

Training Curriculum on Drug Addiction Counseling



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TRAINING CURRICULUM ON DRUG ADDICTION COUNSELING

PARTICIPANT MANUAL



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AUTHORSHIP

Dr. Robert Ali, Director of the WHO Collaborating Center for Research on Treatment of Drug and Alcohol Problems, Adelaide University, Australia

Ms. Vuong Thi Huong Thu, Program Manager, FHI/Vietnam

Dr. Nguyen To Nhu, Program Manager, FHI/Vietnam

Ms. Pham Thi Huong, former Chief of Vulnerable Populations Section, CDC Vietnam

Dr. Kevin Mulvey, former Senior Technical Advisor, FHI/Vietnam

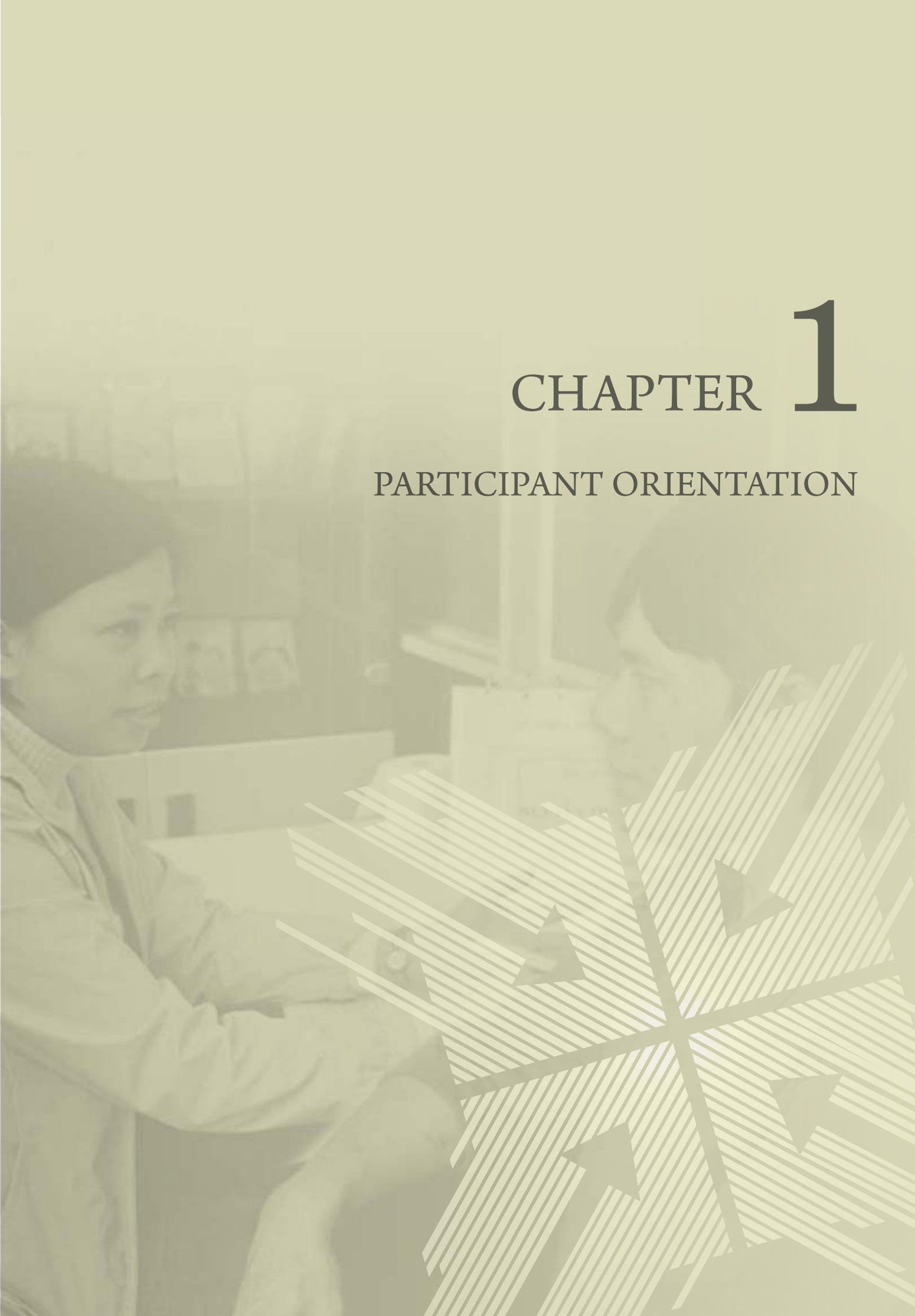
Dr. Hoang Nam Thai, Program Officer, FHI/Vietnam

Daniel M. Levitt, Editor

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CHAPTER 1

PARTICIPANT ORIENTATION



Introduction

Welcome! This training curriculum is designed to teach you the knowledge and skills you need to improve your service to those who use substances, particularly those with or at risk of contracting HIV/AIDS. Congratulations for taking the time to learn more about your work.

The 9 chapters with 35 sessions in this participant package will be delivered in Basic and Advanced training course on Drug Addiction Treatment Counseling. Each session/chapter also can be used separately to target a specific training need. Your trainer will provide you with a specific agenda to each training course.

The learning approach for this training includes:

- Presentations and discussions;
- Demonstration
- Frequent use of small-group
- Partner-to-partner exercises and role plays and
- Reflective writing exercises

Overall Training Goal and Learning Objectives

Overall goal of the training

To increase the knowledge base and skill level of drug addiction counselors, to enhance the effectiveness of their work with drug users.

Learning Objectives

Participants who complete the training will be able to

- Understand and know how to provide counseling sessions to the clients who are drug users, including
 - Describe the roles and responsibilities of drug addictions counselors
 - Articulate the counselling process
 - Explain principles and practices of drug addiction counselling
 - Explain the basis of addiction, recovery and relapse

- Explain information on different types of drug dependence treatment approaches internationally including
 - Abstinence-based treatment models and
 - Substitution treatment models
 - Explain drug treatment services available in Vietnam
 - Explain factors influencing successful drug dependence treatment
- Develop micro drug addiction treatment counselling skills:
 - Conducting an assessment of drug use of clients
 - Motivational interviewing
 - Short-term goal setting
 - Problem solving
- Provide relapse prevention knowledge, skills and services to clients with focus on:
 - Managing high risk situations
 - Refusal skills
 - Coping with cravings
 - Dealing with lapse and relapse
- Conduct an assessment of client's history of drug use, developed individualised management plan and provide on-going follow-up and support.
- Develop counselling skills and techniques in :
 - Time management
 - Stress management
 - Anger management
 - Conflict resolution
 - Management of intoxicated people
 - Family to enhance support
 - Integration HIV prevention in Drug Addiction Counselling
 - Working with youth
 - Working with women
 - Harm reduction issue
- Develop counselling skills and techniques in :
 - Supervision and support
 - Implementing case conference
 - Burn-out prevention

Overview of the Participant Manual

Each session of your Participant's Manual includes:

- Goals and objectives;
- PowerPoint slides;
- Handout including examples, guidelines, exercises, tables..

Besides, at the end of each day, we will have evaluation form and at the end of the training course we will have final evaluation form.

At the end of the advance course, the participants are required to take an exam and only those who past the exam and participated in the class more than 90% can receive the certificate of completion.

Your trainer will also give you a notebook to use as your personal journal. You can use this journal in a number of ways. You can note

- Topics you would like to read more about;
- A principle you would like to think more about;
- A technique you would like to try;
- Ways you might be able to add some of the things you're learning to your practice; and
- Possible agency or personal barriers to using new techniques.

Your trainer may also ask you to write about something specific you are learning.

Getting the Most from Your Training Experience

To get the most from your training experience:

- Speak to your supervisor before the training begins. Find out what his or her expectations are for you.
- Think about what you want to learn from each module.

- Come to each session prepared; review the manual pages for the modules to be presented.
- Be an active participant. Participate in the exercises, ask questions, write in your journal, and think about what additional information you want.
- Speak to your supervisor after the training. Talk to him or her about what you learned to be sure you understand how the information relates to your job.
- Discuss with your supervisor ways that you can put your learning into practice, and continue to follow up with him or her.
- Have fun!

CHAPTER 2

WHAT IS DRUG ADDICTION COUNSELING?

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Unit 2.1

INTRODUCTION TO GENERAL COUNSELLING

Learning Objectives

At the end of this unit, participants will be able to:

- provide the definition of counseling
- understand the context of counseling
- understand the existing myths about drug use and drug users
- state the differences between counseling and health education
- identify attributes that make an ideal counselor

Content and Timeline

Introduction	1 minutes
Presentation	30 minutes
Conclusion	9 minutes

Unit 2.1



LEARNING OBJECTIVES

At the end of this unit, participants will be able to:

- provide the definition of counseling
- understand the context of counseling
- understand the existing myths about drug use and drug users
- state the difference between counseling and health education
- identify attributes that make an ideal counselor

2

CONTEXT FOR COUNSELING (1)

Drug users:

- experience discrimination, stigmatization and rejection in society
- often viewed as criminals and outcasts and a target for society's anger and fear

3

CONTEXT FOR COUNSELING (2)

What do drug users worry about?

- Further discrimination
- Their future
- Others talking about their drug use
- Lack of treatment access
- Counseling won't work
- Lack of treatment (HIV)

4

MYTHS ABOUT DRUG USE

"People who use drugs are always morally weak."

"Addicts are beyond help."

"All drug users are drug addicts."

"All drug users are criminals."

5

WHAT IS COUNSELING?

Counseling is an interactive exchange process between counselors and clients to help clients confidentially explore their problems and enhance their capacity to solve their own problems.

6

AIM OF COUNSELING

Helps clients take charge of their lives by:

- developing their ability to make wise and realistic decisions
- assisting them to alter their own behavior to produce desirable results
- providing information for informed decision making

Counseling can be for individuals, couples, groups or families

7

COUNSELING IS NOT

- Telling or directing
- A conversation
- An interrogation
- A confession
- Praying

8

Unit 2.1

WHAT IS THE DIFFERENCE BETWEEN COUNSELING AND HEALTH EDUCATION? (1)

Counseling	Health Education
Confidential	Not usually confidential
Usually "one-to-one" or small group	Small or large groups of people
Evokes strong emotions in both client and counselor	Emotionally neutral in nature
Counselor listens attentively and reflects	Health educator talks more
Focused, specific and goal-oriented	Generalized

9

WHAT IS THE DIFFERENCE BETWEEN COUNSELING AND HEALTH EDUCATION? (2)

Counseling	Health education
Information used to change attitudes and motivate behavior change	Information used to increase knowledge and to educate
Issue-oriented	Content-oriented
Based on needs of the clients	Based on public health needs

10

WHAT ATTRIBUTES MAKE AN IDEAL COUNSELOR

- Creative and imaginative
- Practical
- Shows respect for client
- Action-oriented
- Doesn't impose own views or concerns

11

THINGS TO AVOID

- Moralizing
- Ordering
- Threatening
- Arguing
- Disagreeing
- Over-interpreting
- Sympathizing
- Judging

12

SUMMARY

- Counseling helps clients take charge of their lives.
- Counseling can be provided to individuals, couples or families.
- An ideal counselor is creative and imaginative, has a practical approach, is able to show respect for clients, is action-oriented and does not impose his/her own views or concerns.
- Counseling is different from health education.

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Unit 2.2

BASIC CONCEPTS OF DRUG ADDICTION COUNSELLING

Learning Objectives

At the end of this session, participants will be able to:

- explain the definition of drug addiction counseling
- explain the role of drug addiction counseling
- list 4 general principles for effective communication
- explain the differences between empathy and sympathy

Content and Timeline

Introduction	1 minutes
Presentation	25 minutes
Conclusion	4 minutes

Unit 2.2



LEARNING OBJECTIVES

At the end of this unit, you will know:

- explain the definition of drug addiction counseling
- explain the role of drug addiction counseling:
 - how to encourage and motivate clients to reduce their drug use-related risk
 - how to support clients to seek care and support
- list 4 general principles for effective communication
- explain the differences between empathy and sympathy

2

DRUG ADDICTION COUNSELING

- **What is drug addiction counseling?**

An intervention which gives the client an opportunity to explore his or her drug use and consequences confidentially, and to discuss available treatment options most appropriate to his/her circumstances
- **Why is drug addiction counseling needed?**
 - to encourage and motivate clients to reduce their drug use-related risks
 - to support clients in seeking care and support
 - drug users who wish to stop using drugs often benefit from counseling in combination with treatment options

3

ROLE OF COUNSELING

Counseling sessions help clients:

- reduce risk or stop drug use
- set goals and develop plans
- develop problem solving and refusal skills
- identify risky situations
- identify ways to deal with risk

4

COMMUNICATION ATTRIBUTES

- Effective communication:
 - clear and non-judgmental
 - assists in building rapport
 - develops a sense of trust
- Effective communication is the key in:
 - undertaking a quality assessment
 - managing drug-related problems

5

GENERAL PRINCIPLES OF COMMUNICATION

- Develop rapport and a sense of trust
- Attend to the person's immediate concerns
- Show concern about the client's drug use problems without prejudice
- Use appropriate language to overcome potential communication barriers

6

EMPATHY VS SYMPATHY

- **Empathize**
 - Listen to and understand client's experience from his/her perspective
 - Not always in agreement
 - Summarize and provide feedback
 - Help client find own solutions
 - Client's suffering is not your burden
- **Sympathize**
 - Always side with client
 - Emotionally involved
 - Experience as if burden is shared

7

SUMMARY

- **Drug addiction counseling is**
 - an intervention, confidential, provides options
- **Role of drug addiction counseling**
 - to encourage and motivate client, to reduce risks associated with drug use
 - to support clients to seek care and support
- **Effective communication**
 - develops rapport, responds to immediate concerns
 - shows concern without prejudice
 - uses appropriate language
- **Empathy works, sympathy doesn't**

8

Unit 2.3

KEY PRINCIPLES IN DRUG ADDICTION COUNSELING

Learning Objectives

At the end of this session, participants will be able to:

- understand the following concepts: voluntary, confidential, reliable, non-judgmental, respectful, safe, and linked to other services
- know how to explain the implication of each principle

Content and Timeline

Introduction	1 minutes
Presentation	20 minutes
Conclusion	4 minutes

Unit 2.3



LEARNING OBJECTIVES

At the end of this unit, participants will be able to:

- list and understand the seven principles of drug addiction counseling
- explain the implications of each principle

2

KEY PRINCIPLES

- Voluntary
- Confidential
- Reliable
- Non-judgmental
- Respectful
- Safe
- Linked with other services

3

VOLUNTARY

- Support clients to make decisions on their own
 - Clients make decisions by themselves
 - Clients do not feel forced to do anything
 - Any breach will damage whatever trust has been built

4

CONFIDENTIALITY

- Confidentiality must be assured
 - Client personal information kept confidential
 - Prevents reference to, or discussion about a client, except as professionally appropriate, and then only with client's consent
 - Any breach of confidence will damage any trust that was built

5

RELIABLE

- Express sincere empathy
- Make clients feel they are being listened to and cared for
- Provide accurate information and clear explanations
- Demonstrate confidentiality

6

NON-JUDGEMENTAL

- Always stay neutral, without reaction to clients' issues
- Counsel only after learning from clients' experience
- Obtain and maintain an understanding of clients' perception of norms

7

RESPECTFUL

- Treat every client the same
- Respect clients as you expect others to respect you
- Mutual respect ensures effective communication and exchange

8

Unit 2.3

SAFE

- Safety is crucial for both counselors and clients
- Includes the safety of the client, his/her information, site property and physical environment

9

LINKED WITH OTHER SERVICES

- Effective counseling is not limited to addressing drug use-related needs alone
- Linkage with other services is key, especially HIV services

10

SUMMARY

- A good understanding of, and adherence to, the 7 principles will enhance the client counselor relationship
- The 7 principles are interlinked and are supportive of each other to ensure the success of counseling

11

Unit 2.4

COUNSELING SKILLS

Learning Objectives

At the end of this session, participants will be able to:

- possess the necessary counseling skills to counsel effectively
- understand the difference between counseling skills and counseling techniques, including goal setting, problem solving, time management, conflict resolution, stress management, and the role of education
- practice some counseling skills

Content and Timeline

Introduction	1 minutes
Presentation	110 minutes
Conclusion	4 minutes

Unit 2.4



LEARNING OBJECTIVES

At the end of this unit, participants will:

- possess the necessary counseling skills to counsel effectively
- understand the difference between counseling skills and counseling techniques, including goal setting, problem solving, time management, conflict resolution, stress management, and the role of education
- have practiced some counseling skills

2

TECHNIQUE

A **technique** is a way of efficiently accomplishing a task in a manner that is not immediately obvious or straightforward

3

SKILL

A **skill** is an ability, usually **learned** and acquired through training, to perform actions which achieve a desired outcome(s)

4

SESSION OUTLINE

PART 1

- Attending
- Open-ended questions
- Paraphrasing
- Summarizing
- Reflection of feeling
- Probing
- Silence

PART 2

- Self - efficacy
- Affirmation
- Reframing
- Rolling with resistance
- Interpreting
- Confronting

5

COUNSELING SKILLS (1)

- Attending
- Open-ended questions
- Paraphrasing
- Summarizing
- Reflection of feeling
- Probing
- Silence

6

ATTENDING

- Listen to verbal content
- Observe non-verbal cues
- Communicate back (e.g. 'um-hm', 'yes', or repeating key words)
- Listen 90% of the time; talk 10% of the time

7

ATTENDING

Helps the client to:

- feel relaxed and comfortable
- express his/her ideas and feelings freely
- trust the counselor

Helps the counselor to:

- obtain accurate information about the client
- notice non-verbal and physical cues

8

Unit 2.4

OPEN-ENDED QUESTIONS

Allow for multiple different ways to answer

Helps the client to:

- keep the conversation flowing to explore more deeply

Helps the counselor to:

- get more information
- see how a person thinks

9

PARAPHRASING

Counselor summarizes clients' words

Helps the client to:

- realize the counselor understood what he/she said
- get a sense of direction

Helps the counselor to:

- summarize complicated information
- spotlight an issue as important

10

SUMMARIZING

Provides an overview of what was discussed

Helps the client to:

- order his/her thinking
- clarify meaning
- realize that the counselor understood what he/she is saying
- have a sense of movement and progress

Helps the counselor to:

- ensure continuity of the session by providing focus
- verify counselor's perception of content
- terminate session in a logical way
- focus on one issue while acknowledging existence of other concerns

11

REFLECTIVE LISTENING (REFLECTION OF FEELINGS)

Can help link emotions to thoughts and behaviors

Helps the counselor to:

- check whether he/she accurately understands what the client is experiencing
- bring out problem areas without pushing the client

12

REFLECTIVE LISTENING (REFLECTION OF FEELINGS)

Helps the client to:

- realize the counselor understood what he/she feels and experiences
- bring to the surface feelings that may have been expressed vaguely
- understand that emotions, thoughts and behaviors are connected

13

REFLECTIVE LISTENING (REFLECTION OF FEELINGS)

Examples of what you might say:

- Because of [ISSUE] you are feeling frustrated.
- Since you relapse frequently you think you don't have will power.
- Your parents' attitude has made you more optimistic.
- You feel your family doesn't trust you and hence you feel sad.
- If I understand correctly, you are saying that you used again because all your efforts not to use didn't make any difference in the way others look at you. That made you feel [EMOTION]

14

PROBING

Asks for more information

- clarification about a point that you think is important

Enables the counselor to:

- focus attention on areas the counselor thinks need attention
- understand better what the client is describing

Helps the client to:

- focus attention on a feeling or specific subject matter
- become aware of, and understand his/her situation or feelings

15

SILENCE

- Can be very powerful
- Can be a time when things really 'sink in' and feelings are recognized and felt strongly
- When combined with attending cues, can serve to encourage the client to continue sharing
- Allows the client to experience the power of his/her own words

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Unit 2.4

SHORT BREAK – 10 MINUTES

17

COUNSELING SKILL (2)

- Self-efficacy
- Affirmation
- Reframing
- Rolling with resistance
- Interpreting
- Confronting

18

SELF - EFFICACY

Belief in clients' ability to undertake tasks or fulfill their goals on their own

For the client:

- gives them confidence they are likely to succeed
- provides them with energy and enthusiasm

For the counselor:

- should be promoted realistically

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AFFIRMATION

Shows positive regard and support of clients' efforts to change their behaviors

For the client:

- improves chances of self-efficacy
- highly motivating

20

REFRAMING

Provides a different meaning or interpretation of information

For the client:

- may give insights into behaviors
- connects consequences they might not have considered

For the counselor:

- supports behavior change, counselor is helping client to achieve

21

ROLLING WITH RESISTANCE

- Simple reflection
- Amplified reflection
- Double-sided reflection

22

INTERPRETING

Critical: Use a non-confrontational opening to avoid your client's feeling judged by your interpretation

Examples:

- "The way I see..."
- "I wonder if..."

23

INTERPRETING

Consists of 3 components:

- Determining and restating basic messages
- Adding the counselor's ideas for a new frame of reference
- Reflecting these ideas with clients

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Unit 2.4

INTERPRETING

Helps the counselor to:

- share a new perspective for the client to consider
- offer new coping strategies to deal with issues

Helps the client to:

- realize there is more than one way to look at situations, problems and solutions
- become more flexible and explore new points of view
- understand the problem more clearly

25

CONFRONTING

Use when it is necessary to show client the difference between what they believe (or think) and what they actually do.

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CONFRONTING

Helps the counselor to :

- establish him/herself as a role model by using direct, honest open communication

Helps the client to:

- break down defenses that the client has consciously or unconsciously put up
- see the difference between what the client thinks and what the client does

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COMMON ROADBLOCKS TO EFFECTIVE COUNSELING (1)

- Ordering or commanding
- Warning or threatening
- Arguing or persuading
- Moralizing
- Ridiculing or labeling

28

COMMON ROADBLOCKS TO EFFECTIVE COUNSELING (2)

- Insincerity
- Repetition
- Clichés
- Jargon
- Collusion

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SUMMARY

- Counseling skills are fundamental tools for drug addiction counseling
- These skills are used with relapse prevention counseling techniques to form the foundation of effective drug addiction counseling

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Handout 2.4

Counseling Skills

Reflective listening

Empathy involves sharing your understanding of your client's point of view. Reflective listening can assist this process. By listening to your clients' words while identifying their emotions, you can help them link what they feel to what they experience. For example, you might say "You feel [EMOTION] because of [EXPERIENCE or BEHAVIOR]."

Do not use reflective listening too often as you may appear shallow. However, reflective listening does show that you are really listening and that you want to understand what your clients are thinking and feeling. You can also bring to the surface feelings that are hidden. This approach helps to show clients that their feelings are related to their behaviors.

Rolling with resistance

Counselors face resistance when clients argue, interrupt or reject their suggestions. It is important not to strengthen this resistance by continuing to disagree. Rolling with resistance means not confronting your client's position.

There are a variety of techniques that can be used. One includes simple reflection. For example, you might say, "It seems you don't appear to see how your drug use can be a problem because your friends don't seem to have any problems". This may lead them to argue against that position. Another technique you can use is double-sided reflection. Here you acknowledge what the client has said and you add the other side of the equation. You might say, "I can see that this must be confusing for you. You are concerned about your drug taking on the one hand, but on the other hand it seems that you're taking more drugs than your friends".

Example: A number of drug user clients believe that drug detoxification can cause harmful damage to the inner organs of their body and can kill them. They believe this because they have seen some of their friends die during or following drug detoxification. Therefore, they think that they need to continue to use drugs in order to prolong their lives, despite the fact that drug use has been causing them so many problems. When encountering a client who has a strong belief in this myth, counselors should not tell him/her that this belief is incorrect because the client may begin to resist what the counselor says, and/or might not want to continue the discussion.

In this situation, you might want to say the following:

Simple reflection: "I understand why you think that way; there are many drug users who have the same opinion."

Double-sided reflection: "From what you have said, I understand that you are very scared about drug detoxification; many drug users believe that drug detoxification might kill them. However, I think that you are also aware that there are many other drug users who have been through detoxification and survived. Is that right?"

Handout 2.4

Open-ended questions

Open-ended questions encourage clients to respond freely and openly to explore their thoughts, opinions and feelings about a certain topic. They cannot be answered with a categorical response such as yes or no.

Reframing

Using this approach helps counselors to acknowledge what a person has said while providing a different meaning or interpretation that is likely to support behavior change. It connects behaviors to consequences that clients might not have considered. For example, a person may brag that she can drink a lot without feeling drunk. You may respond by reframing: "It sounds as if you really can drink a lot, but I wonder if you have considered that this amount of drinking can be very harmful to your health in the long run, even though you may not feel it now?"

One way of expanding on this example is by considering how pain can provide us with a quick feedback mechanism on something that is harmful to our bodies. When you touch a hot stove, your hand feels the pain of the burn. You remove your hand quickly. Similarly, when you have low alcohol tolerance, your body tells you with the sensation of intoxication that you may be harming yourself. Someone who boasts of high alcohol tolerance may not realize that she is causing long-term damage in the long run. By reframing this boasting, you may help her to see the detrimental effects of her actions.

Summarizing

In summarizing, you show that you are actively listening and highlighting important discoveries. Summarizing helps to clarify the purpose and meaning of the counseling session. You can also prompt for more information and provide an opportunity for the client to hear his/her own thinking.

Summarizing can also highlight ambivalence by linking the negatives and the positives of drug use in one statement. For example, you could say "On the one hand....., and on the other hand....."

It can also provide a natural opportunity to end a counseling session.

Paraphrasing

In paraphrasing, you summarize your client's words and allow him/her to see that you have understood his/her thoughts. Paraphrasing spotlights an issue as important and gives the client a sense of direction for what he/she might talk about next. For example, you might say: 'What I hear you say is ..., could you please tell me more about that?'

Handout 2.4

Attending

This skill helps you to ensure that you are listening to the verbal content of the conversation and also attending to the non-verbal cues. You can communicate back with words like “yes” or by repeating key words. By attending, you help the client feel relaxed and comfortable and express his/her ideas freely.

Probing

By probing, you focus attention on specific feelings or behaviors. This should be used for issues that you feel are particularly important. Probing is about saying: “Please tell me more about that!”

Silence

You may want to use silence when you want things to sink in deeply. Silence may prevent clients from moving on to more comfortable issues that may distract them from confronting other, more important issues.

Interpreting

Interpreting enables your client to hear the implications of his/her actions from your point of view. It provides a possible, plausible linkage between his/her thoughts, feelings, actions and consequences.

Interpretations help your client realize there is more than one way to look at situations, problems and solutions. When providing interpretations, be sure to frame them as suggestions rather than as statements, facts or beliefs. You can do this by commencing your interpretation with something like: “It sounds like you are saying...”

Sometimes, people don’t see the linkage between their behaviors and their consequences. Using an interpreting approach may make implicit consequences more explicit. It also uses principles that are similar to the “decision matrix” (to be covered in later units) to address short- and long-term consequences of a given behavior.

For example, you might say: “From what you have said, I think that you realize that smoking is causing you a bad cough and that this may have negative consequences on your health. In fact, it may mean that you have a serious lung condition. Have you ever considered that this might be a potential consequence of smoking?”

Unit 2.5

COUNSELING TECHNIQUES

Learning Objectives

At the end of this session, participants will be able to:

- identify a number of available and effective counseling techniques used to reduce risk of relapse
- discuss the application and context of counseling techniques in drug addiction counseling

Content and Timeline

Introduction	1 minutes
Presentation	25 minutes
Conclusion	4 minutes

Unit 2.5



LEARNING OBJECTIVES

At the end of this unit, participants will be able to:

- identify a number of counseling techniques that can reduce the risk of relapse
- discuss the application and context of counseling techniques in drug addiction counseling

2

COUNSELING TECHNIQUES

- Problem solving
- Goal setting
- Time management
- Stress management
- Dealing with emotions
 - Anger
- Conflict resolution
- Relapse prevention
 - Coping with cravings
 - Refusal skills

3

PROBLEM SOLVING AND GOAL SETTING

- The ability to solve problems is a characteristic of healthy living
- Many drug users have poor problem-solving skills
- Problem-solving skills factor into relapse risk
- Short-term goals based on specific problems:
 - help change appear more achievable
 - help a person experience success and counter feelings of helplessness
 - help increase self-confidence
- Goals need to be clear, specific and matched to the client's stage of change

4

TIME MANAGEMENT

- Developing a daily schedule can:
 - help avoid allocating time for unhealthy behaviors
 - provide structure for the day and help prioritize activities
 - overcome boredom
 - help gain support from families and relatives

5

STRESS MANAGEMENT

- Too much stress can impair performance:
 - Loss of motivation
 - Reduced effectiveness
 - Leads to physical, mental, and behavioral problems
- Teaching stress management techniques can reduce risk of relapse

6

DEALING WITH EMOTIONS

- Anger, anxiety, depression
 - common emotions among people with drug problems
 - can interfere with relationships
 - can precipitate drug relapse

7

CONFLICT RESOLUTION

- Conflict is unavoidable in human relations
 - Not knowing how to handle conflict in a healthy way can lead to major health and relationship problems
 - For drug users, it can also result in relapse

8

Unit 2.5

RELAPSE PREVENTION

- Clients relapse due to a variety of internal or external factors
- Relapse is common; clients will need to regain control to prevent further drug use
- Main interventions/techniques:
 - Identify high-risk situations and develop coping responses
 - Learn to cope with cravings and develop skills to resist offers of drugs

9

SUMMARY

- Counseling techniques can be used in a variety of ways and combinations (think of the list as a menu of options).
- Choice of counseling technique depends on individual client needs.
- Not all techniques will be needed for every client
- Client needs may change over time.

10

Unit 2.6

COUNSELING PROCEDURES

Learning Objectives

At the end of this session, participants will be able to:

- list the counseling procedures
- explain the interaction between the various steps of the procedures
- practice providing counseling sessions according to the counseling procedures through role-plays
- apply goal-setting and problem-solving techniques in role-plays

Content and Timeline

Introduction	1 minutes
Presentation	90 minutes
Break	10 minutes
Role play	45 minutes
Conclusion	4 minutes

Unit 2.6



LEARNING OBJECTIVES

At the end of this unit, participants will be able to:

- list the counseling procedures
- explain the interactions between the various steps of the procedures
- practice providing counseling sessions through role-plays according to the counseling procedures
- apply goal-setting and problem-solving techniques in the role-plays

DEVELOPING A COLLABORATION APPROACH

Counselors must:

- possess a thorough knowledge of addiction and normative patterns of drug use among the client group
- acknowledge that clients are the experts in discussing their own lives
- convey to clients that their counselor serves as an ally



DRUG ADDICTION COUNSELING PROCEDURES

(Applied for drug users and recovering drug users)

INTRODUCTION Counseling Orientation

- Self-introduction
- Services introduction
- Explain confidentiality
- Time management for the counseling session
- Explain reasons for collecting client's information (for 1st time client), or explain the objectives of the session (for returning client)

DRUG ADDICTION COUNSELING PROCEDURES

(Applied for drug users and recovering drug users)

CLIENT ASSESSMENT

- Explore client's motivation to use the service
- Explore demographic and psychosocial assessment information (1st time client)
- Assess drug use history including prior treatment
- Evaluate (or re-evaluate) client's problems (health, social, legal, finance, family, vocation etc.)
- Identify priorities, **main topics of the counseling session**
- Identify support resources for solving problems

ONGOING CLIENT ASSESSMENT: DRUG ADDICTION COUNSELING PROCEDURES

- Find out how the client has been since last session
- Inquire whether there are any urgent problems that need attention and, if so, deal with them
- Inquire whether the client has used drugs since last session
- If the client has used drugs:
 - analyze the reason for relapse and develop strategies to prevent future relapses
 - discuss why abstaining from all drugs is important, particularly when one is attempting to recover from addiction

DRUG ADDICTION COUNSELING PROCEDURES

(Applied for drug users and recovering drug users)

PROBLEM SOLVING

- Determine challenges
- Specify problems
- Brainstorm solutions
- Decide appropriate solutions
- Develop problem-solving plan(s)

Unit 2.6

DRUG ADDICTION COUNSELING PROCEDURES

(Applied for drug users and recovering drug users)

GOAL SETTING →

- The client sets up short-term SMART goals

9

DRUG ADDICTION COUNSELING PROCEDURES

(Applied for drug users and recovering drug users)

ACTION PLAN →

- Determine strength of support resources
- Integrate support services into the implementation plan
- Identify specific implementation steps to change behaviors or maintain positive behaviors

10

DRUG ADDICTION COUNSELING PROCEDURES

(Applied for drug users and recovering drug users)

PLAN REVISION →

- Review the plan with the client
- Anticipate difficulties when implementing the plan
- Develop a coping plan for these difficulties

11

DRUG ADDICTION COUNSELING PROCEDURES

(Applied for drug users and recovering drug users)

SUMMARY →

- Summarize topics and outcomes of the session
- Determine client's confidence to implement the plan as agreed
- Determine client's commitment to plan implementation
- Confirm time for the next session
- Record in counseling logbook client's record

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COUNSELING TIPS

- Use your time wisely
- Repeatedly remind client of the objectives of the counseling session (as needed)
- Focus on client's most important and urgent problem(s)
- Respect client's choices and decisions
- Keep records of counseling session contents for follow-up
- Summarize the main points discussed, including progress made during the session and previous sessions
- Set a time for the next counseling session with client before he/she leaves.

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HOW TO MANAGE YOUR TIME DURING THE COUNSELING SESSION (1)

- Follow the procedures in the counseling session
- Focus on the client's most important problem(s)
- Link topics in order to segue into other appropriate topics
- Stay focused and use summary skills when necessary

14

HOW TO MANAGE THE TIME IN A COUNSELING SESSION (2)

Combine:

- Counseling skills
 - Open-ended questions
 - Affirmations
 - Probing
 - Interpreting
 - Summarizing etc.

With:

- Counseling techniques
 - Problem solving
 - Goal - setting
 - Relapse prevention etc.

15

SUMMARY

- Drug addiction counseling is a dynamic and circular process
- Therapeutic alliance is crucial to the success of counseling
- The counselor needs to guide the client through the process
- Keep the process moving forward by summarizing, reviewing progress and setting new goals

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Unit 2.6

ROLE – PLAY – COUNSELING SESSION

Nam likes to go to the local bar after work. He says that drinking beer never gets him into trouble; rather, he only has a problem with heroin. He enjoys socializing at the neighborhood bar and typically only has a couple of beers and then goes home to his wife. However, after pressing Nam, the counselor finds out that when Nam gets heroin, he gets it from a contact at the bar. It is usually on the weekends, when he typically drinks more heavily than he does on weeknights, and then he meets up with his contact and they go and buy heroin. Nam is primarily a binge user, and in these binges, he often spends 200,000 Dong, a habit he cannot afford.

Time for role play: 30 minutes

Feedback: 15 minutes

- The steps of the counseling session
 - Especially for “problem solving” and “goal setting”
- What worked well
- What opportunities for improvements

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SUMMARY

During this unit, we focused on:

- The counseling procedures
- The relationship between each of the steps in the procedures
- Practicing how to provide counseling sessions according to the counseling procedures through role-play
- Applying goal-setting and problem-solving techniques in role-plays

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Handout 2.6-1

Role of the Counselor

The role of the counselor in addiction counseling is to provide support, education, and non-judgmental assistance to enable change. Counselors must establish a good rapport with their clients. A client recovering from addiction deserves to feel understood and that he or she has an ally. Counselors should convey that they appreciate the difficulty of their clients' struggle and their need for support throughout the recovery process.

Consider the metaphor of a hiker and a guide. While the guide helps the hiker to know where to go, the hiker still climbs the mountain on her own. The counselor guides the client through the early stages of recovery, but the recovery process ultimately belongs to the client. The client alone is responsible and accountable for his or her recovery. The counselor must emphasize this point to facilitate personal responsibility.

Counselors must find a balance between being directive and allowing the client to be self-directed. Striking a balance will be easier if the counselor imposes a structure on the session that includes giving the client feedback about the client's progress in recovery, and evaluating any episodes of use or near use. The counselor identifies the relevant topic for discussion, based on what the client seems to need, and introduces that topic. At times, the counselor may directly pressure the client to change certain behaviors.

However, the client should be encouraged to be self-directed. For example, when counseling on a certain topic like "social pressure to use," your client may explore how best to manage this problem, and you will respond to the client's exploration. If the client seems unable to change some aspect of addictive behavior - for example, going to risky environments - the counselor should accept where the client is at and assist the client to explore those perceptions or situations in a way that might allow himself or herself to do it differently, (i.e. in a better way the next time).

A balance needs to be struck so there is respect for the client and acceptance of where he or she is, and consistent pressure to help the client move in a direction that will help him/her achieve his/her counseling goals.

Counselors should not be harshly judgmental of clients' addictive behaviors. After all, if the client did not suffer from addiction, he or she would not need drug addiction counseling, so blaming the client for exhibiting these symptoms is not helpful. Also, clients often feel a great deal of shame associated with their addictive behaviors. In order to help resolve those feelings of shame and guilt, the counselor should encourage the client to speak honestly about drug use and other addictive behaviors and be accepting of what is said.

Counselors should be respectful of their clients. They should always be professional, including not being late for appointments and never treating or talking to the client in a derogatory or disrespectful manner. Moreover, counselors should avoid too much self-disclosure. While occasional appropriate self-disclosure can help the client to open up or motivate the client by providing personal examples, too much self-disclosure removes the focus from the client's own goals. A good rule for when to self-disclose, if the coun-

Handout 2.6-1

selor is inclined, is for the counselor first to have a clear purpose or goal for the intervention and then to analyze why he or she is choosing to self-disclose at this particular time. If there is any doubt based on this analysis, it may make sense to save self-disclosure until there remains no doubt.

Lastly, counselors need to refrain from responding from the context of their own personal issues. For example, consider the case where a counselor is having marital problems with his spouse and is going to separate. Suppose this counselor is working with a particular client who has an addicted spouse or partner but does not want to separate from his or her partner. It is imperative that the counselor be flexible and respond creatively to the client's own perception of the problem. In this case, the counselor must not rigidly adhere to the notion that breaking ties is the only acceptable path to recovery. In general, projection of the counselor's own needs or experiences onto that of the client's situation can be damaging and/or counterproductive.

Taking into consideration all of these attributes of good counseling, the first meeting with your client should include the following:

- Self- introduction. Tell the client your name and your position and role within the organization.
- Services introduction. Tell the client the services that are provided at your organization and which services you provide. If your organization has linkages to other organizations, it may be helpful to explain them as well.
- Explain confidentiality. Many clients will be concerned about information they tell you about their drug use. It is particularly important that they are aware that the service you provide is confidential. This is covered in more detail in another unit.
- Time management for the counseling session. Make it clear that there is a defined timeframe for the session and starting on time and ending on time are important for respecting the time allotted for each client.
- Explain reasons for collecting your client's information (for 1st time clients) or explain the objectives of the session (for returning clients). It is also important to tell them that you are going to ask them a lot of questions so that you can understand what their problem is and help them work out the best solution.

Handout 2.6-2

Case Example

Scenario: Sometimes Nam likes to go to the local bar for a couple of beers after work. He says that the beer never gets him into trouble; rather, he only has a problem with heroin. He enjoys socializing at the neighborhood bar and typically only has a couple of beers and then goes home to his wife. However, after pressing Nam, the counselor finds out that when Nam gets heroin, he gets it from a contact at the bar. It is usually on the weekends, when he typically drinks more heavily than he does on the weeknights, and then he meets up with his contact and they go and buy heroin. Nam is primarily a binge user, and in these binges, he often spends 200,000 Dong, a habit he cannot afford.

FYI: This is an example of denial. The counselor wants to help Nam to see the link between his alcohol and heroin use. One approach would be to confront the patient gently. The counselor might say, "Well, it sounds like you don't go and get heroin until after you have had a few drinks at the bar. So, even though your drinking doesn't always lead you to getting heroin, in the instances when you do purchase it, you have been drinking first." Amazingly, many clients do not recognize this connection.

The counselor might try to help Nam realize the seriousness of his heroin use by having a conversation about the magnitude of the financial difficulties it is causing. The counselor's aim is to get Nam to change these damaging behaviors, or to reduce as much risk as possible. The optimal change would be if Nam can agree not to go to the bar and not to drink alcohol in addition to not using heroin.

If Nam cannot imagine himself relinquishing this social outlet, a compromise might be that he could drink soda instead of beer, never carry more than 50,000VND, and not go to the bar on weekends. If this type of compromise is established, which is not ideal, the counselor must monitor Nam's progress and press him to avoid the bar, and at minimum reduce the risks associated with his heroin use. Ideally the counselor would help Nam abstain from all drug if this compromise plan does not work.



CHAPTER 3

DRUGS, DRUG ADDICTION, AND TREATMENT APPROACHES

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Unit 3.1

DRUGS, DRUG USE AND ITS CONSEQUENCES

Learning Objectives

At the end of this unit, participants will be able to:

- define and name commonly-used drugs, describe how they are used, and understand the consequences related to their use
- identify drugs commonly used in Vietnam and common patterns of use in Vietnam

Content and Timeline

Introduction	2 minutes
Presentation	50 minutes
Break	10 minutes
Discussion	60 minutes
Conclusion	8 minutes

Unit 3.1



LEARNING OBJECTIVES

At the end of this session, participants will be able to:

- define and name commonly-used drugs, describe how they are used, and understand the consequences related to their use
- identify drugs commonly used in Vietnam and common patterns of use in Vietnam

DISCUSSION: DRUGS IN VIETNAM/ YOUR PROVINCE

- What are common drugs used?
- For each type of drug:
 - Who are its users?
 - How is it used?
 - What are common patterns of use?
 - What are the risks associated with its use?

WHAT IS A PSYCHOACTIVE DRUG?

A psychoactive drug is any chemical substance which, when taken into the body, alters its function physically AND psychologically

KEY MOTIVATORS FOR DRUG USE

- Fun
- Forget
- Function

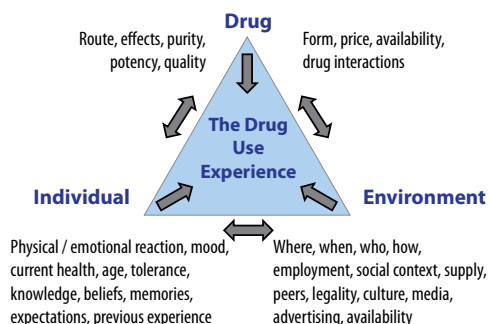
PSYCHOACTIVE DRUGS

- Psychoactive drugs alter:
 - mood
 - cognition (thoughts)
 - behavior

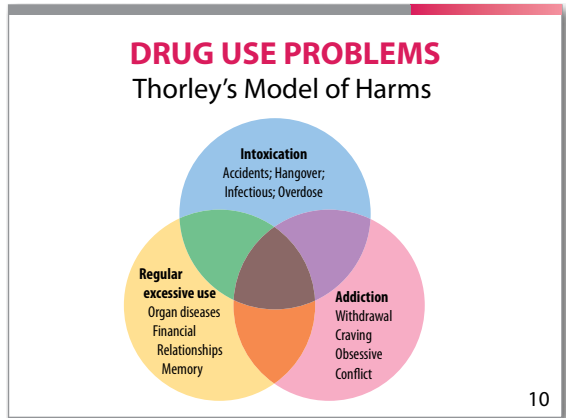
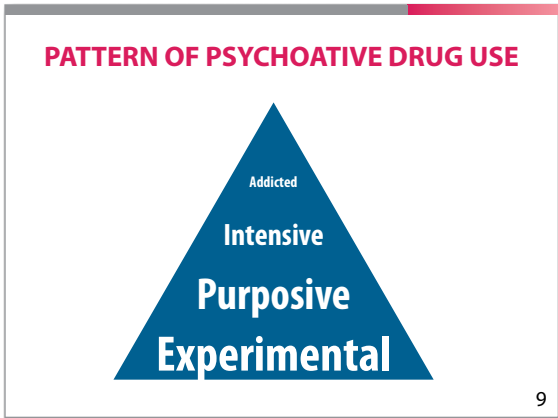
CLASSIFYING PSYCHOACTIVE DRUGS

Depressants	Stimulants	Hallucinogens
Alcohol	Amphetamines	LSD, magic mushrooms, morning glory seeds
Benzodiazepines	Nicotine	Mescaline, MDMA (Ecstasy)
Opioids	Cocaine	PCP, Ketamine
Solvents	Caffeine	Cannabis* (in high doses)
Barbiturates	Khat	Other (e.g. N2O, amyl or butyl nitrite)
Cannabis*		

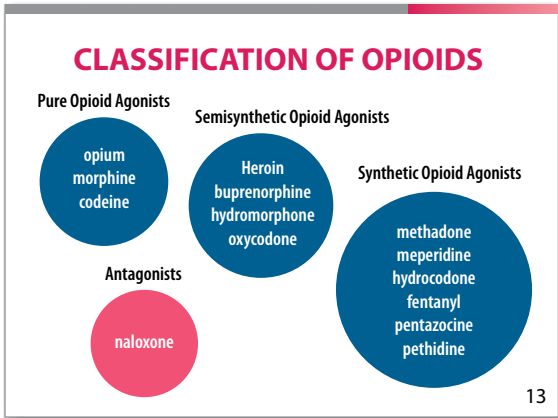
AN INTERACTIVE MODEL OF DRUG USE



Unit 3.1



- ### WHAT IS HEROIN?
-
- In the class of drugs known as "opiates"
 - Chemical name: diacetylmorphine
 - Extracted from the white sap of the flowering poppy plant
 - Pure heroin is a white powder with a bitter taste
 - A less-refined form of heroin is known as "Black Tar", a gooey black or brownish substance
- 12



- ### OPIOIDS PHARMACOLOGY
- 3 main families of opioid receptors (μ , κ , and σ)
 - Opioid receptors are located in the central nervous system, peripheral nervous system, and gastrointestinal tract
 - Opioid receptors are inhibitory
 - inhibit release of some neurotransmitters (e.g., serotonin, GABA, glutamate, acetylcholine)
 - enable the release of dopamine (considered to contribute to the addiction potential of opiates)
 - Effects on the limbic system produce changes in emotion
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- ### HEROIN PHARMACOLOGY
- Morphine is produced through heroin breakdown
heroin \Rightarrow monoacetylmorphine (MAM) \Rightarrow morphine
 - Heroin and MAM get into brain easily, hence more rapid action
 - Heroin excreted in urine as free and conjugated morphine
 - Heroin metabolites present in urine for approximately 48 hours following use.
- 15

- ### HOW IS HEROIN USED?
- Heroin is used in a number of ways:
 - Injected into a vein
 - Smoked
 - Snorted as powder via the nose
 - Used alone or mixed with other drug
- 16

Unit 3.1

HEROIN : IMMEDIATE EFFECTS (1)

- Intense pleasure: Heroin may cause a rush and strong feeling of well-being
- Pain relief: Heroin relieves physical pain
- Hunger or sexual urges diminished
- Drowsiness: as the quantity used increases, the user may feel warm, heavy and sleepy
- Nausea and vomiting can occur, especially among novice users

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HEROIN : IMMEDIATE EFFECTS (2)

- Breathing, and pulse become slower
- Blood pressure lowers
- Pupils contract
- Itchy, flushed skin; dry mouth, skin and eyes

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HEROIN: LONG TERM CONSEQUENCES (1)

- Higher doses - continued use produces tolerance: increased doses needed to achieve same euphoria
- Overdose
 - Coma or death (from slow or ceased breathing)
 - Fluid in the lungs
- Addiction
 - Withdrawal symptoms - restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, goose bumps, poor general self-care
 - imprisonment
- HIV transmission – sharing of equipment

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HEROIN: LONG TERM CONSEQUENCES (2)

Possible:

- Constipation
- Cognitive impairment from hypoxia as a result of repeated non-fatal overdose
- Reproduction and endocrine irregularity
- Intense sadness (depression, dysthymia)

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Amphetamine Type Stimulants

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AMPHETAMINE TYPE STIMULANTS

- Large number of psychoactive substances
- Their effect depends upon
 - location and composition of substituents
- Effects
 - stimulant (e.g. methamphetamine)
 - euphorics (mixed e.g. MDMA)
 - hallucinogen (e.g. DOM: 2,5 dimethoxy-4-methyl-amphetamine)
 - appetite suppressant (e.g. fenfluramine)

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Methamphetamine



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METHAMPHETAMINE

- **Hydrochloride salt:** can be sold as powder.
 - Bitter-tasting crystalline powder easily dissolves in water or alcohol - injected
- **Crystalline:** methamphetamine produced by acidification of methamphetamine base
 - Smoked form. often referred to as "ice" or "crystal,"

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Unit 3.1

HOW IS METHAMPHETAMINE USED ?

- **Smoked, snorted, orally ingested, injected**
- **“Ice”**
 - form of methamphetamine that can be smoked
 - smoked in a pipe or on a foil
 - produces effects that may continue for 12 hours or more

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METHAMPHETAMINE PHARMACOLOGY

Causes massive increase in dopamine

- Enhances release of dopamine as well as serotonin and norepinephrine
- Blocks reuptake of dopamine and inhibits the enzyme that breaks it down

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ACUTE STIMULANT EFFECTS

Desired

- Feeling of wellbeing or euphoria
- Increased energy
- Wakefulness
- Alertness
- Reduced hunger
- Increased clarity of thinking
- Increased competence
- Feelings of sexuality
- Increased sociability
- Improved mood

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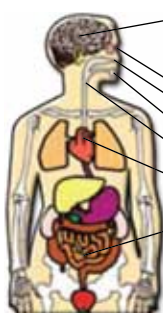
SHORT-TERM STIMULANT EFFECTS

Physical

- Increased heart rate
- Increased pupil size
- Increased body temperature
- Increased respiration
- Increased blood pressure

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LONG TERM EFFECTS OF STIMULANTS



- Strokes, seizures, and headaches
- Irritability, restlessness
- Depression, anxiety, irritability, anger
- Memory loss, confusion, attention problems
- Insomnia
- Paranoia, auditory hallucinations, panic reactions
- Suicidal ideation
- Dry mouth, burned lips
- Worn teeth (due to grinding during intoxication)
- Problems swallowing
- Chest pain, cough, respiratory failure
- Disturbances in heart rhythm and heart attack
- Gastrointestinal complications (abdominal pain and nausea)
- Loss of libido
- Malnourishment, weight loss, anorexia
- Weakness, fatigue
- Tremors
- Sweating
- Oily skin, complexion

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LONG-TERM EFFECTS OF STIMULANTS

Adverse

- Psychological consequences
 - sleep problems, anxiety, panic attacks
 - mood swings
 - depression, paranoia, hallucinations
- Adverse behavioral consequences
 - Violent or aggressive behavior
- Addiction
- Methamphetamine-induced psychosis

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METHAMPHETAMINE-INDUCED PSYCHOSIS

- Typically only after chronic, high dose use
- 1/3 addicted users experience psychotic symptoms
- Associated with rapid routes of administration and sleep deprivation
- Characterised by
 - persecutory delusions
 - hallucinations (hear, see or smell things that are not real)
 - Usually stops in weeks but in some it persists

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MDMA (Ecstasy)



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Unit 3.1

WHAT IS MDMA?

- Stimulant and hallucinogen
- Tablet or capsule
- Chemical name: methylenedioxymethamphetamine
- Street names: "Ecstasy", "XTC", "E",
- Chemically similar substances are commonly sold as MDMA
- Its stimulant effect ("love effect") has made it a favorite at disco's

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MECHANISM OF ACTION

- MDMA initially enhances extracellular brain concentrations of serotonin
 - also induces rapid and substantial elevation of dopamine
- Serotonin (5-hydroxytryptamine):
 - Regulates mood, sexual activity, sleep
 - Important in memory and temperature regulation

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HOW IS MDMA USED?

- Swallowing is primary method of use
- Injecting or smoking are less frequent methods of use
- Sniffing powder form also occurs
- Not uncommon for users to take a second dose of the drug as the effects of the first dose begin to fade

35

WHAT ARE THE IMMEDIATE EFFECTS OF USING MDMA (1)?

- Heightened sense of "closeness"
- Euphoria
- Increased energy
- Sexual arousal
- Large pupils
- Fast heart beat
- Teeth grinding
- Dry mouth
- Tremors
- Heart pounding
- Sweating
- Numbness and tingling

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WHAT ARE THE IMMEDIATE EFFECTS OF USING MDMA (2)?

Health Consequences

- Over-heating
- Seizures
- Cardiac arrhythmias
- Stroke
- Liver damage

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LONG-TERM CONSEQUENCES OF MDMA

- Long-term psychological effects:
 - depersonalisation
 - insomnia
 - depression
- Addiction
- HIV transmission - lack of sexual inhibition and impaired decision making abilities
- Potential adverse effects of MDMA on the developing fetus
- Brain cell damage
 - Whether these persist in the long term is unknown

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CANNABIS



Marijuana



Hashish

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CANNABIS: PROPERTIES

- Major active constituent is THC (delta-9-tetrahydrocannabinol)
 - rapidly absorbed and metabolised when smoked, less so when swallowed
- Attaches to specific cannabinoid receptors in the brain (endogenous brain molecule – anandamide).

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Unit 3.1

CANNABIS: FORM AND ROUTES

Forms include:

- dried flowers/leaves/buds (marijuana/ganja)
 - 1% – 15% THC (depending on genetic and environmental factors)
- extracted dried resin, sometimes mixed with dried flowers and pressed into a cube (hashish)
 - around 10% – 20% THC
- extracted oil using an organic solvent (hashish oil)
 - 15% – 30% THC

Route of administration can affect dose:

- smoked (joint, pipe, bong)
 - 50% absorbed, peak concentration 10 – 30 mins, lasts 2– 4 hours
- ingested (cake, biscuits)
 - 3% – 6% absorbed, peak concentration 2 – 3 hours, lasts up to 8 hours

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CANNABIS: IMMEDIATE EFFECTS

- Euphoria, altered concentration, relaxation, sense of calm or well-being, disinhibition, confusion
- Increased appetite, thirst
- Heightened visual, auditory, and olfactory perceptions, altered interpretation of surroundings
- Analgesia
- Reduced intra-ocular pressure
- Problems associated with intoxication

Cannabis overdose does not result in death.

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IMMEDIATE, HIGH-DOSE EFFECTS

Cannabis also affects:

- short-term memory (impaired)
- ability to learn and retain new information
- task performance
- balance, stability, mental dexterity
- the cardiovascular and respiratory systems

Short-term, high-dose use may result in:

- hallucinations
- delusions, feelings of depersonalisation
- paranoia, agitation, panicky feelings
- psychosis

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CANNABIS: HEAVY USE

- People who use cannabis daily are more likely to:
 - have tried many illicit drugs
 - use alcohol regularly
- People with coexisting mental health problems often report high rates of regular cannabis use

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LONG-TERM EFFECTS

- CNS
- Respiratory system
- Cardiovascular system
- Immune system
- Endocrine and reproductive systems
- Adverse social outcomes
- Mental health problems
- Cognitive impairment
- Addiction

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CANNABIS ADDICTION

- The “cannabis addiction syndrome” is less pronounced than for other drugs (i.e., opioids, alcohol)
- Difficulty predicting development and duration

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SUMMARY (1)

- Psychoactive drugs alter physical and psychological function
- There are examples of depressant, stimulant, and a hallucinogenic drugs that are used in Vietnam
- The drug use experience is an interaction between the drug, the individual and the environment

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SUMMARY (2)

- All drugs have short-term and long-term consequences that are dependent upon their pharmacology, the individual psychology and the sociological context

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Unit 3.2

ALCOHOL PROBLEMS

Learning Objectives

At the end of this unit, participants will be able to:

- describe alcohol use in Vietnam
- explain the concept of standard drinks and their relationship to blood alcohol level
- describe the effects of alcohol
- list 6 risk factors related to high-risk drinking

Content and Timeline

Introduction	2 minutes
Presentation	35 minutes
Conclusion	8 minutes

Unit 3.2



LEARNING OBJECTIVES

At the end of this session, participants will be able to:

- describe alcohol use in Vietnam
- explain the concept of standard drinks and their relationship to blood alcohol level
- describe the effects of alcohol
- list 6 risk factors related to high-risk drinking

2

LEADING 12 AVOIDABLE RISK FACTORS OF DISEASE BURDEN

High Mortality Developing Countries	Low Mortality Developing Countries	Developed Countries
1 Underweight	Alcohol	Tobacco
2 Unsafe sex	Blood pressure	Blood pressure
3 Unsafe water	Tobacco	Alcohol
4 Indoor smoke	Underweight	Cholesterol
5 Zinc deficiency	Obesity	Obesity
6 Iron deficiency	Cholesterol	Low fruit & veg. intake
7 Vitamin A deficiency	Low fruit & veg intake	Physical inactivity
8 Blood pressure	Indoor smoke - solid fuels	Illicit drugs
9 Tobacco	Iron deficiency	Unsafe sex
10 Cholesterol	Unsafe water	Iron deficiency
11 Alcohol	Unsafe sex	Lead exposure
12 Low fruit & veg intake	Lead exposure	Childhood sexual abuse

3

ALCOHOL USE IN VIETNAM

Alcoholism and related disorders

- Prevalence of alcoholism/alcohol misuse
 - Cities (from 5 - 10.4%)/1.16 - 3.61%
 - Mountainous areas (from 7 - 9.7%)/2.34%
 - Rural areas: (from 0.57 - 1.2%)/0.14-0.42%
- Social problems
 - 10 - 80% drinkers report fighting after drinking
 - 8.4-18% drinkers report family break-up.
 - 31.8% drinkers report losing job
 - 50% traffic accidents due to drinking

4



5

5 minutes to affect brain

ALCOHOL

2% excreted unchanged in sweat, breath & urine

- Rapidly absorbed into blood by stomach (20%) and small intestine (80%)
- Metabolised by liver (95-99%)
alcohol → acetaldehyde → acetic acid & H₂O → CO₂
Liver metabolises 1 standard drink per hour
- Distributed in body fluids (not fat)
- 1 standard drink raises BAC by approx. 0.02g% for men and 0.03g% for women.

6

HIGH-AND LOW-RISK DRINKING LEVELS FOR SHORT- AND LONG-TERM HARM

Risk of harm in the short-term		Risk of harm in the long-term	
	Low Risk (standard drinks)		Low Risk (standard drinks)
MALES On an occasional day (NOT every day)	up to 6	MALES On an average day	up to 4
FEMALES On an occasional day (NOT every day)	up to 4	FEMALES On an average day	up to 2

7

LARGE GROUP EXERCISE

- Describe the levels of intoxication for different BAC

8

Unit 3.2

EFFECTS OF ALCOHOL INTOXICATION

- .01-.02g%** Clearing of head
- .02-.05** Mild throbbing in rear of head, slightly dizzy, talkative, euphoric, confident, clumsy, likely to make flippant remarks
- .06-0.1** ↓ inhibitions, ↓ talkativeness, ↓ motor coordination, ↓ pulse, stagger, loud singing!
- 0.2-0.3** Poor judgement, nausea, vomiting
- 0.3-0.4** Blackout, memory loss, emotionally labile
- 0.4+** Stupor, breathing reflex threatened, deep anaesthesia, death

9

PREDISPOSING RISK FACTORS FOR ALCOHOLISM

- Family history of alcohol problems
- Poor coping responses to stressful life events
- Depression, divorce or separation
- Heavy drinking partner
- Working in a male dominated environment.
- Childhood problem behaviours related to impulse control

10

BINGE DRINKING

Binge drinking can lead to:

- increased risk taking
- poor judgment/decision making
- misadventure/accidents
- increased risky sexual behavior
- increased violence
- suicide

11

YOUNG PEOPLE AND ALCOHOL

Risk of alcohol-related harm increases due to:

- smaller physical size
- fewer social controls
- peer values that condone intoxicated behavior
- risk of overdose due to lack of tolerance (physical, behavioral).



Risky and harmful levels may:

- interfere with normal development:
 - physiological
 - social
 - emotional
- increase risk of:
 - suicide
 - risky sexual behavior/ unwanted sex
- cause blackouts
- contribute to poor academic performance
- contribute to, or cause, mental health problems
- cause behavioral problems

12

WOMEN AND ALCOHOL

- Women are more susceptible to the effects of alcohol due to:
 - smaller physical size
 - decreased blood volume
 - lower body water : fat ratio
 - reduced ADH activity in stomach (hence reduced metabolism of alcohol)
- Results in:
 - increased risk of intoxication related harms; e.g. assault, injury
 - earlier development of organ damage

13

SUMMARY

- Alcohol is a legal drug but it can still cause harm.
- One standard drink contains roughly 10 grams of pure alcohol - it raises the blood alcohol level from 0.02 – 0.03% and one hour is required to metabolize it completely.
- Women and young people are especially vulnerable to the effects of alcohol.
- There are recognized risk factors that predispose a person to alcoholism.

14

Unit 3.3

THE BASIC OF ADDICTION

Learning Objectives

At the end of this unit, participants will be able to:

- describe the patterns of psychoactive drug use and avoid misunderstandings about drug users
- understand the biological basis of addiction
- distinguish between physical and psychological addiction
- describe heroin withdrawal

Content and Timeline

Introduction	2 minutes
Presentation	40 minutes
Conclusion	8 minutes

Unit 3.3



LEARNING OBJECTIVES.

At the end of this session, participants will be able to:

- describe the pattern of psychoactive drug use and avoid misunderstandings about drug users
- understand the causes of addiction
- understand the physiological changes in an addicted brain
- distinguish between physical and psychological addiction

2

COMMON BELIEFS ABOUT DRUG USE

- "It's easy to recognize a drug user"
- "Use drugs once and you're addicted"
- "People who are addicted are hopeless and can never be helped to stop using"
- "Heroin is the most addictive drug"
- "You can always stop using a drug before drugs become a problem"

3

PSYCHOACTIVE DRUGS

Psychoactive drugs alter:

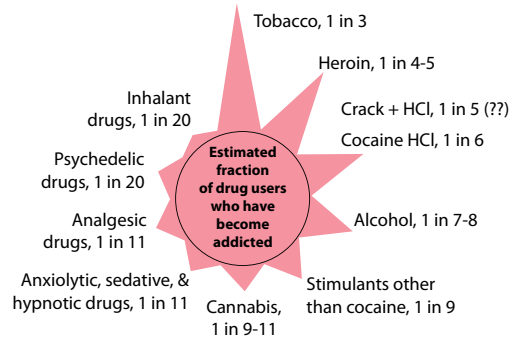
- mood
- cognition (thoughts)
- behavior

4

PATTERN OF PSYCHOACTIVE DRUG USE



5



(Adapted from Anthony et al., 1994; Chen & Anthony, 2004)

6

A KEY PRINCIPLE IN ADDICTION

Drug use should be thought of as a voluntary behavior


7

But...

Drug addiction is not just "a lot of drug use"

8

Unit 3.3



“Addiction as a **chronic relapsing / remitting disease of the brain** is a totally new concept for much of the general public, for many policy makers, and sadly, for many health care professionals as well”

Leshner 1997

9

WHAT IS ADDICTION? (1)

- Addiction is a chronic, relapsing disorder characterized by compulsive drug-seeking and use, in spite of adverse consequences.

10

WHAT IS ADDICTION (2)

Presence of 3 or more of the below during the last preceding 12 months (ICD 10*)

- Tolerance
- Withdrawal syndrome
 - Use of the drug to avoid or reverse withdrawal symptoms
- A strong desire or sense of compulsion to take the substance
- Difficulties in controlling substance-taking behavior in terms of its onset, termination, or levels of use;

*ICD-10 (International Classification of Diseases)

11

WHAT IS ADDICTION (3)

- Progressive neglect of alternative pleasures or interests because of psychoactive substance use
 - Increased time/energy invested in obtaining the substance and/or to recover from its use
- Persistent substance use despite clear evidence of harmful consequences

12

OPIOID WITHDRAWAL

Signs

- Yawning
- Tears
- Dilated pupils
- Sweating
- Runny nose, sneezing
- Tremors
- Goose bumps
- Diarrhea and vomiting

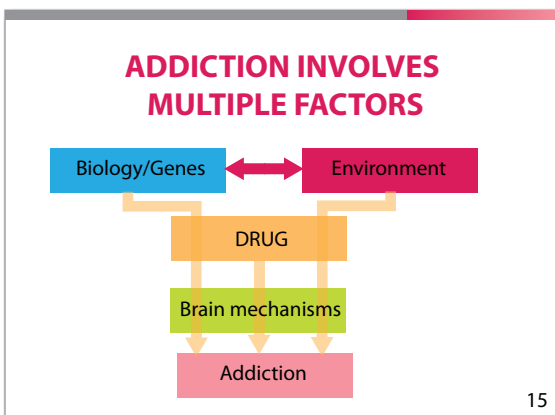
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OPIOID WITHDRAWAL

Symptoms

- Loss of appetite and nausea
- Abdominal pain or cramps
- Hot and cold flushes
- Joint and muscle pain or twitching
- Poor sleep
- Drug cravings
- Restlessness/anxiety

14



15

The addicted brain is distinctly, biologically different from the non-addicted brain

- Receptor function and availability
- Metabolic activity
- Responsiveness to environmental cues
- Gene expression

16

Unit 3.3

DOPAMINE REWARD PATHWAY

prefrontal cortex
nucleus accumbens
VTA

17

DOPAMINE D2 RECEPTORS ARE LOWER IN ADDICTION

Ice & Cocaine
Alcohol
Heroin

control addicted

Reward Circuits
Non-Drug User
Reward Circuits
Drug User

18

SUMMARY

- Drug use can be considered as a continuum with no use at one end and addiction at the other.
- People start and continue to use drugs for different reasons
 - to have fun
 - to forget
 - to improve functionality
- Addiction is a brain disease which makes it hard for the drug user to stop using drugs

19

Unit 3.4

BASIC TREATMENT PRINCIPLES

Learning Objectives

At the end of this unit, participants will be able to:

- identify the key principles in providing high quality drug addiction treatment
- identify the goals of treatment
- develop scenarios about issues related to the basic principles of drug treatment
- describe the settings where treatment occurs
- describe the relationship between different types of treatment

Content and Timeline

Introduction	2 minutes
Presentation	20 minutes
Conclusion	8 minutes

Unit 3.4



LEARNING OBJECTIVES

At the end of this session, participants will be able to:

- identify the key principles in providing high quality drug addiction treatment
- identify the goals of treatment
- describe the settings where treatment occurs
- describe the relationship between different types of treatment

2

IMPORTANT CONSIDERATION

Drug addiction is a chronic relapsing medical condition often associated with periods of psychosocial instability

3

PURPOSE OF TREATMENT

- The right care....
- for right person....
- at the right time....
- in the right way

4

WHAT CAN THE CHRONIC DISEASE MODEL TEACH US ABOUT DRUG ADDICTION TREATMENT?

- Use efficacious medications when necessary
- Encourage lifestyle changes
 - promoted by behavioral treatment and counseling
- Combination of medication and life-style changes is most effective

5

WHAT ARE THE COMPONENTS OF DRUG TREATMENT?

- Setting
 - residential, outpatient, inpatient
- Therapeutic model
 - theory and technique
- Therapeutic focus
 - individual, group, family
- Intensity
 - frequency—days per week; hours per day

6

PRINCIPLES OF EFFECTIVE TREATMENT (1)

- No single treatment is appropriate for all individuals.
- Effective treatment attends to the multiple needs of the individual, not just his/her drug use.
- Treatment needs to be readily available.
- Remaining in treatment for an adequate period of time is critical to treatment effectiveness.

7

PRINCIPLES OF EFFECTIVE TREATMENT (2)

- Treatment progress and drug use during treatment should be monitored.
- Treatment plans need to be assessed and modified continually.
- Medications are an important element, but not the only component.
- Counseling and other behavior components are critical.

8

Unit 3.4

PRINCIPLES OF EFFECTIVE TREATMENT (3)

- Detoxification is only the first stage of treatment and by itself does little to change long-term drug use.
- Treatment programs should provide testing for HIV, hepatitis, TB and other infectious diseases and provide help and means to modify risk behaviors.

9

PRINCIPLES OF EFFECTIVE TREATMENT (4)

- Treatment of comorbid conditions should be integrated.
- Recovery from addiction can be a long-term process and frequently requires multiple episodes of treatment.

10

WHAT ARE THE GOALS OF DRUG TREATMENT?

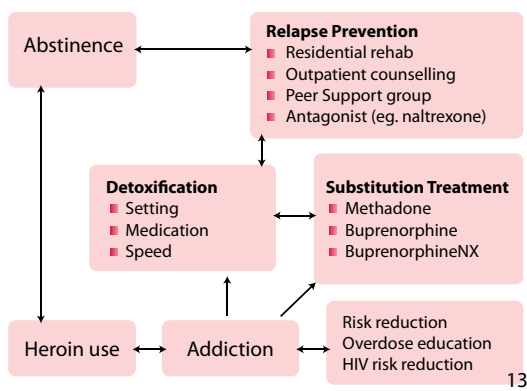
- Ultimate goal:
 - enable the client to achieve lasting abstinence
- Immediate goals:
 - reduce drug use
 - improve the client's ability to function
 - minimize the medical and social complications of drug use

11

TREATMENT OUTCOMES

- Reduction in drug and alcohol use
- Increased personal and social functioning
- Improved public health and safety with reduction in HIV and Hepatitis C transmission and reduction in drug-related criminality

12



13

CONCLUSION

- The ultimate goal of drug treatment is to obtain abstinence from drugs.
- The immediate goals are to reduce drug use, improve functioning, and minimize health and social consequences.
- There are key principles of drug addiction counseling that underpin the success of any treatment intervention.
- There is a range of interrelated treatment approaches to assist heroin addiction.
 - Understanding this is important to provide the best available treatment.

14

Unit 3.5

IMPORTANT FACTORS FOR SUCCESSFUL TREATMENT

Learning Objectives

At the end of this unit, participants will be able to:

- describe the factors that influence successful drug addiction treatment
- describe how to link these factors to the Vietnam context

Content and Timeline

Introduction	1 minutes
Presentation	25 minutes
Conclusion	4 minutes

Unit 3.5

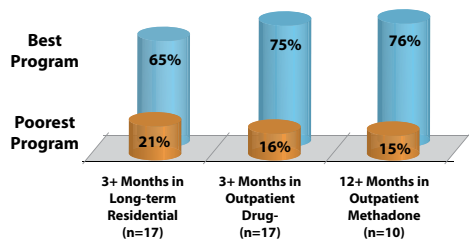


LEARNING OBJECTIVES

At the end of this session, you will be able to:

- describe the factors that influence treatment success
- understand and apply these factors in the Vietnam context

CLIENT RETENTION RATES FOR PROGRAMS



Simpson, Joe, Broome, Hiller, Knight, Rowan-Szal, 1997, PAB

INDIVIDUAL CLIENT FACTORS THAT INFLUENCE TREATMENT OUTCOMES

- Chronic, severe addiction
- Polydrug addiction
- Psychiatric morbidity, including antisocial personality disorder
- Criminality
- Family and social support

PROGRAM OR PROCESS FACTORS THAT INFLUENCE TREATMENT OUTCOMES

- Number and type of services provided
- Program organization
 - Leadership qualities
 - Mix of staff skills
 - Service provision environment

FACTORS THAT INFLUENCE TREATMENT OUTCOMES

- Treatment outcomes depend primarily on the quality of the treatment services, rather than on the individual factors of the client.

ORGANIZATIONAL ESSENTIALS FOR GOOD PATIENT MANAGEMENT

- Basic management skills
- Healthy working environment
- Clear demarcation of tasks
- Team members all understand the team mission and responsibilities to clients
- Staff are well supervised, appraised and supported

REVIEW: TREATMENT OUTCOMES ARE RELATED TO....

- Program organization, leadership, clarity on purpose and goals, and mix of skills
- Duration and intensity of treatment
- Individual readiness to change and problems at beginning of treatment
- Level of compliance, and degree of engagement in the treatment program
- Type of structured counseling or other social interventions

Unit 3.5

SUMMARY: FACTORS THAT IMPACT TREATMENT OUTCOMES

Client factors

- Severity of addiction
- Multiple drug addiction
- Severity and nature of coexisting problems
- Level of social and family support
- Readiness to change

Clinic factors

- Quality of leadership and teamwork
- Treatment environment and setting
- Range of services
- Staff skills mix

9

Unit 3.6

TREATMENT FOR HEROIN ADDICTION

Learning Objectives

At the end of this unit, participants will be able to:

- describe different therapies of drug addiction treatment available in international settings
- describe the strengths and limitations of each of the therapies
- suggest therapy combinations to enhance effectiveness

Content and Timeline

Introduction	1 minutes
Presentation	75 minutes
Conclusion	9 minutes

Unit 3.6



LEARNING OBJECTIVES

At the end of this session, participants will be able to:

- describe the different drug addiction treatment therapies available internationally
- describe strengths and limitations of each of the therapies
- Recommend therapy combinations based on individual client needs

2

WHAT KINDS OF TREATMENTS ARE AVAILABLE FOR DRUG ADDICTION?

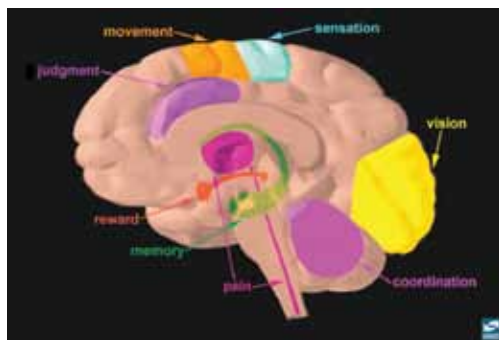
1. Medication therapies
2. Behavioral therapies
3. Combination of medication and behavioral therapies

3

WHAT ARE THE TARGETED OUTCOMES OF MEDICAL DRUG TREATMENT?

- Block or reduce craving
- Block or reduce drug rewards (e.g., high)
- Prevent/treat withdrawal symptoms
- Restore "normal" brain functioning
 - Ameliorate drug-related mood or cognitive deficits
 - Improve impulse control
- Treat underlying psychiatric disorders

4



5

TYPES OF MEDICAL DRUG TREATMENTS FOR HEROIN ADDICTION

- Methadone
- Buprenorphine
- Naltrexone

6

OPIOID SUBSTITUTION TREATMENT

- Use of safe medication: agonist
- Acts in a similar way as opiates
- Longer duration of action
- Action:
 - alleviates withdrawal symptoms
 - reduces or eliminates craving
 - blocks "on top" use
- Long-term treatment
 - maintenance versus detoxification

7

THE AIMS OF OST

- To reduce risk behavior from
 - injecting
 - using heroin
- To improve health, social and psychological well-being
 - improve participation in medical care
 - deal with social problems
 - overcome anxiety and depression
- To reduce criminal activity

8

Unit 3.6

HOW DOES AN AGONIST (METHADONE) WORK ON THE BRAIN?



- Like heroin, an agonist (such as methadone) binds to a specific opiate receptor to elicit a response (i.e., excitation)
- Methadone does not produce same level of euphoria produced by heroin

National Institutes of Health. The Brain: Understanding Neurobiology. Lesson 5: Drug Addiction Is a Disease, So What Do We Do about It? 9

METHADONE: CLINICAL PROPERTIES

- **The 'Gold Standard' treatment**
- Daily dosing (same time, daily) maintains constant blood levels and facilitates normal everyday activity
- Adequate dosage prevents opioid withdrawal without intoxication

10

METHADONE

- Administered by mouth in regular, fixed doses
- Far more gradual onset of action than heroin; patients stabilized on methadone do not experience any rush or euphoria
- Wears off much more slowly than heroin; no sudden withdrawal
- Maintenance treatment reduces desire for heroin (craving)
- Euphoric effects of additional heroin significantly blocked

11

IS METHADONE SIMPLY A SUBSTITUTE FOR OPIATE ADDICTION?

Methadone maintenance is NOT simply addiction substitution. It involves:

- assessment of health, social, legal, financial and vocational status
- safe, stable dosing
- no euphoria or psychomotor instability
- monitoring of heroin and other drug use
- drug counseling
- linkage to other services

12

HOW EFFECTIVE IS METHADONE MAINTENANCE TREATMENT?

- High treatment acceptance and retention
- No long-term adverse health effects
- Methadone maintenance leads to the following:
 - Marked reductions in illicit drug use
 - Marked reductions in criminal activity
 - Dramatic reductions in mortality rates
 - Decreased incidence of HIV infection
 - Marked improvement in health and psychological well being

13

WHAT IS THE IMPACT OF METHADONE ON THE HIV+ DRUG USER?

- Among HIV+ patients, methadone maintenance is associated with more consistent use of antiretrovirals and fewer hospitalizations

Sambamoorthi 2000; Weber 1990; Laine 1998.

14

HOW IMPORTANT IS DOSAGE IN METHADONE MAINTENANCE TREATMENT?

- Multi-site observational study:
 - Continued heroin use in 35% of patients maintained < 35 mg daily; 5% at daily dose >60 mg.
- Random assignment, double-blind clinical trials:
 - Dose dependent increases in retention and decreased rates of illicit opioid use: 80-100 mg superior to 50-65 mg superior to 20 mg superior to placebo (0 mg).

15

WHAT IS THE OPTIMAL DURATION OF METHADONE TREATMENT?

- **Optimum duration not certain**
 - Measured in years, not weeks or months
 - Some need it indefinitely
- **Treatment Duration Study**
 - MMT vs. 180-Day Methadone to Abstinence (MTA) - Sees et al. (2000)
 - Compared MMT with standard counseling to 180-day methadone tapering with enhanced counseling and support services
 - MMT superior to 180-day MTA
 - + greater reductions in heroin use, retention
 - + less criminal activity

16

Unit 3.6

WHAT ARE THE LIMITATIONS AND ADVANTAGES OF METHADONE?

■ Limitations

- Methadone has misuse potential
- Misuse and diversion potentials limit dispensing options
 - + In many countries methadone dispensed under direct observation in highly structured programs

■ Advantage

- Low cost
- While dispensing costs can be high in a closely monitored system...
 - + can be lower in developing countries with lower labor costs

17

METHADONE: ADVANTAGES

- Suppresses opioid withdrawal
- Pure – no ‘cutting agents’ required
- Oral administration
- Once daily dose
- Counselling and support assists long-term lifestyle changes
- Legal and affordable – reduced participation in crime
- Few long-term side effects
- Slow reduction and withdrawal from treatment can be negotiated with minimal discomfort

18

METHADONE: DISADVANTAGES

- Initial discomfort during stabilisation phase
- Opioid addiction maintained
- Can overdose, particularly with polydrug use
- Daily travel to clinic and time commitment
- Diversion risk
- Slow withdrawal undertaken over a period of months
- Protracted withdrawal symptoms
- Side effects

19

COMPARING METHADONE AND HEROIN

METHADONE	HEROIN
Orally effective	Not orally effective
No risk of infection	Parenteral use is a risk factor for transmission of infectious diseases
Long-acting - administered once a day	Short-acting - must be administered several times a day
Causes no sedation or euphoria	Can cause significant sedation and/or euphoria

20

BUPRENORPHINE

- Sublingual tablets
- Partial agonist: can produce typical opioid effects but its maximum effect (“ceiling”) is less than that of heroin or methadone
- Decreased risk of overdose: less effect on breathing
- Mono (Subutex) or combination (Suboxone) tablets
 - Buprenorphine/naloxone combination tablet may reduce potential of misuse
 - Naloxone not absorbed sublingually - antagonist effects only if injected

Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment. About Buprenorphine Therapy.

21

BUPRENORPHINE: FEATURES

- Strong attachment to opiate receptors
- Average dose: 12-16 mg
- Once stabilised, 48-56 hours half-life; some individuals only need 3 to 4 dosages per week
- Relatively easy to stop

22

HOW DOES A PARTIAL AGONIST (BUPRENORPHINE) WORK ON THE BRAIN?



- A partial agonist (such as buprenorphine) binds to a specific opiate receptor to elicit a response (i.e., excitation) similar to methadone
- Buprenorphine does not produce same level of euphoria produced by heroin or methadone

Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment. About Buprenorphine Therapy.

23

NALTREXONE

- Antagonist treatment
- Taken orally, daily
- Individuals must be medically detoxified and opiate-free for several days before naltrexone can be started
- All effects of self-administered opiates, including euphoria, are completely blocked
- Treatment adherence is a problem unless client is highly motivated

24

Unit 3.6

HOW DOES AN ANTAGONIST (NALTREXONE) WORK ON THE BRAIN ?



- An antagonist (such as naltrexone) binds to a receptor and blocks it
- Produces no response and prevents other chemicals (drugs or receptor agonists) from binding or attaching to the receptor

25

Agonist

Antagonist

■ Substitution treatment	■ Blocks treatment
■ Prevents withdrawal	■ Detox first
■ Alleviates craving	■ May reduce craving
■ Produces physical addiction	■ Does not produce physical addiction
■ Blocks the effect of "on top" heroin use	■ Blocks the effect of "on top" heroin use
■ Methadone	■ Naltrexone
■ Buprenorphine (partial agonist)	■ Naloxone (emergency OD)

26

SOME KEY ISSUES ABOUT MEDICAL TREATMENT FOR ADDICTION?

- Agonist maintenance (methadone or buprenorphine) substantially reduces heroin use and the adverse health, legal, financial, vocational and social consequences of heroin addiction
- Problems with treatment adherence limit effectiveness of naltrexone
- Combined treatment (medication and counseling) most effective

27

BEHAVIORAL DRUG TREATMENT

28

WHAT IS THE PRIMARY OBJECTIVE OF BEHAVIORAL DRUG TREATMENT?

- Help drug addicts learn techniques to stop using drugs and cope without drugs

29

HOW ARE CLIENTS MOTIVATED TO STOP USING?

- Change requires recognition that:
 - the addictive behaviors are causing problems
 - the benefits of stopping outweigh the benefits of use
 - sustained abstinence (enjoying life while abstinent) is realistic and achievable
 - despite previous failures, clients can succeed in stopping and staying off drugs

30

BEHAVIORAL DRUG TREATMENT: TYPES

- Psychosocial counseling
- Cognitive behavioral treatments
- 12-step recovery programs

31

THE ROLE OF PSYCHOSOCIAL COUNSELING (1)

- Motivates clients to stop using drugs
- Targets the behavioral, social and psychological triggers that contribute to continued drug use
 - improves interpersonal functioning
 - teaches skills to deal with family problems, pressure from friends who use drugs
 - teaches relapse prevention techniques

32

Unit 3.6

THE ROLE OF PSYCHOSOCIAL COUNSELING (2)

- Encourages patients to make lifestyle changes
 - develops alternative, rewarding activities
 - increases involvement in drug-free social, vocational, and family activities
- Addresses problems resulting from years of addiction (e.g., social, legal, work, health, psychological, and family problems)
- Fosters adherence to treatment regimens
 - increases treatment retention
 - increases adherence to pharmacotherapy

33

COGNITIVE BEHAVIORAL THERAPY (1)

- Core sessions
 - Assessing high-risk situations
 - Coping with cravings and urges to use
 - Managing thoughts about drugs
 - Problem solving and decision making
 - Drug refusal skills
 - Planning for emergencies

34

COGNITIVE BEHAVIORAL THERAPY (2)

- Strategies:
 - Establish positive, collaborative relationship
 - Positively reinforce behavior change
 - Provide corrective feedback when necessary
 - Provide explicit structure and expectations for treatment and daily activities
 - Utilize role-playing, visual imagery, thought stopping, and teach skills to change one's environment or behaviors

35

HOW DO 12-STEP RECOVERY PROGRAMS HELP DRUG USERS? (1)

- Peer-led, mutual support group meetings and other activities
- Shared principles
 - Addiction is a disease, with physical, spiritual and emotional components
 - 12-steps of recovery
- Meetings and contact are an alternative to use
- Slogans and helpful reminders

36

HOW DO 12-STEP RECOVERY PROGRAMS HELP DRUG USERS? (2)

- Begin with person admitting that he/she has a drug problem and that he/she cannot help him/herself
 - concept of surrender
 - often (but not always) a strong spiritual component
- Provides a reference group of people with similar problems
 - provides social acceptance for individual addicted to drugs
 - sense of community with other people

37

HOW DO 12-STEP RECOVERY PROGRAMS HELP DRUG USERS? (3)

- Other group members provide examples of how to deal with drug problems
- Members provide strong support and encouragement to become and remain abstinent from drugs

38

SUMMARY

- There are three main types of drug treatment: medication therapy, cognitive behavioral therapy, and self-help
- The 3 most popular medication therapies are: methadone, buprenorphine and naltrexone
- The main objective of cognitive behavioral treatment therapy is to help willing clients learn techniques to stop using drugs and cope with life without drugs

39

CHAPTER 4

MOTIVATIONAL INTERVIEWING

Unit 4.1: The Stages of Change Model and Key Concepts in Motivational Interviewing	65
Unit 4.2: Principles and Steps for Motivational Interviewing	75
Unit 4.3: Linking Motivational Interviewing to Stages of Change Strategies	99

Unit 4.1

THE STAGES OF CHANGE MODEL AND KEY CONCEPTS IN MOTIVATIONAL INTERVIEWING

Learning Objectives

At the end of this activity the participants will:

- have a good understanding of the Stages of Change Model
- know of unhelpful assumptions that prohibit client behavior change
- understand the key concepts of motivational interviewing
- understand the rationale of motivational interviewing interventions
- appreciate the interplay between the Stages of Change Model to motivational interviewing

Content and Timeline

Introduction	1 minutes
Presentation	50 minutes
Conclusion	9 minutes

Unit 4.1

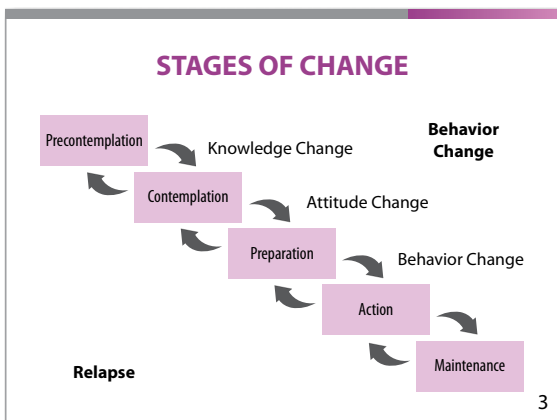


LEARNING OBJECTIVES

At the end of this unit participants will:

- have a good understanding of the Stages of Change Model
- know of unhelpful assumptions that prohibit client behavior change
- understand the concept of motivational interviewing
- understand the rationale of motivational interviewing interventions
- appreciate the interplay between the Stages of Change Model and motivational interviewing

2



3

MOTIVATIONAL INTERVIEWING - MI

- A style of counseling that aims to facilitate patient-driven decisions to change harmful behaviors
- Can be readily incorporated during the counseling process
- MI may be useful with a person who is 'contemplating' changing his/her behavior but may be experiencing ambivalence

4

MI TECHNIQUES ARE USEFUL BECAUSE...

- People come to counselors for a variety of reasons
- BUT many patients do not link their substance use to issues they wish to discuss
- MI can provide motivation for people to contemplate their substance use and build resolve for change
- MI can help clients understand their reasons for wanting to change
- MI can help counselors link appropriate interventions to clients, based on their stage of change

5

MI: 8 UNHELPFUL ASSUMPTIONS

1. The client ought to change behavior
2. The client wants to change
3. Health is the client's primary motivator
4. The intervention has failed if the client doesn't choose to change
5. Clients are either motivated to change, or not
6. Now is the right time to choose to change
7. A tough approach is the best approach
8. The counselor is the expert; the client must follow the counselor's advice

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MOTIVATIONAL INTERVIEWING USES

- Applies to most behaviors
- Assesses the client's stage of change
- Enhances the client's resolve to change
- Provides clarification to problems and mechanisms to resolve those problems
- Helps to assess goals

7

KEY ELEMENTS OF MOTIVATIONAL INTERVIEWING

- Self-confrontation
- Psychological principle: "I learn what I believe as I hear myself speak"
- Respect for client's right to choose

8

Unit 4.1

SUMMARY – MOTIVATIONAL INTERVIEWING

The process of change is a continuum

- Strategies for various interventions are linked to the stages of change
- Pre-contemplation stage: client does not consider giving up
- Contemplation stage: client begins to think about doing something
- Action stage: client attempts to quit or reduce intake
- Maintenance stage: client succeeds in giving up and wants to maintain status
- Lapse stage: client resumes use (a normal part of the change process)

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SUMMARY CONTINUED

- MI is a style of counseling that aims to facilitate patient-driven decisions to change harmful behaviors
- MI may be useful with a person who is “contemplating” changing his/her behavior but may be experiencing ambivalence
- When people hear their own words they are more likely to commit to desired changes

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Handout 4.1

Stages of Change Model

1. The Pre-Contemplation Stage:

In this stage, the user is not considering giving up drugs. You should use this time to develop a relationship with your client and try to raise his/her awareness of the consequences of drug use, including on him/her, his/her family, and the community. Avoid pushing your client too hard! Remember that you must build a solid relationship and assist your clients to begin thinking about making life changes. How do you help? Form a relationship!

Some useful questions:

- How will you know when it is time to think about changing?
- What signals will tell you to start thinking about changing?
- What do you like most about yourself?
- What do you think you do best?
- What is the connection between those qualities and your drug use?
- Picture what your life was like before you began using drugs. How do you feel about that picture?
- Imagine what your life would be like if you continued the way you are going now. How does that make you feel?
- Picture what your life would be like if you changed. What does that image looklike to you?
- What are the good things about your drug use? Let's make a list.
- What are the not-so-good things about your drug use?
- Let's add these to the other side of your list. What would be the worst things that could happen if you changed (e.g. if you gave up drugs)?
- What would be the best thing that could happen to you if you kept going the same way as you are now (i.e. using drugs)?
- Let's make a list on this side of the "good things" about giving up drugs.
- Let's list make a list on this side of the "not-so-good things" about giving up drugs.
- What comes to your mind when you look at these lists?

2. The Contemplation Stage

In the contemplation stage, the user begins to think about doing something about his/her drug use, but has not yet reduced his/her level of drug use. They are usually ambivalent about change. "Contemplation" is often induced by someone or something external. When your client is in this stage, your job is to help him/her by discussing the advantages and disadvantages of reducing use and/or quitting (via motivational interviewing). Make observations and provide information, but avoid arguing. How do you help?

Handout 4.1

During this stage, you may want to one or more of the following:

- Continue to raise awareness of perceived risks of continuation of behavior
- Assist clients to make informed choices (using motivational interviewing techniques)
- Offer continued support, assistance and encouragement
- Acknowledge the “pleasant effects” of substance use and discuss what could be beneficial if the client reduced use
- Avoid too much focus on “action”
- Try to tip the balance in favor of change

Some useful questions:

- What happened that make you think that you need to make some changes in your life?
- What are some of the good things about the way you are currently trying to change? Let’s make a list.
- What are some of the not-so-good or harder things? Let’s add them to the other side of your list.
- What will your life will be like if you make the changes you want to make?
- It’s great that you are thinking about changing. What do you need to help you make the changes you want to make?

3. Preparation for Change

When the client is prepared, behavioral change begins with a change in pattern/level of use. This is the time to make and institute a plan. Prior to developing a plan, you will need to make full assessment of the client’s situation.

It is important to know the following:

- Which drugs your client using
- How much he/she is using
- The frequency of his/her drug use (e.g. daily, 3 times per day, weekly)
- The route of administration (injection, inhalation, oral) and if the client has changed route of administration (also how and why)
- Whether the drug use is experimental, functional, harmful, or because of addiction
- If and how your client has tried to give up or reduce use in the past
- What function your client’s drug use is serving (what needs are being met by his/her drug use)
- The kinds of support your client has
- How he/she is paying for his/her drugs
- Whether your client uses drugs alone, with company or both

Handout 4.1

Some useful questions/suggestions:

- What are some of the barriers to making the changes you want to make?
- Pick one of the barriers to changing and list some of the things that could help you overcome these barriers.
- Can you choose one of these possible solutions and try it out?
- What made you decide on that possible solution?

Part of a counselor's tasks might be to:

- provide feedback
- support self-efficacy
- undertake a full assessment
- advise on options
- assist the client in making a plan
- assist in maintaining motivation
- assist in skill development and use of appropriate strategies
- provide practical assistance
- teach relapse prevention skills

4. The Action Stage

During the action stage, the client attempts to quit or reduce her/his drug use. You can be more active at this stage by helping the client to learn skills and develop strategies that are needed to reduce drug use or live a substance-free life. The client will need to conduct an informal self-assessment to determine what factors are influencing her or his drug use. Clients ought to consider people, places, emotions, stressors...etc. Counseling and support are crucial during this stage.

How do you help? Help by teaching life skills and coping strategies. Be supportive!

Once the client has identified some of the factors that prompt him/her to use drugs, he/she can begin trying to reduce and/or eliminate these from his/her life. For some, this may mean throwing away injection equipment. For others, it may mean finding a job to avoid boredom. Other people may have to avoid friends who are still using drugs. The client may need to talk about the past, or work with his/her family or other people who play a significant role in his/her life. It may also mean changing employment.

Many of these interventions are commonly used in counseling to address problematic behaviors. During this stage the client initiates and tries to maintain her/his new behaviors, working to keep from (re) lapsing. Many of these interventions are commonly used in counseling to address problematic behaviors. During this stage the client initiates and tries to maintain her/his new behaviors, working to keep from (re) lapsing.

Handout 4.1

Part of a counselor's task might be to:

- provide reinforcement during difficult times
- assist the client to maintain his/her status
- teach self-reinforcement skills
- monitor relapse prevention skills
- teach self-monitoring skills
- refer clients to self-help groups as appropriate

Some useful questions:

- Congratulations! What has worked for you in taking these steps?
- What could help to make the process better?
- What else would help?
- Can you break these larger steps you have identified into smaller, easily achievable steps?
- Is there anything I can do to assist you?

5. The Maintenance Stage

A client in the maintenance stage is usually abstaining from substance use and wants to remain that way. Your role is to help the individual develop a healthy lifestyle, which might include moving to a neighborhood where drugs are less prevalent, finding activities that keep him or her off the streets and away from users and dealers, and spending free time with non-users only. Most importantly, individuals in this stage must learn to monitor themselves and recognize when they are entering into risky situations. It may be very difficult to maintain change. Clients will likely feel that the drugs they took were helpful to them in many ways. They may grieve the loss of the drugs, like the death of a good friend.

It is important for counselors to keep in mind why their clients used drugs in the past and what they may be missing (i.e. pleasant hallucinations, good feelings). Clients may also be suffering from painful memories, anxiety or depression as a result of abstaining from drugs. How do you help? Try to understand your client's feelings, what he/she could be missing, and be as supportive as possible.

Some appropriate responses would be to:

- continue to be supportive
- reinforce gains - do not assume all is lost if there is a lapse
- keep the client linked to appropriate services and encourage him/her to access additional services that may be of help
- bring the client back in for a refresher session or a full intervention

Handout 4.1

Some useful questions:

- Congratulations!! What do you think is working to keep you in control of your life?
- Is there anything you can think of that may help to make things better for you?
- What else might help?
- Can you break these things that you have identified into smaller, more easily achievable steps?

6. The Relapse Stage

After trying to abstain, most users go through a stage where they resume taking substances at the same or a slightly reduced dosage as before. This should not be considered failure: relapse is a common part of the recovery process. You need to prepare your client in advance for this stage and then help him/her to get through it. Try to help your client figure out what caused him/her to resume drug use. Not all change strategies work for all users. When your client is ready to try to quit again, you can help him/her develop a more effective plan of action.

How do you help? Assure her/him that lapse and relapse are part of the change process. Help him/her find out why the lapse occurred. When she/he is ready again, be there for her/him.

When an individual returns to use (lapse) or previous pattern of use (relapse), it may be one-off or continued use.

A counselor's tasks might include the following:

- Preparing the client for this stage in advance by explaining that lapse and relapse are commonly part of the process of change
- Assisting the client to reframe his/her experience
- Assisting the client to distinguish between a 'lapse' and 'relapse'
- Helping minimize harm from (re)lapse
- Supporting the client to renew his/her resolution to change
- Supporting the client to identify and try different strategies

Some useful questions:

- Was there anything that worked for a while?
- Why do you think it worked for a while?
- What happened that made it difficult for you to maintain your status?
- What did you learn from this?
- Did you think of some other ways of maintaining the change?
- What happened that made these not work for you?
- What did you learn from this?

Handout 4.1

- Let us try to think of some things that you might try to see if you can get things moving again so that you are more in control of your life. Let's make a list.
- Can you break these things that you have identified into smaller, more achievable steps?
- Is there anything that I can do to assist you?

Summary

- The process of change is a continuum: clients move from one stage to another.
- At the pre-contemplation stage, the client does not consider giving up his/her substance use.
- During the contemplation stage, the client begins to think about doing something about his/her substance use.
- During the action stage, the client attempts to quit, or reduce his/her drug use.
- After trying hard to give up their substance use, most users tend to resume use. This is the lapse stage. Lapse and relapse should be seen as part of the change process, and should not be seen as failure.
- During the maintenance stage, clients have usually succeeded in giving up their reliance on substances and want to maintain their status.

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Unit 4.2

PRINCIPLES AND STEPS FOR MOTIVATIONAL INTERVIEWING

Learning Objectives

At the end of this activity the participants will:

- have a good understanding of the basic principles of motivational interviewing
- understand the steps of a motivational interviewing intervention session
- have had an opportunity to practice these new skills in role-plays
- have learned how to apply motivational interviewing approaches in counseling services

Content and Timeline

Introduction	1 minutes
Presentation	95 minutes
Conclusion	14 minutes

Unit 4.2



LEARNING OBJECTIVES

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- have a good understanding of the basic principles of motivational interviewing
- understand the steps in a motivational interviewing intervention session
- have had an opportunity to practice motivational interviewing skills in role-plays
- have learned how to apply motivational interviewing approaches in counseling services

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MI: 5 KEY PRINCIPLES

- Express empathy
- Reduce ambivalence & develop discrepancy
- Facilitate self-motivational statements
- Avoid or "roll with" resistance
- Use counseling skills to elicit discussion about change
 - Open-ended questions
 - Affirmations
 - Reflective listening
 - Summarizing

3

STEPS IN MOTIVATIONAL INTERVIEWING

1. Assess the client
2. Explore the good & not-so-good things
3. Summarize and help the client make a decision (using the Decision Matrix)
4. Help set goals

4

ASSESSING THE PATIENT

- Establish rapport
- Show empathy
- Take a drug use history (typical day)
- Provide results and feedback on the assessment
 - Be objective

5

EXPLORING THE GOOD THINGS ABOUT DRUG USE

- What are some of the good things about ____?
- People usually use drugs because they help in some way - how have they helped you?
- What do you like about the effects of ____?
- What would you miss if you weren't taking ____?
- What else?
- NOTE: Be sure to give praise & support self-efficacy

6

EXPLORING THE NOT-SO-GOOD THINGS ABOUT DRUG USE

- Can you tell me about the downside of taking ____?
- What are some aspects that you are not so happy about?
- What are the things you wouldn't miss?
- If you continued as before, where do you see yourself 3 years from now?
- What else?
NOTE: Be sure to give praise & support self-efficacy

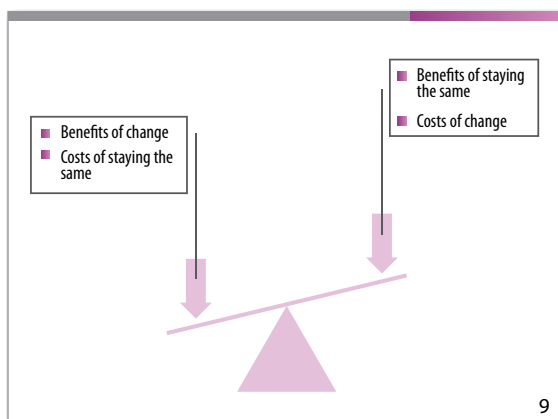
7

MI: SUMMARIZING

- Summarize the good things
- Summarize the not-so-good things (problems)
- Summarize how your clients compare drug use to their life goals
- Summarize, summarize, summarize
- If you get stuck say things like, "So, let's see, so far you have said...."

8

Unit 4.2



THE DECISION MATRIX

	Short-term	Long-term	Score
Benefits			
Costs			

10

- ### ASK FOR A DECISION
- Restate the dilemma or ambivalence:
 - "You were saying that you were trying to decide whether to continue or cut down on _____"
 - "After this discussion, are you more clear about what you would like to do?"
 - "So have you made a decision?"
- 11

- ### GOAL SETTING
- What will be your next (first) step now?
 - What will you do in the next 1 or 2 days (week)?
 - Have you already been doing something to achieve this? If so, can you do more of this?
 - Who will be helping you on this?
 - On a scale of 1-10 how confident are you that you will do this next step?
 - NOTE: Be sure to provide praise and support self-efficacy
- 12

- ### THE 5-MINUTE ASSESSMENT
1. Readiness ruler
 - How important is your drug use to you?
 - On a scale of 1-10
 - (1 = not important, 10 = very important)
 2. Confidence ruler
 - How confident are you about changing?
 - On a scale of 1-10
 - (1 = not confident, 10 = very confident)
 - Why did you score yourself so high/low?
 - What would help to move you higher on the scale?
 3. How high on the scale would you need to be to change?
- 13

- ### FRAMES APPROACH
- Feedback** Assessment & evaluation of the problem
 - Responsibility** Emphasis of client's personal responsibility and that alcohol/drug use is his/her choice
 - Advice** Provision of explicit advice to change or to seek further treatment
 - Menu** Offer alternative strategies: personal choice, goals & control
 - Empathy** A potent determinant of client motivation & change - counselor role is critical
 - Self-efficacy** Instill optimism - chosen goals can be achieved
- 14

- ### RECOGNIZE RESISTANCE
- When patients:
- argue
 - interrupt
 - fail to link (problems to use)
 - ignore problems
 - fail to engage
- 15

- ### REDUCE RESISTANCE
- Roll with resistance
 - Shift the focus
 - Reframe
 - Emphasize personal choice and control
 - Stop providing solutions
- 16

Unit 4.2

IF NO COMMITMENT TO CHANGE IS MADE

- Accept it
- Empathize that ambivalence can be difficult
- Ask if he/she can manage the consequences of not making a decision
- Ask if there is anything else that will help with the decision (i.e. having more time or information...etc)

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REMEMBER

- Leave the door open.....

"In summary, it seems that at the moment you don't want to change this behavior, but if you want to talk about it further at some stage, or if you decide that it is starting to cause you problems, please feel free to come and see me again and we can discuss this further..."

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CONCLUSION - MOTIVATIONAL INTERVIEWING

- Client-centered decision making
- Uses counseling skills to elicit discussions about change
- Helps to identify clients' stage of change
- Links interventions to clients' motivations
- Creates discrepancy between where clients are and where they would like to be

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Handout 4.2-1

Five Key Principles of Motivational Interviewing

Motivational interviewing is directive in that the counselor has certain goals in mind when conducting the interview. These goals are formulated with an awareness of the underlying principles of motivational interviewing. When strategizing an intervention, the MI counselor should employ the following strategies.

Express empathy

In the clinical setting, empathizing means employing an accepting, non-judgmental approach, with efforts to understand the client's point of view and avoidance of the use of labels such as "alcoholic" or "drug addict". It is especially important to avoid confronting, blaming or criticizing the client. Skilful reflective listening, which clarifies and amplifies the client's experience, is a fundamental part of expressing empathy. Engaging with empathy will increase positive counseling outcomes.

Reduce ambivalence/Develop discrepancy

People are more likely to be motivated to change their substance use behavior when they recognize the discrepancy between their substance use and related problems, and the way they would like their lives to be. The greater the difference between a client's most important goals and his/her current behavior, the more likely the client will be able to change. Motivational interviewing will help to create and amplify this discrepancy from the client's point of view. It is important for the client to identify his/her own goals and values, and to express his/her own reasons for wanting to change.

Facilitate self-motivational statements

The counselor should assess the client for:

- willingness to receive information
- acknowledgement of harm associated with behaviors
- a desire/need to change

Eliciting self-motivational statements from the client is one goal of motivational interviewing. It is critical for clients to believe in the possibility of change and to know the range of alternatives. Remember, the client is responsible for recognizing his/her choices and making changes. This is a strategy for helping the client to resolve ambivalence and is aimed at enabling the client to identify arguments supporting the change.

There are 4 main categories of discussions on change:

- Recognizing the disadvantage of staying the same
- Recognizing the advantage of change

Handout 4.2-1

- Expressing an intention to change
- Expressing optimism about change

There are a number of ways of eliciting a discussion about change.

- Ask direct, open-ended questions; for example:
 - “What worries you about your substance use?”
 - “What do you think will happen if you don’t make any changes?”
 - “What might be some good things about cutting down on your substance use?”
 - “How would you like your life to be in 5 years?”
 - “What do you think would work for you if you decided to change?”
 - “How confident are you that you can make this change?”
 - “How important is it to you to cut down on your substance use?”
 - “What are you thinking about your substance use now?”
- Use the importance and confidence rulers. Miller and Rollnick suggest using the ruler to obtain the client’s rating and then ask the following 2 questions:
 - “Why are you at (e.g. 3) and not at 1?” This gets the client to justify, or defend out loud their position, which may motivate the client to change.
 - “What would it take you to go from a (e.g. 3) to a (e.g. 6) (a higher number)? This gets the client to verbalize possible strategies for change and gets him/her to start thinking more about change.
- Probe the decision balance by encouraging the client to talk about the benefits of change and the costs of staying the same.
- Ask the client to clarify or elaborate on his/her statements. For example, you might say the following to a person who reports that one of the not-so-good things about using cocaine is having panic attacks:
 - “Describe the last time it happened.”
 - “What else?”
 - “Give me an example of that.”
 - “Tell me more about that.”
- Ask the client to imagine the worst consequences of not changing or the best consequences of changing.
- Explore the client’s goals and values to identify discrepancies between the client’s values and his/her current substance use. For example, ask:
 - “What are the most important things in your life?”

Examples of self-motivational statements are provided in Handout 4.2-2

Avoid or roll with resistance

Counselors face resistance when clients argue, interrupt or negate counselors’ suggestions. It is important not to strengthen the resistance by continuing to disagree. Reframing client statements can increase motivation without eliciting resistance. A key principle of motivational interviewing is to accept that ambivalence and resistance to change is normal and to invite the client to consider new information and perspectives about their

Handout 4.2-1

substance use. When the client expresses resistance, counselors should reframe or reflect it, rather than oppose it. It is particularly important to avoid arguing in favor of change, as this puts the client in the position of arguing against it.

Rolling with resistance means not confronting the client's position. There are a variety of techniques that can be used. For example, you might say, "You don't appear to be ready to change your behavior at the moment". This simply reflects a client's point of view.

Another technique is double-sided reflection. This involves acknowledging that the client has stated both sides of an ambivalent equation. You might say, "I can see that this must be confusing for you. On the one hand you are concerned about your drug use, but on the other hand you feel that you don't take more drugs than your friends, and they don't appear to be having problems". The purpose of rolling with resistance is to get them to consider new information and perspectives about their substance use.

A number of clients believe that drug detoxification can cause harmful damage to the inner organs of their body and can kill them. They believe this because they have seen many of their friends die during or following drug detoxification. Therefore, they think that they need to continue to use drugs in order to prolong their lives, despite the fact that drug use has been causing them so many problems. When you have clients who have a strong belief in this myth, you should not argue with them, as they may begin to resist your opinion and might not want to continue the discussion.

In this situation, you might want to say something like this:

Simple reflection: 'I understand why you think that way, given many other drugs users also think the same'.

Double-sided reflection: 'From what you have said, I understand that you are very scared of drug detoxification, since many drug users believe that drug detoxification might kill them. However, I think that you are also aware that there are many other drug users who have been successful in stopping drug use after detoxification. Is that right?'

Counseling skills

Motivational interviewing makes use of 4 specific skills. These skills are used together to encourage clients to talk, to explore their ambivalence about their substance use, and to clarify their reasons for reducing or stopping substance use. The skills are often known by the acronym OARS - , Affirmation, Reflective listening, and Summarizing. The fifth skill is "eliciting discussion about change" and involves using the OARS to guide the client to present the arguments for changing his/her substance use behavior.

Handout 4.2-1

OARS

Open-ended questioning

Open-ended questions are questions that require a longer answer, and open the door for the person to talk. Examples of open-ended questions include:

- “What are the things you enjoy about your substance use?”
- “Tell me about the not-so-good things about using_____?”
- “You seem to have some concerns about your substance use; tell me more about them.”
- “What concerns you about that?”
- “How do you feel about_____?”
- “What would you like to do about that?”
- “What do you know about_____?”

Affirming

By including statements of appreciation and understanding, you will help to create a more supportive atmosphere, and build rapport with your client. Affirming the client’s strengths and efforts to change helps build confidence, while affirming self-motivating statements (or discussions about change) encourages readiness to change. Examples of affirmation include:

- “Thanks for coming today.”
- “I appreciate that you are willing to talk to me about your substance use.”
- “You are obviously a resourceful person to have coped with those difficulties.”
- “I can see that you are a really strong person.”
- “That’s a good idea.”
- “It’s hard to talk about.... I really appreciate your keeping on with this.”

Reflective listening

A reflective listening response is a statement that attempts to guess what the client means. It is important to reflect back the underlying meaning and feelings the client has expressed, as well as the words he/she has used. Using reflective listening is like being a mirror for the client so that he/she can hear the counselor say what they have communicated. Reflective listening shows the client that the counselor understands what is being said, or can be used to clarify what the client means. Effective reflective listening encourages the client to keep talking; enough time should be allowed for this to happen.

Handout 4.2-1

In motivational interviewing, reflective listening is used to highlight the client's ambivalence about their substance use, to steer the client towards a greater recognition of his/her problems and concerns, and to reinforce statements indicating that the client is thinking about change. Examples include:

- "You seem surprised that your score shows that you are at risk of problems."
- "It's really important for you to keep your relationship with your boyfriend."
- "You're feeling uncomfortable talking about this."
- "You're angry because your wife keeps nagging you about your substance use."
- "You would like to cut down your substance use at parties."
- "You really enjoy your substance use and would hate to give it up, and you can also see that it is causing some financial and legal problems."

Summarizing

Summarizing is an important way of gathering together what has already been said, and preparing the client to move on. Summarizing adds to the power of reflective listening, especially in relation to concerns and discussions about change. First, clients hear themselves say it, then they hear the counselor reflect it, and then they hear it again in the summary. The counselor chooses what to include in the summary and can use it to change direction by emphasizing some things, and by not emphasizing others. It is important to keep the summary succinct.

An example of a summary appears below:

"So on one hand, you really enjoy using heroin at parties and you don't think you use any more than your friends do. But on the other hand, you have spent a lot of more money than you can afford on drugs, and that really concerns you. You are finding it difficult to pay your bills. Your partner is angry and you really hate upsetting her. You have also noticed that you have trouble sleeping and you're finding it difficult to remember things."

Handout 4.2-2

How to recognize self-motivational statements

Self-motivational Statements	Counter-motivational Assertions
I guess this has been affecting me more than I realized.	I don't have any problem with marijuana.
Sometimes when I've been using, I just can't think or concentrate.	When I'm high, I'm more relaxed and creative.
I wonder if I've been pickling my brain.	I can drink all night and never get drunk.
I feel terrible about how my drinking has hurt my family.	I'm not the one with the problem.
I don't know what to do, but something has to change.	No way am I giving up heroin.
Tell me what I would need to do if I went into treatment.	I'm not going into a hospital.
I think I could become clean and sober if I decided to.	I've tried to quit, and I just can't do it.
If I really put my mind to something, I can do it.	I have so much else going on right now that I can't think about quitting.

Handout 4.2-3

Sample Counseling Session: Exploring the good things and the not-so-good things about a behavior (staying up late)

Trainer: Please take your seat. So I understand that you like to stay up late?

Participant: Yes.

Trainer: Can you tell me why you like doing that?

Participant: I stay up late because it is very quiet, I can think more clearly and I can do a lot of things during a short period of time. That's why I stay up late.

Trainer: So it helps you to think better?

Participant: Yes.

Trainer: Hmm, is there any other reason you like staying up late?

Participant: When I stay up until 11 or 12 o'clock, it gets very difficult for me to sleep, so I just go on and stay up.

Trainer: Hmm, so if you stay up late, it seems increase your ability to stay up even later. Can you tell me about any other benefits of staying up late?

Participant: You know, when I was at university, I found it very easy to perform very difficult tasks during the nighttime. I could do them very quickly, very efficiently. I still can.

Trainer: So it is very efficient for you to work at night. It sounds like this was pretty important for you when you were in school. That worked well for you. Can you tell, are there any problems associated with your staying up late?

Participant: Last night I stayed up very late and today when I had to go to work, I was exhausted. I have been having some trouble getting things done at work. I always feel tired. But I usually catch up on my sleeping on the weekend. I could sleep all day long on a weekend day.

Trainer: Oh. OK. Is there a problem with that? Can you explain to me why it's a problem? **Participant:** You know, when I sleep all daylong, I feel very tired. I can't really get anything done on those days. I'm pretty dysfunctional on those days.

Trainer: OK. There seem to be a few problems that you have just outlined just now, including problems you have with thinking clearly, working efficiently and feeling tired during the day and especially on the weekends. So on one hand, you say that you are pretty accustomed to staying up late because you think it's a more efficient way of getting your thoughts organized and getting work done. This worked back when you were in university, when it didn't seem to

Handout 4.2-3

be much of a problem. But I get the idea that these issues you raised about thinking clearly, working efficiently and being tired on the weekends, are of concern to you now. So there are some things that you like about staying up late, and there are also some things that are problematic with this sleep pattern. I am curious, how important are these problems to you? Are they small, or are they serious?

Participant: *You know, sometimes I think about this a lot. I'm pretty sure that staying up late is not a healthy behavior, and in the long-term, it might not be a good strategy. But you know, it's like a habit, and it's difficult to change.*

Trainer: *Well, I notice that you have a longer list of the problems than the list of what you like about staying up late. And I can hear in your voice sounds that you are worried about the problems. Maybe we can work together, and I can help you to think of some things you can do to try to avoid staying up too late.*

Debrief

This is an example of an interview with somebody who is in the contemplation phase. The counselor started by asking about the things that the client likes about staying up late. The counselor insisted that the client provide a long answer that could be probed for more reasons. In a real interview, the counselor might continue probing until all possible reasons are exhausted. The counselor would also write these things down and repeat them back. The client would then both see and hear during the process, and would have a chance to affirm what was said.

In a real counseling session, the counselor should ask about the importance of each reason. For those that are very important, the counselor should make a special mark, because those are the ones that will require special attention later. Note that the counselor did not assume that there were any problems, but asked if there were any, and then reaffirmed when the client stated there might be. Note also that the counselor did not assume that any were more important than the others, but rather asked if they were important, and then how important. Counselors should also affirm whether or not there are any other problems by asking, "Are there any other problems?" They should then make a longer list of all the problems identified by the client.

The counselor then created a sense of discrepancy by saying, "There seem to be a few problems that you have outlined just now, including problems you have with thinking clearly, working efficiently and feeling tired during the day (and especially on the weekends). So on one hand, you say that you are pretty accustomed to staying up late because you think it's a more efficient way of getting your thoughts organized and getting work done." The client is then left to decide whether or not there exists a discrepancy.

Do not assume that because the list of problems is long, and benefits short, that the balance means that something must be done. One issue may be more important than many others combined. The value of this exercise is that your client has identified these issues,

Handout 4.2-3

and you have written them down. The client is looking at the list and seeing the benefits and problems simultaneously. This may be the first time in the client's life that he/she has seen such a list on paper. This can have remarkable impact on bringing about change.

Sometimes it is difficult for the brain to take all of these things in at one time. Your client may still be confused and may leave needing to think about what you have discussed. Do not be concerned if your client cannot make a commitment right then - it may take a day or 2 for your client to realize "I have to do something about this". At the same time, do not be concerned if, on seeing a long list of problems, your client still wishes to use. For those who are still pre-contemplators, there are other interventions that you can provide. These specific motivational interviewing techniques assist mainly those who are contemplating moving into the action phase.

Handout 4.2-4

Good things and not-so-good things about substance use

Using a table, such as the one below, can be helpful in assisting clients to explore their substance use and to identify issues that may become the focus of their treatment.

Good things about using Drugs	Not-so-good things about using Drugs

Handout 4.2-5

Example of a Counseling Session

Providing feedback and exploring the pros and cons of heroin use - 5 minutes

On completing an assessment questionnaire with Khang (counselor), Tuan (client), an 18-year-old man who lives with his wife and their young child, has scored low-risk for all substances with the exception of heroin, placing him in the moderate risk category.

Techniques and MI strategies that the counselor uses are in brackets and **boldface font**.

Khang. *OK. Thanks for going through this questionnaire with me. Would it be fair to say that heroin is the drug that you use the most at the moment? (affirmation)*

Tuan. Yeah. Pretty much.

Khang. *What do you enjoy about using heroin - I mean what are the good things about it? (open-ended question - exploring pros and cons)*

Tuan. *Well, it makes me relax, especially after coming home from work. It really helps me to unwind and forget the day. It's also good when you are out with friends or at a party or something over the weekend, because you enjoy yourself more.*

Khang. *How much do you inject, say on an average day? (taking a brief history)*

Tuan. *Um. About 2 times a days; I don't really know how much but it costs about 30,000 Dong for one dose.*

Khang. *Is that the amount you usually use on the weekends? (taking a brief history)*

Tuan. *Yeah... Probably a bit more actually... maybe 3 times, I don't know, sometimes I lose track (laughs).*

Khang. *What are the not-so-good things about using heroin? (open-ended question - exploring pros and cons)*

Tuan. *Ask my wife. She is always nagging me about it (laughs). I guess probably the worst thing about it for me is that it seems to affect my memory and concentration at work. Sometimes after using the night before, the next day at work I am a bit hazy and I feel really tired. I feel really bad sometimes - I won't go into work that day.*

Handout 4.2-5

Khang. So using heroin helps you relax and unwind after work, but it also makes you forgetful and tired, and sometimes you miss work because of it. You also said your wife doesn't like you using it - why do you think that is? (**reflective listening, refocus, open-ended question**)

Tuan. She doesn't like me getting 'high' all the time because she says I don't do anything except sit around and watch TV and that I'm always forgetting to do stuff. She says I don't do enough around the house and that she's always left to do all the work and look after the baby. But, I mean, I work and bring home a salary every month...

Khang. And it's hard for you because using heroin helps you relax, but at the same time you're not lending a hand around the house because you are 'high', and sometimes you forget to do things that she is relying on you to do. (**summary, empathy**)

Tuan. Yeah.

Khang. Would you like to see the results of the questionnaire that you did? (elicit)

Tuan. Yes.

Khang. From your answers it appears that your scores for most of the substances we asked about are in the low-risk range, so you are unlikely to have any problems from those substances. However, your score for heroin was high, which means that you are at risk of experiencing health and other problems related to your heroin injecting at your current levels. (provide feedback)

You said you've experienced some of these problems with your memory and concentration and motivation...

Tuan. (interrupts) Yeah, but that could be because I'm always tired because I don't always sleep well if the baby cries at night. (resistance)

Khang. So it seems to you that the only reason you're forgetting things and finding it hard to concentrate and help your wife after work is because you don't get enough sleep? (roll with resistance - amplified reflection)

Tuan. Well, that's part of it anyway. I guess part of it could be from using heroin too much. (ambivalence)

Khang. How concerned are you about the way using heroin affects you? (**open-ended question, elicit self-motivating statement of concern**)

Handout 4.2-5

Tuan. Yeah... I don't know... I mean... I suppose that it is a bit worrying that it's doing this to my brain... I don't know. (**dissonance**)

Tuan. Yeah... I don't know... I mean... I suppose that it is a bit worrying that it's doing this to my brain... I don't know. (dissonance)

Khang. Listen Tuan, you do have many options available, and it's up to you to decide what is best for you. Can I give you some pamphlets about substance use that you can take home with you? They just explain more about the effects that heroin and other drugs can have and provide information about how to cut down, or stop using heroin, if you decide to (hands Tuan written materials). If you want, we could talk about your options more at another time. (written advice, menu, emphasis on personal choice and control)

Tuan. Ah... OK... thanks... I'll have a think about it.

(A longer session could focus on the importance of the relationship between Tuan and his wife and child).

Handout 4.2-6

Four Types of Client Resistance

Arguing

The client contests the accuracy, expertise, or integrity of the clinician.

- *Challenging.* The client directly challenges the accuracy of what the clinician has said.
- *Discounting.* The client questions the clinician's personal authority and expertise.
- *Hostility.* The client expresses direct hostility toward the clinician.

Interrupting

The client breaks in and interrupts the clinician in a defensive manner.

- *Talking over.* The client speaks while the clinician is still talking, without waiting for an appropriate pause or silence.
- *Cutting off.* The client breaks in with words obviously intended to cut the clinician off (e.g., "Now wait a minute. I've heard about enough").

Denying

The client expresses unwillingness to recognize problems, cooperate, accept responsibility, or take advice.

- *Blaming.* The client blames other people for his/her problems.
- *Disagreeing.* The client disagrees with a suggestion that the clinician has made, offering no constructive alternative. This includes the familiar "Yes, but...", which explains what is wrong with suggestions that are made.
- *Excusing.* The client makes excuses for his behavior.
- *Claiming impunity.* The client claims he/she is not in any danger (e.g., from drinking).
- *Minimizing.* The client suggests that the clinician is exaggerating risks or dangers and that it really isn't so bad.
- *Pessimism.* The client makes statements about himself or others that are pessimistic, defeatist, or negative in tone.
- *Reluctance.* The client expresses reservations and reluctance about information or advice given.
- *Unwillingness to change.* The client expresses a lack of desire or an unwillingness to change.

Ignoring

The client shows evidence of ignoring or not following the clinician.

- *Inattention.* The client's response indicates that he/she has not been paying attention to the clinician.
- *No answer.* In answering a clinician's query, the client gives a response that is not an answer to the question.
- *No response.* The client gives no audible verbal or clear nonverbal reply to the clinician's query.
- *Sidetracking.* The client changes the direction of the conversation that the clinician has been pursuing.

Source: Miller and Rollnick, 1991. Adapted from a behavior coding system by Chamberlain et al., 1984. Reprinted with permission.

Handout 4.2-7

Motivational interviewing

Motivational interviewing is a client-centered style of interaction that directs people to explore and resolve their ambivalence about their substance use (the good things versus the not-so-good things) and move through the stages of change. It is especially useful when working with clients in the pre-contemplation and contemplation stages, but the principles and skills are important at all stages. Motivational interviewing is based on the understanding that effective treatment is part of a natural process of change, and that counselors can assist clients to become self-motivated to change.

Create discrepancy and ambivalence using open-ended questions

People are more likely to be motivated to change their substance use behavior when they recognize the discrepancy between their substance use and related problems, and the way they would like their lives to be. The greater the difference between a client's most important goals and his/her current behavior, the more likely the client will be able to change. Motivational interviewing will help to create and amplify this discrepancy from the client's point of view. It is important for the client to identify his/her own goals and values, and to express his/her own reasons for wanting to change.

One of the ways that clients can be encouraged to express their own reasons for change is for the counselor to ask them open-ended questions. This technique, often used in motivational interviewing, gets clients to start thinking and talking about their substance use. Asking open-ended questions also reinforces the notion that the client is responsible for the direction of the intervention, and of their substance use choices.

Roll with resistance

A key principle of motivational interviewing is to accept that ambivalence and resistance to change is normal and to invite the client to consider new information and perspectives on his/her substance use. When the client expresses resistance, counselors should reframe or reflect it, rather than oppose it. It is particularly important to avoid arguing in favor of change, as this puts the client in the position of arguing against it.

Specific skills

Motivational interviewing makes use of 4 specific skills. These skills are used together to encourage clients to talk, to explore their ambivalence about their substance use, and to clarify their reasons for reducing or stopping substance use. The skills are often known by the acronym OARS - Open-ended questioning, Affirmation, Reflective listening, and Summarizing. The fifth skill is "eliciting discussion about change" and involves using the OARS to guide the client to present arguments for changing his/her substance use behavior.

Handout 4.2-7

Open-ended questions

Open-ended questions are questions that require a longer answer, and open the door for the person to talk. Examples of open-ended questions include:

- "What are the things you enjoy about your substance use?"
- "Tell me about the not-so-good things about using_____?"
- "You seem to have some concerns about your substance use; tell me more about them."
- "What concerns you about that?"
- "How do you feel about_____?"
- "What would you like to do about that?"

Affirmation

By including statements of appreciation and understanding, you will help to create a more supportive atmosphere, and build rapport with your client. Affirming the client's strengths and efforts to change helps build confidence, while affirming self-motivating statements (or discussions about change) encourages readiness to change. Examples of affirmation include:

- "Thanks for coming today."
- "I appreciate that you are willing to talk to me about your substance use."
- "You are obviously a resourceful person to have coped with those difficulties."
- "I can see that you are a really strong person."
- "That's a good idea."
- "It's hard to talk about_____, I really appreciate your keeping on with this."

Reflective listening

A reflective listening response is a statement that attempts to guess what the client means. It is important to reflect back the underlying meaning and feelings the client has expressed, as well as the words he/she has used. Using reflective listening is like being a mirror for the client so that he/she can hear the counselor say what he/she has communicated. Reflective listening shows the client that the counselor understands what is being said, or can be used to clarify what the client means. Effective reflective listening encourages the client to keep talking; enough time should be allowed for this to happen.

In motivational interviewing, reflective listening is used to highlight the client's ambivalence about his/her substance use, to steer the client towards a greater recognition of his/her problems and concerns, and to reinforce statements indicating that the client is thinking about change. Examples include:

- "You seem surprised that your score shows that you are at risk of problems."
- "It's really important for you to keep your relationship with your boyfriend."

Handout 4.2-7

- “You’re feeling uncomfortable talking about this.”
- “You’re angry because your wife keeps nagging you about your substance use.”
- “You would like to cut down your substance use at parties.”
- “You really enjoy your substance use and would hate to give it up, and you can also see that it is causing some financial and legal problems.”

Summarize

Summarizing is an important way of gathering together what has already been said, and preparing the client to move on. Summarizing adds to the power of reflective listening, especially in relation to concerns and discussions about change. First, clients hear themselves say it, then they hear the counselor reflect it, and then they hear it again in the summary. The counselor chooses what to include in the summary and can use it to change direction by emphasizing some things, and by not emphasizing others. It is important to keep the summary succinct.

An example of a summary:

“So on one hand, you really enjoy using heroin at parties and you don’t think you use any more than your friends do. But on the other hand, you have spent a lot of more money than you can afford on drugs, and that really concerns you. You are finding it difficult to pay your bills. Your partner is angry and you really hate upsetting her. You have also noticed that you have trouble sleeping and you’re finding it difficult to remember things.”

Eliciting discussion about change

Eliciting self-motivational statements from the client is 1 goal of motivational interviewing. It is critical for clients to believe in the possibility of change and to know the range of alternatives. Remember, the client is responsible for recognizing his/her choices and making changes. This is a strategy for helping the client to resolve ambivalence and is aimed at enabling the client to identify arguments supporting the change.

There are 4 main categories of discussions on change:

- Recognizing the disadvantage of staying the same
- Recognizing the advantage of change
- Expressing an intention to change
- Expressing optimism about change

There are a number of ways of eliciting a discussion about change.

- Ask direct, open-ended questions; for example:
 - “What worries you about your substance use?”
 - “What do you think will happen if you don’t make any changes?”
 - “What might be some good things about cutting down on your substance use?”

Handout 4.2-7

- “How would you like your life to be in 5 years time?”
- “What do you think would work for you if you decided to change?”
- “How confident are you that you can make this change?”
- “How important is it to you to cut down on your substance use?”
- “What are you thinking about your substance use now?”

More on FRAMES

The FRAMES approach can be used to ensure that critical elements are included during the motivational interview. FRAMES is an acronym, and it stands for Feedback, Responsibility, Advice, Menu of alternative change options, Empathy and Self-efficacy.

Feedback

The provision of relevant, personal feedback is critical in individual drug counseling and generally follows a thorough assessment of drug use and related problems. Feedback can include information about the individual’s drug use and problems, information about personal risks associated with current drug use patterns, and general information about substance-related risks and harms. If the client’s problems are likely related to substance use, it is important to inform the client about this potential link as part of the feedback session. In providing feedback, you might compare the client’s substance use and associated problems to others who have similar experiences.

Responsibility

It is important for clients to acknowledge that they are responsible for making decisions about their own behaviors and that they can make choices about their substance use. Counselors should provide messages like “What you do with your substance use is up to you” and “Nobody can decide for you” to enable clients to retain personal control over their behavior and associated consequences. Clients who have this sense of control will be more motivated to make changes and will be less resistant to change. Using language with clients such as “I think you should...”, or “I’m concerned about your (substance) use” is likely to create resistance and motivate them to maintain and defend their current substance use patterns.

Advice

Provision of clear advice regarding the harm associated with continued drug use is fundamental in effective counseling. Clients are often unaware that their current patterns of substance use could lead to health or other problems, or make existing problems worse.

Providing clear advice that cutting down or stopping substance use will reduce their risk of future problems will increase their awareness of personal risk and provide reasons to consider changing their behaviors. The decision matrix can be helpful tool for this element. Advice can be delivered via simple statements such as “the best way you can reduce

Handout 4.2-7

your risk of (e.g. depression, anxiety) is to reduce or stop using _____". The language used to deliver this message is critical: statements such as "I think you should stop using _____" or "I'm concerned about your use of _____" do not exemplify targeted, objective advice.

Menu of alternative change options

Effective interventions provide clients with a range of alternative strategies to cut down or stop their substance use. This allows clients to choose the strategies that are most suitable for their situations and that they feel will be most helpful. Providing choices reinforces clients' sense of control, responsibility and motivation for making changes. Ideally, clients' choices will be linked to their stage of change. You might want to assist clients by doing 1 or more of the following:

- Encourage clients to keep a diary of substance use (where, when, how much, with whom, and why)
- Help clients to prepare substance use guidelines for themselves
- Identify high-risk situations and strategies to avoid them
- Identify other activities instead of drug use - hobbies, sports, clubs, gymnasias, etc
- Encourage clients to identify people who might be able to support the changes they want to make
- Provide information about other self-help resources and written information
- Encourage clients to put aside the money they would normally spend on substances for something else

Empathy

Effective interventions employ a warm, reflective, empathic and understanding approach. These qualities will ensure that clients feel comfortable and welcome. They will also increase the likelihood that clients will remain in counseling and treatment, therefore increasing positive counseling and treatment outcomes. In a clinical situation, empathy comprises an accepting, nonjudgmental approach that tries to understand the client's point of view and avoids the use of labels such as 'drug addict'. It is especially important to avoid confrontation, blaming or criticizing the client. Reflective listening clarifies and amplifies the client's own experience and meaning. Empathetic counselors will have more positive outcomes amongst their clients.

Self-efficacy (confidence)

It is critical to help build clients' confidence that they are able to make changes in their substance use. People who believe that they are able to make changes are much more likely to do so than those who feel powerless or helpless. Counselors should assist clients to make self-efficacy statements; they are more likely to believe what they hear themselves say, rather than what they hear someone else tell them.

Handout 4.2-8

Motivational interviewing: Summary of techniques

1. Listen, build rapport - be respectful of the client's values and choices
2. Recognize your agenda and the client's agenda - remember that motivational interviewing is about collaboration
3. Focus on a **specific behavior**
4. Assess importance and confidence
 - a. "How important is _____ to you, on a scale from 1 to 10?"
 - b. "Why so high/low?"
 - c. "What would help you move higher up on the scale?"
 - d. "How high on the scale would you have to be to make a change?"
 - e. "How confident are you about changing, on a scale from 1 to 10?" (etc.)
5. Work on **importance**
 - a. "What are the good things about this behavior?"
 - b. "What are some of the not-so-good things about it?"
 - c. Share information about risks; don't push information - ask what the client already knows, whether he/she wants to know more; allow the client to make links between behaviors and outcomes
 - d. Manage resistance: shift focus, express empathy, emphasize the client's control, summarize his/her position
 - e. Summarize the pros and cons
6. Build confidence
 - a. "Is there anything you've found helpful in your previous attempts to change?"
 - b. "Is there anything you can learn from any of the problems you faced the last time you tried?"
 - c. "Do you know other people who have successfully changed? What worked for them?"
7. Summarize both importance and confidence with "**where does that leave you now?**"
 - a. I'm not interested in changing
 - "As your counselor/specialist I am concerned about [counselor's agenda]. If you want to discuss this again, I'm here."
 - b. I want to do it!
 - Talk about how (practical aspects)
 - c. I've got to think about it
 - Encourage reflection/monitoring: diary; pros & cons

Unit 4.3

LINKING MOTIVATIONAL INTERVIEWING TO STAGES OF CHANGE STRATEGIES

Learning Objectives

At the end of this activity the participants will have:

- have good understanding of the Stages of Change Model
- understand which intervention strategies/plans are most likely to work with clients at different stages of change
- learn how to apply motivational interview approaches to the Stage of Changes Model
- demonstrate knowledge and skills in role-plays

Content and Timeline

Introduction	1 minutes
Presentation	50 minutes
Conclusion	9 minutes

Unit 4.3



LINKING MOTIVATIONAL INTERVIEWING TO STAGES OF CHANGE STRATEGIES

1

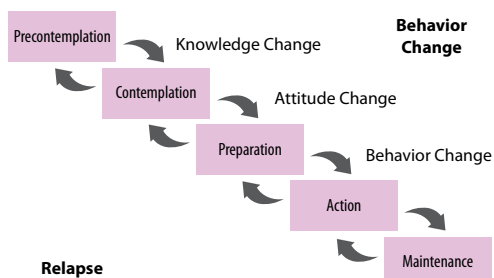
OBJECTIVES

At the end of this unit participants will:

- have good understanding of the Stages of Change Model
- understand which intervention strategies/plans are most likely to work with clients at different stages of change
- learn how to apply motivational interview approaches to the Stage of Changes Model
- demonstrate knowledge and skills in role-plays

2

STAGES OF CHANGE



3

SMALL-GROUP EXERCISE

Divide into 3 groups

- Discuss and develop intervention strategies for 3 categories of clients:
 - Pre-contemplators
 - Contemplators
 - Clients in the maintenance phase

■ 20 minutes

Large-group discussion:

- How do you determine a client's stage of change?
- What is the difference for clients in each stage?
- What are the differences in intervention approaches?

4

PRE-CONTEMPLATION STAGE

Client is

- 'happy' using
- unconcerned
- not aware of a problem
- not showing any indication of wanting to change
- doesn't want to consider change

Intervention strategy

- Raise doubts
- Increase patient perception of potential risks and problems
- Risk reduction

5

CONTEMPLATION STAGE

Client

- acknowledges concerns
- is considering possibility of change
- may still be ambivalent and uncertain

Intervention strategy

- Normalize ambivalence
- Help the client "tip the decisional balance scales" toward change by
 - eliciting and weighing pros and cons of substance use and change
 - changing extrinsic to intrinsic motivation
 - examining the client's personal values in relation to change
 - emphasizing the client's free choice, responsibility, and self-efficacy for change
- Elicit self-motivational statements
- Elicit ideas of client's perceived self-efficacy and expectations of treatment
- Summarize self-motivational statements

6

PREPARATION STAGE

Client

- intending to take action
- making small behavioral changes
- considering options to assist change

Intervention strategy

- make client aware of benefits and consequences of behavior change
- assist client to develop strategies to cope with consequences
- provide practical advice on how to change

7

ACTION STAGE

Client

- is actively taking steps to change
- has not yet reached a stable state

Intervention strategy

- Engage client in treatment
- Support realistic view of change through small steps
- Acknowledge difficulties in early stages of change
- Help identify high-risk situations & develop coping strategies
- Assist in finding things that reinforce positive changes
- Help client to assess if he/she has strong family / social support

8

Unit 4.3

MAINTENANCE STAGE

Client

- has changed / stopped unwanted behavior for a relatively long period (over 6 weeks)
- is working to prevent relapse
- is consolidating gains

Intervention strategy

- prepare the client for the possibility of lapse / relapse
- reinforce the benefits of continued change

9

RELAPSE STAGE

Client

- has experienced relapse
- must now cope with consequences
- must decide what to do next

Intervention strategy

- Help client reenter change cycle - commend any willingness to reconsider change
- Explore meaning and reality of relapse as a learning opportunity
- Assist client to find alternative coping strategies
- Maintain supportive contact

10

SUMMARY – MOTIVATIONAL INTERVIEWING

The process of change is a continuum

- Strategies for various interventions are linked to the stages of change
- Pre-contemplation stage: client does not consider giving up
- Contemplation stage: client begins to think about doing something
- Action stage: client attempts to quit or reduce intake
- Maintenance stage: client succeeds in giving up and wants to maintain status
- Lapse stage: client resumes use (a normal part of the change process)

11

CHAPTER 5

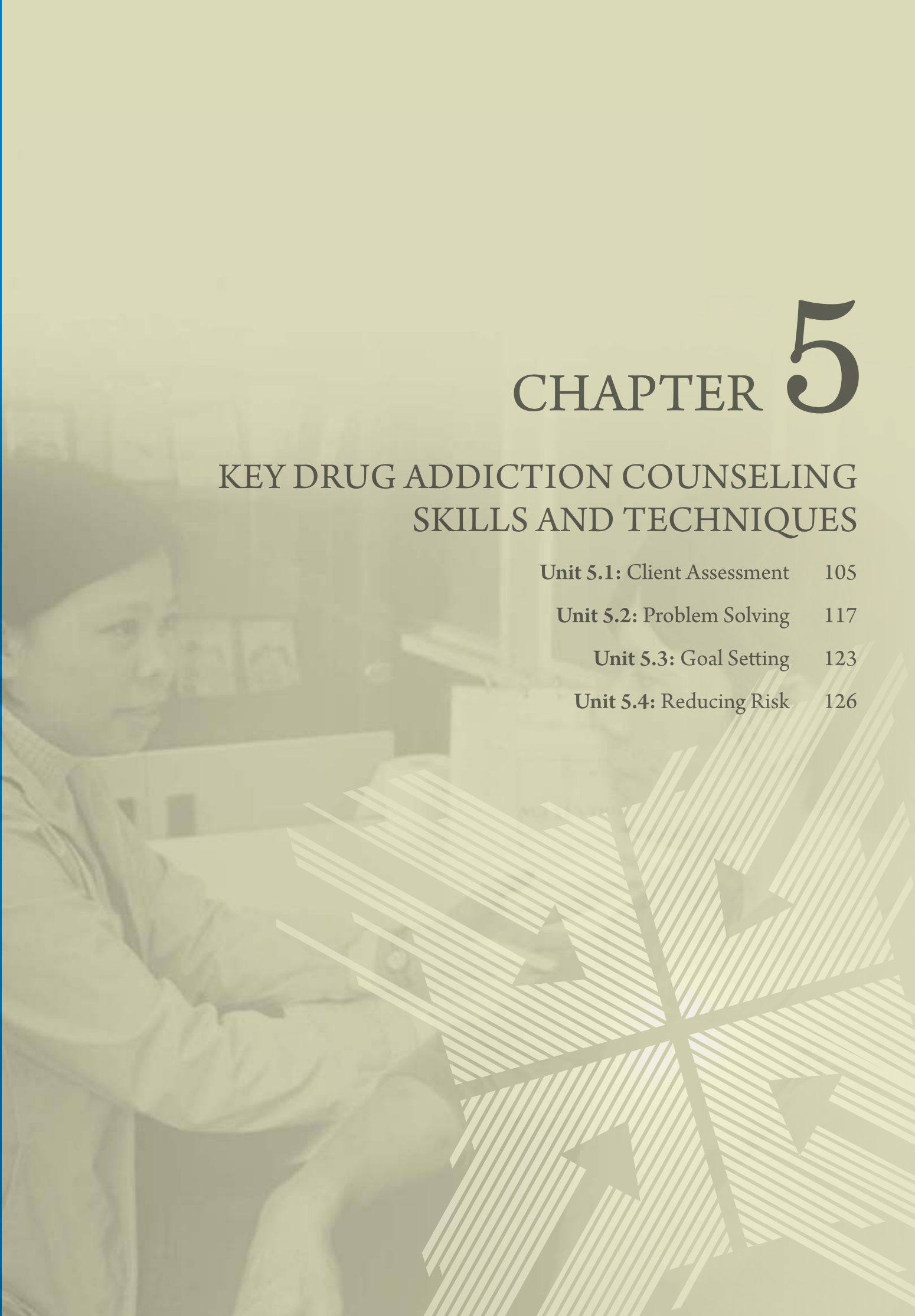
KEY DRUG ADDICTION COUNSELING SKILLS AND TECHNIQUES

Unit 5.1: Client Assessment 105

Unit 5.2: Problem Solving 117

Unit 5.3: Goal Setting 123

Unit 5.4: Reducing Risk 126



Unit 5.1

CLIENT ASSESSMENT

Learning Objectives

At the end of this activity the participants will have:

- understand why it is important to assess clients at the intake stage
- understand the procedures and concepts needed to assess clients
- demonstrate their client assessment knowledge and skills through role-playing
- apply their client assessment knowledge and skills while counseling drug users

Content and Timeline

Introduction	5 minutes
Presentation	75 minutes
Conclusion	10 minutes

Unit 5.1



LEARNING OBJECTIVES

By the end of this unit, participants will:

- understand why assessments are important
- understand the procedures and contents of an assessment
- demonstrate their knowledge and skills of client assessment through role-play
- apply their client assessment knowledge and skill while counseling drug users

2

WHAT IS ASSESSMENT?

- The first of a number of ongoing steps in treatment and recovery
- The process of learning the personal history of the client by listening to the client and his/her family
- Crucial for the counselor to determine the specific interventions that will help to set the client's recovery goals

3

ASSESSMENT OBJECTIVES

- Establish a therapeutic relationship
- Clarify the nature and severity of the client's problems
- Formulate those problems into a treatment plan

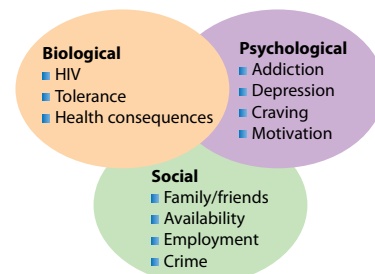
4

CORE ASSESSMENT ISSUES

- What does the client want?
- Is the client addicted?
- What is his/her level of tolerance?
- Is the client using or addicted to other drugs?
- What is his/her motivation for change?
- What are some of his/her social supports?
- Does the client have any other medical or psychiatric conditions?

5

THE "BIOPSYCHOSOCIAL" MODEL OF ADDICTION



6

PROBLEMS TACKLED BY ADDICTION SERVICES



7

TO MAXIMIZE TREATMENT ADHERENCE

Prioritise psychosocial issues first

- Emotional stability
- "Chaotic" drug use
- Accommodation
- Income

8

Unit 5.1

FIVE CRITICAL COMPONENTS OF AN INITIAL ASSESSMENT

- Psychosocial
- Drug use
- Medical and psychiatric issues
- Treatment selection issues
- Examination

9

PSYCHOSOCIAL ISSUES

- Demographics
- Relationship with family
- Relationship with partner
- Education and employment
- Criminal justice
- Living circumstances
- Sources of income

10

DRUG USE HISTORY

- Primary drug
 - Average daily use (quantity/frequency/duration)
 - Time last used
 - Route of administration
 - Age commenced
 - Periods of abstinence
 - Severity of addiction
 - Previous treatment(s)
- Other drugs
 - Current and previous
 - Addiction

11

MEDICAL AND PSYCHIATRIC ISSUES

- Blood-borne viruses (HIV and Hepatitis)
- Pregnancy
- Other major medical conditions
 - Liver
 - Heart
- Major psychiatric conditions
 - Depression, suicide, psychosis
- Opioid-related overdose

12

SELECTION OF TREATMENT

Assess the following:

- Trigger for seeking treatment
- Client goals for treatment
- Stage of change
- Commitment to treatment
 - Confidence to undertake the task (scale)
 - Willingness to change the situation (scale)

13

EXAMINATION

- Mental state
 - Mood
 - Cognition
 - Behavior
- Injection sites
- Signs of intoxication/withdrawal
- Nutritional state

14

ADDICTION (1)

- 1. Tolerance:**
 - Would you say you had to use more [substance] to get intoxicated or the desired effect?OR
 - At any time, did you find that you seemed to be getting less of an effect when you used your usual amount?
- 2. Withdrawal:**
 - Did you experience withdrawal when the effects of [substance] began to wear off?OR
 - Did you take more [substance], or take a similar drug to relieve or avoid feeling withdrawal symptoms?
- 3. Time:** Would you say you spend a large amount of time obtaining [substance], using it, or recovering from its effects?
- 4. Quantity:** Would you say you used [substance] in larger amounts or for a longer period of time than you would have wished?
Did you want to cut down or stop using [substance] or have you had problems trying?

15

ADDICTION (2)

- 5.** Did you reduce or give up important work, recreational or social activities as a result of your [drug] use?
- 6.** Did you continue to use [drug] even though you knew it was causing or making a physical or a psychological problem worse?

16

Unit 5.1

PHYSICAL ADDICTION

- **Tolerance**
Higher dose of the drug is needed to achieve the same effect
- **Withdrawal syndrome**
Develops when drug taking ceases abruptly

17

OPIOID WITHDRAWAL

Symptoms

- Anorexia and nausea
- Abdominal pain or cramps
- Hot and cold flushes
- Joint and muscle pain or twitching
- Poor sleep
- Drug cravings
- Restlessness/anxiety

18

OPIOID WITHDRAWAL

Signs

- Yawning
- Tears
- Dilated pupils
- Sweating
- Runny nose, sneezing
- Tremors
- Goose bumps
- Diarrhea and vomiting

19



20

SEVERITY OF ADDICTION SCALE (SAS)

1. Did you ever think your [drug] use was out of control?	0 Never or almost never	1 Sometimes	2 Often	3 Always or nearly always
2. Did the prospect of not taking any [drug] make you anxious or worried?	0 Never or almost never	1 Sometimes	2 Often	3 Always or nearly always
3. Did you worry about your [drug] use?	0 Never or almost never	1 Sometimes	2 Often	3 Always or nearly always
4. Did you wish you could stop using [drug]?	0 Never or almost never	1 Sometimes	2 Often	3 Always or nearly always
5. How difficult would you find it to stop or go without [drug]?	0 Easy	1 Quite difficult	2 Very difficult	3 Impossible

21

SUCCESSFUL ASSESSMENT

1. Recognize and admit that they have a problem with drug use
2. Agree to accept counseling and treatment voluntarily
3. Understand the pros and cons of drug use
4. Understand they will have to work very hard and cooperate with you if they really want to solve their problems

21

Handout 5.1-1

SAMPLE OF ASSESSMENT SCREENING FORM

Social Record

Client ID:.....

PART 1: SOCIO-DEMOGRAPHIC AND MEDICAL INFORMATION

I. General Information

1. Name: First name initial Last name initial

2. DoB (dd/mm/yyyy) / / 3. Age: 4. Gender: Male Female:

5. Education:

- None
- Primary school
- Secondary school
- High school
- University/tertiary

6. Marital status:

- Never married
- Married
- Separated
- Divorced
- Widow

7. Contact address:

House:

Ward:

Dist.:

City/province:

8. Client is a peer educator

- Yes
- No

9. Does spouse/family use drugs?

- Yes
- No

10. Date of entering O6 rehabilitation center (if any):

..... / /

* Fill: 99/99/9999 if not entering O6 center

11. Release date: / /

99/99/9999 if not from O6 center

II. Employment and Income Information

12. Employment

- Unemployed, looking for a job
- Unemployed, not looking for a job
- Part-time employee
- Working for family
- Full-time employee

Type of work:

13. Does the client want to change his/her employment situation?

- Yes
- No

If yes, describe:

Handout 5.1-1

14(a). Work income/month 14(b). Other income:/month

14(c). Total income:/ month

14(d). Basic needs assessment:

- Client is lacking the resources to provide for basic needs (food, shelter, clothing) (immediate intervention is needed)
- Client has some resources to provide for basic needs, but, these resources are inadequate (there is a need for intervention but it is not critical)
- Client has adequate resources to provide for basic needs (food, clothing, shelter) (there is no need for intervention)

III. Housing

15. Who does the client currently live with?

- Lives alone Lives with spouse/sexual partner Lives with family Lives with friends

16(a). Does the client currently rent or own a house?

- Rent Own

16(b). Please describe your current housing situation

Describe:

16(c). Living arrangement assessment:

- Situation is unsafe, not permanent and/or unacceptable to client (immediate intervention needed)
- Situation is temporary (may need intervention in the future)
- Situation is stable and acceptable to the client (no need for intervention)

Handout 5.1-1

IV. Transportation

17. Do you have transport?

- Bike Bus
 Motobike None
 Car

18. Does the client need other transportation arrangements?

- Yes
 No

* Client ID is the combination of first name initial, last name initial, date of birth (dd/mm/yy), gender (1 male, 2 female), and district (1: Ba Dinh; 2: Dong Da; 3: Hoan Kiem; 4: Hoang Mai; 5: other districts)".

V. Family & social support

19. Evaluate the level of support that the client receives

	Psychological emotional support	Financial support	Health care support	Other
1. Spouse				
2. Partner				
3. Parent(s)				
4. Child				
5. Sibling				
6. Other relatives				
7. Friends				
8. IDU Peer Educators				
9. Other				

Code: 1. Significant support 2. Occasional support 3. Weak support 4. Support not available or unknown

20. Client's level of satisfaction with current level of social support:

- Not at all Slightly Moderately Considerably Extremely

21. Social support assessment

- Client appears to be isolated and lacking any significant, reliable source of social support. Client feels the need for support (immediate intervention is needed)
 Client appears to be lacking in significant sources of social support, but seems comfortable with the situation (intervention may be explored at a later time)
 Client has support, but feels the need for more support (explore more)
 Client has an active, acceptable social support network (no need for intervention)

Handout 5.1-1

VI. Health information

22. Has the client been tested for HIV?

- No
- Yes, negative
- Yes, positive
- Yes, unidentified
- Yes, did not come for the result

Date of testing:/...../.....
Place of testing

23(a). Has the client been tested for HBV?

- No
- Yes, negative
- Yes, positive
- Yes, unidentified
- Yes, did not come for the result

Date of testing:/...../.....
Place of testing

23(b). Has the client been tested for HCV?

- No
- Yes, negative

Date of testing:/...../.....
Place of testing

- Yes, positive
- Yes, unidentified
- Yes, did not come for the result

24. Current health status?

- Excellent
- Good
- Fair
- Poor

25. Has been treated any of the following chronic diseases?

- Hepatitis B
- Hepatitis C
- Tuberculosis
- Others (specify):

26. Has any STIs? (specify)

..

27(a). Client is on ARV treatment

- Yes
- No

27(b). Level of treatment adherence?

- Excellent
- Good
- Fair
- Poor
- Not at all

28(a). Have you ever practiced unsafe sex with women in the last 12 months?

- Yes
- No

28(b). Have you ever had unsafe sex with men in the last 12 months?

- Yes
- No

29. Have you ever had unsafe injecting behavior in the last 12 months?

- Yes
- No

Handout 5.1-1

VII. Mental health information

Attention: If the client answers "no" to any of the following questions, or his/her family reports memory loss, refer the client to the clinic's doctor.

30. Does client know where he/she is?

- Yes
- No

31. Does client know why he/she is here?

- Yes
- No

32. Are any of the following a problem to the client?

- Depression
- Anxiety
- Insomnia
- Forgetfulness
- Suicidal thoughts
- Delusion
- Withdrawal/Social Isolation

33. Mental health assessment

- Client is in immediate need of evaluation by doctor.
- Client is in need of intervention, but the situation is not critical.
- Client may need intervention at a later date, but is presently functioning well.
- Client is coping well. There is no need for intervention at this time.

Handout 5.1-1

Client ID:.....

PART II: DRUG USE INFORMATION

Date of first visit to RCS center (dd/mm/yyyy):/...../.....

VIII. Drug use history: (Before entering the RCS Center)

34. Substance use:

Kind of drug	Age commenced	Average daily use (times/day)	Total of money spent on drugs each day	Route of administration *	Time last used (dd/mm/yy)	Most commonly used **
1. Opiates/heroin						
2. Cocaine/crack						
3. ATS						
4. Cannabis						
5. Alcohol						
6. Tobacco						
7. Other (specify)						

*: 1- oral; 2- nasal; 3- smoking; 4- non-IV injection; 5- IV injection; 6- never used

** : 1- primary; 2- secondary; 3- tertiary

35. How many times has the client undergone drug treatment:time(s)

36. How many times has the client relapsed:time(s)

37. How long has the client abstained from the drug, each time?

Number of abstinence					
Duration (number of days)	1st	2nd	3rd	4th	5th

38. Have you ever shared needles and syringes?

Yes

No

Unknown

Handout 5.1-1

39. Have you ever had an overdose?

- Yes No How many times?

40. Have you ever been involved in criminal activities? Yes No If yes, tick all that apply

- Drug dealing Selling sex
 Stealing Violence
 Other, specify

Handout 5.1-2

INDIVIDUAL SERVICE PLAN

Client ID:.....

RECOVERY PLAN

Name:.....

Date: / /

1	Identified problems/needs
2	Action steps to address problem/needs
3	Social support, timeline, and follow-up plan
4	Referral provided

Is the client at high risk of relapse? Yes No

Sources:

John Howard, 2006. A Toolkit for Building Capacity For Community-based Treatment and Continuing Care of Young Drug Abusers in The Greater Mekong Subregion. The United Nations Economic and Social Commission for Asia and the Pacific.

Unit 5.2

PROBLEM SOLVING

Learning Objectives

At the end of this activity the participants will have:

- understand the rationale behind problem solving
- understand the steps in the problem solving process
- be able to demonstrate their problem-solving knowledge and skills through role-playing
- know how to apply problem-solving skills when counseling drug users

Content and Timeline

Introduction	2 minutes
Presentation	45 minutes
Conclusion	8 minutes

Unit 5.2



LEARNING OBJECTIVES

At the end of this unit, participants will:

- understand the rationale behind problem solving
- understand the steps in the problem-solving process
- be able to demonstrate their problem-solving knowledge and skills through role-playing
- know how to apply problem-solving skills when counseling drug users

2

ACTIVITY

- How do YOU solve your everyday problems?
- What steps do YOU go through?

3

BACKGROUND

- The ability to solve problems is one characteristic of healthy living
- Many drug users appear to have poor problem-solving techniques
- Problem-solving capacity affects relapse risk
- Problem-solving training is associated with better treatment outcomes
- Problem solving can be done individually or in groups

4

TIMING

Problem solving works best when the client:

- is not impaired (e.g. experiencing withdrawal, substantial cognitive impairment or intoxication)
- is in the action stage
- needs a variety of techniques to assist comprehension and remembering

NOTE: Break the action plan into individual steps

5

PROBLEM SOLVING

Step 1: Orientation

- Problems are normal and can be solved
- Stop and think
- Don't rush into action

6

PROBLEM SOLVING

Step 2: Problem definition

- Be specific
- e.g. "My partner does not like me"
 - Too broad
 - Try focusing statement to:
 - "My partner does not like me working late every night"

7

PROBLEM SOLVING

Step 3: Generate solutions (Brainstorming)

- Every problem has a number of potential solutions
- Anything goes
- Quantity breeds quality
- Don't evaluate

8

Unit 5.2

PROBLEM SOLVING

Step 4: Decision making

- Select a short list
- Review pros and cons
- Effective? Possible?
- Select a solution(s)
- Remember: it is the client's choice

9

PROBLEM SOLVING

Step 5: Implementation

- Develop a plan of action (including goal setting)
- Try it out
 - Think it through
 - Role-play
 - Real life
- Does it work? Can it be improved?
- Can the client try another strategy?

10

PROBLEM-SOLVING EXERCISE

- In small groups, apply the problem-solving technique to this problem:
 "I never seem to have time to have fun any more. I am too busy with my work."

11

WHAT CAN GO WRONG? (1)

Obstacle:	Suggestion:
■ Problem poorly defined	■ Be specific
■ Client cannot remember steps	■ Use a variety of teaching methods: explanation, modelling, rehearsal, provide recall aids

12

WHAT CAN GO WRONG? (2)

Obstacle:	Suggestion:
■ No performance	<ol style="list-style-type: none"> 1. Not consistent with stage of change (client not ready to implement)? <ul style="list-style-type: none"> - Consider motivational interviewing 2. Lack of skill? <ul style="list-style-type: none"> - Consider cognitive capacity of client and/or use other teaching/recall aids Ask what has worked in the past?

13

WHAT CAN GO WRONG? (3)

Obstacle:	Suggestion:
■ Counselor begins with problem that is too difficult	■ When teaching a new skill, commence with easy examples
■ Evaluation occurs in brainstorm	■ Explain "rules" clearly

14

WHAT CAN GO WRONG? (4)

Obstacle:	Solution:
■ Slow: counsellor does most of the work	■ This is common in early stages counsellor is teaching a new skill
■ Counsellor forgets aim	■ The aim is to teach the skill to the client - not to solve all the client's problems

15

SMALL-GROUP EXERCISE

- Groups of three (counselor, client & observer)
- Rotate through the two problems:
 - When I feel upset I end up using heroin
 - When I meet friends I end up using heroin

16

Unit 5.2

SUMMARY

- Many clients have difficulties solving problems
- Teaching them the problem-solving techniques can assist
- Remind clients that problems are normal and can be solved
- Help them clients to be specific in identifying problems
- Identify the best options by looking at pros and- and-cons, plausibility and effectiveness
- Help to think through the implementation process

17

Handout 5.2-1

Problem-Solving Worksheet

Procedures

Gather information: Recognize that a problem exists. Is there a problem? You get clues from your body, thoughts, feelings, behavior, reactions to other people, and the ways that other people react to you. Think about the problem situation. Who is involved? When does it happen? Exactly what takes place? What effect does this have on you?

Define the problem: Describe the problem as accurately as you can. What goal would you like to achieve? Be as specific as possible. Break it down into manageable parts.

Brainstorm alternatives: List all the things that a person in your situation could possibly do. Consider various approaches to solving the problem. Even list alternatives that seem impractical. Try taking a different point of view; try to think of solutions that worked before, and ask other people what worked for them in similar situations.

Consider the consequences: Look at each of your alternatives in turn. What things could you reasonably expect to result from taking each action? What positive consequences? What negative consequences are long-term? Which are short-term? Which do you think you could actually do?

Make a decision: Which alternative is the most likely to achieve your goal? Select the one likely to solve the problem with the least hassle.

Do it! The best plan in the world is useless if it isn't put into action. Try it out.

Evaluate its effectiveness: Which parts worked best? Reward yourself for them. Would you do anything differently next time? After you have given the approach a fair trial, does it seem to be working out? If not, consider what you can do to beef up the plan or give it up and try one of the other possible approaches. Remember that when you've done your best, you have done all you can do.

Note: The names for the problem-solving steps in this handout might not be exactly the same as those presented in the PowerPoint slides. However, the concepts behind them are the same.

Handout 5.2-1

Practice exercise

Choose a problem that may arise in the near future. Describe it as accurately as you can. Brainstorm possible solutions. Evaluate the potential outcomes. Prioritize solutions.

Identify the problem situation:		
Brainstorm a list of possible solutions:	Pros:	Cons:
1.		
2.		
3.		
4.		

From: Early Psychosis Intervention Program at <http://www.psychosissucks.ca/epi/>

Unit 5.3

GOAL SETTING

Learning Objectives

At the end of this activity the participants will have:

- understand the rationale behind goal setting
- understand the main characteristics of goal setting
- understand the use of a structured goal setting method
- be able to demonstrate their knowledge and skills through role-play
- understand the relationship between problem solving and goal setting
- be able to apply goal-setting skills when counseling clients

Content and Timeline

Introduction	2 minutes
Presentation	45 minutes
Conclusion	8 minutes

Unit 5.3



LEARNING OBJECTIVES

At the end of this unit, participants will:

- understand the rationale behind goal setting
- understand the main characteristics of goal setting
- understand the use of a structured goal-setting method
- be able to demonstrate their knowledge and skills through role-play
- understand the relationship between problem solving and goal setting
- be able to apply goal-setting skills when counseling clients

2

SMALL-GROUP EXERCISE

- Questions
 - Why set short-term goals when counseling?
 - What are the main characteristics of short-term goals?

3

BENEFITS OF SHORT-TERM GOALS

- Help change appear more achievable
- Help a person experience success and counter learned helplessness
- Help increase confidence
- Encourage further endeavors
- Can act as concrete signposts to guide and measure progress

4

SHORT-TERM GOALS SHOULD BE:

- Geared to the stage of change
 - Not helpful to use action-oriented goals when client is only contemplating change
- Agreed upon
 - Client will be more committed if involved in defining goals
 - Counselor has important role to assist with informed decision making

5

SHORT-TERM GOALS SHOULD BE:

SMART

- | | |
|--------------|--|
| ■ Specific | ■ Clear, concrete |
| ■ Measurable | ■ Describe presence rather than absence |
| ■ Attainable | ■ Attitudes, abilities and skills to make goal come true |
| ■ Realistic | ■ Success breeds success |
| ■ Time-bound | ■ Need a completion date |

6

THE GOAL-SETTING METHOD

1. List goals and select one or two to work toward
2. Define goals clearly and break them down into small steps
3. Review progress and revise
4. Take satisfaction in efforts and achievements

7

GAUGING COMMITMENT

- The Readiness Ruler
- The Confidence Ruler

8

Unit 5.3

SMALL-GROUP EXERCISE

- Groups of three: counselor, client and observer
- Apply the goal-setting technique to this problem:
 - “When I meet friends I end up using heroin”

9

SUMMARY

- Short-term goals are important for moving forward
- Define goals clearly and break into small steps
- Determine commitment through the use of the readiness ruler
- Review progress in order to revise goals as necessary
- Support your clients for undertaking difficult tasks

10

Unit 5.4

REDUCING RISK

Learning Objectives

At the end of this session, participants will be able to:

- understand the definition of risk reduction
- understand the principles of risk reduction
- understand and practice safe injection and safe disposal of used needles and syringes
- know the basics of vein care
- know the basics of prevention of overdose

Content and Timeline

Introduction	1 minutes
Presentation	55 minutes
Conclusion	4 minutes

Unit 5.4



LEARNING OBJECTIVES

At this end of this unit, participants will:

- be able to define risk reduction
- understand the principles of risk reduction
- understand and practice safe injection and safe disposal
- know the basics of vein care
- know how to prevent and deal with overdose

2

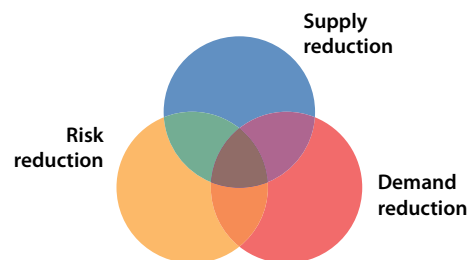
RISK REDUCTION

Aims to reduce the adverse health, social and economic consequences of alcohol and other drugs by minimizing or limiting the harms and hazards of drug use for both the community and the individual.

(Lenton & Single 1998)

3

RESPONSES TO DRUG USE



4

RISK REDUCTION RECOGNIZES THAT:

- Many people use drugs (of one kind or another)
- Many people do not want to stop using drugs
- There are different levels of harm a drug can cause
- The risks of drug use can be reduced
- The risk reduction approach does not promote use
- Risk reduction encourages drug users to lower risk and thus reduce the harm associated with drug use

5

RISK REDUCTION PRINCIPLES

Features of risk reduction:

- Pragmatic
- Prioritizes goals
- Has humanist values
- Focuses on risks and harm
- Does not focus on abstinence
- Seeks to maximize the range of intervention options that are available

6

RISK REDUCTION STRATEGIES

- Needle and syringe exchange/distribution programs
- Methadone maintenance programs
- Education and outreach programs
- Law enforcement policies

7

Vein Care

**How to prevent vein damage
and look after your veins**

8

Unit 5.4

TYPES OF INJECTON

Subcutaneous
(under the skin)



Intramuscular
(into muscle)



Intravenous
(into a vein)



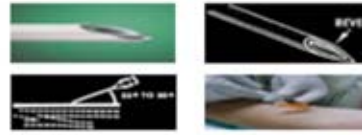
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NEEDLES – KEY POINTS

Bevel: sloping edge

Bore: hole

Gauge: measure of thickness



Slide under the skin at a shallow angle with the bevel facing up

10

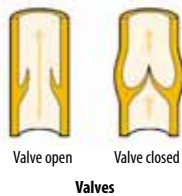
VEINS AND ARTERIES

Veins

- carry blood towards heart
- carry oxygen-depleted blood
- dark red blood
- thin walls/not elastic or muscular
- valves
- no pulse – ooze blood

Arteries

- carry blood away from heart
- carry oxygen-rich blood
- bright red blood
- thick walls, very elastic/muscular
- no valves
- recognizable pulse – spurts blood



Valves

11

VEIN COLLAPSE



Figure 8.1
The lining of the vein can be damaged by the needle, the drug (especially pills), injecting too often or too fast, infection and "flushing"

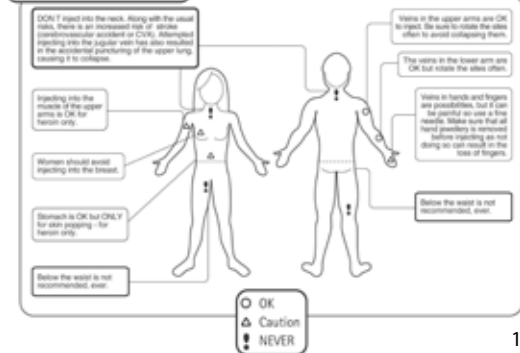
Figure 8.2
Damage to the lining of the vein causes clots to form on the inside of the vein

Figure 8.3
The disruption of blood flow causes more clots to form, making the vein even narrower

Figure 8.4
Eventually the vein blocks, and the clots turn into scar tissue that shrinks and pulls the side of the vein together, collapsing the vein

12

Injecting sites



13

Long-term consequences of vein damage

- Ulcers: broken-down skin
- Abscesses: localized areas of pus within inflamed tissue
- Phlebitis: irritation of smooth inner lining of vein
- Cellulitis: painful inflammation of the skin
- Gangrene: death of body tissue

Seek medical advice

- Infection: Hep C/HIV, bacterial, fungal
- Missed hits: swelling around injection site
- Scar tissue: collapsed veins
- Lumps and bumps under the skin

14

VEIN CARE

- Use a new sterile needle & syringe every time
- Use smallest size needle (27G)
- Clean injection site
- Go slow and be gentle
- Rotate sites
- Learn to inject in both arms
- Don't inject where there is redness, swelling & pain
- Never inject pills
- Maintain a healthy diet & adequate sleep

15



16

Unit 5.4



OVERDOSE

20

OVERDOSE – INTRODUCTION

- **Overdose is now the largest cause of death amongst injecting heroin users.**
- Many drug users overdose because they don't realize the risks they are taking when they inject heroin and use combinations of heroin and other drugs (including alcohol).
- Many deaths happen because people who see overdoses often don't know **WHAT TO DO** to help.

21

HOW AND WHY OVERDOSES HAPPEN

- When injecting drugs
- When you take too much of a drug OR a combination of drugs (some combinations can be **DEADLY**: heroin & alcohol, heroin & downers)
- Anyone who uses drugs can overdose (from first-time users to veterans)
- When using opiates when tolerance is low (it only takes a few days for tolerance of opiates to drop)
- After a week or so without opiates, a dose that at one time wouldn't have touched you can kill you.

22

OVERDOSE RISKS

- Not knowing the **quality** of drugs
- Not knowing body **tolerance**
- **Mixing** drugs (multiple drug use)
- Using **alone** (no one to rescue you)

23

RECOGNIZING OVERDOSE

- Respiratory depression
 - very slow; ultimately no breathing
- Cyanosis
 - turning blue on the lips and fingertips (first)
- Extreme somnolence
 - hard to wake: sleepiness

24

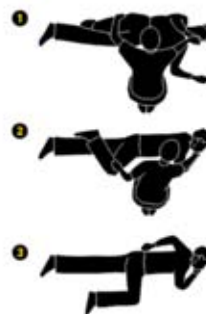
Unit 5.4

OVERDOSE EMERGENCY: WHAT TO DO

- Stay CALM
- ABC
 - Airway
 - Breathing & Pulse
 - Circulation
- Not breathing: Do rescue breathing
- Not breathing, no pulse: Do chest compression (and rescue breathing)
- Breathing and pulse: Recovery position - to protect from blocking the airway & choking on vomir

25

THE RECOVERY POSITION



26

WHAT NOT TO DO IF AN OVERDOSE HAPPENS

- **DON'T** walk the person around – they may **fall!**
- **DON'T** put the person in a **bath or shower** – they could **drown or die of hypothermia!**
- **DON'T** check whether they are conscious by **hurting** them
- **DON'T inject them** with salt water, milk, or other drugs (such as cocaine or speed)

27

TIPS FOR PREVENTING OVERDOSE

- Have an OD plan with the people you get high with
- Be careful if you switch dealers
- Ask around: drug strength will vary
- Prepare your own doses/drugs so you know how strong you've made them and exactly what's in them
- Avoid mixing heroin with other drugs
- Avoid shooting alone

28

SUMMARY

- Risk reduction provides an alternative approach & framework to deal with IDU problems
- Risk reduction principles have been adopted in a number of countries. They have shown to be:
 - pragmatic
 - humane
 - effective
 - holistic
- Risk reduction: a public health approach assisting in the control of HIV infection among IDUs

29

CHAPTER 6

RELAPSE PREVENTION

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Unit 6.1

RELAPSE PREVENTION THERAPY

Learning Objectives

At the end of this session, participants will be able to:

- identify the reasons that lead recovering drug users to relapse
- explain the Relapse Model
- identify high-risk situations in discussions with clients
- understand strategies in addressing and coping with high-risk situations
- explain global relapse prevention interventions
- explain specific relapse prevention interventions

Content and Timeline

Introduction	2 minutes
Whole group discussion	20 minutes
Presentation	70 minutes
Conclusion	8 minutes

Unit 6.1



LEARNING OBJECTIVES

At the end of this session, participants will be able to:

- identify the reasons that lead recovering drug users to relapse
- explain the Relapse Model
- identify high-risk situations in discussions with clients
- understand strategies in addressing and coping with high-risk situations
- explain global relapse prevention interventions
- explain specific relapse prevention interventions

2

RPT BASIC ASSESSMENT

Assess clients on the following categories of high-risk situations and cues for relapse:

- Personal
- Interpersonal/social

3

PERSONAL REASONS FOR RELAPSE (1)

Clients may relapse in order to....

Cope with negative emotional states

- frustration, anger, fear, anxiety, tension, depression, loneliness, sadness, boredom, worry, grief and loss

Cope with negative physical-physiological states

- e.g. craving and withdrawal symptoms that led to use prior to treatment

Enhance positive emotional states:

- e.g. to increase feelings of pleasure, celebration, etc.

4

PERSONAL REASONS FOR RELAPSE (2)

Testing personal control

Use of substance to “test” one’s ability to engage in controlled or moderate use, or to test willpower

5

INTERPERSONAL/SOCIAL

Coping with interpersonal conflict:

- Coping with problems arising from arguments, jealousy, hassles etc.

Social pressure:

- Influences from another individual or group of individuals who exert direct or indirect social pressure to use drugs

Enhancement of positive emotional states:

- Use of substance in a primarily interpersonal situation to increase feelings of pleasure, sexual excitement, freedom, etc

6

RELAPSE

- Previous thinking: relapse to heroin use caused by overwhelming cravings; continued heroin use due to loss of control
 - Now we know it is more complicated
- 90% of recovering users use heroin again within the first year following treatment
 - However: only 60% relapse back to the same intensity of use they had before they entered treatment

7

RELAPSE PREVENTION STEPS

Differentiate between slip, lapse and relapse

- Identify high-risk situations
 - Internal and external precipitants
- Discuss the following:
 - Apparently irrelevant decisions
 - Abstinence Violation Effect
- Develop coping responses to high-risk situations
 - Skills and self-efficacy
- Focus on confidence and competence in client’s decision to stop using drugs

8

Unit 6.1

FACTORS THAT INFLUENCE OUTCOMES

- Personal characteristics
 - e.g. gender, self-efficacy, loss of control
- Drug use factors
 - addiction, cognitive impairment
- Lifestyle
- Environment

9

IDENTIFYING HIGH-RISK SITUATIONS

- Ask clients to monitor and record times and situations when they feel like using drugs
- Probe about potential situations that might lead to relapse
 - include sad and happy events

10

ASK QUESTIONS LIKE:

- What kinds of people, places or things make it difficult for you to feel good about yourself?
- What situations do you consider to be high-risk for using drugs again?
- How will you know when a slip is about to occur?
- What kinds of thoughts trigger your temptation to use drugs again?

11

RPT BASIC PROCEDURES

- Are there specific situations that serve as triggers?
- What are the kinds of interventions that will help the client deal with high-risk situations?
- How did the client feel about the use of drugs after the relapse?
- Were the causes of a slip or lapse the same as those that caused a total relapse?

12

PREPARATION FOR HIGH-RISK SITUATIONS

- Consider clients' list of high-risk situations
- Consider the skills and techniques they have used before, and select appropriate ones
 - might include avoidance, refusal skills, coping with cravings, challenging unhelpful thoughts or relaxation etc.
- Identify new skills and techniques that might be helpful
- Not all situations can be anticipated
 - consider generic coping skills

13

GLOBAL RPT INTERVENTIONS

- Increase lifestyle balance
- Increase awareness of relapse warning signs
 - Analyze relapse 'road maps' (high-risk situations and choices)
- Cope with rationalization and denial
- Stress management
- Assess motivation for change

14

SPECIFIC RPT INTERVENTIONS (1)

- Train clients to cope with cravings
- Take a history of drug-taking and relapse susceptibility
- Train clients to cope with high-risk situations and enhance self-efficacy
- Use a decision matrix (balance sheet of pros and cons for change)

15

DECISION MATRIX

	Short-term	Long-term
Benefit		
Cost		

16

Unit 6.1

SPECIFIC RPT INTERVENTIONS (2)

- Problem solving and relapse management rehearsal
- Coping with lapses
- Dealing with the Abstinence Violation Effect

17

SUMMARY

- Relapse is common and expected
 - Don't be disappointed
 - Anticipate and respond to it
- Negative emotional states are the most common reason for relapse
 - However: there are others; look for them
- Differentiate between slip, lapse and relapse
- Identify high-risk situations
 - These are the focus of interventions
- Develop general and specific strategies
 - Help clients manage the expected and unexpected

18

Unit 6.2

REFUSAL SKILLS

Learning Objectives

At the end of this session, participants will be able to:

- discuss the rationale for learning refusal skills
- understand how to refuse politely when being persuaded to do something against their will
- discuss non-verbal measures
- discuss verbal measures
- practice heroin refusal skills

Content and Timeline

Introduction	2 minutes
Presentation	30 minutes
Conclusion	3 minutes

Unit 6.2



LEARNING OBJECTIVES

At the end of this unit, participants will be able to:

- discuss the rationale for learning refusal skills
- understand how to refuse politely when being persuaded to do something against their will
- discuss non-verbal measures
- discuss verbal measures
- practice heroin refusal skills

2

RATIONALE

- Clients should avoid high-risk situations completely, however, for most it is not a long-term practical solution
- Clients usually underestimate the difficulties encountered when trying to refuse or avoid heroin
- There are a number of strategies that make saying 'NO' easier

3

NON-VERBAL MEASURES

- Make direct eye contact: look directly at the person when you answer
 - Increases effectiveness of the message
- Stand/or sit up straight to create a confident air
- Don't feel guilty about the refusal
 - It won't hurt anyone if you choose not to use
- Go away if the other person keeps insisting or pushing

4

VERBAL MEASURES

- Use a clear, firm, confident tone of voice
- "NO" should be the first word out of your mouth
- Suggest an alternative if you want to do something else with that person
- Tell the person offering you drugs not to ask you now or in the future so the other person stops asking
- Change the subject to something else
- Avoid using excuses and vague answers
 - These imply you will change your mind later

5

ROLE-PLAY: TEACHING REFUSAL SKILLS TO CLIENTS

6

SUMMARY

- Clients should avoid high-risk situations
- Clients need to understand both non-verbal and verbal measures of refusal
- There are a number of strategies for saying no.

7

Unit 6.3

COPING WITH CRAVINGS

Learning Objectives

At the end of this session, participants will be able to:

- define cravings
- describe cravings in discussions with clients
- identify triggers in discussions with clients
- plan strategies with clients on how to cope with cravings

Content and Timeline

Introduction	2 minutes
Presentation	40 minutes
Conclusion	3 minutes

Unit 6.3



LEARNING OBJECTIVES

At the end of this unit, participants will be able to:

- define cravings
- describe cravings in discussions with clients
- identify triggers in discussions with clients
- plan strategies with clients on how to cope with cravings

2

BASIC FACTS ABOUT CRAVINGS (1)

- A natural part of modifying drug use
 - Note that cravings for things can be difficult for anyone, whether or not they use drugs
- Cravings are the result of long-term drug use and can continue long after quitting
 - People with a history of heavy drug use may experience stronger cravings

3

BASIC FACTS ABOUT CRAVINGS (2)

- Cravings can be triggered by:
 - people
 - things
 - situations
 - places
 - feelings

or anything else that has been associated with drug use in the past
- Cravings lose their power if not reinforced by drugs use
 - Using occasionally keeps cravings alive

4

BASIC FACTS ABOUT CRAVINGS (3)

- Cravings are like waves on the beach
 - Each wave starts small and builds up to a high point, then breaks and flows away
 - Cravings rarely last more than a few minutes, with a maximum of 20 minutes



5

BASIC FACTS ABOUT CRAVINGS (4)

- Each time the person does something other than using drugs, the cravings lose their power
 - Peaks become smaller and the waves further apart
 - Abstinence is the best way to ensure the most rapid and complete removal of cravings

6

BASIC FACTS ABOUT CRAVINGS (5)

- Cravings often most intense in the early part of quitting
 - but people may continue to experience them for months and sometimes even years
- Each episode is not always less intense than the previous
 - Sometimes, particularly in response to stress, the peak returns to maximum strength, but it will decline and subside

7

DESCRIBING CRAVINGS (1)

Clients should describe their cravings to help your understanding. Ask the following:

- What are cravings like for you?
- How bothered are you by cravings?
- How long do cravings last for you?
- How do you try to cope with cravings?

8

Unit 6.3

CRAVING INTENSITY

Extent of cravings determined by how much clients dwell on using drugs

9

DESCRIBING CRAVINGS (2)

Ask clients to monitor themselves over the next week

- Write down situations in which they feel the urge to use
- Write down thoughts, feelings and behaviors associated with those situations

10

DESCRIBING CRAVINGS (3)

Summarize the Craving Diary under the headings of 'Behaviors', 'Physical feelings' and 'Thoughts'

Behaviors Physical feelings Thoughts

Explain that cravings are the sum of behaviors, physical feelings and thoughts

11

STRATEGIES TO COPE WITH CRAVINGS (1)

Delay Distract

Behavioral

Decide

After the craving has passed, visit the reasons for ceasing drug use

12

STRATEGIES TO COPE WITH CRAVINGS (2)

Positive self-talk

Cognitive

Relaxation & imagery

13

SUMMARY (1)

- Cravings are common and normal; they are not a sign of failure. Clients should try to learn what triggers them.
- Cravings are like ocean waves. They grow in intensity, but then they start to go away.
- If clients don't use, their cravings will weaken and eventually go away. Cravings only get stronger if clients give in to them.
- Clients can try to avoid cravings by avoiding or eliminating the cues that trigger them.

14

SUMMARY (2)

You can cope with cravings through:

Behavioral means

- Delay
- Distract
- Decide
- After the craving has passed, visit the reasons for ceasing drug use

Cognitive means

- Positive self-talk
- Relaxation and imagery

15

ROLE-PLAY: TRAINERS

Trainer role-play: Cravings

16

Unit 6.3

ROLE-PLAY: PARTICIPANTS

Participant role-plays: Cravings

17

Unit 6.4

STRESS MANAGEMENT

Learning Objectives

At the end of this session, participants will be able to:

- understand the elements of stress
- understand the symptoms of stress
- understand the causes of stress
- understand how stress affects both counselors and clients
- understand ways to mitigate stress

Content and Timeline

Introduction	2 minutes
Large Group Discussion	20 minutes
Presentation	30 minutes
Conclusion	8 minutes

Unit 6.4



LEARNING OBJECTIVES

At the end of this session, participants will:

- understand the elements of stress
- understand the symptoms of stress
- understand the causes of stress
- understand how stress affects both counselors and clients
- understand ways to mitigate stress

2

SMALL-GROUP EXERCISE

- What is stress?
- How do you manage stress in your life?

3

WHAT IS STRESS

- Stress is your mind and body's response or reaction to a real or imagined threat, event or change.
- The threats, events or changes are commonly called stressors.
- Stressors can be internal (thoughts, beliefs, attitudes) or external (loss, tragedy, change).

4

STRESS IS CAUSED BY...

- Major life changes (e.g. moving house, change in the workplace, death of a loved one...).
- Environmental events (e.g. time pressure, competition, and financial problems...)

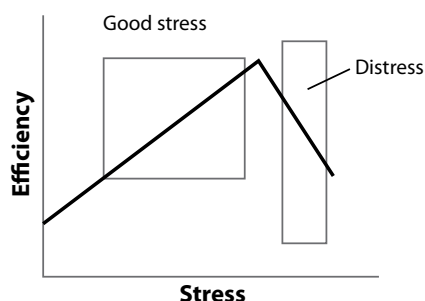
5

STRESS

- Everyday fact of life
- Stress can be good
- Excessive stress can be harmful

6

HANSON'S STRESS MODEL



7

POSITIVE STRESS

- Enables concentration
- Increases performance
- Energizes

8

Unit 6.4

NEGATIVE STRESS

- Loss of motivation
- Reduces effectiveness
- Physical, mental, and behavioral problems

9

PHYSICAL STRESS SIGNS

- Increased breathing
- Increased heart rate
- Muscles tighten
- Cold clammy hands
- Hands shakes (Trembling)
- Sleeplessness
- GI tract disorders
 - Butterflies in stomach
 - Diarrhea
- Fatigue

10

MENTAL STRESS SIGNS

- Anxiety
- Forgetfulness
- Depression
- Apathy
- Confusion

11

BEHAVIORAL SIGNS OF STRESS

- Hostility
- Irritability
- Restlessness
- Under/over eating
- Increased alcohol/drug use

12

HOW TO MANAGE YOUR STRESS

- Identify your stressors
- Know how you react
- Learn techniques to deal with stress
- Integrate stress management into your daily life

13

MENTAL TECHNIQUES

- Work on time management
- Organize
- Problem solve
- Identify important things
 - Identify your values
 - Establish priorities
 - Set goals

14

PHYSICAL TECHNIQUES

- Laughter
- Nutrition
- Exercise
- Deep breathing
- Yoga
- Imagery

15

DIVERSIONS

- Music
- Hobbies
- Play
- Vacation

16

Unit 6.4

EXERCISE

- Write down the things that cause you stress in your life (individual exercise - 5 min)
- Await further instructions

17

SUMMARY

- Stress is real for both you and your client
- Stress has clear signs and symptoms
- Stress can be managed and reduced

18

Unit 6.5

TIME MANAGEMENT

Learning Objectives

At the end of this session, participants will be able to:

- understand the importance of time management in counseling
- know how to apply skills for effective time management during a counseling session
- practice teaching clients how to make an appropriate timetable for relapse prevention

Content and Timeline

Introduction	2 minutes
Presentation	55 minutes
Conclusion	3 minutes

Unit 6.5



LEARNING OBJECTIVES

By the end of this unit, you will:

- understand the importance of time management in counseling
- know how to apply skills for effective time management during a counseling session
- practice teaching clients how to make an appropriate timetable for relapse prevention

2

SMALL-GROUP EXERCISE

- What techniques do you use in order to concentrate on your work after you have been interrupted?
- Why do you think that time management is significant and important for counseling?
- When you are working with clients and the session time is coming to an end, how do you end a conversation/discussion with your client?

3

MYTHS OR FACTS ABOUT TIME MANAGEMENT

- #1: Planning my time just takes more time.
- #2: I get more done in less time when I use alcohol.
- #3: Having a time management problem means that there's not enough time to get done what needs to get done.
- #4: The busier I am, the better I am at using my time.
- #5: I feel very busy, so I must have a time management problem.

4

WHY IS TIME MANAGEMENT NECESSARY?

- Time is a limited resource: it needs to be allocated appropriately to produce the best outcome in the time available
- Priorities should be given to the most important tasks
- Don't spend too much time responding to all needs

5

TIME MANAGEMENT: GENERAL STEPS

- Step 1: Create ideal conditions for working
- Step 2: Prioritize
- Step 3: Plan

6

TIME MANAGEMENT: GENERAL PRINCIPLES

Step 1: Create ideal conditions for working

- Build a work-conducive environment
- Track periodic biological fluctuation
 - Match tasks to the time of day you are best suited to do them

7

Time Management: General Principles

Step 2: Prioritization

- Make a list of things to do
- Prioritize the tasks according to the 2x2 table below and give priority to the tasks in boxes I and II

	Urgent	High	Low
Important		I	II
		III	IV

8

Unit 6.5

TIME MANAGEMENT: GENERAL PRINCIPLES

Step 3: Planning

- Set up a detailed personal plan for long-term goals, including steps to achieve each goal
- Review and adjust the plan everyday/week as necessary
- Include activities relating to personal primary needs, relaxation and entertainment
- Do not set up a plan that is too ambitious

9

MANAGING YOUR TIME DURING A COUNSELING SESSION

- Follow the procedures of each counseling session
- Focus on the client's most important problem(s)
- Link important points and change the topic appropriately
- Stay focused and use summarization skills when necessary

10

MANAGING YOUR TIME DURING A COUNSELING SESSION

- Combine counseling skills
 - Ask open-ended and close questions
 - Probe
 - Interpret
 - Summarize
 - Reflect on emotions
 - Empathize

11

COUNSELING SESSIONS PROCEDURES: 45 MINUTES

- Opening
- Processing
- Closing

12

TIME MANAGEMENT FOR RELAPSE PREVENTION

13

WHY TIME MANAGEMENT IS NECESSARY FOR RELAPSE PREVENTION

- Inappropriate allocation of time can be stressful
- Unmanaged time leads to lack of purpose
- Lack of work can be boring
- Clients can gain support from families and friends if they have an action plan

14

HOW TO MAKE A PERSONAL PLAN

- Encourage clients to make their own personal plan of action - assist only when necessary
- The more detailed the plan, the stronger the commitment for action and the higher the possibility of success
- Discuss with clients the advantages and disadvantages of their choices
- Help by acknowledging the importance of every change clients have made

15

ASSIST CLIENTS TO SET UP A DAILY PERSONAL PLAN

Clients will be able to do the following:

- Make appropriate personal plans: avoid being too ambitious, give priority to easily doable activities
- Understand what plans and activities are required to achieve their goals
- Make a detailed action plan and list of activities for every hour of the day
- Prioritize safe or low-risk activities
 - **Successful plan = no relapse**
 - **Unsuccessful plan = higher risk of relapse**

16

Unit 6.5

TIME MANAGEMENT FOR RELAPSE PREVENTION

- Be aware of your clients' education level and background:
 - If they are illiterate, preparing a plan may be more challenging.
 - Additional strategies may be needed to develop a daily schedule effectively.
- Common barrier:
 - Many clients claim they have nothing to do, or have nothing to put in a daily timetable.

17

PRACTICE: DETAILED DAILY PERSONAL PLAN

Time	Activity	Remarks/notes
7 AM		
8 AM		
9 AM		
10 AM		
11 AM		
12 AM		
1 PM		
2 PM		
3 PM		
4 PM		
5 PM		
6 PM		
7 PM		
8 PM		
9 PM		
10 PM		
11 PM		

18

SUMMARY

- Time is a limited and irreplaceable resource - one must spend it wisely
- Prioritize daily activities for input into a feasible personal plan of action
- Follow the counseling steps and use a mix of skills to ensure counseling sessions have positive outcomes
- Assist clients to set up a detailed daily personal plan to help prevent relapse

19

CHAPTER 7

MANAGING INTOXICATION AND HOSTILITY

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Unit

7.1

ANGER MANAGEMENT

Learning Objectives

At the end of this session, participants will be able to:

- understand the differences between anger and aggression
- understand what triggers anger or aggression
- know strategies to deal with anger and aggression

Content and Timeline

Introduction	2 minutes
Presentation	45 minutes
Conclusion	8 minutes

Unit 7.1



LEARNING OBJECTIVES

By the end of this session, participants will:

- understand the difference between anger and aggression
- understand the triggers for anger and aggression
- know strategies to deal with anger and aggression

2

ANGER MANAGEMENT

- Know the difference between **anger** and **aggression**
- Anger is an emotion - it is alright to be angry
- Aggression is intentionally trying to hurt someone, either physically or emotionally, and is unacceptable

3

WHEN AN ANGRY EPISODE OCCURS, ALL OF THE FOLLOWING ARE INVOLVED

- Cognition – our thoughts
- Emotions – the physiological arousal that anger produces
- Communication – the way we display our anger to others
- Behaviors – the way we behave
- Effect on others from our anger – fear, hostility

4

SMALL-GROUP EXERCISE

- Identify the steps in controlling anger and avoiding aggressive behavior

5

SKILLS NEEDED TO DEAL WITH ANGER

1. Identify aggressive acts by self and others
2. Identify the range of feelings, including anger, and differentiate anger from the list of others
3. Identify potential consequences to self and others from aggressive acts
4. Identify self-destructive behavior
5. Identify thoughts prior to aggressive acts
6. Identify internal cues to feelings of anger
7. Develop coping mechanisms for dealing with anger
8. Express anger without loss of control

6

ANGER MANAGEMENT

- Identify aggressive acts shown by self and others:
 - Throwing something
 - Kicking someone or something
 - Getting in someone's face
 - Shoving, grabbing, hitting
 - Breaking something
 - Calling someone names
 - Giving someone a dirty look
 - Giving the silent treatment
 - Getting others to "gang up"
 - Spreading rumors



7

ANGER MANAGEMENT (2)

- Identify a range of feelings that can lead to anger:
 - Embarrassment
 - Excitement
 - Disappointment
 - Jealousy
 - Fear
 - Helpless
 - Sadness
 - Feeling left out



8

Unit 7.1

ANGER MANAGEMENT (3)

- Identify potential consequences of aggression to others and yourself...what can that mean for you?
→
 - Physical harm to someone or self
 - Destruction of property
 - Loss of family/friends
 - Loss of job
 - Loss of social privileges
 - Going to jail
 - Getting a bad reputation

9

ANGER MANAGEMENT (4)

- Identify self-destructive behavior - this can lead to aggression:
→
 - Negative self-talk
 - Blaming everyone else
 - Taking everything personally
 - Assuming intentions of others
 - Drinking too much
 - Taking drugs
 - Looking for fights

10

ANGER MANAGEMENT (5)

- Identify thoughts prior to aggressive acts:
→
 - You did that on purpose...
 - You wanted to hurt me...
 - You deserve this...
 - You never even asked me...
 - You're being unreasonable...
 - You think you're so good...
 - I'll show you...
 - You started it...
 - There's no justice...

11

ANGER MANAGEMENT (6)

- Identify internal cues to feelings of anger:
→
 - Stomach gets tight/upset
 - Heart beats faster
 - Clenching fists
 - Feel myself getting flushed
 - Pressure on my temples
 - Sweaty palms
 - Clenched jaw

12

GENERAL COPING MECHANISMS FOR DEALING WITH ANGER (1)

1. Exercise everyday
2. Eat well
3. Get enough sleep
4. Find fun distractions
5. Make good decisions about what you see and hear
6. Learn to relax
 - Slowly repeat a calm word or phrase, for example "take it easy",
 - Non-strenuous, slow yoga-like exercises

13

GENERAL COPING MECHANISMS TO DEAL WITH ANGER (2)

7. Take time out
8. Choose friends who make you feel good
9. Learn to forgive and forget
10. Know your feelings
11. Write about those feelings

14

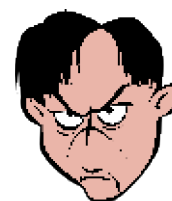
SPECIFIC COPING MECHANISMS FOR DEALING WITH ANGER (1)

- Find your anger triggers
 - develop strategies for those triggers
- Develop better communication skills
- Admit you have a problem and be willing to change
- Get assertiveness training

15

SPECIFIC COPING MECHANISMS FOR DEALING WITH ANGER (2)

- Express angry feelings in ways that are fair to others and yourself
- Use fair words (e.g. "I feel X when you...")



16

Unit 7.1

SPECIFIC COPING MECHANISMS FOR DEALING WITH ANGER (3) ANGER MANAGEMENT STEPS

- Calm down
- Show mutual respect
- Identify the problem
- Find solutions
- Choose the best solution
- Congratulate yourself
- Review the solution that was selected

17

SUMMARY

Help the client to control anger and prevent aggression:

- Know the difference between anger and aggression
- Differentiate anger from other feelings that are often confused or linked
- Identify self-destructive behaviors and thoughts prior to aggression
- Identify internal cues for anger
- Develop coping mechanisms for dealing with anger
- Express anger without loss of control

18

Unit 7.2

DEALING WITH AGGRESSIVE AND POTENTIALLY VIOLENT BEHAVIOR

Learning Objectives

At the end of this session, participants will be able to:

- identify aggressive and potentially violent behavior
- identify ways to defuse and avoid potentially violent confrontations
- develop strategies to manage intimidation, verbal abuse and threats
- explain when and how to exit a scene
- identify the necessary personal safety steps to avoid or reduce physical injury
- assess and manage a range of risky or dangerous situations

Content and Timeline

Introduction	2 minutes
Presentation	110 minutes
Conclusion	8 minutes

Unit 7.2



DEALING WITH AGGRESSIVE AND POTENTIALLY VIOLENT BEHAVIOR

1

LEARNING OBJECTIVES

At the end of this unit, participants will be able to:

- identify aggressive and potentially violent behavior
- identify ways to defuse and avoid potentially violent confrontations
- develop strategies to manage intimidation, verbal abuse and threats
- explain when and how to exit a scene
- identify the necessary personal safety steps to avoid or reduce physical injury
- assess and manage a range of risky or dangerous situations

2

IDENTIFYING AGGRESSIVE AND POTENTIALLY VIOLENT BEHAVIOR

Small-Group Exercise:

- What is your definition of aggressive behavior?
- What is the difference between angry and aggressive behavior?
- Describe a situation you have had with a person being aggressive
 - What behavior did he/she display?
 - Were there warning signs? If so, what were they?
 - What was your response to the situation?

3

3 STEP APPROACH TO MANAGING AGGRESSION

Step 1 – Defuse aggressive behavior

- Clear calm communication
- Empathetic listening, acknowledgement and clarification

Step 2 – Control aggression

- Negotiate assertively and clearly

- Take safety steps, space and scan

Step 3 – Terminate the interaction

- Remove yourself or ask client to leave
- Evade injury and call for assistance
- Defend yourself

4

Staying **CENTERED** and in **CONTROL** is one of the most important steps in dealing with aggressive and potentially violent clients.

Competing and/or engaging with aggressive people will only escalate the situation.

YOU MAY NOT BE ABLE TO MAINTAIN COMPLETE CONTROL OF THE SITUATION

5

STEP 1- DEFUSING AGGRESSIVE BEHAVIOR

Small-Group Exercise:

- What are some of the reasons why people become aggressive (work-specific and in general)?
- What are some of the things that we do that might escalate or inflame the situation?
- How should we communicate with aggressive people (voice tone, body language, words that help)?
- What are the key steps in the listening process? How do people know that you are listening to them?
- What other techniques you could use to help calm an aggressive person?

6

STEP 1 – DEFUSING AGGRESSIVE BEHAVIOR

CENTRED model

Clear calm communication

- Voice tone should be calm and confident – slightly deeper
- Speak clearly and a little slower
- Project a confident, neutral posture
- Use simple words and sentences – keep it simple
- Avoid any blaming/derogatory statements – keep to the problem

7

STEP 1 – DEFUSING AGGRESSIVE BEHAVIOR (continued)

CENTRED model

Empathetic listening, acknowledgement and clarification

- Be patient, allow people time to tell their story – attentive silence
- Acknowledge and follow the conversation by using obvious verbal and non-verbal indicators
- Clarify main themes and obvious feelings when reflecting content
- Use neutral wording, e.g. “I can see that you are angry”
- Use questioning techniques to help clarify or control the interaction

Treat people as you would like to be treated - Respect

8

Unit 7.2

NEUTRAL WORDING

Escalator

- You didn't do this right
- You're wrong
- You haven't done this properly

Neutral

- I can see there are a few areas we need to look at
- I can see there has been some miscommunication
- A lot of people have problems with this

9

TECHNICAL SKILLS

- Avoid using absolutes
- Partly agree with people (as needed)
- Provide options
- Distract or divert attention
- Suggest talking again when calmer
- Refreshment
- Ask permission to take notes
- Get a second opinion
- Change the environment

10

STEP 2 – CONTROLLING AGGRESSIVE BEHAVIOR

Small-Group Exercise

- What should you do in a situation where someone is verbally abusing you?
- What should you do if someone is threatening you?
- What are the key things to avoid when people are being abusive or aggressive?
- What are the important things to consider when negotiating with aggressive people (e.g. body language, voice tone, words, etc.)?

11

RECOGNIZING THE SIGNS OF VIOLENCE: READING BODY LANGUAGE

- No 100% guaranteed way to predict violence
- Raised voice threats clenched fists shaking aunts load breathing skin flushed rapid speech dramatic behavior change look away from you a lot flaring nostrils.
- Listen to your "gut feelings"

12

STEP 2- CONTROLLING AGGRESSIVE BEHAVIOR

CENTRED model

Negotiate assertively and clearly

- Stay calm and look confident
- Use neutral, confident body language
- Use gestures to strengthen the message
- Use simple, concise messages that focus on the outcome
- Use "I" statements
- Use repetition
- Set boundaries

13

STEP 2- CONTROLLING AGGRESSIVE BEHAVIOR (cont)

CENTRED model

Take safety steps, keep space and scan around you

- Some situations require you to withdraw from the situation immediately and not put yourself at risk
- Other strategies
 - Seek assistance from a colleague, supervisor or manager

14

STEP 3 - TERMINATE THE INTERACTION

CENTRED model

- **R**emove yourself or ask client to leave
- **E**vade injury and call for assistance
- **D**efend yourself

15

LEAVING A THREATENING SITUATION

- Agree with your partner when you will leave before you go out to see the client
- Have a plan and identify exits before you start
- Create a safety zone (2-3 meters) if possible before turning your back
- Always turn to your side before turning your back completely on someone
- When you decide to back off, do so without delay
- Make positive assertive movements

16

Unit 7.2

CRISIS COMMUNICATION STRATEGIES

- 1. Defusing aggression** – informal soft warning
 - Clear, calm, communication
 - Empathetic listening, acknowledgement and clarification
- 2. Controlling aggression** – formal firm warning
 - Negotiate assertively and clearly
 - Take safety steps, keep space and scan around you
- 3. Terminate the interaction** – leave or hang up
 - Remove yourself or ask client to leave
 - Evade injury and call for assistance
 - Defend yourself

17

DEVELOPING SELF-CONTROL

Small-Group Exercise

- What can you do if you feel you are losing control/patience/tolerance and a client is getting angry with you?
- What can you do if you feel your team member is being aggressive with a client?
- What are some of the physical symptoms people experience when they get scared?
- What can people do to help manage fear?

18

What to do if you lose control

- Take a deep breath
- Tell yourself:
 - Stay calm
 - Stay focused
 - Focus on what you SHOULD do, not what you SHOULD NOT do
- Take time out
 - Move away
 - Take notes

19

What to do if a team member loses control

- Remove him/her from the situation
 - "You have a phone call."
 - Team members should leave without losing face
 - Clients should not feel like they have material to use against the team member or service center later
- May have to ask client to leave if the staff member refuses to leave
- Step in and ask the client to explain what happened
 - Gives other staff member time to refocus
 - Stay calm
 - Stay focused
 - Focus on what you SHOULD do, not what you SHOULD NOT do

20

OVERCOMING FEAR AND DEVELOPING SELF CONTROL

STOP – losing control

Self-talk

Think rationally

One step at a time

Problem solve actions

21

SUMMARY: 3-STEP APPROACH

Step 1 - Defuse aggressive behavior

- Clear calm communication
- Empathetic listening, acknowledgement and clarification

Step 2 - Control aggression

- Negotiate assertively and clearly
- Take safety steps, space and scan

Step 3 - Terminate the interaction

- Remove yourself or ask client to leave
- Evade injury and call for assistance
- Defend yourself

22

Unit 7.3

CONFLICT RESOLUTION

Learning Objectives

At the end of this session, participants will be able to:

- define conflict
- identify conflict resolution styles
- identify conflict resolution steps
- demonstrate an understanding of the principles through practical exercises and resolution of potential conflicts

Content and Timeline

Introduction	2 minutes
Presentation	80 minutes
Conclusion	8 minutes

Unit 7.3



CONFLICT RESOLUTION

LEARNING OBJECTIVES

At the end of this session, participants will be able to:

- define conflict
- identify conflict resolution styles
- identify conflict resolution steps
- demonstrate an understanding of the principles through practical exercises and resolution of potential conflicts

2

WHAT IS CONFLICT?

- Conflict
 - Disagreement, struggle or fight
- Conflicts are unavoidable in human relations
 - Although conflicts are a normal part of relationships, not knowing how to handle them can cause major relationship and health problems

3

SITUATIONAL CASE STUDY: IDENTIFYING CONFLICT RESPONSE STYLES

How would you respond (behaviorally) to this conflict?

4

CONFLICT RESPONSE STYLES

- Avoidance (Lose - Lose) - (I don't care situation)
 - Person avoids disagreements at all costs
 - Does not tell others when disagrees
 - Does not tell others about feelings
- Confrontation (Win - Lose Situation)
 - Person is hostile, defiant and aggressive in disagreement
 - Confronts others
 - His/her view is the only one worth considering
- Resolution (Win - Win Situation)
 - Uses conflict resolution skills
 - Settles disagreements in a responsible way
 - Remains in control
 - Allows for a win-win situation

5

CONFLICT IS MOST LIKELY TO OCCUR WHEN...

- There is a high level of interdependence
- There are different beliefs
- Resources/rewards are scarce
- The situation is stressful
- There is uncertainty
- **Communication is not clear**

6

CONFLICT: A TOUGH JOB

Perceptions of possible outcomes:

- Win-Lose
- Both partially satisfied
- Irresolvable
- BUT, conflict may have positive effects
 - Increased team effort
 - Better understanding of two parties
 - Impetus for change

NOTE: Still not a good reason to seek conflict!

7

CONFLICT RESOLUTION STEPS

1. Prepare: mentally/physically, time and place; take time to think
2. Keep people and problem separated
3. Explain both sides: define the conflict
4. Put yourself in their shoes
5. Share concerns and needs
6. Brainstorm solutions for compromise: active listening
7. Start with what's doable
8. Develop forgiveness skills
9. Agree on a win-win solution

COMMUNICATION

8

Unit 7.3

CHOOSE A PLACE TO RESOLVE THE CONFLICT FAR FROM THE BATTLEGROUND

- Armies tend to sign treaties far from war zones
 - Too many emotions are rooted in the place where the conflict took/takes place

9

IT IS NOT 'YOU AGAINST ME'

It is 'you and me against the problem'

- The problem is the problem
 - Focusing on the problem, and not the person with the problem, will enhance cooperation

10

DEFINE THE CONFLICT

- Define the conflict objectively
 - If both sides can define what they are fighting about, the chances are increased that misperceptions will be clarified

11

WORK ON ACTIVE LISTENING, NOT PASSIVE HEARING

- Conflicts escalate when you try to talk more than listen
- Listening well is an act of caring
- If you are a good listener, you have many friends
- If you are a poor listener, you have many acquaintances
- Anatomically, we are made to listen more than speak, which is why we have two ears and one mouth

12

PUT YOURSELF IN THEIR SHOES

- How you see the world depends on where you sit. People tend to see what they want to see.
- The ability to see the situation as the other side sees it, as difficult as it may be, is one of the most important skills a negotiator can possess.

13

LIST SHARED CONCERNS AND NEEDS

- Collaboration will increase if the strengths of the relationship - the shared concerns and needs - are given more attention than the unshared views.
 - Agree on what you agree on and focus on these

14

START WITH WHAT IS DOABLE

- Restoration of peace cannot be done quickly.
- If it took a long time for the dispute to begin, it will take time to end it.
- Work on one small, doable thing rather than many large undoable things.

15

DEVELOP FORGIVENESS SKILLS

- Forgiveness looks forward; vengeance looks backward.

16

Unit 7.3

DO THESE CONFLICT RESOLUTION STEPS ALWAYS WORK?

- No!
- Sometimes conflicting parties are so emotionally wounded or ideologically bound that nothing can stop the conflict.
- But many conflicts can be resolved provided these strategies are used appropriately.

17

SUMMARY

- Define the conflict
 - Consider appropriate conflict styles
 - Consider appropriate conflict resolution steps
- Practice
 - Conflict resolution is situational
 - Your counseling skills tie into conflict resolution

18

Handout 7.3

Case Study: Conflict resolution

You are the second child of a family of three brothers. Your older brother is married and has two kids. Due to financial difficulties, your older brother's family is living with your family, comprised of your parents, your older brother's family, yourself and your younger brother. You all share your daily life activities in the same home. Your older brother and his wife have very demanding jobs with an import-export company. You used to work at a big local hotel. Your younger brother still goes to school and your parents are old and fragile. Your family has a tradition of love and caring of each other. An unfortunate thing happened to you about three months ago when the hotel you were working for went out of business. You have been looking for a job since then.

Since your older brother's second child was born, your older brother has sometimes asked you to help with housework: doing the laundry, cleaning, grocery shopping and cooking. You think that his wife should be the one who does these household chores. During the time you have stayed at home, your older brother has reminded you that he expects you to do this work every day. One day, you had a lot of work to attend to and had to be out of the house for the whole day. You did not get home until 7PM. Your older brother's family also came home late. As a result, no one had prepared dinner or done any cleaning. Your older brother became irritated and very loud. He said things that implied that because you were not sharing the costs of living, you were supposed to do the housework in return, regardless of whether you might have some other things to do.

How would you respond to this conflict? (Please be as realistic as you can!)

Write your answers on index cards.

Unit 7.4

MANAGING INTOXICATED CLIENTS

Learning Objectives

At the end of this session, participants will be able to:

- Define conflict
- Identify Conflict Resolution Styles
- Identify Conflict Resolution Steps
- Demonstrate understanding of principles in practical exercise and resolution of possible everyday life conflicts.

Content and Timeline

Introduction	2 minutes
Case study	30 minutes
Group discussion	25 minutes
Presentation	25 minutes
Conclusion	10 minutes

Unit 7.4



LEARNING OBJECTIVES

At the end of this unit, participants will be able to:

- define intoxication and know its effects
- recognize evidence of intoxication at different levels
- know the principles of managing intoxicated clients
- practice managing an intoxicated client

2

INTOXICATION

- Altered mental state of intoxication may lead to injuries or accidents
- Also affects behavior, mood and thinking
- Attempts to discuss matters in depth may make the situation worse
- An intoxicated person may not be able to make logical and informed decisions
 - Counseling at this stage may be a total waste of time

3

EVIDENCE OF MODERATE LEVELS OF INTOXICATION

- Speaking loudly or in an agitated manner
- Making demands
- Invading your personal space
- Not following or ignoring directions
- Acting threateningly
- Becoming physically violent
- Attempting suicide or threatening self-harm
- Glazed eyes

4

EVIDENCE OF HIGHER-LEVEL INTOXICATED BEHAVIOR

- Confusion
- Disorientation
- Slurred or incoherent speech
- Inappropriate emotional and behavioral responses
- Altered state of consciousness
- Poor muscle coordination

5

FACTORS THAT CAN INFLUENCE BEHAVIOR IN AN INTOXICATED CLIENT (1)

In addition to the dis-inhibiting effects of alcohol or other drugs, other factors can include:

- Fear
- Anger
- Physical pain
- Emotional hurt
- Your attitude towards them

6

FACTORS THAT CAN INFLUENCE BEHAVIOR IN AN INTOXICATED CLIENT (2)

- Seeking attention
- Psychosis
- Social and individual expectations about behavior while intoxicated

7

MANAGEMENT OF INTOXICATED BEHAVIOR (1)

- Introduce yourself using your first name and ask the person's name
- Offer to shake his/her hand
- Speak in a calm and level voice
- If you are alarmed, do not display anxiety
- Do not use words the person may not understand
- Do not speak in a loud or authoritarian voice

8

Unit 7.4

MANAGEMENT OF INTOXICATED BEHAVIOR (2)

- Stay calm, relaxed and attentive
- Do not physically intimidate the person (i.e. standing while he/she is sitting)
- Be aware of how you appear to the person
 - Try to appear as someone who can be trusted and who is interested
- If possible, attend to him/her in a quiet environment
 - Can have a calming effect

9

MANAGEMENT OF INTOXICATED BEHAVIOR (3)

- Avoid offering hot drinks such as coffee
- If the person appears very intoxicated, only obtain relevant details
- Don't be judgmental or moralistic when dealing with intoxicated people
- Patronizing attitudes may anger them

10

MANAGEMENT OF INTOXICATED BEHAVIOR (4)

- Be consistent when giving information
 - You may need to repeat information several times
 - Try to avoid giving contradictory advice
- Do not make promises that you do not intend to keep

11

INTERVIEWER SKILLS (1)

- Explain why the questions need to be asked
- Maintain an empathic and non-judgmental attitude
- Give basic information and answer questions accurately and honestly
- Determine level of intoxication
 - Overestimate his/her alcohol or drug use
 - This will enable your client to provide a lower assessment of his/her level of intake

12

INTERVIEWER SKILLS (2)

- When estimating drug use it may be useful to interview family members
- Only use reflective listening techniques and open-ended questions if possible
- Summarize the content you have discussed with the client
- Check what the client wants to do or is prepared to do
- Limit time of interview if very intoxicated
- Make time to see client when not intoxicated
- Discuss his/her behavior when not intoxicated

13

OTHER CONSIDERATIONS

- Violent behavior should not be tolerated
 - Individuals are still responsible for their behavior while intoxicated
 - Police should be called if necessary
- Consider other reasons for intoxication symptoms
 - Consider possibility of injury, trauma or illness: these issues may complicate appearances

14

ROLE-PLAY

Groups of 3

- **Role 1:** Intoxicated drug user arrives confused and agitated
- **Role 2:** Counselor undertakes an assessment of needs and course of action
- **Role 3:** Observer (look at behavior and responses)

15

SUMMARY

- Drug intoxication influences capacity to understand and retain information
- Attempts to discuss in too much detail may make the situation worse
- Signs and symptoms can help identify level of intoxication
- Other factors can influence behavior (other than intoxication)
 - these need to be considered and eliminated
- There are verbal and non-verbal approaches to diffuse the situation
 - This allows you to discuss future options with your client
- Counselors should provide clients with an offer to meet again later to avoid negative responses
- Violent behavior should not be tolerated

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CHAPTER 8

SPECIAL POPULATIONS

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Unit 8.3: Working with Women 180

Unit 8.1

WORKING WITH FAMILIES

Learning Objectives

At the end of this session, participants will be able to:

- understand the role of families in recovery
- understand the effects that substance use has on families
- understand how families can provide enhanced support to recovering drug users
- understand the key elements of a supportive meeting with families

Content and Timeline

Introduction	2 minutes
Presentation and Small-Group Exercise	55 minutes
Role-Play	30 minutes
Conclusion	3 minutes

Unit 8.1



LEARNING OBJECTIVES

By the end of this unit, participants will:

- understand the role of families in recovery
- understand the effects that drug addiction has on families
- understand how families can provide enhanced support to recovering drug users
- understand the key elements of a supportive meeting with families

2

KEY QUESTIONS ABOUT SUBSTANCE USE AND THE FAMILY

- How do families differ in Vietnam? (What is the range of family structures?)
- What impacts does substance use have on families?
- How can drug counselors work with families in a supportive way?

3

LEVEL OF INVOLVEMENT WITH FAMILIES

- **Level 1 - Counselor has little or no involvement**
- **Level 2 - Counselor provides information and advice**
 - Advise families on how to handle the client's needs
 - For large or demanding families, communicate through one or two key members
 - Identify major family dysfunction that interferes with drug addiction treatment
 - Refer family for specialized family therapy
- **Level 3 - Counselor provides family with psychosocial support**
 - Elicit and empathize with family members' concerns and feelings related to client's condition and effect on family
 - Conduct preliminary assessment of family's level of functioning as it relates to client's issues
 - Support family members to cope with situation
 - Tailor drug addiction education to unique needs, concerns, and feelings of family
 - Identify family dysfunction and appropriate referral recommendations
- **Level 4 - Counselor provides systematic assessment and interventions**
- **Level 5 - Family therapy**

4

FAMILY THERAPY VERSUS DRUG ADDICTION COUNSELING

- What is family therapy?
 - Collection of therapeutic approaches
 - Family-level assessment and intervention
- What is the difference between drug addiction treatment and family therapy?
 - Unit of treatment is the family - NOT the client with the drug problem
 - Different approach to problems and solutions

5

INTEGRATED TREATMENT WITH FAMILY SUPPORT

- Benefits
 - Client
 - Families can help build the client's resilience
 - Might also support the treatment process
 - Opportunity to begin to rebuild relationships
 - Clinician
 - Reduce resistance
 - Greater flexibility
- Limitations
 - Not for all families
 - Family members might have serious drug-related problems
 - Client might have been abused by a family member
 - Significant problems in family relationships
 - Requires additional skills
 - Lack of structure

6

MEETING OUTLINE AND PROCESS

7

CLIENT COUNSELING AND PROBLEM IDENTIFICATION

- First provide counseling sessions for client
- Identify client's problems
- Identify family-related issues:
 - Is client having problems with or seeking support from family members?
 - Explore what kind of support your client wants from his/her family
 - Identify client expectations about meeting with family
 - Ask client to identify who he/she would like to participate
- Discuss client's plan to work with his/her family

8

Unit 8.1

MEETING OUTLINE AND PROCESS

- Structure each meeting by setting an agenda
- Define the meeting contents based on analysis of client's needs and expectations
- Contact client's family members for an agreement on the meeting plan: participants, venue, time and content
- Decide who will be the focal contact person for the meeting

9

MEETING GROUND RULES

- Before beginning, explain the following:
 - Counselors cannot reveal information from individual client sessions without their consent
 - Both client and family members must listen to each other without interruption
 - Participants should avoid raising the past and focus on the future
 - Participants will take time out when there is conflict
 - Participants should aim to finish on a positive note
 - Feedback will be provided in the following way: first on what worked well, and second on what can be improved
- DO NOT DWELL ON THE PAST

10

GOALS

11

GOALS

- Acknowledge what the family has gone through
- Educate the family about drug addiction and change
- Educate the family about cravings, lapses and relapses
- Rebuild trust between the client and his/her family
- Build effective communication strategies
- Support and reward safe behavior
- Set limits and consequences
- Spend time together

12

KEY CONTENTS: MEETING WITH FAMILIES

13

PRINCIPLES FOR THE FIRST SESSION

In the first meeting:

- Work out basic communication ground rules
 - Importance of one person speaking at a time
 - Ensure effective communications skills used, including: I-statements, positive specific requests, active listening, validating other person
- Get to know each person
 - Opportunity to work out ways of supporting client
 - Avoid blaming the family
- Keep all informed of what is happening
- Provide all a chance to voice concerns and needs for the future
- Do not impose fixed solutions that might not work for every family

14

TALKING ABOUT CHANGE

- Focus on common underlying themes
 - Role of family
 - Time for recovery
 - Nature of behavioral change
 - Risk of relapse and how to prevent it
 - Planning ahead and coping with setbacks
- Reframe to diffuse conflict
 - Find agreements or compromises over the course of the sessions
 - Use reflective listening and summarization
 - Emphasize points of common interest

15

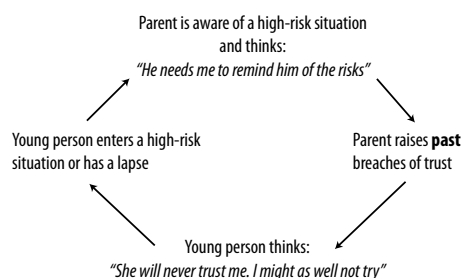
REBUILDING TRUST AND RESOLVING CONFLICT

- Rebuilding trust: critical if client has deceived or stolen
- Invite each person to talk about underlying concerns
- Reflect points of positive concern (e.g. to protect their child)
- Seek recognition of changes already made
- Try to balance problem-focused questions with solution-focused questions

16

Unit 8.1

CYCLE OF BLAME



17

SUPPORTING AND REWARDING SAFE BEHAVIOR (1)

- Develop practical support strategies
- Begin by inviting everyone to contribute their ideas
- Generate two lists:
 - 'Safe situations' list
 - 'Risky situations' list
- Balance protecting clients from risky situations and providing a sense of freedom and responsibility

18

SUPPORTING AND REWARDING SAFE BEHAVIOR (2)

- Help the family develop a plan and strategies that:
 - promote participation in safe situations
 - reduce involvement in risky situations
- Review progress
- Make adjustments
 - Use a problem-solving approach

19

ESTABLISHING LIMITS AND CONSEQUENCES

- Consequences for breaching limits should be:
 - stated clearly and applied consistently
 - developmentally appropriate
 - acceptable to the young person
- Will not work without client's agreement
- Should not be overly harsh

20

SPENDING TIME TOGETHER

- Share rewarding activities
 - What does your client enjoy doing with his/her family?
- Encourage the family to explore how they might strengthen relationships by:
 - spending more time together
 - improving communication

21

MONITORING HIGH-RISK SITUATIONS

- Options for monitoring lapses and relapses:
 - Self-disclosure
 - Identify and respond to early warning signs
 - Identify behaviors and moods which may be early warning signs
 - Random checking
- Frame as supportive rather than punitive
- Might be hard for families to respond to lapses and relapses without conflict
 - Explain that it is natural to feel disappointed about lapses

22

CONSIDERATIONS BEFORE CLOSING A SESSION

- Summarize the positive points or outcomes of the session
- Focus on the things you would like to see occur differently in future sessions
- Summarize activities and/or homework client/family members will do before next session (if any)

23

FAMILY COUNSELING ROLE-PLAY

- **Five roles:** counselor, client, mother, brother and uncle
- **Time:** 40 minutes
- **Objectives:**
 - Discuss current problems of the client; agree on a plan that can help client stay away from heroin with the strong support from family members
 - Provide family members with information about stages of change, the difference between slips, lapses and relapses, and how to support client
- **Results:** A specific plan to which everyone agrees

24

Unit 8.1

ROLE-PLAY DETAILS

■ Background:

Minh Tuan, male, 18 years old, grade 12 school student, single, living with mother and brother. Father died. Family is poor. Mother runs a street-based teashop; brother works outside to earn a living for the whole family.

■ History of drug use:

Started smoking heroin at 16; changed to injecting one year later. Has not shared N&S. Injected 3 times/day (150,000vnd/day) before treatment. HIV status unknown. Currently not using drugs for two months as forced to quit by family - quit by staying at home.

25

ROLE-PLAY DETAILS

■ Family relations:

- **Mother:** Takes care of client the most - does not allow client to go out to hang out with his friends
- **Brother:** Also cares for client, but often blames and shouts at client, thinking it will work. He is the main supporter of the family. Thinks that "He (client) doesn't know how hard it is to earn a living. We had to be strict about his drug use. We took him to a government O6 center for treatment because we suffered enough because of him. Father died because of him, too."
- **Uncle:** Has significant influence on client's family, especially the brother. Psychologically supports client's family after father died.

26

ROLE-PLAY DETAILS

■ Client's problems:

The client is in conflict with his brother regarding how to deal with his addiction to heroin. His mother doesn't want to send him to the O6 center for treatment, but is confused about how to control his drug use at home. He is suffering from cravings and these worsen due to troubles with his brother and mother.

27

ROLE-PLAY

Conduct the role-play!

You have 20 minutes

28

SUMMARY

- Families can contribute to maintaining stability and abstinence, and provide support and rewards for safe behaviors.
- Family involvement requires client consent.
- Ground rules need to be established as part of the first meeting.
- Counselors need to help clarify expectations, build trust, and educate the family.
- Families need to be aware of destructive information sharing.
- Families should look toward the future rather than concentrating on past failures.
- Families that spend time together can promote positive behaviors.

29

Unit 8.2

WORKING WITH YOUTH

Learning Objectives

At the end of this session, participants will be able to:

- understand that adolescence is a developmental stage in life
- know how to identify possible significant others and how they may impact young people's drug use
- have explored some clinical strategies that assist in working with young people
- begin discussing risk-reduction approaches to working with young clients
- develop skills on initiating drug use discussions and developing therapeutic relationships with young people

Content and Timeline

Introduction	2 minutes
Presentation	55 minutes
Conclusion	3 minutes

Unit 8.2



OBJECTIVES

By the end of this session, participants will:

- understand that adolescence is a developmental stage in life
 - know how to identify possible significant others and how they may impact young people's drug use
 - have explored some clinical strategies that assist in working with young people
 - begin discussing risk-reduction approaches to working with young clients
 - develop skills on initiating drug use discussions and developing therapeutic relationships with young people
- 2

SMALL-GROUP EXERCISE

What.....

- are the challenges of working with adolescents?
 - should you focus on during a counseling session with adolescents?
 - are the issues that may affect the outcomes of the counseling session?
 - are the issues that may affect young clients' ability to stop using drugs?
- 3

CHARACTERISTICS OF ADOLESCENTS

- Physical
 - Behavioral
 - Emotional
- 4

NORMAL DEVELOPMENTAL TASKS OF ADOLESCENCE

- Adjust to physical changes
 - Learn to understand and take responsibility for their sexuality
 - Work towards independence from parents
 - Develop a sense of who they are (personal identity)
 - Develop social and working relationships
 - Choose and make plans for a career
- 5



CONSTRUCTION AHEAD

- During late childhood, the number of connections between neurons increases.
- However: for girls (around age 11) and boys (around age 12.5) - some of these connections are removed naturally.



7

CONSTRUCTION AHEAD

- When the pruning is complete, the brain is faster and more efficient.
- But... during the pruning process, the brain is not functioning at full capacity



8

Unit 8.2

PRUNING STARTS AT THE BACK OF THE BRAIN... AND MOVES TO THE FRONT

Notice: Judgment is last to develop!

AGE 24

Ahh... Balance, Finally!

THE ADOLESCENT BRAIN: SUMMARY (1)

- Midbrain (mesolimbic region):
 - Motivation, exploration and learning, social behavior and impulse control
- Prefrontal cortex: executive function
 - Goal setting, planning, priority setting, impulse inhibition
- Under construction: work in progress
 - Pruning and rewiring: critical stages
 - Restructuring: shedding and adding synapses
 - Develops from back to front
- Treatment implications

THE ADOLESCENT BRAIN: SUMMARY (2)

- Work in progress
- Disconnect between feeling brain and thinking brain
- Susceptible to change by good and bad experiences
- Susceptible to drug rewards means that there is heightened risk of addiction

KEY ELEMENTS OF EFFECTIVE ADOLESCENT DRUG TREATMENT

- Assessment and development of individual treatment plans
- Comprehensive, integrated treatment approach
- Family involvement in treatment
- Developmentally appropriate programming
- Retention in treatment for adequate time
- Qualified staff with gender and cultural competence
- Monitoring and documentation of treatment outcomes

WHEN WORKING WITH ADOLESCENTS, REMEMBER...

- Scare tactics don't work
- Adolescents need structure and clear, fair limits
- Adolescents respond well to having freedom of choice
- Adolescents learn best by experience and need to test things out for themselves
- Adolescents like to have their privacy respected
- Try to 'listen' more, 'talk to' less
- Be available as an adult, rather than trying to be one of them
- Try not to let their challenges and/or rebellion stir you up

POINTS TO BE CONSIDERED WHEN WORKING WITH ADOLESCENTS

- Use appropriate counseling skills and techniques
- Correct misinformation
- Counselors do not have to have been drug users to be able to counsel young people
- Don't expect to know all the adolescent language
- Be flexible in considering treatment modalities
- Adolescents may identify more with the counselor than the agency
- It may take longer to build trust/rapport
- Abstinence may not be the goal for some adolescents
- Risk reduction may be more realistic

ROLE-PLAY

Situation

- Client:
 - You are a 15-year-old drug user who has been sent to drug counseling by your parents
- Client's family member:
 - You are concerned about how to manage and support [client] to quit using drugs

Unit 8.2

ISSUES

Confidentiality

- Young people may be very cautious about what they disclose to counselors
- Absolute confidentiality is not possible and should not be guaranteed

Missing counseling appointments is common

- Relapse is common and young people may drop in and out of treatment

17

SUMMARY

- Adolescence can be a mixture of positive and negative changes.
- These changes are behavioral, emotional and physical.
- Because of way their brains are developing, adolescents are more likely to be prone to addiction.
- Drug treatment programs catered to adolescents need to take adolescent special needs into consideration.

18

Unit 8.3

WORKING WITH WOMEN

Learning Objectives

At the end of this session, participants will be able to:

- understand some of the specific issues women face in drug addiction and drug treatment
- understand specific challenges women face in accessing treatment services
- know some of the effective clinical relapse prevention strategies catered to female clients

Content and Timeline

Introduction	1 minute
Small - group discussion	35 minutes
Presentation	55 minutes
Conclusion	4 minutes

Unit 8.3



LEARNING OBJECTIVES

By the end of this unit, participants will:

- understand some of the specific issues women face in drug addiction and drug treatment
- understand specific challenges women face in accessing treatment services
- know some of the effective clinical relapse prevention strategies catered to female clients

2

WHY WOMEN ARE CONSIDERED SPECIAL

- Recent research has shown there are substantial gender differences in drug use and treatment among women
- Women have special needs unique from men
- Women face different sociological, psychological and emotional issues

3

SMALL-GROUP EXERCISE

1. Find a same-sex partner
2. Each partnership take one piece of paper
3. Make 2 columns on the paper
4. Label one "Men" and the other "Women"
5. In partnership, write down gender-specific characteristics of women and men in their separate columns
6. Discuss and record how these differences might affect treatment and relapse prevention approaches

4

THE LIFE CONTEXT OF DRUG USE AMONG WOMEN

Drug use among women differs from that of men in the following ways:

- Biological
- Psychological
- Social

5

WOMEN: BIOLOGICAL DIFFERENCES

Higher risk of alcohol-related harms

- Prone to alcohol-related brain damage at lower levels of drinking and in shorter time
- Develop liver disease sooner and at lower drinking levels
- Higher risk of developing more severe forms of liver disease

Gynecological problems such as inhibition of ovulation

- Obstetric problems
- Birth defects

6

PSYCHOLOGICAL DIFFERENCES

- Men and women are basically alike in terms of:
 - personality, cognitive ability and leadership
- Men grasp situations on a macro level while women rely on detail and subtleties.
- Men are more likely to take risks.
- Men think more independently while women are more willing to follow suggestions.
- Women self-appraisal is lower than that of men.
- Men have pronounced needs to fulfil their goals while women rank relationships first.
- Men get sick twice as much while women tend to be more concerned about their health.
- Women endure pain and monotonous work better.

7

WOMEN: SOCIAL FACTORS

- Higher risk of physical or psychological abuse:
 - 74% of the female treatment population has experienced sexual assault at some time
 - 34% of these women experienced childhood sexual abuse
- female drug users likely to have male sexual partner who injects drugs
- women tend to be introduced to drugs by husband/boyfriend or male family member
- access to drugs usually occurs through the male sexual partner
- women more likely to share needles and to be injected by someone else
- women experience difficulty in avoiding drug use and accessing drug treatment if their male partner is an active drug user

8

Unit 8.3

ISSUES: FEMALE DRUG USERS/SEX WORKERS (1)

- Difficulty negotiating condom use
- Violence
- Young forced into sex work and drug use
- Trafficking to maintain drug use
- Injecting drug users have higher risk of sharing
- Lack of health care

9

ISSUES: FEMALE DRUG USERS/COMMERCIAL SEX WORKERS (2)

- 20-40% female sex workers (FSW) are injecting drug users (IDU)
- FSW who are IDUs experience interdependent problems that drive them to high-risk situations

10

BARRIERS TO ACCESSING TREATMENT: WOMEN

- Drug or alcohol use is less public than men's
- Harder to convince to get treatment
- Less likely to have partner support
- Tend to attribute drug use to coping with fractured relationships, parenting, financial or work-related problems
- More concerned about stigma
- Often afraid of having children taken away

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DOMESTIC VIOLENCE: SPECIAL CONSIDERATIONS

Domestic violence must be addressed with clients in terms of the following:

- Physical health
- Psychosocial Issues
- Emotional health
- Childhood trauma and abuse
- Drug addiction triggers
- Increased stress with abstinence
- Safety
- Potential medications
- Other issues once client is abstinent

12

SEXUAL ABUSE: SPECIAL CONSIDERATIONS

Raising the issue of sexual assault/abuse:

- Make sure confidentiality issues are discussed and understood
- Do not raise the issue until rapport and trust have been established
- Get a feel for what the client's childhood was like, before asking more specific questions
- Use counseling skills to communicate empathy; remember, you can just listen
- Stay calm

13

FEMALE DRUG USERS WHO ARE SEX WORKERS: CONSIDERATIONS

- Individual assessment and treatment program
- Choice of the sex of the counselor
- Discreet waiting rooms
- Wrap around services

14

KEY ELEMENTS OF EFFECTIVE DRUG TREATMENT FOR WOMEN

- Assessment and development of individual treatment plans
- Comprehensive, integrated approach
- Special attention to issues of sexual abuse and domestic violence
- Special efforts to retain female clients in treatment
- Qualified staff (gender and cultural competence)
- Documentation/monitoring of treatment outcomes.

15

WRAPAROUND SERVICES

- Childcare
- Vocational services – accommodation
- Legal support
- Income generating activities

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Unit 8.3

SUMMARY

- Treatment for female drug users, including sex workers who also use drugs, can have positive outcomes
- Female drug users are unique and have different needs and experiences than male drug users
- Sexual abuse and domestic violence histories should be explored

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Handout 8.3

Working with women: Additional information

Physical health

Domestic violence survivors often present with injuries, the long-term consequences of battering, and physical health problems commonly associated with drug addiction (e.g., skin abscesses and hepatitis). Cuts and bruises from domestic violence tend to be on the face, head, neck, breasts, and abdomen. Abdominal pain, sleeping and eating disorders, recurrent vaginal infections, and chronic headaches are also common among survivors.

When a woman presents for treatment with obvious signs of, or complaints about, physical battering or sexual abuse, staff should consider enlisting medical help so the client can obtain proper medical assistance for her injuries.

Other health concerns that need attention early in treatment include screening and care for pregnancy, HIV infection, and other sexually transmitted infections (STIs). Battered women are at high risk for STIs because they are frequently unable to negotiate safe sex with their partners and are often subjected to forced, unprotected sex. They also may have been forced by their partners to share needles.

One of the coping mechanisms used by many survivors is the repression of physical sensations, including physical pain. Often the survivor's awareness of physical pain and discomfort resurfaces only when the traumatic effects of the abuse have been relieved.

Psychosocial issues

Shift of focus and responsibility to the abuser

One important element of treatment for drug addiction is encouraging the client to assume responsibility for her addiction. For a client who has experienced abuse, it is critical at the same time to dispel the notion that she is responsible for her partner's behavior. She is only responsible for her own behavior.

A domestic violence survivor client must realize that she does not and cannot control her partner's behavior, no matter what he says. Treatment should help move her toward becoming an autonomous individual who is not at the mercy of external circumstances. It is critical to provide concrete steps to ensure her safety or, if she decides to leave the batterer, to set up a new life. As she frees herself from the violence, she will feel more independent. A counselor can help reinforce the client's view of herself as capable and competent by eliciting information about her efforts to address the violence, even if they were unsuccessful. A counselor can point out that her efforts reflect determination, creativity, resourcefulness, and resilience - many of the same qualities that will equip her to take responsibility for her drug addiction.

Handout 8.3

Improving decision-making skills

Many drug users have poorly developed decision-making skills. When a female client is battered, that inadequacy may be compounded by the domestic abuse. For some battered women, the batterer has controlled every aspect of their lives, and a “wrong” decision (as perceived by the batterer) may have served as another excuse to batter her. The paralyzing effect of being battered for making independent decisions must be overcome as the survivor begins to exercise choices, without fear of reprisal. One of the first steps in empowering the client is to help her develop, strengthen, focus, or validate her decision-making skills. For some domestic violence survivors, learning to make decisions is a new skill that must be acquired for the first time, rather than a lost skill that must be relearned.

Clients who are able to explore their own wants, needs, and feelings, a process that can be unfamiliar and sometimes uncomfortable, move closer to making longer-term decisions. It is important not to underestimate the importance of making seemingly mundane decisions.

Like most recovering drug users, the survivor client must examine those areas of her life that will either support or undermine her recovery. Like others in treatment, she must disengage from drug-using friends, and she will need support as she begins the task of making new social contacts that support her recovery.

Another therapeutic task for those undergoing drug addiction treatment is reevaluating relationships with partners who support and encourage drinking or drug taking. In a pattern that parallels the experience of many survivors of domestic violence, female drug users are often introduced to and supplied with drugs by male partners. Among the myriad reasons for continuing use are to maintain a relationship, to please a partner, or to share a common activity. For many of these women, recovery will not be possible without separation from their partners - a reality that may be extremely difficult for them to acknowledge, accept, and translate into action. Furthermore, because battering can lead to low self-esteem and confidence in one's ability to make decisions, many clients are likely to need additional help in evaluating and identifying sources of stress in their relationships.

When working with some survivor clients, drug addiction treatment providers may have to discard traditional notions about the wisdom of making major life decisions, such as moving, early in the course of treatment. For a domestic violence survivor who fears being pursued by a batterer, relocation to another community may be a priority. As part of treatment, the stress of a client's uprooting herself and her children and the accompanying risk of relapse must be weighed against safety issues. Should a client decide to move, every effort should be made to refer her to appropriate resources and supportive services within the new community.

Handout 8.3

Ensuring emotional health

Post-traumatic stress disorder (PTSD) is diagnosed using the following criteria: the person experienced, witnessed, or was confronted with an event or events that included actual or threatened death or serious injury, or a threat to the physical integrity of self or others [and] the person's response involved intense fear, helplessness, or horror.

Other criteria include recurrent nightmares, difficulty sleeping, flashbacks, and hyper vigilance - symptoms shared by many battered women.

Emergence of trauma from childhood abuse

Many survivor clients also suffered abuse as children. Emotional and psychological trauma from childhood abuse is often repressed and may surface once the client is in a safe setting, such as an inpatient drug addiction treatment facility. The emergence of this memory can be an overwhelming experience, and treatment providers should not attempt to address it before the survivor is ready, and the program staff are unprepared to handle the results. If the issue surfaces in a group setting, the drug addiction counselor should allow the survivor client to express her emotions initially. Thereafter, however, a client should be referred to a therapist with special training in treating victims of childhood abuse.

Life event triggers

Recovering drug users should be trained to deal with relapse triggers. These are events or circumstances that produce cravings and predispose them to resume their use of alcohol or other drugs. A potential trigger for relapse can be something as seemingly benign as walking through a neighborhood where the recovering individual once purchased drugs. A domestic violence survivor is vulnerable to an additional set of triggers - situations or experiences that may unexpectedly cause her to feel the fear and victimization she experienced when being battered. Such life event triggers may cause the client to relapse and should be addressed directly by counselor and client. Examples of life event triggers are sensory stimuli (sights, sounds, smells), the close physical proximity of certain people, particularly men, or situations that trigger unpleasant memories (such as witnessing a couple arguing). They also include stressful situations that evoke trauma responses and recreate the sense of victimization. Such triggers may push these feelings to the surface many years later, after the survivor is out of the abusive relationship; some disappear over time, but others may always be present to some degree. Counselors should help patients identify these stressful situations and rehearse alternative responses, just as they should for substance use triggers.

Increased stress with abstinence

Survivors of domestic violence usually experience strong emotional reactions when they stop abusing alcohol or other drugs. They may be flooded by formerly repressed emotions and physical sensations.

Handout 8.3

Once they have maintained abstinence, some survivors may suffer because of having additional time and energy formerly spent procuring drugs, leaving them feeling empty or directionless and with too much time to dwell on their life situation.

Perceptions of safety

Paradoxically, the very concept of “safety” may itself seem “unsafe” to a survivor of domestic violence. As one survivor expressed it, “The minute you (think you) are safe, you are not safe.” For these clients, feeling safe from the perpetrator, even if he is dead or incarcerated, is equated with letting one’s guard down and making oneself vulnerable to attack. Survivors tend to be hyper vigilant and are accustomed to being on guard at all times. Treatment providers need to understand and respect the domestic violence survivor’s concept of and need for safety. It is critical to help clients rebuild general trust as part of their long-term therapeutic goals.

Medications

For some survivors, anxiety, depression, suicidal thoughts, and sleep disorders are severe enough to require medication during their treatment for drug addiction. In such cases, it is of utmost importance to strike a balance between the need for medication and the avoidance of relapse. On the one hand, the recurrence of the physical and emotional consequences of abuse may tip a survivor into emotional trauma; on the other hand, however, the client may risk relapse with the possible misuse or abuse of the prescription medication.

Post-abstinence issues

Practical concerns overwhelm many survivors of domestic violence after they become abstinent. These include resolution of legal problems, housing, transportation, employment or supported vocational training, and childcare, among others. Linkages with other programs and agencies become extremely important in meeting these clients’ needs. In addition, survivor clients are likely to need education or reeducation about meeting sexual needs without drugs or alcohol. Referral to training by experts in this area is recommended to ensure that this topic is approached sensitively. In addition, classes in healthy nutrition are a useful adjunct to treatment for survivor clients (as for other recovering drug users).

Social functioning

Although a strong family or friendship support system can be invaluable to drug users as they leave their drug using culture behind and reintegrate with the community, the domestic violence survivor who is recovering from drug addiction may find it especially hard to reestablish ties, make new friends, or, in some cases, build a completely new life for herself.

CHAPTER 9

CLINICAL SUPERVISION AND SUPPORT

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Unit 9.1

FRAMEWORK FOR CLINICAL SUPERVISION

Learning Objectives

At the end of this activity the participants will understand:

- the definition of clinical supervision
- how to develop a supervision policy
- the principles of adult learning
- how to pave the way for supervision

Content and Timeline

Introduction	5 minutes
Presentation	50 minutes
Conclusion	5 minutes

Unit 9.1



LEARNING OBJECTIVES

At the end of this unit participants will understand:

- the definition of clinical supervision
- how to develop a supervision policy
- the principles of adult learning
- how to pave the way for supervision

2

SMALL-GROUP EXERCISE

- What is clinical supervision?
- What is managerial supervision?
- What are the differences?

3

CLINICAL SUPERVISION – WHAT IS IT?

- In-depth regular exploration of supervisee's work with clients in a systematic & planned way
- Integrates into practice:
 - self-awareness
 - relevant theories
 - up-to-date knowledge
 - skills development

4

CLINICAL SUPERVISION IS NOT...

- A measure to meet administrative or managerial goals
 - Strict confidentiality applies (with the usual mandatory reporting requirements re: imminent risk)
 - Ideally the supervisee should not be accountable operationally or professionally to the supervisor
- To emphasize the distinction:
"...clinical supervision focuses on the development of the supervisee specifically as an effective clinician."

Hart 1982

5

BENEFITS OF CLINICAL SUPERVISION

- Improved service to clients
- Higher practitioner job satisfaction
- Less burnout
- Decreased staff turnover
- Lower administration costs
- New skills
- Improved staff communication
- Improved client outcomes? – Needs research

6

COMMON BARRIERS TO SUPERVISION

- Managers do not understand benefits
- Supervisors not trained/experienced
- Supervision program not institutionalized
- Confusion over clinical & managerial supervision
- Lack of common understanding of concepts & terminology
- Inadequately funded
- Difficulties with access

7

DEVELOPING A SUPERVISION POLICY

Each organization needs to develop a supervision policy in conjunction with its workers to ensure the following:

- Common understanding of the purpose
- Clear structure – how, when, where, how often
- There are no barriers to supervision

8

Unit 9.1

PRINCIPLES OF LEARNING WITH SUPERVISION

Learning optimally:

- is self-directed
- is directed by goals and related tasks

9

PROBLEM SOLVERS ARE MORE...

- Curious
- Confident in dealing with uncertainty and complexity
- Able to:
 - take initiative
 - reflect critically
 - evaluate their own performance
 - use supervision and resources effectively

10

SELF-DIRECTED PROBLEM-BASED LEARNING

Supervisor acts as a prompt & resource

- Question generating
 - Which intervention(s) work for a particular client and how best to deliver?
 - What is the best way to proceed in investigating?
- Review and refine until a clear plan can be developed

11

SUPERVISION: GOALS & RELATED TASKS

- Learning is more effective when learning objectives coincide with medium-term goals (over several months of supervision)
- Identify tasks that are required to achieve medium-term goals (task-centered approach)

12

GOALS

- Goals and action plans must be negotiated closely with the supervisee
- SMART goals
 - Specific
 - Measurable
 - Achievable (agreeable)
 - Realistic
 - Timely
- Written down, contracted

13

PAVING THE WAY FOR SUPERVISION

- Preparing the supervisee
- Building belief
- 'Match-making' - finding the best fit

14

WHY MIGHT A SUPERVISEE BE CONCERNED ABOUT SUPERVISION?

- Uncertainty about what is involved
- Loss of independence & autonomy
- Feeling scrutinized, spied on, interrogated
- Potentially open to criticism

15

PREPARING THE SUPERVISEE

What will supervisees need to know?

- Why supervision is necessary
- What to expect
- Their work-related goals
- How to contribute to supervision planning
- The range of training & observation techniques
- Procedures for resolving disputes with a supervisor

16

Unit 9.1

SUPERVISION “MATCH-MAKING”

What are the characteristics of a good supervisor-supervisee relationship?

- Similar ‘world-view’ & shared cultural experiences
- Shared theoretical orientation
- Same profession
(or at least considerable overlap of training and experience)
- Comfortable gender and/or sexual orientation match

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SUMMARY

Clinical supervision is in-depth, regular exploration of a supervisee’s work in a systematic and planned way.

- There are many benefits of clinical supervision, including improved services for clients, higher practitioner job satisfaction, and decreased staff turnover.
- Organizations must have supervisory policies in place.
- There are different ways that supervisees can learn and benefit from clinical supervision.

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Unit 9.2

THE BASICS OF CLINICAL SUPERVISION

Learning Objectives

At the end of this unit, participants will:

- understand the structure and procedures of supervision
- understand the core content of a supervision session
- understand the basics of a case review session

Content and Timeline

Introduction	1 minute
Presentation	50 minutes
Conclusion	4 minutes
Roleplay	60 minutes

Unit 9.2



LEARNING OBJECTIVES

At the end of this unit, participants will:

- understand the structure and procedures of supervision
- understand the core content of a supervision session
- understand the basics of a case review session

2

CLINICAL SUPERVISION

- In-depth regular exploration of a supervisee's work in a systematic & planned way
- Integrates into practice:
 - self-awareness
 - relevant theory
 - up-to-date knowledge
 - skills development

3

SUPERVISION PROCEDURES (1)

Critical issues:

- Establish confidentiality (and its limits)
- Define clinical supervision
 - for the professional well-being & development of the clinician
 - in contrast to line management/supervision
 - not therapy
- Procedure for disputes & grievances

4

SUPERVISION PROCEDURES (2)

Discuss the nature of the supervisory relationship

- Ensure appropriate matching & supervisee choice
- Mutual obligations (an informal contract)
- More goal-orientated than mentoring

5

BRINGING STRUCTURE TO SUPERVISION

- Negotiate degree of structure
 - Informed by organizational requirements
- Agree on what to do & how to go about it
 - Plans & goals for learning
 - Frequency and timing of sessions
 - Style
 - * Mainly case-review, problem solving, skills development, or a more general, reflective process?
 - Supervisor to set tasks?
 - Frequency and process for reviews

6

THE SUPERVISOR'S ROLE

- Skills development
- Provision of support
- Administrative
- Evaluative

7

THE SUPERVISOR'S ROLE: SKILLS DEVELOPMENT

- Evaluates clinical interactions
- Identifies and reinforces effective actions
- Teaches and demonstrates counseling techniques
- Explains the rationale for strategies and interventions
- Interprets significant events

8

Unit 9.2

THE SUPERVISOR'S ROLE: SUPPORT

- Encourages; reduces feelings of isolation; normalizes the difficulty of AOD work and feelings of professional uncertainty

"The supportive functions of clinical supervision include handholding, cheerleading, coaching, morale building, burnout prevention, and encouragement of personal growth. In certain respects the supervisor may be said to befriend the supervisee, although the boundaries of the professional situation make a close personal relationship between the two inappropriate."

Powell 1980 9

THE SUPERVISOR'S ROLE: ADMINISTRATIVE

- Keeps (confidential) notes relating to the sessions
- Confirms to management that supervision took place according to schedule, and that supervision has conformed to agency guidelines
- Notifies relevant authorities of potential for imminent harm and unethical conduct as per mandatory reporting requirements

10

THE SUPERVISOR'S ROLES: EVALUATION

- Assesses & monitors skills & development
- Clarifies clinical performance standards
- Negotiates goals & monitors achievement
- Provides clear & constructive feedback
 - Focuses on strengths unless behavior is dangerous/unethical
 - Tries to empower supervisees to make decisions on their own about how to improve

11

SUPERVISION: ELEMENTS FOR STAFF DEVELOPMENT

- Topics
- Competencies
- Issues

12

STAFF DEVELOPMENT: TOPICS

A few examples:

- Risk - factors & related harm
- Use of multiple drugs
- Comorbid conditions

13

STAFF DEVELOPMENT: COMPETENCIES

A few examples:

- Generic counseling skills
(e.g. empathy, reflective listening, paraphrasing, motivational interviewing, closure skills)
- Assessment skills
- Case planning & management skills
(e.g. liaison, referral, client sharing, reports & records)

14

STAFF DEVELOPMENT: ISSUES

A few examples:

- Legal & ethical issues
- Addiction treatment issues:
 - mode of delivery (e.g. community-based brief interventions, outpatient counseling, residential)
 - cross-cultural concerns
 - needs of disadvantaged populations

15

METHODS FOR TRAINING & OBSERVATION

16

Unit 9.2

CASE REVIEW & ANALYSIS

- Mostly by case presentation
 - Counselors should identify key client information, problems and potential solutions
 - Supervisors should use reflective listening to assist counselors to produce a prognosis and suggested treatment plan
- Supervisors can model/demonstrate a case presentation

17

SKILL REHEARSAL & ROLE MODELING

Skill rehearsal via role-play

- Establish a clear & realistic clinical scenario
- Do not construct extreme scenarios/emotions
- Swap roles so the supervisee has turns at being a client & counselor
- Always debrief & give feedback
- End with summary statement of concepts covered

18

CO-FACILITATION

Supervisor attends & contributes to (but does not take over) a counseling session

- Powerful learning technique
- Particularly useful in early stages of a supervisory relationship & when the supervisee is acquiring new skills
- Choose a client who seems robust enough to cope with two counselors (obtain informed client consent)

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DIRECT OBSERVATION (1)

Choose the client:

- Client should trust the counselor (counselor contacted client at least two times)

Steps for observation:

1. Greet and ask if observation is OK
 - Tell the client the purpose of the observation
 - Emphasize CONFIDENTIALITY
 - Ask about taking notes
 - Conduct observation after the client has agreed:
2. Observing:
 - Position of the observer:
 - Convenient for observing behaviors, facial features of counselor
 - Sit at 30° angle and ~1m away from back of client Key
 - Points for observation:
 - Counseling procedures
 - Counseling content
 - Skills, techniques applied

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DIRECT OBSERVATION (2)

3. Feedback:

- When: After counseling session
- Where: In private
- How:
 - Assure confidentiality
 - Give positive feedback on areas done well
 - DO NOT be critical or judgmental

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OBSERVATION TWO-WAY FEEDBACK

1. First ask the counselor the following:

- How they felt the counseling session went
- What they did well and what they would do differently

Ask about:

- counseling procedures
- skills and techniques
- contents/ plans of action

2. Then do the following:

- Comment on specific techniques and skills done well (give examples)
- Comment on what needs improvement
- Discuss solutions for improvement

22

INDIRECT OBSERVATION – RECORDING THE SESSION

- Can be video or audio
- Goals of session established before recording session
- Supervisee describes to client the purpose
- Supervisee selects segments for viewing/listening
- Tape erased/discarded after review session (as indicated to the client)

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SUMMARY

- Adult learning principles apply to clinical supervision
- Key elements for staff development in supervision are:
 - topics
 - competencies
 - issues
- The supervision strategies include:
 - case review and analysis
 - role-play
 - observation
 - co-facilitation
- Feedback must be clear, appropriate and two-way

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Unit 9.2

**1 HOUR
SUPERVISION
PRACTICE SESSION**

25

Handout 9.2-1

Definition of counseling supervision

A working relationship between a supervisor and a supervisee — the supervisee offers an account or record of his/her work to reflect on and receive feedback and/ or guidance

The objective of this alliance is to enable the supervisee to improve confidence, competence, and creativity in order to provide quality service to his/her clients. Supervision helps to ensure on-going accountability and professional development of professional staff. Supervision also provides an opportunity to prevent burnout by supporting staff with difficult situations.

The supervisor can only work with what the counselor brings. Supervision works best when counselors know how best to use it to their advantage. It may help to train counselors as supervisors so that they can better understand this relationship. The supervisory relationship is educational by nature. The supervisor is there to challenge and support. In many ways, the supervisor-supervisee relationship is like the client-counselor relationship.

The supervisory relationship:

- is purposeful
- ensures that the supervisee's concerns are explored
- facilitates change
- is confidential

Autonomy is promoted in terms of:

- choices
- decisions
- responsibilities
- actions

The supervisory relationship ensures:

- trust
- honesty

Handout 9.2-1

Purpose of supervision:

1. Ethical

Supervision is an ethical requirement for practicing counselors. Drug addiction counseling is new to many countries in the world and further discussion is required in order to regulate and make it professional. Supervision is a way of maintaining accountability among those who offer their services as counselors to the public. This is the way to ensure that counselors are working responsibly and to the best of their abilities.

2. A necessary resource

Supervision is a requirement for all counselors, no matter how experienced or talented. Counseling is often highly personal and taxing because the counselor may:

- be working with people when they are at their most vulnerable, distressed and needy
- become hardened or burned out without realizing it, which will reflect on their work
- work with clients who leave the session puzzled and confused
- need to be encouraged to continue their professional development
- exploit his/her clients without realizing it

Supervision provides an opportunity for counselors to:

- explore the way they work
- obtain different perspectives on their clients
- become more aware of the way they affect and are affected by their clients - discharge their emotions and recharge their energy and ideals
- feel supported in terms of their professional competence
- receive feedback and challenge the quality of their practices
- monitor and develop ethical decision making

Propositions:

- The success of counseling supervision is dependent on the active and responsible participation of the counselor.
- A supervisor should usually have professional experience and expertise at least equal to the counselor.

Handout 9.2-1

In this respect he/she will bring knowledge, understanding and intuition to the relationship. However, in situations where there are no counselors of greater experience, it is possible for an experienced counselor to use a less experienced counselor as supervisor.

- Assumptions that relate to the “best practices” in counseling:
 -
 - Ongoing supervision helps to enable, and as far as possible, ensure the optimum service for a client (or clients collectively).
 - Supervisees are able to engage actively and effectively in the supervision relationship according to their level of skill, experience, assertiveness and self-awareness.
 - The counselor is also a facilitator. As such, she/he has a responsibility to foster the conditions that encourage her/his supervisor to provide his/her best effort.
 - A working agreement between the supervisor and supervisee is mutually and individually contracted with respect to roles, rights and responsibilities.

It is the supervisor’s responsibility to offer appropriate:

- information
- skills
- support
- challenge

Where a supervisor lacks the skills or resources to provide any of the above, he/she should provide the appropriate resources for his/her staff.

Many difficulties in supervision spring from supervisors and supervisees lack of appreciation of the risks and vulnerabilities that come with honest reflection and “adult learning” in a personal context, and therefore not talking openly about them.

There are some situations where a counselor may be stressed or distressed due to life or work pressure. This may affect his/her skill and sensitivity during counseling. In these situations, counselors will need support from their supervisors. This may also necessitate the need to terminate counseling practice for a given period of time.

Supervisors should have a mutually respectful, empathic and genuine relationship with their staff. This will facilitate the optimum environment for counselors to learn, discover and develop. Supervisors should create a safe environment with mutual trust that will encourage counselors to do the same with their clients.

Handout 9.2-1

Responsibilities of supervisors and supervisees

1. Supporting, enabling, ensuring

The supervisor must create a working relationship through which the counselor is supported to:

- work with clients who may be challenging
- work with clients in distress
- work in situations which may be confusing
- develop his/her skills
- affirm the importance of monitoring the ethics of his/her practice and who will act within contracted boundaries to ensure the protection of the client

2. Bringing, reflecting, using

Counselors should:

- be able to bring their work to their supervisors and share it freely and accessibly
- be clear about your needs from supervision
- be open to feedback, and be prepared to monitor their practices
- use the supervision to the best of their ability to improve services for clients
- monitor their use of supervision and take responsibility for giving feedback to their supervisors about its efficacy in improving services

Group supervision

Group supervision is a working alliance between a supervisor and several counselors. In group supervision, each counselor regularly offers an account or recording of his/her work, reflects on it, and receives feedback and guidance from his/her supervisor and colleagues (as appropriate). Group supervision should enable each counselor to improve in competence, confidence and creativity to serve his/her clients with quality services.

Advantages and disadvantages of group supervision

Advantages:

- There is richness in having access to and hearing other people's work
- Provides interaction with colleagues and a sense of belonging for people working in isolation
- Allows fuller feedback and reflection for counselors
- If safe, it is a place where counselors can be authentic, take risks and disclose failure or vulnerability and receive help to do something about it
- Provides an opportunity to receive support and challenge at the same time

Handout 9.2-1

- Counselors can rest as well as be active
- Provides an opportunity to learn to supervise others, and practice
- Provides a venue for facilitated, multi-dimensional feedback (more than 2 ways)

Disadvantages:

- Some may feel cautious to be authentic - this may invite competition
- There is less time for individual presentation
- Different people will experience different emotions and ideas with the same stimulus
- Family patterns often surface in groups — rivalry, etc.
- Dynamics can get messy
- Issues of confidentiality can be tricky (with regard to client, counselor and agency)

Handout 9.2-2

OBSERVATION AND FEEDBACK CHECKLIST

Counselor:

Observer/supervisor:.....

Date: Start time: : End time: :

BASIC PRINCIPLES IN DRUG ADDICTION TREATMENT COUNSELING	Good	Can be done better	Note/comments
1. Participation is totally voluntary			
2. Counselor follows confidentiality principles			
3. Counselor develops trust with patients			
4. Counselor is neutral and not judgmental			
5. Counselor is respectful to clients			
6. Safety for both clients and counselors is observed			
7. Counselor links client to other services and makes necessary referrals (if applicable)			

Handout 9.2-2

COUNSELING TECHNIQUES AND SKILLS	Good	Can be done better	Note/comments
8. Demonstrates responsive listening skills: attentive listening, receives verbal information, nonverbal contact appropriate, short verbal responses			
9. Applies questioning skills: uses open and closed-ended questions appropriately. Open-ended questions are used more frequently			
10. Able to interpret client's information			
11. Appropriate responses to different emotions of the client			
12. Probing skills: uses probing skills appropriately, explores in-depth information from client, stops and stresses points at the right time			
13. Silence skills: knows how to keep silent when client is thinking of appropriate answer or confused			
14. Able to help client become confident in confronting difficulties and challenges			
15. Affirms clients' progress and encourages them			
16. Rolls with resistance, nonconfronting: able to change client mis perceptions about drugs and drug use			

Handout 9.2-2

17. Summarization skills: summarizes after major parts of a counseling session and able to link pieces of information during the session			
18. Uses nonverbal language appropriately			
19. Uses common language to communicate with clients			
20. Analysis skills: uses clients' information to support them to develop effective problem-solving skills and short-term goals			
21. Supports clients in identifying difficulties and challenges during the implementation of problem solving and goal setting			
22. Applies appropriate counseling techniques (relapse prevention, time management, anger management, stress management etc...)			

COUNSELING PROCEDURES	Good	Can be done better	Note/comments
23. Introduces the counseling content with new clients; reviews what had been done since the previous counseling session with established clients			
24. Introduces counseling objectives (orients the counseling content)			

Handout 9.2-2

25. Provides orientation of counseling time frame			
26. Content of the counseling session focuses on a specific problem/ content/technique			
27. Summarizes main content of the counseling session and ends counseling session appropriately. Client knows next steps (action plan)			
28. Adequate documentation during and following the counseling session			
29. Determines the client's commitment to implement plan			
30. Determines the client's confidence to implement the plan			
31. Makes an appointment for a following session with specific time and place			

Other comments:

.....

.....

.....

.....

.....

Observer

Counselor

Handout 9.2-2

HOW TO USE THE OBSERVATION AND FEEDBACK CHECKLIST

1. Observers

- Counselors
- Clinical supervisors at district/provincial level
- Non-government organization program officers
- Independent observers

2. People being observed

- Counselors

3. Observation frequency

- New counselors: at least 1 time/week for the first 6 months
- After 6 months, at least 2 times/year

4. Observation steps

- Ask for client's consent: Counselor needs to explain that the purpose of the observation session is to improve the quality of counseling services provided by the counselor.
- Observer can only observe the counseling session when the client voluntarily agrees.
- Confidentiality commitment: Counselor and observer need to explain to client that they are committed to keeping client's information confidential.
- Selection of observation position: The observer observes the counselor (not the client) so the observer needs to choose a position where he/she can observe counselor's behavior, speech, and body language. Choose a distance that is neither too far nor too close (observer must be able to hear and observe without disturbing the session). Observer should not be visible to the client.
- The best position to observe is behind client (roughly 1m with on a 30 degree angle to the line of communication between counselor and client).
- Observation implementation: Observer (a) observes counselor's nonverbal language during the counseling session, (b) listens to the story between counselor and client, and (c) takes notes on the checklist. Special comments should be written down in the "comments" column. During observation, the observer should be silent to avoid distracting the client or embarrassing the counselor.
- Even when counselor provides wrong information or uses strategy to which observer is opposed, remain silent and neutral unless there are concerns about safety and well being. All cell phones should be turned off.

Handout 9.2-2

5. How to provide positive two-way feedback

- When giving feedback: Observer should give feedback as soon as possible after the counseling session. If feedback is given too late, both counselor and observer may forget important details.
- Where to provide feedback: Feedback should be provided in a private place to ensure that other people cannot hear the discussion between the observer and counselor.
- Principles of feedback: Observers need to show a respectful attitude toward counselors and commit to keeping the observations and feedback confidential.
- Feedback content should be constructive: Praise specific things that counselor has done well and provide solutions that help counselor improve the specific things that he/she needs to do better. Do not judge or criticize. Do not give non-specific feedback. Try to remain objective and do not include personal feelings when giving feedback. At the end of the feedback session, the observer should give the checklist to the counselor.
- Feedback order: 1) ask counselor what he/she things was done well and what he/she feels he/she could have done better during the counseling session; 2) recognize strengths and counseling skills that were been done well; 3) discuss what could have been done better; and 4) identify solutions to improve the things that could have been done better.
- Principles of receiving feedback: Counselor should be open-minded when he/she receives feedback. Do not be defensive. If there is any feedback that is unclear or confusing, it should be clarified with the observer. Do not personalize the feedback.

Unit 9.3

CASE CONFERENCING

Learning Objectives

At the end of this session the participants will be able to:

- discuss group consultation through clinical case conferencing and the pitfalls of this approach
- describe one approach for implementing clinical case conferencing

Content and Timeline

Introduction	1 minute
Presentation	30 minutes
Conclusion	4 minutes

Unit 9.3



LEARNING OBJECTIVES

At the end of this unit, participants will be able to:

- discuss group consultation through clinical case conferencing and the pitfalls of this approach
- describe one approach for implementing clinical case conferencing

2

CASE CONFERRING GROUP DISCUSSION

- Small-group discussion
 - 4-8 members for 1.5 – 2 hrs
- Benefits:
 - Counselors learn from each other's experiences
 - Cost-effective
 - Supportive

3

GROUP DISCUSSION: POTENTIAL DISADVANTAGES

- Finding time
- One or more members may dominate
- One or more members may be passive
- Destructive criticism by fellow workers
- Competitiveness may arise
- Counselor may resist the group's attempt to change/improve his/her case management

**Skilled facilitation may avert
many of these possibilities**

4

GROUP DISCUSSION: OPTIONS

- Group focus
(Supervisor attends to all members simultaneously)
- Peer-led (no supervisor)
- Cooperative
(Supervisor facilitates the group to supervise itself)
 - Peer-led & cooperative formats are an option for experienced workers and cohesive groups

5

OUTLINE OF CASE PRESENTATION

- Basic demographic information
- Living arrangements
- Relationship with family and partner
- Employment and education status
- Drug consumption;
 - Quantity, frequency, route of administration
 - Severity of addiction
 - Duration of current drug use
 - Duration of current treatment
 - Aged commenced use
 - Previous treatment episodes
 - Other drug use
- Health, social, physiological, legal, financial, vocational or spiritual problems
- Summary;
 - Review of current situation
 - Assessment of individual strengths and needs
 - Assessment of constraints and opportunities
 - Assessment of support needed

6

PROCEDURES

Treatment plans should contain:

- a review of the individual's current situation
- an assessment of the individual's strengths and needs
- an assessment of the constraints and opportunities for meeting needs and practical strategies for achieving these
- an assessment of the support needs for the individual to achieve desired objectives
- methods for evaluating outcomes

7

SUMMARY

- Regular small-group case conferences of client progress are important
- Setting ground rules for the discussion is critical
- Each case should be reviewed by its counselor on a six-monthly basis
- Major outcomes of case conferences should be documented in case notes

8

Unit 9.4

PREVENTING AND MANAGING BURNOUT

Learning Objectives

At the end of this activity the participants will understand:

- recognize the differences between stress and burnout
- identify the main features of burnout
- develop strategies to address stress and prevent burnout

Content and Timeline

Introduction	1 minutes
Presentation	50 minutes
Conclusion	4 minutes

Unit 9.4



LEARNING OBJECTIVES

At the end of this unit, participants will:

- recognize the differences between stress and burnout
- be able to identify the main features of burnout
- know how to develop strategies for addressing stress and preventing burnout

2

WHAT IS BURNOUT?

- *“A syndrome of depersonalization, emotional exhaustion and a sense of low personal accomplishment that leads to decreased effectiveness at work” (Shanafelt 2002).*
- A state of mental and/or physical exhaustion caused by excessive and prolonged stress

3

BURNOUT VS. STRESS

- Stress is a subjective feeling, based on an individual perspective
- What one person finds stressful, another may not
- Burnout is not simply excessive stress, but a complex human reaction to stress

4

STRESS

BURNOUT

■ Characterized by over engagement	■ Characterized by disengagement
■ Emotions over-reactive	■ Emotions blunted
■ Produces urgency and hyperactivity	■ Produces helplessness and hopelessness
■ Loss of energy	■ Loss of motivation, ideals and hope
■ Leads to anxiety disorders	■ Leads to detachment and depression

5

WHAT CAUSES STRESS & BURNOUT?

Brainstorm:

- What are the causes of stress/burnout...
 - at work?
 - because of lifestyle choices?
 - because of personality?
- How might this lead to possible “burnout”?

6

WORKPLACE CAUSES OF BURNOUT

- Excessive workload
- Lack of support/recognition
- Little or no control over your work
- Roles not clearly defined
- Reduced advancement opportunities
- Poor leadership
- Conflict

7

LIFESTYLE CAUSES OF BURNOUT

- Working too much, without enough time for relaxing and socializing
- When expected to be too many things to too many people
- Taking on too many responsibilities, without enough help from others
- Not getting enough sleep
- Lack of close, supportive relationships

8

Unit 9.4

PERSONALITY-RELATED CAUSES OF BURNOUT

- Perfectionism
- Need for control
- Exaggerated sense of responsibility
- Difficulty asking for help
- Excessive, unrealistic guilt
- Suppression of feelings
- Difficulty taking vacations and enjoying leisure time

9

BURNOUT – STAGE 1

- Initial belief that new position will satisfy your expectations
- You have boundless energy and enthusiasm
- You have a positive outlook on your new position and believe that anything is possible and achievable

10

BURNOUT – STAGE 2

- Awareness that expectations were unrealistic
- Needs are not satisfied
- Rewards and recognitions are scarce
- Disillusionment and disappointment grow

11

BURNOUT – STAGE 3

- Early enthusiasm and energy give way to chronic fatigue, irritability and other burnout symptoms (physical, psychological and social)

12

BURNOUT – STAGE 4

- Despair is dominant
- Pessimistic attitude
- Exhaustion - both physical and mental
- Life seems pointless

13

SMALL-GROUP EXERCISE

- What are some strategies that you currently use to reduce stress and prevent burnout?
- What are other strategies that you could use?

14

PERSONAL INVENTORY

- Maintain awareness of stress and burnout “early warning signs”
- Believe you can change your behavior
- Develop a personal “stress and burnout” management plan

15

PHYSICAL HEALTH MANAGEMENT

- Rest - helps your body to regenerate
- Proper nutrition
- Exercise
- Deep breathing - calms you
- Relaxation
- Good posture - helps circulation

16

Unit 9.4

MENTAL HEALTH MANAGEMENT

- Take responsibility for your own thoughts and attitudes
- Nurture friendships
- Maintain a balanced life
- Rely on your sense of humor

17

PEER SUPPORT

- Get involved with a network of counselors who share both their stress and successes

18

SIGNS & SYMPTOMS OF BURNOUT

- Negative outlooks (work and personal life)
- Inability to express empathy towards clients
- Physical and emotional exhaustion
- Detached from colleagues
- Aggressive towards staff and clients
- Overall job dissatisfaction
- Excessive mistakes
- Feeling hopeless and disempowered
- Easily frustrated
- Feel you accomplish little no matter how hard you work
- Excessive sick leave

19

BURNOUT RECOVERY

- Slow down
- Get support
- Reevaluate your goals and priorities

20

SUMMARY

- Burnout is a state of mental and/or physical exhaustion caused by excessive and prolonged stress
- Burnout is influenced by:
 - stress at work
 - your lifestyle
 - your personality
- There are things you can do to reduce the risk of burnout
- There are things you can do if burnout occurs

21

Handout 9.4-1

Counseling supervision and support

It is important to acknowledge that drug counseling can be stressful and entails giving a lot of yourself, not just time and energy, but compassion, understanding and hope. Drug counselors, as well as other service providers, encounter many life-and-death issues when attending to their clients that can affect them physically, mentally and spiritually. It is necessary to find a balance, personally and professionally, to sustain your own health and continue working in this field. Be sure to encourage counselors to be aware of signs that they are overworking or not coping well.

Consider the whole person when using the personal approach to take care of yourself. The “whole person” is the body, the mind and the spirit. Providers often only consider one aspect of their “whole” person. They might focus on the body aspect, which is their physical health; or the “mind” aspect, which can be their attitude, or the “spiritual” aspect, which is their sense of peace. These three entities — body, mind and spirit — are connected to each other. There needs to be a balance between these entities: all parts need to be equally nourished. For example, a physically well-nourished person should not neglect his/her spiritual and mental needs. Counselors must also be aware that they are not expected to help clients deal with all of their needs. It is important to establish clear boundaries between our understanding of who we are, who the client is, and what needs both bring to the interaction. When assessing the client’s needs, it is important for the provider to consider, “What can I accomplish here?” and “What am I not able to accomplish?” Counselors can refer their clients to other agencies in the community, and it is important that counselors are familiar with these resources.

If we are clear about our own roles and expectations as counselors, we can help the client to establish clarity as well. In many situations, the combination of a provider’s sense of high commitment, the stress of the job, the lack of adequate support, and the isolation they might feel, can lead to “burnout”. To maintain a sense of balance and establish continuity or longevity in this field, it is important for a counselor to:

- ask for help when they need it
- know his/her personal limits and be able to say “no”
- be able to separate the personal from the professional
- use supervision or client support to discuss their concerns about the work
- be aware of his/her own biases and stereotypes
- learn to be assertive and to set limits with other staff and boundaries with clients
- continue learning new skills and requesting feedback on his/her work

Handout 9.4-1

Counselor support

Counselors should think about their network of colleagues, friends, family, supervisors etc. to see how they can meet these following needs:

- Sharing their work issues in a confidential manner
- Obtaining feedback/guidance
- Developing professional skills, ideas, information
- Venting emotions if they are angry, fed up, and discouraged
- Acknowledging feelings of distress, pleasure, failure and so on
- Feeling valued by those they count as colleagues
- Increasing their physical, emotional or spiritual wellbeing

Some sources for support and recreation include your co-workers, boss, partner, friend, husband, wife, uncle, aunt, cousin, grandmother, weekend workshops, counseling, massage, work team, consultant, religious leader, staff meetings, pets, students, in-service training, television, radio, sport, prayer, meditation, music, dance, literature and so on.

Personal inventory

- How do I know when I am under stress? (This can include physical, emotional and behavioral signs.)
- What are the signs of stress that others recognize in me?
- What are the most frequent sources of stress for me at work? (This can include clinical and administrative issues).
- What are some strategies that I currently use to decrease stress?
- What are some other strategies that I would like to use to decrease stress?

Counseling is a discipline that requires ongoing practice as well as monitoring of the use of such skills by a competent supervisor. The counselor who wishes to provide a therapeutic outcome for clients can only do so after much self-examination, practice of counseling skills, and an understanding of counseling theory.

Please do not provide counseling services while you are under stress, crisis or in a difficult emotional situation. Unless the situation is under control, it is difficult for you in such situations to provide professional counseling. If it is hard for you to make a wise decision yourself, it will be even harder when you are in the role of a counselor.

Handout 9.4-1

Self-care

Counselors and case managers can adversely affect their clients if they do not take responsibility for managing their stress levels. Absenteeism, work avoidance and chronic illness may all be manifestations of counselor stress.

There are two types of stress release:

- Active: Physical release through intense physical activity. This is particularly useful for reducing anger and frustration.
- Passive: Meditation and other relaxation techniques that can assist with nervousness, fatigue or sleep difficulties

Other strategies for managing work-related stress:

- Debrief with a colleague or supervisor (while maintaining client confidentiality)
- Success recording: Challenge yourself to record what you have achieved
- Journal writing
- Other personal self-care strategies

Handout 9.4-2

SELF-ASSESSMENT TOOL: SELF-CARE TO PREVENT BURN OUT

This assessment tool provides an overview of effective strategies to maintain self-care. After completing the full assessment, choose one item from each area that you will actively work to improve

Rate yourself, using the numerical scale below, to fill in the empty boxes: 5 = Frequently, 4 = Occasionally, 3 = Sometimes, 2 = Never, 1 = It never even occurred to me

How often do you do the following activities?

Physical Self-Care

- Eat regularly (that is, breakfast, lunch, and dinner)
- Eat healthy
- Exercise
- Lift weights
- Practice martial arts
- Get regular medical care for prevention
- Get medical care when needed
- Take time off when you're sick
- Get massages or other body work
- Do physical activity that is fun for you
- Get enough sleep
- Wear clothes you like
- Take vacations
- Take day trips or mini-vacations
- Get away from stressful technology such as mobile phones, e-mail, internet,
- Other: _____

Psychological Self-Care

- Make time for self-reflection
- Go to see a counselor
- Write in a journal
- Read literature unrelated to work
- Do something at which you are a beginner
- Take a step to decrease stress in your life
- Notice your inner experience – your dreams, thoughts, imagery, and feelings
- Let others know different aspects of you
- Engage your intelligence in a new area – go to an art museum, performance, sports event, exhibit, or other cultural event
- Practice receiving from others
- Be curious
- Say no to extra responsibilities sometimes

Handout 9.4-2

- Spend time outdoors
- Other: _____

Emotional Self-Care

- Spend time with others whose company you enjoy
- Stay in contact with important people in your life
- Treat yourself kindly (for example, by using supportive inner dialogue or self-talk)
- Feel proud of yourself
- Reread favorite books and see favorite movies again
- Identify comforting activities, objects, people, relationships, and places, and seek them out
- Allow yourself to cry
- Find things that make you laugh
- Express your outrage in a constructive way
- Play with children
- Other: _____

Spiritual Self-Care

- Make time for prayer, meditation, and reflection
- Spend time in nature
- Participate in a spiritual gathering, community, or group
- Be open to inspiration
- Cherish your optimism and hope
- Be aware of nontangible (nonmaterial) aspects of life
- Be open to mystery and not-knowing
- Identify what is meaningful to you and notice its place in your life
- Sing
- Express gratitude
- Celebrate milestones with rituals that are meaningful to you
- Remember and memorialize loved ones who are dead
- Nurture others
- Contribute to or participate in the causes you believe in
- Read inspirational literature
- Listen to inspiring music
- Other: _____

Workplace/Professional Self-Care

- Take time to eat lunch with co-workers
- Take time to chat with coworkers
- Make time to complete tasks
- Identify projects or tasks that are exciting, growth-promoting, and rewarding for you
- Set limits with clients and colleagues

Handout 9.4-2

- Balance your workload so that no particular day is ‘too much!’
- Arrange your workspace to make it comfortable and comforting
- Get regular supervision or consultation
- Negotiate for your needs, such as benefits and pay raises
- Have a peer support group
- Other: _____

This handout was adapted from *Transforming the Pain: A Workbook on Vicarious Traumatization* by Karen Saakvitne and Laurie Anne Pearlman, published in 1996 by TSI Staff.

Training Curriculum on Drug Addiction Counseling

■ **Chapter 1.** Participant Orientation

■ **Chapter 2.** What is Drug Addiction Counseling?

■ **Chapter 3.** Drugs, Drug Addiction, and Treatment Approaches

■ **Chapter 4.** Motivational Interviewing

■ **Chapter 5.** Key Drug Addiction Counseling Skills and Techniques

■ **Chapter 6.** Relapse Prevention

■ **Chapter 7.** Managing Intoxication and Hostility

■ **Chapter 8.** Special Populations

■ **Chapter 9.** Clinical Supervision and Support