Case Management for Recovering Drug Users in Vietnam:
A Training Curriculum

Participant's Manual

ACKNOWLEDGMENTS

If you would like copies of the Trainer's Manual and Participant's Manual, please contact FHI at 84-4-934-8560.

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PART I—PARTICIPANT'S ORIENTATION

Introduction

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

The Vietnam Ministry of Health (MOH) reports that adult HIV prevalence is low but is slowly rising in Vietnam. However, there has been a rapid increase in HIV prevalence among injection drug users (IDUs), and injection drug use is also increasing.

Case management for people who are addicted is critical. Addiction affects so many areas of an addicted person's life that support services are essential to help the individual maintain long-term recovery while managing to live in the community. No one program or system can meet all the needs of people who use drugs. In most places around the world, services tend to be scattered and often are difficult for recovering people to access on their own. DOLISA case workers are in a unique position to help.

The Training

The 11 modules in this training curriculum may be delivered over five consecutive days or may be offered over the course of several weeks or months. Your trainers have provided you with a specific agenda.

A follow-up module is or will be scheduled 3 to 6 months after you complete the training. The follow-up module will give you an opportunity to reflect on how you have used what you learned, hear how others have used the training, and discuss any issues, questions, or problems you have experienced.

The learning approach for this training includes—

- Trainer-led presentations and discussions;

- Frequent use of creative learner-directed activities, such as small-group and partner-to-partner exercises and presentations;

- Reflective writing exercises;

- Skills role plays;

- Periodic reviews to enhance learning retention; and

- Learning assessment exercises.

Your active participation is essential to making this a positive and productive learning experience!

Overall Training Goal and Learning Objectives

Overall goal:

To increase the knowledge base and skill level of DOLISA case workers to enhance the effectiveness of their work with drug users.

Objectives:

Participants who complete the training will be able to:

- Articulate at least four basic principles of social work and at least five guidelines for professional social work conduct;

- Discuss the role of case management practices in their work;

- Identify major classes of drugs of abuse;

- Discuss the effects and consequences of major drugs of abuse;

- Discuss the concept of addiction as a chronic relapsing "brain disease;"

- Identify the relationship of drug use and HIV/AIDS;

- Discuss the stages of change and basic strategies to engage clients and increase motivation;

- Demonstrate basic skill in techniques such as active listening and teaching problem-solving skills and goal-setting strategies;

- Identify at least three main strategies of effective relapse prevention;

- Demonstrate ability to assess client needs and develop a referral plan to match the need;

- Identify resources to develop a comprehensive referral list and discuss strategies to enhance the effectiveness of referrals and other case management activities;

- Understand the importance of self-care; and

- Develop a plan to integrate new learning into practice.

Overview of the Participant's Manual

Each module of your Participant's Manual includes—

- Goals and objectives for the module;

- A timeline;

- PowerPoint slides printed three to a page with space for you to write notes; and

- Resource Pages containing additional information or exercise instructions and materials.

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

- Topics you would like to read more about;

- A principle you would like to think more about;

- A technique you would like to try;

- Ways you might be able to add some of the things you're learning to your practice; and

- Possible barriers to using new techniques.

Your trainers will also ask you to complete short writing assignments.

Getting the Most from Your Training Experience

To get the most from your training experience—

☐ Speak to your supervisor before the training begins. Find out what his or her expectations are for you.

☐ Think about what you want to learn from each module.

☐ Come to each session prepared; review the manual pages for the modules to be presented.

☐ Be an active participant. Participate in the exercises, ask questions, write in your journal, and think about what additional information you want.

☐ Speak to your supervisor after the training. Talk to him or her about what you learned to be sure you understand how the information relates to your job.

☐ Discuss with your supervisor ways that you can put your learning into practice, and continue to follow up with him or her.

☐ **Have fun!**

PART II—MODULE NOTES AND RESOURCE PAGES

MODULE 1—TRAINING INTRODUCTION

Module 1 Goals and Objectives

Training goals

- To create a positive learning community and environment;

- To give participants a chance to assess how ready they are to learn new things and to find out what they want to learn now;

- To give participants background information about why the training is being done;

- To give participants a summary of the overall training goal, objectives, and learning approach; and

- To briefly introduce the idea of *motivational* approaches to counseling and to make that idea personal.

Learning objectives

Participants who complete Module 1 will be able to:

- Explain the overall goal and at least four objectives of the training;

- Describe how ready they are for new learning; and

- State at least one personal learning goal.

Timeline and Content	
Activity	Time
Ceremonial welcome	10 minutes
Trainer welcome, housekeeping, and ground rules	10 minutes
Exercise: Introductions and training expectations	70 minutes
Presentation: Why this training?	10 minutes
Presentation: Training agenda and materials	10 minutes
Break	15 minutes
Exercise: Personal change	25 minutes
Presentation: Introduction to the concepts of motivation and readiness for change	15 minutes
Exercise: Readiness ruler	15 minutes
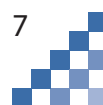
**CASE MANAGEMENT FOR
RECOVERING DRUG USERS
IN VIETNAM:
A TRAINING CURRICULUM**

MODULE 1—TRAINING INTRODUCTION

USAID FROM THE AMERICAN PEOPLE   Pact Vietnam   fhi Family Health International

1.1

_____

_____

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_____

Adult HIV Prevalence in Vietnam

- Vietnam population is approximately **87.3 million** people

- HIV prevalence among the general population is low, but slowly rising; it increased from 0.44% of the population in 2003 to 0.51% today

- Estimated number of HIV-infected people: **~290,000**

1.2

_____

_____

_____

_____

_____

_____

_____

Adult HIV Prevalence in Vietnam

- First reported HIV infection in 1990

- In the early 1990s, the HIV/AIDS epidemic was confined mostly to the south, among older heroin users and sex workers

- Highest prevalence is in most-at-risk groups, such as IDUs, FSWs, and MSMs

1.3

_____

_____

_____

_____

_____

_____

_____

Drug Use and HIV

- Injection drug use is an increasing problem in Vietnam

- Official number of addicted drug users tripled between 1994 and 2004

- Main route of HIV transmission among IDUs: sharing needles, syringes, and other injecting equipment

1.4

Drug Use and HIV

- HIV rate is rising *rapidly* among IDUs

- Recent HIV prevalence among IDUs reported as 23%, and as high as 60% in some cities/provinces*

* Vietnam Ministry of Health report based on sentinel surveillance in 2007 and Integrated Biological and Behavioral Surveillance 2005–2006.

1.5

Government Response

- Vietnam government officials support universal access to prevention, treatment, care, and support services by 2010

1.6

Government Response

- A critical part of an effective response to HIV/AIDS is reaching people who use drugs

- MOLISA/DOLISA workers are in a unique position to help

1.7

Motivation for Change

...is related to the level of probability that a person who uses substances will:

- Enter treatment
- Continue in treatment
- Follow a specific change strategy

1.8

Readiness

Readiness =
Importance X Confidence

1.9

Readiness Ruler

■ The ruler is a tool to help assess a person's readiness for change

1	2	3	4	5	6	7	8	9	10
Not Ready				Unsure					Ready

1.10

11
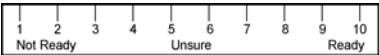
Resource Page 1.1: Personal Change Exercise

☐   What change did you make (or try to make)?

☐   How did you decide to make this change?

☐   What people, events, or circumstances influenced your decision?

☐   What steps did you take to make the change?

☐   Did your level of motivation stay the same throughout the process?

Resource Page 1.2: Readiness Ruler

1. Think about how important it is to you to learn new case management skills, and mark the first ruler at the appropriate point.

2. Think about why you rated yourself as you did, rather than marking "0."

3. Think about how confident you feel about your ability to learn new skills, and mark the second ruler at the appropriate point.

4. Think about why you rated yourself as you did, rather than marking "0."

Importance

0					5					10

Not at all important   Extremely important

Confidence

0					5					10
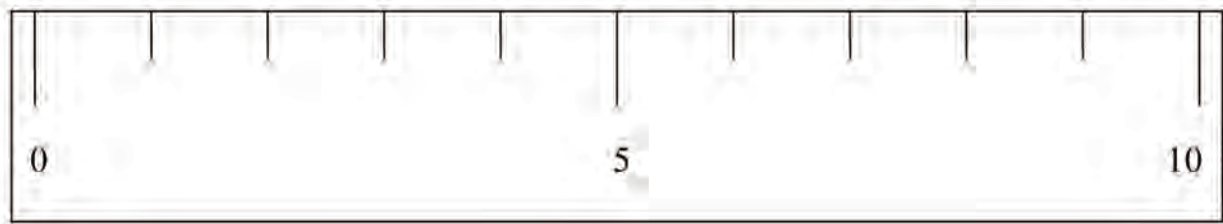
Not at all confident   Extremely confident

MODULE 2—INTRODUCTION TO SOCIAL WORK AND CASE MANAGEMENT

Module 2 Goals and Objectives

Training goals

- To provide participants with basic knowledge about the history and practices of social work;

- To teach participants about the concepts of professional conduct and ethical practice; and

- To introduce participants to the specific practice of case management.

Learning objectives

Participants who complete Module 2 will be able to:

- List at least three components of a definition of social work;

- Provide an overview of the history of social work, including its development in Vietnam;

- Describe the three levels of social work practice;

- Provide a basic definition of case management;

- Describe at least three components of case management;

- Apply principles of case management to their practices; and

- Discuss the role that a code of conduct plays in professional practice.

Timeline and Content	
Activity	Time
Introduction to Module 2	10 minutes
Exercise: The history of social work	60 minutes
Lunch	90 minutes
Energizer	15 minutes
Presentation: Overview of social work practices	10 minutes
Exercise: Principles of social work	45 minutes
Interactive presentation: Introduction to case management	40 minutes
Break	15 minutes
Exercise: Professional codes of conduct	50 minutes
Journal writing	10 minutes
Learning assessment game	15 minutes
Day 1 evaluation and wrap-up	10 minutes
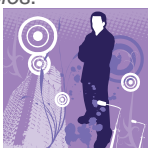
**CASE MANAGEMENT FOR
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**MODULE 2—INTRODUCTION TO SOCIAL
WORK AND CASE MANAGEMENT**

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Definitions of Social Work: Common Elements
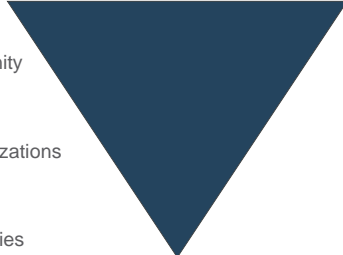
- The idea of social work as a *profession*;
- The concept of people *in a community* or within social systems;
- Providing solid *services*; and, in the last two,
- The idea of *professional principles*.

2.2

Levels of Social Work Practice

- Macro
  - Society, community

- Meso
  - Agencies, organizations

- Micro
  - Individuals, families

2.3

Macro-Level Social Work

Involves society or communities as a whole:

■ Social advocacy and policy development on a national or international scale

■ Community development

■ Social research

2.4

Meso-Level Social Work

Involves work with agencies, small organizations, and other small groups:

■ Policymaking and quality improvement within an agency

■ Developing programs for a particular neighborhood

■ Establishing collaborative relationships and efforts with healthcare or other local institutions

2.5

Micro-Level Social Work
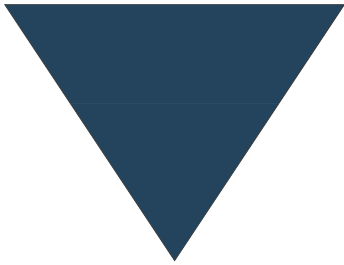
Involves direct service to individuals and families:

■ Therapy or counseling to help individuals make personal changes

■ Group counseling

■ Working with families

2.6

Levels of Social Work Practice

- Macro
  - Society
  - Community
- Meso
  - Agencies
  - Organizations
- Micro
  - Individuals
  - Families

2.7

Discussion Questions

- How do these principles apply to your work?

- How do these principles apply in the setting of Vietnamese cultural values?

2.8

Case Management Definition

- A set of administrative, clinical, and evaluative functions that helps clients find and use the resources they need to recover from a substance use or other problem

- The coordination of professional social services to assist people with complex needs, often for long-term care and protection

2.9

Case Management

Services tend to be scattered

2.10

Case Management

■**Case managers** put the pieces together for their clients

2.11

Case Management: Fundamental Principles

■Help clients link to the complex delivery system

■Help clients benefit from appropriate services

2.12

Case Management Functions

- Assessment
- Planning
- Linkage/referral
- Monitoring
- Advocacy

2.13

Assessment

- Is the foundation for treatment planning

- Establishes a baseline for measuring a client's progress

- Identifies how severe a client's current problems are compared to others

2.14

Assessment

- Helps set priorities for treatment and case management interventions

- Identifies client's strengths that can lead to recovery

2.15

21

Elements of Assessment

- Current and past drug use and drug treatment

- Medical conditions or complications

- Emotional/behavioral/cognitive status

2.16

Elements of Assessment

- Readiness to change

- Relapse or continued-use potential

- Recovery environment

2.17

Planning

A treatment or service plan identifies:

- The client's main problems
- Goals designed for the individual client
- Interventions to help the client achieve these goals

2.18

Linkage/Referral

- Linkage is a critical part of case management because one agency alone cannot meet all of a client's needs

- *Interagency* case management connects agencies to one another to provide more services to clients

2.19

Monitoring

- A case manager ensures that the client engages in services and follows the client's progress

- The case manager coordinates the various services a client needs

2.20

Monitoring

- The case manager identifies barriers (related to both clients and services) and works with the client and referral source to overcome them

2.21
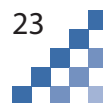
Advocacy

- A clear process of speaking out on issues of concern to apply influence on behalf of a person or persons

2.22

Advocacy

- Case managers need to advocate with many systems, including agencies, families, and legal systems

2.23

Advocacy

- Case managers can advocate by educating non-treatment service providers about a client or substance use problems in general

- At times, the case manager must negotiate an agency's rules on behalf of a client

2.24

Why have a professional code of ethics?

- To define accepted/acceptable behaviors
- To promote high standards of practice
- To provide a benchmark for members to use for self-evaluation

2.25

Why have a professional code of ethics?

- To establish a framework for professional behavior and responsibilities
- To develop a professional identity
- To show professional maturity

2.26

Resource Page 2.1: Definitions of Social Work

Dictionary

Organized work intended to advance the social conditions of a community, and especially of the disadvantaged, by providing psychological counseling, guidance, and assistance, especially in the form of social services.

> The American Heritage® Dictionary of the English Language, Fourth Edition. Copyright © 2009 by Houghton Mifflin Company.

International Federation of Social Workers

The social work profession promotes social change, problem solving in human relationships, and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work.

National Association of Social Workers (U.S.)

Social work is the professional activity of helping individuals, groups, or communities enhance or restore their capacity for social functioning and creating societal conditions favorable to this goal. Social Work practice consists of the professional application of Social Work values, principles, and techniques to one or more of the following ends: helping people obtain tangible services; counseling and psychotherapy with individuals, families, and groups; and helping communities or groups provide or improve processes.

Resource Page 2.2: History of Social Work

Part I

- Social work is rooted in the idea of "charity," which goes back to ancient times.

- Much charity work was done by religious organizations.

- However, what we think of as the profession of social work today arose primarily out of the Western industrial revolution in the 19th century.

- The industrial revolution created much movement from rural to urban areas and, along with it, many social and personal problems.

- In response to these problems, development of social work in the West started with volunteer helpers, then became a profession with paid workers.

- The "settlement house" movement began in Great Britain in the late 1800s.

- The pioneer settlement house was Toynbee Hall, founded in London.

- Settlement houses provided a variety of direct services in poor neighborhoods, including education, housing, legal aid, and health services.

- The movement also focused on looking at the causes of poverty, and advocated for changes in social policy.

- The first settlement house in the United States, Hull House, was founded by Jane Addams.

- Jane Addams is considered a pioneer of social work. She later won a Nobel Peace Prize for her work.

Jane Addams and Hull House Children

- Social work took a step forward as a paying profession in 1898, when the first social work class was added to the curriculum at Columbia University in New York City.
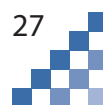
- Although social work was developed in the United Kingdom and the United States, it has become broadly used throughout the world.

- 80 countries have professional associations that are members of the International Federation of Social Workers (IFSW).

- IFSW was established 50 years ago and describes itself as:

  A global organization striving for social justice, human rights, and social development through the development of social work, best practices, and international cooperation between social workers and their professional organizations.

- Workers in different countries follow basic principles of social work, but emphasize different approaches according to their country's needs.

- The profession and practice of social work have spread throughout the world, including into Asia.

- A number of Asian countries, including China, Malaysia, Singapore, and Korea, now have professional social work associations that are members of IFSW.

Part II

The following section on social work in Vietnam is based on a study described in: Hugman, R., Nguyen, T.L., & Nguyen, T.H. (2007). Developing social work in Vietnam. International Social Work, 50(2), 197–211.

- Vietnam has a strong tradition of people giving and receiving help within families and neighborhood networks.

- A period of rapid change and economic progress set the stage for the development of social work as a profession in Vietnam.

- In 1986, Vietnam set out to modernize, industrialize, and create a market economy.

- This period of economic reform (doi moi) has brought many social benefits, but also has created some new social problems.

- Social changes over the past 20 years have weakened support networks, and social problems have increased.

- Vietnam's tradition of giving and receiving help has slowed understanding and support of social work as a paid profession rather than as a volunteer activity that anyone could do.

- Because of this, the need for social workers to be professionally trained has not been easily accepted.

- However, in 1995, the Ministry of Education and Training approved two higher education institutions to begin teaching social work as part of social science programs.

- By 2005, 11 schools were offering a social work curriculum.

- However, a survey of students found that the coursework offered in these programs is based on theory rather than practices or skills.

- One student commented, "Here we still focus on theory, but social work is a practical science or profession. So we should do more practice."

- The function and goals of a social work profession in Vietnam continue to be debated.

Meanwhile, the lack of a National job code means that, in effect, there is no recognition of social work as a job. This presents barriers to its continued development, including:

- o No formal statement of possible duties and responsibilities;

- o No related salary scale or budget for funding government positions or for supporting social welfare agencies, leading to dependence on poorly paid or volunteer workers at the practice level in communes and wards;

- o A lack of laws and policies to support social work; and

- o Lack of common understanding of social work, partially because of the broad meaning of cong tac xa hoi and partially because social work usually does not produce immediate or "dramatic" changes.

- Although social work and social work training still have a way to go in Vietnam, its development has been much more rapid in Vietnam than in other countries (two decades compared with up to a century in Western countries, for example).

- Government departments, such as MOLISA, recognize the importance of developing professional social work in Vietnam.
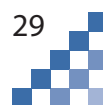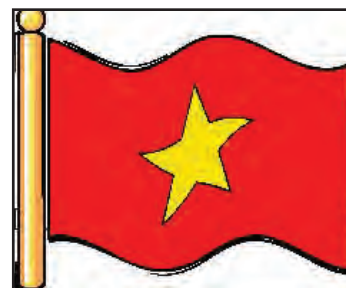
Resource Page 2.3: Principles of Social Work
Approved at the General Meetings of the International Federation of Social Workers and the International Association of Schools of Social Work, October 2004
Used with permission

Human Rights and Human Dignity

Social work is based on respect for the inherent worth and dignity of all people and the rights that follow from this. Social workers should uphold and defend each person's physical, psychological, emotional, and spiritual integrity, and well-being. This means:

1. Respecting the right to self-determination—Social workers should respect and promote people's right to make their own choices and decisions, irrespective of their values and life choices, provided this does not threaten the rights and legitimate interests of others.

2. Promoting the right to participation—Social workers should promote the full involvement and participation of people using their services in ways that enable them to be empowered in all aspects of decisions and actions affecting their lives.

3. Treating each person as a whole—Social workers should be concerned with the whole person, within the family, community, societal, and natural environments, and should seek to recognize all aspects of a person's life.

4. Identifying and developing strengths—Social workers should focus on the strengths of all individuals, groups, and communities and thus promote their empowerment.

Social Justice

Social workers have a responsibility to promote social justice, in relation to society generally, and in relation to the people with whom they work. This means:

1. Challenging negative discrimination*—Social workers have a responsibility to challenge negative discrimination on the basis of characteristics such as ability, age, culture, gender or sex, marital status, socioeconomic status, political opinions, skin color, racial or other physical characteristics, sexual orientation, or spiritual beliefs.

    In some countries the term "discrimination" would be used instead of "negative discrimination." The word negative is used here because in some countries the term "positive discrimination" is also used. Positive discrimination is also known as "affirmative action." Positive discrimination or affirmative action means positive steps taken to redress the effects of historical discrimination.

2. Recognizing diversity—Social workers should recognize and respect the ethnic and cultural diversity of the societies in which they practice, taking account of individual, family, group, and community differences.

3. Distributing resources equitably—Social workers should ensure that resources at their disposal are distributed fairly, according to need.

4. Challenging unjust policies and practices—Social workers have a duty to bring to the attention of their employers, policymakers, politicians, and the general public situations where resources are inadequate or where distribution of resources, policies, and practices are oppressive, unfair, or harmful.

5. Working in solidarity—Social workers have an obligation to challenge social conditions that contribute to social exclusion, stigmatization, or subjugation and to work toward an inclusive society.

Resource Page 2.4: Models of Case Management

1. Brokerage/Generalist

- Brokerage/generalist models try to identify clients' needs and help clients to access identified resources.

- Planning may be limited to the client's early contacts with the case worker rather than an intensive long-term relationship. Planning focuses on connecting the client to another agency or service.

- Ongoing monitoring, if provided, is fairly brief and does not include active advocacy.

- Brokerage/generalist models are sometimes considered inferior because of the limited nature of the client–case worker relationship and the absence of advocacy.

- Nonetheless, this approach shares the basic foundations of case management and has proved useful in selected situations.

- The relatively limited nature of the relationship in this model allows the case worker to provide services to more clients.

- This approach is appropriate when treatment and social services in a certain area are relatively integrated and the need for monitoring and advocacy is minimal.

- The model works best with clients who are not economically deprived, who have significant motivation and enough resources, or who are not in late-stage addiction.

- Small agencies or agencies that offer narrowly defined services may be in an ideal position to offer brokerage-only services.

- This model allows for a "quick response" approach that provides immediate results to clients by linking them with agencies or services that will provide ongoing support.

2. Program of Assertive Community Treatment (PACT)

- PACT involves contact with clients in their homes and natural settings.

- It focuses on the problems of daily living.

- Assertive advocacy is important.

- Caseload sizes are manageable.

- The case worker and client have frequent contact.

- A team approach is followed with shared caseloads.

- Case workers make a long-term commitment to their clients.

- Instead of expecting clients to look for services when they "hit bottom," case workers try to find clients through a process known as "enforced contact."

- One version of PACT, the Assertive Community Treatment (ACT) model, has been used in the United States with people on parole with histories of injecting drugs. Case workers provided direct counseling services and worked with clients to help them develop skills to function successfully in the community. Case management staff also provided family consultations and crisis intervention services. In addition, they operated group sessions to provide skills training in areas such as employment and relapse prevention as well as HIV/AIDS education.

- ACT has time limits and success goals; it is not for clients who require continuous care. Clients are expected to achieve long periods of abstinence and "graduation" from treatment.

3. Strengths-Based Case Management

- The strengths-based perspective of case management was originally developed to help people with persistent mental illness make the move from institutionalized care to independent living.

- The model provides clients with support for taking direct control over their search for resources, such as housing and employment.

- It examines clients' strengths and determines the assets they can use to obtain resources.

- To help clients take control and find their strengths, this model encourages use of informal helping networks (as opposed to institutional networks).

- The model emphasizes the client–case worker relationship.

- It also provides an active, aggressive form of outreach to clients.

4. Clinical/Rehabilitation

- Clinical/rehabilitation approaches to case management are those in which clinical (therapy) and resource acquisition (case management) activities are joined together and addressed by the case worker.

- Many substance abuse treatment programs in the United States use a clinical model in which the same treatment professional provides, or at least coordinates, both therapy and case management activities.

- The clinical/rehabilitation approach has been widely used in the treatment of persons with diagnoses of both substance abuse and psychiatric problems.

5. Prevention Case Management (PCM)

- PCM is specifically focused on HIV-related behavior change.

- PCM involves identification of HIV-related risk behaviors and factors that influence risk taking.

- The prevention case worker uses multiple risk-reduction strategies to change HIV risk behavior.

- The model provides primary and secondary HIV prevention services. (Note: Primary HIV prevention refers to activities directed to keeping an HIV-negative person negative; secondary HIV prevention refers to activities for the person who is already HIV positive or has AIDS.)

- A client-centered prevention plan with specific behavioral objectives for HIV risk reduction is developed.

- Referrals are made to needed medical and psychosocial services, specifically those for sexually transmitted diseases and substance abuse treatment.

Resource Page 2.5: Professional Conduct
Approved at the General Meetings of the International Federation of Social Workers (IFSW) and the International Association of Schools of Social Work (IASSW), October 2004
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It is the responsibility of the national organizations in membership of IFSW and IASSW to develop and regularly update their own codes of ethics or ethical guidelines, to be consistent with the IFSW/IASSW statement, the responsibility to inform social workers and schools of social work about these codes or guidelines. Social workers should act in accordance with the ethical code or guidelines current in their country. These will generally include more detailed guidance in ethical practice specific to the national context. The following general guidelines on professional conduct apply:

1. Social workers are expected to develop and maintain the required skills and competence to do their job.

2. Social workers should not allow their skills to be used for inhumane purposes, such as torture or terrorism.

3. Social workers should act with integrity. This includes not abusing the relationship of trust with the people using their services, recognizing the boundaries between personal and professional life, and not abusing their position for personal benefit or gain.

4. Social workers should act in relation to the people using their services with compassion, empathy, and care.

5. Social workers should not subordinate the needs or interests of people who use their services to their own needs or interests.

6. Social workers have a duty to take necessary steps to care for themselves professionally and personally in the workplace and in society, in order to ensure that they are able to provide appropriate services.

7. Social workers should maintain confidentiality regarding information about people who use their services. Exceptions to this may only be justified on the basis of greater ethical requirements, such as the preservation of life.

8. Social workers need to acknowledge that they are accountable for their actions to the users of their services, the people they work with, their colleagues, their employers, the professional association, and the law, and that these accountabilities may conflict.

9. Social workers should be willing to collaborate with the schools of social work in order to support social work students to get practical training of good quality and up-to-date knowledge.
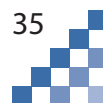
10. Social workers should foster and engage in ethical debate with their colleagues and employers and take responsibility for making ethically informed decisions.

11. Social workers should be prepared to state the reasons for their decisions based on ethical considerations and be accountable for their choices and actions.

12. Social workers should work to create conditions in employing agencies and in their countries where the principles of this statement and those of their own national code (if applicable) are discussed, evaluated, and upheld.

Resource Page 2.6: Code of Ethics
NAADAC, the Association for Addiction Professionals

Principle 1: Nondiscrimination

I shall affirm diversity among colleagues or clients regardless of age, gender, sexual orientation, ethnic/racial background, religious/spiritual beliefs, marital status, political beliefs, or mental/ physical disability and veteran status.

- I shall strive to treat all individuals with impartiality and objectivity relating to all based solely on their personal merits and mindful of the dignity of all human persons. As such, I shall not impose my personal values on my clients.

- I shall avoid bringing personal or professional issues into the counseling relationship. Through an awareness of the impact of stereotyping and discrimination, I shall guard the individual rights and personal dignity of my clients.

- I shall relate to all clients with empathy and understanding no matter what their diagnosis or personal history.

Principle 2: Client Welfare

I understand that the ability to do good is based on an underlying concern for the well-being of others. I shall act for the good of others and exercise respect, sensitivity, and insight. I understand that my primary professional responsibility and loyalty is to the welfare of my clients, and I shall work for the client irrespective of who actually pays his/her fees.

- I shall do everything possible to safeguard the privacy and confidentiality of client information except where the client has given specific, written, informed, and limited consent or when the client poses a risk to himself or others.

- I shall provide the client his/her rights regarding confidentiality, in writing, as part of informing the client of any areas likely to affect the client's confidentiality.

- I understand and support all that will assist clients to a better quality of life, greater freedom, and true independence.

- I shall not do for others what they can readily do for themselves but rather, facilitate and support the doing. Likewise, I shall not insist on doing what I perceive as good without reference to what the client perceives as good and necessary.

- I understand that suffering is unique to a specific individual and not of some generalized or abstract suffering, such as might be found in the understanding of the disorder. I also understand that the action taken to relieve suffering must be uniquely suited to the suffering individual and not simply some universal prescription.
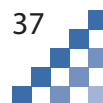
- I shall provide services without regard to the compensation provided by the client or by a third party and shall render equally appropriate services to individuals whether they are paying a reduced fee or a full fee.

Principle 3: Client Relationship

I understand and respect the fundamental human right of all individuals to self-determination and to make decisions that they consider in their own best interest. I shall be open and clear about the nature, extent, probable effectiveness, and cost of those services to allow each individual to make an informed decision of their care.

- I shall provide the client and/or guardian with accurate and complete information regarding the extent of the potential professional relationship, such as the Code of Ethics and professional loyalties and responsibilities.

- I shall inform the client and obtain the client's participation, including the recording of the interview, the use of interview material for training purposes, and/or observation of an interview by another person.

Principle 4: Trustworthiness

I understand that effectiveness in my profession is largely based on the ability to be worthy of trust, and I shall work to the best of my ability to act consistently within the bounds of a known moral universe, to faithfully fulfill the terms of both personal and professional commitments, to safeguard fiduciary relationships consistently, and to speak the truth as it is known to me.

- I shall never misrepresent my credentials or experience.

- I shall make no unsubstantiated claims for the efficacy of the services I provide and make no statements about the nature and course of addictive disorders that have not been verified by scientific inquiry.

- I shall constantly strive for a better understanding of addictive disorders and refuse to accept supposition and prejudice as if it were the truth.

- I understand that ignorance in those matters that should be known does not excuse me from the ethical fault of misinforming others.

- I understand the effect of impairment on professional performance and shall be willing to seek appropriate treatment for myself or for a colleague. I shall support peer assistance programs in this respect.

- I understand that most property in the healing professions is intellectual property and shall not present the ideas or formulations of others as if they were my own. Rather, I shall give appropriate credit to their originators both in written and spoken communication.

- I regard the use of any copyrighted material without permission or the payment of royalty to be theft.

Principle 5: Compliance with Law

I understand that laws and regulations exist for the good ordering of society and for the restraint of harm and evil, and I am aware of those laws and regulations that are relevant both personally and professionally and follow them, while reserving the right to commit civil disobedience.

- I understand that the determination that a law or regulation is unjust is not a matter of preference or opinion, but a matter of rational investigation, deliberation, and dispute.

- I willingly accept that there may be a penalty for justified civil disobedience, and I must weigh the personal harm of that penalty against the good done by civil protest.

Principle 6: Rights and Duties

I understand that personal and professional commitments and relationships create a network of rights and corresponding duties. I shall work to the best of my ability to safeguard the natural and consensual rights of each individual and fulfill those duties required of me.

- I understand that justice extends beyond individual relationships to the community and society; therefore, I shall participate in activities that promote the health of my community and profession.

- I shall, to the best of my ability, actively engage in the legislative processes, educational institutions, and the general public to change public policy and legislation to make possible opportunities and choice of service for all human beings of any ethnic or social background whose lives are impaired by alcoholism and drug abuse.

- I understand that the right of confidentiality cannot always be maintained if it serves to protect abuse, neglect, or exploitation of any person or leaves another at risk of bodily harm.

Principle 7: Dual Relationships

I understand that I must seek to nurture and support the development of a relationship of equals rather than to take unfair advantage of individuals who are vulnerable and exploitable.

- I shall not engage in professional relationships or commitments that conflict with family members, friends, close associates, or others whose welfare might be jeopardized by such a dual relationship.

- Because a relationship begins with a power differential, I shall not exploit relationships with current or former clients for personal gain, including social or business relationships.

- I shall not under any circumstances engage in sexual behavior with current or former clients.

- I shall not accept substantial gifts from clients, other treatment organizations, or the providers of materials or services used in my practice.

Principle 8: Preventing Harm

I understand that every decision and action has ethical implications leading either to benefit or harm, and I shall carefully consider whether any of my decisions or actions has the potential to produce harm of a physical, psychological, financial, legal, or spiritual nature before implementing them.

- I shall refrain from using any methods that could be considered coercive such as threats, negative labeling, and attempts to provoke shame or humiliation.

- I shall make no requests of clients that are not necessary as part of the agreed treatment plan.

- I shall terminate a counseling or consulting relationship when it is reasonably clear that the client is not benefiting from the relationship.

- I understand an obligation to protect individuals, institutions, and the profession from harm that might be done by others. Consequently, I am aware that the conduct of another individual is an actual or likely source of harm to clients, colleagues, institutions, or the profession, and that I have an ethical obligation to report such conduct to competent authorities.

Principle 9: Duty of Care

I shall operate under the principle of Duty of Care and shall maintain a working/therapeutic environment in which clients, colleagues, and employees can be safe from the threat of physical, emotional, or intellectual harm.

- I respect the right of others to hold spiritual opinions, beliefs, and values different from my own.

- I shall strive for understanding and the establishment of common ground rather than for the ascendancy of one opinion over another.

- I shall maintain competence in the area of my practice through continuing education, constantly improving my knowledge and skills in those approaches most effective with my specific clients.

- I shall scrupulously avoid practicing in any area outside of my competence.

Updated August 18, 2008

MODULE 3—DRUGS OF ABUSE: CHARACTERISTICS AND CONSEQUENCES

Module 3 Goals and Objectives

Training goals

☐ To provide an overview of psychoactive drugs of abuse;

☐ To provide an overview of HIV/AIDS and its relationship to drug use; and

☐ To provide information on changing patterns of drug use in Vietnam.

Learning objectives

Participants who complete Module 3 will be able to:

☐ List the four main categories of drugs;

☐ Discuss at least three characteristics of at least two drugs from each category;

☐ Discuss the individual, family, and community consequences of drug use;

☐ Describe the relationship between drug use and HIV/AIDS; and

☐ Discuss changes in drug use in Vietnam over the past 10 years.

Timeline and Content	
Activity	Time
Welcome, concert review of day 1, Module 3 introduction	15 minutes
Presentation: Drugs of abuse: Introduction	15 minutes
Exercise: Characteristics, effects, and health consequences of specific drugs	90 minutes
Break	15 minutes
Exercise: Consequences of drug use	45 minutes
Presentation: Drug use and HIV/AIDS	15 minutes
Presentation: Drug use in Vietnam	15 minutes
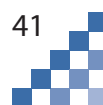
CASE MANAGEMENT FOR RECOVERING DRUG USERS IN VIETNAM: A TRAINING CURRICULUM

MODULE 3—DRUGS OF ABUSE: CHARACTERISTICS AND CONSEQUENCES

3.1

What Is a Drug?

■ In *medicine*: Any substance with the potential to prevent or cure a disease or the potential to enhance physical or mental well-being

3.2

What Is a Drug?

■ In *pharmacology:* Any chemical agent that alters the biochemical or physiological processes of body tissues or organisms
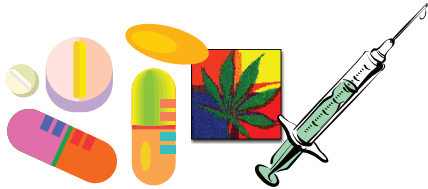
3.3

What Is a Drug?

- In *common usage:* The term refers to illicit drugs that are often used for nonmedical (e.g., recreational) reasons

3.4

Psychoactive Drugs

- Psychoactive drugs alter:
  - Mood
  - Cognition (thoughts)
  - Behavior

3.5

Classes of Psychoactive Drugs

- Stimulants

- Depressants

- Hallucinogens

3.6
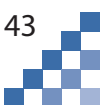
Classes of Psychoactive Drugs

- Stimulants *increase* the activity of the central nervous system (CNS)

- Depressants *decrease* the activity of the CNS

- Hallucinogens produce a spectrum of vivid sensory distortions and markedly alter mood and thinking

3.7

Classes of Psychoactive Drugs

Stimulants	Depressants	Hallucinogens
Cocaine	Alcohol	LSD
Amphetamines	Opioids	Mescaline/Peyote
Methamphetamines	Benzodiazepines	Ecstasy
Nicotine, Caffeine	Barbiturates	Mushrooms

3.8

Psychoactive Drugs

- Just because a drug is legal does not mean it is safer than an illegal drug

3.9

Classes of Psychoactive Drugs: Other

Some drugs don't fit neatly into a category:

Cannabinoids
(marijuana, hashish)

Dissociative anesthetics
(phencyclidine [PCP], ketamine)

Inhalants
(solvents, gases, nitrites)

3.10

Route of Administration

■The *route of administration* of a drug affects how quickly a drug gets to the brain

■The faster the drug hits the brain, the greater and more reinforcing its effect

3.11

Routes of Administration

■Inhaling: 7-10 seconds

■Intravenous injecting: 15-30 seconds

■Injecting into the muscle or under the skin: 3-5 minutes

3.12

Routes of Administration

- Mucous membrane absorption (through the nose or in the mouth): 3-5 minutes

- Orally: 20-30 minutes

- Absorbed through skin: Slowly over a long period of time

3.13

Consequences of Drug Use

- Drug use and addiction affect the individual, family, community, and society

3.14

HIV

Human immunodeficiency virus (HIV)

3.15

HIV

- Attacks CD4 cells and uses them to make more HIV cells

- Leads to a deficiency in the infected person's immune system

3.16

HIV and AIDS

HIV does *not* equal AIDS

3.17

AIDS

Acquired immune deficiency syndrome (AIDS)

3.18

AIDS

- A *syndrome*
  - Is not a specific disease
  - Is a set of signs or symptoms that occur together, as a direct result of a particular cause

- In the case of AIDS, the cause is HIV

3.19

HIV Testing

- In the early stages of HIV infection, HIV can be detected *only* by blood tests that look for antibodies to the virus

- It takes the body 6 weeks to 6 months after exposure to develop enough antibodies to be measured in a test

3.20

Voluntary Counseling and Testing Model

Pretest counseling → HIV testing → Posttest counseling → Risk reduction, treatment, support services

3.21

Goals of Treatment

2 Key Goals of HAART

LOW
Viral Load

HIGH
CD4 Cell Count

3.22

Treatment for HIV/AIDS

- Highly active antiretroviral therapy (HAART) has been available since 1996 and has had a dramatic effect on HIV/AIDS

3.23

Relationship: Drug Use and HIV/AIDS

Drug use:

- Is closely involved in *transmission*
- May affect the rate of *progression*
- Interferes with *treatment*

3.24

Relationship: Drug Use and HIV/AIDS

- IV transmission risk:
  - Immediate reuse of a needle and/or syringe after use by an HIV-positive person
  - Sharing other injecting materials (used water, spoon, filtering material)

3.25

Relationship: Drug Use and HIV/AIDS

- Other transmission risks:
  - Greater likelihood of high-risk sex with infected partners
  - Trading or selling sex for drugs
  - Transmission of the virus from mother to fetus (if she is not treated)

3.26

Relationship: Drug Use and HIV/AIDS

- Drug abuse and addiction may increase the rate of *progression* of HIV and its consequences, especially in the brain

3.27

Relationship: Drug Use and HIV/AIDS

- Interfere with a person adhering to a HAART regimen

- Interfere with the action of HAART and decrease effectiveness

3.28

Drug Use and HIV/AIDS

- Drug abuse treatment is effective HIV prevention

3.29

Drug Use in Vietnam

- The number of people in Vietnam addicted to a drug tripled between 1994 and 2004

3.30

Drug Use in Vietnam: Changes

1996	2001
Primary drug of abuse: Opium	Primary drug of abuse: Heroin (67%)
Other drug use: Little to none	Other drug use: ↑Cannabis, amphetamines, cocaine, sedatives, tranquilizers

3.31

2001 MOLISA SURVEY

■ In large cities, more than 90 percent of individuals addicted to a drug used heroin

3.32

Drug Use in Vietnam

■ Amphetamine use is becoming more popular among urban and more wealthy youth

3.33

Drug Use in Vietnam

- Drug use has shifted from rural to urban areas

3.34

Resource Page 3.1: Drugs of Abuse

Substances: Category and Name	How Administered	Intoxication Effects/Potential Health Consequences
Category: Depressants		*Reduced anxiety, feeling of well-being, lowered inhibitions, slowed pulse and breathing, lowered blood pressure, poor concentration/Fatigue; confusion, impaired coordination, memory, and judgment; addiction; respiratory depression and arrest; death*
Barbiturates Amytal Nembutal Seconal Phenobarbital	Swallowed, injected	*For barbiturates—Sedation, drowsiness/Depression, unusual excitement, fever, irritability, poor judgment, slurred speech, dizziness, life-threatening withdrawal*
Benzodiazepines Ativan Halcion Librium Valium Xanax Rohypnol	Swallowed, injected (Rohypnol can be snorted)	*For benzodiazepines—Sedation, drowsiness/Dizziness*
Gamma-Hydroxybutyrate (GHB)	Swallowed	*For GHB—Drowsiness, nausea and vomiting, headache, loss of consciousness, loss of reflexes, seizures, coma, death*
Methaqualone Quaalude Sopor Parest	Swallowed, injected	*For methaqualone—Euphoria/Depression, poor reflexes, slurred speech, coma*

Substances: Category and Name	How Administered	Intoxication Effects/Potential Health Consequences
Category: Hallucinogens		*Altered states of perception and feeling, nausea/Persisting perception disorder (flashbacks)*
Lysergic acid diethylamide (LSD)	Swallowed, absorbed through mouth tissues	*For LSD and mescaline—Increased body temperature, heart rate, and blood pressure; loss of appetite; sleeplessness; numbness; weakness; tremors*
Mescaline Peyote	Swallowed, smoked	*For LSD—Persistent mental disorders*
Psilocybin "Magic mushroom"	Swallowed	*For psilocybin—Nervousness, paranoia*

Substances: Category and Name	How Administered	Intoxication Effects/Potential Health Consequences
Category: Opioids and Morphine Derivatives		
Codeine Empirin with codeine Fiorinal with codeine Robitussin A-C Tylenol with codeine	Injected, swallowed	*Pain relief, euphoria, drowsiness/*Nausea, constipation, confusion, sedation, respiratory depression and arrest, tolerance, addiction, unconsciousness, coma, death *For codeine—Less analgesia, sedation, respiratory depression than morphine* *For heroin—Staggering gait*
Fentanyl and fentanyl analogs Actiq Duragesic Sublimaze	Injected, smoked, snorted	
Diacetyl-morphine Heroin	Injected, smoked, snorted	
Morphine Roxanol, Duramorph	Injected, swallowed, smoked	
Opium Laudanum Paregoric	Swallowed, smoked	
Oxycodone HCL OxyContin	Swallowed, snorted, injected	
Hydrocodone bitartrate, acetaminophen Vicodin	Swallowed	

Substances: Category and Name	How Administered	Intoxication Effects/Potential Health Consequences
Category: Stimulants		
Amphetamine Biphetamine Dexedrine	Injected, swallowed, smoked, snorted	*Increased heart rate, blood pressure, and metabolism; feelings of exhilaration and energy; increased mental alertness/*Rapid or irregular heart beat, reduced appetite, weight loss, heart failure, nervousness, insomnia *For amphetamine—Rapid breathing/*Tremors, loss of coordination, irritability, anxiousness, restlessness, delirium, panic, paranoia, impulsive behavior, aggressiveness, tolerance, addiction, psychosis
Cocaine	Injected, smoked, snorted	
MDMA (methylenedioxy-methamphetamine) Ecstasy	Swallowed	*For cocaine—Increased temperature/*Chest pain, respiratory failure, nausea, abdominal pain, strokes, seizures, headaches, malnutrition, panic attacks
Methamphetamine Desoxyn	Injected, swallowed, smoked, snorted	*For MDMA—Mild hallucinogenic effects, increased tactile sensitivity, empathic feelings/*Impaired memory and learning, hyperthermia, cardiac toxicity, renal failure, liver toxicity
Methylphenidate Ritalin	Injected, swallowed, snorted	*For methamphetamine—Aggression, violence, psychotic behavior/*Memory loss, cardiac and neurological damage, impaired memory and learning, tolerance, addiction
Nicotine	Smoked, snorted, taken in snuff and spit tobacco	*For nicotine—Adverse pregnancy outcomes, chronic lung disease, cardiovascular disease, stroke, cancer, tolerance, addiction

Substances: Category and Name	How Administered	Intoxication Effects/Potential Health Consequences
Other		
Inhalants Solvents (paint thinners, gasoline, glues) Gases (butane, propane, aerosol propellants, nitrous oxide) Nitrites (isoamyl, isobutyl, cyclohexyl)	Inhaled through nose or mouth	*Stimulation, loss of inhibition, headache, nausea or vomiting, slurred speech, loss of motor coordination, wheezing*/Unconsciousness, cramps, weight loss, muscle weakness, depression, memory impairment, damage to cardiovascular and nervous systems, sudden death
Cannabinoids Hashish Marijuana	Swallowed, Smoked	*Euphoria, slowed thinking and reaction time, confusion, impaired balance and coordination*/Cough and frequent respiratory infections, impaired memory and learning, increased heart rate, anxiety, panic attacks, tolerance, addiction
Dissociative anesthetics Ketamine Ketalar SV	Injected, Smoked, Inhaled	*Increased heart rate and blood pressure, impaired motor function*/Memory loss, numbness, nausea and vomiting
Dissociative anesthetics Phencyclidine (PCP) and analogs	Swallowed, smoked Swallowed, smoked	*For ketamine (at high doses)—Delirium, depression, respiratory depression and arrest* *For PCP and analogs—Possible decrease in blood pressure and heart rate, panic, aggression, violence*/Loss of appetite, depression

Adapted from material from the National Institute on Drug Abuse.

MODULE 4—THE SCIENCE OF ADDICTION

Module 4 Goals and Objectives

Training goals

☐ To provide an overview of the science of addiction as a brain disease.

Learning objectives

Participants who complete Module 4 will be able to:

☐ Define addiction;

☐ Discuss why addiction is considered a brain disease;

☐ Provide a basic description of how drugs create their effects in the brain;

☐ Discuss why people start using drugs; and

☐ Discuss what stigma is and the role it plays in drug addiction and seeking help.

Timeline and Content	
Activity	Time
Introduction to Module 4	10 minutes
Small-group exercise: What is addiction?	20 minutes
Lunch	90 minutes
Energizer	15 minutes
Presentation: The science of addiction 1	20 minutes
Exercise: Brain communication	40 minutes
Presentation: The science of addiction 2	15 minutes
Break	15 minutes
Exercise: Drugs and brain communication	30 minutes
Small-group exercise: Stigma	55 minutes
Learning assessment	20 minutes
Day 2 evaluation and wrap-up	15 minutes
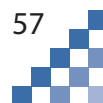
CASE MANAGEMENT FOR RECOVERING DRUG USERS IN VIETNAM: A TRAINING CURRICULUM

MODULE 4—THE SCIENCE OF ADDICTION

4.1

___

Science of Addiction

- Advances in medicine and scientific techniques have given researchers a clearer idea of what addiction is:
  - Magnetic resonance imaging (MRI)
  - Positron emission tomography (PET) scan
  - Advanced genetic research

4.2

___

Science of Addiction

- Addiction is a chronic *disease;* it is as real a disease as diabetes or hypertension

4.3

___

Science of Addiction

- Addiction is "a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences"

U.S. National Institute on Drug Abuse definition

4.4

Disease

- Alteration of the normal structure or function of any body part, organ, or system

- Characteristic set of symptoms and signs

4.5

Chronic Disease

- Long lasting

- Cannot be cured, but can be managed

4.6
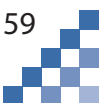
Science of Addiction

■ A *brain* disease because drugs change the structure of the brain and how it works

4.7

Science of Addiction

■ A *chronic* disease because, like diabetes and hypertension:

  ❑ It cannot be cured, **but**
  ❑ It *can* be managed

4.8

Science of Addiction

■ A *relapsing* disease because, due to addiction's chronic nature, relapsing to drug use is not only possible, but likely

4.9

Lapse and Relapse

- A *lapse* is a brief, often one-time, return to drug use
- A *relapse* is a complete return to using drugs in the same way the person did before he or she quit
- A lapse *can* lead to relapse, but it doesn't always
- Relapse *can* be avoided

4.10

Brain Communication

- The brain is a communications center consisting of billions of *neurons*, or nerve cells

4.11
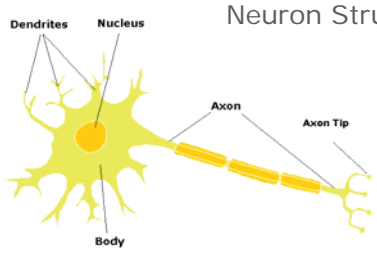
Neuron

4.12

Brain Communication

Neuron Structure

Dendrites Nucleus

Axon

Axon Tip

Body

4.13
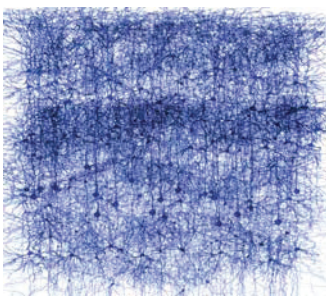
Brain Communication

■ Networks of neurons pass messages back and forth to different structures within the brain, the spinal column, and the peripheral nervous system

4.14

Neurons

■ A "forest" of neurons in the neocortex

4.15

Brain Communication

- A neurotransmitter and its receptor operate like a key and lock

4.16

Dopamine
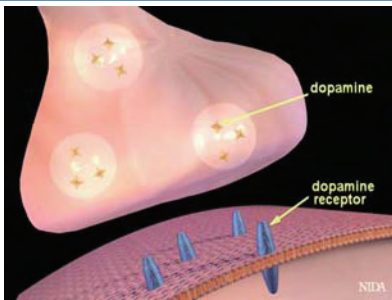
4.17

Dopamine Transporters
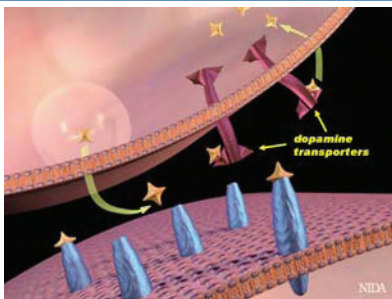
4.18

Brain Communication

■ Psychoactive drugs tap into the brain's communication system and mimic or disrupt the way nerve cells normally send, receive, and process information

4.19

Cocaine Entering the Brain
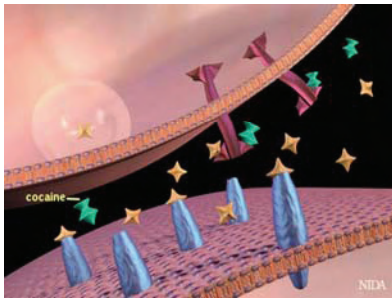
4.20

Parts of the Brain Most Affected by Drug Use

■ The brain stem

■ The limbic system

■ The cerebral cortex
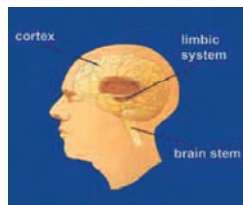
4.21

Parts of the Brain Most Affected by Drug Use

- **The brain stem** controls functions critical to life, such as heart rate, breathing, and sleeping

- **The limbic system** contains the brain's reward circuit

- **The cerebral cortex** processes information from our senses and is the *thinking* center of the brain

4.22

Addiction and the Reward Circuit

- The brain's *reward circuit* is critical to the development of addiction

4.23

Addiction and the Reward Circuit

- Our brains are wired to ensure that we repeat life-sustaining activities by associating those activities with pleasure or reward

4.24
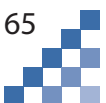
Addiction and the Reward Circuit

- The overstimulation of this circuit, which rewards our *natural* behaviors (eating, drinking, sexual behavior), produces the euphoric effects sought by people who abuse drugs and **teaches them to repeat the behavior**

4.25

Addiction and the Reward Circuit

- The brain adjusts to the overwhelming surges in dopamine (and other neurotransmitters) by producing *less* dopamine or by reducing the number of receptors

4.26

Addiction and the Reward Circuit
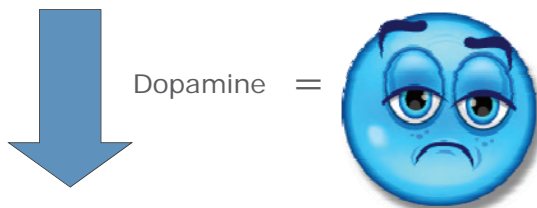
Dopamine =

4.27

Cocaine Reduces Dopamine Receptor Availability: PET Scan
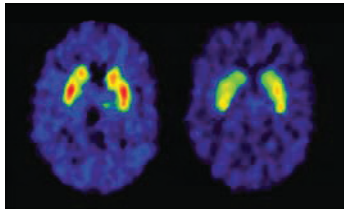
Healthy brain   Brain of cocaine user

Red=High levels of dopamine receptors

NIDA. *Science & Practice Perspectives 3*(2), 2007.

4.28

Addiction and the Reward Circuit

■ Now, a person **needs** to take drugs just to bring his or her dopamine function back to **normal**

4.29

Progression of Addiction 1

4.30

Progression of Addiction 2

4.31

Progression of Addiction 3

4.32

Progression of Addiction 4

4.33

WHO's ICD Criteria for Diagnosing Drug Addiction or Dependence

- A strong desire to take the drug
- Difficulties in controlling its use
- Continuing to use despite harmful consequences

4.34

WHO's ICD Criteria for Diagnosing Drug Addiction or Dependence

- Higher priority given to drug use than to other activities and obligations
- Increased tolerance
- A physical withdrawal state (sometimes)

4.35

Why Do People Start Taking Drugs?

- To feel **good**

- To feel **better**

4.36
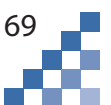
Why Do People Start Taking Drugs?

- To **do** better

- Curiosity, peer pressure

4.37

Why Doesn't Everyone Who Tries a Drug Become Addicted?

- *Vulnerability* to addiction differs from person to person

4.38

Why Doesn't Everyone Who Tries a Drug Become Addicted?

- Between 40 and 60 percent of a person's vulnerability to addiction is **genetic**

4.39

Why Doesn't Everyone Who Tries a Drug Become Addicted?

- Environmental factors (e.g., conditions at home, at school, and in the neighborhood) play a role as well

4.40

Why Doesn't Everyone Who Tries a Drug Become Addicted?

Biology/Genes

Biology/Environment Interactions

Environment
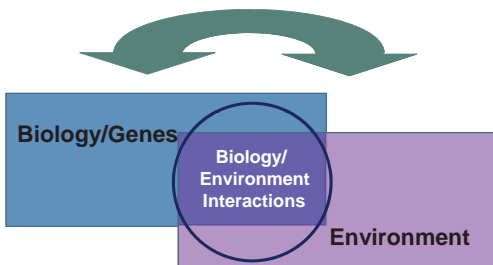
4.41

Why Doesn't Everyone Who Tries a Drug Become Addicted?

- *How* a drug is used is also a factor
- Smoking or injecting a drug increases its addictive potential

4.42

Social Stigma

■ Severe social disapproval of personal characteristics or beliefs that are against cultural norms

Source: Wikipedia

4.43

Social Stigma

■ Social stigma often leads to status loss, discrimination, and exclusion from meaningful participation in society

4.44

Journal Writing

■ Are you surprised by anything you've heard?
■ Are you having trouble accepting a *disease* model of addiction?
■ Has your thinking changed in any way?
■ What questions do you still have?

4.45

Resource Page 4.1: Basic Principles of Effective Drug Treatment

1. **No single treatment is appropriate for all individuals.** Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

2. **Treatment needs to be readily available.** Because individuals who are addicted to drugs may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.

3. **Effective treatment attends to multiple needs of the individual, not just his or her drug use.** To be effective, treatment must address the individual's drug use and any associated medical, psychological, social, vocational, and legal problems.

4. **An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.** A client may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a client at times may require medication, other medical services, family therapy, parenting instruction, vocational rehabilitation, and social and legal services. It is critical that the treatment approach be appropriate to the individual's age, gender, ethnicity, and culture.

5. **Remaining in treatment for an adequate period of time is critical for treatment effectiveness.** The appropriate duration for an individual depends on his or her problems and needs. Research indicates that, for most clients, the threshold of significant improvement is reached at about 3 months in treatment. After this threshold is reached, additional treatment can produce further progress toward recovery. Because people often leave treatment prematurely, programs should include strategies to engage and keep them in treatment.

6. **Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.** In therapy, clients address issues of motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community.

7. **Medications are an important element of treatment for many clients, especially when combined with counseling and other behavioral therapies.** Methadone is very effective in helping heroin addicts stabilize their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some addicts and some clients with co-

occurring alcohol dependence. For persons addicted to nicotine, a nicotine replacement product (such as patches or gum) or an oral medication (such as bupropion) can be an effective component of treatment. For clients with mental disorders, both behavioral treatments and medications can be critically important.
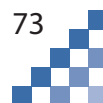
8. **Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.** Because addictive disorders and mental disorders often occur in the same individual, clients presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder.

9. **Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.** Medical detoxification safely manages the acute physical symptoms of withdrawal associated with stopping drug use. Although detoxification alone is rarely sufficient to help addicts achieve long-term abstinence, for some individuals it is a strongly indicated precursor to effective drug addiction treatment.

10. **Treatment does not need to be voluntary to be effective. Strong motivation can facilitate the treatment process.** Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of drug treatment interventions.

11. **Possible drug use during treatment must be monitored continuously. Lapses to drug use can occur during treatment.** The objective monitoring of a client's drug and alcohol use during treatment, such as through urinalysis or other tests, can help the client withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that the individual's treatment plan can be adjusted. Feedback to clients who test positive for illicit drug use is an important element of monitoring.

12. **Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases and counseling to help clients modify or change behaviors that place themselves or others at risk of infection.** Counseling can help patients avoid high-risk behavior. Counseling also can help people who are already infected manage their illness.

13. **Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.** Relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence.

From: U.S. National Institute on Drug Abuse. (1999). *Principles of drug addiction treatment: A research based guide*. Bethesda, MD: Author.

MODULE 5—TREATMENT FOR DRUG ADDICTION: OVERVIEW

Module 5 Goals and Objectives

Training goals

- To provide participants with an overview of drug treatment settings, modalities, and intervention models in Vietnam and elsewhere;

- To provide participants with an opportunity to discuss and consider basic principles of drug treatment;

- To provide participants with information about family involvement in treatment; and

- To discuss the effects that various individual, program, and societal factors have on treatment outcome.

Learning objectives

Participants who complete Module 5 will be able to:

- List at least four elements of drug treatment;

- List at least four principles of effective treatment;

- List three advantages of including family members in substance abuse treatment and case management;

- List at least three strategies for engaging families in treatment;

- Describe the drug treatment options available in Vietnam; and

- List at least four factors that influence treatment outcomes.

Timeline and Content	
Activity	Time
Exercise: Module 4 review	30 minutes
Module 5 introduction	5 minutes
Interactive presentation: Two broad goals of drug treatment: Recovery and risk reduction	15 minutes
Exercise: Elements of drug treatment	30 minutes
Exercise: Principles of effective drug treatment	30 minutes
Presentation: Treatment models	20 minutes
Break	15 minutes
Interactive presentation: Family involvement in treatment and case management	45 minutes
Exercise: Treatment options in Vietnam	15 minutes
Presentation: Continuum of Intervention: A pilot program in Vietnam	10 minutes
Small-group exercise: Influences on treatment outcomes	25 minutes
Lunch	90 minutes

CASE MANAGEMENT FOR RECOVERING DRUG USERS IN VIETNAM: A TRAINING CURRICULUM

MODULE 5—TREATMENT FOR DRUG ADDICTION: OVERVIEW

USAID | Pact Vietnam | fhi Family Health International

5.1

Goals of Treatment

RECOVERY

■ A process of change through which an individual stops using drugs (abstinence) and achieves improved health and quality of life

5.2

Goals of Treatment

RISK REDUCTION

■ HIV/AIDS prevention, such as needle/syringe exchange
■ Overdose prevention
■ Reduced drug use

5.3

Risk Reduction—Clean Needle and Syringe Programs

- Vietnam has instituted NSPs

- NSPs are cost-effective and cost-efficient strategies for preventing the spread of HIV among, and from, IDUs

5.4

Clean Needle and Syringe Programs—Distribution Channels

80.74% — Peer educators
7% — Collaborators, pharmacies, health clinics, VCT
12.26% — Others
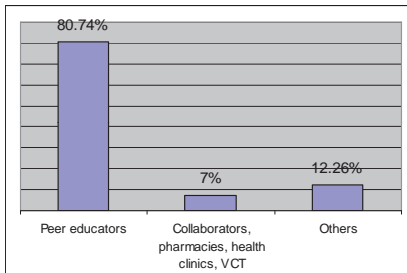
More than 90% of used needles and syringes have been collected by peer educators

5.5

Principles of Effective Drug Treatment

- How do the principles apply to the *elements of treatment* on the graphic?

- In what ways is each principle integrated or not integrated into drug treatment in Vietnam as you know it?

5.6

Detoxification

■ Treatment of withdrawal syndrome, or detoxification, is a precursor of treatment, not a treatment model

■ Detoxification alone does not typically produce the lasting behavioral changes necessary for recovery

5.7

Detoxification

■ *Withdrawal syndrome* is the acute reaction that occurs in the body when a drug user stops or reduces the amount of drugs being used

■ *Medical detoxification* is a process whereby individuals are systematically withdrawn from addicting drugs, typically under the care of a physician

5.8

Detoxification in Vietnam

■ Government 06 centers (nonmedical detoxification)

■ Detoxification with medication: Mental Health Institute of Bach Mai Hospital

■ Detoxification with acupuncture: Central Acupuncture Hospital

■ Detoxification with traditional medicines: Central Traditional Medicine Hospital

5.9

Models of Treatment:
Medication-Assisted Treatment

- Methadone is the most commonly used medication for treating opioid addiction
- Methadone is on the WHO's list of essential medications

5.10

Models of Treatment:
Medication-Assisted Treatment

- "…even after 40 years, substitution therapies such as methadone are still the most promising method of reducing drug dependence."

  □ WHO guidelines

5.11

Models of Treatment:
Medication-Assisted Treatment

- At the right dose, methadone blocks the euphoric effects of heroin and other opioids and decreases cravings

5.12

Methadone Maintenance Treatment in Vietnam

- Clinics dispense methadone 7 days a week and provide counseling and other services 5 days a week

5.13

Models of Treatment: Medication-Assisted Treatment

- Clients stabilized on adequate, sustained dosages of methadone can:
  - Work
  - Take care of their families
  - Avoid the crime and violence of the street culture
  - Reduce their exposure to HIV

5.14

Models of Treatment: Medication-Assisted Treatment

- Methadone maintenance treatment can:

  ⬆ The length of time a person stays in treatment

  ⬇ Or eliminate illicit opioid and other drug use

  ⬇ Risky behaviors associated with opioid use

  ⬇ Mortality and illness

5.15

Models of Treatment: Medication-Assisted Treatment

⬆ Clients' emotional well-being

⬇ Social costs associated with illicit drug use

⬇ Crime

⬇ HIV and hepatitis C transmission

5.16

Models of Treatment: Medication-Assisted Treatment

■ Many people stay on methadone for long periods or for life, which is called methadone maintenance treatment (MMT)

5.17

Methadone Maintenance Treatment in Vietnam

■ MMT is an important component of the 2006 Law on HIV/AIDS Prevention and Control

5.18

Pilot MMT Sites

5.19

Contingency Management

■ Drug use is maintained by the positively reinforcing effects of the drug itself OR

■ By the negative reinforcement of relieving the pain of withdrawal

5.20

Contingency Management

■ Abstinence, in and of itself, may not be sufficiently reinforcing to maintain a person's motivation to stop using drugs

5.21

Contingency Management

- CM motivates clients' behavioral changes and reinforces abstinence by systematically *rewarding* desirable behaviors and ignoring or punishing others

5.22

Contingency Management

- Typical rewards used in CM include:
  - Cash
  - Food
  - Vouchers that can be exchanged for merchandise
  - A chance to enter a contest to win a larger prize
  - Privileges

5.23

Contingency Management

- Targeting *small* changes is the most effective strategy
- More frequent reinforcers, even if small, have a greater effect than larger, more remote rewards or punishments

5.24

Contingency Management

■ Rewards must be delivered as promised for the treatment to remain credible

5.25

Contingency Management

The challenge:
■ Identifying rewards that are both practical and sufficiently powerful—over time—to replace or substitute for the potent, pleasurable, or pain-reducing effects of the drug

5.26

Family Involvement in Treatment

■ More than 90 percent of drug users in Vietnam live with family

5.27

Family Involvement in Treatment

- Family members frequently experience anger, shame, guilt, sadness, and hopelessness
- The result:
  - Isolation
  - Destructive alliances
  - Overinvolvement with family members
  - Significant medical and stress-related problems

5.28

Family Involvement in Treatment

- Family services ensure that family functioning adjusts to and positively influences the recovery of the client

5.29

Family Involvement in Treatment

- A primary goal of involving families in treatment and case management is to increase family members' understanding of the client's substance use disorder as a *chronic disease*

5.30

Family Involvement in Treatment

- Family involvement in substance abuse treatment and case management is not the same as "family therapy"
  - Some families have extremely difficult problems and should be referred for more intensive work
  - Case workers and counselors need to remember their professional boundaries and know when to refer

5.31

Including Families in Treatment Can:

- Increase family support for the client's recovery
- Provide an opportunity to identify and support changes in family patterns that work against recovery
- Prepare family members for what to expect in early recovery

5.32

Including Families in Treatment Can:

- Educate the family about relapse warning signs
- Help family members address feelings of anger, shame, and guilt and resolve issues relating to trust and intimacy
- Take advantage of family strengths
- Encourage family members to obtain long-term support

5.33
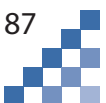
Aftercare

■Obstacles upon release:
- ◻Difficulty accessing medical care and medications
- ◻Untreated mental illness
- ◻Unstable living circumstances
- ◻Lack of support from family members
- ◻Little relapse prevention and other follow-up treatment for addiction and other issues

5.34

Pilot Transitional Program: Community Centers to Support Recovering Drug Users

■ A PEPFAR pilot program
■ Based in the Nhi Xuan 06 Center

5.35

Pilot Transitional Program: Community Centers to Support Recovering Drug Users

■A comprehensive continuum of services that includes prerelease and postrelease services

■Purpose: To ensure services to prevent drug use relapse and reduce relapse resulting in placement back in centers

5.36

Pilot Transitional Program: *Community Centers to Support Recovering Drug Users*

■ **Prerelease** services:
- ❑ Individual counseling sessions
- ❑ Family education groups
- ❑ Early recovery skills groups
- ❑ Relapse prevention groups
- ❑ Conjoint (family and resident) sessions

5.37

Pilot Transitional Program: *Community Centers to Support Recovering Drug Users*

■ **Postrelease** services:
- ❑ HIV/AIDS care: VCT, ART, opportunistic infection prevention
- ❑ Peer education
- ❑ Drug addiction counseling
- ❑ Linkage to continuing services, supports, relapse prevention

5.38

Continuum of Services for Individuals Transitioning from 06 Centers Back to Their Communities

06 Center Services

- ❑ Case management
- ❑ VCT for HIV/AIDS
- ❑ Assessment
- ❑ HIV prevention education
- ❑ Addiction counseling
- ❑ Psychosocial counseling and case management
- ❑ ART treatment

Ensuring services to prevent drug use relapse and to reduce placement back into centers

Pre-departure planning and "handover" from 06 center case workers to community-based case workers

Community-Based Services

- ❑ Continued case management by case workers and social workers in community
- ❑ Linkages to:
  - Health facilities, VCT, ART
  - Support groups
  - Home care teams
- ❑ Relapse prevention, including:
  - Narcotics Anonymous
  - Job placement
  - Methadone
  - Family and peer support groups

5.39

Influences on Treatment Outcomes

- The characteristics of individuals seeking treatment
- The nature and severity of their problems
- The treatment process and the services provided
- Posttreatment environmental and social conditions
- The interactions among these factors

5.40

Resource Page 5.1: Elements of Drug Treatment Worksheet

Modality

Interventions

Intensity

Duration

Continuum of Care

TREATMENT

Setting

Models of Intervention
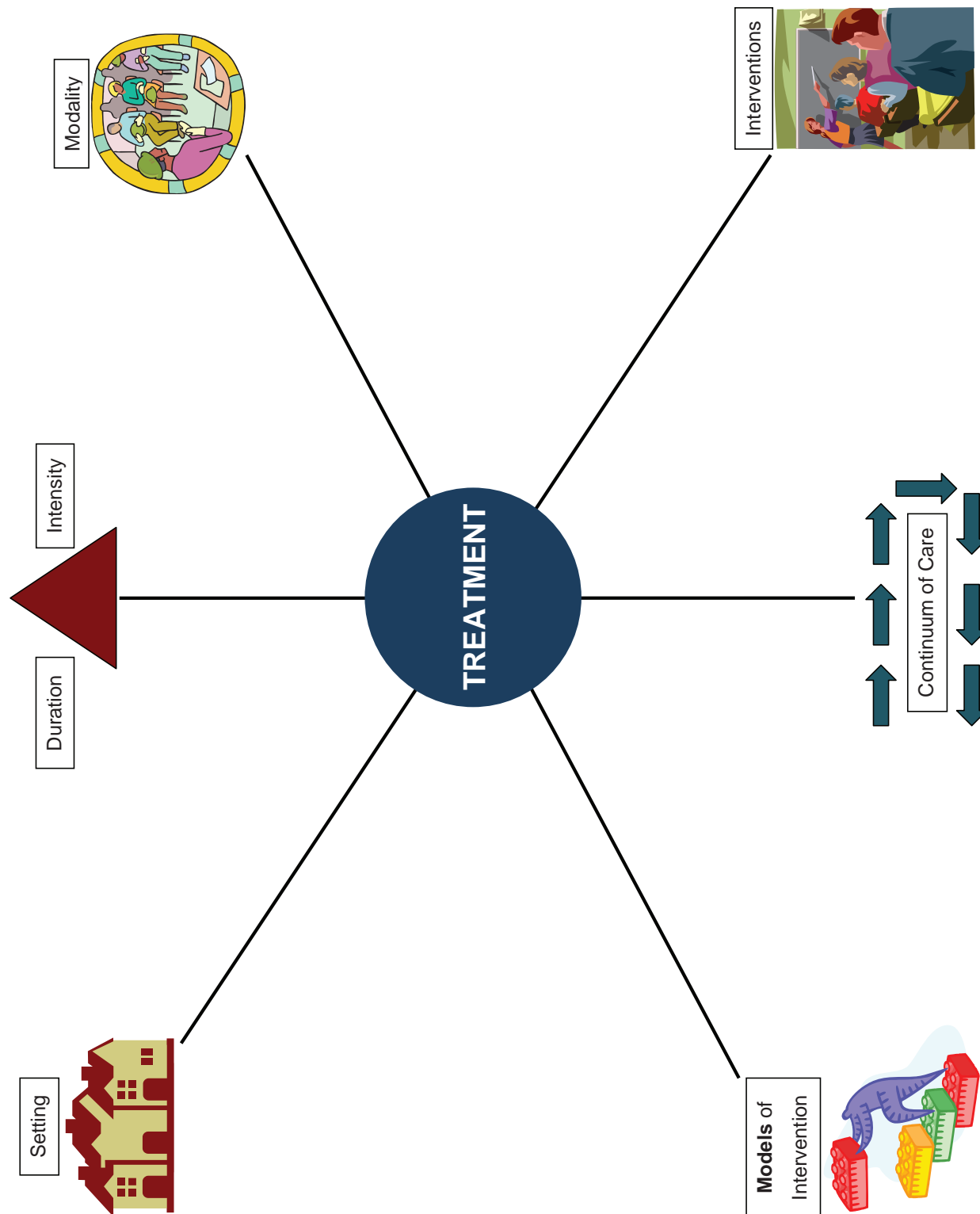
Resource Page 5.2: Elements of Drug Treatment

Setting

Treatment setting refers to where services are offered. Treatment services are offered in a variety of settings:

- Outreach settings include drop-in centers, homeless shelters, or the street.

- Outpatient drug-free programs provide treatment at a program site, but the person lives elsewhere (usually at home). These programs are abstinence based and do not typically use treatment medications. Outpatient treatment is offered in a variety of places: health clinics, community mental health clinics, workers' offices, hospital clinics, local health department offices, or residential programs with outpatient clinics. Many provide services in the evenings and on weekends so that participants can go to school or work.

- Medication-assisted outpatient treatment for opioid addiction is provided in outpatient methadone clinics, general medical clinics, or doctors' offices. Some outpatient programs also refer patients to doctors for medications that help treat alcohol addiction.

- Hospital-based inpatient treatment settings typically are separate units in a general medical hospital. They may provide detoxification and ongoing treatment (usually short term), as well as treatment of other medical problems.

- Nonmedical residential programs provide a living environment with treatment services. These programs typically do not have full-time medical staff, and clients must have completed detoxification before entering.

- Halfway houses or transitional living facilities provide a supportive living environment for clients who have typically completed primary residential treatment and are ready to go back to work or school. These facilities provide evening relapse prevention treatment, behavioral guidelines, and a place to live for those who have no family or are not ready to return to their families.

Intensity and Duration

Intensity is related to how many hours per day a person is involved in treatment activities:

- Restrictive settings (inpatient or residential programs) are more intensive than others because clients typically spend much of the day involved in treatment activities.

- Outpatient programs may be more or less intensive. Outpatient day treatment or partial hospitalization programs may offer nearly as many hours of treatment activities per day as residential or inpatient programs, typically 5 days per week.

- Intensive outpatient programs may offer treatment activities for 9–20 hours per week.

- Other outpatient programs may meet only once a week for 1 or 2 hours.

The duration of treatment also varies. For example, treatment programs may provide structured services for weeks, months, or a year or more.

Research consistently shows that treatment is most effective if it lasts for at least 90 days.

Modality

Modality refers to how services are offered: in groups, individually, with family members, or in any combination of the three.

Interventions

Interventions refer to the range of services offered in program settings. Examples of interventions are:

- Assessment;

- Education about addiction;

- Counseling;

- Treatment for mental health problems;

- Special groups or other services for particular populations, such as women;

- Relapse prevention training;

- Medication;

- Orientation to support groups;

- Case management; and

- Employment training and general schooling for adolescents.

Continuum of Treatment

A continuum of treatment is the range of services offered over time to a client based on his or her specific needs.

This continuum may include moving from a more intensive form of treatment to a less intensive form (e.g., from residential treatment to a halfway house or from a transitional living program to outpatient treatment) or moving from less intensive to more intensive treatment when necessary (e.g., moving from a drop-in group to medication-assisted treatment when the person needs more help with abstinence).
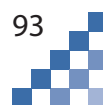
A continuum also includes consistent case management to make sure clients' other needs are met (e.g., referral for medical care, VCT, financial counseling, family therapy, housing, job skills training).

The graphic below shows a continuum of care for one client: A peer outreach counselor starts talking to him, and he decides to start attending a drop-in group. He continues to use heroin, even though he wants to quit, so is referred to a methadone clinic for more intensive services. At the same time, his case worker is working with him to be tested for HIV, obtain a psychiatric evaluation for depression, and (once he has been on methadone for a while) become involved in vocational training.
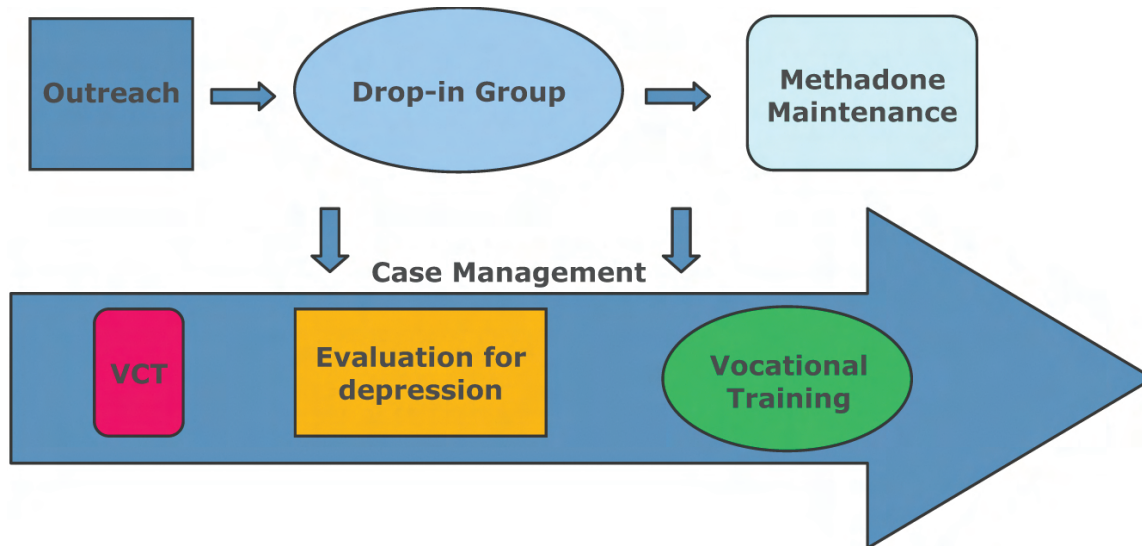
Models

A treatment model is a set of guiding principles and specific techniques for working with clients.

Although case workers do not directly provide treatment to clients, case workers can benefit from understanding some of the most commonly used and research-validated models of treatment.

Some theoretical models of treatment have been found to be more effective than others in helping people with drug problems. These models have been studied extensively, though primarily in the West.

The primary research-based models used in many countries around the world are:

- Medication-assisted treatment for opioid addiction;

- Cognitive–behavioral therapy;

- Motivational approaches;

- Matrix model;

- 12-step facilitation;

- Contingency management; and

- Therapeutic community.

Basic descriptions of these models are in Resource Page 5.4.

Resource Page 5.3: Basic Principles of Effective Drug Treatment

1. **Addiction is a complex but treatable disease that affects brain function and behavior**
   Drugs of abuse alter the brain's structure and function, resulting in changes that persist long after drug use has ceased. This may explain why drug abusers are at risk for relapse even after long periods of abstinence and despite the potentially devastating consequences.

2. **No single treatment is appropriate for everyone**
   Matching treatment settings, interventions, and services to an individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

3. **Treatment needs to be readily available**
   Because drug-addicted individuals may be uncertain about entering treatment, taking advantage of available services the moment people are ready for treatment is critical. Potential patients can be lost if treatment is not immediately available or readily accessible. As with other chronic diseases, the earlier treatment is offered in the disease process, the greater the likelihood of positive outcomes.

4. **Effective treatment attends to multiple needs of the individual, not just his or her drug abuse**
   To be effective, treatment must address the individual's drug abuse and any associated medical, psychological, social, vocational, and legal problems. It is also important that treatment be appropriate to the individual's age, gender, ethnicity, and culture.

5. **Remaining in treatment for an adequate period of time is critical**
   The appropriate duration for an individual depends on the type and degree of his or her problems and needs. Research indicates that most addicted individuals need at least 3 months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment. Recovery from drug addiction is a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug abuse can occur and should signal a need for treatment to be reinstated or adjusted. Because individuals often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.

6. **Counseling—individual and/or group—and other behavioral therapies are the most commonly used forms of drug abuse treatment**
   Behavioral therapies vary in their focus and may involve addressing a patient's motivation to change, providing incentives for abstinence, building skills to resist drug use, replacing drug-using activities with constructive and rewarding activities, improving problemsolving skills, and facilitating better interpersonal relationships. Also,

participation in group therapy and other peer support programs during and following treatment can help maintain abstinence.

7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies**
For example, methadone and buprenorphine are effective in helping individuals addicted to heroin or other opioids stabilize their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some opioid-addicted individuals and some patients with alcohol dependence. Other medications for alcohol dependence include acamprosate, disulfiram, and topiramate. For persons addicted to nicotine, a nicotine replacement product (such as patches, gum, or lozenges) or an oral medication (such as bupropion or varenicline) can be an effective component of treatment when part of a comprehensive behavioral treatment program.

8. **An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs**
A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient may require medication, medical services, family therapy, parenting instruction, vocational rehabilitation, and/or social and legal services. For many patients, a continuing care approach provides the best results, with the treatment intensity varying according to a person's changing needs.

9. **Many drug-addicted individuals also have other mental disorders**
Because drug abuse and addiction—both of which are mental disorders—often co-occur with other mental illnesses, patients presenting with one condition should be assessed for the other(s). And when these problems co-occur, treatment should address both (or all), including the use of medications as appropriate.

10. **Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse**
Although medically assisted detoxification can safely manage the acute physical symptoms of withdrawal and, for some, can pave the way for effective long-term addiction treatment, detoxification alone is rarely sufficient to help addicted individuals achieve long-term abstinence. Thus, patients should be encouraged to continue drug treatment following detoxification. Motivational enhancement and incentive strategies, begun at initial patient intake, can improve treatment engagement.

11. **Treatment does not need to be voluntary to be effective**
Sanctions or enticements from family, employment settings, and/or the criminal justice system can significantly increase treatment entry, retention rates, and the ultimate success of drug treatment interventions.
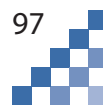
12. **Drug use during treatment must be monitored continuously, as lapses during treatment do occur**

    Knowing their drug use is being monitored can be a powerful incentive for patients and can help them withstand urges to use drugs. Monitoring also provides an early indication of a return to drug use, signaling a possible need to adjust an individual's treatment plan to better meet his or her needs.

13. **Treatment programs should assess patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases as well as provide targeted risk-reduction counseling to help patients modify or change behaviors that place them at risk of contracting or spreading infectious diseases**

    Typically, drug abuse treatment addresses some of the drug-related behaviors that put people at risk of infectious diseases. Targeted counseling specifically focused on reducing infectious disease risk can help patients further reduce or avoid substance-related and other high-risk behaviors. Counseling can also help those who are already infected to manage their illness. Moreover, engaging in substance abuse treatment can facilitate adherence to other medical treatments. Patients may be reluctant to accept screening for HIV (and other infectious diseases); therefore, it is incumbent upon treatment providers to encourage and support HIV screening and inform patients that highly active antiretroviral therapy (HAART) has proven effective in combating HIV, including among drug-abusing populations.

Excerpted from: U.S. National Institute on Drug Abuse. (2009). *Principles of drug addiction treatment: A research based guide, 2nd edition* (pp. 2–5). Bethesda, MD: Author.

Resource Page 5.4: Basic Principles of Effective Drug Treatment Worksheet

Modality

Interventions

Intensity

Duration

Continuum of Care

TREATMENT

Setting

Models of Intervention
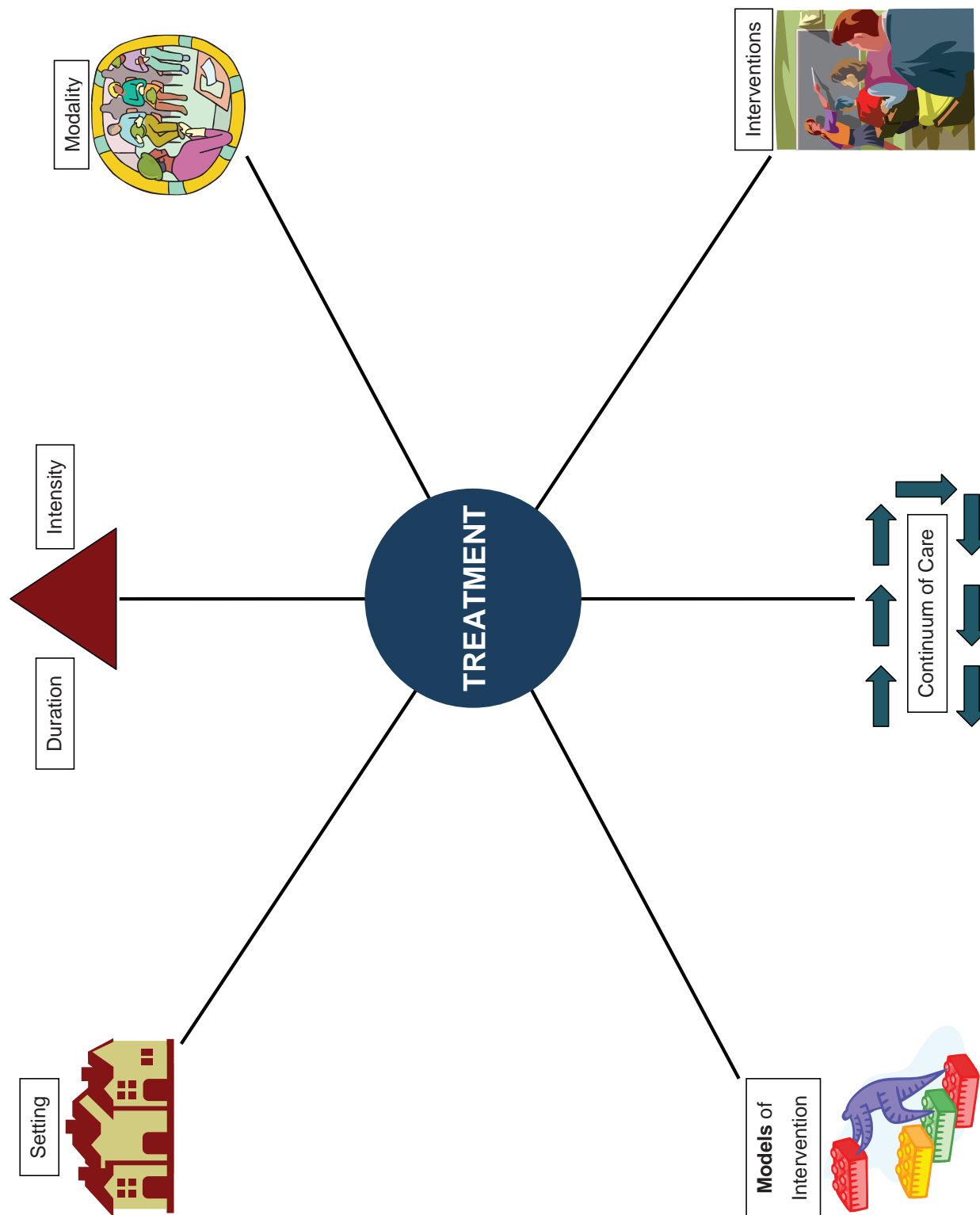
Resource Page 5.5: Research-Based Treatment Models: Overview Readings

Sources:

Center for Substance Abuse Treatment. (2006). *Substance abuse: Clinical issues in intensive outpatient treatment*. Treatment Improvement Protocol (TIP) Series 47. DHHS Publication No. (SMA) 06-4182. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Substance Abuse Treatment. (2005). *Substance abuse treatment and family therapy*. Treatment Improvement Protocol (TIP) Series, No. 39. DHHS Publication No. (SMA) 04-3957. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Cognitive–Behavioral Therapy (CBT)

- CBT merges two treatment models—cognitive therapy and behavioral therapy.

- Cognitive therapy is based on the theory that people often have beliefs, assumptions, and automatic thoughts that influence their behavior, but may be unhelpful and unrealistic.

- Cognitive therapy focuses on changing thoughts and assumptions to solve problems and decrease psychological distress.

- Behavioral therapy treats emotional and behavioral disorders as learned responses that can be replaced by healthier ones with appropriate training.

- Behavioral therapy helps people identify behavior that is not helping them and try out new ways of behaving.

- Behavioral therapy can include a range of relaxation and coping techniques.

- CBT integrates features of both.

- The CBT approach to treating drug users focuses on teaching clients skills that help them recognize and reduce risks of relapse, maintain abstinence, solve problems, and enhance self-efficacy (a client's ability to recognize his or her own strengths and to believe that change is possible).

- Clients learn to identify personal cues or triggers—the people, situations, or feelings that may lead to drinking or drug use.

- Such triggers may be internal (such as physiological craving or stress reactions) or external (such as seeing friends with whom the client has used drugs).

- Clients are taught new coping and problem-solving skills and strategies for effectively counteracting urges to drink or use drugs.

- CBT approaches also are applied to other challenges in recovery, such as repairing relationships and coping with emotions.

Strengths	Challenges
CBT actively engages clients in therapy and experiential learning.	Clients with poor reading or cognitive skills may need alternatives to written assignments.
CBT is suitable for clients from diverse backgrounds and with varying histories of alcohol and drug use.	The approach requires specific counselor training in CBT principles and techniques.
CBT provides structured methods for understanding relapse triggers and preparing for relapse situations.	Client motivation is critical because of the extent of homework assignments.
CBT can help clients with a number of life situations.	CBT was developed as an individual, not group, counseling approach.
	Although numerous manuals on CBT are available in English, they may be less available in Vietnamese.

Motivational Approaches

- Motivational approaches (motivational interviewing [MI] and motivational enhancement therapy [MET]) are based on the perspectives that change occurs in stages, motivation for change varies over time, and motivation can be enhanced.

- People's motivation for change also depends on the person's cultural setting.

- Motivational approaches frequently include other problem-solving or solution-focused strategies that build on clients' past successes.

- Motivational approaches acknowledge that drugs of abuse have rewarding properties that can disguise, at least temporarily, their hazards and negative long-term effects.

- Through empathic listening and skillful interviewing, the motivational worker encourages the client to:

  o Identify discrepancies between significant life goals and the consequences of substance abuse;

  o Believe in his or her capabilities for change;

  o Choose among available strategies and options; and

  o Take responsibility for initiating and sustaining healthful personal behavior.

- Workers pose questions to clients in a way that solicits information while strengthening clients' motivation and commitment to positive change.

- The worker acts as a coach or consultant rather than as an authority figure.

Strengths	Challenges
MI and MET are client centered and relevant to clients' personal interests.	MI and MET rely heavily on clients' capabilities and level of self-awareness.
MI and MET focus on realistic, attainable goals.	Commonly used problem-oriented assessment instruments are incompatible with a motivational approach.
MI and MET encourage client self-efficacy and self-sufficiency.	Motivational approaches require significant staff training and ongoing supervision.
MI and MET emphasize positive, empathic support that does not undermine or elicit anger from clients.	Motivational approaches may be difficult to combine with approaches that expect adherence to program-imposed goals.
	MI and other motivational approaches were developed as individual approaches; their effectiveness for use with groups is unproved.

Matrix Model

- The Matrix model[1,2] was developed during the 1980s as an effective way to treat people dependent on stimulant drugs, particularly cocaine and methamphetamine.

- Research has found it to be an effective treatment approach for that group.

- The model has been modified to include treatment for people who use other drugs, including heroin, although research has not yet been done to evaluate the effectiveness of this approach with groups other than stimulant users.

- The Matrix model integrates several research-based techniques (including cognitive–behavioral, motivational enhancement, education, and family approaches) to target clients' behavioral, emotional, cognitive, and relationship issues.

- The Matrix approach includes:

  o Establishing a strong therapeutic relationship between the client and worker;

  o Teaching clients how to structure time and live an orderly and healthful lifestyle;

  o Providing accurate, understandable information about addiction;

  o Providing opportunities to learn and practice relapse prevention and coping techniques;

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[1] Rawson, R. A., Marinelli-Casey, P., Anglin, M. D., Dickow, A., Frazier, Y., Gallagher, C., et al. (2004). A multi-site comparison of psychosocial approaches for the treatment of methamphetamine dependence. *Addiction* 99(6), 708–717.
[2] Obert, J. L., London, E. D., & Rawson, R. A. (2002). Incorporating brain research findings into standard treatment: An example using the Matrix model. *Journal of Substance Abuse Treatment* 23(2), 107–113.

- o Involving family and significant others in the therapeutic and educational processes to gain their support for—and prevent their sabotage of—treatment;

- o Encouraging clients to participate in community-based support groups; and

- o Conducting random urinalyses or breath tests to assess treatment effectiveness.

- The Matrix Institute has provided training on the Matrix model around the world, including in Vietnam.

- Elements of the Matrix model are being used in some drop-in centers, such as the Community Center To Support Recovering Drug Users in Hanoi.

Strengths	Challenges
The model integrates a cognitive–behavioral approach with family involvement, psychosocial education, 12-step support, and urine testing.	Some materials may need to be modified for clients whose cognitive functioning is impaired.
The model follows a manual, providing therapists with specific instructions and practical exercises.	The manual would need to be translated into Vietnamese.
The model has been used extensively with people dependent on stimulants and has been shown to be effective.	The program requires special staff training and supervision.
	The highly structured content may not appeal to all clients.
	The tight structure and schedule may not leave enough time for effective case management.

12-Step Facilitation

- The 12-step facilitation model of treatment is based on the concepts of 12-step mutual support groups, such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Cocaine Anonymous (CA).

- The 12 steps of these programs focus on:

- o Admitting there is a problem;

- o Seeking help;

- o Engaging in a thorough self-examination;

- o Making a confidential self-disclosure;

- o Making amends for harm done; and

- o Helping other drug addicts who want to recover.

- The 12-step facilitation model of treatment focuses on helping clients understand AA/NA principles, start working through the 12 steps of recovery, learn about and accept their addiction, achieve abstinence, and become involved in community-based 12-step groups.

- Group work focuses on accepting the disease, assuming responsibility for the recovery process and one's actions, renewing hope, establishing trust, changing behavior, practicing self-disclosure, developing insights into one's behavior, and making amends.

- Clients are encouraged strongly to:

    o Accept their addiction;

    o Develop or adopt spiritual values;

    o Develop a sense of fellowship with others in recovery; and

    o Attend meetings in the community.

Strengths	Challenges
The 12-step approach emphasizes an array of recovery tasks in cognitive, spiritual, and health realms.	It can be difficult to monitor accurately clients' compliance with assigned step tasks, including meeting attendance.
Research has found that the 12-step approach can be effective with clients from diverse backgrounds.	12-step groups' emphasis on a higher power may be unacceptable to some clients.
	Although 12-step programs are available throughout the world, including in some parts of Asia, these programs do not have a major presence in Vietnam. (However, some community-based drop-in centers are integrating the social support concept by developing peer-led support groups for IDUs.)

Contingency Management

- Contingency management (CM) is based on operant conditioning theory.

- Operant conditioning theory maintains that future behavior is based on the positive or negative consequences of past behavior.

- For example, drug use is maintained by the positively reinforcing effects of the drug itself or by the negative reinforcement of relieving the pain of withdrawal.

- Abstinence, in and of itself, may not be sufficiently reinforcing to maintain a person's motivation to stop using drugs, particularly in early abstinence. Other rewards must be found that reinforce ongoing abstinence and lifestyle change.

- CM motivates clients' behavioral change and reinforces abstinence by systematically rewarding desirable behaviors and ignoring or punishing others.

- Reinforcers are typically positive, pleasurable, and rewarding events or objects, but some negative reinforcers also are effective.

- *Removing* a fine or restriction after a client has complied with a specified regimen is an example of negative reinforcement.

- CM programs select a targeted behavior that is attainable in a reasonable amount of time and has a direct effect on the desired outcome.

- For example, expecting clients who have never submitted a drug-free urine sample to achieve immediate abstinence may be optimistic. Abstinence from a specific substance might precede abstinence from all substances.

- Targeting *small* changes is an effective strategy.

- More frequent reinforcers, even if small, have a greater effect than larger, more remote rewards or punishments.

- Desired behavior should contribute to the treatment goals. Simply attending counseling sessions may not affect a person's drug use.

- Of course, all rewards must be delivered as promised for the treatment to remain credible.

- A challenge in this treatment model is to identify a reward for a desired behavior that is both practical and sufficiently powerful—over time—to replace or substitute for the potent, pleasurable, or pain-reducing effects of the drug.

- The reward also must be available without too much cost or expenditure of staff energy.

- The rewards and punishments must be tailored carefully to clients' responses, as well as program capabilities. Something that is rewarding for one client may not be for another.

- Most of the financial or voucher-based CM interventions use an escalating series of rewards for achievement of the target behavior, such as drug-free urine specimens. The escalating rewards provide a greater incentive for sustaining the desired behavior.

- CM interventions depend on detailed and precise measurements of the targeted behavior. Self-reported drug use status is not adequate for awarding vouchers. Rather, drug use status must be determined by frequent testing of observed urine specimens. Similarly, if work activity is the target behavior, it is not enough to ask clients about their attendance or productivity. Objective, verifiable measures that demonstrate accomplishments must be used.

Strengths	Challenges
CR and CM have been shown to increase treatment adherence and reduce drug use significantly when incentives are used.	Clients may return to baseline drug use rates when incentives are terminated.
CR and CM can be combined readily with other psychosocial interventions and pharmacotherapies.	CM approaches can be labor intensive, require specialized staff or training for implementation, and require frequent client attendance.
CR and CM can be implemented with a variety of low-cost incentives such as donated goods or services.	For maximal effectiveness, rewards must be sufficiently large—and increase in value—to have continuing appeal to clients.
CR and CM have extensive and robust scientific support in both laboratory and clinical studies.	Many research studies demonstrating CR and CM effectiveness have used small samples and incurred large costs for incentives.
	Resources required for implementing CR and CM (e.g., onsite urine-testing capabilities or alternatives to costly incentives) may be unavailable.

Therapeutic Community

- The therapeutic community (TC) is an intensive, primarily long-term (up to 1 year) residential model.

- TCs use an approach known as "community as method"[3]; this approach views the community as a whole—its social organization, its staff and clients, and its daily activities—as the therapeutic agent.

- This community-as-method philosophy and a distinct therapeutic structure define TCs.

- Because of their intense, long-term nature, TCs are particularly appropriate for clients who have histories of severe substance use disorders and criminal behavior.

- TCs feature a structured day that includes ordered, routine activities to counter the characteristically disordered lives of clients and to distract them from negative thinking and boredom.

- TCs center daily activities on group sessions and hierarchical job functions that teach participants specific behaviors and skills.

- The TC model can be, and often is, modified to fit cultural perspectives, but generally includes the following components:

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[3] De Leon, G. (2000). *The therapeutic community: Theory, model, and method*. New York: Springer Publishing Company.

o A sense of community. Community is created partly by a separation from other agency or institutional programs and, more important, from the drug-using environment. A TC facility contains communal space for promoting a sense of commonality during collective activities. Treatment or educational services are delivered within the peer community.

o Peers and staff members as role models. TC members and staff members serve as positive role models by demonstrating expected behaviors and reflecting the values and teachings of the community. The strength of the community for social learning rests on the number and quality of its positive role models.

o Work as therapy and education. Consistent with the TC's self-help approach, all clients are responsible for the daily management of the facility, and work roles are designed to bring about essential educational and therapeutic effects.

o Peer encounter groups, awareness training, and emotional growth training. The encounter session is the main therapeutic group. It heightens clients' awareness of specific attitudes or behavioral patterns that need to change. Other groups focus on helping clients identify feelings and express them appropriately and constructively.

- The TC model is used in countries around the world, and every continent (except Antarctica) has professional associations of TCs.

- The Asian Federation of Therapeutic Communities has 13 member countries, including Vietnam.

- In 2005 and 2006, representative staff from 26 government 06 centers (9 in the north and 17 in the south) received intensive training in the TC model sponsored by the U.S. Department of State.

- After each training module, the staff of some centers integrated some elements of the TC approach.

- However, there still is no full TC model program in Vietnam, and no 06 centers use a complete set of TC guidelines and principles.

- Tran Viet Trung, Deputy Director of the Department for Social Evil Prevention/MOLISA has expressed a commitment to establishing some pilot TC villages in Vietnam.[4]

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[4] Personal communication with Mr. Trung through his translator. January 12, 2009.

Strengths	Challenges
The TC approach is effective for people with long histories of substance dependence and antisocial behavior.	The approach may be too confrontational for some clients.
The TC approach is particularly effective in teaching clients how to plan, set, and achieve goals and to be accountable.	Effective TC treatment requires extensive staff training.
The TC approach is effective in reducing recidivism among clients who have served time in prison.	Treating clients with mental disorders can pose difficulties.
	Finding an effective mix of professional clinicians and recovering staff (who may not be trained in assessment, treatment planning, and counseling) can take time.

Family-Based Approaches

- Although family involvement is not a specific "model" of treatment, but research shows that family involvement in treatment enhances outcomes.

- Treatment programs, particularly those focusing on adolescent substance users, may *primarily* use a family-systems therapy approach.

- Most programs include family services as *part* of their approach.

- Programs frequently offer family education, family support groups, and family counseling.

- Families of people who abuse substances live in a world shaped by substance use. Their world may include inconsistent behaviors and few or very rigid rules.

- Family members frequently experience anger, shame, guilt, sadness, and hopelessness.

- The result can be an unhealthy environment in which individuals may be isolated, engage in destructive alliances, be overly involved with other family members, or develop significant medical and stress-related problems.

- No matter how alienated family members may be, however, they are critical to the strength and duration of the client's recovery.

- Family members are the individuals who were part of the client's life before treatment and will be part of his or her life after treatment.

- Family-based services ensure that family functioning adjusts to and positively influences the recovery of the client.

- One main goal of involving families in treatment is to increase family members' understanding of the client's substance use disorder as a chronic disease.

- Family-based services can[5]:

  o Increase family support for the client's recovery. Family sessions can increase a client's motivation for recovery, especially as the family realizes that the client's substance use disorder is intertwined with problems in the family.

  o Identify and support a change of family patterns that works against recovery. Relationship patterns among family members can work against recovery by supporting the client's substance use, family conflicts, and inappropriate coalitions.

  o Prepare family members for what to expect in early recovery. Family members unrealistically may expect all problems to dissipate quickly, increasing the likelihood of disappointment and decreasing the likelihood of helpful support for the client's recovery.

  o Educate the family about relapse warning signs. Family members who understand warning signs can help prevent the client's relapses.

  o Help family members understand the causes and effects of substance use disorders from a family perspective:

    - Most family members do not understand how substance use disorders develop or that patterns of behavior and interaction have developed in response to the substance-related behavior of the family member who is in treatment.

    - It is valuable for individuals in the family to gain insight into how they may be maintaining the family's dysfunction.

    - Workers can help family members address feelings of anger, shame, and guilt and resolve issues relating to trust and intimacy.

  o Take advantage of family strengths. Family members who demonstrate positive attitudes and supportive behaviors encourage the client's recovery. It is important to identify and build on strengths to support positive change.

  o Encourage family members to obtain long-term support. As the client begins to recover, family members need to take responsibility for their emotional, physical, and spiritual recovery.

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[5] Edwards, J. T. (1990). *Treating chemically dependent families: A practical systems approach for professionals.* Minneapolis, MN: Johnson Institute.

Strengths	Challenges
Studies have shown that more than 90 percent of drug users in Vietnam live with family. Vietnamese families play a particularly critical role in supporting recovery.	Engaging families in treatment can be difficult because of the stigma and shame associated with substance use.
Family involvement in substance abuse treatment is positively associated with increased treatment engagement, decreased dropout rates during treatment, and better long-term outcomes.	Staff need specific training in working with families.
When families are involved in treatment, the focus can be on the larger family issues, not just the substance abuse. Both the individual with the substance use disorder and the family members get the help they need to achieve and maintain abstinence.	Families may be too dysfunctional (or involved with substance abuse themselves) to benefit from treatment program services. Programs need to have a well-developed referral network of sources for more intensive therapy when necessary.

MODULE 6—MOTIVATION AND THE STAGES OF CHANGE

Module 6 Goals and Objectives

Training goals

- To provide an overview of the concept of motivation;

- To provide an overview of the nature and stages of change; and

- To give participants a chance to explore the characteristics of people in each stage of change.

Learning objectives

Participants who complete Module 6 will be able to:

- List at least three characteristics of motivation;

- List six stages of change; and

- Talk about two or three characteristics of clients in each stage of change, and one appropriate motivational strategy for each stage.

Timeline and Content	
Activity	Time
Energizer	15 minutes
Module 6 introduction	5 minutes
Exercise: Personal change	10 minutes
Interactive presentation: The nature of motivation	25 minutes
Presentation: Introduction to the stages of change model	20 minutes
Small-group presentations I—Preparation: Characteristics of clients and appropriate strategies for each of the stages of change	30 minutes
Break	15 minutes
Small-group presentations II—Presentation: Characteristics of clients and appropriate strategies for each of the stages of change	30 minutes
Exercise: Introduction to worker style	30 minutes
Learning assessment	15 minutes
Day 3 evaluation and wrap-up	15 minutes

CASE MANAGEMENT FOR RECOVERING DRUG USERS IN VIETNAM: A TRAINING CURRICULUM

MODULE 6—MOTIVATION AND THE STAGES OF CHANGE

6.1

Personal Change Exercise

- What change did you make?
- How did you decide to make this change?
- What people or events influenced your decision?
- What steps did you take to make the change?

6.2

Motivation Is Multidimensional

- Internal urges and desires
- External pressures and goals
- *Perceptions* about risks and benefits of behaviors
- What a person *thinks* about his or her situation

6.3

Motivation Is Dynamic and Fluctuating

- A dynamic state that can fluctuate over time and in relation to different situations
- Can go back and forth between conflicting objectives
- Varies in intensity, faltering in response to doubts and increasing as doubts are resolved and goals are envisioned more clearly

6.4

Motivation Is Dynamic and Fluctuating

- Can vary greatly among potential behavior changes
- Is affected by interactions between the individual and other people or environmental factors

6.5

Natural Change

Change occurs:

- In daily life
- Among all people
- In relation to many behaviors
- Without professional intervention

6.6

Stages of Change Model

Precontemplation

Contemplation

Preparation

Action

Maintenance

Relapse

Knowledge Change

Change

Attitude Change

Behavior Change

6.7
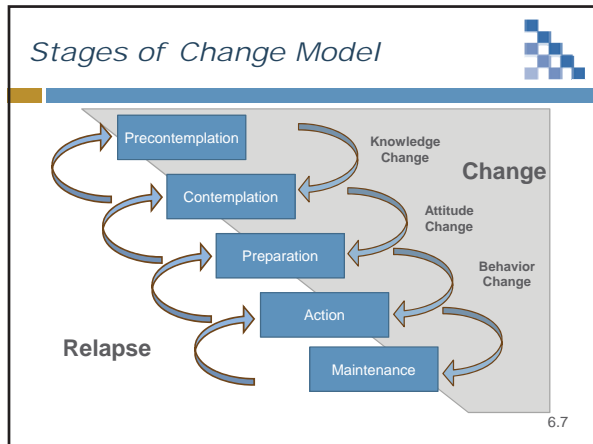
Motivational Support and Stage of Change

- Workers can enhance their clients' motivation for change at each stage of the change process

6.8

Motivational Support and Stage of Change

- Clients need and use different kinds of motivational support according to their stage of change

6.9

Motivation Is Influenced by the Worker's Style

- Worker style may be one of the most important factors for predicting client response to an intervention
- The ability to establish a helping alliance and good interpersonal skills are more important than a worker's professional training or experience

6.10

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Resource Page 6.1: Characteristics of Clients and Appropriate Strategies for Each of the Stages of Change

Precontemplation

Characteristics

During the precontemplation stage, people who use substances are not considering change and do not intend to change behaviors in the foreseeable future. They may be partly or completely unaware that a problem exists, they have to make changes, and they may need help to change. People in this stage defend their drug-using behavior and do not think it is a problem. They may be defensive when others pressure them to quit. Alternatively, they may be unwilling or too discouraged to change their behavior. Individuals in this stage usually have not experienced adverse consequences or crises because of their substance use and often are not convinced that their pattern of use is a problem or even risky. However, even people who have previously recognized that they have a problem and have made efforts to change may revert back to the precontemplation stage.

Appropriate Strategies

- Establish rapport, ask permission to raise the topic of change, and build trust.

- Raise doubts or concerns in the client about substance-using patterns by:

  o Exploring the meaning of events that brought the client to treatment or the results of previous treatments.

  o Eliciting the client's perceptions of the problem.

  o Offering factual information about the risks of substance use.

  o Providing personalized feedback about assessment findings.

  o Exploring the pros and cons of substance use.

  o Helping a significant other intervene.

  o Examining discrepancies between the client's and others' perceptions of the problem behavior.

- Express concern and keep the door open.

Contemplation

Characteristics

As individuals become aware that a problem exists, they begin to realize there may be cause for concern and reasons to change. Typically, they are ambivalent, simultaneously admitting reasons to change and reasons not to change. Individuals in this stage are still using substances, but they are thinking about stopping or reducing use in the near future. At this point, they may seek relevant information, reevaluate their substance-using behavior, or seek help for possibly changing behavior. They typically weigh positive and negative aspects of making a change ("I know I need to, but …"). Individuals frequently remain in this stage for long periods, often for years, vacillating between wanting and not wanting to change.

Appropriate Strategies

- Normalize ambivalence;

- Help the client "tip the scales" toward change by:

    o Asking them about and weighing pros and cons of substance use and change.

    o Changing extrinsic to intrinsic motivation.

    o Examining the client's personal values in relation to change.

    o Emphasizing the client's free choice, responsibility, and self-efficacy for change.

- Elicit self-motivational statements of intent and commitment from the client;

- Get the client's ideas about his or her own self-efficacy and expectations regarding treatment; and

- Summarize self-motivational statements.

Preparation

Characteristics

Once a person begins to plan for change, he or she enters the preparation stage, during which commitment is strengthened. Preparation entails specific planning for change, such as deciding whether treatment is needed and, if so, what kind. Preparation also entails an examination of perceived capabilities—or self-efficacy—for change. Individuals in the preparation stage are still using substances, but typically they intend to stop using very soon. They may experiment with small changes as their determination to change increases. They may have already attempted to reduce or stop use on their own or may be experimenting with ways to quit or cut back. They begin to set goals for themselves and make commitments to stop using, even telling people close to them about their plans. Too often, people skip this stage; they try to move directly from contemplation into action and are unsuccessful because they have not adequately researched or accepted what is required to make a major lifestyle change.

Appropriate Strategies

- Clarify the client's own goals and strategies for change;

- Offer a menu of options for change or treatment;

- With permission, offer expertise and advice;

- Negotiate a change—or treatment—plan and behavior contract;

- Consider and lower barriers to change;

- Help the client enlist social support;

- Explore treatment expectancies and the client's role;

- Ask the client what has worked in the past for him or others whom he knows;

- Help the client to negotiate finances, child care, work, transportation, or other potential barriers; and

- Have the client publicly announce plans to change.

Action

Characteristics

Individuals in the action stage choose a strategy for change and begin to follow it. At this stage, clients *believe* they can change their behavior and actively modify their habits and environment. They make drastic lifestyle changes and may face challenging situations and the physiological effects of withdrawal. In this stage, individuals develop plans to deal with both personal and external pressures that may lead to slips. They begin to reevaluate their self-image as they move from excessive or hazardous use to abstinence or safe use. People in this stage also tend to accept help and seek support from others. The action stage can last from 3 to 6 months following termination or reduction of substance use.

Appropriate Strategies

- Engage the client in treatment and reinforce the importance of remaining in recovery;

- Support a realistic view of change through small steps;

- Acknowledge difficulties for the client in early stages of change;

- Help the client identify high-risk situations and develop appropriate coping strategies to overcome these;

- Assist the client in finding new reinforcers of positive change; and

- Help the client assess whether he or she has strong family and social support.

Maintenance

Characteristics

During the maintenance stage, people try to sustain the gains achieved during the action stage. People work to stay abstinent and prevent recurrence. Extra precautions may be necessary to avoid problem behaviors. Individuals learn to detect and guard against dangerous situations and other triggers that may cause them to use substances. People in maintenance look at how they live their lives. They work on acquiring new skills to deal with challenges and avoid relapse. They can anticipate relapse situations and prepare coping strategies. In most cases, individuals attempting long-term behavior change return to use at least once and revert to an earlier stage. Recurrence of symptoms is part of the learning process. Knowledge about personal cues for substance use is helpful for future change attempts. Maintenance requires prolonged behavioral change—by remaining abstinent or reducing consumption to acceptable, targeted levels—and continued vigilance for a minimum of 6 months to several years.

Appropriate Strategies

- Help the client identify and sample drug-free sources of pleasure (i.e., new reinforcers);

- Support lifestyle changes;

- Affirm the client's resolve and self-efficacy;

- Help the client practice and use new coping strategies to avoid a return to using;

- Maintain supportive contact (e.g., explain to the client that you are available to talk between sessions);

- Develop a "fire escape" plan if the client resumes substance use; and

- Review long-term goals with the client.

Recurrence

Characteristics

Most people do not immediately sustain the new changes they are attempting to make, and a return to substance use after a period of abstinence is the rule rather than the exception. These experiences contribute information that can help or hinder subsequent progression through the stages of change. Recurrence, often referred to as relapse, is the event that triggers the individual's return to earlier stages of change and cycling through the process again. Individuals may have had unrealistic goals, used ineffective strategies, or put themselves in environments that are not conducive to successful change. Most substance users require several cycles through the stages of change to achieve successful recovery.[1] After a return to substance use, clients usually revert to an earlier stage of change—not always

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[1] J. Prochaska, J. Norcross, & C. DiClemente. (1994). *Changing for good*. New York: William Morrow and Company.

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to maintenance or action, but more often to contemplation. They often feel demoralized and possibly even hopeless about change. They may even become precontemplators again, temporarily unwilling or unable to change soon. However, a recurrence of symptoms does not necessarily mean a client has abandoned a commitment to change.

Appropriate Strategies

- Help the client reenter the change cycle and commend any willingness to reconsider positive change.

- Explore the meaning and reality of the recurrence as a learning opportunity.

- Assist the client in finding alternative coping strategies.

- Maintain supportive contact.

MODULE 7—SKILL BUILDING: ENGAGING CLIENTS

Module 7 Goals and Objectives

Training goal

- To introduce participants to basic principles of working with drug users;

- To explore how these principles can be incorporated into their work with clients;

- To provide information about reflective listing—a technique for establishing rapport; and

- To provide an opportunity to practice skills.

Learning objectives

Participants who complete Module 7 will be able to:

- Name at least four basic principles of working with drug users;

- Apply the principles to their own work;

- Explain the concept and types of reflective listening; and

- Demonstrate beginning skills in reflective listening.

Timeline and Content	
Activity	Time
Welcome, concert review of days 2 and 3, and Module 7 introduction	20 minutes
Exercise: Working with clients: Basic principles	45 minutes
Presentation: Establishing rapport: Reflective listening	15 minutes
Exercise: "Slow-motion" reflective listening role plays	60 minutes
Break	15 minutes

**CASE MANAGEMENT FOR
RECOVERING DRUG USERS
IN VIETNAM:
A TRAINING CURRICULUM**

**MODULE 7—SKILL BUILDING:
ENGAGING CLIENTS**

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7.1

Reflective Listening

Reflective listening involves:

■ Making a reasonable guess about what the client means

■ Rephrasing the client's statement to reflect what the worker thinks he or she heard

7.2

Reflective Listening

■Involves restating in a different way what clients have said
■Reduces the likelihood of resistance
■Encourages clients to talk

7.3

Reflective Listening

- Communicates respect
- Solidifies the therapeutic alliance
- Clarifies exactly what clients mean
- Reinforces motivation

7.4

Reflective Listening

True reflective listening requires:

- Continuous tracking of the client's responses
- Understanding of cultural communication style
- Formulation of appropriate reflections
- Ongoing adjustment of the worker's thoughts about the client's behavior

7.5

Reflective Listening

- People frequently make *assumptions* about what others mean when they talk

- This process is not always conscious

- Reflecting back to the client is a way of *confirming* rather than *assuming* what the client means

7.6

Reflective Listening

Three types of reflection:

- Simple reflection
- Amplified reflection
- Double-sided reflection

7.7

Reflective Listening

Simple reflection, the most basic type:

- Involves reflecting the client's statement back to him or her in a simple, neutral form

- Acknowledges and validates what the client has said

7.8

Reflective Listening

Amplified reflection:

- Reflects the client's statement in an exaggerated, but not sarcastic, form

- Can move the client toward positive change rather than resistance

7.9

Reflective Listening

Double-sided reflection:

- Acknowledges what the client has said, but also states contrary things he or she has said in the past

- Requires the use of information that the client has offered previously

7.10

Resource Page 7.1: Basic Principles for Working with Clients

Clients who use or are in early recovery from drug use often do not trust people who say they want to help, particularly those who work for a government agency. Developing a relationship takes time and patience; several visits may be required before a drug user discusses drug use and other problems with you. Genuine interest in developing rapport and understanding drug use issues and the lives of clients will go a long way when working with clients.

There are some basic principles of developing helping relationships that are trusting and productive:

1. Be reliable and professional.

- Follow through on agreements and commitments made: Nothing damages a relationship of trust more than broken agreements and promises.

- *Think* before you make a commitment: Anything you agree to or promise must be realistic and possible.

- Be on time for appointments.

- Maintain confidentiality:

    o Any information, including photos, that could implicate an individual or identify locations of drug use should be kept secure.

    o Such information must not be shared with people and agencies that are not directly involved with drug use issues.

    o Clients are unlikely to share information if they suspect that the information will be used against them.

    o Confidentiality is an important ethical component of professional social work practice.

- Be honest. It is better to say "I cannot give you money to buy drugs" than to say "I don't have any money."

- Clients will respect your decisions if you set firm and clear relationship boundaries.

- Do not personalize: Drug users may be suspicious or aggressive when they do not know you. Do not respond in a negative or aggressive manner.

2. Be respectful.

- Society usually talks down to people who use drugs and treats them as if they are children who need to be scolded or taught to do the right things.

- Someone who does not do this and talks with them in a caring manner is more likely to be respected and trusted.

- Talking to people about their personal histories helps in understanding people's vulnerability, but may also be painful to the people concerned. This pain should be acknowledged and respected.

- Visual indications that a drug user's story shocks you or is distasteful should be avoided.

- Personal stories should be listened to with respect.

- Drug users are the local "experts" on drug use issues. This knowledge should be respected.

- Acknowledging their expertise reinforces that they are valuable individuals and enhances the relationship.

- When clients are treated with respect and as "experts," they are more likely to provide insight into the social and environmental issues that affect their lives.

- It is helpful to acknowledge when you have learned something new during a conversation.

- Use basic courtesies and compliments:

  o Common basic courtesies and compliments create a sense of humanity and companionship.

  o You can compliment a person on even a small positive change.

3. Create a relaxed atmosphere by providing incentives.

- Incentives can be part of a structured contingency management approach, as discussed in Module 5, or can be tailored to the person's situation.

- Simply offering a client a cup of tea helps create a friendly atmosphere.

- Practical incentives such as food, vitamins, needles, and condoms help build a relationship.

- Inviting drug users to structured social events creates an environment in which they can talk openly about drug use and other problems they may have.

4. Be flexible and patient.

- Building relationships with drug users may mean following their schedules and meeting them at a time and a place that can accommodate them.

- Talking with drug users when they are hurrying to buy or use drugs may be inappropriate.

- Expect that clients will take time to learn new skills; acknowledge *any* progress or steps taken.

- Understand that repetition is important to learning, particularly when a client is cognitively impaired because of drug use. Be prepared to repeat, repeat, repeat.

- Clients must feel that you are interested in them as people. Often this means discussing a range of problems that drug users are concerned about, such as their health needs, social issues, and police violence, before you can focus on drug use issues.

5. Share your own experiences appropriately.

- Sharing your own story of drug use can help a client relate to you.

- BUT take care not to focus on yourself and not to assume that your story is similar to another's in all ways.

- Maintaining appropriate boundaries is important; sharing details is not necessary or desirable.

- Telling "drug stories" (i.e., "I remember one time ...") is not therapeutic.

- Sharing too much personal information can put you at risk.

6. Listen, listen, listen.

- Spend time listening; show understanding of others' feelings.

- Don't be distracted by other activities when talking with clients.

- Appropriate eye contact affirms that you are listening.

- Clients often have no one with whom to share their feelings. They may be abused in their homes and may have been harshly treated by society, their families, or the police.

- You should demonstrate that you are willing to listen *without* judgment.

- People who use drugs are judged harshly by most societies. Listening carefully to them is important, as is understanding the context and situations in which incidents may have occurred.

- By displaying an understanding of clients' feelings, you are being empathetic and a good counselor.

- One way of ensuring that clients feel "heard" and not judged is to ask about the good things about using drugs as well as the "less good" things.

- Clients expect you to ask them about all the bad things associated with their drug use; they do not expect you to show interest in knowing about the things they enjoy about drug use.

- This is also a basic technique of motivational enhancement, and can help give you an idea of where a client is in the stages of change.

- Examples of asking about the positives of drug use:

    o What are some of the good things about ...?

    o People usually use drugs because they help in some way. How have they helped you?

    o What do you like about the effects of ...?

    o What would you miss if you weren't ...?

    o What else do you like about ...?

- Examples of asking about the "less good" aspects of drug use:

    o Can you tell me about the down side?

    o What are some things you are not so happy about?

    o What are the things you *wouldn't* miss?

    o How does your drug use fit in with your goal of ...?

    o If you continue as you are, how do you see yourself 3 years from now?

    o What else?
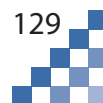
Resource Page 7.2: Slow-Motion Reflective Listening Role-Play Instructions

Introduction

In this small-group exercise, you will take turns playing three roles:

- Client;

- Worker; and

- Observer.

The "slow motion" of the exercise is that the "worker" role is played by *two* people who will act as a team to respond to the client. New skills are not easy to learn. Slowing your responses and taking the time to learn from one another will reduce some of the stress of role playing and will help you learn in a thoughtful manner.

Role play each scenario for 5 minutes, then take 5 minutes to process each role play. Switch roles for each scenario.

Instructions for Each Role Play

Decide who will play each role. The person who will be the "client" should:

- Turn to Resource Page 7.3 and select a role. Another option is to create a role based on a familiar client;

- Take a minute to plan your approach to the role; and

- Play your role as realistically as possible, based on your experiences.

The "worker" team should:

- Review the selected "client" role;

- Decide which of you will be the "voice" of the "worker";

- Confer before responding to the "client" (slow motion); and

- Use Resource Page 7.4: Slow-Motion Reflective Listening Role-Play Help Sheet, as needed.

The observer should:

- Observe the apparent effects of the reflective listening of the "worker" team; and

- Try to identify which type of reflective listening the team is using.

Instructions for Processing Each Role Play

The "worker" team shares:

- What its experience was like;

- What it thought worked well; and

- What it thought did not work well or what it would do differently next time.

The "client" shares:

- What the experience was like;

- What worked well (what interventions seemed to make him or her feel "heard"); and

- What might have worked better.

The "observer" shares:

- Any observations about the process; and

- The types of reflective listening used.

Resource Page 7.3: Slow-Motion Reflective Listening Role-Play Client Scenarios

Role 1: Tuan

Tuan is 27 years old and has never married. He returned from a 2-year stay in a rehabilitation center 2 months ago. He stayed abstinent while he was there. Tuan has moved back in with his mother (his father is deceased), three siblings, and his grandmother. His mother watches his every move and asks other community members to watch him, too. His grandmother won't speak to him because he has shamed the family. He feels like using heroin again and has been meeting old using friends. His attitude is, "Why not? Everything is messed up anyway." Tuan has spoken to the worker before about how hurt he feels that his grandmother won't speak to him. He was close to her as a child, and her silence hurts.

Role 2: Quan

Quan is a 45-year-old male injection drug user who returned from a rehabilitation center 3 months ago. He is back with his wife, three children, and his mother-in-law. His wife had a very difficult time while he was away and is angry with him. She is pressuring him to start working and taking care of his family, but he is having trouble finding a job. Everyone in the district knows about him and won't give him a chance. Quan is frustrated and discouraged. He has started spending time away from home to avoid his wife. He has told the worker that he worries that the effects of his drug use and his time away have affected his children and he is afraid of losing his family entirely.

Role 3: Ha

Ha, a 25-year-old female, has worked as a sex worker since she was 16. Her mother was also a sex worker and died of AIDS a year ago. Ha has used drugs for years and started injecting heroin 2 years ago. She is homeless, but stays with friends when she can. Her mother's death has scared her, but she hasn't been tested for HIV. She is ambivalent about being tested. She knows she should be tested, but she is scared of finding out the test results. Ha occasionally goes to a drop-in center. She has told a worker that she feels "tired and old" and wants to get out of sex work. She doesn't trust the drop-in center staff or volunteers and feels hopeless. Still, she continues to visit the drop-in center.

Role 4: Van Anh

Van Anh is an 18-year-old female who started using stimulants with her boyfriend. She says it was fun at first, but her use is getting out of control. She started injecting methamphetamine 2 months ago. Her parents have found out and have threatened to send her to a rehabilitation center. Van Anh participates in a needle exchange program. She is well educated about HIV and is trying to be careful. She talked to a worker once about her use. She is scared that her parents will send her to a center, but doesn't want to break up with her boyfriend or stop using drugs. She wishes she hadn't started injecting and could still just take pills or snort cocaine "for parties."

Resource Page 7.4: Slow-Motion Reflective Listening Role-Play Help Sheet

Type of Reflective Listening	Description and Example
Simple reflection	• Reflects the client's statement in a neutral form. • Can use the client's exact words or can be rephrased. • Acknowledges and validates what the client has said. *Client:* I don't plan to quit using any time soon. *Worker:* You don't see abstinence in your near future. *Client:* That's right!
Amplified reflection	• Reflects the client's statement in an exaggerated (but not sarcastic) form. • Can move the client toward positive change rather than resistance. *Client:* I don't know why my wife is worried about this. I don't drink any more than my friends. *Worker:* So there's absolutely no reason for your wife to worry. *Client:* Well, I can maybe see how she would worry a *little*.
Double-sided reflection	• Acknowledges what clients have said, but also states contrary things they have said in the past. • Requires the use of information that clients have offered previously, although perhaps not in the same session. *Client:* Maybe I should give up using completely, but I'm not going to do that! *Worker:* On the one hand, you can see that there are some real problems here, but quitting altogether clearly is not what you want to do. On the other hand, you're very worried about the effects of your use on your family. It must be confusing for you.

MODULE 8—SKILL BUILDING: BASIC STRATEGIES OF MOTIVATIONAL ENHANCEMENT

Module 8 Goals and Objectives

Training goal

- To provide an overview of and practice in using basic motivational enhancement strategies.

Learning objectives

Participants who complete Module 8 will be able to:

- List and explain five basic strategies of motivational enhancement; and

- Demonstrate beginning skill in using these strategies.

Timeline and Content	
Activity	Time
Module 8 introduction	5 minutes
Exercise: Readiness ruler	5 minutes
Interactive presentation: Five basic strategies	30 minutes
Exercise: Basic strategies role plays	60 minutes
Lunch	90 minutes

CASE MANAGEMENT FOR RECOVERING DRUG USERS IN VIETNAM: A TRAINING CURRICULUM

MODULE 8—SKILL BUILDING: BASIC STRATEGIES OF MOTIVATIONAL ENHANCEMENT

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8.1

Five Basic Strategies
Open-Ended Questions

- Cannot be answered "yes" or "no"
- Cannot be answered with one or two words

8.2

Five Basic Strategies
Open-Ended Questions

- Help the worker understand his or her clients' points of view

- Elicit clients' feelings about a given topic or situation

- Facilitate dialog

8.3

Five Basic Strategies
1 Open-Ended Questions

- Ask for information in a neutral way

- Encourage the client to do most of the talking

- Help the worker avoid making prejudgments

- Move communication forward

8.4

Five Basic Strategies
2 Affirming Clients

- Supports and promotes their sense of self-efficacy

- Acknowledges their difficulties

- Validates their experiences and feelings

- Increases their confidence to take action and change their behavior

8.5

Five Basic Strategies
3 Rolling with Resistance

- One view of resistance is that a resistant client behaves defiantly

- A more constructive view of resistance: As a signal that the worker needs to change direction or listen more carefully to the client

8.6

Five Basic Strategies
3 *Rolling with Resistance*

■ Arguing or directly confronting a client's statements often backfires and actually strengthens a client's resistance

8.7

Five Basic Strategies
3 *Rolling with Resistance*

■ Reflective listening
■ Shifting focus
■ Agreement with a twist
■ Reframing

8.8

Five Basic Strategies
3 *Rolling with Resistance*

Reflective listening involves the worker's:

■ Making a reasonable guess about what the client means

■ Rephrasing the client's statement to reflect what the worker thinks he or she heard

8.9

Five Basic Strategies
3 Rolling with Resistance

- Reflective listening includes:
  - Simple reflection
  - Amplified reflection
  - Double-sided reflection

8.10

Five Basic Strategies
3 Rolling with Resistance

- Shifting focus:
  - Helps the client shift focus from obstacles and barriers
  - Offers an opportunity for the worker to affirm the client's choices regarding how to conduct his or her life

8.11

Five Basic Strategies
3 Rolling with Resistance

- Agreement with a twist:
  A subtle strategy that involves agreeing with the client, but with a slight twist or change of direction that propels the discussion forward

8.12

Five Basic Strategies
3 Rolling with Resistance

- Reframing:
  - Offers a new and positive interpretation of negative information provided by the client
  - Acknowledges the validity of the client's perception, but offers a new meaning for consideration

8.13

Five Basic Strategies
4 Summarizing

- Capturing the essence of what clients have expressed
- Communicating it back to them

8.14

Five Basic Strategies
4 Summarizing

Summaries help clients by:

- Reinforcing what they have said
- Demonstrating that the worker has been listening carefully
- Helping clients consider their responses and experiences
- Preparing clients to move forward

8.15

Five Basic Strategies
4 Summarizing

- Summarizing is a good way to review previous sessions and to end a current session

- The worker should encourage the client to correct summaries

8.16

Five Basic Strategies
5 Encouraging Change Talk

- One signal that clients' ambivalence and resistance are diminishing is *change talk*

8.17

Five Basic Strategies
5 Encouraging Change Talk

- Reflecting the statement
- Nodding or making approving facial expressions
- Making affirming statements
- Asking for elaboration, specific examples, or more details

8.18

Five Basic Strategies
5 Encouraging Change Talk

- Questions beginning with "What else" invite further amplification
- Asking clients to identify the extremes of the problem ("What are you most concerned about?") enhances motivation
- Asking clients to envision what they would like for the future helps them establish specific goals

8.19

Five Basic Strategies
5 Encouraging Change Talk

Sample questions to evoke change talk:

- What worries you about your drug use?
- What makes you think you may need to make a change?
- What do you think might happen if you don't make a change?
- What do you think would work for you if you needed to change?

8.20

Resource Page 8.1: Readiness Ruler

1. Think about how important it is to you to learn new case management skills, and mark the first ruler at the appropriate point.

2. Think about why you rated yourself as you did, rather than marking "0."

3. Think about how confident you feel about your ability to learn new skills, and mark the second ruler at the appropriate point.

4. Think about why you rated yourself as you did, rather than marking "0."
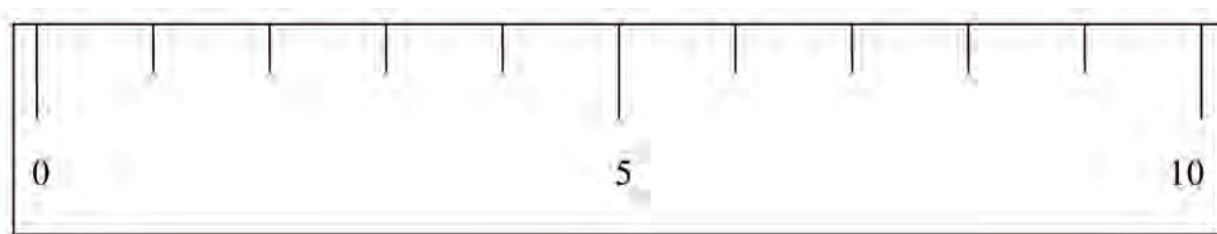
Importance

Not at all important   Extremely important
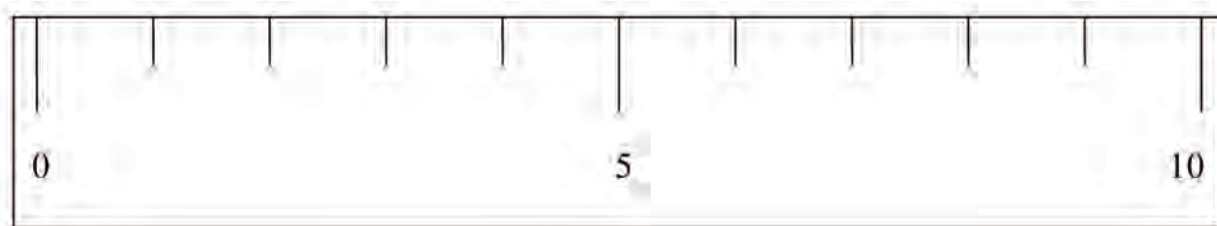
Confidence

Not at all confident   Extremely confident

Resource Page 8.2: Asking Open-Ended Questions

Closed Question	Open-Ended Question
You are here because you are concerned about your use of alcohol, correct?	Tell me, what brings you here today?
How many children do you have?	Tell me about your family.
Do you agree that it would be a good idea for you to go through detoxification?	What do you think about the possibility of going through detoxification?
I'd like you to tell me about your heroin use. On a typical day, how much do you use?	Tell me about your heroin use during a typical week.
Do you like to smoke?	What are some of the things you like about smoking?
How has your drug use been this week compared with last week: more, less, or about the same?	What has your drug use been like during the past week?
Do you think you use amphetamines too often?	In what ways are you concerned about your use of amphetamines?
How long ago did you have your last drink?	Tell me about the last time you had a drink.
When do you plan to quit injecting heroin?	What do you want to do about your heroin use?

Resource Page 8.3: How to Recognize Change Talk

Examples of Change Talk
I guess this has been affecting me more than I realized.
Sometimes when I've been using, I just can't think or concentrate.
I guess I wonder whether I've been pickling my brain.
I feel terrible about how my injecting heroin has hurt my family.
I don't know what to do, but something has to change.
I think I could cut down my use if I decided to…
If I really put my mind to something, I can do it.

Resource Page 8.4: Basic Strategies—Role-Play Instructions

Introduction

In this small-group exercise, you will spend 5 minutes in each of three roles:

- Client;

- Worker; and

- Observer.

After each role play, you will spend 5 minutes processing the experience.

The purpose of this exercise is to practice both choosing a response strategy and using the technique. It also gives you an idea of the client's perspective of these strategies.

Instructions for Each Role Play

Client

You will tell the worker about any changes you have made on your readiness rulers since you began the training. For example:

- Were there any changes from ruler 1 to ruler 3?

- What influenced the changes, if any?

- Why have there been no changes?

- How do you feel about the training experience?

- What was relevant to your learning and change process?

Worker

Begin by asking the client about his or her readiness ruler.

Respond to the client using as many of the five strategies as appropriate. Take your time; you do not need to respond to the client quickly. When you are learning a new technique, it takes longer to formulate a response. Use Resource Page 8.5: Basic Strategies—Role-Play Help Sheet as needed.

Observer

Observe the interaction, and track:

- The strategies used by the responder; and

- The speaker's responses.

Use Resource Page 8.5: Basic Strategies—Role-Play Help Sheet to track the strategies you hear by checking the appropriate descriptions and taking short notes about the speaker's responses.

Instructions for Processing Each Role Play

The client shares:

- What the experience was like;

- What worked well; and

- What might have worked better.

The worker shares:

- Which strategies felt most comfortable;

- Which felt most uncomfortable; and

- What the experience was like in general.

The observer shares:

- Which strategies he or she observed;

- The responses from the client; and

- Any other observations about the process.

Use reflective listening and affirming in processing the role play.

Switch roles and repeat the role play until all three of you have had a chance to play each role.

Resource Page 8.5: Basic Strategies—Role-Play Help Sheet

Strategy	Description
Open-Ended Questions	• Cannot be answered yes or no or with one or two words • Are not rhetorical • Elicit clients' feelings about a given topic or situation • Solicit additional information in a neutral way • Encourage the client to do most of the talking
Affirming	• Supports and promotes the client's sense of self-efficacy • Acknowledges his or her difficulties • Validates his or her experiences and feelings • Emphasizes experiences that demonstrate strength, success, or power
Listening Reflectively	• Makes a reasonable guess about what the client means • Rephrases the client's statement to reflect what the counselor thinks he or she heard • Continuously tracks the client's verbal and nonverbal responses and their possible meanings • Requires understanding of the communication style of the client's culture • Formulates reflections at the appropriate level of complexity • Involves ongoing adjustment of the worker's hypotheses about the client's behavior
Summarizing	• Captures the essence of what a client has expressed • Communicates it back to the client

Strategy	Description
Eliciting and Reinforcing Self-Motivational Statements	• Reflect the statement • Require nodding or making approving facial expressions • Involve making affirming statements • Ask for elaboration, explicit examples, more details • Use questions beginning with "What else" • Ask the client to identify the extremes of the problem ("What are you most concerned about?")

MODULE 9—SKILL BUILDING: HELPING CLIENTS DEVELOP RELAPSE-PREVENTION SKILLS

Module 9 Goals and Objectives

Training goals

- To provide participants with an overview of relapse triggers and relapse-prevention training; and

- To provide an opportunity for participants to practice skills.

Learning objectives

Participants who complete Module 9 will be able to:

- Explain the concept of "triggers" for drug use;

- Name at least six examples of internal and external triggers; and

- List at least five basic guidelines for effective skills training.

Timeline and Content	
Activity	Time
Module 9 introduction	5 minutes
Interactive presentation: Introduction to relapse triggers and relapse prevention	30 minutes
Skills training exercise: Preparation	10 minutes
Break	15 minutes
Exercise: Skills training	120 minutes
Day 4 learning assessment	20 minutes
Day 4 evaluation and wrap-up	10 minutes

CASE MANAGEMENT FOR RECOVERING DRUG USERS IN VIETNAM: A TRAINING CURRICULUM

MODULE 9—SKILL BUILDING: HELPING CLIENTS DEVELOP RELAPSE-PREVENTION SKILLS

9.1
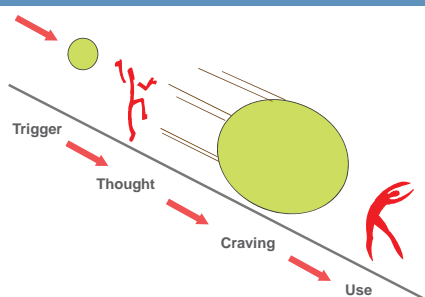
Triggers and Craving

- Places, people, and things associated with drug use can *trigger* thoughts about using drugs and having a *craving* for drugs
- The brain may even trigger physical reactions that are similar to those initially created by the drug itself

9.2

Triggers and Cravings

Trigger

Thought

Craving

Use

9.3

Triggers and Cravings

Trigger

Thought

Interruption

Craving

Use

9.4
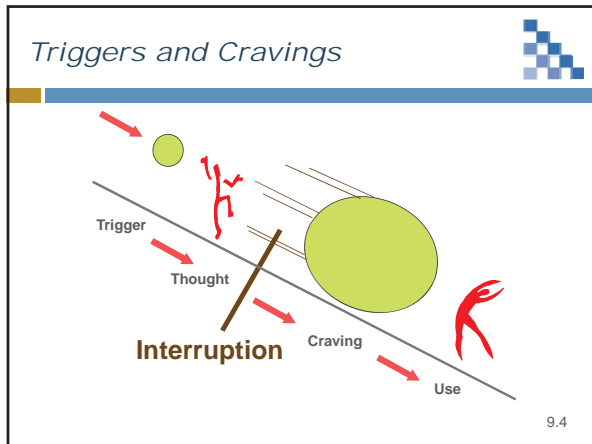
Triggers and Cravings

- The best time to stop the trigger-thought-craving-use response is before it happens

- A large part of relapse-prevention training is helping clients identify and avoid their individual triggers, and manage cravings when they happen

9.5

Triggers and Cravings

- The worker can help the client identify his or her triggers by:

  - Explaining the trigger-thought-craving-use process
  - Providing the client with examples of triggers
  - Using open-ended questions to help the client think about his or her specific triggers

9.6

Analyzing Lapses and Relapse

- Relapse analysis involves looking closely at the person's thoughts, feelings, and behaviors before the person last used

9.7

Resource Page 9.1: Basic Guidelines for Effective Skills Training[1]

General Principles

- The content and timing of skills training need to be highly individualized, depending on the client's stage of change, goals, and circumstances.

- The worker should not rush through skills-training material to try to cover all of it in a few weeks; some patients may need several weeks to master a basic skill.

- Working at the client's pace is more effective than rushing the client and risking the therapeutic relationship.

- Workers should use language that is compatible with the client's level of understanding and sophistication.

- Workers should frequently ask clients whether they understand a concept and whether the material is relevant to them.

- The worker should be alert to signals from clients who think the material is not well suited to them. Signals include avoiding eye contact, overly brief responses, failure to provide examples, failure to do homework, and so on.

- One important way to ensure that skills training is relevant to a client is to use specific examples and situations provided by the client.

Guidelines

1. Model Skills and Help Clients Practice

- Modeling helps a client learn new behaviors by having the client participate in role plays with the therapist during treatment.

- A client learns to respond in new, unfamiliar ways by first watching the worker model those new strategies.

- Once the worker has modeled a new skill, the client can practice those strategies in the supportive context of the relationship.

2. Use Repetition

- People master complex new skills by trying them out, making mistakes, identifying those mistakes, and trying again.

- It is important that workers recognize how difficult, uncomfortable, and even threatening it is to change established habits and try new behaviors.

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[1] Primary source: Carroll, K.M. (1999). *Therapy manuals for drug abuse: Manual 1, A cognitive–behavioral approach—Treating cocaine addiction.* NIH Publication Number 99-4309. Bethesda, MD: National Institute on Drug Abuse.

- For most clients, mastering a new approach to old situations takes several attempts.

- Clients may have problems with attention, concentration, and memory because of drug use.

- Repetition may be necessary to help them understand and retain new material.

- Clients also may seek counseling at a point of extreme crisis (e.g., learning they are HIV positive, losing a job).

- These clients may be so preoccupied with their current problems that focusing on the worker's thoughts and suggestions is difficult.

- Repetition is often necessary for a client to understand or retain a concept or idea.

3. Get a Commitment

- It is important that clients practice new skills outside the sessions.

- The worker should get a commitment from the client to practice new skills.

- The worker should not expect a client to practice a skill without understanding why it is helpful.

- The worker needs to stress the importance of out-of-session practice.

- The worker should be direct and ask clients whether they are willing to practice skills outside the sessions and whether they think doing so would be helpful.

- A client's hesitation or refusal may signal issues that are important to explore with the client, such as ambivalence about stopping drug use, fear of failure, or simply not understanding the task.

- Example:

   o It is important for us to talk about and work on new skills when we meet, but it is even more important to put these skills to use in your daily life. You are the expert on what works and doesn't work for you, and the best way to find out what works is to try it out. Are you willing to try _____ before we meet again?

4. Anticipate Obstacles

- The worker should help clients anticipate obstacles they might encounter in carrying out practice assignments and apply a problem-solving strategy to help work through these obstacles (more about problem-solving later in the module).

- Clients should be active participants in this process.

- Ask questions like:

    o What might be hard about practicing this skill this week?

    o Do you see any reasons why you might not be able to practice this skill this week?

    o What will be hardest about telling Dong you can't go to the karaoke bar with him tonight?

5. Monitor Closely and Use the Information

- Monitoring homework assignments is critical to enhancing learning.

- Checking on task completion underscores the importance of practicing coping skills outside the sessions.

- It provides an opportunity to discuss the client's experience with practicing the tasks so that any problems can be addressed.

- Clients are more likely to practice an exercise if they expect the worker to ask about a practice experience.

- Monitoring assignments involves more than simply asking whether the client completed it. Workers should explore:

    o When the client practiced the assignment;

    o How it went;

    o How the client felt about it; and

    o What the client learned about himself or herself in carrying out the task.

6. Explore Resistance

- Asking why a client did not complete an assignment is also important. A client may have several reasons for not practicing. For example:

    o He or she may feel hopeless and not think it is worth trying to change behavior.

    o He or she may expect change to occur through willpower alone, without making specific changes in particular problem areas.

    o His or her life is chaotic and crisis ridden, and he or she is too disorganized to carry out the tasks.

- By exploring the specific nature of a client's difficulty, a worker can help him or her solve problems.
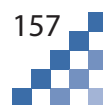
7. Praise Approximations

- Clients will not always complete all practice exercises.

- The worker should try to shape the client's behavior by:

    o Praising even small attempts at working on assignments;

    o Highlighting anything clients reveal that was helpful or interesting in carrying out the assignment;

    o Reiterating the importance of practice; and

    o Developing a plan for completion of the next session's homework assignment.

- Examples of praising approximations:

    o OK, so you went to the bar with Dong Friday night instead of telling him you couldn't go. But you left early because you started feeling uncomfortable—that's great!

    o I'm glad to hear you thought about whom you could call in an emergency. Maybe this week you can get that list on paper!

Resource Page 9.2: Client Scenarios

Scenario 1: Tuan

Tuan is 27 years old and has never married. He returned from a 2-year stay in a rehabilitation center 2 months ago. He stayed abstinent while he was there. Tuan moved back in with his mother (his father is deceased), three siblings, and his grandmother. Tuan has remained abstinent since his return to the community and has told you that he doesn't want to use again. His mother watches his every move and asks other community members to watch him, too. His grandmother won't speak to him because he has shamed the family. Tuan has spoken to you before about how hurt he feels that his grandmother won't speak to him. He was close to her as a child, and her silence hurts. Lately, he has been having some heroin cravings and tells you that twice he has met old using friends in the park where he used to use drugs. Tuan has been having a hard time finding a job and has been spending time in a café near his home. He tells you he sees his old dealer in there once in a while.

Scenario 2: Quan

Quan is a 45-year-old male injection drug user who returned from a rehabilitation center 3 months ago. He is back with his wife, three children, and his mother-in-law. His wife had a very difficult time while he was away and is angry with him. She is pressuring him to start working and taking care of his family, but he is having trouble finding a job. Everyone in the district knows about him and won't give him a chance. Quan is frustrated and discouraged. He has started spending time away from home to avoid his wife, just walking around the city. He occasionally finds himself near his old dealer's house, but hasn't gone in. He has told the worker that he has been tempted and has come close to using again. He worries that his drug use and his time away have affected his children and is afraid of losing his family entirely.

Scenario 3: Ha

Ha, a 25-year-old female, has been a sex worker since she was 16. Her mother was also a sex worker and died of AIDS a year ago. Ha has used drugs for years and started injecting heroin 4 years ago. She spent 2 years in a rehabilitation center and has not used drugs since she got out. She is currently homeless, but stays with friends when she can. Her mother's death has scared her, but she hasn't been tested for HIV. She is ambivalent about being tested. She knows she should be tested, but she is scared of finding out the test results. Ha occasionally goes to a drop-in center. She has told a worker that she feels "tired and old" and wants to get out of sex work. She recently found a job in a shop, but continues to see old clients from time to time for extra money. She says it is very hard for her to do sex work without being high, but she "toughs it out." She doesn't fully trust the drop-in center staff or volunteers and feels hopeless. Still, she continues to be abstinent and visits the drop-in center.
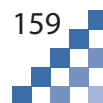
Scenario 4: Van Anh

Van Anh is a 19-year-old female who started using stimulants with her boyfriend. She started injecting methamphetamine 2 months ago. She says it was fun at first, but her use was getting out of control. Her parents found out and have threatened to send her to a rehabilitation center. Van Anh has stopped using, but still sees her boyfriend. She says that he tells her he supports her decision to quit, but doesn't think he has a problem with his own use. Though he doesn't use around her, he frequently sees Van Anh while he is high. She has told you that she can sometimes smell methamphetamine on him. She still goes clubbing with her boyfriend and with girlfriends. Once, she got drunk and used methamphetamine that night. She feels sure she won't let that happen again.

Resource Page 9.3: Refusal Skills

Ideally, a recovering person will avoid high-risk situations and people completely. However, that is not always practical or possible. For example:

- Some people, like drug dealers, will have a financial incentive to keep the recovering person in the drug-using world and may even try to find the person.

- Clients may be in a close, intimate relationship with someone who still uses drugs and may be unwilling or unable to avoid this person.

- The client may be offered drugs by someone he or she doesn't know.

The worker can help the client maximize the chances of staying in recovery by teaching refusal skills or how to say no to drug use.

The worker can tell the client there are several ways to say no:

- By simply leaving the scene–either quietly while no one notices or by making an excuse or joke out of it: "You guys are too crazy for me. See you later."

- By being direct and definite: "No. I don't do drugs anymore."

- By negotiating and setting limits: "Listen, I've decided to stop, and I'd like you not to ask me to use with you anymore. If you can't do that, I think you should stop coming over to my house."

The worker can explore with the client which response is best for each situation and person, as well as the extent to which exposure to drugs can be renegotiated. For example:

So, you feel like you want to stay with Quan for now, but he's not willing to stop using heroin. Being with him is pretty risky for you, but maybe we can think of some ways to reduce the risk. Have you thought about asking him not to bring drugs into the house or use in the house? You've said you know it's hard for you that he continues to do that, in terms of your staying abstinent and having drugs around your kids.

The worker also can help the client by educating him or her on nonverbal and verbal ways of saying no effectively. For example:

- Look directly at the person when you answer to increase the effectiveness of the message.

- Stand or sit up straight to create a confident air.

- Don't feel guilty about the refusal; you aren't hurting anyone by not using.

- Use a clear, firm, confident tone of voice.

- No should be the first word out of your mouth.

- Suggest an alternative activity if you want to do something else with that person.

- Tell the person offering you drugs not to ask you now or in the future so the other person stops asking.

- Change the subject to something else.

- Avoid vague answers; they imply you will change your mind later.

- Walk away if the other person insists.

Saying no can be difficult, and the worker can best help the client by role playing with him or her. To do this, the worker should:

- Pick a concrete situation that occurred recently for the client;

- Ask the client to provide some background on the target person;

- Have the client first play the target individual so that the worker can get an idea of the style and likely responses of the person who offers the drug and can model effective refusal skills;

- Reverse the roles so the client can practice; and

- Process the role play with the client, praising any effective refusal skills shown by the client and suggesting alternatives when necessary. For example:

That was good! How did it feel to you? I noticed that you looked me right in the eye and spoke right up; that was great. I also noticed that you left the door open to future offers by saying you had stopped shooting up for a while. Let's try it again, but this time, try to do it in a way that makes it clear you don't want Phat to offer you drugs ever again.

Resource Page 9.4: Time Management

When a person is addicted, their life is structured around finding drugs, finding ways to pay for drugs, using drugs, and recovering from drug use. Or, if a person has been in an 06 center his or her schedule has been dictated by others. Once a person is in recovery or leaves the center, their lives are suddenly unstructured. This lack of structure can be dangerous to the recovering person.

Learning time management and scheduling skills can help people in recovery:

* Feel more in control of life and reduce anxiety;

* Avoid triggers;

* Counter the drug-using lifestyle; and

* Provide a basic foundation for ongoing recovery.

Making a daily plan of activities that promote recovery reduces the possibility of boredom, impulsive decision making, exposure to triggers, and relapse. The worker can help clients create a realistic daily schedule using a planning book or calendar page (see sample schedule page at the end of the Resource Page).

One of the main goals of scheduling is to ensure that the rational part of clients' brains takes charge of their behavior rather than the emotional, addicted part of their brains where cravings start. When clients make a schedule and stick to it, they put their rational brains in charge. People need to learn to structure their time if they are serious about recovery.

It is important for clients to plan their activities and to **write them down**. Schedules that exist only in one's head are too easy to revise or abandon. Scheduling every hour of the day and sticking to the schedule can be a big help for clients in early recovery. When clients are making their schedules, special attention should be paid to weekends and any other times clients feel they are particularly vulnerable to substance use.

The worker can help a client learn to schedule by:

* Educating him or her as to why it is important;

* Helping him or her think through possible daily activities to include on a schedule;

* Helping him or her identify potential problems; and

* Helping him or her evaluate how well the schedule worked.

The worker can help the client start small (e.g., scheduling only part of the current day), and
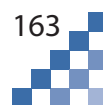
move on to developing more comprehensive daily or even weekly schedules. Starting with "have to" and routine activities also helps get the process moving. For example:

Worker: Tran, let's just start with this afternoon. Is there anything you have to do?

Tran: Well, I have an appointment at the clinic at 15:00.

Worker: OK, let's put that on the schedule now. How long do you expect it will take?

Tran: Probably about an hour.

Worker: We'll put it in the schedule for 15:00–16:00. Anything else?

Tran: That's all I have to do. But I usually have dinner with my parents at about 18:00. And there's a drop-in group I like at 20:00 tonight.

Worker: Shall we put the drop-in group on today's schedule?

Tran: Sure, I'll go tonight.

Worker: We have a great start here! Now, what time do you usually go to bed?

The worker also can combine scheduling with helping the client develop new, non-drug-using activities by asking questions like:

- Is there anything you used to do and enjoyed before you got so into drugs?

- Would you be interested in getting involved in that again?

- What kinds of things do you think you might enjoy doing that you haven't tried?

Scheduling time with family members and non-drug-using friends can help clients reconnect and repair relationships as well.

Daily Schedule

Day _____   Date _____

24:00 _____

 1:00 _____

 2:00 _____

 3:00 _____

 4:00 _____

 5:00 _____

 6:00 _____

 7:00 _____

 8:00 _____

 9:00 _____

10:00 _____

11:00 _____

12:00 _____

13:00 _____

14:00 _____

15:00 _____

16:00 _____

17:00 _____

18:00 _____

19:00 _____

20:00 _____

21:00 _____

22:00 _____

23:00 _____

Resource Page 9.5: Thought-Stopping Techniques

Because not all triggers can be avoided, workers can teach clients some simple thought-stopping techniques to help them quickly interrupt the trigger-craving cycle. These techniques include:

- Visualization;

- Relaxation;

- Rubberband snap; and

- Calling someone.

Not all these techniques work well for all people or at all times. Some people have trouble visualizing, for example, and that technique may never work for them. Someone else may prefer calling someone as a thought stopper, but may not be able to do that if he or she is in a meeting at work, for example. Similarly, relaxation or visualization obviously would not be safe when driving. A discreet snap of a rubber band followed by a quick non-using thought may work very well in both those situations.

The worker should offer the client an opportunity to learn and try all the techniques to ensure that the person has a range of possibilities available at all times.

Visualization

One technique is to visualize a switch or lever and imagine actually moving it from ON to OFF to stop drug- or alcohol-using thoughts. Clients need to know that it is important to have another thought ready to replace the drug- or alcohol-using thoughts. This thought should be pleasurable or meaningful and have nothing to do with drug use. For example, a mother may want to visualize her child smiling at her. Another person may want to think about a particularly beautiful place he or she loves. The worker should work with the person ahead of time to identify an appropriate thought.

Another type of visualization is called *urge surfing*: The person visualizes an urge or craving as a wave, watching it rise, crest, and wash onto a beach. This imagery reinforces that urges and cravings usually peak and subside rather quickly if they are not acted on and that the person does not have to be swept away or drowned by the sensations.

Relaxation

Relaxation can help people cope with the emotional and physical sensations of cravings. Cravings often create feelings of hollowness, heaviness, and cramping in the stomach. These feelings often can be relieved by breathing in deeply (filling the lungs with air) and slowly breathing out, repeating the process three times, and focusing on relaxing the body as much as possible for a few minutes. This process can be repeated as often as the feelings return. Relaxing the body can be combined with visualizing a relaxing scene.

Rubberband Snap

The rubberband technique helps recovering people snap their attention away from thoughts of using drugs or alcohol. It is a classic behavioral conditioning technique that can be used in a wide range of situations.

To use the technique, a person puts a rubberband loosely around his or her wrist. When a craving or using thought occurs, he or she snaps the rubberband lightly against their wrist and says NO (either aloud or to themselves) to the drug or alcohol thoughts. As with visualization, people need to have another thought ready to replace the drug- and alcohol-using thoughts.

This technique works best if people leave the rubberband on all the time.

Calling

Calling someone can effectively interrupt cravings. Talking to others provides an outlet for feelings and allows people to hear their thought process. People in recovery should program the numbers of supportive people, including family members, into their mobiles so they can call someone whenever support is needed.

Teaching Thought-Stopping Techniques

Workers can help clients learn to use thought-stopping techniques by:

- Describing and explaining each technique;

- Asking, What do you think might work best for you? or What would you be willing to try this week?
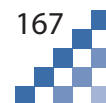
- Helping the client identify alternative, positive thoughts by asking questions such as, Could you visualize a place where you always feel comfortable and safe? or What is your primary motivation for staying in recovery? or Is there something you're particularly interested in that you could think about?

- Helping the client identify people he or she could call by asking:

  o Is there someone you can call at any time of the day or night?

  o Who would be most supportive of your recovery?

  o Do you have that number in your mobile?

- Following up with the client at the next visit and asking:

  o How did _____ work for you?

  o Is there another technique you think might work better?

The different techniques require different approaches. For example, the worker doesn't have to "teach" the client how to snap a rubber band, and the client probably doesn't need to practice it in the office. However, the worker can help the client develop an alternative thought, and talk through when to use the snap. Visualization and relaxation techniques, on the other hand, can and should be practiced in the office. In this case, too, the worker helps the client develop an effective alternative thought. Calling someone seems obvious, but clients often need to practice calling people when they are not in crisis, so it will feel natural and obvious when they are.

The worker should emphasize that, if the thought-stopping technique works but the thoughts keep coming back, the person may have to change his or her immediate environment or engage in non-trigger activities that require full concentration. The worker can offer suggestions, and help the client come up with his or her own ideas and plan.

A few examples of non-trigger activities to suggest include:

- Exercise;

- Meditation;

- Attending a support group meeting;

- Eating or sleeping;

- Recreational activities or hobbies;

- Movies; and

- Spending time with family.
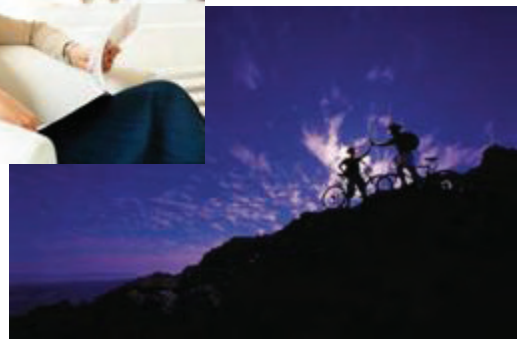
The worker can help the client identify alternative activities by asking:

- Is there anything you used to do for fun before you used drugs that you might want to try again?

- What do you like to do to relax that doesn't involve using?

- Are there any sports or hobbies you would like to try?

Resource Page 9.6: Problem Solving

Making the substantial lifestyle changes needed for recovery involves finding solutions for many problems. Some clients may have so many problems that even minor things seem overwhelming. For example, a straightforward goal like going to a job service center to meet a counselor and signing up for assistance may require solving a number of problems: The client may not have readily available transportation, childcare may be needed, or the only available appointments may conflict with other important activities.

For many clients, their drug use has resulted in either avoidance of such problems (simply skipping the job service center appointment) or making impulsive decisions that are not in their best interest ("This isn't going to work. I'm never going to get a job, so I might as well start using again."). Such poor problem-solving behavior usually results in negative consequences that increase the severity of existing problems or create additional problems.

Fortunately, clients can *learn* to be effective problem solvers. Workers can teach clients a six-step problem-solving process. Timing is important, however. Teaching problem solving works best when the client is in the action stage of change and motivated to learn it, and is not impaired (e.g., not actively using alcohol or other drugs, not in withdrawal, and doesn't have significant cognitive impairment).

Problems vary in degree of difficulty and importance, and the time and effort put into problem solving will vary accordingly. However, the *process* of problem solving is much the same no matter what the problem is.

Step one in the problem-solving model is to let the client know that:

- Problems are normal; everyone has them;

- People can learn to be better problem solvers;

- Resisting the temptation either to respond to a first impulse (or to do nothing) is an important first step; and

- When a problem arises, it is important to stop and think before taking action.

Step two is to identify the problem.

Identifying that there *is* a problem is usually not too difficult—people tend to know that there is a problem because they feel stressed and anxious. What can be a bit more difficult is defining exactly what the problem is. If the client is unable to clearly define a problem, the worker can help him learn by guiding him or her through a process of clarifying the situation.

For example, if a client is upset about his or her current job and is considering quitting, the worker could ask questions such as:

- How is your relationship with your supervisor?

- Have you received any negative feedback or evaluations?

- What are your relationships like with your co-workers?

More and more detailed questions could be posed to narrow down the problem. Over time, the client can learn to do this process himself.

Step three is brainstorming possible solutions.

The worker can guide the client in this step by teaching him the following about brainstorming:

- In brainstorming, it's important to come up with as many solutions as possible.

- Write them all down.

- At this point, do not reject any idea or try to think of just the best idea.

- Use your imagination and think of *all* possibilities.

- Even ideas that are impractical or clearly not possible may have *elements* that are useful.

- Do not evaluate plausibility and "do-ability" until all ideas have been identified.

The worker can guide the client through this process by reminding him when he seems to be judging the options, and asking "what else?"

Step four is evaluating and selecting a solution.

Now is the time to consider the pros and cons of each possible solution. For each idea, the worker can ask the client to answer the following questions:

- What is the best possible thing that could happen if you choose this alternative?

- What is the worst possible thing that could happen?

- What is the most likely thing that will happen?

- Would this be a short-term or long-term solution?

- What is your reaction (thoughts, feelings, memories, and future projections) when you think about implementing each alternative?

- Are there any potential negative consequences (both now or in the near future)?

- How much time will it take to carry this out?

- Is it going to require money?

- Do you have the skills to carry this out? Do you have the necessary resources?

- Does this require the cooperation of other people and, if yes, are they likely to cooperate?

- What difficulties might you face when carrying out this solution?

And, finally, Which option offers the best outcomes and seems to have the best chance for success?

The actual solution needs to be selected by the client, not the worker. The client is the expert in what is the most appropriate choice for him. Having said this, it's important that the worker not allow clients to undertake solutions that appear inherently dangerous (e.g., confronting a threatening person).

Step five is developing a plan of action.

Many solutions will have several steps. The worker can help the client break the chosen solution down into manageable steps and determine how and when he will carry out each step (goal setting)

Step six is reviewing progress and evaluating the outcome.

Once a solution is chosen, the worker should discuss the next step, evaluating its effectiveness. This step emphasizes problem solving as an ongoing process. It is important that counselors help clients determine how they will know if a solution is effective. Determining this ahead of time helps clients to be more realistic and perhaps optimistic about finding effective solutions to problems.

To help the client evaluate a solution, the worker can ask or suggest that the client consider questions like:

- After you have given the approach a fair trial, does it seem to be working out?

- Are you making progress?

- Has the problem been solved?

- Does the *problem* need to be reevaluated?

- Which parts worked best?

- Would you do anything differently next time?

- If not, what could you do to beef up the plan? Or do you need to give it up and try one of the other possible approaches?

MODULE 10—EFFECTIVE CASE MANAGEMENT FOR SUBSTANCE USERS

Module 10 Goals and Objectives

Training goals

- To provide participants with an overview of a six-step model of case management and referral;

- To provide participants with an opportunity to begin developing a referral database with their colleagues; and

- To provide participants with an overview of burnout prevention

Learning objectives

Participants who complete Module 11 will be able to:

- List and provide a brief description of six basic steps of case management and referral;

- Develop a beginning referral database; and

- Develop a plan for personal burnout prevention.

Timeline and Content	
Activity	Time
Welcome, concert review of day 4, Module 10 introduction	10 minutes
Group presentations: Six basic steps of case management—Preparation	50 minutes
Group presentations: Six basic steps of case management—Presentations, Part 1	30 minutes
Small-group exercise: Step 3—Developing a referral database—Preparation	30 minutes
Break	15 minutes
Small-group exercise: Developing a referral database—Presentation	30 minutes
Group presentations: Six basic steps of case management—Presentations, Part 2	60 minutes
Lunch	90 minutes
Exercise: Avoiding burnout: Counselor self-care	75 minutes

**CASE MANAGEMENT FOR
RECOVERING DRUG USERS
IN VIETNAM:
A TRAINING CURRICULUM**

**MODULE 10—EFFECTIVE CASE
MANAGEMENT FOR SUBSTANCE USERS**

10.1

Case Management—Review

- Case management: The coordination of professional social services to assist people with complex needs, often for long-term care and protection

10.2

Case Management—Review

- Linkage is a critical part of case management because no one agency can meet all the needs of a client

- The goal of interagency case management is to connect agencies to one another to provide additional services to clients

10.3

Recovery-Oriented Systems of Care

- Because addiction is a chronic disease, it needs a long-term approach to treatment and recovery
- A new way of conceptualizing this long-term approach is called recovery-oriented systems of care

10.4

Recovery-Oriented Systems of Care

- Recovery-oriented systems of care range from early intervention and addiction treatment to long-term recovery
- Recovery-oriented systems of care offer ongoing, professional, and peer-driven services and supports

10.5

Recovery-Oriented Systems of Care

- Recovery-oriented systems of care can be created and sustained by careful, individualized case management services

10.6

Burnout

■ When the difficulties and stress of work begin to interfere with their personal and family lives, workers can suffer from **burnout**: emotional and physical fatigue caused by stress

10.7

Exercise

■ Which of the strategies on Resource Page 10.7 do you use *now* to effectively manage your work stress?

■ In which categories could you do more?

10.8

Help Your Partner!

Use:
■ Open-ended questions
■ Reflective listening
■ Motivational assessment with the readiness ruler
■ Problem solving (see Resource Page 9.6)

10.9

Help Your Partner!

- What skills did you notice your partner using?

- What was most helpful to you?

- Are there any ways in which your partner could have been *more* helpful?

10.10

Resource Page 10.1: Step 1—Assessment

The first step in effective case management is assessing a client's real-world needs.

Assessment is the basis for all case management activities. Although someone else (such as a treatment counselor) might actually conduct the assessment, case workers need to understand the process and use all available assessment information in planning case management activities.

Much has been written about assessment and assessment tools. A full discussion is outside the scope of this training, but this Resource Page provides some basic, helpful information.

Areas of Assessment

A thorough assessment includes collecting the following information about the client:

1. Background and current status
- Family situation and relationships;

- Trauma history;

- History of domestic violence (either as a batterer or as a battered person);

- Marital status;

- Past and present legal involvement;

- Financial and work situation;

- Education;

- Housing status;

- Employment status; and

- Strengths and resources.

2. Current and past drug use history
- Age at first use;

- Drugs used (including alcohol);

- Amounts used;

- How used (injection, oral, etc.);

- Patterns of drug use;

- Consequences of drug use;

- Treatment episodes; and

- Family history of drug use problems.

3. Medical conditions or complications, such as:
- Injection-related medical issues;

- HIV/AIDS;

- Tuberculosis;

- Hepatitis;

- Sexually transmitted diseases;

- Liver disease;

- Physical disability; and

- High blood pressure, diabetes, and other health problems.

4. Emotional/behavioral/cognitive status
- Family history of mental health problems;

- Client history of mental health problems, including diagnosis, hospitalization, and other treatment;

- Current symptoms and mental status;

- Medications and history of medication adherence (medication may affect behavior; adherence or nonadherence to medication regimens can provide some idea of how well a client will follow through in other areas); and

- Cognitive function (e.g., does the client have a cognitive deficit? Will he be able to remember appointments? Can she understand and follow through on directions?).

5. Readiness to change (this needs to be reassessed often)
- Where is the client in the stages of change cycle?

- What is the client ready to work on (some clients will be agreeable to one case management option, but not another)?

- How ready is he or she to take a step toward change (the readiness ruler can be a good tool here)?

6. Relapse or continued-use potential (related to readiness to change)
- How is the client managing cravings?

- Can he or she identify personal relapse triggers?

- What is the client's recovery environment?

- What supports does he or she have for recovery?

- Is he or she still spending time with friends or family who use drugs or alcohol?

- Does his or her family support recovery?

7. Immediate threats to the client's safety: Is the client:
- Expressing thoughts of suicide?

- Threatening harm to someone else?

- In danger?

Suspicions of immediate danger should be investigated by asking questions like, Do you feel safe at home? Do you feel safe in your current relationship? Is someone threatening you now or making you feel unsafe?

8. General ability to function
- Ability to obtain and follow through on medical services;

- Ability to apply for benefits on her own;

- Ability to obtain and maintain safe housing;

- Skill in using social service agencies; and

- Skill in accessing mental health and substance abuse treatment services.

Assessing these areas of functioning gives evidence of the client's degree of impairment and barriers to the client's recovery. These areas can be assessed by asking the client about his or her past experiences (e.g., When did you last see a doctor? Did you make the appointment yourself? Are you receiving government benefits? Did you complete the application yourself?).

Assessing these areas of functioning gives evidence of the client's degree of impairment and barriers to the client's recovery. The case worker may have to perform many services on behalf of the client until the client can master these skills.

9. Vocational skills

- Basic reading and writing skills;

- Ability to follow instructions;

- Ability to arrange for necessary transportation;

- Manner of dealing with authority;

- Ability to be punctual; and

- Communication skills.

Conducting an assessment

Using reflective listening and open-ended questions can elicit much more information than closed questions. Ask clients:

- What drugs have you used in the last year? not Do you use drugs?

- Tell me about your heroin use, not Do you inject heroin?

- What is your heroin use like in a typical day? not Do you use heroin more than once a day?

One effective, nonthreatening technique to use when conducting an assessment is the "sandwich" approach. In this approach:

- The bottom "slice of bread" is a casual conversation; you build rapport with the client by welcoming him or her, chatting a bit, listening to concerns, and asking whether he or she has questions.

- The sandwich "filling" is a more structured interview. You ask specific (preferably open-ended) questions in the areas noted above.

- The top "slice of bread" is, again, more casual. You thank the client for coming, give affirmation, and ask whether he or she has questions.

Resource Page 10.2: Step 2—Setting and Prioritizing Goals

Effective goals are:

- Specific (What exactly will you accomplish?)

- Measurable (How will you know when you have reached this goal?)

- Attainable (Is achieving this goal realistic with effort and commitment? Do you have the resources to achieve this goal? If not, how will you get them?)

- Relevant (Why is this goal significant to your life? Do you value it?)

- Time limited (When will this goal be achieved?)

Each goal, especially a long-term goal (e.g., completing schooling), should be broken down into short-term objectives and possibly into even smaller steps or strategies.

Distinct, manageable objectives keep people from feeling overwhelmed and provide a benchmark against which to measure progress.

You can help a person break down goals into manageable, measurable objectives by asking questions such as:

- What will be your first (or next) step?

- What will you do in the next 1 or 2 days (week)?

- What have you already been doing to achieve this goal? What else can you do?

- Who can help you?

- On a scale of 1–11, how confident are you that you will do this next step?

Goals need to be prioritized. A client in recovery can easily be overwhelmed by working on too many goals at the same time.

Generally, client needs can be prioritized in the following order:

- Emergencies;

- Basic needs; and

- Other needs.

Emergency needs include:

- Life-threatening situations (serious illness, suicidal thoughts);

- Family violence; and

- Disaster situations.

Basic needs include:

- Employment and money;

- Food;

- Housing and utilities (such as electricity and water); and

- Transportation.

Other needs are those that are not considered emergency or basic needs:

- Basic medical care;

- Child care;

- Schooling; and

- Client goals for the future.

Meeting clients' emergency and basic needs comes first. After that, the worker can help clients prioritize goals by asking questions such as:

- What would you like to work on first?

- Which of the goals that we've talked about are most important to you?

- Which of these goals do you think you can achieve first?

- Which of these goals do you think will help you most in your recovery?

Other important elements of setting goals include:

- Identifying needed resources (including referrals) and support; and

- Identifying possible barriers and solutions for achieving goals.

Successful completion of an objective provides the client with the satisfaction of gaining a needed resource and demonstrating success. Failure to complete an objective can be emphasized as an opportunity to reevaluate one's efforts. In this situation, the case worker can help the client come up with alternative approaches or begin an advocacy process.

A deliberate, careful approach to identifying client goals offers benefits that go beyond actual achievement of goals. Clients benefit by:

- Learning a process for systematically setting goals;

- Understanding how to achieve desired goals through the accomplishment of smaller objectives;

- Gaining mastery of themselves and their environment through brainstorming on ways to overcome possible barriers to a goal or objective; and

- Experiencing the process of accessing and accepting assistance from others in setting goals and attaining them.

These and other outcomes make planning and setting goals as important as the final outcome in some cases: It's the path, not just the destination.

Resource Page 10.3: Step 3—Developing a Referral Database: Exercise Instructions

In your small group:

- Share with others everything you know about local, district, and provincial social service organizations, including governmental agencies, nongovernmental organizations, and faith-based organizations.

- Create a list, map, or other graphic depiction of available resources.

- Include substance abuse treatment, mental health treatment, general medical care, HIV/AIDS services (voluntary counseling and testing and medical services, including antiretroviral treatments), legal services, family planning, services for pregnant and postpartum women, housing agencies, and vocational and other service organizations their clients could need and use.

- Include health and other services in correctional or rehabilitation facilities where drug users are incarcerated or housed.

- Consider community peer support groups for injection drug users, those living with AIDS, and groups for special populations, such as women, female and male sex workers, and men who have sex with men.

- Include everything you know about each organization or group, including its target audience, criteria for admission, how it accepts referrals, and potential barriers.

- Share ideas about ways of identifying more resources.

- Add the names and e-mail addresses of group members for future networking.

When you return home:

- Find out everything you can about the resources on the list.

- Establish and maintain relationships with civic groups, agencies, other professionals, government entities, and the community at large to ensure appropriate referrals, identify service gaps, expand community resources, and address unmet needs.

- Add new service organizations and pilot programs that may be appropriate for your clients.

Resource Page 10.4: Step 4—Preparing the Client for Referral

Clients need to be prepared for referrals. The case worker can help a client understand the need for a particular referral and how it can help the client.

The case worker also can use active listening skills to identify and acknowledge how the client is feeling about getting help. Asking for help is often one of the most difficult things a person has to do, and people often have feelings that may prevent them from asking for help. Some common feelings include:

- Shame;

- Fear;

- A sense of powerlessness; and

- Distrust.

Cultural beliefs also can influence how a client views asking for help.

The case worker also can initiate a discussion about possible barriers to following through on the referral (Can you see any reason why this might not work for you?). There may be a number of possible barriers, such as the emotional factors noted above, and more concrete reasons, such as lack of money or child care. The case worker can use problem-solving techniques to help the client find ways to address barriers.

Clients also need to know generally what to expect. The case worker obviously needs to give the client basic and necessary information: the name of the agency, the phone number, the address, and the name of a contact person (if possible). The case worker also should provide as much specific information as possible, such as:

- A description of the services the agency provides;

- Hours the agency is open;

- Any fees charged; and

- The admission process.

If the case worker has a professional relationship with someone at the agency, it can help the client to know that, and to hear a little about the person (Miss Tran is soft spoken and caring; I think you'll like her).

Once the client accepts the referral, the case worker needs to decide whether the client or the case worker should make the first contact. If it is an emergency referral (e.g., if the client is seriously ill or having suicidal thoughts), it is generally in the client's best interest for the case worker to make the referral and, often, accompany the client. Some agencies or organizations require the case worker to make a formal, sometimes even written, referral.

In nonemergency situations, and when the referral source does not require a formal referral, the case worker may choose to let the client make the first contact. This decision should be based on the case worker's assessment of the client's functioning. Some clients may need considerable help accessing services.

Resource Page 10.5: Step 5—Following Up on Referrals

Once a referral has been made, the next step is follow-up. The next time the case worker sees the client, he or she should:

- Ask the client if he or she used the referral;

- Give positive feedback if the client contacted the referral source (That took a lot of courage; I am glad you were able to follow through);

- Check to see how things went (the client may have kept his or her appointment, but didn't feel comfortable, was not greeted warmly, or for some reason didn't like the organization; this should lead to a discussion of alternatives);

- Check to see why a client did not use a service (Tell me more about why you did not keep your appointment); and, when necessary,

- Initiate another discussion of barriers or reexamine how important the goal and referral are to the client.

Part of follow-up is continuing to support and participate with the client by:

- Exchanging relevant information with the agency or professional to whom the referral is being made in a manner consistent with confidentiality standards;

- Summarizing relevant aspects of the client's personal and cultural background, treatment plan, recovery progress, and problems inhibiting progress to ensure quality of care, gain feedback, and plan changes in the course of treatment;

- Contributing as part of the client's treatment team;

- Coordinating all treatment and social services activities provided to the client by other resources; and

- Periodically reviewing the client's goals and making other referrals as needed.

Resource Page 10.6: Step 6—Maintaining Referral Sources

The case worker must maintain his or her referral database over time. What is the likely outcome of referring a client to an agency that no longer exists? To a contact person who is no longer working there?

The case worker also needs to know what to send with a client: Does the agency need a formal referral form? Does the client need to complete some paperwork prior to the appointment? Are certain types of identification required? These things can change over time.

In general, maintaining a referral database involves:

- Making sure the information in the database remains current; for example:

    o   Agency name

    o   Address

    o   Telephone number

    o   Contact person(s)

    o   Type(s) of services provided

    o   Eligibility requirements

    o   Service area

    o   Agency caseload or capacity

    o   Referral procedures

- Continuously assessing and evaluating referral resources to determine their effectiveness;

- Providing appropriate feedback to agencies about clients' reports of their experiences;

- Making sure clients can actually access the services;

- Keeping track of which clients seem to do best with which agencies; and

- Adding new service agencies or pilot programs to the list.

Case workers also should develop professional relationships with appropriate people at other agencies. These relationships can smooth the way for referrals and provide conduits for updated information about other agencies' services and policies.

Resource Page 10.7: Elements of Self-Care for Case Workers

Physical Health
- Eat well to maintain high energy and avoid illness:

    o Consume fresh fruits and vegetables daily.

    o Avoid prepared and fast foods that are high in sodium, sugar, and fat.

- Exercise regularly.

Rest and Relaxation
- Set aside time to rest and relax.

- Take regular vacations.

- Develop interests, hobbies, and friendships away from work.

- Practice Tai Chi, yoga, or another meditative discipline.

Healthy Boundaries
- Keep work and personal lives as separate as possible. You should not spend your free time hanging around your work site.

- Take your lunch break and leave work on time as much as possible.

- Avoid taking work home with you.

- Maintain clear boundaries with clients. Your job is not to be a client's "friend":

    o Do not "hang out" with clients after hours.

    o Sharing stories from your life and even just joking around after hours or during your work day can blur boundary lines, which can confuse clients.

    o Clients may start to see you as a friend rather than a professional helper. This could lead to a client's expecting special treatment, an unhealthy situation for both of you.

Personal Support System
- Be aware that your own recovery or personal growth issues can affect your work.

- Develop and use a personal support system away from work. This may consist of friends, family, those who share your religious affiliation, your partner, or a support group.

- If needed, seek therapy to cope with personal issues and keep them separate from work.

- Surround yourself with positive people when you are not at work.

- Discuss your feelings and issues with others who are working in similar situations. Sharing with others in a similar situation lowers stress levels and helps you keep an objective perspective.

- Learn to recognize when you need help, and ask for it.

Professional Issues and Development

- Work closely with your supervisor; be open about any difficulties you are having.

- Work to improve relationships with your supervisor and fellow case workers when necessary.

- Participate in all available training, and further your education by reading.

- Exchange ideas for service improvement with your supervisor and colleagues.

- Do not work in isolation. Working with a team offers great support.

- Work on time management issues if necessary.

- When available, join professional associations for education and support from colleagues in your field.

- Strive for excellence, NOT perfection.

Resource Page 10.8: Planning for Change

1. The category of self-care I most need to work on is:

_____

_____

2. I would like to make the following **specific** change:

_____

3. My current level of readiness to make this change is:

  Not ready   Unsure   Ready

4. First steps I am willing to take are:

a. _____

b._____

c._____

d._____

5. Some things that could interfere with my plan are:

_____

_____

6. Ways I could overcome these barriers include:

_____

_____

_____

_____

MODULE 11—INTEGRATING LEARNING INTO PRACTICE

Module 11 Goals and Objective

Training goals

- To encourage participants to think about resources, barriers, and strategies for change; and

- To provide an opportunity to develop a personal practice integration plan.

Learning objective

Participants who complete Module 11 will have developed a personal practice integration plan.

Timeline and Content	
Activity	Time
Module 11 and exercise introduction	10 minutes
Break	15 minutes
Exercise: Developing a practice integration plan	60 minutes
Learning assessment competition	20 minutes
Day 5 and overall evaluations	15 minutes
Program completion ceremony and socializing	30+ minutes

Resource Page 11.1: Practice Integration Plan

1. The most important thing I learned from this training, and don't want to forget, is:

_____

_____

_____

_____

2. I would like to make the following **specific** changes in my practice:

Change	When

3. To help me make these changes, I will do the following (e.g., talk to my supervisor, read more, adapt practices to fit the Vietnamese cultural context, attend advanced training):

_____

_____

_____

_____

4. The first steps I plan to take are:

a. _____
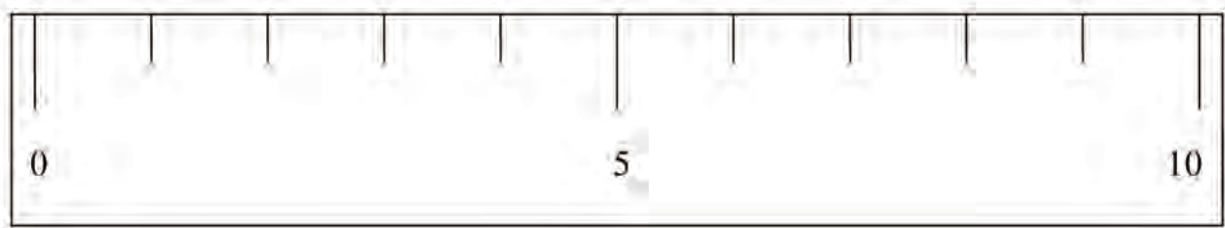
b. _____

c. _____

d. _____

5. Some things that could interfere with my plans are (e.g., anticipated barriers):

_____

_____

_____

6. Ways I could overcome these barriers include:

_____

_____

_____

_____

7. The following people (include supervisors, potential mentors, and so on) could help me in the following ways:

Person	Possible Ways to Help

8. My current level of readiness to integrate new ideas into my practice is:

| 0 | 5 | 10 |

Not ready   Unsure   Ready

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Participant's Manual