Training Curriculum on Drug Addiction Counseling

Chapter 3
Drugs, Drug Addiction, and Treatment Approaches
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TRAINING CURRICULUM
ON DRUG ADDICTION
COUNSELING

TRAINER MANUAL
# TABLE OF CONTENTS

## Part I: The Basics of Individual Drug Addiction Counseling

### Chapter 1. Trainer Orientation

### Chapter 2. What is Drug Addiction Counseling?
- 2.1. Introduction to general counseling
- 2.2. Basic concepts of drug addiction counseling
- 2.3. Key principles in drug addiction counseling
- 2.4. Counseling skills
- 2.5. Counseling techniques
- 2.6. Counseling procedures

### Chapter 3. Drugs, Drug Addiction, and Treatment Approaches
- 3.1. Drugs, drug use and its consequences
- 3.2. Alcohol problems
- 3.3. The basic of addiction
- 3.4. Basic treatment principles
- 3.5. Important factors for successful treatment
- 3.6. Treatment for heroin addiction

### Chapter 4. Motivational Interviewing
- 4.1. The Stages of Change Model and key concepts in motivational interviewing
- 4.2. Principles and steps for motivational interviewing
- 4.3. Linking motivational interviewing to stages of change strategies

### Chapter 5. Key Drug Addiction Counseling Skills and Techniques
(Stanford role-play sessions)
- 5.1. Client assessment
- 5.2. Problem solving
- 5.3. Goal setting
- 5.4. Reducing risk

### Chapter 6. Relapse Prevention
- 6.1. Relapse prevention therapy
- 6.2. Refusal skills
- 6.3. Coping with cravings
- 6.4. Stress management
- 6.5. Time management
Part II: Advanced Individual Drug Counseling

Chapter 7. Managing Intoxication and Hostility
  7.1. Anger management
  7.2. Dealing with aggressive and potentially violent behavior
  7.3. Conflict resolution
  7.4. Managing intoxicated clients

Chapter 8. Special Populations
  8.1. Working with families
  8.2. Working with youth
  8.3. Working with women

Chapter 9. Clinical Supervision and Support
  9.1. Framework for clinical supervision
  9.2. The basics of clinical supervision
  9.3. Case conferencing
  9.4. Preventing and managing burnout

Part III: Appendices

Appendix I: Sample training schedule
Appendix II: Sample evaluation form
Appendix III: Sample written exam
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CHAPTER 3

DRUGS, DRUG ADDICTION, AND TREATMENT APPROACHES

Unit 3.1: Drugs, Drug Use and Its Consequences 3
Unit 3.2: Alcohol Problems 55
Unit 3.3: The Basic of Addiction 73
Unit 3.4: Basic Treatment Principles 99
Unit 3.5: Important Factors for Successful Treatment 117
Unit 3.6: Treatment for Heroin Addiction 129
Unit 3.1
DRUGS, DRUG USE AND ITS CONSEQUENCES
OVERVIEW

I. Introduction
Introduce the unit by explaining that you will discuss drugs, drug use and its consequences in general, and specifically in Vietnam.

II. Presentation
Use the PowerPoint slides to present on drugs, drug use and its related consequences.

Break (during Presentation session)

III. Discussion
Facilitate a 30-minute discussion and a 30-minute report-back session based using the instructions in the manual.

IV. Conclusion
Review the key points of this unit and answer participants’ questions (if any).

Unit 3.1: Drugs, Drug Use and Its Consequences

Goal: To provide participants with basic knowledge about drugs, drug use and its related consequences in general, and specifically in Vietnam.

Time: 130 minutes

Objectives: At the end of this session, participants will be able to:
- define and name commonly-used drugs, describe how they are used, and understand the consequences related to their use
- identify drugs commonly used in Vietnam and common patterns of use in Vietnam

Methodology:
- Discussion handouts (provided to incite questions before the session)
- Presentation and discussion
- Small-group exercises

Teaching aids:
- PowerPoint slides
- LCD projector
- Flipchart and papers
- Markers
In this unit we will focus on drugs, their use and the consequences people face as a result of using them.
LEARNING OBJECTIVES
At the end of this session, participants will be able to:
- define and name commonly-used drugs, describe how they are used, and understand the consequences related to their use
- identify drugs commonly used in Vietnam and common patterns of use in Vietnam

Say: When we finish this session, I hope you will have a better understanding about the drug use situation in Vietnam, including types of commonly-used drugs, how they are used and the effects of using each of those drugs. The 4 main drugs that I am going to talk about, and that are commonly used in Vietnam, are Heroin, amphetamine, ecstasy and cannabis.

For each of these drugs, I am going to talk about what it is, how it is used, and its effects, including both immediate- and long-term effects.
DISCUSSION: DRUGS IN VIETNAM/ YOUR PROVINCE

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

Teaching instructions: Divide the participants into 3 groups ask them to spend 15 minutes in their groups answering the questions in the slide. Then reconvene the group and ask 1 group to report back. The other 2 groups should provide additional insights after the report-out to fill potential gaps.

You may wish to include additional questions for the groups before they begin their brainstorms, such as:

- Local names for the drug(s)
- Common route of administration (injected, snorted, mixed with another drug, etc.)
- Popularity of the 4 drugs among different risk groups (youth, college students, sex workers, urban professionals, etc.)
- Current popularity and popularity over time (increased, decreased, stabilized, etc.)
Teaching instructions: Show the title of this slide first, ask the question below, and facilitate a discussion before revealing the definition on the slide.

Say: Although this session focuses on the drug use situation in Vietnam, I want to make sure that you all understand the common definition of the drugs that we are going to talk about.

How do you define “drugs”?

Teaching instructions: Allow the participants to provide answers.

Say: A psychoactive drug is any chemical substance which when taken into the body alters its function physically and psychologically.

Do any of you use drugs?

Teaching instructions: Wait for a moment to see if participants respond. If no one does, or if they all say no, then proceed with the next question.

Say: Do any of you drink coffee? How about smoking cigarettes or drinking alcohol? You see, there are a variety of substances that you may not have thought of as psychoactive drugs.
Why do you think people take drugs?

Teaching instructions: Allow some time for the participants to contribute their ideas. After they have responded, continue below.

While there are many reasons for initiation and continued use of both licit and illicit drugs, key motivators pivot around three main factors. These motivators are not mutually exclusive. They include for fun, for forgetting and to improve functioning. A person may take drugs for any or all of these reasons. He/she may not be aware that these are the underlying drivers of his/her drug use.

Can you give examples for each of these 3 categories?

Teaching instructions: Allow participants to come up with their own answers. Some may have trouble coming up with answers for improving function. You can suggest taking caffeine pills or amphetamines to stay awake, or using aspirin or even heroin to stop pain.
Psychoactive drugs alter: 
- mood 
- cognition (thoughts) 
- behavior

**Mood.** When a psychoactive drug enters a user’s body, it changes his mood. For example, he may become happier. He may feel that he has just become a different person.

**Cognition.** (or thoughts). Users may perceive things differently when they are taking drugs. This relates to the way they process information and apply knowledge. It affects their memory, organization and planning skills, their ability to think abstractly, and their decision-making. All of this will influence their thinking. For example, when they are not intoxicated (not under the influence of a drug) they might have a different perception about risk-taking, and understand that sharing needles is dangerous and puts them at risk. However, when intoxicated, they may perceive things differently and perceive needle sharing as low risk or as an acceptable risk. Remember: drug users may use many drugs. So if they are intoxicated with alcohol and decide to use heroin, needle sharing may not seem so risky. Also, remember that drug users who use Heroin do not always wait until they are withdrawing to use Heroin again; some use again while still intoxicated.

**Behavior.** The way people act under the effects of drugs is noticeably different. Their physical appearance may be altered, they may be unsteady on their feet, or they may have slurred speech etc. There can also be other differences in behavior, such as violence and acting out-of-character.
Teaching instructions: Show only the title of this slide, and ask participants to list all of the psychoactive drugs they know. Draw a table on flipchart paper with 3 columns, without naming the columns. Fill in the drugs the participants suggest based, on the 3 columns in the chart in this slide. Afterwards, present the contents of this slide and proceed with the suggested wording below.

▲ Say: There are various drug classifications. These are somewhat arbitrary groupings, but they provide a useful reference tool for approximating relative drug effects, possible risks, and potential withdrawal features. The classification in this slide shows how these drugs affect the brain.

Classifications are intended as a general guide only, as variations in effects and intensity may occur for drugs within the same class. For example, although ecstasy produces similar stimulant effects to amphetamines, the effects are generally not as intense. In higher doses, ecstasy may have additional hallucinogenic effects for some people.

Opioids have been classified as depressants as a result of their primary effect on the brain. For the purposes of this training course, cannabis has been placed in the central nervous system (CNS) depressant category because of its primary effects as a CNS depressant, and in the hallucinogens category because, at high doses, cannabis may produce hallucinogenic effects.


<table>
<thead>
<tr>
<th>Depressants</th>
<th>Stimulants</th>
<th>Hallucinogens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Amphetamines</td>
<td>LSD, magic mushrooms, morning glory seeds</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>Nicotine</td>
<td>Mescaline, MDMA (Ecstasy)</td>
</tr>
<tr>
<td>Opioids</td>
<td>Cocaine</td>
<td>PCP, Ketamine</td>
</tr>
<tr>
<td>Solvents</td>
<td>Caffeine</td>
<td>Cannabis* (in high doses)</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>Khat</td>
<td>Other (e.g. N2O, amyl or butyl nitrite)</td>
</tr>
<tr>
<td>Cannabis*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
This model presents a systems perspective on the drug use experience. It combines Zinberg's interactive model of drug-related harm with the principles of Social Learning Theory. The Interactive Model suggests that the interaction between the drug, the environment and the individual is crucial to the overall experience from drug use. Each factor cannot be considered alone.

Within each domain (drug, individual and environment), the relative importance of each factor, (such as emotions, peer pressure, or route of administration) on influencing one's drug use experience will vary from person to person and situation to situation.

Some factors may overlap from one domain into another (e.g. drug availability may be an environmental factor, a drug factor, or both). The most important point is that each domain, and interactions between domains, need to be considered when examining the drug use experience.
**Say:** This slide represents the relative proportions of people who use psychoactive drugs based on their type of use.

The vast majority of drug users are people who use drugs on an experimental basis. They use them infrequently, based on opportunity and availability. Most of them can cease drug use of their own free will and will not go on to more intensive patterns of drug use.

As drug use becomes more intense and regular, it takes more precedence in an individual’s life and tolerance emerges along with other features or consequences of intensive use. Ultimately, drug addiction emerges. The proportion of drug users who ultimately become addicted to drugs is influenced by many things. Remember that not all people who use a drug will ultimately become addicted.
Teaching instructions: Show only the title of this slide and proceed with the group work and discussion below. Reveal the diagram of the model after participants have had a chance to respond to the question below.

Break the participants into 3 groups. Ask each group to come up with a list on flipchart paper of the risks and problems associated with drug use. Allow a few minutes for them to brainstorm, then bring the groups back together and ask 1 person from each group to report back.

FYI: Thorley conceptually described problems associated with drug use as belonging to three domains: intoxication, regular use and addiction.

The diagram shows that his domains are not mutually exclusive and that it is possible to have problems in 1, 2 or all 3 domains. The problems listed in each of the domains in this diagram are not exhaustive.

Intoxication

A single episode of intoxication can cause a variety of problems.

- Accidents often occur when one is intoxicated (drunk).
- Hangover usually follows intoxication.
- Overdose from heroin can result from intoxication.
- Risk perception is altered when one is intoxicated and one is more likely to share injecting equipment.
Regular use

Heavy regular use can cause a variety of problems.

- Long-term excessive alcohol use can cause liver damage.
- Heavy drug use is expensive.
- Regular heavy use can cause personality changes (depression, mood shifts) and can lead to relationship problems.
- Repeated heavy heroin use may cause frequent, non-fatal overdoses that can cause brain injury and poor memory or memory loss.

Addiction

The features of addiction will be covered in a later lecture.

- Physical addiction is characterized by the presence of withdrawal symptoms.
- Psychological addiction is characterized by the presence of cravings and use, despite its harm.
**Say:** Have you ever seen heroin?

*Here is a picture of heroin. It is the first illicit drug that we will discuss.*

*What do you know about heroin?*

**Teaching instructions:** Allow participants a few minutes to respond openly to your question. Then proceed to the next slide.
**WHAT IS HEROIN?**

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

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**Say:** Heroin is a derivative of the opium poppy plant. It belongs in the class of drugs known as "opiates". Opiates are derived from the white sap of the flowering poppy plant, which contains morphine and codeine, both of which are effective painkillers and are used in many prescription medicines.

Pure heroin is a white powder with a bitter taste. Less refined forms of heroin are known as "Black Tar", a gooey black or brownish substance.

Its chemical name is diacetylmorphine.
FYI: Heroin fits into a larger family of opioids: some that are natural such as opium, some that are synthesized from natural opioids, such as heroin, and some that are completely synthetic, such as methadone.

**Pure opioid agonists:** Of 20 naturally occurring alkaloids, only morphine and codeine have analgesic (pain-killing) properties.

**Semisynthetics opioid agonists:** e.g. heroin - a chemical derivatives of morphine

**Synthetic opioid agonists:** E.g. methadone and dextropropoxyphene - share a common structure that enables interaction with the opioid receptors in the brain. These entirely artificial drugs have been synthesized without beginning with a naturally occurring opioid.

Commonly used opioid include:

- Heroin
- morphine/morphine-based medications
- codeine phosphate and codeine-based preparations e.g. cough mixtures
- methadone
- oxycodone-based medications
- dextropropoxyphene-contained in medications
Opioids act on 3 main families of opioid receptors (μ, κ, and σ). The μ receptor is linked to addiction. The opioid receptors are located in the brain, spinal cord and periphery (including non-neuronal pathways in the gastrointestinal (GI) tract, resulting in effects such as cough and respiratory suppression, reduced GI motility (hence nausea and vomiting), small pupils, and urinary retention (from increased bladder and urethral tone).

Opioid receptors are inhibitory. They inhibit the release of other neurotransmitters such as serotonin, GABA, and glutamate. They also enable the release of dopamine which contributes to the addiction potential of opiates.

Effects exerted through the limbic system in the brain produce changes in emotions, such as the euphoric high.
The variety in chemical structures of the opioid class result in important differences in their absorption and metabolism. Morphine is rapidly metabolized by the liver after oral administration, so only a small amount reaches the rest of the body and the brain. Heroin (diacetylmorphine) is metabolized first to monoacetylmorphine (MAM), then to morphine. As heroin and MAM are more fat-soluble than morphine, they can cross the adult blood-brain barrier more rapidly than morphine, which results in more intense feelings of euphoria.

Codeine is also converted to morphine in the liver. 8-10% of Caucasians and 2% of Asians lack a specific enzyme and codeine will have no analgesic effect for them.
Say: Heroin is used in a number of ways. Heroin can be:

- injected into a vein (this is called “mainlining”)
- smoked in a water pipe or standard pipe
- snorted as powder via the nose
- used alone or mixed with another drug
HEROIN: IMMEDIATE EFFECTS (1)

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

Teaching instructions: Show only the title of this slide, and ask the question below. Allow participants some time to provide answers, and then reveal the bullets as you discuss them below.

**Say:** What are the immediate effects of heroin use?

Once heroin is injected, smoked or snorted, the user experiences a feeling of euphoria, also referred to as a “rush”. At the time of the rush, the user usually feels a warm flushing of the skin, dry mouth, and a heavy feeling in the extremities. He may also experience nausea, vomiting, and severe itching.

The time it takes to achieve this feeling of euphoria differs depending on the way the heroin is used. If injected into a vein, euphoria is reached in 30 seconds. If sniffed or smoked, euphoria may be reached in 10 minutes.

The effect varies depending on the person.

After the rush, users are usually drowsy for several hours. Their mental function is clouded, and their heart rate and breathing slow. Once the effects of the drug wear off, the euphoria subsides.
Some of the immediate effects of heroin use also include slower breathing and pulse, lower blood pressure, contraction of pupils, itchy, flushed skin, and dry mouth, skin and eyes.

The small pupils are due to increasing parasympathetic nerve tone in the pupil. The urinary retention is due to increased urethral and bladder tone.

**HEROIN: LONG TERM CONSEQUENCES (1)**

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

**Teaching instructions:** Show only the title of this slide, and ask the question below. Allow participants to provide answers, and then reveal the bullets as you discuss them.

**Say:** What are the consequences of heroin use?

**FYI:** Continued use produces tolerance, hence increased doses must be used to achieve the initial euphoria, putting users at great risk of overdose. **Tolerance** to opioids develops rapidly, commencing with the first dose and involves:

- Down-regulation - reduced number of receptors
- Desensitization - diminished response to receptor action

At higher doses, sedation can be extreme and an overdose can result:

- Unconsciousness, coma and death from respiratory failure

When not taking the drug, users often experience symptoms of withdrawal such as restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, and cold flashes with goose bumps.

Heroin is a highly addictive drug that alters brain function. Problems with health, social, financial, vocational, family and/or legal areas can occur.

Heroin use also puts users at high risk of HIV transmission through the sharing of injecting equipment and the impairment of judgment, which increases the likelihood that they will engage in high-risk behavior.
Teaching instructions: Use the notes below to discuss the long-term consequences of heroin use.

FYI: There is little evidence of long-term direct toxic effects on the central nervous system from using opioids. However, the following complications may result from long-term chronic opioid use.

**Constipation**

Constipation is characterized by bloating, vague abdominal discomfort.

Physical examination and investigations are negative, though patients may have a dilated bowel (with no obstruction).

**Depression**

Changing drug-use behaviors requires significant social change. It is not unusual for patients to experience depression or sadness in the face of significant change, and to require time to adjust to a different lifestyle.

**Brain damage**

There is a risk from repeated non-fatal overdoses of significant impairment in mental function. Organizational skills, planning skills and memory may be affected.
Endocrine

Heroin use affects the endocrine system by changing the sex hormones in women. This results in menstrual changes and reduced libido. It can lead to reduced testosterone in men and reduced libido.

Sources:

Amphetamine Type Stimulants

Say: Now we will discuss Amphetamine type stimulants.
Amphetamine type stimulants are a family of substances that have a common core composition and are differentiated by the composition and location of side arms that hang off the central molecule. They have varied effects that depend on the location and composition of the substituent(s). Today we will discuss two of them, namely methamphetamine and MDMA (Ecstasy).
What do we know about methamphetamine?


<table>
<thead>
<tr>
<th><strong>METHAMPHETAMINE</strong></th>
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<tbody>
<tr>
<td><strong>Hydrochloride salt:</strong> can be sold as powder.</td>
</tr>
<tr>
<td>- Bitter-tasting crystalline powder easily dissolves in water or alcohol - injected</td>
</tr>
<tr>
<td><strong>Crystalline:</strong> methamphetamine produced by acidification of methamphetamine base</td>
</tr>
<tr>
<td>- Smoked form. often referred to as “ice” or “crystal,”</td>
</tr>
</tbody>
</table>

**Say:** There are many different forms of methamphetamine. The salt variety is typically a powder that dissolves easily and is often injected or snorted. Crystalline "ice" or tablets, which have been compressed, are the same composition, but of higher purity. The freebase form can be sold as a yellow-brown liquid.
Methamphetamine comes in many forms and can be smoked, snorted, orally ingested, or injected.

“Ice,” is a form of methamphetamine that can be smoked. Ice is a large, usually clear crystal of high purity that is smoked in a glass pipe. The smoke is odorless, leaves a residue that can be re-smoked, and produces effects that may continue for 12 hours or more.
Say: Methamphetamine increases the levels of dopamine in the brain. It does this by causing the release of dopamine from the nerve cells, as well as by blocking the reuptake of dopamine back into the nerve cells. It also inhibits the enzyme that breaks down dopamine if it stays outside the nerve cells for too long.

Besides increasing dopamine levels, methamphetamine also increases levels of serotonin and noradrenalin. Dopamine and serotonin cause the sensation of pleasure that drug users seek. The unintended side effects (increase of noradrenalin) are often problematic for the drug user.
Say: Users like the central nervous system effects and dislike the peripheral nervous system effects, such as the release of adrenaline, which raises the heart rate.

What are the immediate effects of methamphetamine use?

Teaching instructions: Allow participants a few minutes to come up with answers, and then proceed.

Say: Immediately after smoking the drug or injecting it intravenously, users experience an intense euphoric rush or “flash” that lasts only a few minutes and is described as extremely pleasurable. Snorting or oral ingestion produces a euphoric high, but not an intense rush. Snorting produces effects within 3 to 5 minutes, and oral ingestion produces effects within 15 to 20 minutes.

ACUTE STIMULANT EFFECTS

Desired
- Feeling of wellbeing or euphoria
- Increased energy
- Wakefulness
- Alertness
- Reduced hunger
- Increased clarity of thinking
- Increased competence
- Feelings of sexuality
- Increased sociability
- Improved mood
Say: The physical effects of methamphetamines are similar to those of other stimulants. When taken by mouth, snorted or smoked, the user usually experiences feelings of euphoria, heightened alertness and greater energy. Heart rate and blood pressure increase, and sensations of hunger and fatigue are reduced. Heart palpitations may be experienced. The mouth usually becomes dry and swallowing is difficult, which makes eating food difficult. Urination is also difficult. The users’ pupils are large, and reflexes are faster. Rapid speech often occurs. Methamphetamine users may feel invincible and attempt to perform tasks they are incapable of performing.

<table>
<thead>
<tr>
<th>SHORT-TERM STIMULANT EFFECTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
</tr>
<tr>
<td>▪ Increased heart rate</td>
</tr>
<tr>
<td>▪ Increased pupil size</td>
</tr>
<tr>
<td>▪ Increased body temperature</td>
</tr>
<tr>
<td>▪ Increased respiration</td>
</tr>
<tr>
<td>▪ Increased blood pressure</td>
</tr>
</tbody>
</table>
LONG TERM EFFECTS OF STIMULANTS

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

**Say:** Here, for your reference, is a slide that lists some of the long-term effects of stimulants on the body.
Say: With prolonged exposure to methamphetamine, serious physical, psychological and health problems can develop. Addiction and mood disorders may develop. Mood disorders can lead to depression or violence.
Say: There is great risk of psychosis with chronic, high-dose usage. Psychosis is 11 more times likely to happen among methamphetamine users than among non-methamphetamine users. One-third of dependent users have symptoms. Hallucinations and delusions are common. These usually stop after a few weeks when users stop using methamphetamine, but they persist in about 10% of users.
The common street name for MDMA is ecstasy. What do you know about MDMA?

Teaching instructions: Allow participants to provide answers before moving to the next slide.

MDMA is both a stimulant and a hallucinogen. Like methamphetamine, it is an amphetamine-type substance. MDMA is sold as a tablet or capsule. It is a synthetic chemical that can be extracted from an essential oil from the sassafras tree. Its chemical name is 3,4-methylenedioxymethamphetamine. Counterfeit methamphetamine is often sold as ecstasy.
Ecstasy predominantly works on the brain by increasing the concentration of serotonin outside of the nerve cells. It also causes a large increase in the amount of dopamine outside of the nerve cells. These changes in the levels of serotonin and dopamine cause increases in nervous activity.

Serotonin is the main transmitter in the brain that is responsible for regulating mood, sexual activity and sleep. These are the desired effects that the drug user seeks. In addition, serotonin is important in memory and temperature control. The long-term use of ecstasy impairs memory while the short-term effect in some people is overheating.
Street doses of MDMA generally run from 50-150mg. An average single dose is generally considered to be about 100mg.

MDMA is usually pressed into pills or loaded into capsules. The primary route is oral and the effect lasts approximately 3-6 hours. Less frequent is injection or smoking of the drug, though this does occur. A powder form of MDMA can also be sniffed, but this is less common.

MDMA is notoriously unreliable in content. There are a number of chemically similar substances to MDMA that are commonly sold as MDMA on the street. These include methamphetamine.
Mild to moderate doses of MDMA produce a euphoric sense of well-being and a feeling of connectedness with, and empathy for, other people. MDMA also causes an enhanced sense of pleasure and self-confidence, and increased energy. This “love effect” has become most closely associated with MDMA use. Its stimulant effect has made it a favorite on the club and “rave” circuits.

In the hours after taking the drug, MDMA produces significant reductions in mental abilities. These changes, particularly those affecting memory, can last for up to a week, and possibly longer in regular users. The fact that MDMA impairs information processing emphasizes the potential dangers of performing complex or even skilled activities, such as driving a car, while under the influence of this drug.

Over the course of the week following moderate use of the drug, many MDMA users report feeling a range of emotions, including anxiety, restlessness, irritability, and sadness, that in some individuals can be as severe as true clinical depression. Similarly, anxiety, impulsiveness, aggression, as well as sleep disturbances, lack of appetite and reduced interest in and pleasure from sex, have been observed in regular MDMA users. Some of these disturbances may not be directly attributable to MDMA, but may be related to drugs often used in combination with MDMA, such as marijuana, or from adulterants found in MDMA tablets.

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

- Heightened sense of “closeness”
- Euphoria
- Increased energy
- Sexual arousal
- Large pupils
- Fast heart beat
- Teeth grinding
- Dry mouth
- Tremors
- Heart pounding
- Sweating
- Numbness and tingling
WHAT ARE THE IMMEDIATE EFFECTS OF USING MDMA (2)?

**Health Consequences**
- Over-heating
- Seizures
- Cardiac arrhythmias
- Stroke
- Liver damage

**Say:** *All of these adverse consequences are extremely rare.*
Long-term psychological effects:
- depersonalisation
- insomnia
- depression

Addiction

HIV transmission - lack of sexual inhibition and impaired decision making abilities

Potential adverse effects of MDMA on the developing fetus

Brain cell damage
- Whether these persist in the long term is unknown

Teaching instructions: Show the title of this slide only, and ask the question below. After allowing participants to respond, reveal the bullets on the slide and discuss them using the information below.

Say: What are the consequences of MDMA use?

For some people, MDMA can be addictive. Almost 60 percent of people who use MDMA report withdrawal symptoms, including fatigue, loss of appetite, depressed feelings, and trouble concentrating.

For pregnant women taking MDMA, the potential adverse effects of MDMA on the developing fetus are of great concern.

Use of MDMA has been linked to high-risk sexual behaviors that may lead to HIV-infection or other sexually transmitted diseases. Some report using MDMA as part of a multi-drug experience, mixing other legal and illegal substances.

Damage to brain cells has been associated with evidence of both short- and long-term memory impairment and difficulties with learning. It is unknown whether this damage causes any long-term problems.
Say: *Now we will discuss cannabis.*
THC is only 1 of 60 cannabinoids present in the plant Cannabis sativa. It is the one responsible for its psychoactive effects.
Say: There are a few different ways that cannabis is smoked, based on international experience. I would like to tell you a few terms that are used to describe these mechanisms.

**Joint** - a cigarette containing cannabis or cannabis + tobacco  
**Pipe** - a tube with a “cone”/reservoir at the end - many different styles  
**Bong** - a “cone” attached to a vessel containing water, with a mouthpiece

What are some of the ways cannabis is smoked or consumed in Vietnam?

**Teaching instructions:** Allow participants to provide some answers, and be sure to make a note of them for future trainings.


CANNABIS: IMMEDIATE EFFECTS

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

Cannabis overdose does not result in death.

**Say:** This list outlines some of the possible effects that may occur as a result of using cannabis. However, the relative severity of these effects or their consequences may vary enormously according to individual chemistry, previous use, experiences and expectations, and a range of environmental or other factors.

Gaining an understanding of the impact, effects, and harms for a person using psychoactive drugs, rather than focusing on the drug itself, is a key in gaining credibility and developing a relationship with clients who use psychoactive drugs.

Remember that adverse effects (considered of clinical importance from the perspective of a counselor), may have little relevance for the person using the drug.
Say: This is a list of some of the immediate, high-dose effects of cannabis.

- Pseudo-hallucinations are ones which a person is able to tell are not real. A true hallucination is one in which the person is unable to recognize the hallucination from reality.
- Cardiovascular and respiratory system effects include increased heart rate and low blood pressure (if the person stands up too quickly).
- A short-lived psychotic state, associated with a high dose, is possible. It usually resolves within a week of abstinence. It may be difficult to distinguish from the precipitation of psychosis in those with a predisposition to mental illness.


Say: Cannabis may precipitate or exacerbate certain mental health problems (such as schizophrenia) in those with a predisposed vulnerability, but this link has not been proven conclusively. In many individuals, mental health problems that arise during periods of psychoactive drug use may resolve and not recur when the person has been abstinent from the drug. Clients who have experienced adverse psychological or physical effects linked with their use of psychoactive drugs should be actively discouraged from reinstating use.

Heavy users can exhibit lethargy, emotional apathy, mental slowing, memory impairment, and poor planning ability - sometimes referred to as the “amotivational syndrome.” However this condition has not been clinically proven and some argue that the effects experienced are merely the consequences of constant intoxication.

Source: Swift, W., Hall, W. & Teesson, M. 2001, ‘Cannabis Use and Dependence Among Australian Adults: Results from the National Survey of Mental Health and Wellbeing’, *Addiction*, 96, 737–748.
Slide 45

Say: There are a number of long-term effects due to regular and heavier use of cannabis.

**Respiratory system effects include:**
- bronchitis, asthma, sore throat, chronic irritation (because it exacerbates asthma)

FYI: Cannabis contains more tar than cigarettes. Cannabis smoke may be more highly carcinogenic than tobacco smoke. Many cannabis users are also dependent tobacco users. Harmful effects are mostly associated with the route of administration. For example, smoking it may lead to chronic bronchitis. Smoking can also result in cancer.

**Cardiovascular system effects include:**
- increases in heart rate but decreases in the strength of contraction

FYI: People with cardiovascular disease may experience a decreased exercise tolerance.

**Cognitive impairment may include:**
- depression, anxiety, rapid mood changes reported
- precipitation of schizophrenia in vulnerable population

FYI: Effects may be subtle, but include effects on memory, attention, organization, and integration of complex information. Although the current evidence suggests that these effects are not grossly debilitating, their reversibility is unknown.
CANNABIS ADDICTION

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

**Say:** Cannabis addiction is characterized by a variety of cognitive, physical, and behavioral symptoms, such as poor ability to control use, continued use despite evidence of problems, withdrawal syndrome (anxiety, depression, mood swings, sleep disturbance, memory problems, non-specific physical discomfort) and high tolerance (Palmer 2001).

Concerns are emerging that addiction may develop rapidly in younger people and may be more severe than previously thought.

*It is estimated that 2 joints per day for 3 weeks is sufficient to induce withdrawal symptoms in some people, although daily use for several years has not resulted in withdrawal symptoms on cessation in others.*


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

Teaching instructions: Use the information on this and the following slide to summarize what you have discussed, and add any relevant points that may have been raised during your discussions.
SUMMARY (2)

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

**Teaching instructions:** Thank the participants for their participation in the discussions and ask them if they have any questions. Answer the questions that pertain to this or previous units. If participants ask questions about material that will be covered in a later unit, request that they save their questions for that unit.
Unit 3.2

ALCOHOL PROBLEMS
OVERVIEW

I. Introduction

Introduce the unit by explaining that you will discuss alcoholism, and problems related to alcohol abuse and intoxication.

II. Presentation

Use the PowerPoint slides to present on alcohol and alcohol-related problems.

III. Conclusion

Review the key points of this unit and answer participants’ questions (if any).

Unit 3.2: Alcohol Problems

Goal: To provide participants with basic knowledge on alcohol use and its related consequences in general, and specifically in Vietnam.

Time: 45 minutes

Objectives: At the end of this session, participants will be able to:
- describe alcohol use in Vietnam
- explain the concept of standard drinks and their relationship to blood alcohol level
- describe the effects of alcohol
- list 6 risk factors related to high-risk drinking

Methodology:
- Presentation
- Group exercise

Teaching AID:
- PowerPoint slides
- LCD projector
- Flipchart and papers
- Markers
We have discussed drug use and various types of drugs and their effects - including heroin. Now we will focus on alcohol.
LEARNING OBJECTIVES

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

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

Teaching instructions: Use the bullets on the slide to present directly.
**LEADING 12 AVOIDABLE RISK FACTORS OF DISEASE BURDEN**

1. Underweight
2. Unsafe sex
3. Unsafe water
4. Indoor smoke
5. Zinc deficiency
6. Iron deficiency
7. Vitamin A deficiency
8. Blood pressure
9. Tobacco
10. Cholesterol
11. Alcohol
12. Low fruit & veg intake

**High Mortality Developing Countries**

- Alcohol
- Blood pressure
- Tobacco
- Underweight
- Zn deficiency
- Iron deficiency
- Vitamin A deficiency
- Blood pressure
- Tobacco
- Cholesterol
- Alcohol
- Low fruit & veg intake
- Physical inactivity
- Illicit drugs

**Low Mortality Developing Countries**

- Tobacco
- Blood pressure
- Alcohol
- Underweight
- Obesity
- Cholesterol
- Alcohol
- Low fruit & veg intake
- Physical inactivity
- Illicit drugs

**Developed Countries**

- Tobacco
- Blood pressure
- Alcohol
- Cholesterol
- Obesity
- Low fruit & veg intake
- Physical inactivity
- Illicit drugs

**Say:** Alcohol causes significant harmful effects in developed as well as developing countries. It is among the top 12 leading avoidable risk factors for disease and is becoming increasingly problematic. Communities have the opportunity to reduce morbidity and mortality if they are able to reduce the overall consumption of alcohol.
ALCOHOL USE IN VIETNAM

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

Teaching instructions: Discuss the points on the slide, and note the differences between urban and rural/mountainous regions.

Say: Vietnam is not excluded from problems associated with alcohol and we will discuss how to prevent these problems during this session. Note that the prevalence of alcohol addiction (alcoholism) and abuse is higher than the prevalence of alcoholism in each area. Note also that the prevalence of alcoholism is higher in cities than in rural or mountainous areas. This is typically because drinking rates in the community are higher in cities.

Social problems associated with excessive alcohol consumption are common. These problems typically relate to intoxication or regular use. Of particular concern are higher rates of traffic accidents associated with drinking.
Say: Have a look at the glasses in this slide and tell me what you see.

Teaching instructions: Wait a few moments to allow participants to provide some answers to your question, and then proceed

Say: These are different glasses for various alcoholic drinks. The glasses hold different volumes: sparkling wine: 100ml; wine: 100ml; regular beer: 285ml; fortified wine: 60ml; and spirits: 30ml.

Each of these is 1 standard drink. Although the concentration of alcohol in each drink is different, each of these glasses contains approximately 10 grams of pure alcohol because the volume of the drink is adjusted to give about the same amount of alcohol. (Note that the wine glass only has 100 milliliters of wine in it, which is much less than the amount of wine that someone might pour into a glass. Note also the spirit, which could be whisky for instance, is only 30 milliliters). A standard drink raises the blood alcohol concentration (BAC) by approximately 0.02g% for men, and 0.03g% for women.
Slide 6

Teaching instructions: Use the information below to present the bullets on this slide.

FYI: The alcohol molecule is small and highly water-soluble. Its rate of absorption depends on the stomach emptying time - the rate of alcohol absorption is slow in the stomach and faster in the small intestine. Food in the stomach delays emptying and hence slows alcohol absorption and a lower peak BAC will result.

The pharmacokinetics of alcohol are as follows:

Rapidly absorbed into blood by stomach (20%) and small intestine (80%)  
Metabolised by liver (95–99%): alcohol — acetaldehyde — acetic acid & H₂O — CO₂  
Liver metabolises 1 standard drink per hour  
Distributed in body fluids (not fat)  
1 standard drink raises BAC by approx. 0.02g% for men and 0.03g% for women.
**Teaching instructions:** Use the information below to present on Slide 7.

**FYI:** The two tables in this slide describe the risk of harm due to alcohol consumption in terms of immediate and long-term effects.

The table on the left shows the risk of harm due to immediate effects of consuming alcohol. For males and females, there is relatively low risk with consumption of up to 4 drinks on a single occasion. Once this limit is exceeded, the risk of injury is no longer considered low.

The table on the right shows the risk of harm due to a lifetime of alcohol consumption on any given day: in essence, the cumulative effects of drinking alcohol throughout one’s life. This is based on calculations of the cumulative risk of alcohol-related chronic disease or injury over a person’s lifetime. The risk is considered low if 0-2 drinks are consumed on a given day. As the number of drinks on a given day exceeds 2, the risk is no longer considered low.

The level of acceptable risk listed in these guidelines is based on the risk of dying from an alcohol-related disease or injury. The chances of this happening are about one in one hundred (one death for every hundred people). In other words 1-in-100 deaths are predicated for a lifetime consumption level above two standard drinks per day.

Other factors will increase alcohol-related harm. These include situations where alcohol consumption may endanger one’s life (or example, drinking and driving or operating heavy machinery).
For healthy men and women, drinking more than four standard drinks on a single occasion significantly increases the risk of alcohol related injury arising on that occasion. The safest option for children and young people under the age of 18 is to avoid drinking alcohol entirely. Drinking alcohol during pregnancy raises the risk of birth defects.

While it is clear that women have greater physiological vulnerability than men, there are other gender differences related to risk-taking. Men are more likely than women to engage in risky behavior, especially when consuming alcohol. This is generally reflected in alcohol related injury data. At comparatively low levels of consumption, however, there are no apparent gender differences. As consumption levels increase, gender differences becomes more obvious.
Teaching instructions: Guide the participants through a large-group exercise. Draw three columns on flipchart paper and label them: Low, Moderate, and Severe. Proceed with the questions below, and fill in participant responses based on where they belong on the chart.

**Say:** Now I want you to tell me if you know the levels of impairment or intoxication that come with varying Blood Alcohol Levels. In other words can you describe what people would look like or feel like with different blood alcohol concentrations?

* Please give me some examples of levels of alcohol intoxication at different blood concentrations? What would somebody look like with a BAC of 0.05g%, which is considered relatively low? How about 0.1g%? What about 0.3g%?
Please note that these numbers are not precise and actual effects of BAC will vary from individual to individual. Remember the experience of a drug is an interaction between the drug, the individual and the environment. The effect alcohol has on the brain is not only based on how much alcohol you drink, but also individual factors, such as tolerance, and environmental factors, such as where you drink etc. So if you are not used to drinking, a low blood alcohol concentration may still make you feel quite intoxicated.

### EFFECTS OF ALCOHOL INTOXICATION

<table>
<thead>
<tr>
<th>BAC Level</th>
<th>Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>.01-.02g%</td>
<td>Clearing of head</td>
</tr>
<tr>
<td>.02-.05</td>
<td>Mild throbbing in rear of head, slightly dizzy, talkative, euphoric, confident, clumsy, likely to make flippant remarks</td>
</tr>
<tr>
<td>.06-.1</td>
<td>讲话，愉快，自信，笨拙，可能说些轻率的言论</td>
</tr>
<tr>
<td>0.2-.3</td>
<td>Poor judgement, nausea, vomiting</td>
</tr>
<tr>
<td>0.3-.4</td>
<td>Blackout, memory loss, emotionally labile</td>
</tr>
<tr>
<td>0.4+</td>
<td>Stupor, breathing reflex threatened, deep anaesthesia, death</td>
</tr>
</tbody>
</table>
Certain factors predispose a person to heavy, regular alcohol consumption and alcoholism. They include a variety of environmental and genetic factors. There is well-documented evidence of family predisposition to alcoholism. You have 8 times the risk of becoming an alcoholic if a close relative is an alcoholic. However, this does not mean it is inevitable.

<table>
<thead>
<tr>
<th>PREDISPOSING RISK FACTORS FOR ALCOHOLISM</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Family history of alcohol problems</td>
</tr>
<tr>
<td>■ Poor coping responses to stressful life events</td>
</tr>
<tr>
<td>■ Depression, divorce or separation</td>
</tr>
<tr>
<td>■ Heavy drinking partner</td>
</tr>
<tr>
<td>■ Working in a male dominated environment.</td>
</tr>
<tr>
<td>■ Childhood problem behaviours related to impulse control</td>
</tr>
</tbody>
</table>
**Slide 11**

**BINGE DRINKING**

Binge drinking can lead to:
- increased risk taking
- poor judgment/decision making
- misadventure/accidents
- increased risky sexual behavior
- increased violence
- suicide

**Say:** Binge drinking is regular drinking to the point of heavy intoxication. For men, this may be more than six standard drinks on a single occasion. There are several risks that come from this type of drinking. This slide shows some of the things that binge drinking can lead to. What are some other things you can think of that might happen?

**Teaching instructions:** Give participants a few moments to provide some answers.
Young people (up to 18 years) and young adults (19-25 years) are particularly vulnerable to the risks of alcohol consumption. Young people's patterns and levels of drinking place them at significantly higher risk of harm compared with the community in general.

The reasons for increased risk include:

- smaller physical size
- fewer social controls
- their friends condone intoxicated behavior
- risk of overdose due to lack of tolerance

There are multiple potential harms that can occur as a consequence of heavy drinking. Commonly, the harms are a direct result of the problems from intoxication, but less commonly there are also problems associated with regular use or alcoholism.

A blackout occurs when a person is so intoxicated that he/she cannot remember what he/she did or said while drinking.
Women are more susceptible to the effects of alcohol due to:
- smaller physical size
- decreased blood volume
- lower body water: fat ratio
- reduced ADH activity in stomach (hence reduced metabolism of alcohol)

Results in:
- increased risk of intoxication related harms; e.g. assault, injury
- earlier development of organ damage

**Say:** Women are more susceptible to the effects of alcohol because:

- they are smaller in size than men
- they have lower blood volume
- they have a smaller body water: fat ratio
- they have reduced ADH (alcohol dehydrogenase) activity in their stomachs (hence reduced metabolism of alcohol)

**This results in:**

- increased risk of related harms from intoxication; such as assault, injury, unwanted sexual behavior
- earlier development of organ damage

Because they have higher blood alcohol concentration after drinking the same quantity as men, they have increased likelihood of organ damage. Alcohol dehydrogenase levels in the stomach of females are only 50% of those in males, which results in slower alcohol metabolism in the stomach before the alcohol is absorbed.

Higher alcohol-related risks in women are thus related to higher BAC in women as compared to men, when consuming equal volumes. Alcohol consumption during pregnancy can also be harmful to the unborn child.
SUMMARY

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

Teaching instructions: Review the key messages of this unit

Thank the participants for their participation in the discussions and ask them if they have any questions. Answer the questions that pertain to this or previous units. If participants ask questions about material that will be covered in a later unit, request that they save their questions for that unit.
Unit 3.3

THE BASIC OF ADDICTION
OVERVIEW

I. Introduction 2 Min
Introduce the unit by explaining that you will discuss the continuum of drug use, why people take drugs, the definition of drug addiction, and opioid withdrawal symptoms.

II. Presentation 40 Min
Use the PowerPoint slides to present on the basis of addiction.

III. Conclusion 8 Min
Review the key points of this unit and answer participants’ questions (if any).

Unit 3.3 The Basic of Addiction

Goal: To provide participants with basic knowledge on drug addiction.

Time: 50 minutes

Objectives: At the end of this session, participants will be able to:
- describe the patterns of psychoactive drug use and avoid misunderstandings about drug users
- understand the biological basis of addiction
- distinguish between physical and psychological addiction
- describe heroin withdrawal

Methodology:
- Presentation
- Group exercise

Teaching aids:
- PowerPoint slides
- LCD projector
- Flipchart and paper
- Markers
We will now discuss the basic of addiction.
LEARNING OBJECTIVES.

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

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

Teaching instructions: Use the bullets on the slide to present directly.
Teaching instructions: Break the class into small groups of 4 to 5 people. Ask each group to appoint someone to report back on the group discussion and ask them to spend 5 minutes discussing the statements in the slide. Ask them to discuss whether these beliefs about drug users are myths or facts. Ask the groups to report back and to explain their reasoning for each decision. Once all groups have reported back, proceed with the suggested wording below.

Say: I would like to offer you a few facts to consider

- Most drug users are experimenters and are not easily distinguished from anyone else.
- Not everyone who uses drugs becomes addicted. We will discuss this in more detail during this unit.
- Drug addiction counseling works! Many drug users stop using drugs on their own.
- Tobacco is more addictive than heroin.
- Addiction creeps up slowly and is often missed until it is too late. While many experimenters stop without developing problems, not everyone is that fortunate.
Say: You have seen this slide before. Remember that psychoactive drugs alter a user’s:

**Mood:** When psychoactive drugs enter a user’s body, they change the user’s mood. For example, he/she might become more confident in herself. She might be happier, more enthusiastic, sexually aroused, or calmer, depending on the drug.

**Cognition (or thoughts):** Users may perceive things differently when they take drugs. While they may understand clearly that sharing needles puts them at risk, their judgment may dissipate when under the influence of a drug.

**Behavior:** The way a person acts under the effects of drugs is noticeably different. He/she may be more willing to take risks, more sociable, or more withdrawn.
Say: This slide demonstrates the proportionate kinds of users among those who use drugs.

The vast majority of drug users are people who only experiment with drugs. They use them infrequently based on opportunity and availability. Many of them can and will cease using drugs of their own free will, and will not go on to more intensive patterns of drug use.

Some individuals use drugs to help them achieve something, like staying awake, or to kill pain. These are called purposive users.

As drug use becomes more intensive and more regular, it becomes a bigger feature of a drug user's life; tolerance emerges along with intensive drug use consequences, such as relationship, financial and/or employment-related consequences.

The proportion of drug users who ultimately become addicted is influenced by many factors. Not everyone who uses a drug will ultimately become addicted.
The risk of addiction is different for different drugs. As you can see, the different spikes have different heights. Higher spikes imply higher proportions of those who have ever used that drug that become addicted. Tobacco has the highest ratio at 1:3 (1 out of every 3 who have ever smoked tobacco become addicted) while for heroin the ratio is between 1:4 to 1:5. In other words, between 20-25% of those who ever use heroin become addicted.

These proportions are also culturally dependent. The figures quoted by Anthony are for America. There will be differences in different cultures and other environmental settings. Routes of administration and formulation also have an effect on the risk of addiction. Rapid routes of administration, like injecting or inhalation (smoking), have higher risks of addiction than slow routes of administration, such as the oral route. Drug formulation also has an effect. Note that crack cocaine may have a higher risk of addiction than cocaine hydrochloride salt.

Environmental factors, substance related factors, and individual factors all influence risk of addiction. Just as the experience of use is influenced by the interaction between the drug, individual and environment, so is the risk of addiction.
Say: Using drugs is a voluntary and preventable behavior. The key motivators for a person to use drugs are to have fun, to forget, and to function optimally (purposeful use). Initially, drug users can control their own drug use relatively well. This initial phase is a good phase in which to focus primary prevention and early intervention programs to prevent drug use from escalating, especially amongst youth.

Many factors influence people when they consider using drugs. While many individual factors are important, social conditions also have a direct impact on whether people use drugs as well.

Those who tend to be impacted most negatively from drug use tend to come from marginalized segments of the population and experience greater stigma and/or exclusion.

Therefore, counselors need to be considerate and try to understand more about where their clients come from and what they have experienced in their lives.
But...

*Drug addiction* is not just “a lot of drug use”

**Say:** BUT addiction is not just a lot of drug use; it is more than that. It is the compulsive use of drugs despite related harms and consequences, including psychological and physical changes in the brain. The drug controls the user’s life.

All drug users believe that when they start to feel that problems are arising from their drug use, they will stop and avoid addiction. What they do not realize is that the changes inside their brains happen slowly and in a way that is difficult to reverse.
Teaching instructions: Use the information below to discuss how little is understood about addiction.

FYI: There is sufficient information available now to confirm that addiction is not a failing of moral weakness, but rather a disease of the brain. Addiction to a substance is the interaction between neurobiological, psychological and social factors. Unfortunately, this concept is not commonly understood. Many policy makers and even many health care professionals do not know that addiction is a brain disease. One important role for counselors is to transfer this message to the community and local authorities to change attitudes and approaches toward addiction. Consider individuals who are addicted to drugs as patients with a medical condition who need to be treated. Without treatment, the drug using behavior is beyond their control.

Psychoactive substances have effects on perception, emotion and motivation. There is evidence from brain imaging studies, such as magnetic resonance imaging and positron emission tomography (an imaging technique that produces a threedimensional image of the functional processes in the brain) that drugs have direct effects on brain cell activity. At the cellular level, drugs exert their effects on neurotransmitters, the messengers that relay information between brain cells.

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

Leshner 1997
WHAT IS ADDICTION? (1)

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

**Say:** Addiction is a chronic, relapsing disorder characterized by compulsive drug-seeking and use, in spite of adverse consequences. Addiction has physical as well as psychological dimensions. As a clinician treating people who are addicted to drugs, it is important to remember that both dimensions of addiction need to be managed effectively.
>> Say: Some people think of drug addiction as strictly physical. Drug addiction has BOTH physical and psychological features.

Teaching instructions: Use the information below to explain how addiction is classified. Note that the criteria continue onto the following slide.

FYI: A diagnosis of addiction should only be made if 3 or more of the following occurred simultaneously at some time during the previous year:

- A physiological withdrawal state when substance use has ceased or reduced, as evidenced by withdrawal syndrome for the substance, or use of the same (or closely related) substance, with the intention of relieving or avoiding withdrawal symptoms
- Evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses (clear examples of this are found in alcohol- and opiate-addicted individuals who take daily doses sufficient to incapacitate or kill non-tolerant users) a strong desire or sense of compulsion to take the substance
- Difficulties in controlling substance-taking behavior, in terms of its onset, termination, or level of use
- Progressive neglect of alternative pleasures or interests because of psychoactive substance use; increased time/energy invested in obtaining the substance and/or to recover from its use
Persistance with substance use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking, depressive mood states consequent to periods of heavy substance use, or drug-related impairment of cognitive functioning (efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and extent of the harm)

Impairment of cognitive functioning (efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and extent of the harm)

The first 2 criteria relate to physical addiction while the remaining criteria relate to psychological addiction. Only 3 of these criteria, simultaneously present in the previous 12 months, are required to categorize an individual as addicted. The presence of 1 of the physical criteria is not required to categorize one as addicted.

ICD-10 also describes harmful use as a pattern of psychoactive substance use that causes damage to one's health. The damage may be physical (as in cases of hepatitis from the self-administration of injected drugs) or mental (e.g., episodes of depressive disorder secondary to heavy consumption of alcohol). The diagnosis requires that actual damage was caused to the mental or physical health of the user.
Teaching instructions: Use the bullets on the slide to present directly. Use the FYI below to provide additional information.

FYI: Often doctors and other health professionals overestimate the importance of physical addiction in determining opioid addiction. However, it is common in opioid substitution programs to look for evidence of opioid withdrawal and to estimate an individual's level of tolerance to assist in making an assessment of the appropriate dosage of opioid substitution medication. Note that tolerance is defined as the level of increased dosage of a psychoactive substance that is required to achieve the effects originally produced by lower doses of the same substance. For example, if a person is suffering opioid withdrawal syndrome, a larger dose will be required to block the effects of withdrawal than previously required. Hence, opioid withdrawal and tolerance are linked.
Teaching instructions: Before showing the bullets on this and the following slide, ask the participants if they can identify the difference between "signs" and "symptoms". After listening to their responses, ask them for examples of the signs of opioid withdrawal vs. the symptoms of opioid withdrawal. Then reveal the bullets on this and the following slide, and fill in gaps based on the participants' responses.

FYI: Signs - What you see:

- People withdrawing from heroin may experience from moderate to severe (but not life-threatening) withdrawal syndrome.
- Signs and symptoms of heroin withdrawal may be mistaken for a bad dose of the ‘flu’.
- Heroin withdrawal is rarely fatal unless the person becomes dehydrated or has a coexisting, serious medical condition.
- The onset and duration of withdrawal varies according to the drug used.
- Withdrawal symptoms from heroin may commence 6-24 hours after the last dose, and may last for 5-7 days.
- Methadone withdrawal may commence 2-3 days after the last dose and last for up to 3 weeks.
- There may be a prolonged withdrawal phase following an acute phase, often associated with depression. This may last several months and is associated with a higher risk of relapse.

**OPIOID WITHDRAWAL**

**Signs**
- Yawning
- Tears
- Dilated pupils
- Sweating
- Runny nose, sneezing
- Tremors
- Goose bumps
- Diarrhea and vomiting
Slide 14

OPIOID WITHDRAWAL

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

FYI: Symptoms - What people complain they feel

Teaching instructions: Discuss the symptoms that were not raised by the participants. Then continue with the suggested language below.

⚠️ Say: So far we have covered some myths and facts about heroin addiction, identified that not everyone who uses heroin becomes addicted, and discussed heroin withdrawal syndrome. We have also looked at some of the physical elements of addiction. We discussed briefly the fact that addiction risk is an related to the interaction between substance use, and the environment in which it is used, and individual factors about the user. We are now going to look more closely at individual biological factors.
Addiction involves the interaction of multiple factors that influence vulnerability and risk. The factors include:

- biological/genetic factors
- environmental factors
- type of drug
- brain chemistry

The interaction between these affects the brain in such a way that leads to increased vulnerability to addiction.
Teaching instructions: Use the information below to present on this slide.

FYI: There are four main ways that the addicted brain is different from the non-addicted brain. We will briefly look at each in turn.

As mentioned previously, drugs directly influence nerve cells by altering the number and sensitivity of receptors that switch on nerve cell activity. This will be discussed in greater detail shortly.

Beyond a drug’s effects on receptors, drugs also alter the brain’s metabolic activity. There are many areas of the brain that have reduced metabolic activity following drug use. Continuous reduction in the nerve cells’ ability to use glucose (energy) results in disruption of many brain functions.

Drug use can also affect an individual’s responsiveness to environmental cues and genetic expression. Drugs can influence the genes in the nucleus of brain cells that are responsible for protein expression, which in turn can influence an individual’s cravings to use drugs.

The genetic risk of addiction is the topic of intensive research. There is an eight-fold increase in the risk of addiction if a drug user also has a family member who suffered from addiction to the same drug.
FYI: The reward pathway

In order to understand how drugs affect the brain, it is important to understand the reward (mesolimbic) pathway. While there are other brain message systems affected by drugs, this one is of particular importance.

The reward pathway involves several parts of the brain, some of which are highlighted in this slide. Tell participants that this is a view of the brain cut down the middle. An important part of the reward pathway is demonstrated in purple, and the major structures are highlighted: the ventral tegmental area (VTA), the nucleus accumbens, and the prefrontal cortex. The VTA is connected to both the nucleus accumbens and the prefrontal cortex, and sends information to these structures via nerve cells. The nerve cells of the VTA contain dopamine, which is released in the nucleus accumbens and in the prefrontal cortex. This pathway is activated by psychoactive drugs.

- The VTA and the nucleus accumbens are both in the midbrain and are responsible for motivation, learning and reinforcement.
- They are activated by drugs; dopamine sends information from the VTA to the nucleus accumbens and then to the prefrontal cortex.
- The prefrontal cortex has influence on abstract thinking, planning and memories.
- These actions influence the desire to use drugs.
The act of liking something is controlled by the forebrain. If you have a pleasant reward from something, your reaction is to “like” it. However, when you anticipate the reward, and do things motivated by that anticipation, your brain has decided you need it. The act of needing something is a midbrain dopamine phenomenon. We have basic biological needs such as food, water, and sex, for survival. Drugs activate the same pathway and trick the brain into believing that drugs are necessary for survival.

Food and water are essential for life. When you have just had lunch and something to drink, the desire for food and water is not particularly high. But imagine if you refrained from eating well past 8 PM. Your desire for food and water would likely be much different. Imagine now that you go 2 days without drinking and eating; a bottle of water will be far more important than anything else. The pathway in your brain we just discussed helps you to prioritize how important things are and what you need to do to manage those priorities.

Drugs have a way of influencing this pathway and trick the brain into believing they are essential for life. If someone addicted to heroin did not have his hit for 2 days; his hunger for the drug might be as intense as our hunger for food if we did not eat for 2 days. However, although increases in dopamine are important in reinforcing the effects of drugs, these increases alone do not adequately explain addiction.
FYI: Drugs affect the brain in such a dramatic way that the brain tries to adapt. One way the brain adapts is to reduce the number of dopamine receptors on the nerve cells. Studies have shown that dopamine receptor availability is significantly decreased across a wide variety of types of drug addictions. Moreover, these decreases persist for 4 to 6 months after last use.

When you are addicted, the nerve cells no longer operate in the same way. You can see in this slide that the levels of dopamine are not the same.

The brains in the left-hand column are of non-drug/alcohol users while the brains in the right-hand columns are brains from individuals who are addicted. You can see there is much less dopamine (the red color) in the brains of those who are addicted, versus those who are not.

How does the reduction in dopamine receptors change the effects of drugs on dopamine? Drugs increase dopamine release from cells in ways that are both quantitatively and qualitatively greater than those from a natural stimulus. Increases in dopamine release are 5-10 times greater from drugs than from natural stimuli. Moreover, some drugs block the transporter that recycles dopamine back into the nerve cell. The net result is that, following drug use, dopamine stays in the synapse a longer period of time. Thus, despite the fact that the number of dopamine receptors is decreased in a drug user, the probability of nerve transmission from a drug is very high, not only because the dopamine concentration is very large, but also because dopamine remains in the synapse longer. The drug user learns that natural stimuli no longer produce pleasure, but drugs do - a fact that drives and motivates subsequent drug use behavior.
Once you are exposed to a stimulus, your motivation to repeat exposure to that stimulus may be high or low, depending on how you respond to it. You may even predict what will happen if you are exposed to that stimulus again. Perhaps you felt good the first time you were exposed. You might predict you will feel good the second time. Therefore, there is incentive for you to be exposed again: feeling good. Drugs impair our judgment such that the incentive to obtain them is excessive. Drug users who are addicted make irrational decisions because of this impaired judgment. They become highly motivated to obtain drugs and to use them.
FYI: Almost no one becomes addicted the first time he/she uses a drug. Drug use, misuse, and addiction can be thought of as points along a continuum. Any use of a mind-altering drug that causes physical or psychological harm is drug use, but the point when drug use becomes drug addiction is often less clear to the drug user. Different drug users may reach the point of addiction at different times. People start and continue to use drugs due to recreation and experimentation, self-medication, social relationships and/or peer pressure, or to improve their functionality.

Addiction is a brain disease that makes it hard for a drug user to stop using drugs. People who are addicted have difficulty controlling their use, give priority to their drug use over other activities, experience withdrawal symptoms when they stop, have strong cravings to use drugs, continue to use even when having problems, and/or use drugs to feel normal.

It is important to understand that a person who is addicted to a drug will need time to recover and that addiction can be a chronic, relapsing disorder.

It is also important to note that addiction is not a brain disease alone, but is influenced by the social contexts in which the addiction develops and is expressed. If we see addiction as a psychological illness, with critical biological, behavioral, and social contexts, the treatment strategies must include biological-, behavioral-, and social-context elements. Both the underlying brain disease and the behavioral and social cue components must be addressed.
Teaching instructions: Thank the participants for their participation in the discussions and ask them if they have any questions. Answer the questions that pertain to this or previous units. If participants ask questions about material that will be covered in a later unit, request that they save their questions for that unit.
Unit 3.4
BASIC TREATMENT PRINCIPLES
OVERVIEW

I. Introduction 2 Min
Introduce the unit by explaining that you will discuss the basic principles and practices of drug addiction treatment.

II. Presentation 20 Min
Use the slides to present on the basic principles and practice of drug addiction treatment.

III. Conclusion 8 Min
Review the key points of this unit and answer participants' questions (if any).

Unit 3.4: Basic Treatment Principles

Goal: To help participants understand the basic principles of addiction treatment.

Time: 30 minutes

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

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

Methodology:

- Presentation

Teaching aids:

- PowerPoint slides
- LCD projector
- Flipchart and paper
- Markers
Say: The purpose of this unit is to provide you with a basic understanding of the principles for providing high-quality drug addiction treatment. We will discuss the settings in which treatment can occur and the relationship between different types of treatment.
LEARNING OBJECTIVES

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

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

Teaching instructions: Use the bullets on the slide to present directly.
Before we discuss the basic principles in providing drug addiction treatment, we need to revisit this important consideration about drug addiction. Understanding that drug addiction is a medical condition often associated with periods of psychosocial instability will help orient our discussion of the principles of treatment, and the settings where it is most effective.
Clinical practice should follow these four common principles: the right care for the right person at the right time and in the right way. This may sound simple, but these are very important in order to ensure that treatment is effective. Determining the right care requires skill and commitment to make high quality assessments and to refer individuals to the full range of available services. This means matching the service to the client’s specific problem, while taking into consideration his/her personal resources (both cognitive and social) and his/her current stage of change. (Note that we will discuss Stage of Change Theory in more detail in a subsequent unit). High-quality services adhere to effective, proven, strategic models.

Appropriate timing means ensuring that services are available when the individual is interested and prepared to commit to doing something about his/her substance use. In considering all four of these elements, you are ensuring that the treatment program is catered to an individual’s needs. Effective treatment also necessitates that treatment progress be monitored and review regularly.

Identifying the right care involves understanding an individual’s needs and capabilities, and matching treatment to his/her stage of change. In the right way implies that the clinical service is being provided in a way that is consistent with the stated philosophy, objectives, and techniques of the treatment program. It can also mean the individual counselor is using skills and techniques in the way they are intended to be used.
Say: Treating chronic diseases such as diabetes, asthma and hypertension, involves the same principles that we apply in drug addiction treatment. Like patients with diabetes or heart disease, people in treatment for drug addiction often take medications as part of their treatment regimen, but they also need to learn skills and techniques for behavior change. Using efficacious medications and encouraging lifestyle changes through behavior change treatment and counseling can be as effective for drug users as it is for patients who have other chronic diseases. Combining medication and behavior change is the most effective approach, as opposed to using either in isolation.

Clinicians should also apply the same nonjudgmental approach to treating drug users as they would in treating other chronic conditions, such as hypertension.
Say: There is no single way to approach drug treatment.

The treatment setting, model, therapeutic focus and intensity will vary. For example, the treatment setting may be residential, where someone lives at the same place they are receiving treatment (such as in a rehabilitation center). It may also be an outpatient setting, where the client comes on a regular basis to receive treatment, or an inpatient setting, where the client stays at a voluntary health facility.

The therapeutic model will vary depending on the theory and technique utilized by the care provider. Counseling can be cognitive, or behavioral, or both.

The therapeutic focus might include only the individual, the individual in group therapy, or individual with his/her family.

Treatment intensity also varies. It may be that treatment is offered a certain number of days per week or a certain number of hours per day. It may be time-limited or open-ended.

All of these factors influence the suitability and appropriateness of the treatment option.
Let’s begin with the key principles of effective treatment.

No single treatment is appropriate for all individuals. Clients love to have choices. Their goals, problems, and resources will influence their treatment selection. It is important that you get detailed information during your assessment and are aware of available therapies. Take time to discuss these with your client and determine which treatment option he/she thinks would work best for him/her. For example, some clients may want to be treated with antagonist medication such as naltrexone, others may want to try traditional medicine or acupuncture, while others might consider methadone most acceptable to them.

Effective treatment attends to the multiple needs of the individual, not just his/her drug use. Drug users usually enter treatment with multiple problems. Treatment programs need to acknowledge this and try to address the different needs of each individual, rather than focusing on drug use alone. From clients’ perspectives, their other needs are important to them and need to be considered, in order for them to have trust and confidence in the treatment team. Having said that, the drug addiction treatment service may not provide all the services that are required to address the client’s needs. Instead, the counselor may do it by linking and referring to other treatment services that specialize in those areas.

Treatment needs to be readily available because barriers to access will deter many from seeking treatment. Delays in access to treatment significantly reduce the likelihood clients will enter treatment. When they are ready to start, we should be ready to receive them.

Remaining in treatment for an adequate period of time is critical to treatment effectiveness. Clients who remain in treatment for an adequate period of time generally have better treatment outcomes. Those who leave treatment early are much more likely to relapse to drug use. At least 3 months in treatment is required for significant changes to occur. Some forms of treatment, such as methadone, require a longer time for the changes to be maintained.
**PRINCIPLES OF EFFECTIVE TREATMENT (2)**

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

**Teaching instructions:** Show the title of this slide only and reveal each bullet as you discuss them below.

**Say:** Treatment progress and drug use while in treatment should be monitored. Sometimes the progress is slow, other times it is fast. It is critical that progress and drug use in treatment is monitored to determine whether the treatment is helping and whether any alterations to treatment are required.

Treatment plans need to be assessed and modified continually. Regular review and update of goals and progress are important to modify the treatment plan as necessary.

Medicines for treating addiction are important but other components for effective treatment are also important.

Counseling and other behavior components are critical. Medication without counseling is not as effective as a combination of the two. Similarly, counseling without medication is not as effective as combination of the two. In addition to counseling, effective programs also employ behavior change treatment components.
Detoxification is only the first stage of treatment and by itself does little to change long-term drug use. Some patients may think that detoxification is all they need to do to stay abstinent. It is important to emphasize that detoxification is only the first stage of treatment. Relapse prevention counseling is essential. Patients who don’t have counseling after detox are at high risk of relapse. Estimations in Vietnam suggest that over 95% of patients who undergo detox only will return to using drugs.

Treatment programs should provide testing for HIV, hepatitis, TB and other infectious diseases, and provide help and means to modify risk behaviors. High rates of hepatitis, TB and HIV exist among injection drug users, especially in Vietnam. In some settings like rehabilitation centers, the HIV rate is as high as 70%, TB 5% and hepatitis C up to 80%. Assessment and referral is critical to address and modify risks and to provide appropriate treatment.
PRINCIPLES OF EFFECTIVE TREATMENT (4)

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

**Say:** Treatment of comorbid conditions should be integrated. Patients commonly have other physical and psychiatric conditions such as depression and anxiety. These need to be recognized and treated.

Recovery from addiction can be a long-term process and frequently requires multiple episodes of treatment. It is unusual for a drug user to require a single episode of treatment alone to recover from addiction. Remember that drug addiction is a chronic relapsing medical disorder. Repeated treatment episodes may be necessary.
**WHAT ARE THE GOALS OF DRUG TREATMENT?**

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

*Say:* For most users, the ultimate goal of drug treatment is to achieve abstinence. However, some users may wish only to reduce drug use, improve their ability to function, and minimize the medical and social complications of their drug use.
TREATMENT OUTCOMES

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

**Say:** There is a range of possible treatment outcomes that include reduction in drug and/or alcohol use, increased personal and social functioning, and improved public health and safety. This might include reduction in HIV and hepatitis C transmission, and reduction in drug-related criminality.
Say: *This diagram is important for understanding a client’s heroin addiction treatment options. You can see that treatment options are interconnected.*

FYI: This slide is intentionally made as a build slide (each component is added as you advance forward).

The first build is designed to show the connection between abstinence and heroin use, and to identify that people may give up heroin use without ever becoming addicted or seeking treatment.

The second build shows the linkage between heroin use and addiction, to identify that it is possible for a person to stop his/her addiction without the need for treatment.

The next build shows the linkage between addiction and risk-reduction measures. People may not be prepared to change their drug use behavior, but counselors should still provide risk-reduction information, which includes overdose education and HIV risk reduction.

The next build shows the linkage between addiction and detoxification. Detoxification is a process; it is not a treatment. Clients need to be linked to relapse prevention approaches in order to maintain abstinence. It is important that the relapse prevention approaches are provided in a range of settings (either outpatient or inpatient) and provide drug-free counseling or medications such as Naltrexone.

The next build shows the relationship between addiction and substitution treatment. The main substitution treatment available in Vietnam is methadone maintenance treatment. The double-headed arrow between detoxification and substitution treatment indicates
that some people try detoxification unsuccessfully and move to substitution treatment. Some others, who have completed substitution treatment, still need to detoxify to be drug-free. There is an artificial division between relapse prevention and substitution treatment. Trainees should be advised that substitution treatment ideally involves the co-administration of drug addiction counseling.

⚠️ Say: Information about risk reduction, HIV prevention and overdose, needs to be provided to all clients, whether or not they wish to enter treatment.

Some clients will undergo detoxification before entering into relapse prevention treatment, while others may end up in a substitution treatment program because they find detoxification too difficult to complete. Detoxification requires medication to reduce the severity of withdrawal symptoms, and must be administered at a comfortable pace otherwise it increases the risk of a client's leaving the program and relapsing. Detoxification is usually undertaken in an inpatient residential setting, although it can also occur in hospitals and community-based settings. Ambulatory withdrawal is uncommon in Vietnam (ambulatory withdrawal is the provision of medication to manage withdrawal from alcohol, opioids and benzodiazepines).

After substitution treatment, clients still need detox (from the methadone), and relapse-prevention aftercare is critical.

Both substitution treatment and relapse-prevention treatment must be coupled with drug addiction counseling. Some relapse-prevention treatments teach general life skills, while others provide psychosocial support.
CONCLUSION
- The ultimate goal of drug treatment is to obtain abstinence from drugs.
- The immediate goals are to reduce drug use, improve functioning, and minimize health and social consequences.
- There are key principles of drug addiction counseling that underpin the success of any treatment intervention.
- There is a range of interrelated treatment approaches to assist heroin addiction.
  - Understanding this is important to provide the best available treatment.

Teaching instructions: Review the key messages of this unit

FYI:
- Goals of drug addiction treatment:
  - The ultimate goal of all drug addiction treatment, for those who wish to abstain, is to enable clients to achieve lasting abstinence. The immediate goals are to reduce drug use, improve the clients’ ability to function, and minimize the health and social complications of drug use.

- Key principles in providing drug addiction treatment:
  - No single treatment is appropriate for all individuals.
  - Effective treatment attends to the multiple needs of the individual, not just his/her drug use.
  - Treatment needs to be readily available.
  - Remaining in treatment for an adequate period of time is critical to treatment efficacy.
  - Treatment progress and drug use while in treatment should be monitored.
  - Treatment plans need to be assessed and modified continually.
  - Medications are an important element, but not the only component, of a comprehensive treatment program.
  - Counseling and other behavior components are critical.
  - Detoxification is only the first stage of treatment and by itself does little to change long-term drug use.
  - Treatment programs should provide testing for HIV, hepatitis, TB and other infectious diseases, and provide assistance to help clients modify risk behaviors.
  - Treatment of comorbid conditions should be integrated.
  - Recovery from addiction can be a long-term process and frequently requires multiple episodes of treatment.
**Teaching instructions:** Thank the participants for their participation in the discussions and ask them if they have any questions. Answer the questions that pertain to this or previous units. If participants ask questions about material that will be covered in a later unit, request that they save their questions for that unit.
Unit 3.5

IMPORTANT FACTORS FOR SUCCESSFUL TREATMENT
Overview

I. Introduction
Introduce the unit by explaining that you will discuss the factors that influence the success of drug addiction treatment.

II. Presentation
Use the PowerPoint slides to address the important factors for successful treatment.

III. Conclusion
Review the key points of this unit and answer participants’ questions (if any).

Unit 3.5: Important Factors for Successful Treatment

Goal: To help participants understand the factors that influence successful addiction treatment.

Time: 30 minutes

Objectives: At the end of this session, participants will be able to:
- describe the factors that influence successful drug addiction treatment
- describe how to link these factors to the Vietnam context

Methodology:
- Presentation and discussion

Teaching aids:
- PowerPoint slides
- LCD projector
- Flipchart and paper
- Markers
IMPORTANT FACTORS FOR SUCCESSFUL TREATMENT
LEARNING OBJECTIVES

At the end of this session, you will be able to:
- describe the factors that influence treatment success
- understand and apply these factors in the Vietnam context

Teaching instructions: Use the bullets on the slide to present directly.
Say: This chart demonstrates that there can be substantial variation in the success of a given treatment program, regardless of the treatment setting. Long-term residential rehabilitation treatment, along with outpatient drug-free counseling and outpatient methadone treatment, have comparable levels of retention amongst the best programs. However, there is a significant difference between successful and unsuccessful programs for each of these three types of treatment in terms of retention. The long-term residential rehab facilities in this chart were for voluntary treatment programs, not those provided in Vietnam 06 government rehabilitation centers.

What do you think are the factors that lead to these differences?

Teaching instructions: Allow the participants to provide answers. Write their answers on flipchart paper and categorize them as either individual factors or program factors. After completing your brainstorm, proceed to the next two slides.
There are a number of individual client factors that can contribute to or hinder the success of a treatment program.

- Long-term users with severe addiction to multiple drugs who also have psychiatric disorders are less likely to have successful treatment outcomes.
- Users who lack non-drug using social networks or family support are less likely to have successful treatment outcomes.
- None of these factors is necessary for poor treatment outcome, and presence of one or more of these factors should not be used to discriminate who receives treatment.
Some of the other factors that relate to treatment outcomes include the following:

- **The number and type of services provided** - Treatment outcomes may be affected by whether or not the services are linked to other health and social support programs (for example, HIV counseling and testing, peer education, and/or case management).

- **Program organization** - If the paperwork, enrollment procedures, rules and requirements are too complicated, clients may not be inclined to initiate or continue with the program.

- **Leadership qualities** - Team cohesion and management will affect treatment outcomes.

- **Mix of staff skills** - Treatment outcomes will also depend on how well trained the staff are, and whether or not they bring a variety of experiences and skills to address client needs and issues.

- **Environment** - The physical/social environment is critical. Treatment outcomes will depend on whether or not clients feel comfortable attending the services in the treatment environment, including the cheerfulness of the physical space, and the reception they receive when coming for services.
Treatment outcomes depend primarily on the quality of the treatment services, rather than on the individual factors of the client.

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

**Does this surprise you?**

**Teaching instructions:** Allow participants some time to discuss this statement. Encourage them to challenge the statement and come up with reasons why they might disagree, if they do.
If service quality is poor, treatment outcomes are also likely to be poor. The next few slides will address some of the key elements that need to be in place to ensure treatment services are of good quality. This slide shows some of the essential organizational qualities that need to be in place to deliver quality treatment services.

- **Basic management skills** - The team leader should have a good understanding of organizational theory and practice, and sound management skills.
- **Healthy working environment** - The work environment should be welcoming for both staff and clients. This includes addressing safety concerns.
- **Clear demarcation of tasks** - Each member of the team should know his/her role and responsibilities, as well the roles of each of the other team members. Any concern about overlapping areas of responsibility must be resolved.
- **Team members all understand the team mission and responsibilities to clients** - The team should meet regularly to discuss client progress and solve team-related issues.
- **Team members must have a solid understanding of the purpose and goals of treatment.**
- **Staff are well supervised, appraised and supported. Leadership is key.** The team leader should lead by example, but also spend time with staff to assess their skills and respond to any gaps identified. Mentoring and supervision are critical for maintaining staff productivity, job satisfaction, and for obtaining positive treatment outcomes.
REVIEW: TREATMENT OUTCOMES ARE RELATED TO....

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

Teaching instructions: Use the bullets on the slide to present directly.
Teaching instructions: Review the key points of this unit using the bullets in the slide.

FYI: It is important to reemphasize that program-related factors have a greater influence on treatment outcomes than individual factors.

Teaching instructions: Thank the participants for their participation in the discussions and ask them if they have any questions. Answer the questions that pertain to this or previous units. If participants ask questions about material that will be covered in a later unit, request that they save their questions for that unit.
TREATMENT FOR HEROIN ADDICTION
OVERVIEW

I. Introduction
Introduce the unit by explaining that you will discuss three kinds of drug addiction treatment available worldwide.

II. Presentation
Use the PowerPoint slides to present on the different treatment modalities. The treatment modalities in this unit are divided into 3 kinds of therapy: medical treatment therapies, behavioral therapies, and a combination of medical and behavioral therapies.

III. Conclusion
Review the key points of this unit and answer participants’ questions (if any).

Unit 3.6: Heroin Addiction Treatment

Goal: To ensure participants have a good understanding of the three different treatment approaches.

Time: 85 minutes

Objectives: At the end of this session, participants will be able to:
- describe different therapies of drug addiction treatment available in international settings
- describe the strengths and limitations of each of the therapies
- suggest therapy combinations to enhance effectiveness

Methodology:
- Presentation and discussion

Teaching aids:
- PowerPoint slides
- LCD projector
- Flipchart and paper
- Markers
Say: In this unit we will discuss the different kinds of treatment for heroin addiction available internationally.
At the end of this session, participants will be able to:

- describe the different drug addiction treatment therapies available internationally
- describe strengths and limitations of each of the therapies
- Recommend therapy combinations based on individual client needs
Drug addiction is a chronic, relapsing medical disorder that is treatable. Through treatment tailored to individual needs, patients can learn to control their addiction and live normal, productive lives.

There are medication treatment and behavioral treatments, and a combination of the two.
WHAT ARE THE TARGETED OUTCOMES OF MEDICAL DRUG TREATMENT?

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

**Say:** What are the targeted outcomes of medication treatment? There are several potential sites in the brain that are targeted by medications to help addicted individuals recover. Some medicines have more than one action and also work at more than one site in the brain. Others have just one action and work at one site. Some medicines are effective at treating several different drug addictions, while others are only effective for only one type of drug addiction. We will discuss these in greater detail.

There is a variety of possible outcomes that medical interventions might achieve. Medication can block or reduce drug cravings, or block or reduce drug rewards (for example, by blocking the high one gets from heroin), or prevent and/or treat withdrawal symptoms or restore “normal” brain functioning. Medication may also be used to treat any underlying psychiatric disorders. Medicines that have been developed for treating opiate addiction are the most effective.

To understand how medical treatment targets the brain, it is important to understand how different drugs affect the brain and the body. The next few slides will give us a closer look at the brain.
Say: The brain consists of several regions, each responsible for specific activities that are vital for living, such as movement, judgment, sensation, vision, reward, memory, pain and coordination.

Drugs affect brain chemistry and hence change the way the brain functions. The medicines for treating addiction work on brain cells that are particularly vulnerable to addiction and its consequences. The sites where these brain cells reside include the areas responsible for reward and judgment.
We will now discuss the different kinds of medical treatment for heroin addiction in detail.

There are three medicines most commonly used to treat people addicted to heroin: methadone, buprenorphine and naltrexone.

These medications have proven effectiveness, but factors such as dosage, relapse potential and side effects, continue to be researched.
Opioid substitution treatment (OST) works at the same site in the brain as heroin (the mu opioid receptor). But these medicines are safer and work for a longer duration than heroin. Treatment with these medicines requires usually between 1 and 3 years, but some may need it indefinitely. They can also be used to detoxify from heroin.

They work by:

- alleviating withdrawal symptoms
- reducing or eliminating cravings to use heroin
- blocking the effects of heroin use by increasing tolerance to opioids
The ultimate goal of OST is to assist people who are dependent on opioid drugs to reduce their risk behaviors and to improve their health. OST is one of the most successful methods of reducing risks associated with opioid addiction.

The World Health Organization has a list of essential medicines that all nations are recommended to have to provide the basic level of services to serve the health of the population. Both methadone and buprenorphine are listed by the World Health Organization as essential medicines.
Say: How does an agonist like methadone work on the brain?

Agonists are chemicals that bind to a specific receptor to elicit a response. Methadone is an agonist that, like heroin, binds to opiate receptors. Unlike heroin, however, methadone does not produce the same level of euphoria or the same level of impairment to coordination and movement.

Look at the left of this diagram for a visual representation of methadone binding to an opiate receptor in the place of heroin.

Methadone is recognized as the ‘gold standard’ treatment for managing opioid addiction and has been found to be an effective public health and risk reduction measure. Its use is usually restricted to specific medical conditions, such as treating opioid addiction and the management of chronic pain.

Methadone is highly effective when taken orally. When taken daily, such as during maintenance for opioid addiction, its effect persists and the duration of its effect is extended beyond 24 hours. Although it is a potent analgesic for chronic pain, the analgesic effect of methadone lasts for less than 24 hours. If used for pain control, the dose needs to be given every 4-6 hours.

**Methadone:**

- is detectable in plasma 30 minutes following ingestion
- has a peak concentration after about 4 hours
- has a single dose half-life of 15-22 hours (high variability)
- has a maintenance dosing half-life of 22 hours and suppression of withdrawal for 24-36 hours
- has a stability that varies with metabolic rate, which varies according to genetic makeup, environmental and disease factors (e.g. pregnancy, HIV medications and TB medications increase methadone metabolism)
- oral form only marginally less potent than injection form
Say: *What is methadone?*

**Methadone** is a safe and effective medication for opiate addiction, administered by mouth in regular, fixed doses. Methadone has far more gradual onset of action than heroin, and as a result, patients stabilized on these medications do not experience any rush or euphoria. In addition, methadone wears off much more slowly than heroin, so there is no sudden withdrawal, and the brain and body are not exposed to the marked fluctuations seen with heroin use. Maintenance treatment with methadone markedly reduces cravings or desire for heroin. If an individual is maintained on adequate, regular doses of methadone (once a day) and tries to take heroin, the euphoric effects of that heroin will be significantly blocked.

 Patients on maintenance treatment do not suffer the medical abnormalities and behavioral destabilization that rapid fluctuations in drug levels cause for heroin addicts. This treatment is referred to as an agonist treatment. An agonist is a substance that initiates a physiological response when it combines with a receptor.
IS METHADONE SIMPLY A SUBSTITUTE FOR OPIATE ADDICTION?

Methadone maintenance is NOT simply addiction substitution. It involves:
- assessment of health, social, legal, financial and vocational status
- safe, stable dosing
- no euphoria or psychomotor instability
- monitoring of heroin and other drug use
- drug counseling
- linkage to other services

Say: Methadone maintenance therapy (MMT) is not simply substitution for opiate addiction.

Rather, it involves the use of a safe medicine that is provided in a safe treatment environment. This includes an assessment of needs linked to a tailored response. Methadone does not produce the same euphoria or impairment that heroin produces. The use of heroin and other drugs is closely monitored and adjustments are made as needed.

MMT also involves drug counseling, assessment of health, social, legal, financial and vocational status, and linkage to other services.
HOW EFFECTIVE IS METHADONE MAINTENANCE TREATMENT?

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

**Say:** *MMT has been shown to have high treatment acceptance and retention with no serious, long-term adverse health effects. Clients in MMT stay in treatment longer than all other forms of treatment.*

Evidence suggests that methadone maintenance leads to:

- marked reductions in illicit drug use
- marked reductions in criminal activity
- dramatic reductions in mortality rates
- decreased incidence of HIV infection
- marked improvement in health and psychological well being
Among HIV-positive IDU patients, methadone maintenance is associated with more consistent use of antiretrovirals and fewer hospitalizations.

Sources:
In one multi-site observational study, it was found that among those patients who were maintained on less than 35 mg daily of methadone while on treatment, 35% continued to use heroin. However, only 5% of those with a daily dose of greater than 60 mg of methadone continued to use heroin. These data suggest the higher dosage of 60 mg is more effective at achieving results.

Other random assignment, double-blind clinical trials have found a dose-dependent relationship between methadone treatment and illicit drug use. They found that higher dosages correlate with higher retention in the treatment program and decreased rates of illicit drug use. Specially, a dose of 80-100 mg is superior to 50-65 mg, which is superior to 20 mg, which is superior to a placebo (0 mg).

Note: The best dose for an individual needs to be determined by the clinician, through individual assessment, to determine whether the client demonstrates any of the following:

- persistent withdrawal symptoms
- persistent cravings
- blocking of the effects of heroin while on methadone
### Optimum Duration of Methadone Treatment

- **Optimum duration not certain**
  - Measured in years, not weeks or months
  - Some need it indefinitely

- **Treatment Duration Study**
  - MMT vs. 180-Day Methadone to Abstinence (MTA) - Sees et. al. (2000)
  - Compared MMT with standard counseling to 180-day methadone tapering with enhanced counseling and support services
  - MMT superior to 180-day MTA
    - greater reductions in heroin use, retention
    - less criminal activity

---

**Say:** The optimal duration of treatment is still being explored. However, it is possible to say that methadone maintenance treatment is typically measured in years, rather than months.

A study in 2000 by Sees et al compared MMT, including standard counseling, to a 180-day methadone tapering program called “methadone to abstinence” (MTA), including counseling and support services.

The study found that MMT with standard counseling was superior to the 180-day MTA. It also found that those in the MMT group had greater treatment retention, and reduction in heroin use and criminal activity. The days per month of heroin use decreased from 30 to 5 for both groups during the first 180 days, but then increased to 15 days per month for the 180-day MTA group, while remaining at 5 days per month for MMT.

**Source:** Sees et. al. JAMA 2000;283: 1303-10.
Methadone is the most widely used medication for heroin addiction treatment. However, key issues such as length of treatment and range program services are still being researched. Like some of the other medications, methadone has misuse potential if diverted or used in a way that isn’t intended, which requires it to be dispensed under direct observation in highly structured programs.

Although methadone costs relatively little ($50-100 annual), staff dispensing costs can be high. Dispensing costs will be lower in countries where labor costs are lower.
There are many advantages to undergoing OST, including improvement in one’s health, social, financial, legal and vocational circumstances.
There are a few long-term, adverse health effects from the use of methadone. Those include:

- Weight gain, possibly influenced by fluid retention and dietary changes
- Reduced production of saliva - may contribute to dental problems
- Endocrine changes - may result in impotence, low libido, disrupted menstrual cycle
- Possible harm in presence of underlying disease; e.g. kidney or liver problems

Some of these effects disappear when the dose is adjusted.

Overdose risk in methadone is higher during the induction phase, while tolerance to opioids is still low and the dose has not been stabilized. There is also a risk if the client is taking other CNS depressants, such as benzodiazepines or alcohol, in large quantities. Death due to overdose is caused by respiratory depression based on its effects on the brain.

Daily attendance at a methadone treatment setting involves a substantial amount of time. This can be a significant problem, particularly when a person is attempting to regain employment.

Some drug users complain of protracted withdrawal symptoms following the cessation of methadone maintenance treatment. These symptoms can continue for weeks to months and many drug users find this distressing.
Say: *A direct comparison between methadone and heroin shows several advantages in treating a client with methadone. What do you think may be some of the other benefits of using methadone?*

**Teaching instructions:** Allow the participants some time to answer your question; fill in any gaps or clarify as needed.

After facilitating the discussion, **BREAK HERE for 10 minutes** to allow participants to relax before proceeding with the next slides.

Say: *Let’s take a 10-minute break now to allow you some time to get up, stretch, and relax for a moment before we proceed.*
Buprenorphine is delivered in the form of sublingual tablets under the tongue.

Buprenorphine is a partial opioid agonist, which means that although buprenorphine can produce typical opioid effects, its maximum effect is less than that of heroin or methadone. During the induction phase, buprenorphine is safer in terms of overdose risk than a full opioid agonist like methadone because it has limited effect on respiration.

The maximum effects of buprenorphine appear to occur in the 16-32 mg dose range. Higher doses are unlikely to produce an additional effect, but will increase the duration of action, and may only need dosing on alternate days.

It is easier to stop buprenorphine than methadone.

Because of its opioid agonist effects, buprenorphine can be misused, particularly by individuals who are not physically addicted to opioids. Naloxone is added in combination with buprenorphine to decrease the likelihood of diversion and misuse. Sublingual buprenorphine has good bioavailability, while sublingual naloxone has poor bioavailability. (Bioavailability is the amount of drug which reaches the site of physiological activity after administration). Thus, when the buprenorphine/naloxone tablet is taken as prescribed, the buprenorphine opioid agonist effect predominates, and the naloxone does not precipitate opioid withdrawal in the opioid-addicted user. However, if injected by a dependent opioid user, naloxone has good bioavailability and can precipitate opioid withdrawal.

One disadvantage of buprenorphine is its high cost.

BUPRENORPHINE: FEATURES

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

Teaching instructions: Use the bullets on the slide to present directly.
Say: How does a partial agonist (buprenorphine) work on the brain?

Buprenorphine, a partial agonist, binds to a specific opiate receptor to elicit a response in the same way as heroin and methadone. The agonist effects of buprenorphine increase linearly with increasing doses of the drug until they reach a plateau, and no longer continue to increase with further increases in dose. This is known as the "ceiling effect." This prevents buprenorphine from producing the same level of euphoria produced by heroin. It also means it has less effect on respiration, so there is lower risk of overdose during the induction phase.

Thus, buprenorphine carries a lower risk of misuse, addiction, and side effects compared to full opioid agonists. In fact, because it has such high receptor affinity, in high doses and under certain circumstances, buprenorphine can displace any full opioid agonists from the receptor and block their effects. In doing this, it can precipitate withdrawal symptoms if administered to an opioid-addicted individual while a full agonist is in the bloodstream.

NALTREXONE

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

**Say:** Naltrexone is an antagonist. It is taken orally, daily, for a sustained period of time.

*Individuals must be medically detoxified and opiate-free for several days before naltrexone can be taken.*

*When used this way, all the effects of self-administered opiates, including euphoria, are completely blocked. This treatment is referred to as opioid antagonist treatment.*

*Naltrexone is associated with significant risk of overdose risk if not carefully supervised. Naltrexone is not widely used compared to buprenorphine and methadone.*
Say: Antagonists are chemicals that bind to a receptor and block it, producing no response and preventing other chemicals (drugs) from binding or attaching to the receptor. Naltrexone is an antagonist that binds to the opiate receptor and blocks heroin from binding.

There are significant differences between agonist and antagonist treatments. In addition, there are significant differences in patient acceptability and retention. Opiate agonist treatments are much more likely to attract and retain patients in treatment than antagonist treatments.
SOME KEY ISSUES ABOUT MEDICAL TREATMENT FOR ADDICTION?

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

**Say:** Let’s review some of the key issues in considering the range of medical treatment options.

- Agonist maintenance (methadone or buprenorphine) substantially reduces heroin use and the adverse health, legal, financial, vocational and social consequences of heroin addiction.
- Problems with treatment adherence limit the effectiveness of naltrexone.
- Combined treatment (a combination of medication and counseling) is the most effective means of achieving positive treatment outcomes.
We have talked a lot about the kinds of medication treatment options for drug addiction. Now let’s discuss behavioral treatment options.
WHAT IS THE PRIMARY OBJECTIVE OF BEHAVIORAL DRUG TREATMENT?

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

**Say:** The primary objective of behavioral drug treatment is to help drug addicts learn mechanisms to stop using drugs and cope without them.
HOW ARE CLIENTS MOTIVATED TO STOP USING?

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

**Say:** For the addicted drug user, drugs are highly rewarding and essential elements of life. Change requires recognition that:

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

*In this unit, you will learn to assist clients to change their behaviors and to provide them with strategies to reduce and eventually abstain from drug use, if they wish to do so.*
There are numerous effective behavioral drug treatment approaches. In this unit, we will discuss psychosocial counseling, cognitive behavioral treatment, and 12-step recovery programs.
Psychosocial treatment encompasses a wide range of non-pharmacological approaches commonly used to treat addictive disorders. Many of these approaches are derived from social learning theory. They share the basic tenet that, while biological and genetic factors play a significant role, problematic drug use behaviors are learned in a social environment and can be replaced by new, learned behaviors.

Psychosocial counseling is an important tool in drug treatment. It helps motivate clients to stop using drugs. It targets the behavioral, social and psychological triggers that contribute to continued drug use. Specifically, it improves interpersonal functioning, teaches skills to deal with family problems and pressure from friends who use drugs, and it provides a venue for training relapse prevention techniques.

The most widely used psychosocial approaches that have received consistent empirical support are brief interventions, motivational approaches, and various forms of cognitive behavioral therapy, including training on coping skills, relapse prevention and behavioral couples therapy.
Counseling encourages patients to make lifestyle changes by developing alternative, rewarding activities and increasing involvement in drug-free social, vocational, and family activities. It addresses problems resulting from years of addiction (such as social, legal, work, health, psychological, and family problems) and fosters adherence to treatment regimens. For example, counseling increases treatment retention and adherence to pharmacotherapy.

Psychosocial interventions can be used as stand-alone treatment in conjunction with pharmacotherapies. Psychosocial interventions are used to elicit a person's interest or commitment to change. They are also used to teach them the skills to maintain changes.
Cognitive behavioral interventions comprise a range of approaches that are broadly based on learning principles and the idea that behavior is influenced by the cognitive process. Most treatment approaches that are supported by research evidence are cognitive behavioral in orientation. The most prominent of these approaches are training on coping skills, and relapse prevention strategies.

Cognitive behavioral therapy is based on the following specific skills and techniques sessions:

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

Relapse is common in drug addiction treatment: as many as 60% of treated clients relapse within the first 12 months. Evidence shows that specific situations and mood states are associated with relapse. Factors such as negative emotional states, interpersonal conflict and social pressure are associated with relapse. Relapse prevention is not as much a specific intervention, as it is a set of strategies that aim to help the client achieve relative gains in treatment.
COGNITIVE BEHAVIORAL THERAPY (2)

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

Say: Cognitive behavioral therapy uses the following strategies:

- Establish a positive, collaborative relationship
- Positively reinforce behavior change
- Provide corrective feedback when necessary
- Provide explicit structure and expectations for treatment and daily activities – including scheduling of time, self-help meetings, exercise, work etc.
- Utilize role-playing, visual imagery, thought stopping (which is a way of blocking thoughts that may be harmful or lead to harmful behaviors), and teach skills to change one’s environment or behaviors
Say: 12-step recovery programs, such as Narcotics Anonymous (NA) and Alcoholics Anonymous (AA), are based on peer-led, mutual support group meetings and related activities. Group members share the principles that addiction is a disease with physical, spiritual and emotional components, and that there are 12-steps of recovery.

The members come to meetings or use their telephone contacts as an alternative to drug use.

Users are helped to remember not to use via slogans and helpful reminders.
Say: The process involves:

- admitting that one cannot control one’s addiction or compulsion
- recognizing a greater power that can give strength
- examining past errors with the help of a sponsor (experienced member)
- making amends for these errors
- learning to live a new life with a new code of behavior
- helping others that suffer from the same addictions or compulsions

These recovery programs begin with clients admitting that they have a drug problem and that they cannot help themselves. The program encourages participants to surrender, and often includes a spiritual component.

The 12-step program establishes a reference group of people with similar problems which provides social acceptance for addicted individuals and a sense of community with other people.
HOW DO 12-STEP RECOVERY PROGRAMS HELP DRUG USERS? (3)

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

**Say:** During the therapy, other group members provide examples of how to deal with drug problems. The program provides strong support and encouragement for its members to become and remain abstinent from drugs.
There are three main types of drug treatment: medication therapy, cognitive behavioral therapy, and self-help.

The 3 most popular medication therapies are: methadone, buprenorphine and naltrexone.

The main objective of cognitive behavioral treatment therapy is to help willing clients learn techniques to stop using drugs and cope with life without drugs.

FYI: If untreated, drug addiction leads to higher morbidity and mortality. Comprehensive treatment reduces morbidity and mortality and improves health and vocational, social, financial, family, and legal functioning.

The ultimate goal of drug treatment is to enable clients to reduce their drug use and achieve lasting abstinence if they are willing.

Immediate goals of drug treatment:
- reduce drug use
- improve the patient’s ability to function
- minimize the health and social complications of drug use

Key points
- Drug treatment falls into one of three main categories: medication treatment, behavioral treatment and self-help.
- The three drugs most commonly used to treat individuals addicted to opiates are methadone, buprenorphine and naltrexone.
- Among HIV+ patients, substitution treatment is associated with more consistent use of antiretrovirals and fewer hospitalizations.
- The primary objective of behavioral drug treatment is to help drug users learn mechanisms to reduce and eventually stop using drugs, and cope without them.

Teaching instructions: Thank the participants for their participation in the discussions and ask them if they have any questions. Answer the questions that pertain to this or previous units. If participants ask questions about material that will be covered in a later unit, request that they save their questions for that unit.
## FHI Addictions Counseling Training Manual - Glossary of Terms

<table>
<thead>
<tr>
<th>TERM</th>
<th>DICTIONARY DEFINITION</th>
<th>ADDICTIONS COUNSELING DEFINITION</th>
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</thead>
<tbody>
<tr>
<td>abstract thinking</td>
<td>thinking that is not based on a particular instance; theoretical</td>
<td>the ability to think about something from a range of different perspectives</td>
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<tr>
<td>addiction</td>
<td></td>
<td>the overpowering physical or emotional urge to continue alcohol/drug use in spite of an awareness of adverse consequences; there is an increase in tolerance for the drug and withdrawal symptoms sometimes occur if the drug is discontinued; the drug becomes the central focus of life</td>
</tr>
<tr>
<td>addiction counseling</td>
<td></td>
<td>professional and ethical application of basic tasks and responsibilities which include clinical evaluation; treatment planning; referral; service coordination; client, family, and community education; client, family, and group counseling; and documentation</td>
</tr>
<tr>
<td>affirmation</td>
<td>the act of stating something as a fact; asserting strongly</td>
<td>agreeing with what a client is saying in a supportive way</td>
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<tr>
<td>ambivalence</td>
<td>the state of having mixed feelings or contradictory ideas about something or someone</td>
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<tr>
<td>arguing</td>
<td>exchanging or expressive diverging or opposite views, typically in a heated or angry way</td>
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<tr>
<td>attending</td>
<td></td>
<td>listening to verbal content, observing non-verbal cues, and providing feedback that assures you are listening</td>
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<tr>
<td>autonomy</td>
<td>freedom from external control; independence</td>
<td>respecting a client's ability to think, act and make decisions for him/herself</td>
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<tr>
<td>behavior modification</td>
<td>the application of conditioning techniques (rewards or punishments) to reduce or eliminate problematic behavior, or to teach people new responses</td>
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<td>TERM</td>
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<tr>
<td>behavioral</td>
<td>counseling that is based on the premise that primary learning comes from experience</td>
<td>an approach that views counseling and therapy in learning terms and focuses on altering specific behaviors</td>
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<tr>
<td>counseling</td>
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<tr>
<td>big deep moments</td>
<td></td>
<td>moments in a conversation that have significant impact on a person's thinking and commitment for change</td>
</tr>
<tr>
<td>burnout</td>
<td>physical or mental collapse caused by overwork or mental stress</td>
<td>depletion of motivation, interest, energy, resilience and often effectiveness of counselors caused by overwork or mental stress</td>
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<tr>
<td>case conferencing</td>
<td></td>
<td>a structured meeting between professionals to discuss relevant clinical aspects of a client</td>
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<tr>
<td>cliché</td>
<td>a phrase or expression that is overused and betrays a lack of original thought</td>
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<tr>
<td>client</td>
<td></td>
<td>individuals, significant others, or community agents who present for alcohol and drug use education, prevention, intervention, treatment, and consultation service</td>
</tr>
<tr>
<td>client-centered</td>
<td>conducted in an interactive manner responsive to individual client needs</td>
<td>an approach to counseling that allows clients to retain ownership of their issues and building on their abilities to change behavior</td>
</tr>
<tr>
<td>closed question</td>
<td>question with more than one possible answer from which one or more answers must be selected</td>
<td></td>
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<tr>
<td>cognitive</td>
<td>counseling that is based on the belief that our thoughts are directly connected to how we feel</td>
<td>an approach to counseling which focuses on improving clients' ability to test the accuracy and reality of their perceptions</td>
</tr>
<tr>
<td>counseling</td>
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<tr>
<td>collusion</td>
<td>secret or illegal cooperation or conspiracy</td>
<td>clinical collusion: conspiring with another individual against a client's interest; remaining silent/not intervening when a client says or does something that (the counselor) knows is morally/legally wrong</td>
</tr>
<tr>
<td>competency</td>
<td></td>
<td>the requisite knowledge, skills, and attitudes to perform tasks and responsibilities essential to addiction counseling</td>
</tr>
<tr>
<td>confidential</td>
<td>intended to be kept secret</td>
<td>intended to be kept secret for the protection and safety of the client</td>
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<td>TERM</td>
<td>DICTIONARY DEFINITION</td>
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<tr>
<td>confronting</td>
<td>compelling (someone) to face or consider something</td>
<td>expanding (or challenging) a client’s awareness via reflections and questions focused on actual and potential inconsistent and illogical ways of thinking and communicating</td>
</tr>
<tr>
<td>continuum of care</td>
<td></td>
<td>the full array of alcohol and drug use services responsive to the unique needs of clients throughout the course of treatment and recovery</td>
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<tr>
<td>corrective feedback</td>
<td>information about reactions to a person’s performance/behavior intended to modify or improve the behavior</td>
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</tr>
<tr>
<td>counseling</td>
<td>provision of advice, especially formally</td>
<td>an interactive exchange process between counselor and clients to help clients confidentially explore their problems and enhance their capacity to solve their own problems</td>
</tr>
<tr>
<td>counselor</td>
<td>a person trained to give guidance on personal, social or psychological problems</td>
<td>counselors are similar to therapists in that they use a variety of techniques to help clients achieve stronger mental health. (one of the most commonly understood methods involves a one-on-one exploration of a client’s inner beliefs and background (psychotherapy) or a similar exploration in a group setting (group therapy).)</td>
</tr>
<tr>
<td>craving</td>
<td>a powerful desire for something</td>
<td></td>
</tr>
<tr>
<td>denial</td>
<td>the action of declaring something to be untrue</td>
<td>failure to accept an unacceptable truth or emotion or to admit it into consciousness; used as a defense mechanism</td>
</tr>
<tr>
<td>directive</td>
<td>involving the management or guidance of something</td>
<td></td>
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<tr>
<td>disagreeing</td>
<td>having or expressing a different opinion</td>
<td></td>
</tr>
<tr>
<td>discrimination</td>
<td>the unjust or prejudicial treatment of different categories of people or things, usually based on race, sex, gender…etc</td>
<td></td>
</tr>
<tr>
<td>double-sided reflection</td>
<td></td>
<td>reflecting both the current, resistant statement, and a previous, contradictory statement that the client has made</td>
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<tr>
<td>TERM</td>
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<tr>
<td>empathy</td>
<td>the ability to understand and share the feelings of another</td>
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<tr>
<td>exploration</td>
<td>thorough analysis of a subject or theme</td>
<td></td>
</tr>
<tr>
<td>extrinsic</td>
<td>not part of the essential nature of someone or something; coming or operating from outside</td>
<td>something that comes from the outside; an outside feeling or point of view</td>
</tr>
<tr>
<td>goal</td>
<td>the object of a person's ambition or effort; an aim or desired result</td>
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</tr>
<tr>
<td>goal-centered</td>
<td>based on the short-, intermediate- and/or long-term goals of an individual or group</td>
<td>working toward achieving specific implicit or explicit objectives of counseling</td>
</tr>
<tr>
<td>harm</td>
<td>physical injury (especially that which is deliberately inflicted)</td>
<td>any event or stimulus that causes a negative outcome</td>
</tr>
<tr>
<td>harmful use</td>
<td></td>
<td>patterns of use of alcohol or other drugs for non-medical reasons that result in health consequences and some degree of impairment in social, psychological, and occupational functioning for the user</td>
</tr>
<tr>
<td>interpreting</td>
<td>understanding an action, mood or way of behaving as having a particular meaning or significance</td>
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<tr>
<td>intervention</td>
<td>action taken to improve a situation</td>
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<tr>
<td>intoxication</td>
<td>of alcohol or a drug, the state of losing one’s control over one’s faculties/ behaviors</td>
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<tr>
<td>jargon</td>
<td>special words or expressions that are used by a particular profession or group and are difficult for others to understand</td>
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<tr>
<td>judging</td>
<td>forming an opinion or conclusion about something</td>
<td>forming an opinion about something and projecting it on to other people</td>
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<tr>
<td>TERM</td>
<td>DICTIONARY DEFINITION</td>
<td>ADDICTIONS COUNSELING DEFINITION</td>
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<tr>
<td>lapse</td>
<td>a temporary failure of concentration, memory or judgement</td>
<td>the reuse of drugs after a period of stopping</td>
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<tr>
<td>moaralizing</td>
<td>commenting on issues of right and wrong, typically with an unfounded air of superiority</td>
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<tr>
<td>motivational interviewing</td>
<td>a client-centered, semi-directive method of engaging intrinsic motivation to change behavior by developing discrepancy and exploring and resolving ambivalence within the client</td>
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<tr>
<td>nonjudgmental</td>
<td>avoidal moral arguments</td>
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<tr>
<td>open-ended question</td>
<td>question whose answers have no determined limit or boundary</td>
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<tr>
<td>ordering</td>
<td>commanding or giving instruction authoritatively</td>
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<tr>
<td>over interpreting</td>
<td>placing too much emphasis on a specific client response (verbal or nonverbal)</td>
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<tr>
<td>paraphrasing</td>
<td>expressing the meaning of something someone has written/said using different words, especially to achieve greater clarity</td>
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<tr>
<td>personal resilience</td>
<td>ability to withstand or recover from difficult situations on one's own</td>
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<tr>
<td>prevention</td>
<td>the theory and means for delaying or denying uptake of drug use in specific populations. prevention objectives are to protect individuals prior to signs or symptoms of substance use problems; to identify persons in the early stages of substance abuse and intervene; and to end compulsive use of psychoactive substances through treatment</td>
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<tr>
<td>principle</td>
<td>a fundamental source or basis of something</td>
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<tr>
<td>probing</td>
<td>asking for more information and/or clarification about a point that you think is important</td>
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<tr>
<td>procedure</td>
<td>an established or official way of doing something</td>
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<tr>
<td>psychoactive</td>
<td>a pharmacological agent that can change mood, behavior, and cognition process</td>
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<tr>
<td>substance</td>
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<tr>
<td>rapport</td>
<td>a close and harmonious relationship in which the people or groups concerned understand each others feelings or ideas and communicate well</td>
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<tr>
<td>reflective</td>
<td>to listen carefully to what the client has said and repeat back what was said in a directive way</td>
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<tr>
<td>listening</td>
<td></td>
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<tr>
<td>reframing</td>
<td>framing or expressing words, concepts or plans differently</td>
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<tr>
<td>relapse</td>
<td>the return to the pattern of substance abuse as well as the process during which indicators appear prior to the client’s resumption of substance use</td>
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<tr>
<td>reliability</td>
<td>the degree to which something is consistently good in quality or performance</td>
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<tr>
<td>resistance</td>
<td>any feeling thought and communications on part of the clients that prevent them from participating effectively in counseling.</td>
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<tr>
<td>resourcefulness</td>
<td>having the ability to find quick and clever ways to overcome difficulties</td>
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<tr>
<td>respect</td>
<td>a feeling of deep admiration for someone or something elicited by their qualities, abilities or achievements</td>
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<tr>
<td>risk</td>
<td>a situation involving exposure to danger</td>
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<tr>
<td>rolling with</td>
<td>meeting resistance to change from a client by moving in the direction he/she is headed with a response that is intended to diffuse the resistance</td>
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<tr>
<td>resistance</td>
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<tr>
<td>self-efficacy</td>
<td>belief in a client's own ability to undertake a task(s) and/or fulfill goals</td>
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<tr>
<td>self-responsibility</td>
<td>(responsibility for one’s self) - the state or fact of having the duty to deal with one’s self</td>
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<tr>
<td>significant others</td>
<td>sexual partner, family member, or others on whom an individual is dependent for meeting all or part of his or her needs</td>
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<tr>
<td>simple reflection</td>
<td>to repeat or rephrase what the client has said</td>
<td></td>
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<tr>
<td>skill</td>
<td>the ability to do something well; expertise</td>
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<tr>
<td>sobriety</td>
<td>the quality or condition of abstinence from psychoactive substance abuse</td>
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<tr>
<td>stage of change theory</td>
<td>a theory that espouses that behavior change does not happen in one step, rather, people tend to progress through different stages on their way to successful change; each progresses through the stages at his/her own rate</td>
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<tr>
<td>substance use</td>
<td>consumption of low and/or infrequent doses of alcohol and other drugs, sometimes called “experimental,” “casual,” or “social” use, such that damaging consequences may be rare or minor</td>
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<tr>
<td>summarizing</td>
<td>giving a brief statement of the main points of (something)</td>
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<tr>
<td>supervision</td>
<td>observation and direction execution of a task, project or activity</td>
<td>the administrative, clinical, and evaluative process of monitoring, assessing, and enhancing counselor performance</td>
</tr>
<tr>
<td>sympathizing</td>
<td>agreeing with a sentiment or opinion</td>
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<tr>
<td>sympathy</td>
<td>understanding between people; a common feeling because you have experienced the same or similar event.</td>
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<tr>
<td>technique</td>
<td>a way of carrying out a particular task</td>
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<tr>
<td>therapeutic alliance</td>
<td></td>
<td>the relationship between a mental health professional and a client it is the means by which the professional hopes to engage with, and effect change in, a client</td>
</tr>
<tr>
<td>threatening</td>
<td>causing someone to be vulnerable or at risk</td>
<td></td>
</tr>
<tr>
<td>voluntary</td>
<td>done, given or acting of one's own free will</td>
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