

Leader's Guide Drug Addiction and Basic Counselling Skills

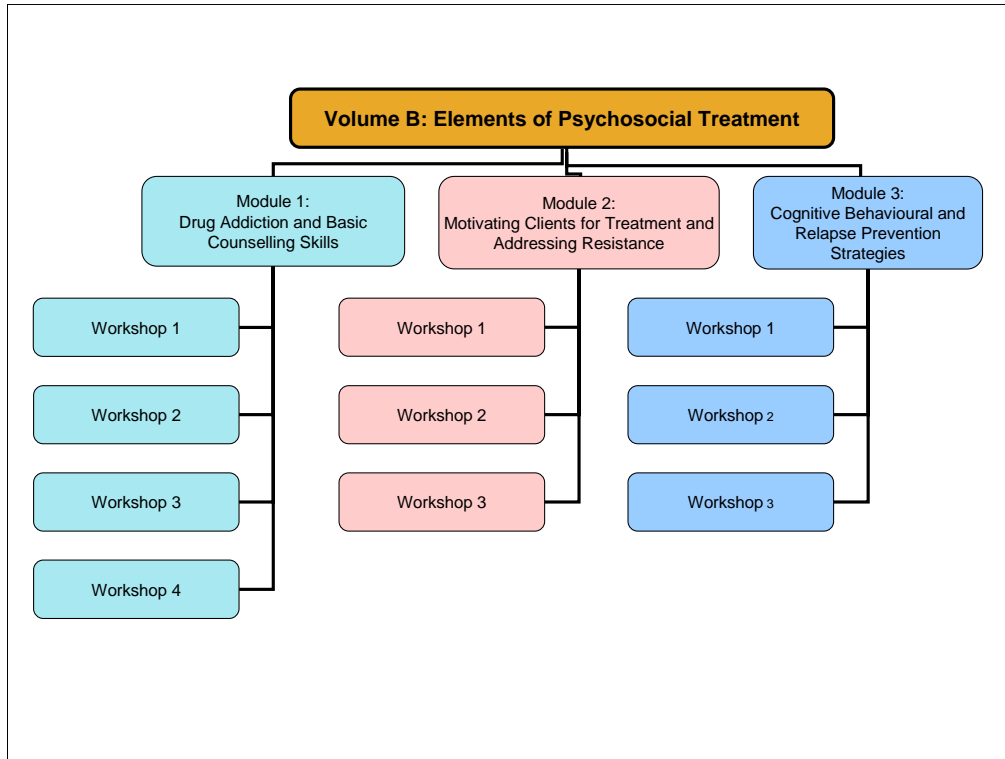


Treatnet Training Volume B, Module 1: Updated 13 February 2008

1

Instructions

1. Introduce yourself.
2. Explain the purpose of this series of trainings sponsored by the United Nations Office on Drugs and Crime: “The capacity building programme mission is to transfer technology and knowledge on substance abuse intervention to service providers in the participating local areas. Service providers include managers, physicians and psychiatrists, counsellors, psychologists, social workers, peer educators, outreach workers, and other professionals working in the substance abuse field.”
3. Thank participants for their interest in this series of trainings before starting your presentation.



Instructions

Review the organization of Volume B using the provided chart.

Module 1: Training goals

1. Increase knowledge of the biology of drug addiction, principles of treatment, and basic counselling strategies
2. Increase skills in basic counselling strategies for drug addiction treatment
3. Increase application of basic counselling skills for drug addiction treatment activities

3

Instructions

1. Read the training goals to your audience.
2. Explain that it is very important that participants not only gain new knowledge during this training but that they also practise the new skills so that they can apply them to their everyday work with clients who have substance abuse problems.
3. Also explain your training and follow-up plans to participants. Stress that after this training, you will be available to answer questions and provide feedback and advice regarding their demonstrations of the newly learned techniques and skills.

Module 1: Workshops

Workshop 1: Biology of Drug Addiction

Workshop 2: Principles of Drug Addiction Treatment

Workshop 3: Basic Counselling Skills for Drug Addiction Treatment

Workshop 4: Special Considerations when Involving Families in Drug Addiction Treatment

4

Instructions

1. Read the name of each workshop to your audience.
2. Explain that Workshops 1 and 3 are more extensive than Workshops 2 and 4.
3. Review your agenda with the audience.
4. Explain that Workshop 3 is extremely important and that extensive practising is required for that particular workshop.

Icebreaker: If I were the President

If you were the President (King, Prime Minister, etc.) of your country, what 3 things would you change related to drug policies, treatment, and / or prevention?



15 minutes

5

Instructions

This activity is optional.

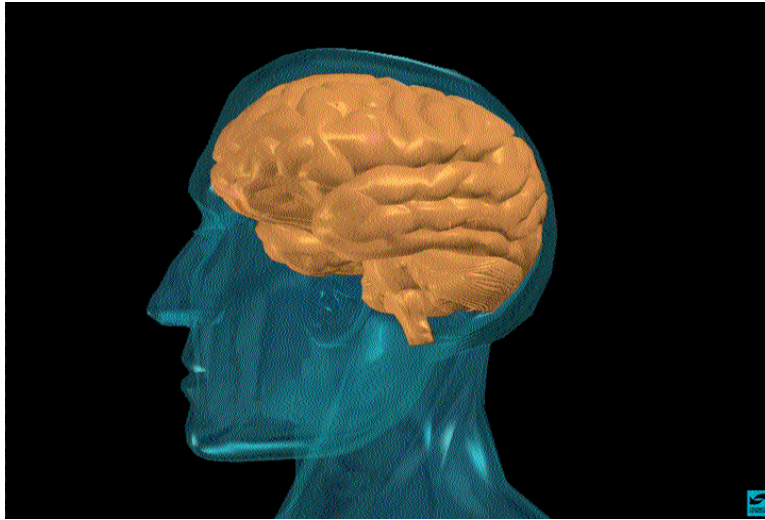
1. Read the icebreaker to your audience.
2. Encourage participation by respecting participants' opinions. Every comment is welcome.

Notes for the Trainer

You may adjust the number of items they comment on according to the number of participants. If you have more than 12 participants, you might ask them to say only one thing that they would change.

Remember that the purpose of icebreakers is to motivate and involve participants at the beginning of a training session by introducing a fun exercise that requires them to interact.

Workshop 1: Biology of Drug Addiction



6

Instructions

1. Introduce Workshop 1 by reading the title.

Pre-assessment

Please respond to the pre-assessment questions in your workbook.

(Your responses are strictly confidential.)



10 minutes

7

Instructions

1. Ask participants to complete the 5-question pre-assessment.
2. Allow participants 10 minutes to complete these questions.
3. The pre-training and post-training assessments may create tension among audience members. To reduce such tension, explain to your audience that both assessments are confidential and that participants do not need to provide any personal information.
4. Explain that these assessments are conducted so as to insure that the training is appropriate for your particular audience, to measure the effectiveness of the training, and to provide opportunities for improving the trainings.

Training objectives



At the end of this workshop you will be able to:

1. Understand the reasons people start drug use
2. Identify 3 main defining properties of drug addiction
3. Identify 3 important concepts in drug addiction
4. Understand characteristics and effects of major classes of psychoactive substances
5. Understand why many people dependent on drugs frequently require treatment

8

Instructions

1. Once your audience has completed the pre-assessment, read them the training objectives
2. Explain to participants that these objectives should be achieved as a team.

Introduction to Psychoactive Drugs

9

Instructions

1. Tell participants that you will now provide an introduction to psychoactive drugs.

What are psychoactive drugs? (1)

“...Any chemical substance which, when taken into the body, alters its function physically and/or psychologically....”

(World Health Organization, 1989)

“...any substance people consider to be a drug, with the understanding that this will change from culture to culture and from time to time.”

(Krivanek, 1982)

10

Instructions

1. Read the World Health Organization definition of psychoactive drugs.
2. You might invite participants to give their own definitions of “a drug.”

Additional Information for the Trainer

When absorbed into the body, drugs interact with and modify cells, organs, and bodily systems by:

- Altering the way the body normally functions (increasing, slowing, or enhancing bodily processes, or level or quality of functioning)
- Altering the operation of tissues, organs, and systems
- Affecting hormones and enzymes
- Impacting processes such as digestion, respiration, circulation, and mental functioning

The second definition introduces the social and political context of drug use and the notion that perceptions, laws, and practises regarding drugs and their use may change over time.

(Source: Slide and notes adapted from the National Centre for Education and Training on Addiction [NCETA], Australia, 2004.)

What are psychoactive drugs? (2)

Psychoactive drugs interact with the central nervous system (CNS) affecting:

- mental processes and behaviour
- perceptions of reality
- level of alertness, response time, and perception of the world

11

Instructions

1. Read the slide to your audience.
2. Explain that these drugs achieve their effects by interacting with the central nervous system (CNS).
3. Provide some examples from the following:
 - Examples of affected mental processes and behaviour: memory, attention, the way people talk, increased impulsiveness or aggressiveness.
 - Examples of altered perceptions of reality. For instance, psychoactive drugs change alertness, response time, and perception of the world. For example, they can slow down reaction time while driving. Some can cause visual/auditory hallucinations.

(Source: Slide and notes adapted from NCETA, 2004.)

Why do people initiate drug use? (1)

Much, if not most, drug use is motivated (at least initially) by the pursuit of pleasure.



12

Instructions

1. Read the slide to your audience.
2. You might invite participants to give their own opinion about why people start drug use.

(Source: NCETA, 2004.)

Why do people initiate drug use? (2)

Key Motivators & Conditioning Factors

- Forget (stress / pain amelioration)
- Functional (purposeful)
- Fun (pleasure)
- Psychiatric disorders
- Social / educational disadvantages

Also, initiation starts through:

- Experimental use
- Peer pressure



13

Instructions

1. Read the slide to your audience.
2. Explain to participants that while there are many reasons for the initiation into and continued use of both licit and illicit drugs, key motivators pivot around the main factors included in the slide.
3. Explain that these motivators are not mutually exclusive. They may co-occur for many people. A person may take drugs for any or all of the reasons shown.
4. Explain that a person may not be aware that these are the underpinning drivers of drug use. For example, a young woman who finally gets into treatment, after being referred by her general practitioner, may realize during treatment that traumatic events that happened to her in childhood (childhood sexual abuse is very common among women in AOD treatment) are integrally linked to her problematic drug use.

(Source: NCETA, 2004)

Why do people initiate drug use? (3)

After repeated drug use, “deciding” to use drugs is no longer voluntary because

DRUGS CHANGE THE BRAIN!

14

Instructions

1. Read the slide to your audience.
2. Explain that Workshop 1, “Biology of Drug Addiction,” will explore how psychoactive drugs change the way the brain works.

What is Drug Addiction?

15

Instructions

1. Read the slide to your audience.

What is drug addiction?

Drug addiction is a complex illness characterised by compulsive, and at times, uncontrollable drug craving, seeking, and use that persist even in the face of extremely negative consequences.

16

Instructions

1. Read the slide to your audience.
2. Explain that drug addiction is a state in which an organism engages in a compulsive behavior, even when faced with negative consequences. This behavior is reinforcing, or rewarding. A major feature of addiction is the loss of control in limiting intake of the addictive substance. The most recent research indicates that the reward pathway may be even more important in the craving associated with addiction, compared to the reward itself. Scientists have learned a great deal about the biochemical, cellular and molecular bases of addiction; it is clear that addiction is a disease of the brain. State that you will provide 2 examples of the interaction between drugs that are addictive, their cellular targets in the brain, and the reward pathway.

(Source: NIDA, 1999.)

Characteristics of drug addiction

- Compulsive behaviour
- Behaviour is reinforcing (rewarding or pleasurable)
- Loss of control in limiting intake



17

Instructions

1. Read the slide to your audience and explain the 3 main characteristics of drug addiction.
2. Use some examples. For instance, the compulsive behaviour of seeking a drug in spite of the consequences (family or job problems, being jailed).
3. Ask participants to provide some examples as well.

(Source: www.projectcork.org)

Note for the Trainer

Please be aware that the confidentiality of clients needs to be maintained. Ask for general examples and not for particular cases.

Important terminology

1. Psychological craving
2. Tolerance
3. Withdrawal symptoms

18

Instructions

1. Explain to your audience that you will review 3 important concepts related to drug addiction.
2. Read these important terms, but do not explain them at this point.

Psychological craving

Psychological craving is a strong desire or urge to use drugs. Cravings are most apparent during drug withdrawal.



19

Instructions

1. Explain to your audience what psychological craving is by reading the slide.
2. Provide some examples. For instance, a woman who quit smoking years ago, but who still feels cravings when exposed to certain situations (friends who smoke, parties, coffee time).

Tolerance

Tolerance is a state in which a person no longer responds to a drug as they did before, and a higher dose is required to achieve the same effect.



20

Instructions

1. Explain to your audience what tolerance is by reading the slide.
2. Provide some examples. For instance, a man who has been drinking heavily for a while who is able to drink more than other people and not feel the effects of alcohol because he has developed a tolerance for the drug.
3. Ask your audience to provide some examples as well.

Additional Information for the Trainer

“The most common change produced by prior experience with a drug is a decrease in responsiveness to its effects. When an organism becomes less sensitive to the actions of a drug by virtue of past experience with the drug, we refer to this change as acquired tolerance.”

(Source: NIDA Research Monograph Series, #18)

Withdrawal

The following symptoms may occur when drug use is reduced or discontinued:

- Tremors, chills
- Cramps
- Emotional problems
- Cognitive and attention deficits
- Hallucinations
- Convulsions
- Death



21

Instructions

1. Read the slide to your audience.
2. Ask participants to provide examples of withdrawal symptoms from their experience with clients.

Additional Information for the Trainer

“The essential feature of Substance Withdrawal is the development of a substance-specific maladaptive behavioural change, with physiological and cognitive concomitants, that is due to the cessation, or reduction in, heavy and prolonged substance use (Criterion A). The substance-specific syndrome causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion B). The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder (Criterion C).” (APA, 1995, p. 184-185)

(Source: American Psychiatric Association [APA]: DSM-IV, 1995)

The slide features a white background with a thin black border. A blue horizontal bar with a rounded right end is positioned in the upper third of the slide, containing the text 'Drug Categories' in white. Below this bar, a large orange outline of a rounded rectangle is centered, extending across most of the slide's width. In the bottom right corner of the slide, the number '22' is printed in a small, black font.

Instructions

1. Inform participants that you will now discuss the categories of psychoactive drugs.

Classifying psychoactive drugs

Depressants	Stimulants	Hallucinogens
Alcohol	Amphetamines	LSD, DMT
Benzodiazepines	Methamphetamine	Mescaline
Opioids	Cocaine	PCP
Solvents	Nicotine	Ketamine
Barbiturates	Khat	Cannabis (high doses)
Cannabis (low doses)	Caffeine	Magic mushrooms
	MDMA	MDMA

Instructions

1. Explain that drug classifications provide a useful reference tool for approximating relative drug effects, possible harms, and potential withdrawal features.
2. Explain that there are limitations to classifications and that classifications are intended as a general guide only, as variations in effects and intensity may occur for drugs within the same class, e.g., although ecstasy produces similar effects to amphetamines, it is not as intense and may have additional hallucinogenic effects for some people.
3. Explain that for the purposes of this training, cannabis has been placed in the central nervous system (CNS) depressants category because of its primary effects as a CNS depressant, and in the hallucinogens category because at high doses, cannabis may produce hallucinogenic effects. Opioids have been classified as CNS depressants as a result of their primary effect on the CNS.

Additional Notes for the Trainer

Abbreviations in slide

- DMT: N,N-dimethyltryptamine
- PCP: phencyclidine
- MDMA: 3,4 methylenedioxyamphetamine

(Sources: Victoria Police, 2002, *Custodial Drug Guide: Medical Management of People in Custody with Alcohol and Drug Problems*, Custodial Medicine Unit, Victoria Police, Mornington, Victoria, and NCETA, 2004.)

Alcohol



24

Instructions

1. Tell participants that you will now discuss alcohol.

Alcohol: Basic facts (1)

Description: Alcohol or ethylalcohol (ethanol) is present in varying amounts in beer, wine, and liquors

Route of administration: Oral

Acute Effects: Sedation, euphoria, lower heart rate and respiration, slowed reaction time, impaired coordination, coma, death

25

Instructions

1. Read the slide to participants.
2. Ask participants for examples of the acute effects of alcohol.

Alcohol: Basic facts (2)

Withdrawal Symptoms:

- Tremors, chills
- Cramps
- Hallucinations
- Convulsions
- Delirium tremens
- Death



26

Instructions

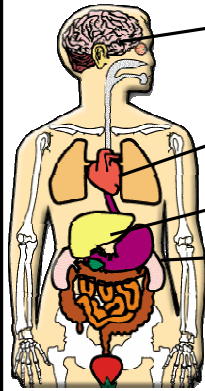
1. Read the slide to participants.

Additional Information for Trainers

Delirium tremens is a medical emergency associated with untreated alcohol withdrawal. It occurs 3-14 days after drinking is stopped. Delirium tremens include agitation, restlessness, gross tremor, disorientation, fluid and electrolyte imbalance, sweating and high fevers, visual hallucinations, and paranoia. The prevalence is < 5% of patients, and it may lead to death.

(Source: NCETA, 2004.)

Long-term effects of alcohol use



- Decrease in blood cells leading to anemia, slow-healing wounds and other diseases
- Brain damage, loss of memory, blackouts, poor vision, slurred speech, and decreased motor control
- Increased risk of high blood pressure, hardening of arteries, and heart disease
- Liver cirrhosis, jaundice, and diabetes
- Immune system dysfunction
- Stomach ulcers, hemorrhaging, and gastritis
- Thiamine (and other) deficiencies
- Testicular and ovarian atrophy
- Harm to a fetus during pregnancy

Instructions

1. Read the long-term effects of alcohol use to your audience.
2. Point to the areas of the body that are affected by the use of alcohol when reading the content to participants.

Tobacco



28

Instructions

1. Tell participants that you will now discuss tobacco.

Tobacco: Basic facts (1)

Description: Tobacco products contain nicotine plus more than 4,000 chemicals and a dozen gases (mainly carbon monoxide)

Route of administration: Smoking, chewing

Acute Effects: Pleasure; relaxation; increased concentration; release of glucose; increased blood pressure, respiration, and heart rate

29

Instructions

1. Read the slide to your audience.
2. Explain that in addition to nicotine, cigarette smoke is primarily composed of a dozen gases (mainly carbon monoxide) and tar. The tar in a cigarette, which varies from about 15 mg for a regular cigarette to 7 mg in a low-tar cigarette, exposes the user to an increased risk of lung cancer, emphysema, and bronchial disorders.
3. Explain that nicotine is absorbed readily from tobacco smoke in the lungs, and it does not matter whether the tobacco smoke is from cigarettes, cigars, or pipes. Nicotine also is absorbed readily when tobacco is chewed. With regular use of tobacco, levels of nicotine accumulate in the body during the day and persist overnight. Thus, daily smokers or chewers are exposed to the effects of nicotine for 24 hours each day. Adolescents who chew tobacco are more likely than nonusers to eventually become cigarette smokers.
4. Explain that nicotine provides an almost immediate “kick” because it causes a discharge of epinephrine from the adrenal cortex. This stimulates the central nervous system and endocrine glands, which causes a sudden release of glucose. Stimulation is then followed by depression and fatigue, leading the user to seek more nicotine.
5. Ask participants for examples of the acute effects of tobacco.

(Source: U.S. National Institute on Drug Abuse (NIDA), InfoFacts.)

Tobacco: Basic facts (2)

Withdrawal Symptoms:

- Cognitive / attention deficits
- Sleep disturbance
- Increased appetite
- Hostility
- Irritability
- Low energy
- Headaches



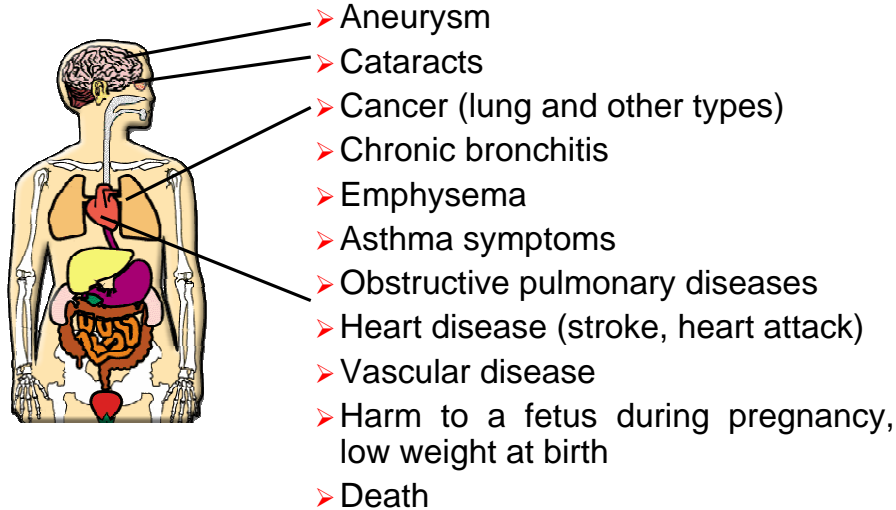
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Instructions

1. Read the withdrawal symptoms of tobacco to participants.
2. Explain that research has found that when chronic smokers are deprived of cigarettes for 24 hours, they have increased anger, hostility, and aggression, and loss of social cooperation. Persons suffering from withdrawal also take longer to regain emotional equilibrium following stress. During periods of abstinence and/or craving, smokers have shown impairment across a wide range of psychomotor and cognitive functions, such as language comprehension.

(Source: NIDA, InfoFacts.)

Long-term effects of tobacco use



Instructions

1. Read the long-term effects of tobacco use to your audience.
2. Point to the areas of the body that are affected by the use of tobacco when reading the content to your audience.
3. Explain that some of the long-term effects of tobacco use are an increased risk of lung cancer, emphysema, and bronchial disorders. The carbon monoxide in tobacco smoke increases the chance of cardiovascular diseases. The U.S. Environmental Protection Agency has concluded that secondhand smoke causes lung cancer in adults and greatly increases the risk of respiratory illnesses in children and sudden infant death.

(Source: NIDA InfoFacts.)

Additional Information for the Trainer

Emphysema is a lung disease in which tissue deterioration results in increased air retention and reduced exchange of gases. The result is breathing difficulties and shortness of breath.

Cannabinoids



Marijuana



Hashish

32

Instructions

1. Tell participants that you will now discuss cannabinoids.

Cannabis: Basic facts (1)

Description: The active ingredient in cannabis is delta-9-tetrahydrocannabinol (THC)

- **Marijuana:** tops and leaves of the plant Cannabis sativa
- **Hashish:** more concentrated resinous form of the plant

Route of administration:

- Smoked as a cigarette or in a pipe
- Oral, brewed as a tea or mixed with food

33

Instructions

1. Read the slide to your audience.
2. Explain that marijuana is a dry, shredded green/brown mix of flowers, stems, seeds, and leaves of the hemp plant Cannabis sativa. It is usually smoked as a cigarette (joint, nail) or in a pipe (bong). It also is smoked in blunts, which are cigars that have been emptied of tobacco and refilled with marijuana, often in combination with another drug. It might also be mixed in food or brewed as a tea. As a more concentrated, resinous form it is called hashish, and as a sticky black liquid, it is called hash oil. Marijuana smoke has a pungent and distinctive, usually sweet-and-sour odour.
3. Explain that the main active chemical in marijuana is THC (delta-9-tetrahydrocannabinol). The membranes of certain nerve cells in the brain contain protein receptors that bind to THC. Once securely in place, THC sets off a series of cellular reactions.
4. Ask participants for examples of the acute effects of marijuana.

(Source: NIDA InfoFacts.)

Activity 1

Think of all the names for marijuana in your community and how this drug is consumed.



Share your thoughts with the rest of the group.

34

Instructions

1. Explain that there are countless street terms for marijuana including “pot,” “herb,” “weed,” “grass,” “widow,” “ganja,” and “hash,” as well as terms derived from trademarked varieties of cannabis, such as “Bubble Gum,” “Northern Lights,” “Fruity Juice,” “Afghani #1,” and a number of “Skunk” varieties.
2. Ask participants to provide the different names for marijuana in their region.

Notes:

We recommend that you employ no more than 10 minutes for this activity.

Cannabis: Basic facts (2)

Acute Effects:

- Relaxation
- Increased appetite
- Dry mouth
- Altered time sense
- Mood changes
- Bloodshot eyes
- Impaired memory
- Reduced nausea
- Increased blood pressure
- Reduced cognitive capacity
- Paranoid ideation

35

Instructions

1. Read the acute effects of cannabis to your audience.
2. Explain that the negative short-term effects of marijuana may include problems with memory and learning; distorted perception; difficulty in thinking and problem solving; loss of coordination; and increased heart rate.
3. Ask participants to provide examples of the acute effects of cannabis from their professional experience.

(Source: Adapted from NIDA InfoFacts.)

Cannabis: Basic facts (3)

Withdrawal Symptoms:

- Insomnia
- Restlessness
- Loss of appetite
- Irritability
- Sweating
- Tremors
- Nausea
- Diarrhea



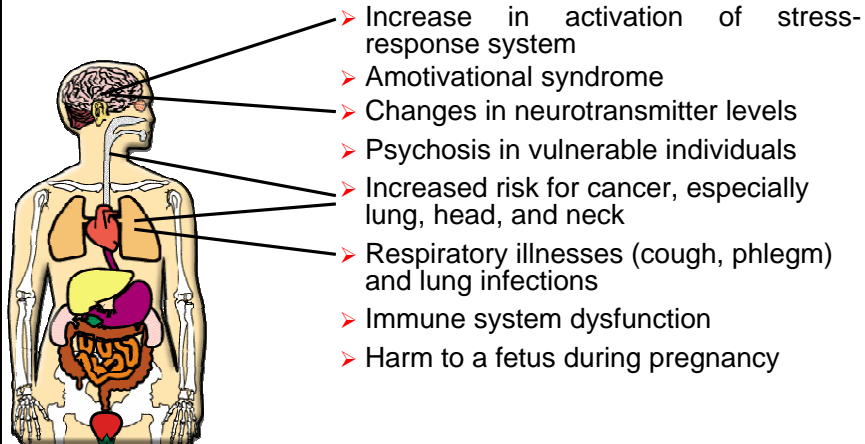
36

Instructions

1. Explain to participants that many people have believed that marijuana is not physically addictive. However, there appears to be a characteristic withdrawal profile indicating that physical dependence does actually occur.
2. Read the symptoms of cannabis withdrawal to your audience.

(Source: NIDA InfoFacts.)

Long-term effects of cannabis use



37

Instructions

1. Read the long-term effects of cannabis use to your audience.
2. Point to the areas of the body that are affected by the use of this drug.

Additional Information for the Trainer

Research findings on long-term marijuana abuse indicate some changes in the brain similar to those seen after long-term abuse of other major drugs. For example, cannabinoid (THC or synthetic forms of THC) withdrawal in chronically exposed animals leads to an increase in the activation of the stress-response system and changes in the activity of nerve cells containing dopamine. Dopamine neurons are involved in the regulation of motivation and reward, and are directly or indirectly affected by all drugs of abuse.

Frequent, long-term marijuana users may show signs of a lack of motivation and tend to perform worse at work or school in comparison to individuals who do not consume marijuana. This is sometimes termed “amotivational syndrome.” This syndrome may include fatigue, not caring about what happens in one’s life, no desire to work regularly, and a lack of concern about the way one looks. As a result of these symptoms, some users tend to perform poorly in school or at work.

(Source: NIDA InfoFacts.)

Stimulants



38

Instructions

1. Tell participants that you will now discuss stimulants, and point out the photographs of methamphetamine and cocaine.

Types of stimulants (1)

Amphetamine Type Stimulants (ATS)

- Methamphetamine
 - Speed, crystal, ice, yaba, shabu
- Amphetamine
- Pharmaceutical products used for ADD and ADHD

Methamphetamine half-life: 8-10 hours



39

Instructions

1. Read the slide to your audience.
2. Explain that methamphetamine is an addictive stimulant drug that strongly activates certain systems in the brain. Methamphetamine is chemically related to amphetamine, but the effects of methamphetamine on the central nervous system are greater. Both drugs have some limited therapeutic uses, primarily in the treatment of obesity.
3. Explain that methamphetamine is made in illegal laboratories and has a high potential for abuse and addiction.
4. Explain that methamphetamine is taken orally or intranasally (snorting the powder), by intravenous injection, and by smoking. Immediately after smoking or intravenous injection, the methamphetamine user experiences an intense sensation, called a “rush” or “flash,” that lasts only a few minutes and is described as extremely pleasurable. Oral or intranasal use produces euphoria—a high, but not a rush. Users may become addicted quickly and use the drug with increasing frequency and in increasing doses.

(Source: NIDA InfoFacts.)

Additional Information for the Trainer

Abbreviations in slide:

ADD – Attention Deficit Disorder

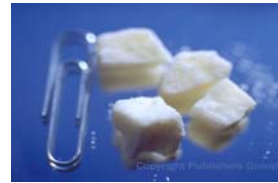
ADHD-Attention Deficit and Hyperactivity Disorder

Types of stimulants (2)

Cocaine

- Powder cocaine
(Hydrochloride salt)
- Smokeable cocaine
(crack, rock, freebase)

Cocaine half-life: 1-2 hours



40

Instructions

1. Read the slide to your audience.
2. Explain that cocaine is a powerfully addictive stimulant drug. The powdered hydrochloride salt form of cocaine can be snorted or dissolved in water and injected.
3. Explain that “crack” is cocaine that has not been neutralized by an acid to make the hydrochloride salt. This form of cocaine comes in a rock crystal that can be heated and its vapours smoked. The term “crack” refers to the crackling sound that is made when it is heated.

(Source: NIDA InfoFacts.)

Activity 2

What stimulants are used in your community and how are they consumed?



Share your thoughts with the rest of the group.

41

Instructions

1. Explain that there are countless street terms for cocaine including “coke,” “blow,” “snow,” “flake,” “toot”, etc.
2. Read the activity to your audience asking them to provide the various street names for this drug in their region.

Note

We recommend that you employ no more than 10 minutes for this activity.

Stimulants: Basic facts (1)

Description:

Stimulants include: (1) a group of synthetic drugs (ATS) and (2) plant-derived compounds (cocaine) that increase alertness and arousal by stimulating the central nervous system

Route of administration:

Smoked, injected, snorted, or administered by mouth or rectum

42

Instructions

1. Read the slide to your audience.
2. Explain that cocaine is a strong central nervous system stimulant that interferes with the re-absorption process of dopamine, a chemical messenger associated with pleasure and movement. The build-up of dopamine causes continuous stimulation of receiving neurons, which is associated with the euphoria commonly reported by cocaine users.
3. Explain that methamphetamine has strong effects on the central nervous system, even when small amounts of the drug are used.

(Source: NIDA InfoFacts.)

Stimulants: Basic facts (2)

Acute effects:

- Euphoria, rush, or flash
- Wakefulness, insomnia
- Increased physical activity
- Decreased appetite
- Increased respiration
- Hyperthermia
- Irritability
- Tremors, convulsions
- Anxiety
- Paranoia
- Aggressiveness

43

Instructions

- Read the slide to your audience.
- Explain that the physical effects of **cocaine** use include constricted blood vessels, dilated pupils, and increased temperature, heart rate, and blood pressure. The duration of cocaine's immediate euphoric effects, which include hyperstimulation, reduced fatigue, and mental alertness, depends on the route of administration. The faster the absorption, the more intense the high. On the other hand, the faster the absorption, the shorter the duration of action. The high from snorting may last 15 to 30 minutes, while that from smoking may last 5 to 10 minutes. Increased use can reduce the period of time a user feels high and increases the risk of addiction.
- Explain that effects in the central nervous system (CNS) of **methamphetamine** include increased wakefulness, increased physical activity, decreased appetite, increased respiration, hyperthermia, and euphoria. Other CNS effects include irritability, insomnia, confusion, tremors, convulsions, anxiety, paranoia, and aggressiveness. Hyperthermia and convulsions can result in death.

Stimulants: Basic facts (3)

Withdrawal symptoms:

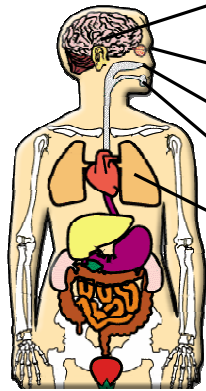
- Dysphoric mood (sadness, anhedonia)
- Fatigue
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Craving
- Increased appetite
- Vivid, unpleasant dreams

44

Instructions

1. Read the slide to your audience.

Long-term effects of stimulants



- Strokes, seizures, headaches
- Depression, anxiety, irritability, anger
- Memory loss, confusion, attention problems
- Insomnia, hypersomnia, fatigue
- Paranoia, hallucinations, panic reactions
- Suicidal ideation
- Nosebleeds, chronic runny nose, hoarseness, sinus infection
- Dry mouth, burned lips, worn teeth
- Chest pain, cough, respiratory failure
- Disturbances in heart rhythm and heart attack
- Loss of libido
- Weight loss, anorexia, malnourishment,
- Skin problems

45

Instructions

1. Read the long-term effects of stimulant use to your audience, pointing to the areas of the body that are affected by the use of these drugs.
2. Explain the long-term effects of **cocaine**: Regardless of how cocaine is used or how frequently, a user can experience acute cardiovascular or cerebrovascular emergencies, such as a heart attack or stroke, which could result in sudden death. Cocaine-related deaths are often a result of cardiac arrest or seizure followed by respiratory arrest. Use of cocaine in a binge, during which the drug is taken repeatedly and at increasingly high doses, may lead to a state of increasing irritability, restlessness, and paranoia. This can result in a period of full-blown paranoid psychosis, in which the user loses touch with reality and experiences auditory hallucinations. Other complications associated with cocaine use include disturbances in heart rhythm and heart attacks, chest pain, respiratory failure, strokes, seizures, and headaches, as well as gastrointestinal complications such as abdominal pain and nausea. Because cocaine has a tendency to decrease appetite, many chronic users can become malnourished.
3. Explain the long-term effects of **methamphetamine**: Methamphetamine releases high levels of the neurotransmitter dopamine, which stimulates brain cells, enhancing mood and body movement. It also appears to have a neurotoxic effect, damaging brain cells that contain dopamine as well as serotonin, another neurotransmitter. Over time, methamphetamine appears to cause reduced levels of dopamine, which can result in symptoms like those of Parkinson's disease, a severe movement disorder.

(Source: NIDA InfoFacts.)



Instructions

1. Explain to participants that these photos are of a woman who was a methamphetamine consumer. This is an example of how this drug can harm a person in less than 3½ years of use.

(Source: "Faces of Meth," United States, 2005.)



Instructions

1. Explain to participants that these photos are of a man who was a methamphetamine consumer. Methamphetamine causes the skin to feel tingly, which can lead to vigorous scratching. Chronic users of methamphetamine may believe that the tingling is created by bugs crawling under their skin and therefore try to scratch or dig the bugs out. This can lead to serious and permanent disfigurements.

(Source: Methamphetamine Treatment: A Practitioner's Reference, California Department of Alcohol and Drug Programs [ADP], 2007, www.adp.ca.gov)



Instructions

1. Explain to participants that these photos are of a man who was a methamphetamine injector. These skin problems are related to the fact that methamphetamine injectors (and injectors of most illegal drugs) often use unsanitary equipment, leading to infected injection sites. These scars from infected injection sites are often referred to as “tracks.”

Methamphetamine use leads to severe tooth decay



“Meth Mouth”

(New York Times, June 11, 2005) 49

Instructions

1. Tell participants that this photo is of a person who was a methamphetamine consumer. “Meth mouth” is the rapid decay of teeth and gums that is caused by the acidic nature of methamphetamine, lowered saliva production, drug-related cravings for sugary soft drinks, poor dental hygiene, and other effects of methamphetamine use.

(Source: American Dental Association, “Methamphetamine use: Meth mouth,” www.ada.org/public/topics/methmouth.asp)

Opioids



50

Instructions

1. Introduce opioids by reading the slide to your audience.
2. Point to the different pictures showing the different forms of opioids, including prescription drugs.

Opioids

- Opium
- Heroin
- Morphine
- Codeine
- Hydrocodone
- Oxycodone
- Methadone
- Buprenorphine
- Thebaine

51

Instructions

1. Read the list of drugs included in this category.

Opioids: Basic facts (1)

Description:

Opium-derived or synthetic compounds that relieve pain, produce morphine-like addiction, or relieve symptoms during withdrawal from morphine addiction.

Route of administration:

Intravenous, smoked, intranasal, oral, and intrarectal

52

Instructions

1. Read the slide to your audience.
2. Heroin, for example, is processed from morphine, a naturally occurring substance extracted from the seed pod of the Asian poppy plant. Heroin usually appears as a white or brown powder.
3. Explain that opioids also have medical uses as pain relievers, cough suppressors, diarrhea control, and drug dependence treatment.

(Source: NIDA InfoFacts.)

Opioids: Basic facts (2)

Acute effects:

- Euphoria
- Pain relief
- Suppresses cough reflex
- Histamine release
- Warm flushing of the skin
- Dry mouth
- Drowsiness and lethargy
- Sense of well-being
- Depression of the central nervous system (mental functioning clouded)

53

Instructions

1. Read the slide to your audience.

Opioids: Basic facts (3)

Withdrawal symptoms:

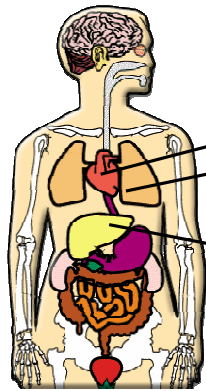
- Intensity of withdrawal varies with level and chronicity of use
- Cessation of opioids causes a rebound in functions depressed by chronic use
- First signs occur shortly before next scheduled dose
- For short-acting opioids (e.g., heroin), peak of withdrawal occurs 36 to 72 hours after last dose
- Acute symptoms subside over 3 to 7 days
- Ongoing symptoms may linger for weeks or months

54

Instructions

1. Read the slide to your audience.

Long-term effects of opioids



- Fatal overdose
- Collapsed veins
- Infectious diseases
- Higher risk of HIV/AIDS and hepatitis
- Infection of the heart lining and valves
- Pulmonary complications & pneumonia
- Respiratory problems
- Abscesses
- Liver disease
- Low birth weight and developmental delay
- Spontaneous abortion
- Cellulitis

Instructions

1. Read the long-term effects of stimulant use to your audience
2. Point to the areas of the body that are affected by the use of these drugs.

Additional Information for Trainers

Chronic users of opioids may develop collapsed veins, infection of the heart lining and valves, abscesses, cellulitis, and liver disease. Pulmonary complications, including various types of pneumonia, may result from the poor health condition of the abuser, as well as from heroin's depressing effects on respiration.

Heroin abuse during pregnancy and its many associated environmental factors (e.g., lack of prenatal care) have been associated with adverse consequences including low birth weight, an important risk factor for later developmental delay. In addition to the effects of the drug itself, street heroin may have additives that do not readily dissolve and result in clogging of the blood vessels that lead to the lungs, liver, kidneys, or brain. This can cause infection or even death of small patches of cells in vital organs.

(Source: NIDA InfoFacts.)

Other drugs

- Inhalants
 - Petroleum products, glue, paint, paint removers
 - Aerosols, sprays, gases, amyl nitrite
- Club drugs (MDMA-ecstasy, GHB)
- Hallucinogens (LSD, mushrooms, PCP, ketamine)
- Hypnotics (quaaludes, mandrax)
- Benzodiazepines (diazepam / valium)
- Barbiturates
- Steroids
- Khat (*Catha edulis*)

56

Instructions

1. Explain to participants that there are other drugs that also are considered psychostimulants.
2. Read the list of these drugs to your audience.
3. Ask participants to provide examples or to comment on the effects of these drugs, if they are familiar with them.
4. Optional exercise: divide your audience into groups of 4 or 5 people. Ask them to research each of these drugs and present the information to each other in the next training. If they are not receiving more training, they could send you the information that they found or share it with you in a meeting.

Activity 3

Working individually or in small groups, think of the drugs that are consumed in your area and the way they are consumed both by youth and adults:



Share your thoughts with the rest of the group.

57

Instructions

1. Divide your audience into groups of 4 or 5 people.
2. Ask them to think about the drugs mostly consumed in their geographical area and the way these drugs are consumed by youth and adults.
3. After 10 minutes of group reflection, ask them to share their thoughts with the rest of the audience.

Notes

We recommend that you not employ more than 15 minutes for this activity.

Introduction to Addiction and the Brain

58

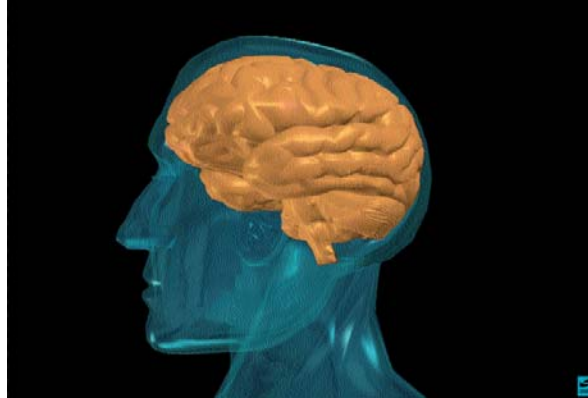
Instructions

1. Tell participants that you will now discuss addiction and the brain.

(Source: The next series of slides on the brain are courtesy of the NIDA Web site (www.nida.nih.gov). From: *A Slide Teaching Packet: The Brain and the Actions of Cocaine, Opiate, and Marijuana.*)

Addiction = Brain Disease

Addiction is a brain disease that is chronic and relapsing in nature.

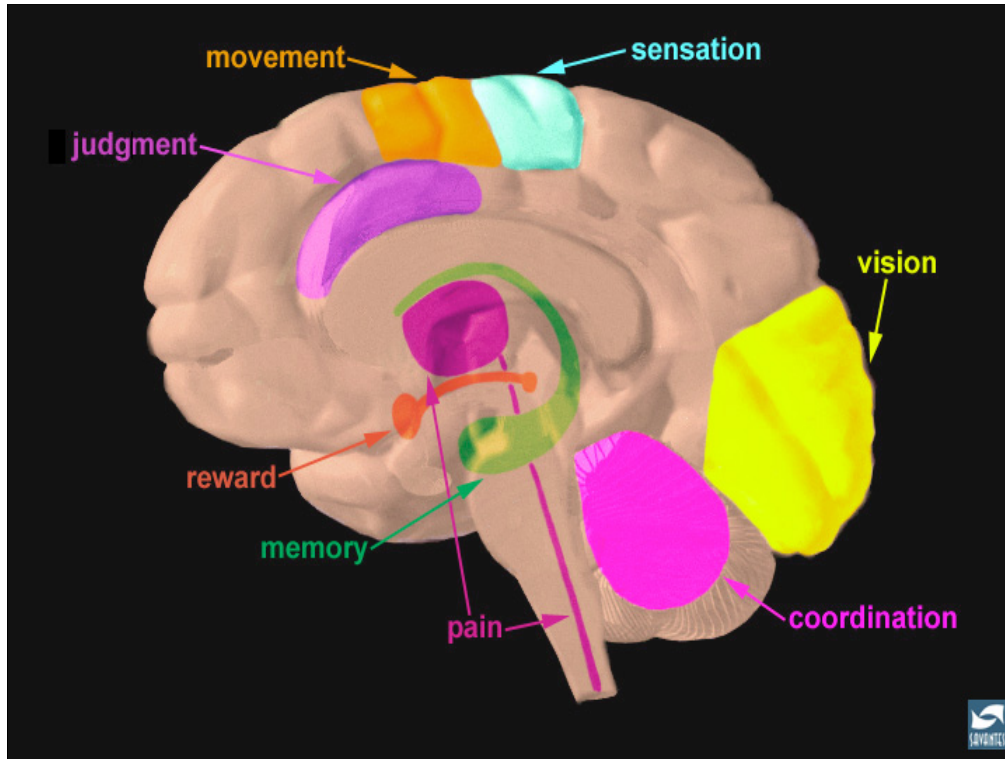


59

Instructions

1. Indicate that you will explain the basic workings of the brain and how and where drugs such as methamphetamine work in the brain.
2. Tell participants that you will discuss the "reward pathway" of the brain and the effects of addictive drugs on that pathway.
3. Explain that the brain is the **most complex organ in the body**. The brain is made up of a complex network of billions of nerve cells called *neurons*, as well as other kinds of cells, all protected by the bones of the skull. The typical brain weighs only about 3 pounds, but it is the source of most qualities that make you who you are. Neurons in the brain and spinal cord are part of the nervous system and act as a body's "Command Central."
4. Explain that the brain is constantly active, even when we are asleep. As a matter of fact, asleep or awake, the brain requires 20% of the heart's output of fresh blood and 20% of the blood's oxygen and glucose to keep functioning properly. Glucose is a type of sugar that is our brain's primary fuel.
5. Explain that the brain produces enough electrical energy to power a 40-watt light bulb for 24 hours. That's a lot of energy for a human organ a little bigger than a softball.

(Source: NIDA)

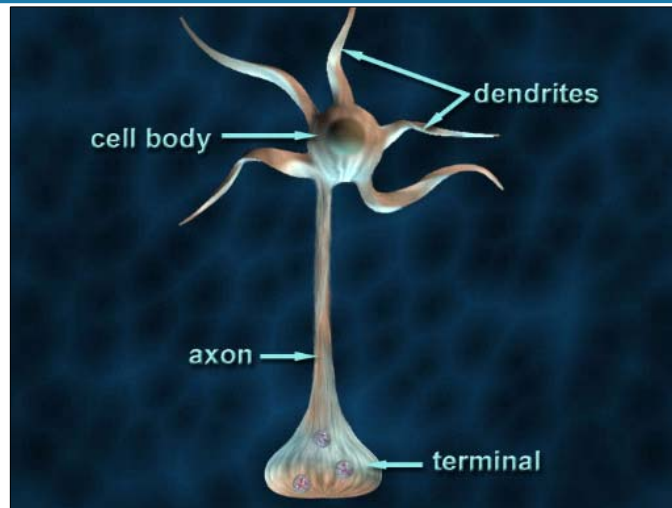


Instructions

1. Explain that certain parts of the brain govern specific functions.
2. Point to areas such as the sensory (blue), motor (orange), and visual cortex (yellow) areas of the brain to highlight their specific functions.
3. Point to the cerebellum (pink), for coordination, and to the hippocampus (green), for memory.
4. Indicate that nerve cells or neurons connect one area to another via pathways to send and integrate information.
5. Explain that the distances that neurons extend can be short or long.
6. Point to the reward pathway (orange). Explain that this pathway is activated when a person receives positive reinforcement for certain behaviours ("rewards").
7. Indicate that you will explain how this happens when a person takes an addictive drug.
8. As another example, point to the thalamus (magenta). This structure receives information about pain coming from the body (magenta line within the spinal cord), and passes the information up to the cortex.

(Source: NIDA)

How a neuron works

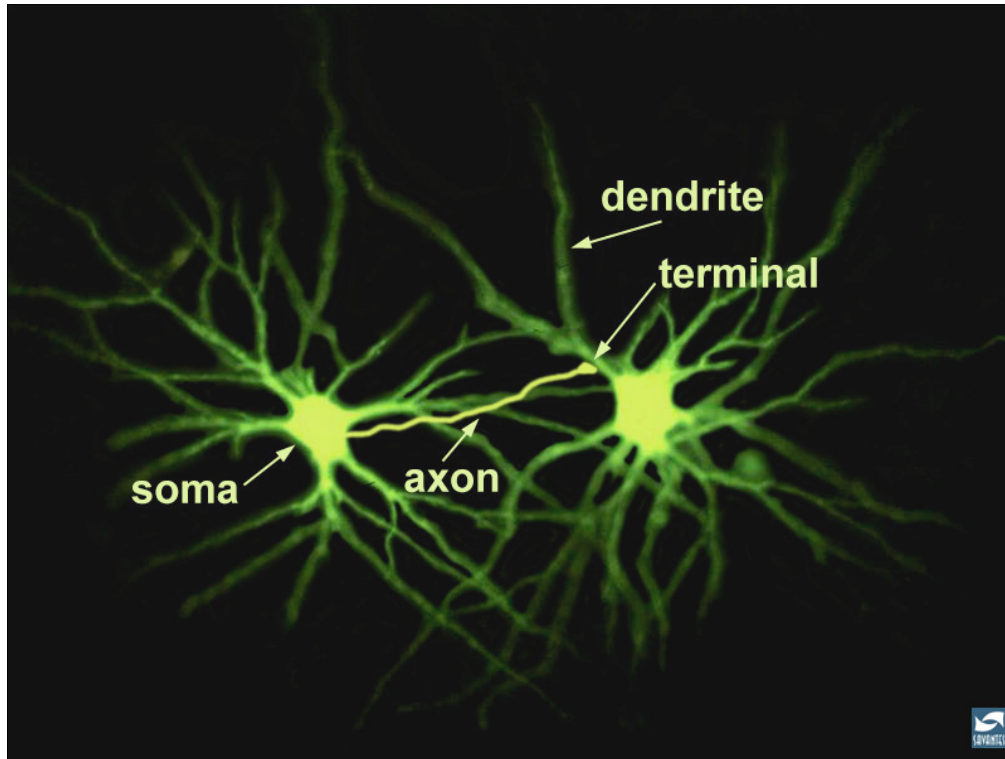


61

Instructions

1. Describe neurons using the schematic in this slide. The cell body, which contains the nucleus, is the center of activity. Dendrites receive chemical information from other neurons that is converted to electrical signals that travel towards the cell body. When the cell body receives enough electrical signals to excite it, a large electrical impulse is generated and it travels down the axon towards the terminal. In the terminal area, chemicals called neurotransmitters are released from the neuron in response to the arrival of an electrical signal.
2. Indicate that the different regions of the brain are connected by nerve cells or neurons via pathways. These pathways of neurons send and integrate information (electrical and chemical).
3. Tell participants that you will explain this in more detail, using the neurochemical serotonin as an example.

(Source: NIDA)



Instructions

1. Remind participants that the different regions of the brain are connected by nerve cells or neurons via pathways. These pathways of neurons send and integrate information (electrical and chemical).
2. Indicate that these pathways are made up of neurons.
3. Point to the paths connecting the two neurons.
4. Explain that this image contains real neurons from the thalamus. They have been filled with a fluorescent dye and viewed through a microscope.
5. Remind your audience about the anatomy of a neuron; point to the cell body (soma), dendrites and axon (marked with text). At the end of the axon is the terminal, which makes a connection with another neuron. [Note: the axon has been drawn in for clarity, but actually, the axons of these neurons travel to the cerebral cortex]
6. Explain the normal direction of the flow of information (electrical and chemical) or impulse flow. An electrical impulse (the action potential) travels down the axon toward the terminal.
7. Point to the terminal. The terminal makes a connection with the dendrite of a neighboring neuron, where it passes on chemical information. The area of connection is called the synapse. While the synapse between a terminal and a dendrite (shown here) is quite typical, other types of synapses exist as well--for example a synapse can occur between a terminal and a soma or axon.

Source: NIDA (www.projectcork.org)

The reward system

Natural rewards

- Food
- Water
- Sex
- Nurturing



63

Instructions

1. Introduce the concept of reward by explaining that humans, as well as other organisms, engage in behaviours that are rewarding. Pleasurable feelings provide positive reinforcement so that the behaviour is repeated. There are natural rewards as well as artificial rewards, such as drugs.
2. Read the list of natural rewards to the audience.

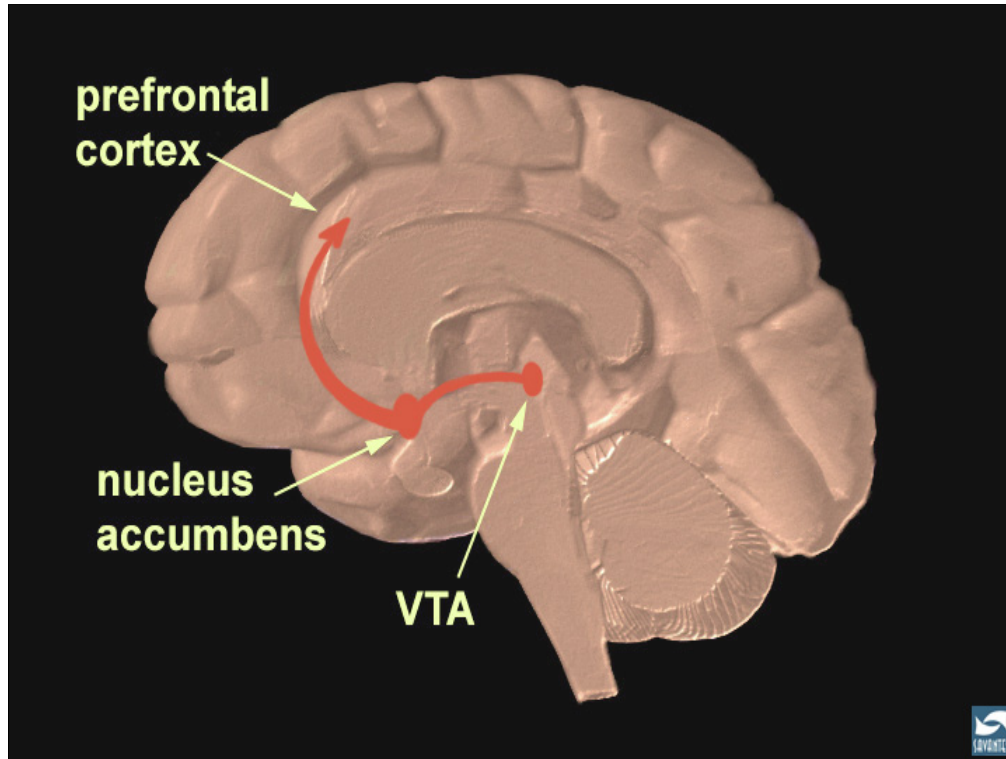
How the reward system works



64

Instructions

1. Explain that natural rewards such as food, water, sex, and nurturing allow the organism to feel pleasure when eating, drinking, procreating, and being nurtured. Such pleasurable feelings reinforce the behavior so that it will be repeated. Each of these behaviors is required for the survival of the species.
2. Remind your audience about the pathway in the brain that is responsible for rewarding behaviors as illustrated in more detail in the next slide.



Instructions

1. Tell participants that this is a view of the brain cut down the middle. An important part of the reward pathway is shown and the major structures are highlighted.
2. Point to the ventral tegmental area (VTA), the nucleus accumbens, and the prefrontal cortex.
3. Explain that the VTA is connected to both the nucleus accumbens and the prefrontal cortex via this pathway and it sends information to these structures via its neurons. The neurons of the VTA contain the neurotransmitter dopamine, which is released in the nucleus accumbens and in the prefrontal cortex (point to each of these structures).
4. Reiterate that this pathway is activated by a rewarding stimulus.

Notes

The pathway shown here is not the only pathway activated by rewards. Other structures are involved, too, but only this part of the pathway is shown for the sake of simplicity.

(Source: NIDA)

Activating the system with drugs



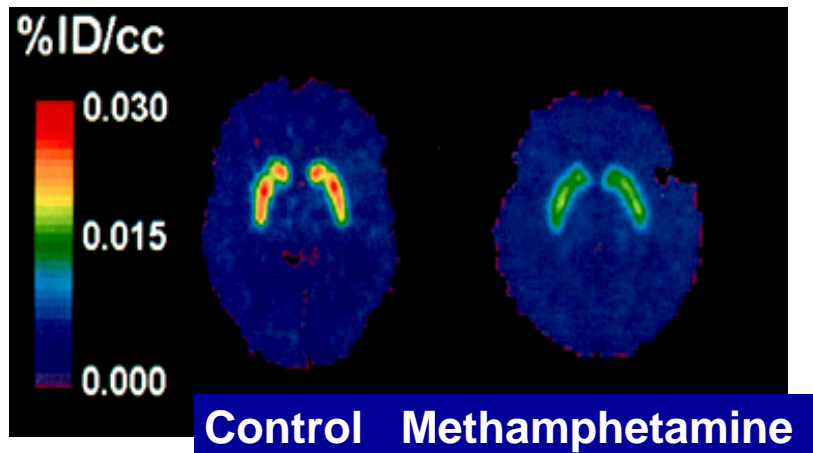
66

Instructions

1. Explain that the discovery of the reward pathway was achieved with the help of animals such as rats. Rats were trained to press a lever for a tiny electrical jolt to certain parts of the brain.
2. Point out that when an electrode is placed in the nucleus accumbens, the rat keeps pressing the lever to receive the small electrical stimulus because it feels pleasurable. This rewarding feeling is also called positive reinforcement.
3. Explain that drugs have the same positive reinforcement effect by activating the reward system artificially (not natural rewards).

(Source: NIDA.)

The brain after drug use (1)



(Source: McCann et al. (1998). *Journal of Neuroscience*, 18, 8417-8422.)

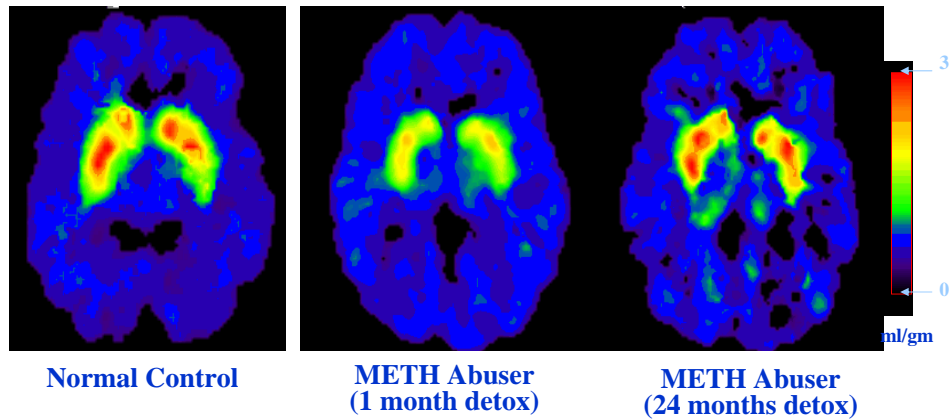
67

Instructions

1. Explain to your audience that this slide has two brain images of the “reward centres of the brain”: one from a control subject and the other from a methamphetamine-using subject, who is one month abstinent from methamphetamine.
2. Point to the difference in dopamine transporters (this is essentially a measure of dopamine activity) in the images (red means higher amounts, green and blue, lower amounts).
3. Explain that decreased dopamine activity in methamphetamine users is probably why users in early recovery have depressed feelings (anhedonia) and have difficulty concentrating. It is important for recovering users and for clinicians to understand that during the first months of recovery, the brain has not fully recovered and this affects how people think and feel.

(Source: NIDA InfoFacts)

Partial Recovery of Brain Dopamine Transporters in Methamphetamine (METH) Abuser After Protracted Abstinence

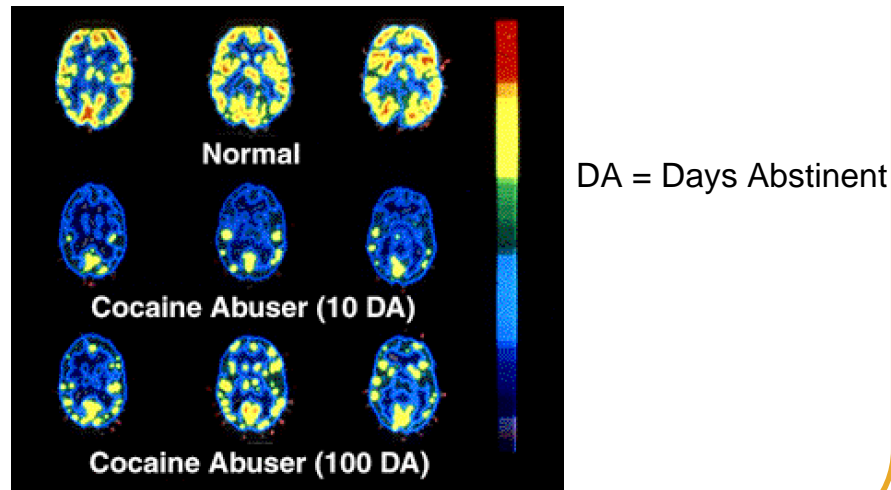


Instructions

1. Explain to your audience that this slide has three brain images of the brain reward system (the yellow-red area): a normal control subject, a methamphetamine user 1 month after detoxification, and a methamphetamine user 24 months after detoxification.
2. Point to the difference in dopamine transporters between the first two brain images (normal control and 1-month post-detoxification; red means higher amounts, green and blue mean lower amounts). Point to the difference in dopamine transporters.
3. Point to the difference in dopamine transporters between the second and third brain images (1-month post-detoxification and 24-months post-detoxification).
4. Explain that decreased dopamine transporters binding in methamphetamine users recovers after months of abstinence. Point at the first and third brain images to show that the normal control brain and the 24-months post-detoxification brain are alike in dopamine transporters in comparison to the 1-month post-detoxification brain. This recovery in dopamine activity is essentially the brain healing from the damage done by methamphetamine.

(Source: Volkow, N.D., et al., *Journal of Neuroscience*, 2001, Vol. 21, pp. 9414-9418.)

The brain after drug use (2)



69

Instructions

1. Explain to your audience that this slide has three sets of brain images: the top one from a control subject, the middle one from a cocaine user after 10 days of abstinence, and the bottom one from a cocaine user after 100 days of abstinence.
2. Point to the difference in dopamine transporters between the first two sets of brain images (normal control and cocaine user after 10 days of abstinence; red means higher amounts, green and blue mean lower amounts). Point to the difference in dopamine transporters.
3. Point to the difference in dopamine transporters between the second and third sets of brain images (cocaine user after 10 days of abstinence and cocaine user after 100 days of abstinence).
4. Explain that decreased dopamine transporters binding in cocaine users show some recovery after 3 months of abstinence. Point at the first and third sets of brain images to show that the normal control brain and the brain of a cocaine user who has been abstinent for 100 days are more alike in dopamine transporters in comparison to the cocaine user after 10 days of abstinence, but the 100-day abstinent brain has not yet reached functionality comparable to a non-user.

Additional Information for Trainers

This PET scan shows us that once *addicted* to a drug like cocaine, the brain is affected for a long time. In other words, once addicted, the brain is literally *changed*. Let's see how...

In this slide, the level of brain function is indicated in yellow. The top row shows a normal-functioning brain without drugs. You can see a lot of brain activity. In other words, there is a lot of yellow color.

The middle row shows the brain of a person addicted to cocaine after 10 days without any cocaine use at all. What is happening here? [Pause for response.] *Less yellow* means *less normal activity* occurring in the brain—even after the cocaine abuser has abstained from the drug for 10 days.

The third row shows the same brain after 100 days without any cocaine. We can see a little more yellow, so there is some improvement—more brain activity—at this point. But the brain is *still* not back to a normal level of functioning more than 3 months later. Scientists are concerned that there may be areas in the brain that never fully recover from drug abuse and addiction.

(Photo courtesy of Nora Volkow, Ph.D. Volkow ND, Hitzemann R, Wang C-I, Fowler JS, Wolf AP, Dewey SL. Long-term frontal brain metabolic changes in cocaine abusers. *Synapse* 11:184-190, 1992; Volkow ND, Fowler JS, Wang G-J, Hitzemann R, Logan J, Schlyer D, Dewey S, Wolf AP. Decreased dopamine D2 receptor availability is associated with reduced frontal metabolism in cocaine abusers. *Synapse* 14:169-177, 1993.)

Drugs change the brain

After repeated drug use, “deciding” to use drugs is no longer voluntary because

DRUGS CHANGE THE BRAIN!

70

Instructions

1. Read the slide to your audience.
2. Explain that when you first think about trying drugs, it is usually a voluntary decision. “Maybe I should see what it’s like...just this once,” you might think. Or a friend dares you. Or you just want to feel good or forget your troubles. Most drugs of abuse—including nicotine, alcohol, marijuana, cocaine, and heroin—activate a part of the brain called the *reward system*, and that makes you feel good. But just for a little while.

Drug abuse has serious consequences. The most serious consequence is that prolonged drug use *changes the brain* in fundamental and long-lasting ways. Eventually, it becomes difficult to experience other pleasures.
3. Explain that after repeated drug use, you reach a point when deciding to use drugs is no longer voluntary. Scientists have proof now that drugs literally *change* your brain. It’s as if a “switch” goes off in the brain. At that point, the *drug abuser* becomes a *person addicted to drugs*.
4. Explain that addiction is actually a different state of being—a *brain disease*. Addiction is a chronic relapsing disease characterized by compulsive, often uncontrollable drug seeking and drug use in the face of negative consequences.
5. Explain that most people addicted to drugs need professional help and treatment to help them cope with these changes and *possibly* change the brain back to normal.

(Source: Adapted from NIDA, 1999.)

Questions?



Comments?

71

Instructions

Ask participants if they have any questions on the presented information or if they need clarification on anything.

Thank you for your time!

End of Workshop 1

72

Instructions

1. Thank your audience for their time.
2. Give participants a break, if necessary.

Workshop 2: Principles of Drug Addiction Treatment



73

Instructions

1. Introduce Workshop 2 by reading the title.

Training objectives



At the end of this workshop you will be able to:

1. Identify 3 basic components of comprehensive treatment for substance abuse
2. Identify 2 individual factors that help people stay in treatment
3. Identify 3 factors within a programme that help people stay in treatment
4. Understand and identify 5 basic principles of effective treatment

74

Instructions

1. Read the training objectives.
2. Explain to participants that these objectives should be achieved as a team.

Comprehensive Treatment

75

Instructions

1. Introduce the next section by saying that you will be talking about what comprehensive substance addiction treatment is

Addiction treatment goals

The goals of addiction treatment are to help the individual:

- Stop or reduce the use of drugs
- Reduce the harm related to drug use
- Achieve productive functioning in their **family**, at **work**, and in **society**

76

Instructions

1. Read the slide to your audience.
2. Ask participants for examples of “productive functioning in their clients’ lives.”
3. Explain that because addiction has so many dimensions and disrupts so many aspects of an individual’s life, treatment for this illness is never simple. Drug treatment must help the individual stop using drugs and maintain a drug-free lifestyle, while achieving productive functioning in the family, at work, and in society.

(Source: Adapted from NIDA, 1999.)

Why is comprehensive addiction treatment needed?

- Addicted individuals usually suffer from mental health, occupational, health, or social problems that make their addictive disorder difficult to treat
- For most people, treatment is a long-term process that involves multiple interventions and attempts at abstinence

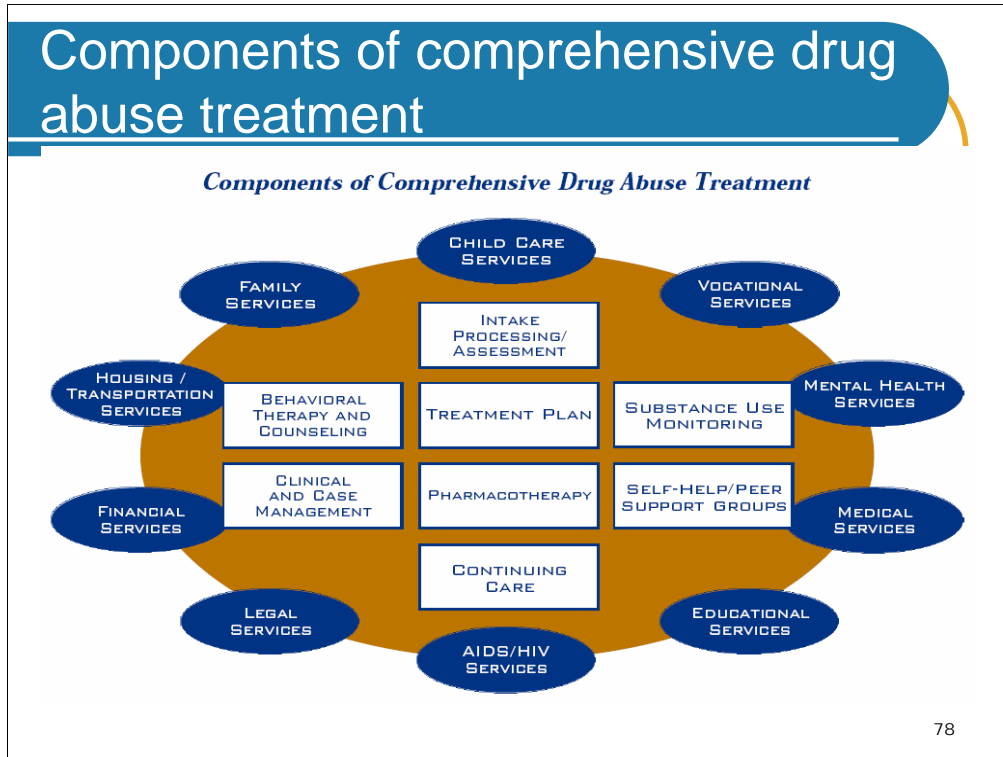
77

Instructions

1. Read the slide to your audience.

(Source: NIDA, 1999.)

Components of comprehensive drug abuse treatment



Instructions

1. Explain that this graphic illustrates how treatment needs to be comprehensive and involve many different aspects of the individual's life. Treatment varies according to the type of drug primarily consumed and the characteristics of your client. Also, substance-using clients may have additional problems: mental health, social and family problems, unemployment, etc., that need to be addressed.
2. Explain that comprehensive treatment of drug abuse should include: (1) **Psychosocial and behavioural therapy**. Drug addiction treatment can include behavioural therapy (such as counselling, cognitive therapy, or psychotherapy), medications, or the combination of behavioural and medication therapies. Behavioural therapies offer people strategies for coping with their drug cravings, and teach them ways to avoid drugs, prevent relapse, and help them deal with relapse, if it occurs; (2) **Treatment medications** such as methadone, levo-alpha-acetylmethadol (LAAM), and naltrexone, are helpful for individuals addicted to opiates. Nicotine preparations (patches, gum, nasal spray) and bupropion are helpful for individuals addicted to nicotine. Medications such as antidepressants, mood stabilizers, or neuroleptics, may be critical for treatment success when clients have co-occurring mental disorders, such as depression, anxiety disorder, bipolar disorder, or psychosis; (3) **Case management** and referral to other medical, psychological, and social services are crucial components of treatment for many clients.
3. Explain that the best programmes provide a combination of therapies and other services to meet the needs of the individual client, which are shaped by such issues as age, race, culture, sexual orientation, gender, pregnancy, parenting, housing, and employment, as well as physical and sexual abuse.

Activity 1: Your organisation

Using the previous graphic, think about all the services that your organisation provides.

- What services do your clients most often need?
- What services could your organization add to meet your clients' needs?



10 minutes



79

Instructions

1. Ask participants to think about the services that their clients need most often.
2. Also ask them to think about the services that they would add in their organizations to meet their clients' needs.
3. Show the previous slide to help them through this reflection.
4. Have participants share their thoughts with the rest of the group.

Treatment duration

Individuals progress through drug addiction treatment at various speeds, so there is no predetermined length of treatment.

In general, longer treatment duration results in better outcomes.

80

Instructions

1. Read the slide to your audience.
2. Explain that in residential or outpatient treatment, participation for less than 90 days is of limited or no effectiveness, and treatments lasting significantly longer often are indicated.
3. Explain that for methadone maintenance, 12 months of treatment is the minimum, and some opiate-addicted individuals will continue to benefit from methadone maintenance treatment over a period of years.
4. Explain that continuing care is always desirable to prevent relapse among clients.

(Source: NIDA, 1999.)

Treatment compliance (1)

Client factors that affect treatment compliance are

- Readiness to change drug-using behaviour
- Degree of support from family and friends
- Pressure to stay in treatment from the criminal justice system, child protection services, an employer, or family members

81

Instructions

1. Read the slide to your audience.
2. Explain to participants that since successful outcomes often depend upon retaining the person long enough to gain the full benefits of treatment, strategies for keeping an individual in the programme are critical. Whether a client stays in treatment depends on factors associated with both the individual and the programme.
3. Explain that client factors related to engagement and retention include motivation to change drug-using behaviour, degree of support from family and friends, and whether there is pressure to stay in treatment from the criminal justice system, child protection services, employers, or the client's family.
4. Ask participants to provide examples from their personal or professional experience of client factors that have affected treatment compliance.

Treatment compliance (2)

Factors within the program that affect treatment compliance are

- A positive therapeutic relationship between the counsellor and client
- A clear treatment plan, which allows the client to know what to expect during treatment
- Medical, psychiatric, and social services
- Medication available when appropriate
- Transition to continuing care or “aftercare”

82

Instructions

1. Read the slide to your audience.
2. Explain that successful counsellors are able to establish a positive, therapeutic relationship with the client. The counsellor should insure that a treatment plan is established and followed so that the individual knows what to expect during treatment. Medical, psychiatric, and social services should be available. Since some individual problems (such as serious mental illness, severe drug use, or criminal involvement) increase the likelihood of a client dropping out, intensive treatment with a range of components may be required to retain clients who have these problems. The provider should then insure a transition to continuing care or “aftercare” following the client’s completion of formal treatment.

Drug addiction treatment

Drug addiction treatment is offered in specialized facilities and mental health clinics by a variety of professionals such as:

- Medical doctors
- Psychiatrists
- Psychologists
- Social workers
- Nurses
- Case managers
- Certified drug abuse counsellors
- Other substance abuse professionals

83

Instructions

1. Read the slide to your audience.
2. Ask participants to identify other providers that might be included in this list.

Activity 2: Group activity

Identify factors within your program (or others' programs) that may do the following:

1. Help clients to comply with their treatment plan
2. Interfere with clients' compliance with their treatment plan



15 minutes



84

Instructions

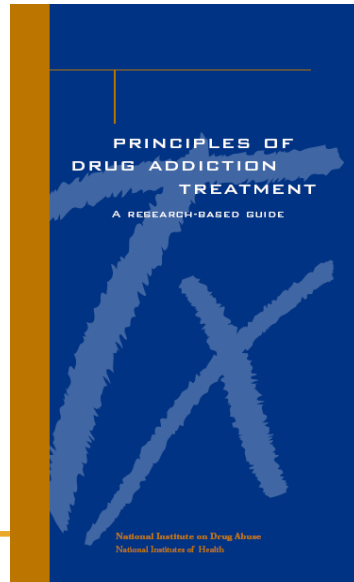
This activity helps participants to explore programme factors that may be improved in their centre or organisation to help clients comply with their treatment plans.

1. You may choose to divide participants into small groups or ask them to do this exercise as one group, or you may have participants do this exercise individually.
2. Then ask participants to identify factors within a treatment programme that may help clients comply with their treatment plan, and then list factors that may interfere with clients' compliance.
3. Allow them about 10 minutes to make their lists.
4. After this time, ask them to share their thoughts with the rest of the audience.

Notes

We do not recommend that you spend more than 15 minutes on this activity.

Principles of Addiction Treatment



85

Instructions

1. Explain to your audience that the information in the following slides is taken from the NIDA booklet *Principles of Drug Addiction Treatment* (NIDA, 1999).
2. We strongly recommend that you also introduce other principles that have been created specifically for your region by governmental or nongovernmental institutions.

Principles of effective treatment (1)

1. **NO** single treatment is **APPROPRIATE FOR ALL**
2. Treatment needs to be **READILY AVAILABLE**
3. Effective treatment attends to **MULTIPLE NEEDS**, not just to drug use problems
4. The treatment plan must be **ASSESSED CONTINUALLY** and **MODIFIED AS NECESSARY** to insure that it meets the client's changing needs
5. Remaining in treatment for an **ADEQUATE PERIOD OF TIME** is critical for treatment effectiveness.

Continued

86

Instructions

1. Read the slide to your audience.

Additional Information for Trainers

NO SINGLE TREATMENT IS APPROPRIATE FOR ALL INDIVIDUALS. Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

TREATMENT SHOULD BE READILY AVAILABLE. Individuals who are addicted to drugs may be uncertain about entering treatment. Therefore, taking advantage of opportunities when clients are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.

EFFECTIVE TREATMENT ATTENDS TO MULTIPLE NEEDS OF THE INDIVIDUAL, NOT JUST HIS OR HER DRUG USE. To be effective, treatment must address the individual's drug use and any associated medical, psychological, social, vocational, and legal problems.

AN INDIVIDUAL'S TREATMENT AND SERVICES PLAN MUST BE ASSESSED CONTINUALLY AND MODIFIED AS NECESSARY TO INSURE THAT THE PLAN MEETS THE PERSON'S CHANGING NEEDS. A client may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counselling or psychotherapy, a client at times may require medication, other medical services, family therapy, parenting instruction, vocational rehabilitation, and social and legal services. It is critical that the treatment approach be appropriate to the individual's age, gender, ethnicity, and culture.

REMAINING IN TREATMENT FOR AN ADEQUATE PERIOD OF TIME IS CRITICAL FOR TREATMENT EFFECTIVENESS. The appropriate duration for an individual depends on his or her problems and needs. Research indicates that for most clients, the threshold of significant improvement is reached at about 3 months in treatment. After this threshold is reached, additional treatment can produce further progress towards recovery. Because people often leave treatment prematurely, programmes should include strategies to engage and keep clients in treatment.

Principles of effective treatment (2)

6. **Counselling** (individual and/or group) and other behavioural therapies are **CRITICAL**
7. **Medications** are **IMPORTANT** elements of treatment for many clients, especially when combined with behavioural therapy
8. People with coexisting mental disorders should be treated in **AN INTEGRATED** way
9. **Detoxification** is only the **FIRST STAGE** of addiction treatment and by itself does little to change long-term drug use.

Continued

87

Instructions

1. Read the slide to your audience.

Additional Information for Trainers

COUNSELLING (INDIVIDUAL AND/OR GROUP) AND OTHER BEHAVIOURAL THERAPIES ARE CRITICAL COMPONENTS OF EFFECTIVE TREATMENT FOR ADDICTION. In therapy, clients address issues of motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding non-drug-using activities, and improve problem-solving abilities. Behavioural therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community.

MEDICATIONS ARE AN IMPORTANT ELEMENT OF TREATMENT FOR MANY CLIENTS, ESPECIALLY WHEN COMBINED WITH COUNSELLING AND OTHER BEHAVIOURAL THERAPIES. Methadone and levo-alpha-acetylmethadol (LAAM) are very effective in helping individuals addicted to heroin or other opiates stabilise their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some people addicted to opiates and some clients with co-occurring alcohol dependence. For persons addicted to nicotine, a nicotine replacement product (such as patches, gum, nasal spray) or an oral medication (such as bupropion) can be an effective component of treatment. For clients with mental disorders, both behavioural treatments and medications can be critically important.

ADDICTED OR DRUG-ABUSING INDIVIDUALS WITH COEXISTING MENTAL DISORDERS SHOULD HAVE BOTH DISORDERS TREATED IN AN INTEGRATED WAY. Because individuals can suffer from both addictive disorders and mental disorders, clients presenting for either condition should be assessed and treated for both disorders.

MEDICAL DETOXIFICATION IS ONLY THE FIRST STAGE OF ADDICTION TREATMENT AND BY ITSELF DOES LITTLE TO CHANGE LONG-TERM DRUG USE. Medical detoxification safely manages the acute physical symptoms of withdrawal associated with stopping drug use. While detoxification alone is rarely sufficient to help addicted people achieve long-term abstinence, for some individuals it is an important precursor to effective drug addiction treatment.

Principles of effective treatment (3)

10. Treatment does **NOT need to be voluntary** to be **effective**
11. Possible drug use during treatment must be **MONITORED** continuously
12. Treatment programs should provide assessment for **HIV/AIDS** and other infectious diseases as well as counselling to help clients change behaviours that place themselves or others at risk of infection
13. Recovering from drug addiction can be a **LONG-TERM PROCESS** and frequently requires multiple episodes of treatment

88

Instructions

1. Read the slide to your audience.

Additional Information for Trainers

TREATMENT DOES NOT NEED TO BE VOLUNTARY TO BE EFFECTIVE. Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can significantly increase both treatment entry and retention rates and the success of drug treatment interventions.

POSSIBLE DRUG USE DURING TREATMENT MUST BE MONITORED CONTINUOUSLY. Lapses to drug use can occur during treatment. The objective monitoring of a client's drug and alcohol use during treatment, such as through urinalysis or other tests, can help the client withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that the individual's treatment plan can be adjusted. Feedback to clients who test positive for illicit drug use is an important element of monitoring.

TREATMENT PROGRAMMES SHOULD PROVIDE ASSESSMENT FOR HIV/AIDS, HEPATITIS B AND C, TUBERCULOSIS, AND OTHER INFECTIOUS DISEASES, AND COUNSELLING TO HELP CLIENTS CHANGE BEHAVIOURS THAT PLACE THEMSELVES OR OTHERS AT RISK OF INFECTION. Counselling can help clients avoid high-risk behaviour. Counselling also can help people who are already infected manage their illness.

RECOVERING FROM DRUG ADDICTION CAN BE A LONG-TERM PROCESS AND FREQUENTLY REQUIRES MULTIPLE EPISODES OF TREATMENT. As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programmes during and following treatment is often helpful in maintaining abstinence.

Categories of Treatment

89

Instructions

1. Tell participants that you will now discuss categories of treatment.

Categories of treatment

Research treatment components include

- Detoxification
- Pharmacological treatment
- Residential treatment
- Outpatient Treatment

90

Instructions

1. Read the list of categories of treatment to your audience.
2. Explain that you will go over each of them in the upcoming slides (please do not review them at this point).

Additional Information for Trainers

Outpatient treatment is also known as ambulatory treatment.

(Source: NIDA, 1999.)

Medical detoxification

- Detoxification is a process where individuals are treated for withdrawal symptoms upon discontinuation of addictive drugs
- Detoxification treatment is conducted under the care of a physician in an inpatient or outpatient setting

91

Instructions

1. Read the slide to your audience.
2. Explain that Volume C of this training package includes a module on detoxification that can be reviewed for further information on this subject. Make this information available for your audience.

Additional Information for Trainers

Detoxification is a precursor of treatment because it is designed to treat the acute physiological effects of stopping drug use but does not usually produce lasting changes.

Pharmacological treatment

- Medications to reduce the severity and risk of withdrawal symptoms
- Medication to reduce relapse to illicit drug use
- Agonist maintenance treatment for opiates (methadone, buprenorphine)
- Antagonist treatment for opiates (naloxone, naltrexone)

92

Instructions

1. Read the slide to your audience.

Residential treatment

Residential treatment programs provide care 24 hours / day in non-hospital settings.

Models of care include:

- Therapeutic community (TC)
- Residential, or “rehab,” program

93

Instructions

1. Read the slide to your audience.

Residential treatment models

- Therapeutic community (TC):
 - Highly structured treatment (6-12 months)
 - Focus on re-socialization
 - Developing personal accountability
- Residential (“rehab”) program
 - Typically 30 days long
 - Aftercare includes counselling and / or peer support

94

Instructions

1. Read the slide to your audience.
2. Ask participants for examples of residential treatment models from their region or for any other comments they may have.
3. Be prepared with examples in case participants do not provide examples.

Outpatient treatment

Recommended elements of outpatient treatment include the following:

- Weekly sessions for around 90-120 days
- Family involvement
- Positive reinforcement approaches
- Cognitive-behavioural materials
- 12-step meetings or support group participation
- Urinalysis and breath alcohol testing
- Medication as appropriate

95

Instructions

1. Read the slide to your audience.
2. Explain that outpatient treatment is usually more economical than residential treatment and is more suitable for individuals who work or have extensive social support. Outpatient intensive treatment can be comparable to residential programmes in services and effectiveness.
3. Ask participants for examples of outpatient treatment from their region or for other comments.
4. Be prepared with examples in case participants do not provide examples.

Notes:

1. Outpatient treatment may require multiple sessions in a week, depending on the intensiveness of the program and the needs of the patient. Usually outpatient treatment takes between 3 to 4 months of weekly clinical sessions.
2. 12-step groups are not available in many countries and cultures. There might be other types of support groups available, depending on the geographic area.

Ethical and Legal Issues

96

Instructions

1. Tell participants that you will now discuss some ethical and legal issues of addiction treatment.

Ethical guidelines

Ethical Values:

Be good!

Do good!

And above all: Do no harm!

97

Instructions

1. Read the slide to your audience.
2. Explain that all ethics can be summarised in three main ideas: Be good, do good, and above all, do not harm your clients and/or their families.
3. Explain that it is essential that all clinicians are familiar with, and work within, a structured ethical framework specific to their fields.
4. Advise clinicians to obtain a copy of the relevant ethical guidelines or code of conduct from their respective professional bodies, if available.

Additional Information for Trainers

You may want to explain to participants that there are basic ethical principles that any clinician working in the substance abuse field should follow:

- Autonomy: acknowledging the right of another to choose and act in accordance with his or her wishes or beliefs
- Non-maleficence: obligation not to harm others intentionally
- Beneficence: Taking positive steps to help others
- Justice: equitable distribution of burdens and benefits
- Fidelity: fulfilling one's responsibilities of trust in a relationship
- Veracity: truthfulness

Notes

We recommend that you complement this professional ethics section with your local ethical professional guidance and organisational ethical standards. This section is a training resource that is not comprehensive and in no way replaces any existing ethical guidelines for professionals working in the drug field.

(Source: The materials in this section on ethics are adapted from the Addiction Technology Transfer Center (ATTC) Toolbox Training: A Substance Abuse Educational Series for Helping Professionals 2006-2007, Kansas City, Missouri, United States.)

Ethical and legal issues

Ethical guidelines are

- A set of professional standards
- A set of principles to guide professional behaviour
- Often a matter of opinion and cultural context
- Not always a legal concern

Legal guidelines are

- Determined by laws
- Implemented if ethics are consistently violated
- Often enforced by civil or criminal penalties

98

Instructions

1. Read the slide to your audience.
2. Point out the differences between the two categories.
3. Provide examples of ethical guidelines and legal guidelines in your local area.
4. Ask participants if they have questions about the difference between these two categories.

Professional and ethical issues

Treatment professionals should have a copy of the following:

- Relevant ethical guidelines or code of conduct for your region
- Laws or regulations affecting their clinical professions

99

Instructions

1. Read the slide to your audience.
2. Explain that a treatment professional should be familiar with, and work within, a structured ethical framework.
3. Explain that a good clinician should adhere to the existing laws regarding clinical work and that it is the clinician's responsibility to have an updated copy of those regulations and to be familiar with them.

Professional boundaries

Maintain a professional relationship with a client at all times

- Avoid dual relationships with clients
- Avoid sexual relationships with clients
- Avoid personal relationships with clients

100

Instructions

1. Read the slide to your audience.
2. Explain the importance of being clear about professional boundaries. Maintaining professional boundaries is among the more challenging aspects of working in the drug field.
3. Explain that some drug addiction clinicians come with their own experience of drug problems, and can effectively use this background as part of an intervention. In general, it is very important for the clinician to be clear about when and why to self-disclose. The clinician should ask, "Will the client benefit? Do I have any other motives in self-disclosing? Am I placing myself at risk, personally or professionally, by self-disclosing?"
4. Explain that clinicians who do not have specialist training in the treatment of drug problems should receive ongoing weekly supervision and support. The most common trap in counselling for ex-users is to become over-involved, which could lead to developing personal relationships that extend beyond the therapeutic relationship. These relationships are not appropriate and are invariably unhelpful to the client. Other ethical principles concerned with maintaining appropriate boundaries include the following:
 - Clinicians should avoid dual relationships that could impair their professional judgement or increase the risk of exploitation. For example, clinicians should avoid providing treatment for employees, students, supervisees, close friends, and relatives.
 - Therapeutic treatment for clients involving physical contact/medical treatment should require, in writing, the client's full acknowledgement and consent regarding the purposes of the procedure and the expected effects.
 - Sexual relationships between clinicians and clients are unethical.
 - Personal relationships with ex-clients should be avoided.
4. Explain that other serious consideration must be given to factors such as the type of relationship, potential harmful effects on the client, and the amount of time between the end of the professional relationship and the start of any non-professional liaison.
5. Explain that dual relationships could impair the clinician's judgement and/or increase the risk of exploitation of a client.
6. Ask your audience for examples of crossing professional boundaries and their consequences for the clinician and/or the client.

Confidentiality (1)

- The client's rights and the limits of confidentiality should be explained at the beginning of treatment
- The relationship with any client should be private and confidential
- Client information should not be communicated outside of the treatment team
- Information should only be released with the client's or guardian's permission

101

Instructions

1. Read the slide to your audience.
2. Stress that the rights of clients and limits of confidentiality should be explained at the beginning of each therapeutic relationship.
3. Explain that the relationship with any client should be private and confidential at all times.
4. Explain that client information should not be communicated to any person other than those qualified to help within the case management/managed care programme designed specifically for that person, and information should only be released with the client's permission.

Confidentiality (2)

Confidentiality must be maintained at all times, except when to do so could result in harm to the client or others.

102

Instructions

1. Read the slide to your audience.
2. Explain that information obtained in clinical or consulting/counselling relationships may be communicated only for professional purposes and only to persons legitimately concerned with the case. Written consent of the client or guardian is required for this.
3. Explain that the principle of confidentiality must be maintained at all times, except in those unusual circumstances whereby to do so would result in clear danger to the client or others. In these circumstances, a decision to break confidentiality can only be taken after staff discussion and consensus that it is the most appropriate course of action.
4. Explain that staff may not disclose information about criminal acts of a client unless there is an overriding legal or social obligation; for example, if a client threatened to kill a third party and clearly had intentions of following through on this threat. Staff would be obliged to disclose this information to the third party (and/or the authorities), following the appropriate discussion as described above.
5. Check the legislation in your region to see if mandatory reporting of child abuse provides for breaches of confidentiality. Explain these regulations to your audience at this point.

Activity 3: Case study

Discuss in small groups the following cases:

- A) A young man tells his clinician that he intends to kill his former girlfriend just as soon as she returns from an out-of-town trip.
- B) A client's employer comes to you asking for information on your client's test results.

How should the clinician act in cases A and B?



15 minutes



103

Instructions

1. Divide the class into two groups. Group 1 takes the A case study and group 2 takes the B case study.
2. Give them 10 minutes to discuss the case in group.
3. Ask them to share their thoughts with the rest of the class.
4. Remind the audience at the end of the exercise that in circumstances such as this one, a decision to break confidentiality can only be taken after staff discussion and consensus that it is the most appropriate course of action, and you must always comply with the local regulations in this regard.

Notes

There might be diverse right answers. The most important one is that clinicians should share this situation with their supervisors and find the way to proceed together.

Additional principles of counselling

An addiction treatment professional should

- Respect the client
- Be a role model
- Control the therapeutic relationship
- Emphasise the client's personal responsibility for recovery
- Provide direction and encourage self-direction
- Be conscious of his or her own issues

104

Instructions

1. Read the slide to your audience.

Additional Information for Trainers

Respect the Client: The skill of a clinician lies in communicating respect for the client. The client needs to accept that everyone possesses the inherent strength and capacity to “make it” in life, and that each person has the right to choose their own alternatives and make their own decisions. Clinicians should always be professional; for instance they should not be late for appointments and should never talk to or treat the client in a derogatory or disrespectful manner.

Be a Role Model: The clinician should set an example for the client through their behaviour and attitudes.

Control the Therapeutic Relationship: Once an assessment is made and counselling has begun, the clinician should guide the client away from trivialities or irrelevancies. Clinicians who allow themselves to be manipulated will not command clients' respect.

Emphasise the Client's Personal Responsibility for Recovery: The clinician should guide clients in the early stages of recovery and help them understand that the recovery process ultimately rests with the client.

Providing Direction and Encouraging Self-Direction: The clinician must strike a balance between providing direction and allowing the client to be self-directed. It is essential that the clinician gives the client feedback on his or her progress in recovery. Clinicians should introduce the relevant topics for discussion based on what the client seems to need. At times, the clinician may direct the client to change certain behaviour, for example, to start attending self-help meetings. However, the client should also be encouraged to be self-directed. For example, if the client is coping with “social pressure to use,” he or she may explore how to manage this problem best, and then the clinician responds to the client's ideas. If clients seem unable to change some aspect of addictive behaviour, the clinician should accept the situation and assist them in exploring their perceptions or situations in a way that might allow the client to deal with them differently. A balance needs to be maintained between respect for clients, acceptance of where they are in the recovery process, and provision of motivation for abstinence and recovery.

Be Conscious of Your Own Issues: Clinicians need to be aware of the possibility of their personal issues being triggered by a client's problems. Clinicians must consciously refrain from basing their responses on their own issues or history. For example, a clinician in recovery may feel that it is important to break ties with addicted peers to maintain sobriety. If this clinician happens to work with a client who has an addicted sister with whom the client has a valued relationship, it is important that the clinician be flexible and respond creatively to the client's perception of the problem.

Questions?



Comments?

105

Instructions

1. Ask participants if they have any questions on the presented information or if they need clarification on anything.

Thank you for your time!

End of Workshop 2

106

Instructions

1. Thank your audience for their time.
2. Consider giving participants a break, if necessary.

Workshop 3: Basic Counselling Skills for Drug Addiction Treatment



107

Instructions

1. Introduce Workshop 3 by reading the title.

(Sources: Ranganathan, Jayaraman, & Thirumagal, 2002, and Addy, Ritter, Lang, Swan, & Englander, 2000.)

Training objectives (1)



At the end of this workshop you will be able to:

1. Identify a minimum of 4 counselling strategies useful in drug abuse treatment
2. Conduct a minimum of 3 counselling strategies
3. Structure a regular counselling session
4. Understand the importance of clinical supervision
5. Conduct a minimum of 3 listening strategies and 3 responding and teaching strategies to be used in counselling for drug abuse treatment

108

Instructions

1. Read the training objectives to your audience.
2. Explain that it is very important for this workshop, in particular, to not only provide new knowledge but also to allow participants the opportunity to practise new skills so that they apply these skills to their everyday work with clients who have substance abuse problems.
3. Remind your audience of your training and follow-up plan for them. Stress that after this training, you will be available to answer questions and provide feedback and advice regarding their demonstrations of new techniques and skills.

Introduction to Counselling

109

Instructions

1. Introduce this section by explaining that you will provide an overview of the definition of counselling and some of its characteristics.

What is counselling? (1)

Counselling involves the following:

- Interactive relationship
- Collaboration
- Set of clinical skills & teaching techniques
- Positive reinforcement
- Emotional support
- Formal record

110

Instructions

1. Explain to your audience that counselling is a dynamic process based on a collaborative relationship. Counselling involves a repertoire of clinical skills that emphasise self-help and decision-making. Sessions should be formally recorded and clinicians should have clinical casework supervision.
2. Explain to participants that the workshop content on “generic” counselling concepts can be used within any counselling model (e.g., cognitive behavioural therapy, psychodynamic psychotherapy, dialectical behaviour therapy).

(Source: Adapted from Addy, Ritter, Lang, Swan, & Engelder, 2000.)

What is counselling? (2)

The purpose of counselling is to establish:

- Goals of treatment
- Treatment modality
- Treatment plan
- Scheduling of sessions
- Frequency and length of treatment
- Potential involvement of others
- Termination of treatment

111

Instructions

1. Read the slide to your audience.
2. Explain that the outcome of meetings between clinicians and clients will depend a great deal on how comfortable the client feels with the clinician, so that they may entrust their genuine feelings to the clinician, including information that they are reluctant to share. This can be achieved by the use of certain communication skills that create an atmosphere of support for the client and the process.

(Source: Adapted from Ranganathan, Jayaraman, & Thirumagal, 2002.)

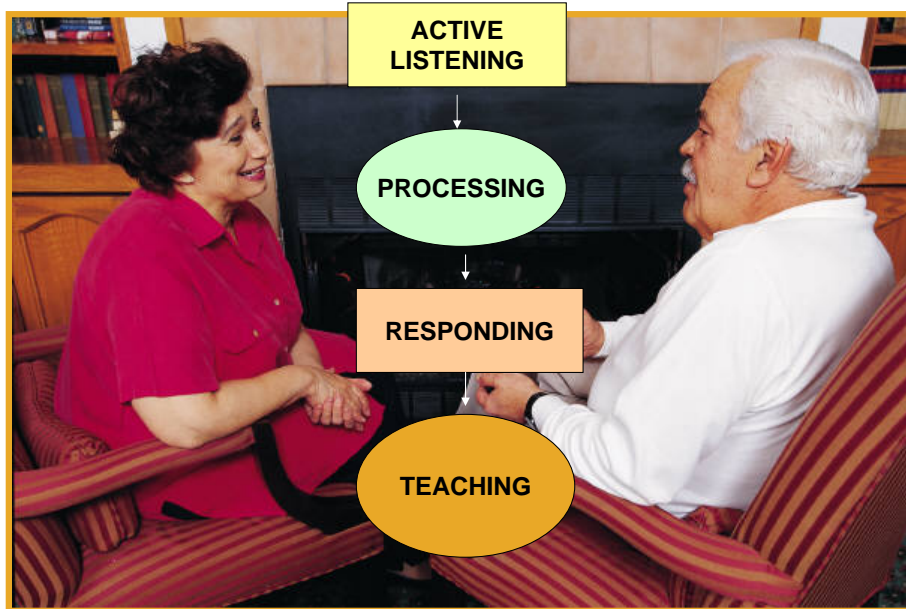
Basic Counselling Skills

112

Instructions

1. Tell participants that you will now discuss basic counselling skills.

Basic Counselling Skills



Instructions

1. Introduce the counselling skills by explaining that the process of communication between the client and the clinician in the counselling situation is a continuous two-way sequence of events. This sequence of events insures that the clinician listens (receives the message), processes (considers the message in combination with previous knowledge and experience), and responds (delivers a response to the original message).
2. Explain to the audience that many of these skills are intuitive and that many participants may already have many of these skills in their repertoire.

(Source: Adapted from Ranganathan, Jayaraman, & Thirumagal, 2002.)

Notes

This figure will be used throughout this workshop to help participants understand the sequence of counselling skills they are about to learn.

Active Listening



114

Instructions

1. Introduce “active listening” by reading the slide.
2. Tell participants that “active listening” includes a series of micro-skills that you will review in the next slides:
 - Attending
 - Paraphrasing
 - Reflection of feelings
 - Summarising

Notes

We do not recommend that you explain each one of them at this point.

Active listening

Active listening by the clinician encourages the client to share information by providing verbal and nonverbal expressions of interest.

115

Instructions

1. Read the slide to your audience.
2. Explain that active listening is the central skill and act of counselling. Hearing is the capacity to hear sound, whereas listening in the counselling situation is the capacity to hear what your client is saying verbally and nonverbally, understand it, and communicate your understanding and empathy to your client.
3. Explain that “reward listening” is active listening with empathy, where you reward the speaker by showing your interest and encouragement.

Additional Information for Trainers

Empathy is the ability to understand how clients feel about themselves and their environment.

Reward listening is important in order to:

- Establish and maintain rapport
- Help clients to disclose
- Help clients to express feelings
- Create a mutual knowledge base for both the client and clinician.

For example, small rewards are brief verbal expressions of interest designed to encourage the client.

For example:

- “Um-hmm, please continue.”
- “I see.”
- “So...”

Respect and acceptance are essential in the practise of reward listening. You need to communicate your sincerity in your manner, your body language, and your face without saying it in words. It is not sufficient to simply say things like “I really care” or “You can trust me.”

Active listening skills

Active listening includes the following skills:

- Attending
- Paraphrasing
- Reflection of feelings
- Summarising

116

Instructions

1. Read the slide to your audience.
2. Explain that each of these micro-skills will be reviewed in the next set of slides.

Attending (1)

Attending is expressing awareness and interest in what the client is communicating both verbally and nonverbally.

117

Instructions

1. Read the slide to your audience.
2. Explain that “attending” refers to a concern by the clinician with all aspects of the client’s forms of communication. It includes listening to the verbal content, observing nonverbal cues, and then communicating back to the client that she or he is paying attention. The skill of attending is the foundation upon which all other skills are built.

Attending (2)

Attending helps the clinician

- Better understand the client through careful observation

Attending helps the client

- Relax and feel comfortable
- Express their ideas and feelings freely in their own way
- Trust the counsellor
- Take a more active role in their own sessions

118

Instructions

1. Read the slide to your audience.
2. Explain that attending enables the clinician to obtain accurate inferences about the client through careful observation.

Attending (3)

Proper attending involves the following:

- Appropriate eye contact, facial expressions
- Maintaining a relaxed posture and leaning forward occasionally, using natural hand and arm movements
- Verbally “following” the client, using a variety of brief encouragements such as “Um-hm” or “Yes,” or by repeating key words
- Observing the client’s body language

119

Instructions

1. Read the slide to your audience.
2. Explain that different cultures have different rules for these guidelines; for example, eye contact may be considered threatening in some cultures while in others it may be considered a sign of respect and attention.
3. Ask participants for more examples related to these guidelines, such as “arm movements.”

Example of attending

Um-hm.

Please continue...

I see.

I am so tired, but I cannot sleep...so I drink some wine.

...When I wake up...it is too late already...

Too late for work...my boss fired me.

120

Instructions

1. Ask somebody in the audience to play the role of Anna (the client) and read her comments (in the white bubbles).
2. You may want to play the role of the clinician or ask a participant to play that role (blue bubbles).
3. Ask your audience if they have any questions or comments.

Activity 1: Case study

“The client asked the clinician about the availability of medical help to deal with his withdrawal symptoms. The clinician noticed that the client is wringing his hands and looking very anxious.”

Discuss how the clinician should respond.



15 minutes

121

Instructions

1. Divide the audience into groups of 4-5 each.
2. Read the case study out loud to your audience.
3. Ask the groups to discuss what the clinician response should be. Some potential responses include:
 - a. Responding with a general statement that medications will be provided
 - b. Help the client express his or her fears
 - c. Answer specific questions that he or she may have
 - d. Other responses (ask them to describe them)

Notes

There might be diverse right answers. The most important ones are a combination of all (a, b, and c) starting with helping the client to express his or her fears and establishing a good rapport or clinician-client relationship.

We do not recommend that you use more than 15 minutes for this activity.

Paraphrasing (1)

Paraphrasing is when the clinician restates the content of the client's previous statement.

- Paraphrasing uses words that are similar to the client's, but fewer.
- The purpose of paraphrasing is to communicate to the client that you understand what he or she is saying.

122

Instructions

1. Read the slide to your audience.
2. Explain that paraphrasing is a response that restates the content of the client's previous statement. In paraphrasing, the clinician reflects back to the client the essence of his or her last few comments. Paraphrasing often uses words that are similar to the client's, but fewer in number.

Paraphrasing (2)

Paraphrasing helps the **clinician**

- verify their perceptions of the client's statements
- spotlight an issue

Paraphrasing helps the **client**

- realise that the counsellor understands what they are saying
- clarify their remarks
- focus on what is important and relevant

123

Instructions

1. Read the slide to your audience.
2. Explain that paraphrasing can be an indicator to clients of the clinician's accurate insights. It also clarifies the client's meaning to have their words rephrased concisely and often leads them to expand their discussion on the same subject. It can spotlight an issue, thus offering a direction for the clients' subsequent remarks.
3. Explain that paraphrasing enables clinicians to verify their perceptions of the verbal content of the client's statements and to spotlight an issue so that the client has an opportunity to continue talking about that particular problem.

Example of paraphrasing

My mom irritates me. She picks on me for no reason at all. We do not like each other.

So...you are having problems getting along with your mother. You are concerned about your relationship with her.



Yes!

124

Instructions

1. Ask somebody in the audience to play the role of Anna (the client) and read her comments (in white bubbles).
2. You may want to play the role of the clinician or ask a participant to play that role (blue bubble).
3. Ask your audience if they have any questions or comments.

Reflection of feelings (1)

Reflection of feelings is when the clinician expresses the client's feelings, either stated or implied. The counsellor tries to perceive the emotional state of the client and respond in a way that demonstrates an understanding of the client's emotional state.

125

Instructions

1. Read the slide to your audience.
2. Explain that in using the technique of "reflection of feelings," the clinician expresses the essence of the client's feelings, either stated or implied. Unlike paraphrasing, the focus is primarily on the emotional element of the client's communication. The clinician tries to perceive the emotional state of the client and respond in a way that demonstrates an understanding of that state. It lets the client know that the clinician understands what the client is feeling. This empathy reinforces the client's willingness to express feelings more openly. It also gives the client an opportunity to recognise and accept his or her feelings.

Reflection of feelings (2)

Reflection of feelings helps the **clinician**

- Check whether or not they accurately understand what the client is feeling
- Bring out problem areas without the client being pushed or forced

Reflection of feelings helps the **client**

- Realise that the counsellor understands what they feel
- Increase awareness of their feelings
- Learn that feelings and behaviour are connected

126

Instructions

1. Read the slide to your audience.
2. Explain that through such reflection of feelings, problem areas can be identified without the client feeling pushed. It also helps the client understand that feelings can cause certain types of behaviour.

Example of reflection of feelings

When I get home in the evening, my house is a mess. The kids are dirty... My husband does not care about dinner...I do not feel like going home at all.

You are not satisfied with the way the house chores are organized. That irritates you.



Yes!

127

Instructions

1. Ask somebody in the audience to play the role of Anna (the client) and read her comments (in white bubbles).
2. You may want to play the role of the clinician or ask a participant to play that role (blue bubble).
3. Ask participants if they have any questions or comments.

Summarising (1)

Summarising is an important way for the clinician to gather together what has already been said, make sure that the client has been understood correctly, and prepare the client to move on. Summarising is putting together a group of reflections.

128

Instructions

1. Read the slide to your audience.
2. Explain that “summarising” is the tying together by the clinician of the main points discussed in a counselling session. Summarising can focus on both feelings and content (information), and is appropriate after discussion of a particular topic within the session or as a review at the end of the session of the principal issues discussed. In either case, the summary should be brief, to the point, and without new or added meanings.

Summarising (2)

Summarising helps the **clinician**

- Provide focus for the session
- Confirm the client's perceptions
- Focus on one issue while acknowledging the existence of others
- Terminate a session in a logical way

Summarising helps the **client**

- Clarify what they mean
- Realise that the counsellor understands
- Have a sense of movement and progress

129

Instructions

1. Read the slide to your audience.

Example of summarising

We discussed your relationship with your husband. You said there were conflicts right from the start related to the way money was handled, and that he often felt you gave more importance to your friends. Yet on the whole, things went well and you were quite happy until 3 years ago. Then the conflicts became more frequent and more intense, so much so that he left you twice and talked of divorce, too. This was also the time when your drinking was at its peak. Have I understood the situation properly?



Yes, that is it!

130

Instructions

1. Ask somebody in the audience to play the role of Anna (the client) and read her comment (in white bubble).
2. You may want to play the role of the clinician or ask a participant to play that role (blue bubble).
3. Ask your audience if they have any questions or comments.

Processing



131

Instructions

1. Tell participants that you will now discuss the counselling skill of processing.

Processing (1)

Processing is the act of the clinician thinking about his or her observations about the client and what the client has communicated.

132

Instructions

1. Read the slide to your audience.
2. Explain that “processing” takes place within the clinician, between listening to the client and responding to the client. This includes the clinician’s ability to mentally catalogue data—the client’s beliefs, knowledge, attitudes, and expectations—and then categorise factors influencing the client’s judgement and performance.

Processing (2)

Processing allows the counsellor to mentally catalogue the following data:

- Client's beliefs, knowledge, attitudes, and expectations
- Information given by his or her family
- Counsellor's observations

133

Instructions

1. Read the slide to your audience.

Responding



134

Instructions

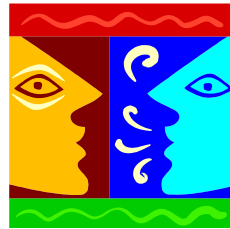
1. Tell participants that you will now discuss the counselling skill of responding.
2. Tell participants that “responding” includes a series of micro-skills that you will review in the next slides:
 - Providing basic empathy
 - Probing
 - Interpreting
 - Silence.

Notes

We do not recommend that you explain each one of these skills at this point.

Responding

Responding is the act of communicating information to the client that includes providing feedback and emotional support, addressing issues of concern, and teaching skills.



135

Instructions

1. Read the slide to your audience.

Expressing empathy

Empathy is the action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experiences of another.



136

Instructions

1. Read the slide to your audience.
2. Explain that empathy is not an ability or tendency to identify with a person's experiences. Rather, it is a learnable skill for understanding another's meaning through the use of reflective listening, whether or not the clinician has had similar experiences (Miller & Rollnick, 1991).

(Source: Definition of "empathy" in the slide is from Merriam-Webster's Collegiate Dictionary, 11 Edition, 2003.)

Example of expressing empathy

I see.

*I understand.
I am sorry
about your job.*

I am so tired, but I cannot sleep... So I drink some wine.

When I wake up...I am already too late for work. Yesterday my boss fired me...

...but I do not have a drinking problem!

137

Instructions

1. Ask somebody in the audience to play the role of Anna (the client) and read her comments (in white bubbles).
2. You may want to play the role of the clinician or ask a participant to play that role (blue bubbles).
3. Ask participants if they have any questions or comments.

Probing (1)

Probing is the counsellor's use of a question to direct the client's attention to explore his or her situation in greater depth.

138

Instructions

1. Read the slide to your audience.
2. Explain that probing enables clinicians to better understand what the client is describing.

Probing (2)

- A probing question should be open-ended
- Probing helps to focus the client's attention on a feeling, situation, or behaviour
- Probing may encourage the client to elaborate, clarify, or illustrate what he or she has been saying
- Probing may enhance the client's awareness and understanding of his or her situation and feelings
- Probing directs the client to areas that need attention

139

Instructions

1. Read the slide to your audience.
2. Explain that probing questions:
 - should be open-ended, requiring more than a one-word answer from the client. Probing helps to focus the client's attention on a feeling or content area.
 - may encourage the client to elaborate, clarify, or illustrate what he or she has been saying. Probing sometimes enhances the client's awareness and understanding of his or her situation and feelings.
 - direct the client's attention to areas that, according to the counsellor, need attention.

Example of probing

Work problems related to drug use?

Tell me about the problems you have been having at the work place?

I was always known to be a good worker. I even received an award. Lately I had some issues...my husband is just not helping...that is why I am always late.

Actually I have had lots of problems, not only being late.

140

Instructions

1. Ask somebody in the audience to play the role of Anna (the client) and read her comments (in white bubbles).
2. You may want to play the role of the clinician or ask a participant to play that role (blue bubbles).
3. Ask participants if they have any questions or comments.

Interpreting (1)

Interpreting is the clinician's explanation of the client's issues after observing the client's behaviour, listening to the client, and considering other sources of information.

141

Instructions

1. Read the slide to your audience.
2. Explain that it is very important that the clinician uses the skills of attending, paraphrasing, reflection of feelings, and summarising prior to and in conjunction with interpreting.
3. Explain that the first step in interpreting is to determine the basic messages the client has expressed or displayed, and restate them. As the clinician is restating them, she or he may have some idea about alternative ways of viewing the client's situation, or may begin to see connections, relationships, or patterns in the events the client describes. When these ideas are included in the material being restated to the client, the clinician offers the client a new frame of reference from which to view his or her situation.

Interpreting (2)

Effective interpreting has three components:

1. Determining and restating basic messages
2. Adding ideas for a new frame of reference
3. Validating these ideas with the client

142

Instructions

1. Read the slide to your audience.
2. Explain that interpreting helps the client to:
 - a. realise that there are more ways than one to look at most situations, problems, and solutions
 - b. become more flexible and to explore new points of view
 - c. understand his or her problems more clearly.
3. Explain that interpreting enables the clinician to:
 - a. share a new perspective for the client to consider
 - b. open the way for the client to develop new coping strategies to deal with the issues she or he faces.

Example of interpreting

*You say you had difficulty in getting along with your boss. Once you mentioned that sometimes you simply broke the rules for the sake of breaking them. You also said that you are always late, even when your husband had everything ready for the children. In the past, you said it was because of the negative behaviour of your boss. This time you blamed your husband. **Is it possible that your problems at work, like being late, are related to your alcohol use?***



I always thought I could control it.

143

Instructions

1. Ask somebody in the audience to play the role of Anna (the client) and read her comments (in white bubble).
2. You may want to play the role of the clinician or ask a participant to play that role (blue bubble).
3. Ask participants if they have any questions or comments.

Silence

Silence can encourage the client to reflect and continue sharing. It also can allow the client to experience the power of his or her own words.

144

Instructions

1. Read the slide to your audience.
2. Explain that silence can be very powerful. It can be a time when things really “sink in,” and feelings are strongly felt and recognised. When combined with “attending cues,” it can serve to encourage the client to continue sharing. Silence can allow clients to experience the power of their own words. Through commitment and experience, the clinician acquires skills to help clients in the process of achieving an addiction-free, qualitatively better life.

Activity 2: Now it's your turn!

Rotating Roles

This role-play gives you and your colleagues an opportunity to practise as clinicians and clients.

- Role-play with one of your partners the new counselling skills you have learned. A third partner will be an observer. After 10 minutes switch roles (30 minutes total).
- Each observer will provide feedback at the end of each role-play (5 minutes).



35 minutes



145

Instructions

1. Divide the audience into groups of three. Each person in the group will play the following three roles for 10 minutes each: clinician, client, and observer.
2. Rotate roles every 10 minutes.
3. Once they have practised their roles, ask participants for a report of what they observed in others and themselves. Ask them to name the best skills shown in each group and also the most common mistake per group.

Notes

We do not recommend that you use over 35 minutes for this activity.

Teaching Clients New Skills



146

Instructions

1. Tell participants that “teaching clients new skills” includes a series of micro-skills that you will review in the next slides:
 - Use repetition
 - Practise
 - Give a clear rationale
 - Monitoring and encouraging
 - Use the assignments
 - Explore resistance
 - Praise approximations
 - Develop a plan.

Notes:

We do not recommend that you explain these skills at this point.

Teaching clients new skills

Teaching is the clinician's transfer of skills to the client through a series of techniques and counselling strategies.



147

Instructions

1. Read the slide to your audience.
2. Explain that learning new and effective skills requires time and practise for everyone, and it is especially important for drug users. Drug users have very defined routines around acquiring, preparing, and using a drug and then recovering from it. It is important for the clinician to recognise how difficult it is for them to change these patterns, especially when they encounter withdrawal symptoms. In addition to this, clients usually seek help after long periods of chronic use. Drugs may have affected their attention, memory, and other cognitive skills, and therefore it may be difficult for them to understand, memorize, and use new skills to cope with their drug dependence. Therefore, repetition of sessions or parts of the sessions may be necessary for clients who do not easily understand the concepts or the rationale of the treatment. The clinician should feel free to repeat explanations of sessions as many times as necessary.

(Source: Adapted from Carroll, 2002.)

Use repetition

Repetition entails counsellors restating information and clients practising skills as needed for clients to master the necessary knowledge and skills to control their drug use.



148

Instructions

1. Read the slide to your audience.
2. Explain that many addicted individuals need practical advice on how to become abstinent or control their drug use. In many instances, drug users have very defined routines around acquiring, preparing, using, and recovering from a drug.
3. Explain the importance for the clinician or counsellor to recognize how difficult it is for them to change these patterns especially when they encounter the withdrawal symptoms. Therefore repetition of sessions or parts of the sessions may be necessary for patients who do not easily understand the concepts or the rationale of the treatment.

Encourage practise

Mastering a new skill requires time and practise. The learning process often requires making mistakes and being able to learn from them. It is critical that clients have the opportunity to try new approaches.



149

Instructions

1. Read the slide to your audience.
2. Explain that practising is a central component of the learning process. Mastering a new skill requires time and practise. The learning process often requires making mistakes, making changes based on those mistakes, and then trying again over and over until the skills are mastered.
3. Explain the importance of clinicians offering their clients plenty of opportunities for practise, both within sessions and outside of them. Each session should include opportunities for clients to rehearse and review ideas, raise concerns, and get feedback from the clinician. Suggested practise exercises are provided for each session. These are basically homework assignments that provide a structured way of helping clients test unfamiliar behaviours or try familiar behaviours in new situations.
4. Explain that practise is only useful if the client sees its value and actually tries the exercise. Compliance with extra-session assignments is a challenge for many clients. Several strategies are helpful in encouraging clients to do their homework.

(Source: Carroll, 2002.)

Give a clear rationale

Clinicians should not expect a client to practise a skill or do a homework assignment without understanding **why** it might be helpful.

Clinicians should constantly stress how important it is for clients to practise new skills outside of the counselling session and explain the reasons for it.



150

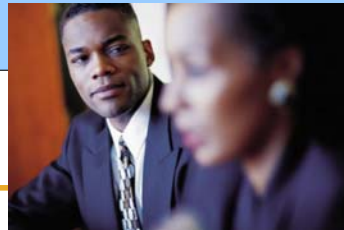
Instructions

1. Read the slide to your audience.
2. Explain to training participants that giving a clear rationale for the homework or other assignments is critical. Many people drop out and do not practice their homework because they do not understand the importance of the suggested assignments and practising them. It is critical that clients know the reasons why you are making a specific recommendation or assignments.
3. Explain also that clinicians should not expect a client to practise a skill or do a homework assignment without understanding why it might be helpful. Thus, as part of the first session, clinicians should stress the relevance of practise outside of the session.

(Source: Carroll, 2002.)

Activity 3: Script 1

“It will be important for us to talk about and work on new coping skills in our sessions, but it is even more important to put these skills into use in your daily life. It is very important that you give yourself a chance to **try new skills** outside our sessions so we can identify and discuss any problems you might have putting them into **practise**. We’ve found, too, that people who try to practise these skills tend to do **better in treatment**. The practise exercises I’ll be giving you at the end of each session will help you try out these skills.”



151

Instructions

1. You may want to play the role of the clinician or ask a participant to play that role.
2. Ask participants if they have any questions or comments.

Activity 3: Case study

Script 1

Discuss in groups the teaching strategies employed by the clinician.



10 minutes



152

Instructions

This activity is based on the previous slide (Script 1).

1. Explain the exercise to your audience by saying that you are asking them to identify and discuss the teaching strategies employed by the clinician.
2. Show the previous slide again to the audience so they can read it as many times as they need.

Notes

We do not recommend that you use more than 10 minutes for this activity.

Monitoring and encouraging

Monitoring: to follow-up by obtaining information on the client's attempts to practise the assignments and checking on task completion. It also entails discussing the clients' experience with the tasks so that problems can be addressed in session.

Encouraging: to reinforce further progress by providing constructive feedback that motivates the client to continue practising new skills outside of sessions.

153

Instructions

1. Read the slide to your audience.
2. Explain that following-up on assignments is critical to improving compliance and enhancing the effectiveness of these tasks. Checking on task completion underscores the importance of practising coping skills outside of sessions. It also provides an opportunity to discuss the client's experience with the tasks so that any problems can be addressed in treatment. In general, clients who do homework tend to have clinicians who value homework, spend a lot of time talking about homework, and expect their clients to actually do the homework.
3. Explain that the early part of each session must include at least *5 minutes* for reviewing the practise exercise in detail. It should not be limited to asking clients whether they did it. If clients expect the clinician to ask about the practise exercise, they are more likely to attempt it than are clients whose clinician does not follow through. Similarly, if any other task is discussed during a session (e.g., implementation of a specific plan to avoid a potential high-risk situation), be sure to bring it up in the following session. For example, a hypothetical follow-up question could be something such as, "Were you able to talk to your brother about not coming over after he gets high?"

(Source: Carroll, 2002.)

Use the assignments

Use the information provided by the clients in their assignments to provide constructive feedback and motivation.

Focus on the client's:

- Coping style
- Resources
- Strengths and weaknesses

154

Instructions

1. Read the slide to your audience.
2. Explain that the work clients do in implementing a practise exercise as well as their thoughts about the task convey a wealth of important information about the clients, their coping style and resources, and their strengths and weaknesses. It should be valued by the clinician and put to use during the sessions.
3. Explain that a simple self-monitoring assignment, for example, can quickly reveal clients' understanding of the task or basic concepts of therapy, level of cognitive flexibility, insight into their own behaviour, motivation, coping style, impulsivity, verbal skills, emotional state, and much more.
4. Rather than simply checking homework, the clinician should explore with clients what they learned about themselves in doing the task. This, along with the clinician's own observations, will help guide the topic selection and pacing of future sessions.

(Source: Carroll, 2002.)

Explore resistance

Failure to implement skills outside of sessions may be the result of a variety of factors (e.g., feeling hopeless). By exploring the specific nature of a client's difficulty, clinicians can help them work through it.

155

Instructions

1. Read the slide to your audience.
2. Explain that some clients do practise exercises at the last minute in the waiting room before a session, while others do not even think about their practise exercises. Failure to implement coping skills outside of sessions may have a variety of meanings: clients may feel hopeless and therefore do not think it is worth trying to change behaviour; they expect change to occur through willpower alone, without making specific changes in particular problem areas; the clients' life is chaotic and crisis-ridden, and they are too disorganised to carry out the tasks; and so on. By exploring the specific nature of clients' difficulty, clinicians can help them work through it.

(Source: Carroll, 2002.)

Praise approximations

Counsellors should try to shape the patients' behaviour by praising even small attempts at working on assignments, highlighting anything they reveal as helpful or interesting.

156

Instructions

1. Read the slide to your audience.
2. Explain that most clients do not immediately become fully abstinent upon treatment entry and that many are not fully compliant with practise exercises. Clinicians should try to shape the clients' behaviour by praising even small attempts at working on assignments, highlighting anything the client reveals as helpful or interesting in carrying out the assignment, reiterating the importance of practise, and developing a plan for completion of the next session's homework assignment.

(Source: Carroll, 2002.)

Activity 4: Case study

Script 2

Discuss the teaching strategies employed by the counsellor in the following example:

“I noticed that you did not fully complete your homework, but I am really impressed with the section that you have completed. This is great...in this section you wrote that on Monday morning you had cravings but you did not use. That is terrific! Tell me a little more about how you coped with this situation. In this other section, you wrote that you used alcohol. Tell me more about it...let’s analyse together the risk factors involved in this situation.”



10 minutes

157

Instructions

1. Explain the exercise to your audience by saying that you are asking them to identify and discuss the teaching strategies employed by the clinician in the example.

Notes

We do not recommend that you use more than 10 minutes for this activity.

Develop a plan (1)

A **plan for change** enhances your client's self-efficacy and provides an opportunity for them to consider potential obstacles and the likely outcomes of each change strategy.



158

Instructions

1. Read the slide to your audience.
2. Explain the importance of establishing a plan for completion of the next session's homework assignment.
3. Stress that it is extremely motivating for clients to be **well prepared**.

Develop a plan (2)

- Offer a menu of change options
- Develop a behaviour contract or a Change Plan Worksheet
- Reduce or eliminate barriers to action



159

Instructions

1. Read the slide to your audience.
2. Explain the importance of establishing a plan for completion of the next session's homework assignment.
3. Review the Change Plan Worksheet form with your audience. Read and explain all components of this form.

Activity 5: Role-playing

This role-play gives you and your colleague another opportunity to practise as counsellors and clients.

- Observe the role-playing
- Complete the Change Plan Worksheet form and ask each other the following questions:
 - “When do you think is a good time to start this plan for change?”
 - “Who can help you to take action on this plan?”



30 minutes



160

Instructions

1. Ask for a volunteer to play the role of the client for this role-play.
2. You will play the clinician.
3. Portray a session in which you use the Change Plan Worksheet form. This will help teach your audience how to use this form with a client.
4. Ask participants if they have any questions before they practise in couples.
5. Divide the class in pairs. One will take the role of the clinician and the other will be the client.
6. Allow each participant 10 minutes to complete the Change Plan Worksheet.
7. Change roles and allow the other half of the class to play the clinician's role for another 10 minutes.

Questions?



Comments?

161

Instructions

1. Ask participants if they have any questions on the presented information or if they need clarification on anything.

Thank you for your time!

End of Workshop 3

162

Instructions

1. Thank participants for their time.
2. Consider giving participants a break, if necessary.

Workshop 4: Special Considerations when Involving Families in Drug Abuse Treatment



163

Instructions

1. Introduce Workshop 4: "Special Considerations when Involving Families in Drug Abuse Treatment."

Training objectives



At the end of this workshop you will be able to:

1. Understand the importance of involving a client's family in the treatment process
2. Identify a minimum of 4 family feelings and reactions to their relative's drug dependence
3. Identify strategies to insure that the client's confidentiality is maintained when you are working with relatives
4. Understand the basics of child protection
5. Identify a minimum of 3 strategies for engaging families in treatment
6. Conduct a minimum of 2 strategies for engaging families in treatment.

164

Instructions

1. Read the training objectives to your audience.
2. Explain that these objectives should be achieved as a team.
3. Remind participants of your training and follow-up plan for them. Stress that after this training, you will be available to answer questions and provide feedback and advice regarding their demonstrations of new techniques and skills.

Introduction to Family Support



165

Instructions

1. Tell participants that you will now provide an introduction to family support in counselling.

Family support

The family is a powerful source of assistance and support.

Families and significant others can effectively participate in the treatment process if the client consents.



166

Instructions

1. Read the slide to your audience.
2. Tell participants that research studies have shown that treatment outcomes of addictive clients are improved if family members are involved in treatment.
3. Explain that a client's family is a potentially powerful source of assistance and support. When appropriate, and with informed consent, families and significant others can effectively participate in the treatment process.

(Source: Addy, Ritter, Lang, Swan, & Engeland, 2000.)

The goals of involving the family

Involving the family

- Helps family members understand and cope with the client's addiction
- Helps achieve the recovery goals of the drug-dependent person



167

Instructions

1. Read the slide to your audience.

Working with Families

168

Instructions

1. Read the slide to your audience.
2. Explain that clinicians may not directly work with family members but should be conscious of the presence of family in the client's life. This can assist clinicians in developing creative or different options for change and to broaden their thinking beyond solely focusing on the individual.
3. Tell your audience (without providing details at this point) that you will be talking about the following issues:
 - First contact with a client
 - Family reactions
 - How to engage families
 - Educating the family
 - Improving communication.

First contact with your client

At the point of first contact with a client, counsellors should ask questions such as:

- Who is important in your life at this moment?
- How do they support you?
- Do they know that you are getting treatment?
- Would they support you in getting treatment?
- Would you like them to be involved in treatment and, if so, in what way?

169

Instructions

1. Read the slide to your audience.
2. Explain that at the point of first contact with a client, clinicians should ask clients about their family and significant others. It is important that this happens at the first point of contact with a client in order to establish a framework for family-inclusive work.
3. Explain that it is the clinician's role to keep the concept of family alive in all ongoing client work. The role of family can change over time, and while clients may initially not wish their family to be involved in their treatment, this may change. In order to do this, clinicians should continue to ask questions regarding the client's family to insure that the client is being understood within the broader context of family and community.

Family reactions (1)

Family members usually experience the following feelings and reactions in response to their relative's drug problems:

- **Denial**
- **Shame**
- **Self-blame**
- **Anger**
- **Confusion**

Continued

170

Instructions:

1. Read the slide to your audience.

Additional Information for the Trainer

Denial

Relatives may deny that a member of their family has a drug problem even when faced with strong evidence of such. As a clinician, you need to be careful not to reinforce this denial by being disapproving or judgemental.

Shame

Whether the substance is socially acceptable, such as alcohol is in some cultures, or is illicitly obtained, people in the family often feel ashamed. Their first response to the problem may be an effort to hide it.

Self-blame

Some family members may feel they are to blame for the situation and reproach themselves. Parents may feel they have failed.

"This is the child on whom so many hopes have been pinned, but perhaps I got it wrong. Did I over-indulge him or did I sometimes neglect his real needs?"

Anger

Throwing blame around is another common family response. The school, friends, society as a whole, the pub, or pushers are all blamed. Alternatively, the user or drinker may be blamed. For example, a parent might ask, "How could he have betrayed me like this?" Or a wife who is taking tranquilizers daily may blame her husband, who drinks too much, for all the difficulties in the family.

Confusion

Family members often feel at the mercy of conflicting emotions. While they strive to protect the user from harm or censure, they may feel furious that he or she has been "so stupid." Some people deny these unpleasant feelings by saying, "There must be some mistake. Even if it is true, I am not going to let it upset me."

(Source: Adapted from UNODC.)

Family reactions (2)

- **Preoccupation**
- **Making changes in themselves**
- **Bargaining**
- **Controlling**
- **Disorganisation**

171

Instructions

1. Read the slide to your audience.

Additional Information for the Trainer

Preoccupation

The preoccupation of family members with their addicted relative is similar to the person's obsession for drugs. Their entire thinking usually revolves around the person with the addiction, and so they often forget to take care of their needs. Their lives are almost always modified to suit the needs of the person who is *drug dependent*. Acute stresses may drive the spouse or parent to a behaviour or activity which she or he compulsively performs.

Making changes in oneself

Most family members believe that the addicted person is taking drugs because of specific problems. As a result, the family takes the responsibility to deal with those problems. They try to establish a pleasant atmosphere at home hoping that it will help the addicted person to stay away from drugs. The family may go out of their way to please the addicted member and maintain a warm and caring attitude towards them even when the situation is difficult.

Bargaining

The goal of bargaining is to offer the addicted person something in return for the desired behaviour. But such bargaining does not work at all. Instead, it leads to frustration and depression.

Controlling

The family attempts to control their family member's drug taking in the hope of getting them out of this problem (e.g., the wife/mother may hide or empty the drug packets or break the bottles, ask the addicted person to avoid his friends, extract promises from him, cry, plead, threaten and shout at him to stop his use of drugs). In spite of these efforts, the person continues to take drugs. Realising that her efforts have failed, she requests others – elders in the family, his non-drug taking peers – to intervene and advise him. He may comply for a short period of time but in the long run, this too does not work.

Disorganisation of the family

The family gives up all attempts to make their family member stop using drugs because, for example, the wife/mother realises that none of these methods help. When she takes stock of the situation at home, she finds everything in chaos. She has no control over the addicted person; other family members' lives have also been affected; she is unable to exercise control even over her own emotions.

(Source: Adapted from UNODC.)

Activity 1: Identify maladaptive reactions

Discuss the maladaptive reactions of Anna's husband in the following scenario:

Anna has been in treatment for alcoholism for 3 months. Anna's husband is suspicious about her behaviour and is tracking all her movements through the day. His compulsive preoccupation drives him to waste his energy in unproductive ways, and as a result, he fails to do his own work. He tries to hide Anna's problem from everybody and denies that there is a problem. It is too shameful for him, Anna, and the rest of the family. He justifies her alcohol abuse in public by saying that she is under a lot of pressure from her work. He denies that she drinks at home. He takes responsibility for Anna. For example, he calls her office every day to make sure she is at work and if she is not, he makes excuses for her absence."



10 minutes

172

Instructions

1. Read the case study out loud to your audience (or you might ask a volunteer to read it for you).
2. Ask your audience to take some time to review it again trying to identify maladaptive reactions from Anna's husband.
3. Ask volunteers to share their thoughts with the rest of the participants.

How to engage the family (1)

To effectively engage family members:

- Recognize their perceptions of the situation
- Provide a range of service options for families to choose from
- Actively engage family members (follow-up with phone calls and letters)
- Don't give up easily
- Deliver flexible services

Continued

173

Instructions

1. Read the slide to your audience.
2. Provide some examples or ask participants to provide examples of ways to engage the family in treatment.

(Source: Adapted from the U.S. Center for Substance Abuse Treatment (CSAT), 2006: Counselor's Family Education Manual: Matrix Intensive Outpatient Treatment for People with Stimulant Use Disorders.)

How to engage the family (2)

To effectively engage family members:

- Make sure that the family's greatest need is the one addressed first
- Be responsive to a crisis
- Insure that the service offered is what the family wants
- Present clear information
- Insure that promises and commitments are met
- Promote strengths-oriented conversations

174

Instructions

1. Read the slide to your audience.
2. Provide examples or ask participants to provide examples on ways to engage the family in treatment.

(Source: CSAT, 2006.)



Building Positive Communication Between the Client and the Family

175

Instructions

1. Tell participants that you will now discuss “Building positive communication between the client and the family.”

Communication problems

Frequently, a client's addiction can create many problems within a family.

- Family members often feel guilty, angry, hurt, and defensive
- These feelings can negatively affect the way they communicate with one another
- Negative patterns of interacting often become automatic

176

Instructions

1. Read the slide to your audience.
2. Provide examples or ask participants to provide examples on family communication problems.

(Source: CSAT, 2006.)

Positive communication skills

Positive communication skills include the following:

- Avoid assuming what the other is thinking
- Communicate directly instead of hinting
- Avoid double messages
- Admit mistakes
- Use “I” statements

177

Instructions

1. Read the slide to your audience.
2. Provide examples or ask participants to provide examples on positive communication skills.

(Source: CSAT, 2006.)

Avoid assuming what the other is thinking

Nancy asked her husband Pete, “Will you be coming home right after work?” Pete exploded, “You don’t have to check up on me every 5 minutes! Do you want a urine sample, too?” Nancy responded angrily, “Well, you’ve sure given me enough reasons to check up on you.”

178

Instructions

1. Read the slide to your audience
2. Read the following information to your audience:

“Pete assumed that Nancy was suspicious when she asked whether he was coming right home from work and felt frustrated and angry that she didn’t trust him or notice the changes he’d made in recovery. What Nancy was really wondering when she asked the question was whether Pete would be able to pick up the dry cleaning before the shop closed or whether she needed to make plans to leave work early.”

3. Ask the audience to fix the communication. An example of a communication fix is:

Pete could have avoided the fight by not assuming that he knew what Nancy was thinking. He could have answered, “Yes, why do you ask?” in a neutral tone of voice or answered directly and waited for her response.

Communicate directly instead of hinting

Ricardo, a 17-year-old in recovery, was playing a video game when his mother, Rosa, walked by and said, "Ricardo, the kitchen trash can is getting full." Ricardo responded, "Uh huh," and continued playing his game. Half an hour later, Rosa noticed that Ricardo hadn't emptied the trash. She angrily confronted Ricardo for not taking the trash out right away. Ricardo responded to her anger by loudly saying, "Hey, I'll do it when I'm ready to do it!"

179

Instructions

1. Read the slide to your audience.
2. Ask the audience to fix the communication between Ricardo and Rosa. An example is:

Instead of hinting that she wanted Ricardo to take out the trash right away, Rosa could have asked him directly by saying, "Ricardo, I need you to take out the trash in the next 15 minutes; I will be starting dinner soon and will have a lot of vegetable scraps." Ricardo would then have known that she meant "now" and not "sometime."

(Source: CSAT, 2006.)

Avoid double messages

Tanya asked her husband, Andre, “Do you mind if I go fishing with Sharonne Saturday?” Andre had been planning to spend time with Tanya on the weekend and didn’t want her to go with Sharonne. However, he replied, “Sure, go ahead.” As he said this, his arms were stiffly crossed across his chest and he didn’t look directly at Tanya. Tanya felt uneasy and said, “You’re really OK with it?” Andre responded angrily, “I said I was, didn’t I? The discussion escalated into an argument.

180

Instructions

1. Read the slide to your audience.
2. Ask the audience to fix the communication between Tanya and Andre. An example is:

Andre could have been honest with Tanya about his feelings, instead of showing them indirectly. He could have said, “Well, I was hoping we could spend some time together Saturday. I’ve been working too much and I miss seeing you.” Tanya would then have understood clearly what his needs were and either changed her plans or negotiated a way to spend time with him.

(Source: CSAT, 2006.)

Admit mistakes

Bob forgot that it was his and Catherine's 5th wedding anniversary. A coworker invited him to bowl a few frames after work, and he accepted. When he arrived home, he discovered the table set for two and Catherine in tears. When she confronted Bob about being so late, he responded defensively. "You know I have trouble remembering these things. You should have reminded me! How am I supposed to know you were planning a special dinner?" Catherine responded, "How could you forget our anniversary?" Bob was feeling guilty at this point, but not wanting to admit he was wrong, defensively replied, "Listen, Catherine, we've been married for 5 years now. What's the big deal?" Catherine locked herself in the bedroom.

181

Instructions

1. Read the slide to your audience.
2. Ask the audience to fix the communication between Bob and Catherine. An example is:

When Bob realized that he had forgotten their anniversary, he could have simply admitted his mistake and apologized sincerely. Although the ensuing discussion still would have been difficult, it may not have escalated.

(Source: CSAT, 2006.)

Use “I” statements

Pam, a senior in high school, was out on a date. Her curfew was midnight, and she was already late. When Pam arrived home at 1 a.m., her mother, Emily, was extremely worried. Emily greeted Pam at the door saying, “You’re late! You could have picked up a phone and called. You’re always so inconsiderate!” Pam responded angrily, “I am not always inconsiderate!” A fight ensued.

182

Instructions

1. Read the slide to your audience.
2. Ask the audience to fix the communication between Pam and Emily. An example is:

Emily could have used an “I” statement saying something like, “I really worry that something has happened to you when you’re late and I don’t hear from you. Please give me a quick call if you’ll be late.” Emily would have directly addressed an important issue in a calm way, and Pam would not have felt the need to defend herself aggressively. Pam also may be more likely to call her mother the next time she is late.

(Source: CSAT, 2006.)

Activity 2: How to engage the family

Take time to think about strategies to involve the family and how you would implement them in your organisation. Share your ideas with the rest of the group.



15 minutes



183

Instructions

1. Read the slide instructions on the activity to your audience.
2. Ask for a volunteer to write down all the ideas on how to involve the family in the treatment process.
3. Review the list of ideas at the end of the exercise.
4. Discuss how they can implement some of these ideas.

Notes

We do not recommend that you use more than 15 minutes on this activity.

Confidentiality

184

Instructions

1. Tell participants that you will now discuss the importance of confidentiality in counselling.

Confidentiality

It is the right of the client to determine to whom they or others disclose details of their treatment.

No information regarding a person's treatment should be disclosed without the client's explicit consent in writing.

185

Instructions

1. Read the slide to your audience.
2. Explain that when working with family members, clinicians often face the dilemma of breaching client confidentiality. This particularly occurs when family members contact the organisation seeking information about whether the client is attending appointments, is still using drugs, or where they are living.
3. Explain that family-inclusive practise supports the rights of all clients to a confidential service. It is the right of the client to determine to whom they or others disclose details of their treatment. No information regarding a person's treatment should be given without the client's explicit consent.

(Source: Adapted from Patterson & Clapp, 2004.)

Organisations' confidentiality policy

Organisations should have policies and procedures in place to assist practitioners in insuring confidentiality for the client and their records. These policies should include:

- Having an agreement with the client and informed consent before releasing any information regarding treatment
- Having a signed "release of information" form from the client
- Clarifying to the client the purpose and types of case records and what happens to them

186

Instructions

1. Read the slide to your audience.
2. Explain that organisations should outline their confidentiality policy for all clients attending the service, and this should include information on the limits of confidentiality.
3. Explain that organisations should insure that they:
 - have prior agreement with the client and informed consent before releasing any information regarding treatment
 - have a signed "release of information" form from the client
 - clarify with the client the purpose and types of case records and what happens to them
 - do not disclose to a family member details of a client's treatment without consent. In some cases, a worker may want to give family members general information about the types of services offered to clients without identifying that the client is a user of the service
 - do not tell family members whether the client is attending the service without prior client consent.

(Source: Adapted from Patterson & Clapp, 2004.)

Precautions

Written consent should be obtained before disclosing:

1. Details of a client's treatment to any family member
2. Information about the client's attendance

187

Instructions

1. Read the slide to your audience.
2. Explain that when undertaking joint work with clients and family members, clinicians should establish confidentiality guidelines for this work in conjunction with both parties prior to commencing. Clinicians should take reasonable steps to insure that information disclosed by them in joint work is shared knowledge; however, it is recognised that from time to time workers might not be clear where information they hold has come from.

(Source: Adapted from Patterson & Clapp, 2004.)

If in doubt ...

- Ask your client if it is OK to talk about it
- Respect the client's or the family member's wishes if they decide they do not want to talk about a particular issue
- In some circumstances, employ different practitioners for the family and the client
- If a family member requests a service, but the client does not want to be involved, refer the family member to another service

188

Instructions

1. Read the slide to your audience.
2. Explain that if in doubt, a reasonable question to be asked of both the client and family member is:

"Is it OK if we talk about this here?"

3. Explain that both parties should be respected if they decide they do not want to talk about a particular issue. In some circumstances, it might be more appropriate for different clinicians to work with the client and family member. Each clinician would maintain their own client's confidentiality unless there are circumstances (as mentioned earlier) that warrant a breach.

If a family member requests a service from the organisation but the client does not want to be involved and will cease contact if this service is offered, the family member should be referred to another service to assist them with their issues.

4. Ask participants to provide some examples. We recommend that you think about some examples before your presentation in case participants do not come up with any.

(Source: Adapted from Patterson & Clapp, 2004.)

Support and Information for Clients who have Children

189

Instructions

1. Tell participants that you will now discuss support and information for clients who have children.
2. Explain that adults attending alcohol and drug treatment services may be parents of young children or adolescents. Clinicians might identify a need to provide support and information to clients who are parents. While most alcohol and drug treatment agencies are not funded to deliver parenting support services, organisations may consider developing responses to the needs of clients and their children as part of family-inclusive practise.

(Source: Adapted from Patterson & Clapp, 2004.)

Support and information for clients who have children

Clinicians should identify the needs of clients with children. These might include:

- Referral to a specialist in parenting or family support programs
- Attention to child safety issues within the physical environment of the agency
- Provision of “child-friendly” areas within the clinic, including toys and resources for children, posters, and other aids to establish a welcoming and age-appropriate environment
- Provision of information on a range of welfare, child care, and family recreation services available in the local area

190

Instructions

1. Read the slide to your audience.
2. Explain that the effects of drug use can significantly impact the ability of parents to care for their children. Referral to specialist parenting programmes or family therapy services can provide clients who are parents with support in areas such as parenting skills and information, validation, counselling, and respite.
3. Explain that parent support programmes are being developed within the alcohol and drug treatment sector as early intervention strategies, with the aim of acknowledging and minimising the impact of parental drug use on children and other family members.
4. Ask your audience to describe any services or programs that support or serve clients who have children.

(Source: Adapted from Patterson & Clapp, 2004.)

Child protection

Organisations should have policies and procedures in place to assist practitioners in responding to suspicions of child abuse and neglect such as:

- Access to immediate supervision from an experienced practitioner
- Knowledge of what constitutes risk
- Knowledge of the child protection system
- Training in how to discuss concerns about safety with clients

191

Instructions

1. Read the slide to your audience.
2. Explain that although the primary focus of treatment providers is the adult client, clinicians should keep the needs and rights of children in mind throughout their contact with clients. Safety issues for children can arise quickly when parents or other caregivers are affected by alcohol and drug use. This can include exposure to violence, exposure to known perpetrators of sexual abuse, exposure to criminal activities, or being left in the care of unsuitable caregivers.
3. Explain that clinicians in the alcohol and drug abuse field are likely to receive information about activities that might impact the safety of children, and have a responsibility to respond. They do not have to make the assessment but should notify authorities on the basis of reasonable suspicion and concern. Organisations should have policies and procedures in place to assist clinicians in responding to suspicions of child abuse and neglect. These should include access to immediate supervision from an experienced clinician, knowledge of what constitutes risk, knowledge of the child protection system, and training in how to discuss concerns about safety with clients.

(Source: Adapted from Patterson & Clapp, 2004.)

Questions?



Comments?

192

Instructions

1. Ask your audience if they have any questions on the presented information or if they need clarification on anything.

Post-assessment

Please respond to the post-assessment questions in your workbook.

(Your responses are strictly confidential.)



10 minutes

193

Instructions

1. Ask participants to complete the 5 post-assessment questions. They have 10 minutes to complete these questions.
2. Remind them that both the pre-training and post-training assessments are conducted so as to insure that the training is appropriate for your particular audience, to measure the effectiveness of the training, and to provide opportunities for improving it.
3. The assessments may create tension among audience members. To reduce such tension, explain to participants that both assessments are confidential and that they do not need to provide any personal information.



Thank you for your time!

194

Instructions

1. Thank your audience for their time.
2. Remind participants to use the forms in clinical settings.
3. Encourage your audience to keep in touch with you to resolve any doubts or answer any questions they might have.
4. Provide your contact information.