Understanding and Managing Harmful Drinking and Substance Use: Practitioner Guide

THE TALKING THERAPIES UK PRACTITIONER GUIDES



Understanding and Managing Harmful Drinking and Substance Use: Practitioner Guide

Delivering the programme as guided self-help, with the whole workbook

A practitioner guide · 8 contacts · with the whole workbook

TALKING THERAPIES UK

First edition · 2026

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First edition, 2026.

This guide accompanies the Understanding and Managing Harmful Drinking and Substance Use programme on the Talking Therapies UK self-help platform, and holds its workbook in full. It is drawn from the programme and is kept current with it: whenever the programme changes, the guide is set again.

Revised and expanded edition, November 2026: the approach and its evidence, written practitioner notes and a worked example for every contact, the module's own teaching set out for the practitioner, and the answers to every sorting task and quiz.

Revision 2. This printing was set on 25 November 2026 from the programme as it stood that day.

A note on clinical responsibility. This guide supports qualified practitioners delivering guided self-help within their competence, their supervision and their organisation's policies. It does not replace clinical judgement, and its thresholds are guidance: where your service's policy differs, follow your service's policy.

Set in Poppins and Roboto, the Talking Therapies UK typefaces.

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How to use this guide

This guide is for qualified practitioners who support clients through the Understanding and Managing Harmful Drinking and Substance Use programme as guided self-help: a short supported contact after each of its 8 modules, with the client working through the programme or its workbook in between. It holds the whole workbook as well, every chapter and worksheet as the client reads it, so you can see exactly what the client has in front of them.

Part 1 sets out the model the programme is built on, what the research shows, and who the programme is for. Part 2 covers what every contact needs: your part in guided self-help, how to structure a contact, how to review each kind of worksheet, what to do when the work is not being done, how to adapt the programme, the check-ins and when to step up, and risk. Read Parts 1 and 2 before you begin with a client.

Part 3 has a chapter for each contact, to read before that contact: what the client has read in the module, why the skill matters, the messages to reinforce, a plan, the questions to ask, a worked example with dialogue, how to review the week's worksheets with their answers, and what to do when the skill is hard, how to adapt it and its cautions. Part 4 covers ending the work, supervision, and the checklist.

From Part 5 the guide holds the workbook itself, complete, in a part for each module: every chapter and worksheet as the client reads it, so you can see exactly what the client has in front of them without buying the workbook as well. The answers to its sorting tasks and quizzes are in Part 3, in the chapter for each contact.

The guide follows the programme as it stands on the platform, so its plans name the programme's own modules, teaching and worksheets, and it is set again whenever the programme changes.

What this guide covers

- The model the programme is built on, and what the research shows
- Who the programme suits, how to assess for it, and when it is not enough on its own
- Your part in guided self-help, and how to structure each contact
- For each of the 8 contacts: what the client has read, why it matters, a worked example with dialogue, a plan, and the worksheets with their answers
- What to do when a skill is hard to learn or use, how to adapt it, and its cautions
- Keeping the work going, adapting the programme, the check-ins and stepping up, and risk at every contact
- Ending well, supervision, and a checklist for delivering the programme as designed
- Every chapter and worksheet of the workbook, as the client reads it

PART 1

The approach and the evidence

The model the programme is built on, what the research shows, and who the programme is for.

In this part

- Chapter 1, The purpose and the evidence: what this programme does, the evidence for its stages-of-change and relapse-prevention content, and the line it does not cross
- Chapter 2, Who the programme is for: who it suits, how to assess for it, and when it is not enough on its own

CHAPTER 1

The purpose and the evidence

A spectrum, not a label

This programme is built for hazardous and harmful substance use, the broad range sitting below dependence, where a client's own drinking or drug use is causing or risking harm but has not produced the physiological and psychological dependence that specialist treatment services and, often, medically supported withdrawal are built for. The AUDIT-C, the three-question screening tool used in module 1, was developed and validated as a brief, reliable way of identifying this range in routine settings (Bush, Kivlahan, McDonell, Fihn, & Bradley, 1998), and its scoring is what the programme's own sorting exercise in module 1 is built around.

The programme's account of why harmful use develops and persists draws on the stages-of-change model, which frames ambivalence about change as a normal stage to move through rather than a failure of resolve (Prochaska & DiClemente, 1983). Its central relapse-prevention content, the craving curve, urge surfing, the abstinence violation effect, and the distinction between a lapse and a relapse, draws directly on the relapse prevention model developed by Alan Marlatt and Judith Gordon, still the dominant framework used in substance-use treatment for helping someone recover from a slip without it becoming a full return to the old pattern (Marlatt & Gordon, 1985). Where UK clinical guidance is directly relevant, the programme's psychoeducation is consistent with the National Institute for Health and Care Excellence's guidance on preventing and managing alcohol-use disorders (NICE, 2010, 2011).

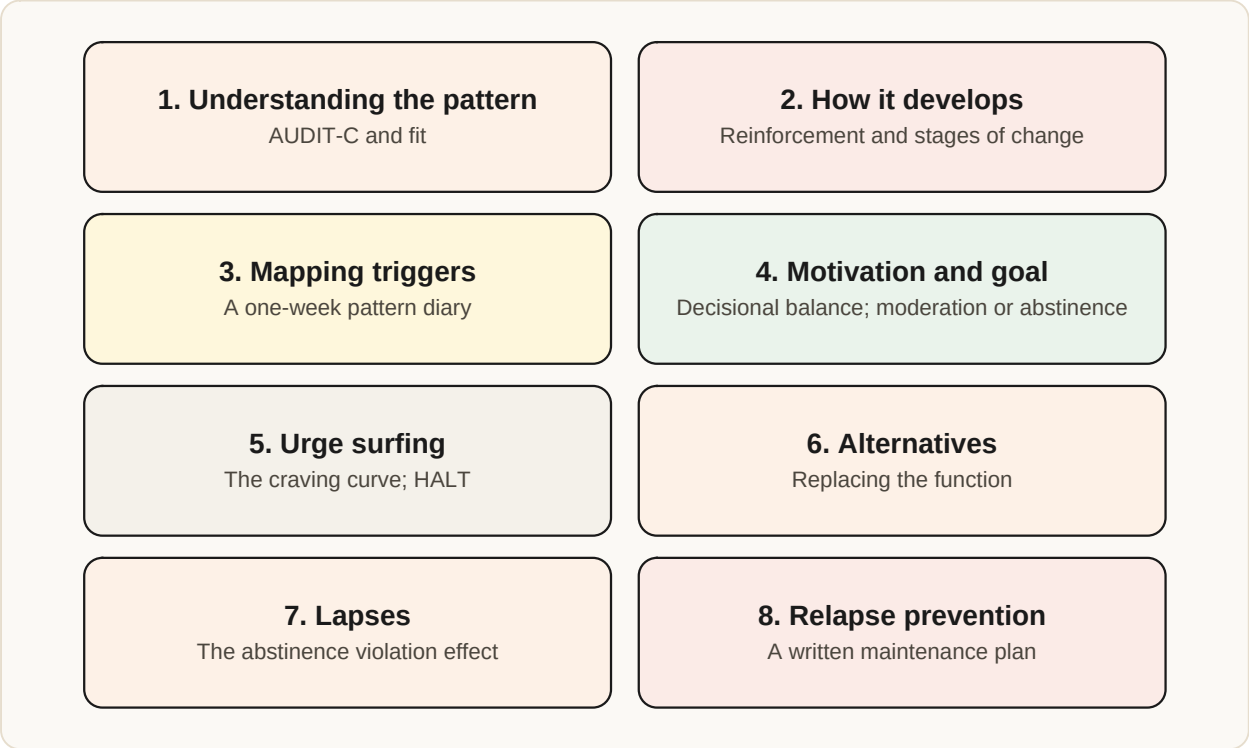


FIGURE 1.1 Eight modules: from screening to a maintained plan
The programme screens and locates the client's own pattern first, then builds the motivational, pattern-mapping and goal-setting groundwork before the practical skills, and closes with lapse response and relapse prevention.

The PHQ-9 and WSAS are taken in module 1, and the PHQ-9, GAD-7 and WSAS in modules 4 and 8.

What the practitioner adds

The practitioner's central task across this programme is holding a position Marlatt himself described as central to relapse prevention: taking a lapse seriously without treating it as proof the whole effort has failed. A client who has had a difficult week with their drinking or drug use is often at their most ashamed and most likely to disengage at exactly the point contact with a practitioner would help most; a calm, non-judgemental, curious response from the practitioner, treating the lapse as data rather than as a verdict, does more to keep the client engaged than any specific technique. The second task is honest, ongoing screening: a pattern that looked hazardous at module 1 can look different by module 4 or 8, in either direction, and the practitioner should not assume the module 1 picture still holds without checking.

The line this programme does not cross

This programme does not manage alcohol or drug withdrawal, does not replace assessment and treatment by a specialist alcohol and drug service, and is not the right tool for a pattern that has crossed into dependence, marked by withdrawal symptoms, a need to use increasing amounts for the same effect, or a felt inability to stop without support. Where module 1's screening or anything disclosed later in the programme points towards dependence, the practitioner should say so plainly and signpost to the client's GP or local drug and alcohol service rather than continuing with this programme's self-help techniques.

CHAPTER 2

Who the programme is for

Harmful and risky substance use sits on a spectrum, and most of that spectrum is never seen by specialist addiction services at all. At one end is use that carries no meaningful risk; further along is hazardous use, a pattern that increases the chance of future harm without having caused it yet; further still is harmful use, where real harm, to physical health, relationships, work, mood, or safety, is already occurring; and at the far end is dependence, a distinct clinical state with its own behavioural, cognitive and physiological features. This programme is built for the hazardous and harmful end of that spectrum, for people whose own drinking or other substance use has become a genuine concern but who are not physically dependent, and it is deliberately not built for dependence, which needs a different kind of help first and is explained fully, with the reasoning behind that boundary, in Module 1. This programme draws on several converging evidence bases. The National Institute for Health and Care Excellence's guidance on alcohol-use disorders, set out in public health guideline PH24 and clinical guideline CG115, establishes screening and brief structured intervention as the appropriate first response to hazardous and harmful drinking, reserving more intensive medical and psychosocial treatment for dependence; this programme is built in that spirit, as a structured brief intervention a person can work through at their own pace. The AUDIT-C screening tool, a shortened three-question version of the World Health Organization's Alcohol Use Disorders Identification Test, gives a quick and well-validated way of placing a person's own drinking on this spectrum, and Module 1 walks through it in full. Marlatt and Gordon's relapse prevention model, developed from the 1980s onward and still the dominant framework in the field, supplies two of this programme's central techniques: urge surfing, a specific way of riding out a craving rather than fighting it or being swept along by it, and a clear-eyed account of what actually happens psychologically after a lapse, named the abstinence violation effect, which this programme works with directly rather than pretending lapses will not happen. Prochaska and DiClemente's stages-of-change model, originally developed by studying how people actually change addictive behaviours successfully, frames readiness to change as something that moves through recognisable stages rather than being simply present or absent, which this programme uses to help you locate yourself honestly and work from where you actually are rather than where you feel you ought to be. The programme is framed primarily, though not exclusively, around alcohol, and it is worth being honest about why. Alcohol is where the validated UK screening tools, the clearest guideline-level evidence for structured self-help, and the largest body of relapse-prevention research all sit most solidly for an adult population working independently. Other substances are not absent from this programme's thinking, and several of the vignettes and much of the underlying psychology throughout, reinforcement, tolerance, cue reactivity, the stages of change, urge surfing, the abstinence violation effect, apply to cannabis, stimulants and other substances in broadly the same way. But some substances carry withdrawal risks that alcohol shares with very few others, and a small number carry risks that are substantially more dangerous again; these differences matter enormously for safety and are set out plainly in Module 1, because the single most important thing this programme can do for some readers is to send them to a GP or a specialist drug and alcohol service before they attempt anything else, rather than to a self-help course. Who this is for. The programme is suitable for

adults whose own honest answers to the AUDIT-C screen and the pattern description in Module 1 place them in the hazardous or harmful range, who are experiencing some degree of risk or harm, whether to physical health, mood, relationships, work, finances or safety, from their own drinking or other substance use, and who show no signs of physical dependence: no withdrawal symptoms such as shaking, sweating, nausea or anxiety when use is delayed or stopped, no drinking or using first thing to feel normal or to settle such symptoms, and no history of a withdrawal seizure or delirium. Many adults whose substance use has become a genuine worry fit this description precisely: drinking considerably more than the UK low-risk guideline of fourteen units a week, or using another substance in a way that is clearly causing some harm, without having crossed into the territory where stopping abruptly carries its own medical danger. Who this is not for, and where to go instead. If your own pattern shows any sign of physical dependence as just described, please see your GP before attempting to cut down or stop, even gradually; Module 1 explains exactly why this matters and what a GP or specialist alcohol service can offer that this programme cannot. If your main substance of concern is an opioid, a benzodiazepine, or another substance with a similarly dangerous withdrawal profile, a specialist drug and alcohol service is the right route in place of this programme regardless of how dependent you believe yourself to be, because the risk calculation for these substances is different from alcohol's in ways Module 1 sets out in full. If you are under eighteen, young people's substance misuse services are the age-appropriate route. If your concern is someone else's drinking or substance use rather than your own, a structured self-help course aimed at your own behaviour is the wrong tool for that situation; the practice's separate programme, Supporting Someone Else's Drinking or Substance Use, is written specifically for family members and carers in that position. And if you are experiencing a mental health crisis, including thoughts of suicide or self-harm, please use the safety information in Module 1 and seek urgent help before, or alongside, anything in this programme.

What the programme covers

1. Understanding Harmful and Risky Substance Use
2. How Harmful Use Develops and Is Maintained
3. Mapping Your Own Pattern and Triggers
4. Building Motivation and Setting Your Goal
5. Urge Surfing and Managing Cravings
6. Building Alternatives and Coping Skills
7. Lapses, Shame, and the Abstinence Violation Effect
8. Relapse Prevention and Maintaining Change

Who it suits

- Adults whose difficulties are of mild to moderate severity on assessment, in the area the programme addresses.
- Clients who want to work on the difficulty themselves between contacts, and can set aside time each week to read and to complete the worksheets.
- Clients who can read and write in English, or who have the support to do so.

When it is not enough on its own

- Current risk to self or others, including thoughts of ending their life with any plan or intent: assess and manage the risk first, under your service's policy.
- Severe difficulties on assessment, including a PHQ-9 of 20 or more or a GAD-7 of 15 or more: offer high-intensity therapy, or deliver the programme only alongside it.
- Psychosis, mania, or drug or alcohol dependence that is not being treated.
- A previous course of guided self-help that did not help, where the reasons have not changed.

Assessing for the programme

The programme suits an adult whose own use of alcohol or another substance sits in the hazardous or harmful range, causing or risking harm to health, relationships, work or finances, without signs of dependence, and where module 1's AUDIT-C and sorting exercise support this. There is no single cut-off score to apply mechanically; the client's own account of impact and any withdrawal history matters alongside the AUDIT-C figure.

When another approach should come first

- Any sign of physical dependence, withdrawal symptoms such as shaking, sweating, or anxiety when use stops or reduces, drinking first thing to settle the body, or a felt inability to stop without support, needs assessment by a GP or a specialist alcohol and drug service before this programme; stopping or sharply reducing alcohol after sustained heavy use can be medically dangerous and needs supervision.
- Use of any illicit drug alongside alcohol, or a pattern involving more than one substance, needs a specialist assessment first, since this programme's content and techniques are written with alcohol as the primary example.
- A client who is pregnant or planning pregnancy needs their GP or midwife involved directly regarding any alcohol or drug use; this is a medical conversation this programme is not built to replace.
- Thoughts of suicide or self-harm, or any safety concern, needs direct attention first (Chapter 9); substance use and low mood frequently interact, and either can worsen the other.

Risk

Ask about the client's own safety at every contact (Chapter 9), and ask specifically about any physical withdrawal symptoms whenever use is reduced or paused during the programme; a client attempting a sudden full stop after years of heavy drinking needs medical guidance, not just this programme's psychological techniques.

PART 2

Delivering it well

How guided self-help works and what your part in it is: structuring each contact, reviewing the worksheets, keeping the work going, adapting it, the check-ins, and risk.

In this part

- Chapter 3, Guided self-help and your part in it: what guided self-help is, what the research says about support, and what your role is and is not
- Chapter 4, Structuring each contact: agreeing the work at the start, a thirty-minute contact minute by minute, and working by telephone or video
- Chapter 5, Reviewing the worksheets: why the practice matters, a method for reviewing it, and what to look for in each kind of worksheet the programme uses
- Chapter 6, When the work is not being done: why practice does not happen, and what helps

CHAPTER 3

Guided self-help and your part in it

What guided self-help is

Guided self-help pairs a structured programme, which the client works through on their own, with brief, regular contact with a trained practitioner. The programme carries the teaching: it explains the difficulty, teaches the skills, and sets the practice for each week. Your task is to help the client use it. In Understanding and Managing Harmful Drinking and Substance Use that means 8 contacts of about thirty minutes, one after each module, by telephone, video or in person, with the client reading the module and completing its worksheets in between.

This division of labour is what makes guided self-help efficient, and it is also where it most often goes wrong. A practitioner who re-teaches each module in full turns a thirty-minute contact into an under-powered therapy session and leaves no time for the client's own practice, which is where change happens. A practitioner who asks only "How did it go?" leaves the client alone with the hardest parts. The contact plans in Part 3 are built to avoid both: most of each contact is spent on what the client did, what they learned from doing it, and what they will do next.

What the research says about support

Self-help is not a lesser treatment when it is supported. Cuijpers and colleagues (2010) pooled the studies that had compared guided self-help directly with face-to-face psychotherapy for depression and anxiety disorders, and found no significant difference in effect between the two, at the end of treatment or at follow-up. Farrand and Woodford (2013) pooled randomised trials of written cognitive behavioural self-help, found it effective for anxiety and depression, and examined how the support offered alongside it relates to its effect.

Two practical conclusions follow for your contacts. The support needs to be regular and planned, booked in advance and kept, rather than offered when the client asks for it. And it needs to be about the client's use of the programme, rather than a parallel conversation about everything else in their week.

Your part, and its limits

Roth and Pilling (2008) set out the competences needed to deliver cognitive and behavioural therapies well, distinguishing the generic competences of any good therapeutic work (engaging the client, building and keeping a working alliance, ending well) from those specific to an approach. In guided self-help the generic competences carry most of the weight. Your part has five elements:

1. Engage the client and keep the alliance: warmth, interest in the client's own words and examples, and reliability, so that contacts happen when agreed and start and end on time.

2. Review the practice: look at what the client did, with their permission, and help them draw out what they learned from it.

3. Solve problems: when the practice did not happen or did not help, find out why, and agree a smaller and clearer next step.

4. Monitor outcome: score the check-ins with the client, compare them over time, and act on the stepping-up guidance in Chapter 8.

5. Keep the work safe: ask about risk at every contact, and know what you will do with the answer (Chapter 9).

What the role is not matters as much. It is not an assessment of the whole person, a formulation of their history, or open-ended therapy. When a client brings something that needs more than the programme can offer, such as a trauma history that is beginning to surface, a relationship in crisis, or a worsening of their difficulties, acknowledge it, record it, and decide with the client and your supervisor whether a different step of care is needed, rather than stretching the contacts to hold it.

The stance that helps

Clients who do well in guided self-help tend to describe a practitioner who was interested, who noticed the effort they had made, and who was clear about what came next. Specific recognition ("You filled in the diary on five days, including the Thursday you said was the worst of the week") does more than general reassurance. Curiosity about what got in the way ("What was happening on the two days the diary stayed empty?") does more than encouragement to try harder. And a

clear, small plan at the end of each contact, written down by the client in their own words, does more than a long list of good intentions.

The stance in a cognitive behavioural programme

Cognitive behavioural work rests on collaborative empiricism: the client and the practitioner treat the client's beliefs and patterns as ideas to be tested rather than facts to be argued with. In brief contacts this means asking more than telling, and turning disagreement into an experiment ("What would you expect to happen if you tried it this week? How could we find out?"). Keep a light written record of what the client has learned in their own words, so that each contact builds on the last.

CHAPTER 4

Structuring each contact

Agree the work at the start

At the first contact, agree and record:

- How many contacts there will be (8), how long each lasts (about thirty minutes), and when they will happen.
- What happens if a contact is missed, and how the client can reach the service between contacts.
- That the check-in questionnaires are part of the work, and that you will look at the scores together each time they are due.
- That you will ask about risk at every contact, what you will do if you are worried about the client's safety, and the limits of confidentiality that follow from that.
- What the client hopes will be different by the end, in their own words, and how the two of you will know.

The client's materials

Where the workbook is included with the programme, a client enrolled on it downloads the workbook free, with their name in it, from My programmes, and can print the worksheets as often as they need. Otherwise, and for a client who is not enrolled, the workbook is bought from the shop at talkingtherapies.co.uk. A workbook's worksheets may be copied only as the licence line at the foot of its pages allows, so each client needs a workbook of their own or a place on the programme. Clients who find reading hard can use the programme's narrated audio, module by module.

A thirty-minute contact

Each chapter in Part 3 has a plan for its contact. All of the plans share one shape, and knowing why each part is there makes it easier to adapt a contact that does not go as planned.

0 to 5 minutes: agenda and risk

Agree what the contact will cover, and ask about risk since the last contact. Asking about risk first, briefly and routinely, means it is never squeezed out at the end, and makes it an ordinary part of the work rather than a sign that something is wrong.

5 to 12 minutes: the practice

Look at what the client did since the last contact. This comes before anything new because it tells you what the client has understood and what they can already do, and because reviewing it is how the client learns that the practice matters. If nothing was done, this is the time to find out why (Chapter 6).

12 to 20 minutes: the module's key ideas

Ask what made sense in the module and what did not, and talk through the ideas the client found hardest, using their own examples. You are checking and deepening understanding, not delivering the module a second time.

20 to 27 minutes: the next practice

Agree exactly what the client will practise before the next contact: what, when, where, and what might get in the way. A plan tied to a specific time or cue is more likely to happen than a general intention (Gollwitzer and Sheeran, 2006). Ask the client to write it down.

27 to 30 minutes: summary and close

Ask the client to say what they are taking away, in their own words. Book the next contact, and check that they know how to get help before it.

When the plan has to change

If the client arrives in distress, or with a problem that cannot wait, the agenda changes: risk first, then what can usefully be done in the time, with the module's work carried to the next contact. Do not let every contact become crisis management, though. If two contacts in a row are taken over, review with the client and with your supervisor whether guided self-help is the right step at present.

Working by telephone or video

- At the start of each contact, confirm who you are speaking to and where they are, so that help could be sent if it were needed.
- Check that the client can talk privately, and agree what you will both do if someone comes into the room.
- Have the week's worksheet in front of you both. Ask the client to read out what they wrote, or to share it through your service's secure route if its policy allows.
- Agree at the first contact what will happen if the call drops: who will call whom, and how soon.

Recording each contact

Keep a short record of each contact: what you asked about risk and what the client said; the check-in scores when due; what practice was done and what the client learned from it; the plan for the next week; and anything to take to supervision.

CHAPTER 5

Reviewing the worksheets

Why the practice matters

The programme teaches a skill in a module, but the client learns it between contacts, by using it in their own life. Reviewing the practice at every contact does three things: it shows the client that the practice is the centre of the work rather than an optional extra; it lets you see what they have understood, which is often different from what the module said; and it turns an experience ("I tried it and it didn't work") into learning ("It didn't work when I was already at nine out of ten; at six it did").

A method for reviewing any worksheet

1. Ask permission to look at what the client wrote, and let them choose what to share. A client who has written something personal may want to summarise it rather than read it out.
2. Notice the effort first, and be specific about it.
3. Ask what the client noticed or learned while doing it, before you offer anything yourself.
4. Correct gently where the client has misunderstood the task, using their own example rather than a new one.
5. Link what they learned to the next practice: "Given that, what would you like to try this week?"

The chapters in Part 3 say what each of this programme's worksheets asks and, for sorting tasks and quizzes, give the answers with the reasons the programme gives. What follows is how to review each kind of worksheet the programme uses.

Sorting tasks

A sorting task asks the client to place a set of examples into the categories the module has taught, such as the skill each example shows or the state of mind it belongs to. It checks understanding before the client is asked to use the ideas on their own experience. Go through the items the client placed differently from the answers, and ask what made them choose as they did: a wrong placement usually shows which distinction is not yet clear, and is worth more than a right one. When the categories are confusing, go back to the module's definitions and work through one of the client's own examples together, rather than giving the answers.

Reflections

A reflection asks the client to write in their own words about what the module means for them. It is how the general teaching becomes personal. With the client's permission, read what they wrote with them, and reflect back the one or two things that stand out, especially any link between the skill and their own situation. When the page is blank, it often means "I didn't know what you wanted" rather than "I don't care": ask the question in the contact, and write the client's answer down with them, so that the page holds their words.

Written answers

A written answer asks the client to apply the module to their own life. Read it with them, with their permission, and help them make it specific: who, where, when, and what exactly. When the client has written in generalities (“I need to be calmer”), ask for one example from the past week.

When-then plans

A when-then plan links a specific cue (“when I put the kettle on in the morning”) to a specific action (“I will do one minute of paced breathing”). Plans in this form are more likely to be acted on than general intentions (Gollwitzer and Sheeran, 2006). Check that each plan names a cue that happens every day without fail and an action that takes a couple of minutes. When the plans do not happen, find out which part failed: a cue that did not occur needs a more reliable cue, and an action that felt too much needs a smaller action.

Ratings

A rating puts a number on something that is otherwise hard to compare from week to week. Compare the ratings with the last time they were made, and ask what has changed where a rating has moved by more than two points. When the client finds it hard to put a number on something, anchor the ends of the scale with real moments from their own week.

Thought records

A thought record separates a situation, the thought it brought, and the feeling that followed, and then weighs the thought against the evidence. Check that the three are kept apart and that the balanced thought weighs the evidence rather than simply cancelling the first thought. When thoughts and feelings run together, ask “What went through your mind?” for the thought and “What did you feel?” for the emotion, and fill in one line together.

CHAPTER 6

When the work is not being done

Why practice does not happen

Every guided self-help practitioner meets a client who has not done the week's practice. It is the most common difficulty in the work, and the most useful one to understand, because the reason it did not happen usually points to what will help. The common reasons are these:

- Practical: no time, no privacy, the worksheet was lost, the module was not read.
- Unclear: the client did not understand what to do, or what it was for.
- Doubt: the client does not believe it will help, often because something similar has not helped before.
- Avoidance: the practice brings the client close to what they fear or find painful, and not doing it brings relief.
- Low mood and low energy: depression makes every task harder to start, and makes the client blame themselves for not starting.
- Ambivalence: part of the client wants things to change and part of them does not, or not yet.
- Events: something happened in the week that took over.

Responding without blame

Ask with curiosity rather than disappointment: "What got in the way?" and then "What would have made it possible?" A client who expects to be told off will often say what they think you want to hear, or not come back. Thank them for telling you, and treat the missed practice as information.

Then match the response to the reason. A practical barrier needs a practical solution, agreed before the contact ends. An unclear task needs explaining again, ideally by doing part of it together in the contact. Doubt is best met by an experiment ("Would you be willing to try it three times this week, and see what you notice?") rather than by argument. Avoidance usually needs a smaller step that comes less close to what is feared. Low mood needs a smaller, fixed task, and recognition that starting at all is the achievement.

Making the practice smaller and fixed

The most reliable change you can make is to shrink the practice and fix it to a moment in the client's day. "Practise the skill every day" rarely happens. "When I sit down with my first cup of tea, I will spend two minutes on it" often does, because the cue does the remembering (Gollwitzer and Sheeran, 2006). Ask the client to write the plan in the form "When ..., I will ...".

Working with ambivalence

When the client is in two minds about change, arguing for change usually strengthens the other side of the argument. Motivational interviewing (Miller and Rollnick, 2013) offers a better route: ask about the client's own reasons for wanting things to be different, listen for them, and reflect them back; acknowledge the reasons for staying the same as real; and leave the decision with the

client. “On the one hand the arguments with your partner are exhausting you; on the other, trying something new in the middle of one feels impossible. Where does that leave you for this week?”

Practical barriers to reading and writing

Some clients find the reading or the writing hard, through dyslexia, a visual impairment, limited English, or simply tiredness. The programme’s narrated audio covers every module. Worksheets can be completed in the contact, with you writing down what the client says. Shorter, more frequent practice, five minutes most days, often works better than one long session a week.

When to pause, or change step

If two contacts in a row pass without any practice, review with the client whether this is the right time and the right programme, and take it to supervision. Guided self-help suits people who can do some work between contacts; for someone who cannot at present, a different step of care, or a planned pause and a return when circumstances change, may serve them better than continuing.

The end of the sample

This is a free sample of “Understanding and Managing Harmful Drinking and Substance Use: Practitioner Guide”, and it ends here.

Everything you have read here is from the opening of the book, set exactly as it is printed in it. The rest follows in the same way, chapter by chapter, with its worksheets, its examples and its reference list.

The full book is on sale in the Talking Therapies UK shop. A copy is yours to keep, as a PDF and an ebook, licensed to you by name: a short line saying so is printed at the foot of each page of the PDF and on the title page of the ebook.