rely on our individual experience alone. A combination of experience as well as information gained through research is often best to provide an effective service to clients. When decisions are made using the best and most up-to-date information available, this is known as 'evidence-based practice'.

When looking up research on a particular topic, there may be a lot of research that has been done, as well as technical terms used that can sometimes be confusing. With practice, it gets easier to find what you are looking for and to understand the words used. Here are some tips to get you started on how to find useful information to inform your clinical work.

WHAT KIND OF INFORMATION IS AVAILABLE?

The best information is usually found in 'the literature'. Literature can mean different things in different situations. In evidence-based practice it usually refers to journal articles, reports, books and other sources written or reviewed by experts and researchers in a particular subject area.

What is a journal article?

A journal article talks about the research findings written by a clinical expert in the field or a researcher. Articles are published in journals, which are similar to magazines, but have an academic audience. Journal articles often follow a specific structure in the way they are written. This involves the telling the reader what is the purpose of the article ('research question'), how the information was collected and analysed ('study methods' and 'results'), followed by a discussion of the results and how they fit in with what is already known on the topic.

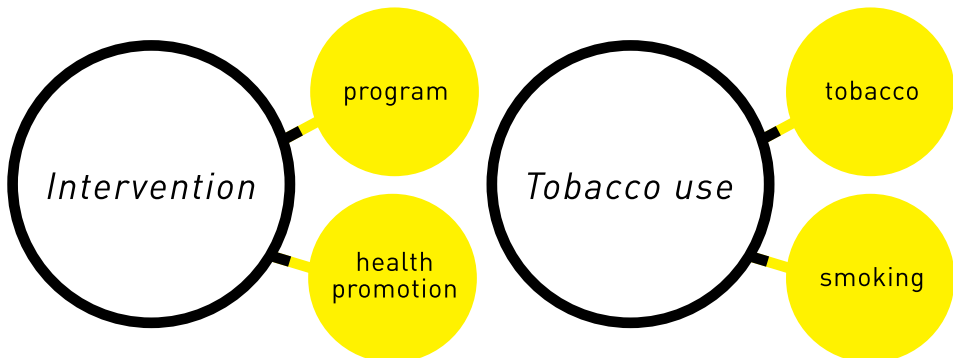
What is a report?

Reports are formal documents that provide information about different issues or research findings. They are written by institutions (like universities), government departments or by individuals. They are often used to help the reader make decisions or take some kind of action. Reports can be published as a document by itself or as part of a series of documents.

HOW TO FIND UP-TO-DATE INFORMATION ABOUT A HEALTH TOPIC

Normally you would have a topic that you want to find more information on. First, it is good to think about the main ideas in your topic. For example, you may want to find out about *interventions for tobacco use*.

Here are some of the main ideas you could search for:



It is important to think of a number of ways to describe the topic you are interested in, because people often use different words to talk about the same idea. For example, an author might use the words ‘tobacco use’ rather than ‘smoking’ in a report about Quit programs.

Websites often organise information under headings to make it easier to find; for example, smoking intervention literature could be grouped together under ‘brief intervention’ or ‘pharmacotherapy’ because these words are also used when talking about interventions. So thinking of different words to describe your topic before you start searching can help you find more information.

The following examples show you different ways to find the relevant literature on tobacco smoking.

1. Australian Indigenous Health/InfoNet

This website focuses on Aboriginal health and contains journal articles, reports and other useful information.

- Go to: www.healthinfonyet.ecu.edu.au
- Substance use resources are grouped under *Protective & risk factors*
- Click on *Protective & risk factors*
- Click on *Tobacco use*
- When the *Tobacco use* page opens you will see many types of useful information on tobacco use (e.g. policy and strategy, specific programs and projects, resources for practitioners and a bibliography that lets you search all of the tobacco literature listed on this website).
- There are three places on the *Tobacco use* page with information on smoking interventions:
 - Look under *Publications*, click on *Specific topics* and then, from the drop-down list, click on *Prevention and treatment*
 - There is also a list of programs under *Programs and projects*. Some include useful evaluations to tell you why the program has been successful or not
 - Also search the *Bibliography* for a specific topic.

2. Searching the Bibliography on the HealthInfoNet website

A bibliography is a list of resources (reports, articles, books etc.) on a particular topic. To access the bibliography on the HealthInfoNet website:

- Go to: www.healthinfonet.ecu.edu.au
- Substance use resources are grouped under *Protective & risk factors*
- Click on *Protective & risk factors*
- Click on *Tobacco use*
- Click on the text under *Tobacco bibliography* (on the right hand side of the *Tobacco use* page)
- Results of the tobacco search will appear
- Click on *Refine search* to adjust the search
- Then use the *Refine search* screen to limit your results. For example, using our example on interventions for tobacco use problems:
 - In *Title (all of these words)* or *Keyword* box: type the word ‘intervention’
 - In the *Document type* list: tick *Journal article and Report*
 - In the *State* list: click on the state or territory that you are interested in
 - In *Publication date* choose recent years
 - Click on *Submit*
 - When the results appear click on the titles for more details

Another way to do a quick search on the HealthInfoNet website

- Go to: www.healthinfonet.ecu.edu.au
- In the search box, type the name of the drug you are wanting to find some information on e.g. tobacco

3. Google Scholar

Google Scholar does not focus only on Aboriginal health issues but can be useful if you need additional information. Google Scholar focuses on university and publisher websites so it is easier to find journal articles here than on regular Google. However, because you are searching across many websites at the same time, you need to add more details to narrow the search down:

- Go to: scholar.google.com
- Look at the main ideas in your topic again:
 - Intervention
 - Tobacco use
- There needs to be at least one word from each idea in your topic. Narrow the search further by adding the words like *Australian* and *Indigenous*
- Type your words into the search boxes. For example: “Australia Indigenous tobacco use intervention”.

4. Google

‘Regular’ Google (www.google.com) is good for finding government reports and other documents:

When you have an exact title of a specific report or document

- Type the name of the report in with quotation marks around the title; for example: “National Complementary Action Plan Background Paper 2003–2009”.

When you do not have an exact title but are looking for a report on a particular topic – for example, alcohol use published by the Australian Government

- Type in: Indigenous alcohol Australian government.

How to work out whether the articles/reports you have found are worth using (using the REVIEW criteria)

As a health professional it is important to make sure the information you have found is reliable. Because anyone can create or edit websites, it is a good idea not to automatically trust this information. For example, information found in an article written by an expert in Aboriginal health is more likely to be reliable than information found on an unknown website or written by an unknown author. The websites of key organisations are usually a good source. Government and university websites also have good information. There is a list of other useful websites at the end of this section that you can use as a starting point. Commercial websites like Wikipedia often have a mix of information from many unknown authors. These websites can be great for providing an overview of a topic, but you should check any claims that are made before using the information.

As a general rule, start by asking yourself a few questions about any information source before trusting and/or using the information you find. The REVIEW checklist can help you decide whether or not to use information:

R	<i>Relevance</i>	Is this resource related to my topic? Note: it is likely that there may not be research available conducted in your community and this may mean that you need to look at research conducted in another community or region.
E	<i>Expertise of author</i>	What qualifications or expertise does the writer have in this area?
V	<i>Viewpoint of author/organisation</i>	Is the author or organisation coming from a particular viewpoint? What do you think they were trying to do by writing this information?
I	<i>Intended audience</i>	Who is the resource targeted at? (e.g. clinicians, patients, carers, government ministers, the media, young people) Knowing the intended audience can help you decide if the information is appropriate for your situation.
E	<i>Evidence</i>	What proof does the author provide to back up what they say?
W	<i>When published</i>	Is the information still up to date?

Source: This acronym was developed by Emma Pallister while working on a project at the University of Sydney Library.

If you ask these questions and your answers do not give you confidence in the author or website, consider looking for other sources.

SOME OTHER USEFUL WEBSITES

General Aboriginal health

- Closing the Gap Clearinghouse: www.aihw.gov.au/closingthegap
- Indigenous Health InfoNet: www.healthinfonet.ecu.edu.au

Alcohol and drugs

- Australian National Council on Drugs: www.ancd.org.au
- National Indigenous Drug and Alcohol Committee: www.nidac.org.au
- Australian Drug Foundation: www.adf.org.au
- Drug Info Clearinghouse: www.druginfo.adf.org.au
- Koori Druginfo: www.kooridruginfo.adf.org.au
- National Alcohol Guidelines website: www.alcohol.gov.au
- National Inhalants Information Service: www.inhalantsinfo.org.au
- National Cannabis Prevention and Information Centre (NCPIC): ncpic.org.au
- Centre for Excellence in Indigenous Tobacco Control: www.ceitc.org.au
- Smoke Check: www.smokecheck.com.au
- National Drug and Alcohol Research Centre (NDARC): www.ndarc.med.unsw.edu.au
- National Institute on Drug Abuse (NIDA) fact sheets: www.drugabuse.gov/infofacts/infofactsindex.html

Mental health and wellbeing

- Beyondblue: www.beyondblue.org.au
- Headspace: www.headspace.org.au
- Reach Out: www.reachout.com

Looking after yourself

OVERVIEW

Helping clients with alcohol and drug issues can be a stressful job. This section gives some tips about how to look after yourself when working with clients.

WHEN SEEING CLIENTS AT THEIR HOME

Some services require clients to be seen at their home (home visits). Home visits should be done with a colleague. When visiting a client at their home, make sure that someone else on your team (a colleague or manager) knows where and when you are going (e.g. leave details about the client's home address, when you left, and what time you expect to return to the office). If your client does not want to meet at their home and suggests meeting in a more open space (e.g. a park or coffee shop), make sure you tell your colleagues where you are meeting the client.

Sometimes work pressures and limited available staff makes it impossible to conduct a home visit with someone else. If you have to do a home visit by yourself, think about what can be done to ensure your safety. Instead of talking with the client inside their house you might talk with them in a more open space (e.g. at the front door or on the veranda). Details about how home visits should be conducted should be part of each organisation's health and safety policies and procedures. Ask your supervisor if you are not familiar with these policies and procedures.

Cultural considerations

- In some smaller communities, get advice from community leaders or other senior people about whether it is appropriate to take a male and a female worker when doing home visits.
- Get advice from community leaders or other senior people about local cultural protocols.

AVOIDING BURNOUT

Working in drug and alcohol can be very stressful. Here are some things you might try to avoid feeling burned out by your work:

- Remember that you are not the person that is seeking help, your client is – so try to leave any work ‘problems’ at work.
- Sometimes Aboriginal and Torres Strait Islanders find it hard to leave clients’ problems in the office. When you are at work you are employed by an organisation as a worker. When you are at home with your family you are a parent or niece or nephew or grandchild or son or daughter.



Avoiding burnout if you are required to do work out of hours

This can be especially hard if there is only a small team of workers available. If you find that you are being called out to help sort out problems for your clients after hours, make sure you talk about this with your supervisor. They can help come up with a plan to make sure you are not working all the time (e.g. if you are called to look after a client after hours, you might be able to take that time off later – ‘in-lieu’).

- Make sure you attend regular weekly or monthly case meetings as this can help encourage a more holistic (individual, family and community) approach to the client’s wellbeing.
- If you have a client who needs specialist help (e.g. for mental health, liver health, sexual health) make sure you refer the client on to this other health professional.
- Try not to give your private phone number or home address to clients or their families. This can sometimes be difficult in smaller communities, but the main point is to make sure that you get some time to yourself (outside of the issues that you are helping your clients with at work).
- Try to plan something special each week just for you, and your family (e.g. fishing, camping, dancing, painting or anything else you like doing).
- Take your annual leave when it is due.

RECOGNISING YOUR LIMITS

When to say no to ...

- *Clients*: if you ever feel like your client is threatening you (or your colleagues or family), make sure you talk about it straight away with your mentor or supervisor. Sometimes, in this situation, the client may be referred to another team member or health professional for help (see Aggressive clients, p. 398).
- *Committees*: Aboriginal and Torres Strait Islander people are often asked to be representatives on many committees in their community, state or territory and nationally. It is ok to say no and to consult and negotiate for someone else to be elected onto the committee.
- *Your colleagues*: Aboriginal and Torres Strait Islander staff have the right to say no and they should be allowed to give a reason why they should not have to do something which is requested of them. This is especially the case when it could have a cultural impact on them or their family.

WHAT ABOUT SUPERVISION AND MENTORING?

Supervision and mentoring is an important part of being a clinician. It gives the clinician an opportunity to talk ('debrief') about any issues that have come up in their work with clients. Arrange to have weekly meeting to debrief with a mentor or supervisor. Do not feel guilty about approaching them and giving or getting feedback about your work and about your clients. Most supervisors and mentors will appreciate hearing your feedback.

Appendix

<u>Some commonly used words</u>	420
<u>The stages of change story</u>	423
<u>AUDIT</u>	424
<u>AUDIT-C</u>	426
<u>Indigenous Risk Impact Screen (IRIS)</u>	427
<u>Blood and other tests to assess drinking</u>	430
<u>An alcohol withdrawal scale</u>	432
<u>Getting information and advice</u>	435
<u>CPR guide</u>	436

Some commonly used words

Abstinence	Staying away from using alcohol or drugs
Adolescence	Stage of life between childhood and adulthood
Apathy	Lack of motivation or lack of ability to start things
CPR	Cardiopulmonary resuscitation (e.g. mouth to mouth resuscitation)
Circulates	Moves through the body in the bloodstream
Cirrhosis	Advanced scarring of the liver (e.g. from alcohol or viral hepatitis). A liver with cirrhosis is described as cirrhotic
'Come down' or 'crash'	After stimulant use, the person can experience a period where they feel down and need a lot of sleep. This is called a 'come down' or a 'crash'
Compulsion	A sense that a person needs the drug rather than just wants it
Craving	A strong desire for the drug if it is not there
Delusions	A set of beliefs that are not true and not based in reality
Delirium	Mental confusion e.g. during through severe alcohol withdrawal or head injury
Dependence	When a person is hooked on alcohol or drugs. They may have withdrawals or trouble controlling their use
Depressant	A drug or medicine that slows down the brain (a 'downer'). In high doses many depressants can slow or stop breathing
Disinhibited	The person says or does the first thing that comes into their mind (impulsive behaviour)

Dopamine	A chemical that is released in the reward centre of the brain that makes us feel pleasure
Drug treatment service	Also called 'drug and alcohol service', 'drug or alcohol clinic', 'drug treatment clinic'
Emotionally detached	Isolates themselves from friends or family, does not want to connect with others
Empathy	Listening well and showing you care, standing in the client's shoes
Euphoria	A strong sense of happiness, feeling high
Gastritis	Inflamed lining of the stomach. This often causes nausea and pain
Genetic	The part of our make-up that we inherit from our parents, through our genes
Hallucinations	Seeing things or hearing things that are not there. Also can be feeling, tasting or smelling things that are not real
Harm reduction	Ways to reduce the bad effects of alcohol or drug even if a person will not or cannot stop using
Introverted	Inward looking
Metabolise	How the body breaks down or changes a particular drug
Nausea	Feeling sick in the stomach, like you might vomit
Neurotransmitters	Chemical messengers in the brain, for example dopamine
Orientation	Does the person know where they are, who they are and what day it is?
Pharmacotherapies	Medicines

Route of use	How a drug is taken e.g. swallowed, injected, snorted, sniffed
Quick onset of effect	Drugs whose effect comes on quickly
Prevention	Ways to try to stop a person ever starting to misuse alcohol or drugs
Paranoid	Suspicious of other people even when there is no real reason
Relapse	Starting back on alcohol or drugs
Relapse prevention	Ways to prevent a person going back to problem alcohol or drug use
Screening	Ways to pick up a problem before the person comes to ask for help (e.g. for alcohol, drugs or mental health)
Sedative	A drug that makes you feel sleepy or calm e.g. benzos
Stimulant	A drug or medicine that speeds up the brain (an 'upper'). In high doses some stimulants may cause seizures or problems with heart rhythm
Tolerance	The person needs more of the drug to feel the same effects
Withdrawal	When someone who is dependent on alcohol or other drugs first stops using they may feel unwell or have sleep or mood changes for a period of time. This experience is known as 'withdrawal'

To look up other words you may not know

See www.easyread.drugabuse.gov for easy to read drug facts

See www.nlm.nih.gov/medlineplus for easy to read descriptions about medical terms

The stages of change story

(see *Stages of Change* picture, p. 199)

Not Worried <i>Pre-contemplation</i>	Drinking has become a problem for the person in the centre of the circle. He or she is too close to the drinking. The drinker is not worried about his or her drinking. Family members (at the edge of the circle) are worried and want the drinker to change but the drinker “cannot listen”.
Thinking <i>Contemplation</i>	Something has happened to start the drinker thinking that there is a problem and that not everything about drinking is good. He or she has started to listen to what family is saying but still is not ready to change.
Trying <i>Preparation and action</i>	The drinker is halfway between grog and the family. The drinker wants to change and starts making plans to cut down or stop drinking. The person may start trying different things like light beer or not drinking on certain days.
Doing <i>Action</i>	The drinker has made up his or her mind to change. He or she has now cut down or stopped drinking and has moved closer to family. It is still early days but changes have been made.
Sticking to it <i>Maintenance</i>	The person no longer has a problem with drinking. He/she is sticking to the plan that was made. The problem drinking circle has been left and the person has moved back to family.
Oops! Learning <i>Relapse</i>	The person has stopped drinking but has not learnt how to ‘say no’ or has found ways to be strong with other drinkers. He or she may start drinking too much again. The person is learning new ways to stay strong. The family is helping the person.

AUDIT *Plain English version*

1 How often do you drink?

☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4+ times a week

2 When you have a drink, how many do you usually have in one day?

☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7-9 ☐ 10+

3 How often do you have six or more drinks on one day?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

4 In the last year, how often have you found you weren't able to stop drinking once you started?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

5 In the last year, how often has drinking got in the way of doing what you need to do?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

6 In the last year, how often have you needed a drink in the morning to get yourself going?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

7 In the last year, how often have you felt bad about your drinking?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

8

In the last year, how often have you had a memory lapse or blackout because of your drinking?

☐ Never

☐ Less than monthly

☐ Monthly

☐ Weekly

☐ Daily or almost daily

9

Have you injured yourself or anyone else because of your drinking?

☐ No

☐ Yes, but not in the past year

☐ Yes, during the past year

10

Has anyone (family, friend, doctor) been worried about your drinking or asked you to cut down?

☐ No

☐ Yes, but not in the past year

☐ Yes, during the past year

Notes on how to use AUDIT

Alcohol consumption should ideally be recorded in standard drinks. If you are helping a client fill it in, you can convert the number of drinks they have into standard drinks. There are many guides available to help you do this. One is in the appendices of the Guidelines for Treatment of Alcohol Problems (Haber et al., 2009; available from www.alcohol.gov.au).

We have provided a plain English version of the World Health Organization's (WHO's) Alcohol Use Disorders Identification Test (AUDIT). It was adapted for Koori use by Sydney South West Area Health Service in 2009. To see the original AUDIT, go to the 'Guidelines for the Treatment of Alcohol Problems' or google: AUDIT babor 2001.

To score a client using AUDIT

- Response boxes for the first 8 items are scored from left to right as 0, 1, 2, 3, 4.
- Response boxes for the last two items are scored 0, 2, 4.
- Add the scores for each item.
- If the score is eight or more, the person is likely to have a drinking problem. They could benefit from brief intervention or other help.
- The higher the score, the more likely they are to be dependent on alcohol.
- Scores of 20 and above suggest dependence. In this case, the client will need a full assessment and more intensive help to address their drinking.

AUDIT-C Plain English version

1

How often do you drink?

☐ Never

☐ Monthly or less

☐ 2-4 times a month

☐ 2-3 times a week

☐ 4+ times a week

2

When you have a drink, how many do you usually have in one day?

☐ 1 or 2

☐ 3 or 4

☐ 5 or 6

☐ 7-9

☐ 10+

3

How often do you have six or more drinks on one day?

☐ Never

☐ Less than monthly

☐ Monthly

☐ Weekly

☐ Daily or almost daily

Notes for using AUDIT-C

These three short questions can be included in the adult health check. If the person is being helped to complete the questionnaire, record their answers in standard drinks.

Look at the responses and see if the person is drinking above recommended limits (i.e. more than four standard drinks on any occasion, or more than two standard drinks on a regular basis).

Some people use a scoring system:

- Response boxes are scored from left to right as 0, 1, 2, 3, 4.
- For a woman, a total score of three or more is a positive test.
- For a man, a total score of four or more is a positive test.

Anyone who drinks above recommended guidelines, or gets a 'positive' score should have a brief assessment about their drinking, and be offered a brief intervention if necessary (see Brief Intervention, p. 82)

These questions are the first three questions of AUDIT (p. 424). Because they are the alcohol consumption questions, they are known as AUDIT C.

IRIS

The Indigenous Risk Impact Screen (IRIS) is used to screen clients for possible alcohol, drug or mental health problems.

Part 1: Alcohol and drug risk

- | | | |
|-------|--|--|
| 1 | In the last 6 months have you needed to drink or use more to get the effects you want? | 1 = No
2 = Yes, a bit more
3 = Yes, a lot more |
| <hr/> | | |
| 2 | When you have cut down or stopped drinking or using drugs in the past, have you experienced any symptoms, such as sweating, shaking, feeling sick in the tummy/ vomiting, diarrhoea, feeling really down or worried, problems sleeping, aches and pains? | 1 = Never
2 = Sometimes when I stop
3 = Yes, every time |
| <hr/> | | |
| 3 | How often do you feel that you end up drinking or using drugs much more than you expected? | 1 = Never/hardly ever
2 = Once a month
3 = Once a fortnight
4 = Once a week
5 = More than once a week
6 = Most days/every day |
| <hr/> | | |
| 4 | Do you ever feel out of control with your drinking or drug use? | 1 = Never/hardly ever
2 = Sometimes
3 = Often
4 = Most days/every day |
| <hr/> | | |
| 5 | How difficult would it be to stop cut down on your drinking or drug use? | 1 = Not difficult at all
2 = Fairly easy
3 = Difficult
4 = I couldn't stop or cut down |

- | | | |
|---|--|--|
| 6 | What time of the day do you usually start drinking or using drugs? | 1 = At night
2 = In the afternoon
3 = Sometimes in the morning
4 = As soon as I wake up |
|---|--|--|

-
- | | | |
|---|---|--|
| 7 | How often do you find that your whole day has involved drinking or using drugs? | 1 = Never/hardly ever
2 = Sometimes
3 = Often
4 = Most days/every day |
|---|---|--|

Part 2: Mental health and wellbeing risk

- | | | |
|---|--|---|
| 8 | How often do you feel down in the dumps, sad or slack? | 1 = Never/hardly ever
2 = Sometimes
3 = Most days/every day |
|---|--|---|

-
- | | | |
|---|--|---|
| 9 | How often have you felt that life is hopeless? | 1 = Never/hardly ever
2 = Sometimes
3 = Most days/every day |
|---|--|---|

-
- | | | |
|----|--|---|
| 10 | How often do you feel nervous or scared? | 1 = Never/hardly ever
2 = Sometimes
3 = Most days/every day |
|----|--|---|

-
- | | | |
|----|--------------------|---|
| 11 | Do you worry much? | 1 = Never/hardly ever
2 = Sometimes
3 = Most days/every day |
|----|--------------------|---|

-
- | | | |
|----|--|---|
| 12 | How often do you feel restless and that you can't sit still? | 1 = Never/hardly ever
2 = Sometimes
3 = Most days/every day |
|----|--|---|

-
- | | | |
|----|---|---|
| 13 | Do past events in your family, still affect your well-being today (such as being taken away from family)? | 1 = Never/hardly ever
2 = Sometimes
3 = Most days/every day |
|----|---|---|

How to score a client on IRIS

Separately add the scores for items from the 'Alcohol and Drug Risk' questions, and for items from the 'Mental Health and Emotional Well-being Risk' questions. For each section compare the score to the risk cut offs. If the person scores above that cut-off, follow the action outlined:

	Tally these questions	Risk cut-off	Action, if score above the cut-off
Alcohol and drug use risk	1-7	10	With consent from the client offer brief intervention for alcohol and drug use.
Mental health and wellbeing risk	8-13	11	With consent from the client offer brief intervention for mental health and emotional wellbeing.

Find out more about IRIS and IRIS training:
www.health.qld.gov.au/atod/prevention/iris.asp

IRIS is produced by the Queensland Government.

Tests for assessing alcohol use

Blood tests

Many heavy drinkers have completely normal blood tests, even though alcohol is causing big problems in their lives.

Blood tests can be helpful:

- To see if alcohol is harming their liver
- If someone has elevated blood tests:
 - Then this can help motivate them to change. People with raised liver blood tests (liver enzymes) are more likely to develop health problems from alcohol compared with other drinkers.
 - The tests often go back to normal when they stop drinking. Getting feedback from a doctor that their liver tests are getting better can help to encourage the person.
- To check for viral hepatitis (like Hep C). People with viral hepatitis have to be particularly careful about what they drink.
- To check for liver failure because of severe scarring (cirrhosis).

The most common blood tests used to assess drinkers are:

- **Liver enzymes** – These can be elevated when someone is drinking, but often return to normal if they stop. Examples are: GGT (gamma glutamyltransferase), AST (aspartate aminotransferase) and ALT (alanine aminotransferase). Alcohol is a common cause of raised test results, though factors like medicines or sicknesses can also raise levels.
- Measures of how the liver is working as a factory:
 - **INR** – is a measure of how long it takes for blood to clot. Raised levels in cirrhosis show that the liver is not making enough clotting factors.
 - **Albumin** – is a protein made by the liver. Low levels happen in cirrhosis.
- Blood count and appearance of blood cells:
 - The red blood cells become larger (mean corpuscular volume or MCV is raised), because alcohol affects the developing cells. This can take three months to go back to normal when the person stops drinking.
 - Platelets may be low with liver disease. Platelets help the blood to clot and to stop bleeding.
 - In more severe liver disease white and red blood cells may also be low

- Others:
 - Bilirubin goes up with cirrhosis, and is raised when someone is jaundiced (yellow whites of the eyes).
 - There is a test for liver cancer called AFP (alpha fetoprotein)
 - Amylase or lipase levels are used to test for pancreatitis (inflamed pancreas)

Scans

A doctor may order tests to look at the liver:

- The ultrasound is the simplest test to examine the liver.
- CT scans are sometimes used to show up the liver and spleen. Sometimes a dye (contrast) is injected into the arm, to more clearly show up liver features, including whether there could be a tumour.
- Some hospitals or clinics have a new form of scanner called a fibroscan. This is like an ultrasound, and measures the stiffness of the liver to show the amount of scarring.

Looking inside the oesophagus or stomach

The doctor may want to check if the drinker has an inflamed stomach lining or oesophagus from drinking. Or they may want to check for bulging veins at the bottom of the oesophagus (varices). The client is given a benzo (like a short acting form of Valium) so that they are not aware what is going on and cannot remember the procedure. A long flexible telescope is put down through their mouth and into their stomach to look directly at what is going on. Sometimes if there are bulging blood vessels, the doctor can put a band put around them to tie them off at the same time (banding of varices).

Alcohol Withdrawal Scale

- Rate how severe each symptom is (using the guide over the page).
- How often you monitor the withdrawal will depend on how severe the withdrawal is (or is expected to be).
- Be aware that other conditions (e.g. anxiety, chest infection) can also put up the total score [see Alcohol withdrawal, p. 86].

Date										
Time										
1 Sweating										
2 Tremor										
3 Anxiety										
4 Agitation										
5 Temperature										
6 Hallucinations										
7 Orientation										
Total Score										
Sedation given? (type/dose)										
Comments										

1	Sweating	5	Temperature (°C)
0 =	No abnormal sweating	0 =	37.0 or less
1 =	Moist skin	1 =	37.1 to 37.5
2 =	Beads of sweat e.g. on face	2 =	37.6 to 38.0
3 =	Whole body wet with sweat	3 =	38.1 to 38.5
4 =	Maximum sweating – clothes and sheets are wet	4 =	above 38.5
2	Tremor	6	Hallucinations
0 =	No tremor	0 =	No evidence of hallucinations
1 =	Slight tremor when forearms stretched out	1 =	Things around them seem strange but aware this change is not real
2 =	Slight tremor of hands (or arms), even when hands are resting	2 =	Sees or hears things that are not there, aware that these are not real if this is pointed out
3 =	Clear tremor of arms & legs that is there all the time.	3 =	Believes the hallucinations are real but still knows who & where they are and what day it is (oriented)
3	Anxiety	4 =	Believes they are somewhere totally different from where they are, or everything around them is completely different; cannot be convinced otherwise
0 =	No anxiety	7	Orientation
1 =	Slight anxiety	0 =	Fully oriented: knows where they are, their own name and what day it is (e.g. the day, month or year, or recent events that have happened)
2 =	Clear anxiety, gets startled easily	1 =	Not sure of where they are or what day it is (but knows their own name)
3 =	Anxiety sometimes becomes panic	2 =	Does not know where they are or what day it is
4 =	Panic-like anxiety all the time	3 =	Not sure who they are, does not know where they are or what day it is. May make sense some of the time
4	Agitation	4 =	Does not know who or where they are or what day it is; you cannot communicate with them in a way that makes any sense
0 =	Rests normally, can sit still		
1 =	Fidgets, cannot sit or lie still, trouble sleeping at night		
2 =	Moves constantly, wants to get out of bed/chair, but will lie/sit down if asked to		
3 =	Constantly restless; gets out of bed or chair for no reason, returns there if you help them		
4 =	Extremely restless, ignores requests to stay in bed or on chair		

Example of a completed Alcohol Withdrawal Scale

This client was having a home detox, and was being monitored daily.

Date	3/12	4/12	5/12			
Time	10.30am	2pm	10am			
1 Sweating	0	1	1			
2 Hallucinations	0	1	2			
3 Anxiety	1	1	2			
4 Agitation	0	0	1			
5 Temperature	0	0	1			
6 Hallucinations	0	0	0			
7 Orientation	0	0	0			
Total Score	1	3	7			
Sedation given? (type/dose)	0	0	0			
Comments		Asked GP to review: re valium	Moved to hospital			

Getting information and advice

	For clients, family and friends Alcohol and Drug Information Services (ADIS) provide 24 hour confidential information and counselling support	For health professionals In most states and territories, 24 hour clinical support and advice is available
<i>ACT</i>	(02) 6207 9977	(02) 9361 8006 1800 023 687 (regional toll-free)
<i>NSW</i>	(02) 9361 8000 (Sydney) 1800 422 599 (regional toll-free)	(02) 9361 8006 or 1800 023 687 (regional toll-free)
<i>NT</i>	1800 131 350 (toll-free)	1800 111 092
<i>QLD</i>	(07) 3837 5989 (Brisbane) 1800 177 833 (regional toll-free)	(07) 3636 7098 or (07) 3636 7599 Note: this service only operates during business hours. It provides limited clinical advice, such as information about medicines and how medicines may interact with each other.
<i>SA</i>	1300 131 340	(08) 8363 8633
<i>TAS</i>	1800 811 994 (toll-free)	1800 630 093
<i>VIC</i>	1800 888 236 (toll-free)	1800 812 804
<i>WA</i>	(08) 9442 5000 (Perth) 1800 198 024 (regional toll-free)	(08) 9442 5042 (Perth) 1800 688 847 (regional toll-free)

DRSABCD Action Plan

D

DANGER

Ensure the area is safe:

- for yourself
- others
- the patient.

R

RESPONSE

Check for response

- ask name
 - squeeze shoulders
- No response**
- send for help

Response

- make comfortable
- check for injuries
- monitor response.

S

SEND for help

Call triple zero

(000) for an ambulance

or ask another person to make the call.

A

AIRWAY

Open airway by tilting head with chin lift.

Open mouth

If foreign material is present:

- place in recovery position
- clear airway with fingers.

B

BREATHING

Check for breathing
look, listen, feel.

Not normal breathing

- start CPR.

Normal breathing

- place in recovery position
- monitor breathing
- manage injuries
- treat for shock.

C

CPR

Start CPR –
30 chest compressions;
2 breaths

Continue CPR until help arrives or patient recovers.

D

DEFIBRILLATE

Apply defibrillator if available, and follow voice prompts.



© St John Ambulance Australia 2011. St John first aid products are for the Australian market only. All users have been trained in the use of the information but St John makes no responsibility for its use by other parties or individuals. St John encourages first aid training as this information is not a substitute for first aid training. This information is for use over a 12 month period only.



Index

Note: Page numbers in **bold typeface** refer to main discussions.

12-step groups 54–55
3Ds approach 28

A

- AA 54–55
Aboriginal Drug and Alcohol Council Inc. (SA) 64
Aboriginal-specific rehabs 59
abscess 205, 291
abstinence 18, 420
abuse of family members, types of 372–374
acamprosate 50, 99–100
accommodation 46–47
acetaldehyde 75
acid (LSD) 226
Acquired Immune Deficiency Syndrome 311
action plans 35
ADAC 64
addictive drugs 7
ADHD 169
ADIS 59
adjustment disorders 269
adolescence 420
advocating for your client 45–49
aggressive clients **398–402**
 causes of aggression 398–399
agonists 141, 203
agoraphobia 269
AHPRA 316
AIDS 311
air fresheners 208
Al Anon 55
Alateen 55
albumin 430
alcohol **65–104**. *see also*
 alcohol withdrawal
 abuse 70
 brain damage 97, 367
 breastfeeding and 360
 cannabis use with 241
 dependence on 66, 70, 75, 78, 101
 as a ‘downer’ 10
 drinking guidelines 70
 drinking limits for driving 322
 driving under influence of 322–323
 effects of intoxication 68–69, 72, 200, 201
 harms, long-term 73–75
 harms, short-term 71
 hep C with 304
 history of drinking
 in Aboriginal and Torres Strait Islander communities 66
 medicines to reduce cravings for 50
 overdose 68, 103
 during pregnancy 350
 problem drinking 70
 smoking and 117
 stimulant use with 242
 supply in Torres Strait 403
Alcohol and Drug Foundation 407
Alcohol and Drug Information Service 59, 435
alcohol-based products 192
alcohol poisoning 68, 103
Alcohol-Related Birth Defects 367
Alcohol-Related Neurodevelopmental Disorder 366
alcohol restrictions 339–342
alcohol withdrawal
 brain activity and 198
 detox 89
 DTs 96–97
 early treatment of 98
 features of 75, 86–88, 91
 helping a person stay dry after 98–103
 managing complications of 96–98
 monitoring 90–91
 other problems that look like 94
 in prison 390
 seizures 87–89, 92
 tips for managing 94
 using diazepam in 92–94, 97
 using thiamine in 95, 97
Alcohol Withdrawal Scale 91, 432–434
alcoholic hepatitis 73
Alcoholics Anonymous 54–55
alcoholism 66, 70
Alepam 176
Alodorm 176
Alpraz 176
alprazolam 176
alternative sentencing 327
amphetamines
 ‘come down’ or ‘crash’ 165
ecstasy use with 242
history of 161
during pregnancy 352
psychosis from use of 278
as an ‘upper’ 10, 160
withdrawal 168
amphetamine powder 162
amyl nitrate 208, 210
anabolic steroids 236
Anglicare 48–49
Antabuse 51, 99–100, 254
antagonists 50, 203
antenatal care 354
Antenex 176
anti-depressants 53, 256
anti-psychotics 53, 279–280
anti-viral tablets 288
antibiotics 287
antihistamines 188
antiretroviral drugs 315
anxiety **261–274**
APSA 407
ARB 367
areca nut 161, **232–233**, 404
arguing with clients 24
ARND 366
artery damage 290
assessing
 client at risk of self-harm or suicide 258–259
 client who drinks alcohol 77–82
 client who feels anxiety 266
 client who smokes tobacco 113
 client who uses benzos 179
 client who uses cannabis 135–136
 client who uses

hallucinogens 229
 client who uses opioids
 146–148
 client who uses several
 drugs 242–243
 client who uses stimulants
 168–169
 client with depression
 253–254
 general principles of 11–16,
 22
 NAS 358
 Ativan 176
 atypical depression 254
 AUDIT 76, 424–425
 AUDIT-C 76, 426
 auditory hallucinations 276
 Australasian Professional
 Society on Alcohol and other
 Drugs 407
 Australian Health Practitioner
 Regulation Agency 316
 Australian Indigenous
 HealthInfoNet website 407,
 411
 Australian Winter School 407
 AWS 91

B

babies
 going home with new baby
 362
 harms to fetus 349–352
 FASD 364–368
 withdrawals (Neonatal
 Abstinence Syndrome)
 349, 357–359
 bad trips 228, 230
 bagging 209
 banding of varices 431
 barbiturates 231
 base methamphetamine 162
 BBVs 292, 298, 302
 benzene 208
 benzodiazepines (benzos)
 173–184
 breastfeeding and 361
 to deal with anxiety 274
 dependence on 177–178, 180
 as a ‘downer’ 10
 harms and treatments 191
 heroin use with 241
 names of 176
 overdose 183–184
 during pregnancy 352, 357
 seizures 174, 178, 180
 for withdrawal 52
 withdrawal from 178–179
 withdrawal in prison 393
 betel nut 161, **232–233**, 404
 biological reasons
 for anxiety 262
 for depression 250
 for developing psychosis 278
 genetic make-up 6, 278, 421
 bipolar disorder 254, 277
 birth certificate 45
 black market tobacco 110
 blood alcohol limit (for driving)
 322–323
 blood-borne viruses 292, 298,
 302
 blood poisoning 292
 blood tests 430–431
 blood vessel disease 109
 blue meanies 226
 brain abscess 312
 brain reward pathway 7–8, 196
 breastfeeding **359–361**
 breathalyser 243
 brief intervention. *see also*
 counselling; motivational
 interviewing
 for clients who drink 81
 for clients who misuse
 benzos 180
 FLAGS 19, 83
 general principles 19
 for injecting drug users 300
 buprenorphine
 action on opioid receptors
 203
 as alternative painkiller 187
 breastfeeding and 361
 driving and 324
 for opioid dependence 51,
 149, 150–151
 during pregnancy 356
 in prison 392
 buprenorphine–naloxone 150
 bupropion 118, 124
 burnout 417
 Buscopan 52, 149
 bush camps 378
 butane 208

C

caffeine
 breastfeeding and 360
 in energy and cola drinks
 193
 nicotine and 117
 during pregnancy 350, 355
 Campral 50, 99–100, 254
 cancer
 liver cancer 310
 from smoking tobacco 109
 cannabis **127–138**
 alcohol use with 241
 dependence on 7, 134
 equipment for use 129
 names for 128
 during pregnancy 351
 laws about 133
 psychosis from use 278
 as a ‘sideways’ drug 10
 in Torres Strait 404
 types of 128–129
 withdrawal from 135, 137
 withdrawal in prison 391
 Capadex 186
 carbon monoxide 107, 108
 carbon monoxide monitor 125
 cardiovascular disease 109
 case management 41, 43–49
 CBT 36, 55–56, 169, 280
 cellulitis 206, 291
 Centrelink 45–46
 Centrelink Community
 Engagement Officers 47
 Centrepay 46, 369
 certificate courses (TAFE) 406
 Champix 118, 123, 355, 391
 child protection agencies
 antenatal care and 354
 clients who are dealing
 with 48
 reporting to 375–377
 in states and territories 375
 when to consult 370–372
 child sexual abuse 372
 children in care 377
 chlamydia 284, 286, 287
 chop chop 110
 chroming 209
 chronic dysthymia 254
 Chronic Obstructive Pulmonary
 Disease 109

- cigarette smoking. *see* nicotine;
tobacco
- 'circle of change' 21, 199, 423
- cirrhosis 420
- cirrhotic liver 73, 202, 309
- citrus to reduce nicotine
 cravings 116
- cleaning fluids 208
- clinical depression 249, 254
- clonazepam 176
- clonidine 149
- coca leaves 161
- cocaine 10, 161, 162, 164, 352
- codeine 140, 186, 190
- cognitive-behavioural therapy
 36, 55–56, 169, 280
- coke (cocaine) 10, 161, 162
- cola drinks 193
- cold medicines 188–189
- combined oral contraceptive
 pills 344
- 'come down' or 'crash'
 after stimulant use 165, 420
 from hallucinogens 228
- community action 68, **332–342**,
 368
- dry community declarations
 340–341
- comorbidity
 with anxiety 267
 with depression 252
 with psychosis 277
- condoms 313–314, 347
- conferences 407–408
- confidentiality 2, 12, 305,
 371–372
- contingency management 170
- contraception **344–348**
- COPD 109
- coping strategies
 for clients 29
 for psychosis 281
- correctional centres 385
- cot death 350, 362
- cough, cold and flu medicines
 188–189
- counselling 20–42. *see*
 also brief intervention;
 motivational interviewing
 for anxiety 270–272
 for benzo misuse 181
 for cannabis users 136
- change issues in 21–23, 26,
 27, 35–36, 81
 for inhalant users 214
 for opioid users 154
 planning for 31
 for polydrug users 244
 for pregnant women 353
 referral and 40–42
 stages of change 199, 423
 for stimulant users 169
 traditional settings 30
- counselling skills 42
- counsellors 41–42
- counter-transference 37
- courts
 alternative sentencing by
 327
 culturally appropriate
 327–328
 going to 47–48
 problem-solving 327, 328
 treatment orders 329
- CPR 420
- CPR Guide 436
- crack cocaine 162
- 'crash'. *see* 'come down'
- cravings 420
- coping with 28
 medicines for 50
- criminal justice system 385.
 see also courts; prison
 populations
- cryotherapy 288
- crystal meth 7, 160, 162
- CT scans 431
- cultural considerations
 in assessing anxiety 268
 depression and 250, 254
 for drug and alcohol workers
 335
 home visits 416
 psychosis and 278
 self-harm in ceremony 257
 sickness and 14, 111
 tobacco smoking and 111
- culturally appropriate courts
 327–328
- custodial centres 385

D

- de-escalation techniques
 400–401
- debriefing 402, 408, 418
- decriminalisation of cannabis
 133, 326
- delirium 420
- delirium tremens (DTs) 96–97
- delta-9 tetrahydrocannabinol
 130
- delusions 276, 420
- dental problems 143, 204
- deodorants 208
- Department of Housing 47
- dependence on alcohol and
 drugs. *see also* under alcohol;
 under different drug names
 assessing 11–16
 dependence, definition of
 420
 features of 12
 medicines for 50–53
 multiple dependence 6
 protective factors 5
 reasons for 4–9
- Depoprovera 345
- depressants 10, 69, 420
- depression **249–256**
 illnesses that get confused
 with 252
 stimulant withdrawal
 compared to 168
 suicide risk 257
 types of 254
- designer drugs as 'downers' 10
- detention centres 385
- detox
 for alcohol withdrawal 89
 for benzo misuse 181
 general principles 18, 46
 for opioid use 148
 for polydrug use 244
 for young people 384
- dexamphetamine 162
- dextropropoxyphene 186, 187
- Di-gesic 186
- diabetes (type II) 110

diazepam. *see also*
 benzodiazepines
 in alcohol withdrawal 92–94, 97
 brand names for 176
 in opioid withdrawal 149
 during pregnancy 355
 regimes for use 93
 Disability Support Pension 45
 discrimination
 alcohol prohibition and 341
 hepatitis and 305
 HIV and 316
 disulfiram 51, 99–100
 doctor shopping 177
 domestic violence 373–374
 dopamine 7–8, 164, 421
 ‘downers’ 10, 198
 drink driving
 with alcohol 322–323
 driving skills 323
 with drugs 323
 drinking history 77–79
 drinking patterns 67
 drinks: energy and cola 193
 drug cutting 293
 drug-induced psychosis 53, 275, 277
 drug route 7, 422
 drug types 10
 dry areas 340–341
 DTs 96–97
 Ducene 176

E

early childhood 362–363
 ecstasy (MDMA) **162, 204**
 amphetamine use with 242
 effects of 163
 during pregnancy 352
 as an ‘upper’ 10, 160
 ECT 256
 educating
 drug and alcohol workers 406–408
 young people 64, 379–380
 electroconvulsive therapy 256
 embolism 291, 292
 emergencies
 in drinkers 102–103
 emergency contraception 347–348

emergency housing 47
 for OST 153
 encephalopathy 97–98
 endocarditis 292
 Endone 140, 157, 190
 endorphins 203
 energy drinks 193
 ethanol 68
 ethyl alcohol 68
 evidence-based practice 409–415
 expiation notices 326

F

families
 helping family members 62–64
 seeking information from 15, 80
 working with 38–39
 families at risk **369–377**
 family therapy 280
 family violence 373–374
 fantasy 220
 FAS 206, 366
 FASD 68, 350, 364, 366–368
 fatty liver 73
 fibroscan 431
 fit 296–297
 Fitpack 298
 FLAGS 19, 83
 flashbacks from hallucinogens 229
 floor price 340
 flu medicines 188–189
 flu virus 302
 flunitrazepam 176
 fly spray 208
 Foetal Alcohol Spectrum Disorders 68, 206, 350, 364, 366–368
 Foetal Alcohol Syndrome 206, 366
 food vouchers 48
 freebase 162
 freon 208
 frequency of use. *see* prevalence (how common is it)
 full agonists 141, 203

G

Gastrostop 52
 GABA 69, 175
 gamma-aminobutyric acid (GABA) 69, 175
 gamma-hydroxybutyrate (GHB) 220
 gardasil 288
 gastritis 73, 421
 GBH 220
 generalised anxiety disorder 269
 genetic make-up 6, 278, 421
 genital warts 285–286, 288
 genotypes of hep C 305
 GHB 10, **220–222**
 glues 208, 211
 goal setting 34, 43–44
 gold tops 226
 gonorrhoea 286, 287
 Google Scholar 413
 grievous bodily harm 220
 guardianship **318–321**
 guardianship orders 319, 320
 State and Territory boards 321

H

hair spray 208
 hallucinations 421
 hallucinogens **226–230**
 Hardship Advance 45
 harms. *see also* harm reduction
 of alcohol 71, 73–75
 of alcohol-based products 192
 of alcohol to unborn child 364–366
 of antihistamines 188
 of benzos 177, 191
 of betel nut 233
 of cannabis 131–132, 133
 of cannabis with other drugs 134
 of cough, cold and flu medicines 189
 of energy and cola drinks 193
 of GHB 221–222
 of hallucinogens 228–229
 of inhalants 211–212

from injecting **289–294**
 of kava 219
 of ketamine 224
 of khat 235
 of opioids 142–143, 144
 of painkillers 187
 of polydrug use 240–242
 of stimulants 165–167
 of tobacco smoking 109–111
 to unborn babies 349–352
 harm minimisation policy 300.
see also harm reduction
 harm reduction 421. *see also*
 harms
 alcohol 101
 benzos 183
 cannabis 137
 community action for 68, 336
 general principles for 18,
 38–39
 GHB 222
 hallucinogens 230
 inhalants 215
 injecting drugs 295
 kava 219
 ketamine 225
 opioids 156–157
 painkillers 187
 passive smoking 125
 polydrug use 245
 prescribed medicine misuse
 190
 stimulants 172
 substance misuse **283–316**
 harmful drinking 70
 hash 129
 HCV PCR 305
 HCV RNA 305
 heart disease 109
 heart valve infection 292
 heartburn 73
 hepatitis B (hep B) **302–303,**
 308–309
 hepatitis organisations 306
 injecting opioid use and 143
 NSPs and 298
 from sharing injecting
 equipment 292
 hepatitis C (hep C) **302–310**
 breastfeeding and 361
 blood tests for 305
 hepatitis organisations 306
 injecting opioid use and 143

NSPs and 298
 from sharing injecting
 equipment 292
 herbal teas 355
 heroin 10, 140, 203, 241, 351
 herpes 284, 285–286, 288
 HIV/AIDS **311–316**
 NSPs and 298
 from sharing injecting
 equipment 292
 in Torres Strait 403
 home detox 181, 383
 home visits 416
 Homelessness Services 47
 housing 46–47
 huffing 209
 Human Immunodeficiency
 Virus 311
 hydroponic cannabis 129
 Hypnodorm 176

I
 ibuprofen 186, 187
 ice 7, 160, 162
 identity, proof of 45
 Implanon 346
 implant contraceptives 346
 Indigenous Risk Impact Screen
 (IRIS) 76, 427–429
 infections
 abscess 205
 cellulitis 206
 from poor injection technique
 291–292
 with untreated HIV 312
 information
 for clients, family and friends
 435
 for health professionals 435
 searching for 409–415
 inhalants **194, 207–216**
 dependence on 213–214
 as a ‘downer’ 10
 during pregnancy 352
 withdrawal from 213–214
 injectable contraception
 (‘Depo’) 345
 injecting drug use
 benzos 177
 generally 15, 53
 hallucinogens 228
 harms from **289–294**
 in prisons 393

 reducing spread of HIV 314
 safer injecting 295–297
 steroids 236
 in Torres Strait 404
 INR 430
 interferon 307
 intrauterine devices (IUDs) 346
 IRIS 76, 427–429
 IUDs 346

J
 jaundice 73, 202
 juvenile diversion programs
 326
 juvenile justice centre 388

K
 K 223
 Kalma 176
 Kapanol 190
 Kaposi’s sarcoma 312
 Karma 129
 kava 10, **218–219**
 ketamine **223–225**
 ketamine hydrochloride 223
 khat **234–235**
 Korsakoff’s Syndrome 73, 97
 Kronik 129

L
 lapse 30
 legal issues **317–330**
 alcohol, drugs and driving
 322–324
 child protection 371
 guardianship 318–321
 hepatitis 305
 HIV testing 316
 law on cannabis use 133
 law on kava use 218
 law on ketamine use 223
 law on khat use 234
 liquor licensing laws 338
 programs to reduce re-
 offending or avoid prison
 325–330
 licensed venues 338, 340
 licensees 338
 lighter fluid 208
 liquid E 220
 liquid ecstasy 220

liquid paper 208
 liquor licensing accords 341
 liquor licensing laws 338
 liquor licensing offices 339
 liquor restrictions 339–342
 liver damage 73, 202, 303
 liver enzymes 430
 liver transplant 310
 lorazepam 176
 loss of control 12
 LSD 10, 226–230
 lung disease 109

M

magic mushrooms 10, 226–230
 poisoning from 228
 major depression 249, 254
 make-up, genetic 6, 278
 Marijuana Anonymous 55
 Maxolon 52, 355
 MCAT 160
 MDMA. *see* ecstasy (MDMA)
 medicines
 for alcohol dependence
 99–100
 anti-depressants 53, 256
 anti-psychotics 53, 279–280
 antiretroviral drugs 315
 benzos. *see* benzodiazepines
 for NAS 358–359
 for nicotine dependence 117,
 123–124
 none for cannabis
 dependence 137
 none for inhalant
 dependence 215
 none for stimulant
 dependence 171
 opioid blockers 50
 over-the-counter, misused
 186–189
 for polydrug use 244
 prescribed, misused
 190–192
 prescription opioids 157, 190
 for quitting smoking 118. *see*
 also nicotine replacement
 therapy
 role of 50–53
 for withdrawal generally 52
 medicine diversion in prison
 394

men
 contraception 347–348
 men's groups 56
 spread of HIV 312
 mental health **247–282**
 Mental Health Act 325
 mental health professionals
 41–42
 mental illness
 anxiety as symptom of 269
 in client who commits an
 offence 325
 in client who misuses
 prescription medicines
 191
 drug dependence and 6
 medicines for 53
 in prison 387–388, 390, 396
 stimulant use and 165
 types of 269
 meow meow 160
 mephedrone 160
 MERIT program 328
 methadone
 breastfeeding and 360
 driving and 324
 as an OST 51, 150–151
 in prison 392
 supervised dosing of 351
 treatment during pregnancy
 356
 methamphetamine 160, 161,
 164
 microdots 226
 midazolam 97
 Modified Finnegan Score 358
 Mogadon 176
 Moggies 176
 money vouchers 48
 monoamines 164
 mood disorders 254
 morning after pill 347–348
 morphine 157, 190, 358–359
 motivational interviewing
 24–26, 114, 382
 MS Contin 140, 190
 Murelax 176
 mushies 226
 mutual support groups
 for alcohol use 100
 generally 54–57
 for opioid users 155

N

NA (Narcotics Anonymous)
 55, 155
 naloxone 154, 203, 392
 naltrexone 50, 99–100,
 153–154, 254
 Narcan 154, 203
 Narcotics Anonymous 55, 155
 NAS 349, 357–359
 nasal decongestants 189
 National Centre for Education
 and Training on Addiction
 407
 National Child Protection
 Clearinghouse website 376
 National Drug Strategy
 2010–2015 300
 National Immunisation
 Program 288
 National Indigenous Drug and
 Alcohol Committee (NIDAC)
 407
 National Poisons Information
 Centre 213
 NCETA 407
 needle 296–297
 Needle and Syringe Programs
 296, 297, **298–300**, 387
 neglect 373
 Neonatal Abstinence Syndrome
 349, 357–359
 nerve cells 8, 197
 neurotransmitters 8, 421
 Newstart Allowance 45, 46
 nicotine. *see also* nicotine
 patches; nicotine
 replacement therapy
 breastfeeding and 360
 caffeine, alcohol and
 prescribed medicines with
 117
 chemicals in tobacco smoke
 108
 dependence on 111–112,
 123–124
 during pregnancy 350
 in tobacco 106
 as an 'upper' 10
 withdrawal from 112
 withdrawal in prison 391
 nicotine patches 118–120, 122

nicotine replacement therapy (NRT) **51, 118–122**
 pregnancy and 122, 355
 in prison 391
 short-acting 120–121

NIDAC 407

nitrazepam 176

nitrous oxide 208

noradrenaline 164

Normies 176

Normison 176, 191

Norspan patch 187

NRT. *see* nicotine replacement therapy

NSPs 296, 297, **298–300**, 387

Nurofen Plus 186

O

obsessive compulsive disorder 269

OCD 269

olanzapine 97, 279

Opal fuel 209, 216

opioids **139–158**. *see also*

opioid substitution treatment

dependence on 144–145

as a ‘downer’ 10

medicines that block effects of 50

overdose of 142–143,

155–156, 293

during pregnancy 351,

355–357

prescription opioids 157

withdrawal from 145–146, 149

withdrawal in prison

391–393

opioid receptors 141, 203

opioid substitution treatment

(OST) 51, 150–153, 391, 393

oral contraceptive pills 344

combined 344

progestogen only 345

OST 51, 150–153, 391, 393

osteomyelitis 292

overdose

of alcohol 68, 103

of benzos 183–184

of GHB 221–222

from injecting drugs

293–294

of ketamine 225

of opioids 142–143, 155–156, 293

of stimulants 171

oxazepam 176, 191

oxycodone 190

OxyContin 140, 157, 190

P

painkillers 53, 186–187

paint 10, 208. *see also*

inhalants

paint stripper 208

paint thinners 208

Panadeine Forte 190

Panadeine Plus 186

pancreatitis 73

panic disorder 269

Papua New Guinea 313, 403–404

paracetamol 186, 187

parenting

effects of alcohol and drugs

on 362–363

going home with new baby

362

keeping children safe

369–370

parenting skills 369

partial agonists 141

passive smoking 110, 125

Paxam 176

pegylated interferon 307

penicillin 287

pepper plant 218

petrol 10, 208, 209. *see also*

inhalants

pharmacotherapies

for alcohol dependence 99

for opioid dependence

153–154

pharmacy drugs **185–206**

phenobarbitone (phenobarb)

358–359

physical abuse 372

physical examination 16

the pill 344–345, 347–348

pituri 106

pleasure pathway in brain 7–8, 196

PMR 272

pneumonia 312

PNG 313, 403–404

polydrug use **237–246**

polydrug dependence 243

polysubstance use 238

poppers 208, 210

post-sentencing programs 329

post-traumatic stress disorder 269

postnatal depression 249, 254

pre-sentence programs 328

precipitated withdrawal 153

pregnancy **349–359**

alcohol and drug use in 68, 70, 110, 364–366

FASD **364–368**

NRT and 122, 355

spread of HIV 313, 314

STIs and 285

tips for discussing substance use 353

treatments for alcohol and drug use 354–357

prescription medicines. *see* medicines

prevalence (how common is it)

alcohol use 67

alcohol or drug problems in young people 381

alcohol use during pregnancy 364

anxiety 262

benzodiazepine use 174

betel nut use 232

cannabis use 128

depression 249

driving under influence 322

drug use in prison 388

GHB use 220

HIV 313

inhalant use 209

khat use 234

opioid use 141

polydrug use 239

psychosis 275

stimulant use 160

STIs 284

suicide 258

tobacco use 107

preventing
 aggression 399–400
 alcohol and drug use,
 generally 64
 alcohol and drug use through
 communities 333–334,
 337–342
 anxiety 274
 benzo misuse 184
 cannabis use 138
 depression 260
 Foetal Alcohol Spectrum
 Disorders 367–368
 inhalant use 216
 opioid misuse 157–158
 painkiller use 187
 polydrug use 246
 prescribed medicine misuse
 190
 psychosis 282
 relapse generally 27–29
 spread of STIs 288
 stimulant use 172
 stimulant withdrawal 170
 suicide 260
 price controls on alcohol
 339–340
 prison populations **385–397**
 alcohol and drug issues 387,
 389, 395–396
 mental illness 387–388,
 390, 396
 programs to reduce re-
 offending or avoid prison
 325–330
 privacy. *see* confidentiality
 problem solving 32–33
 problem-solving courts 327,
 328
 progestogen only pills 345
 progressive muscular
 relaxation 272
 prohibition 341
 ProVen 186
 psilocybin 226
 psychiatrist 41–42
 psychological abuse 373
 psychological harms
 of cannabis 131–132
 of injecting drugs 294
 of kava 219
 of opioids 143
 of stimulants 166

psychologist 41–42
 psychosis **275–282**
 psychotic depression 254
 types of 277
 PTSD 269
 public advocate 318
 public guardian 318
 pulmonary embolism 291

Q

qad 234
 qat 234
 quetiapine 279

R

Ralozam 176
 Ranzepam 176
 reactive disorders 269
 recovery 54
 referral
 for anxiety 274
 of client at risk of self-harm
 or suicide 259
 to other health professionals
 40–42
 for polydrug use 245
 to rehab 60
 refrigerants 208
 rehab
 for alcohol use 101
 benefits of 58–59
 choosing a centre 59–61
 for opioid use 150
 for young people 383–384
 relapse prevention 422
 alcohol use 101
 counselling 30, 39
 generally 27–29
 opioid use 149
 psychosis 281–282
 release from correction
 payment 45
 remand centres 385
 replacement medicines 51
 research (evidence-based
 practice) 409–415
 residential rehabilitation. *see*
 rehab
 resins 208
 resistance in clients 25
 responsible service of alcohol
 338

Revia 99–100
 reward pathway in brain 7–8,
 196
 ribavirin 307
 risk factors
 for developing psychosis 278
 families at risk 369–377
 high-risk situations 28–29
 for infection with hep C or
 hep B 303
 risky drinking 70
 for suicide 258
 Ritalin 162
 Rivies 176
 Rivotril 176
 roadside testing 323
 Rohies 176
 Rohypnol 176
 roid rage 236
 Roofies 176
 route of use 7

S

sadness, long-term 254
 safety issues
 keeping children safe 324
 looking after yourself 3,
 416–418
 safer injecting 295–297
 Salvation Army 48–49
 Sarah's 176
 scarring from injecting 205
 scheduling clients 401
 schizoaffective disorder 277
 schizophrenia 277, 279
 screening/testing
 for alcohol problems 76, 81,
 430–431
 for anxiety 268
 blood tests 430–431
 for hep B 308
 for hep C 305
 for HIV 315
 liver scans 431
 oesophagus or stomach 431
 for polydrug use 243
 screening, definition of 422
 for STIs 286
 sedatives 10, 422
 seizure
 aggression and 399
 alcohol withdrawal 86–88,
 90–93

- alcohol withdrawal and pregnancy 354
- with antihistamines 188
- with benzos 174, 178, 180
- with caffeine 193
- Chamfix not to be used 123
- diazepam for 92–93
- with GHB 221
- with inhalants 214
- managing emergencies 102
- opioid withdrawal 145
- prison and 389, 390
- stimulant use 166
- with stimulants 165, 166, 171
- what to do for 90
- Zyban side effect 124
- self-effectiveness 25
- self-harm **257–260**
- septic arthritis 292
- septicaemia 292
- Serepax 176, 191
- Seroquel 279
- serotonin 164
- sex 313–314
- sexually transmissible infections **284–288**, 312, 313
- shabu 160
- shafting 162
- shame and drug injecting 299
- sharing injecting equipment 296–297
- shelving 162
- shock treatment (ECT) 256
- shrooms 226
- side effects
 - of anti-psychotics 280
 - of antiretroviral drugs 315
 - of hep C treatment 307
- 'sideways' drugs 10
- SIDS 350, 362
- skin infections 312
- skunk 129
- sleep improvement without benzos 182
- sleep problems 84
- sleeping pills 174
- sly-grogging 341
- SMART Recovery 55–56
- smokerlyser 125, 355
- sniffing 209
- social phobia 269
- social skills training 280
- soda bulbs 208
- solvent 208
- special K 223
- speed 160, 162
- Spice 129
- St Vincent De Paul 48–49
- stages of change story 21, 199, 423
- stain removers 208
- standard drink sizes 70
- State debt recovery payments 46
- staying clean 18
- staying dry 18
- sterilisation 348
- steroids 236
- Stilnox 231
- stimulants **159–172**, 422.
 - see also* stimulant-induced psychosis
 - alcohol use with 242
 - dependence on 167
 - overdose of 171
 - during pregnancy 352
 - seizures 165, 166, 171
 - as an 'upper' 10
 - withdrawal from 168, 170
 - withdrawal in prison 391
- stimulant-induced psychosis 166, 170–171, 278
- STIs **284–288**, 312, 313
- stress management 272–273
- Strong Spirit Strong Mind 20, 406
- suboxone 150–151, 392
- substance-induced mood disorders 254
- Subutex 51, 149, 150–151
- Sudden Infant Death Syndrome 350, 362
- sudden sniffing death 211
- suicide **257–260**
- supermarket drugs **185–206**
- supervised dosing of
 - methadone or buprenorphine 151
- sympathetic nervous system 164
- synergism 240
- syphilis 285–286, 287
- syringe 296–297
- systemic infection 292

T

- T-cells (CD4) 315
- TAFE (certificate courses) 406
- talking therapies 256
- Tameze 176
- tax on alcohol 340
- TB 403
- teamwork 2
- teeth 143, 204
- Temaze 176
- temazepam 176, 191
- Temtabs 176
- Tenant Advice and Advocacy services 47
- teratogen 364
- testing. *see* screening/testing
- testosterone 236
- THC 130, 351
- therapeutic community 59
- thiamine 53, 95, 97
- trichloroethane 208
- thrush 312
- tobacco **105–126**. *see also*
 - nicotine
 - tobacco plant 106
 - tobacco smoke 107–108
- tolerance 8, 9, 422
- toluene 208
- Torres Strait Islanders **403–404**
- track marks 205
- traditional cultures. *see*
 - cultural considerations
- tranquillisers 174
- transference 37
- transport to rehab 61
- trauma issues 40
- travel vouchers 48
- treatment orders 329
- treatment plan 43–44
- trichloroethylene 208
- Triple P Parenting Program 369
- trips 226
- tuberculosis 403

U

ultrasound 431
 university courses 406
 'uppers' 10, 160, 198
 urine drug screen 148, 243

V

vaccination
 for hep B 308
 for STIs 288
 Valium 92, 176, 191
 Valpam 176
 varenicline tartrate 118, 123, 391
 varnish 208
 vasectomy 348
 vein damage 290
 Viagra 192
 virus 302
 blood-borne viruses 292, 298, 302
 flu virus 302
 Human Immunodeficiency Virus 311. *see also* HIV/AIDS
 visual aids 26
 vitamin B1 53, 95, 97
 vitamin K 223
 vitamin supplements 353
 volatile substance **208–216**
 Voodoo 129

W

Wernicke's Syndrome 73, 97–98
 withdrawal. *see also* alcohol withdrawal; *withdrawal under different drug names*
 definition of 422
 in general 8, 9, 10, 12
 managing 17
 medicines for 52
 in prison 390–393

women
 alcohol tolerance in 68
 contraception 347–348
 pregnancy, breastfeeding and early childhood **349–363**
 spread of HIV 313
 women's groups 56
 wood cement 211
 workplaces 400

X

X 176
 Xanax 175, 176
 Xannies 176
 xylene 208, 211

Y

'yarning' approach 11, 77
 young people
 alcohol use by 70
 educational resources for 64
 preventing alcohol or drug use 378–380
 in prison 388
 working with alcohol or drug users 381–384
 Youth Allowance 45

Z

Z drugs 231
 zolpidem 231
 zopiclone 231
 Zyban 118, 124, 355
 Zyprexa 279



ISBN: 978-1-74210 267-2 (hard copy)
978-1-74210-268-9 (online)