Addiction Advisor

A division of Triage Healthcare

How to Motivate Someone to Seek Help for Drug Addiction

eatment options in your local area

HOW TO MOTIVATE SOMEONE TO SEEK HELP FOR DRUG ADDICTION

Drugs of addiction (heroin, cocaine, crack, cannabis, alcohol, nicotine...) have many differences in their effects, but they all share a common single factor – serious malfunctioning of the brain's reward system (more on this below). While it may be difficult, it is possible to modify the functioning of this reward system by using the techniques described below. This information booklet will support you in helping someone else to seek help for their drug problem, through use of these techniques, whatever that person's addictive drug of choice.

It is often the case that a friend or relative of someone who is using drugs recognises that this has become a problem before the person themselves. Denial is an essential component of becoming addicted to drugs – after all none of us really like to admit we have a problem with anything, and in the addictive process this tendency becomes all the more pronounced.

Denial is a major barrier in the way of overcoming drug addiction – an absolutely essential first step is for the person to actually accept that at least they might have a problem. If they are able to reach this conclusion, then they will become amenable to speaking to an independent professional in confidence. If they remain convinced that there is no problem, then it is highly unlikely that they will wish to speak to anyone – after all – what would be the point? (they say to themselves).

In the paragraphs below, I summarise the techniques that can be used to convince someone to overcome that first hurdle – acceptance of the fact that 'they might have a problem'. These techniques are based on an intervention used by professionals in the field known as 'Motivational Interviewing'. To use these techniques yourself will probably be more difficult for you than for a professional – for the simple reason that at some level you are emotionally involved with the individual you are trying to help.

As such, it may well be the case that the behaviour of this individual triggers unpleasant feelings in you such as anger, exasperation, irritation, depression. If you are to motivate this person to seek help you must do your best to stand back from these feelings. I recognise that this is very easy for me to say, whilst being very hard for you to do. However, you must do your best if you wish to maximise your chances of success in convincing the person to seek help.

The bottom line here is that People Nearly Always Need to Make Decisions For Themselves. This is not just related to addictive illness, but is generally true in life. Someone is much more likely to want to do something if they feel that this has been their own decision, rather than an 'order' from someone-else, or that they have to do it just to keep someone else happy. The essential 'trick' is to get the person to believe that they have made their own decision to seek help. In fact this is not a 'trick' at all. Hopefully, the person really will make their own decision to seek help. Your role will be to help them to reach a stage in their thinking process whereby they are ready to make that decision. You will not achieve this by lecturing or demanding or bullying or begging. You will achieve this by developing a certain 'attitude' in your interactions with the person. You will learn this attitude over time by implementing the techniques below. It won't come easy at first, but keep on trying and eventually it will become second nature to you.

There is an acronym for the techniques you must implement – FRAMES. Try to remember this as a first step in modifying YOUR behaviour in order to get the best out of the person you are trying to help.

FRAMES: stands for:

F: Feedback

R: Responsibility

A: Advice

M: Menu of Options

E: Empathy

S: Self-efficacy

Really, these are in the wrong order. It should read: FRESAM. Stage one of learning these techniques is about Feedback and Responsibility. Stage two is about Empathy and Self-efficacy. Finally, as the person starts to accept that they might have a problem with their drug use, Advice and Menu of options comes into play.

STAGE ONE: FEEDBACK AND RESPONSIBILITY

FEEDBACK

When you are talking with someone about their drug problem, or about issues you feel are related to their drug use, then you should try to 'Feedback' to them. In feeding back, your aim is to HIGHLIGHT INCONSISTENCIES in the statements made by the person in a way that does NOT engender a feeling of resistance in the person. Within the process of conversation if you find yourself disagreeing with what they are saying, or noticing that problems they are blaming on other things are actually due to their drug use then:

1. NEVER directly disagree with them – rather walk away if you are about to.
2. DO NOT PRETEND that you do agree with them either.
3. In general, avoid making statements of fact.
4. DO ask open-ended questions (questions which deliver a response other than a simple yes or no) if you can. Closed questions (requiring a yes or no answer) are still much better than making statements.
5. Keep in mind the idea that you are going to 'Roll with Resistance'. You are not going to become resistant or defensive yourself in response to the person's statements, but you are not going to give in to them either – you are going to 'roll along with them'.

Here's an example of a bad response:

Drug user: 'I'm feeling terrible this morning.'
Helper: 'Well maybe you shouldn't do so much of that stuff then'.
Drug user: 'What do you mean?'
Helper: 'I mean that you need to stop taking that stuff.'

The 'helper' has made statements, which although may be justified are only likely to force the 'drug user' further into denial. In this case the drug user is likely to leave the conversation thinking 'What rubbish; it's nothing to do with drugs'. (Remind yourself: Your job is not to justify yourself; it is to move the person towards accepting that they might have a problem with drug misuse.)

Here's an example of a good response:

Drug user: 'I'm feeling terrible this morning.'
Helper: 'In what way?'
Drug user: 'I think I'ld better take the day off work.'
Helper: 'Will they mind?'
Drug user: 'They said it could be a disciplinary next time, didn't they.'
Helper: 'Why's that?'
Drug user: 'Too many days sick.'
Helper: 'Do you think you've taken too many days sick?'

This kind of response has completely avoided talking about drug use, and has generally avoided saying anything that could be construed by the drug user as a criticism. If the conversation ends here, then the drug user is more likely than not to leave the conversation thinking: 'Have I taken too many days sick?' This would be a first step in the right direction towards contemplation of the possibility that too many days sick might be related to drug use. This has been achieved through an empathic response, and the use of questions rather than statements. Note also that although the helper demonstrated concern, they did not say anything to the effect that it didn't matter about taking time off work. This is an important balance to achieve – demonstrating empathy whilst not 'letting the person off the hook' either.

The conversation might continue as follows:

Drug user: 'What – are you saying I should go to work?'
Helper: 'No, of course I'm not, that has to be your decision.'

This is a good response from the helper even though it does not involve asking a question. The helper has hopefully defused the possibility of the drug user feeling attacked, or ordered to do something. Additionally, the reply has made it clear that it is the user's responsibility to make a decision. The helper has effectively 'rolled with

resistance', so as not to engender defensiveness; but equally they have not clearly given the user their support in taking the day off work. Drug users who are experiencing problems will often have a tendency to blame others for the occurrence of these problems. They will do this to protect their sense of self-esteem which is most likely rather fragile. More on this below under 'Responsibility'.

The conversation may continue further:

Drug user: 'You're really getting on my nerves now.'
Helper: 'I'm sorry you feel like that. Why am I getting on your nerves?'
Drug user: 'You're always having a go at me, going on.'
Helper: 'Why do you think that?'
Drug user: 'I can just tell what you're thinking – thinking I'm no good – like I'm a waste of space.'
Helper: 'I've never said that. And I don't think you're a waste of space. Do you think you're no good?'
Drug user: 'Sometimes.'

Through the use of a mixture of open-ended and closed questions, and a reasonably empathic response, the helper has managed to lead the user to contemplate that they are not happy with themselves, rather than blaming someone else for their feelings. Also note how the helper started to defuse the situation by saying 'I'm sorry you feel like that.' Importantly this did not involve a direct apology, it did sound concerned, and it placed the responsibility for the unpleasant feelings with the person that was experiencing them (the drug user).

The conversation might continue:

Helper: 'How long have you felt like this?'
Drug user: 'Ages now, it's just slowly built up.'
Helper: 'Why do you think that is then? I mean I know you're a good person at heart. Can you think of anything that might have triggered it off?'
Drug user: No, not really – well, I know I'm doing a few lines, but I can't see that's anything to do with it.'

BINGO! NOW – DON'T RUSH IT.

Helper: 'May be you're right.'

At this point it's probably best to leave the conversation here. The idea that drug use 'might' be the cause of problems has reached the person's consciousness, even though he/she is still denying it verbally. The helper's words 'May be..(you're right)' are likely to ring in the person's mind after you leave the conversation. You have made a generally supportive statement ('may be you're right'), but have hopefully left a nagging doubt about this in the user's mind. This is the art of HIGHLIGHTING AMBIVALENCE in the drug user's statements and feelings.

Naturally, all these examples of dialogue are a little superficial, but I hope they demonstrate the kind of approach necessary. You will need to develop your own style, so that things don't sound unnatural at first. Work at first on developing a style of asking questions without making statements. From this work towards asking more open-ended questions (Why, What, Where, Who, When, How etc.) that do not lead to simple yes/no answers. Don't expect this to work straight away – it may take months before you make progress. In the first place, while you are getting used to applying these techniques, if you feel things are going in the wrong direction during a particular conversation, then try to end that conversation as soon as possible without getting drawn into an antagonistic response. Walk away, think how you could have done it better, and try again the next day, next week or next month.

RESPONSIBILITY

If someone is going to make changes to their addictive behaviour they must first accept that it is their responsibility to make these changes and no-one else's if this is to occur. Others may support and advise, but it is the person with the problem that has to take the ultimate responsibility for actually making those changes. This applies to most situations in life. Of course, changes in behaviour can sometimes be enforced through the use of physical force or threats. In your situation, you will have to use more subtle techniques.

It is so easy for all of us to get into the habit of thinking that our problems are actually someone else's problems. This is not purely related to addictive behaviour. However, it tends to be exaggerated in addictive illness due to the subconscious drive of the addicted drug user to keep using drugs at all costs. As a helper, you should accept that the user is driven to

deny that drug taking is a problem by subconscious influences beyond his or her direct control. Equally, they are likely to be highly defensive about admitting to any other kind of problem in life – just in case this is used as a 'way in' to confront them with their drug problem. If you wish to motivate the person to accept that they might have a problem, then you will not judge them for this tendency to deny. It really is beyond their direct personal control at this stage.

However, you must never allow their determination and need to convince you that they have no problem, to lead you to believe that it is your problem. If the drug use is causing problems, then these problems are ALWAYS the responsibility of the person using the drugs. In fact, if that person is to make real progress in sorting out their life, then they should really start to take responsibility for ALL the problems in their life, whether or not these are directly related to addiction.

When I say this, I do not mean that there should be any sense of blame or fault attached. Everyone has problems, even though some might like to convince you otherwise. Problems are simply a part of life. And there is no need to apportion blame. The act of blaming someone for a problem is really the same as saying "I can't do anything to change that problem; I can't sort it out because it's their fault – it's them that must do something about it, not me." If the drug user fails to take personal responsibility for sorting out problems in their life, then in time these problems will build up and place them at risk of a return to drug use as a means of escape.

If you are to motivate the person to contemplate the possibility that they might wish to seek help for their drug use, then you will have to lead them to start to take personal responsibility for their actions. You will achieve this by modifying your own behaviour, as well as through conversation (see above – feedback).

BEHAVIOUR

The way to behave towards your drug user can be summarised as follows:

'As much as possible, you must allow the natural consequences of the user's behaviour to occur, without interfering to modify these consequences.'

Or in short hand: **'Neither help nor hinder'.**

All behaviour has consequences, and drug use can clearly have pleasant consequences, for the user when they are intoxicated especially in the earlier phases of the addictive process. However, because you are reading this information, I can safely assume that the consequences of your user's addictive behaviour have become largely negative. The challenge is to modify your own behaviour as far as possible so that you do not end up rewarding this behaviour in any way. As I say this, I'm sure you do not feel as though your behaviour is in any way rewarding of the person's continued drug use.

However, by 'reward' I mean 'any' behaviour on your part that may lead the person to be more likely to continue to use drugs. For example, you may be the kind of person that puts the drug user to bed when they arrive home and collapse on the sofa. Alternatively, you may be the kind of person that locks the front door and refuses to let them in. Both these actions are equally likely to 'reward' the user, and lead to the drug use continuing longer than it might do otherwise. In the first case (putting the person to bed) you have demonstrated a caring response that will be sought out again and again the more often you repeat it. In the second case (locking the door), you have 'set yourself up' to be blamed by the person for the situation they have created. Doubtless, you feel justified in locking the door, and you most likely are. But justification is not the point here. The point is that the drug user is most likely to feel a gross sense of injustice – most of you who have tried this particular response (locking the door) will have experienced an angry response from the person left outside, and in some cases a violent response. The fact that the person experiences a sense of injustice will lead him/her further away from accepting that they might be creating a problem and much further along the line to blaming all their problems on you. However justified you may be in taking this action, this is not the desired response in the drug user. The response we are looking for is one whereby the person starts to experience the fact of the matter that there is no-one left to blame for the situation other than him/herself.

There are two caveats to this.

Firstly, considering the example of locking the door. You should not lock the door if you are only locking the door to stop the person coming in intoxicated. You SHOULD lock the door if this is your usual behaviour of an evening – if you were going to lock it whether or

not the person came home intoxicated, then do lock it. Reasoning: do not alter your behaviour depending on the addictive behaviour of the person you are trying to help.

Secondly, if things have reached the point where you are at risk from physical violence, then you will have to take the appropriate action by calling the police, or leaving the premises and the immediate risk of danger. Equally, if the drug user is themselves in immediate danger to their life, then of course you should call the doctor or an ambulance. There is only so far you can go with such an approach; the further you are prepared to go the more likely I think you are to achieve your aim, but in the above two examples (calling the police or ambulance), I would personally call it a day.

So if you cannot limit the effects of the drug use by helping the person when they are suffering, and if you cannot try to stop the effects of the drug use by punishing the person when they behave unreasonably, then what can you do? The simple is answer is: try to do nothing. Neither help nor hinder. By doing nothing, you will maximise the chances of the person being forced into a position where they are actively experiencing the problems consequent to their drug use, and where they have no-one left to blame for this other than themselves. This may sound harsh, and certainly I do not suggest that you should rush to apply these tactics early in the course of the addiction. Simple caring support may be helpful early on in the course of this disease. However, by the time it has become entrenched behaviour, and if the person is taking no responsibility for this behaviour, then the time for simple caring is probably well past.

If you are living with or are emotionally involved with the person, then this will be very difficult to achieve. But if you are to motivate the user to the point where they wish to do something about their drug problem, then this is exactly what you must do.

EXAMPLES OF BEHAVIOUR

Drug user: Asks you for money (for drugs).
Response: You should refuse.
Reason: If the drug user wants drugs then they must take responsibility for all aspects of their drug use including finding (or stealing) money for purchase.

Drug user: Hides drugs in the bedroom.
Response: Leave the drugs exactly where you find them (unless you think risks to others such as small children outweigh this).
Reason: If you throw the drugs away, or even leave them there but point out that you have found them, then you are interfering with the direct consequences of the drug-using behaviour.

It may seem contradictory that you should refuse to give money for drugs, but should leave them there when you find them in the house. These responses are consistent with each other because it is NOT your immediate aim to stop the drug user using. It is your aim simply to 'distance' yourself as far as possible from the drug-related behaviour. Effectively you must allow your user to 'dig his/her own hole', until such time they start to contemplate that the problems may be due to their drug use, or/and they indicate that they may be ready to seek help for this.

Drug user: Leaves his/her crashed car at the scene of the crash and arrives home clearly intoxicated (but uninjured). Asks you to say that you were driving if the police arrive.
Response: You should refuse to do this.
Reason: The user must be allowed to experience the consequences of the addictive behaviour.
Drug user: Locks the door and hides when hearing the police arrive outside.
Response: Do not interfere: Do your best to watch the television and ignore the situation. Avoid interfering by opening the door, if you feel this is appropriate.
Reason: Allow the consequences to occur as much as is possible as if you were not involved in any way.

Of course, there will be a limit to how long you are able to tolerate the effects of the addictive behaviour without taking proactive action of some kind. I mentioned two examples above – leaving or calling the police if you are at risk of violence, calling an ambulance if the person's life appears to be at immediate risk. Equally, the long-term effects of this behaviour on your own self-esteem and life in general may eventually become too much to ware.

Drug user: Steals money or possessions from you yet again.
Response: Ignore the theft.
Reason: Allow the user to experience the consequences of his/her behaviour without interfering.
Problem: How long can you carry on like this?

If you are living with this person, eventually you may feel that you have no option other than to ask them to leave (or leave yourself). Day-in, day-out for years, you will have experienced the consequences of this person's behaviour, and there is only so much anyone can take. If you do decide to ask them to leave, and despite everything you still wish to help the drug user, then you should make it clear that you are doing this only because you can no longer tolerate the consequences of the drug use. Do not blame the person themselves – do blame the drugs. Make it clear that it is only the person themselves that can do something about this, and that if they wish to seek help you will be available to support them in doing this – but only if it is they who make the first move, and then continue to make further moves.

STAGE TWO: EMPATHY AND SELF-EFFICACY

EMPATHY

Empathy is defined as 'the power of understanding and imaginatively entering into another person's feelings'. Professional therapists will all try to achieve an empathic understanding of their client's feelings. If they fail to do so, this will soon become clear to the client, and the therapeutic relationship will break down – the therapy will fail. There is a very important distinction to make between empathy and sympathy. Just because you have empathically understood a person's feelings, does not automatically mean that you will demonstrate sympathy for those feelings. Equally it does not mean that you will criticise those feelings. It simply means that you have understood and no more. In fact you should in most cases avoid both sympathising with and criticising your drug user. So if this is the case, why should you try to empathise – why bother trying to understand their feelings?

If you do manage to accurately empathise with someone, then this will become clear to that person in due course – they will come to sense that you have an understanding of them. If that person is to trust you to help them, if they are to let their pride down, and reveal their fears and desires, they will have to believe that you are likely to understand these and relate to them on an intuitive level. If they sense that you will not understand them as a person, their guard will remain up – the risks of opening up will seem to outweigh the potential benefits of doing so. As you care enough about this person to be reading this now, it is likely that at least at some point in the past you have shared an empathic understanding of some kind. If the drug user in your life is to sense that it may be worth the risk of dropping their guard and admitting to you that they might have a problem, then they will have to trust that you still have some kind of an empathic understanding of their feelings. It may well be the case that you have been so bruised and battered over the years that you no longer feel an understanding or connection with this person. You will need to re-establish this if you are to succeed in your aim.

As a starting point in re-discovering a sense of empathy, you will need to understand in the first instance that your drug user is suffering from a disease, a disease of the central nervous system, and to view them as such.

Most people happily lead their lives imagining that they are personally in control of all their thoughts and actions, and that when they do something it's because they have thought about it and made a decision to do it. In fact, at many times in life nothing could be further from the truth. Think about this – you can control the rate of your breathing by saying to yourself "I'm going to take a few deep breaths in rapid succession", or "I'm going to hold my breath for one minute". Does that mean that you are totally in control of your breathing? Do you breathe by thinking about it? No – you don't – you probably haven't thought about your breathing all day until you read this. Moreover, if you did breathe by thinking about it what would happen when you go to sleep? – well, none of us would have made it past our first night on this earth. Can you hold your breath for five minutes? I very much doubt it. After a period of minutes an automatic mechanism kicks in whereby you simply have to take a breath whether you like it or not. This is one simple demonstration of the power of areas of the brain responsible for the subconscious to overcome your conscious thoughts.

I was told about another example by a colleague of mine who works as a psychiatrist. His work at that time

was on a general psychiatric ward looking after many seriously suicidal patients. His patients had all recently made serious attempts on their lives, and some of them were being held in padded rooms due their continuing attempts to kill themselves. One such patient managed to start a small fire in the corner of his room. As the fire caught hold and grew he started to panic and banged on the door of his room to be let out. As the door was opened the rush of air into the room fanned the fire, and smoke started to fill the whole ward.

Not a single patient attempted to stay in the building as the smoke spread. Not a single patient attempted to harm themselves in any way as they left the ward. All patients gathered outside the building to wait for the fire brigade to arrive. Some of them rushed there in panic. No patient took the opportunity to 'escape' from the hospital grounds once outside even though many were held there against their will under the Mental Health Act.

What is the explanation for this? Simply that the rudimentary, ingrained fear of fire caused the subconscious to take over and cause all the patients to save themselves, including the one that started the fire in the first place. For this short period of time the intensely depressive thoughts that led these patients to try to take their lives were overcome by a more primal need to escape and survive. If any of them had been able to think through the situation and control their behaviour by their thoughts, then some of them would have died that day. None did.

Now my point here is that the subconscious can be very powerful, and is quite capable of overcoming rational, conscious thought. So how is this related to drug addiction? It is these same subconscious, primeval parts of the brain that have become all powerful in people who are addicted to drugs (including alcohol). In particular there is one area of the brain that acts as a 'reward centre' (the nucleus Accumbens). When you are healthy, this part of the brain provides you with feelings of satisfaction and pleasure when you do things that are necessary for survival, such as eating, or having sex (necessary for survival of the human race). In the process of addiction, the brain's reward centre literally gets hijacked by the addictive drug. Use of addictive drugs causes the release of the same natural chemicals in the same part of the brain, as does survival activity such as sex and eating. After years of heavy drug use, the reward centre no longer responds well to activities such as eating, and sex; it increasingly responds only to the drug use.

The problem experienced by an addict on cessation of drug use is that the brain has by now become convinced that it needs a continued supply of drugs in order to survive. Messages are sent to consciousness telling the person to find their drug of choice at all costs. Imagine yourself without water in the desert for several days – how strong would your desire for water be? Is there anything that you would not do in order to get just one glass of pure, cold water? You may be prepared to do things that you would never do in any other situation. You may even be prepared to kill to get that glass of water. This is the power of the survival instinct.

This is my final example and for good reason. The craving that the dying person in the desert feels when thinking of water is the same sensation that is experienced by the addict when craving for drugs. Exactly the same brain mechanisms are involved in both responses. If you were that person in the desert and I placed a glass of water in front of you, could you refuse it? Could you refuse it even if you knew it was poisoned?

At this point in time, continued drug use really is largely beyond your user's personal, conscious control. As such, they should not be blamed for this. In order to help them to a position whereby they can start to establish a degree of conscious control over this behaviour you will need to modify your own behaviour as described in this booklet. Through the processes of feedback and allowing the person to experience the consequences of their actions, as described above, they will hopefully slowly become ready to admit that they may have a problem. They are highly unlikely to admit this to anyone, unless they sense that person has a degree of empathic understanding for them. If you never had this understanding for the person, then it is highly unlikely that you will develop it now. However, as you are driven to help them, it seems likely to me that at least at some point in the past that understanding was there.

Try to remember what your drug user used to be like. Understand that they are suffering from a disease. Bear these things in mind when interacting with the person.

SELF-EFFICACY

Self-efficacy refers to trying to enhance the person's own sense of their ability to change things for the better. This involves praising them/rewarding them for positive behaviour. Under 'responsibility' above, I talked about the importance of avoiding responses of any kind to the negative behaviours caused by drug use. However, if positive behaviours occur these should be recognised and responded to. These differing responses are consistent with the 'rules' of behavioural modification therapy. If you are trying to modify someone's behaviour, then the rule of thumb is to ignore unwanted behaviours and to reward desired behaviours. This can work well in children who are bed-wetting – they are not punished when they wet the bed, but if they do manage to go through the night without wetting, they are rewarded with a gold star. The problem with this approach in adults is that it can sometimes be seen through easily, and then experienced as 'manipulation'. You will have to be subtle in your use of praise. For example, use inflection of voice to ask a question in a way that sounds pleasantly surprised:

'You cooked for yourself tonight? That must be the first time in a while. (+/-Well done).'
'You finally finished that project? That's great.'
'Did I notice that you got in on time for the whole week?'

If you sense that your rewarding questions and statements are being received appreciatively, you can become a little more direct with these:

'It's good to see you taking a bit more care of yourself.'
'I like it when you smile.'

The importance of enhancing your drug user's sense of self-efficacy is evident from the central importance of the need for them to take personal responsibility to sort out their own problems. If they have no belief in their ability to impact positively on their environment, then the idea of taking responsibility for their actions will appear to be an overwhelming challenge.

STAGE THREE: ADVICE & MENU OF OPTIONS

The final stage of implementing these motivational tactics involves the giving of advice and alternative options by which the person may move forwards. This is the final stage, because it is vital that you avoid giving any advice until the person indicates that they are ready to be receptive to this. In other words, your drug user will have already indicated that they accept that they at least might have a problem, by the time you use these tactics.

If you deliver advice before the person has indicated a willingness to listen, then your advice will do worse than fall on deaf ears. It is only likely to push the person further into denial – to listen to your advice before they have reached their own conclusion that they might have a problem, would be to accept that they do have a problem before they have done so! Remember the theme that people have to come to their own conclusions; they have to believe that they have reached these conclusions by themselves. You must not force this, and you must not rush it. Bide your time and use the techniques above – Feedback, Responsibility, Empathy and Self-efficacy. In time, your user will hopefully reveal to you that the idea that they might have a problem with substances is starting to reach consciousness. It is only at this point that you can start to give advice, and you must give it in such a way that you do not push the person back into denial once again. You will achieve this through your style, and by the use of a 'Menu of Options'.

In the examples of conversation above, the nearest the drug user got to accepting that he/she might have a problem was to state:

Drug user: **'**No, not really – well, I know I'm doing a few lines, but I can't see that's anything to do with it.'
Helper: 'May be you're right.'

I suggested the conversation should be left here, hopefully with the words 'May be' ringing in the user's mind.

Alternatively it may continue:

Drug user: 'Why, do you think the drugs have got anything to do with it?'
Helper: 'Well looking from the outside, it does seem to be the cause of a few problems you're having. I mean I might be wrong. What do you think?'
Drug user: 'I'm not sure.'

Helper: 'I can say that you haven't looked very well to me for quite some time now. Do you feel ill?'
Drug user: 'I'm feeling worn out the whole time.'
Helper: 'Is there anything you'd like me to do?'
Drug user: 'What can you do – what is there to do?'
Helper: 'Well may be we should try to find out if the drugs have got anything to do with this or not – may be they have, may be they haven't'.
Drug user: 'And how are we going to do that?'
Helper: 'If I find out some information, I could leave it with you to have a look at.'
Drug user: 'And how's that going to help?'
Helper: 'I don't know; could it do any harm?'
Drug user: 'I suppose not.'

Within the next day or so (not rushed) you should then leave some independently written informational materials for the person to browse. Don't expect immediate results, and don't expect the person to read them immediately. Leave it for them, and don't follow up. Wait for them to bring it up in conversation. When and if your user does raise the issue, whether in a positive or a negative light, you should be prepared to suggest a number of options for a meaningful way forward. Things will probably still be at the phase of change of the person's thinking whereby you will have to approach it from the angle of 'let's ascertain whether you have a problem or not'.

Your options here will include:

1. Visiting the GP to see if there is any sign of damage due to drug use and for general advice.
2. Making a self-referral to your local NHS Community Drug and Alcohol Team for an assessment.
3. Make an appointment with a counsellor for a more general look at the problems in the person's life, and an impression on whether drug use is causing or exacerbating these.

The important point here is that the drug user makes the decision about which one of these routes to follow – your role is merely to give advice as to the possible options. If you leave only one option, then this has effectively become your decision and not the user's. If your drug user is not ready to approach any of these options at this time, do not force the issue; but you will be on safer ground by now than before if you choose to bring the issue up again yourself at some point in the future. The person has by now clearly started to contemplate that there might be a problem. You have also introduced a number of means by which he/she can establish INDEPENDENTLY whether or not this is the case.

And this is also a central point – you must not take on the role of the professional helper. I do not say this out of any sense of ego or protecting my own role or that of my colleagues. I say this because, if handled in the right way, the professional role has many advantages over your own in terms of moving the person on – purely because the drug user is more likely to believe that the professional's advice is independent of any ulterior motive. When you are emotionally involved with someone you are trying to help, that person will often have a tendency to think that you are trying to do this for yourself on some level – to ease your own burden. Equally, as they are emotionally involved with you and they are aware that their behaviour impacts on you in various ways, it is more difficult for your drug user to admit to you that they may be responsible for the difficulties you are experiencing, than it is to admit this to someone independent who they perceive as non-judgemental. All good workers in the field will try to demonstrate 'unconditional positive regard' for their drug addicted patients. And it is much easier for them to do it than it is for you, for the simple reason that they are not at the receiving end of the user's behaviour on a regular basis.

CONCLUSION

Try to remember the following essential principles in your interactions with your drug user:

1. People need to make their own decisions – support but do not order, bully or beg.
2. Never directly disagree with the person, but do not pretend that you agree with them either (if you don't).
3. Ask questions, avoid statements!
4. Try to highlight inconsistencies in the statements made in a way that does not engender a feeling of resistance in the person you are trying to help.
5. Roll with Resistance.
6. Demonstrate empathy and concern – try to avoid outright sympathy or criticism.
7. Don't rush it – bide your time and wait for a spontaneous response.
8. Accept that the person's drug use is driven by subconscious influences, and is largely beyond their direct control. The person is suffering from a disease of the central nervous system called drug dependency.
9. Allow the natural consequences of the drug-using behaviour to occur – neither help nor hinder.
10. Try to avoid taking on the role of the professional helper.

OTHER WAYS FORWARD

1. If you make no progress using the techniques above, it may be the case that a home visit by a professional trained in these techniques will cause a shift in thinking of the person you are trying to help.

HELP FOR YOU

3. The organisation Families Anonymous developed out of Alcoholics Anonymous and is specifically aimed at friends and relatives of those with a drug problem. They hold a large number of group sessions throughout the UK. If you require details of the nearest such meeting to you, telephone: 0845 1200 660.

4. Living with or caring for someone with a drug problem can often be a very draining and demanding task. It is often the case that carers in this situation become depressed or just need someone to talk to in confidence about their problems.

The author is available for personal appointments in Harley Street. To book an appointment telephone 020 7125 0166.