Helping Persons with Substance Abuse Series

Psychosocial Interventions for Persons with Substance Abuse: Theory and Practice

Editors
Pratima Murthy
S. Bala Shanthi Nikketha

National Institute of Mental Health and Neuro Sciences
De-Addiction Centre

Developed under WHO-GOI Collaborative Programme
2006-2007

1

Introduction

Pratima Murthy*

It is estimated that there are about 62.5 million alcohol users, 8.7 million cannabis users and about 2 million opiate users in our country. There are an estimated 250 million tobacco users of age 10 and above. Serious public health problems result from alcohol and other drug consumption. Drug abuse and its impact among women is now becoming more evident in India. Licit substances like tobacco and alcohol are widely prevalent, while abuse of illicit substances like cannabis, heroin, other opiates including opium and propoxyphene is recognized throughout the country. The abuse of psychotropic substances and solvents is also increasingly being recognized. Substance abuse (alcohol, tobacco and other drugs) is associated with a range of physical, psychological, social and occupational problems.

Common Drugs of Abuse in India (Males)	
Drug Type	**Current Prevalence**
Tobacco	55.8%
Alcohol	21.4%
Cannabis	3.0%
Heroin	0.2%
Opium	0.5%
Other Opiates	0.1%
(National Household Survey 2002)	

Interventions for substance abuse are largely limited to specialized de-addiction centers and limited to tertiary intervention for those with established late stage problems. It is well recognized that early problems related to substance abuse respond well to brief interventions. Physicians require sensitization and training in recognizing substance abuse related problems and offering intervention to such patients. A simple 5-A strategy of *Asking* every patient about the use of substances (just as we ask for a history of diabetes or hypertension), *Assessing* the pattern of use and resulting problems (establishing a link between substance use and presenting problem), *Advice* (clear strong advice to stop or cut down), *Assisting* (in the form of specific interventions) and *Arranging* (by making appropriate referrals when required) is recommended, especially for licit substance use (alcohol and tobacco). Illicit substance abuse is often not identified because it is not asked. This is also the case with psychotropic drug abuse. A vigilant physician will make sure to incorporate history of substance use as part of routine history taking. This must be done as a part of health evaluation without attaching any stigma or moral overtones to substance use.

Knowing what to do is especially important in order to be able to effectively intervene for substance abuse and dependence (a pattern of regular use, development of tolerance to drug effects, withdrawal symptoms when the substance is discontinued, stereotyped pattern of use and continued use despite knowledge

* Pratima Murthy, MD, DPM, Professor of Psychiatry and Head, De-Addiction Centre, National Institute of Mental Health and Neuro Sciences, Bangalore.

of harm). There are well established psychosocial interventions, which if provided in an effective and timely fashion, can motivate a person to reconsider his/her substance use habit, make lifestyle changes, and learn alternative ways of pleasure seeking and coping. Psychosocial interventions work on the premise that individuals, if appropriately helped are capable of positive change.

Much of the therapeutic nihilism (the belief that nothing works) associated with substance use is related to the delays in help seeking and help providing. Help is rarely offered early in the substance abuse phase, it is often delayed until end-stage addiction develops. At this stage, the recurrent, relapsing nature of the problem makes treatment more difficult. However, it must not be forgotten that addiction, much like hypertension or diabetes is a chronic, relapsing condition and requires long-term intervention and monitoring. There are effective strategies that can be taught to patients to anticipate and prevent relapses. Helping them through this process is only possible if the physician maintains follow-up contact with the patients.

Good communication skills are a prerequisite to effective psychosocial interventions, not just for substance use, but for any chronic illness or lifestyle disorder, where the therapeutic alliance formed between the patient and physician determines adherence to treatment and follow-up as well as outcome. Such skills to be possessed by the treating physician include skills for dealing with patients resistant to change, and an optimism that every patient is amenable to change sooner or later. Renewed offers of help and support to the patient may be critical in bringing about this change.

There has been a vast explosion of knowledge on the biology of addiction. It is now known that reward pathways in the brain mediate several phenomena related to addiction including drug reinforcement, craving, motivation and withdrawal. Similar pathways have been implicated in other behavioural addictions like pathological gambling. Use of appropriate pharmacotherapy along with psychosocial interventions has been shown to improve treatment outcome in substance use disorders.

Providing interventions to substance users is both challenging and frustrating. However, given the extent of the problem, it is simply neither practical nor wise to limit care of substance abuse only to specialized de-addiction centers. It is necessary to develop a stepped care approach, where early and initial intervention can be offered by the primary care physician. The trained physician can be an effective agent of change. It is also important that a network of referral agencies be available to the physician so that he/she will feel supported and know where to refer difficult, treatment resistant individuals and those with multiple substance related complications.

About this manual

This manual provides both the theory and practical steps of carrying out psychosocial interventions. It begins by providing an overview of the array of psychosocial interventions that are available. A major focus is on brief interventions which are eminently possible even in busy practice and clinical settings, and on motivation enhancement which is a strategy that can be used for any behavior where change is desired. Specific techniques to prevent relapses that can be taught to patients are discussed.

As mentioned earlier, continuing support after initial treatment is particularly important and such support needs to be mobilized outside the treatment and in the community. This includes self help groups like the Alcoholics Anonymous, Narcotics Anonymous and so on. Family members are often the worst affected by substance use. They need to be supported and involved in the care of the substance users. Some of the skills for carrying out family intervention can easily be picked up by the caring physician, while cases requiring intensive family intervention may be referred to specialists. Finally, understanding that the physician can also be an effective agent of change in the community, the role in community based interventions is addressed.

While this manual is primarily intended for physicians, it is of potential use to all professionals involved in providing intervention to persons with substance abuse and dependence. For those who are primarily interested in the practical steps of carrying out interventions, the appendix provides an overview of simple steps, as well as a quick pharmacology reckoner on medication that can be used in substance withdrawal and dependence. Information about the Alcoholics Anonymous (AA) and Narcotics Anonymous is also provided.

Throughout the manual, some expressions are used interchangeably. These include substance abuse/ drug abuse, patient/client, abuse/harmful use and addiction/dependence.

Suggested Reading:

1. Benegal, V. (2005) National experiences, India: alcohol and public health. Addiction, 100(8),1051–1056.
2. Koob, G.F. (2006) The neurobiology of addiction: a neuroadaptational view relevant for diagnosis. Addiction, 101, (Suppl 1).
3. Grant, J.E., Brewer, J.A., Potenza, M.N. (2006) The neurobiology of substance and behavioural addictions. CNS Spectr, 11(12):924-930.
4. McLellan, T.A., Lewis, D.C., O'Brien, C.P. (2000) Drug Dependence, a Chronic Medical Illness. JAMA, 284;13, 4 :1689- 1695.
5. Miller, W.R., Wilbourne, P.L. (2002) Mesa Grande: A methodological analysis of clinical trials of treatment for alcohol use disorders. Addiction, 97,265-277.
6. Murthy, P. (2002) Women and Drug Abuse: The Problem in India. Ministry of Social Justice and Empowerment, Government of India and United Nations Office on Drugs and Crime, Regional Office for South Asia.
7. Ray, R. (2004) The Extent, Pattern and Trends of Drug Abuse in India, National Survey. Ministry of Social Justice and Empowerment, Government of India and United Nations Office on Drugs and Crime, Regional Office for South Asia.
8. Srivastava, A., Pal, H., Dwivedi, S.N., Pandey, A. (2002) National Household Survey of Drug Abuse in India. Report submitted to Ministry of Social Justice and Empowerment, Government of India and United Nations Office on Drugs and Crime, Regional Office for South Asia.

2

Planning Psychosocial Intervention

Seema Yadav, Anju Dhawan*

Introduction

Substance use disorder is a bio-psycho-social condition and requires a multi-pronged approach for its management. It is fairly established from research in the area of substance abuse that the effective treatment of substance use disorder requires comprehensive management. This includes management of physical complications resulting from cessation of drug use. It involves addressing broader issues of motivation, lifestyle adjustment, reducing risk behavior, and developing skills to cope with factors that could trigger drug use, or to prevent an occasional lapse from becoming a full-blown relapse to regular drug use. Donovan and Wallace (1986) have articulated a bio-psycho-social model in addictive behaviors. This has been the most often used model for treatment of substance use disorder. It addresses the issue of substance use disorder from biological, psychological, and social perspectives. The components include:

1. *Biomedical modalities* focus on improved detoxification regimens, anti-craving medication, antagonist medication, substitution treatment, and other pharmacological approaches.
2. *Psychological treatment* modalities range from addiction counseling to psychodynamic and cognitive-behavioral treatment modalities, including insight-oriented psychotherapy, behavior therapy, family therapy and motivational intervention.
3. *Socio-cultural treatment modalities* include the community reinforcement approach, therapeutic communities, vocational rehabilitation and culturally specific interventions.

Very often a combination of components of psychological treatments and socio- cultural treatment is done. Psychosocial interventions include a broad range of psychological and behavioral strategies used either alone or in combination with pharmacotherapy and other medical or social interventions. Psychosocial interventions may be delivered in the context of abstinence-based treatments or in conjunction with pharmacological approaches. The level of intensity, frequency and duration of these interventions may vary depending upon approach and settings (out patient, partial hospitalization, inpatient, or residential based treatment settings). Modes of delivering psychosocial intervention also

* Seema Yadav MSW, Medical Social Service Officer, National Drug Dependence Treatment Centre, All India Institute of Medical Sciences, New Delhi.

* Anju Dhawan MD, Associate Professor, National Drug Dependence Treatment Centre, All India Institute of Medical Sciences, New Delhi.

differ and may be delivered in individual, or group sessions and may also include family members, or peer group. Psychosocial intervention increases effectiveness of pharmacological approaches and is more effective than either alone.

Important Psychosocial Interventions

Many of the psycho-social interventions can be easily practiced with some training. Choice of intervention may be influenced by stage of treatment, nature of drug use, treatment setting and availability of trained manpower. An overview of some of the major interventions is being provided. Models of delivering these interventions can be therapist mediated or based on self-help approach or through peer group (peer led interventions).

Brief Intervention

Brief or time limited intervention is an effective intervention approach with harmful or hazardous substance users. It can be used at specialist drug abuse treatment settings as well as other opportunistic settings such as primary health care emergency departments by trained health care professionals. Brief intervention is generally conducted to achieve a specific short term goal like facilitating referral to specialized treatment setting, reducing frequency and quantity of substance use, reducing risk associated with substance use, etc. The FRAMES model of brief intervention is discussed in Chapter 3. It has been found effective in decreasing alcohol use for at least one year in non-dependent drinkers in primary care clinics, managed care settings, hospitals, and research settings, with similar effect sizes for men and women and for all age groups over 18, including older adults. It can reduce health care utilization as measured by reductions in emergency room visits and hospital days, reductions in hospital readmissions, and reductions in physician office visits. Brief interventions may reduce mortality, health care and societal costs.

Motivation Improvement Therapy

Motivation has been described as a prerequisite for treatment, without which the clinician can do little. Similarly, lack of motivation has been used to explain the failure of individuals to begin, continue, comply with and succeed in treatment. Motivation can be understood not as something that one has but rather as something one does. It involves recognizing a problem, searching for a way to change, and then beginning and sticking with that change strategy. There are many ways to help people move toward such recognition and action. Motivational interventions are based on principles of motivational psychology; it is a therapist mediated, patient centered intervention. Studies over the past 10 years have demonstrated that motivational interventions are moderately successful in initiating change among a variety of individuals with alcohol-related problems.

Research has shown that motivation-enhancing approaches are associated with greater participation in treatment and positive treatment outcomes. Such outcomes include reduction in consumption, increased abstinence rates, social adjustment, and successful referrals to treatment.

Relapse Prevention

Relapse prevention therapy was originally designed as a maintenance program following the treatment of substance use disorders although it is also used as a stand alone treatment program. It is a self-control therapist mediated psychosocial intervention program designed to educate individuals who are trying to maintain changes in their substance use behavior, about how to anticipate and cope with the problem of relapse. It involves specific techniques of exploring the positive and negative consequences of continued use, self-monitoring to recognize drug cravings early on and identifying high-risk situations for use, and developing strategies for coping with and avoiding high-risk situations and the desire to use. The central element involves anticipating the problems patients are likely to meet, and helping them develop effective coping strategies. Relapse prevention therapy can be grouped into three categories:

1. Coping skills training: Equipping the patient to handle difficult life situations without resorting to substance use.
2. Cognitive therapy: cognitive-behavioral therapy attempts to help clients recognize and understand the causes of their problem and teach them the skills necessary to overcome them.
3. Lifestyle modification: effective substance use treatment requires modification in life style. Filling the void created by stopping drug use is important and can be done by involvement in drug free pleasurable activities such as meditation, exercise, and spiritual practices.

Relapse Prevention (RP) is among widely adopted cognitive—behavioral treatment interventions for alcohol, smoking, and other substance use. Relapse prevention therapy as a specific intervention is one of a number of evidence-based practices for substance use disorders and now has a well-documented track record of producing positive outcomes.

Network Therapy

Over the past decade, the network therapy approach has proven to be one of the most exciting new approaches for the treatment of alcohol and drug abuse problems. Its appeal is threefold: it integrates the best of modern ideas about psychosocial and biological treatments for addictive disorders; it mobilizes the potential power of family and friendship networks in support of effective treatment; and it can be easily mastered by both experienced therapists and addiction

counselors. Extending treatment beyond the individual is the core of network therapy wherein selected family members (pre-existing everyday social network) and friends (networks developed specifically for the purpose of facilitating the patient's treatment) are enlisted to provide ongoing support and to promote attitude and behavior change. The goal of this approach is the prompt achievement of abstinence with relapse prevention. Analyses across studies of the effectiveness of spouse and family involvement in treatment for alcoholism have demonstrated that their inclusion enhances treatment effectiveness.

Early involvement by network supporters helps the alcoholic stay in treatment during the initial phase when they are likely to drop out and also helps to provide a long-term social context that is supportive of abstinence. Net work therapy is useful for those who cannot control their intake of drugs after taking the first dose and those who have experienced relapse in the past, as well as for those who are not willing to stop their drug taking behavior. People with brief history of drug use and those who have not benefited from out patient treatment can be enrolled in net work therapy. Network Therapy has been found a useful psychosocial adjunct for achieving diminished illicit heroin use for patients on buprenorphine maintenance.

Community Reinforcement Approach (CRA)

Community reinforcement approach generally utilizes social, recreational, familial, vocational and other community reinforcers to aid patients in the recovery process. Typical components might include vocational counseling; job finding agencies; recreational counseling and activities; social skills training; social clubs; family/significant other/buddy/sponsor support; contingency management, problem solving, time and money management training; and may include self help groups like Alcoholics Anonymous. The setting of treatment is varied and usually involves contact with patients in natural settings (at home, on the street, drop-in center, detoxification center, etc.). It has been successfully utilized for intervention in the areas of substance use where standard pharmacological intervention is not available or is not required like solvent use, cannabis and cocaine use. It has also been proved to enhance treatment retention and lower drop-out rate among opiate users.

Multi-Systemic Therapy (MST)

Multi-systemic therapy (MST) is an intensive family- and community-based treatment program designed to make positive changes in the various social systems (home, school, community, peer relations) that contribute to the serious antisocial behaviors of children and

adolescents. With roots in social, ecological and family systems theories, MST views youth as embedded within multiple interconnected systems, including the nuclear family, extended family, neighborhood, school, peer culture and community and the risk factors across these systems are identified and addressed in the natural environment. The assumption in MST is that favorable outcomes are more likely to be generalized and sustained when skills are practiced and learned where the youth and family actually live. It seeks to empower parents with the skills and resources needed to independently address the difficulties that arise in raising teenagers and to empower youth to cope with family, peer, school, and neighborhood problems. It places special attention on factors in the adolescent and family's social networks that are linked with antisocial behavior. Therapist teams provide services in the home and school and are available around the clock and provide services at times convenient to the family. Important intervention strategies include strategic family therapy, structural family therapy, behavioral parent training, and cognitive behavior therapies.

Therapy should be able to achieve goals within 4 months on an average. MST, when integrated with contingency management for adolescent substance abuse yields encouraging results. Research findings have provided clear support for the effectiveness of MST in treating adolescent substance use problems. Multi systemic approach has been found to be effective in reducing substance-related arrests.

The Matrix Model

The matrix model is a comprehensive approach which includes a combination of different models used in psychosocial intervention and has been widely used for intervention with stimulant users. The program includes education for family members affected by the addiction. The therapist functions simultaneously as teacher and coach, fostering a positive, encouraging relationship with the patient and using that relationship to reinforce positive behavior change. The interaction between the therapist and the patient is realistic and direct, but not confrontational or parental. Therapists are trained to conduct treatment sessions in a way that promotes the patient's self-esteem, dignity, and self-worth. A positive relationship between patient and therapist is a critical element for patient retention. Treatment materials draw heavily on other tested treatment approaches. This approach includes elements pertaining to the areas of relapse prevention, family and group therapies, drug education, and self-help participation. One of the main concerns of psychosocial treatment of substance use disorder is maintenance of abstinence. Thus it is important to focus on `relapse' and related issues. A number of projects have demonstrated that participants treated with the Matrix Model demonstrate statistically significant reductions in drug and alcohol use, improvements in psychological indicators, and reduced risky sexual behaviors associated with HIV transmission. These reports along with evidence suggesting comparable treatment response for methamphetamine users and cocaine users and demonstrated efficacy in enhancing naltrexone treatment of opiate addicts, provide a body of empirical support for the use of the model.

Self Help Approaches

- Twelve-Step Facilitation Therapy (AA and NA): This therapy assumes alcoholism and substance use as a spiritual and medical disease. The treatment approach facilitates

patients' active participation in the fellowship meetings of Alcoholics Anonymous and Narcotic Anonymous and regards active involvement as the primary factor responsible for sustained sobriety (recovery). Twelve Step Facilitation therapies consist of a brief, structured, and manual-driven approach to facilitate early recovery from alcohol abuse/ alcoholism and other drug abuse/addiction. It is intended to be implemented on an individual basis in 12 to 15 sessions and is based in behavioral, spiritual, and cognitive principles that form the core of 12- step fellowships. It is suitable for those who are alcohol or other drug dependent/problem users. No experimental studies have unequivocally demonstrated the effectiveness of AA or TSF approaches for reducing alcohol dependence or problems.

- Therapeutic Community : Therapeutic Community as a treatment approach is generally addressed for individuals with a low likelihood of benefiting from outpatient treatment, such as those having a history of multiple treatment failures or whose profound impairment in social relational skills or ability to attain and sustain employment impede adherence to outpatient treatment. Rather than viewing substance abuse as an illness (as defined by the disease concept), therapeutic community theory views it as a deviant behavior. Its basic approach is treating the whole person through the use of peer community.

The traditional therapeutic stay of 12 to 18 months has evolved from a planned duration of stay of 2 to 3 years. Recent changes in client population, clinical realities and funding requirements have encouraged the development of modified residential therapeutic communities with shorter duration of stay (3, 6 and 12 months) as well as therapeutic community oriented day treatment models. There is relatively weak evidence regarding the effectiveness of therapeutic communities as the number of treatment completers is low (10% to 25%). However among the completers it has been found to be effective. It can be viewed as an important treatment option for opioid-dependent individuals who will not accept or cannot access opioid agonist maintenance treatment or for individuals dependent on other classes of drugs.

The following table summaries the important psychosocial interventions and indications.

Intervention	**Basic approach**	**Evidence for effectiveness**
Brief Intervention	FRAMES	Harmful users
Motivation Improvement Therapy	Motivational Interviewing	All type of substance users
Relapse Prevention	Cognitive Behavior approach	All substances specially in maintenance program
Network Therapy	Social Networks/social support/ peer support approach	Treatment non seekers and enhancing compliance
Community Reinforcement Approach	Behavioral approach	Adolescent solvent users, cannabis and cocaine users
Multi Systemic Therapy	Social cognitive approach	Adolescent (specially solvent) users
Matrix Model	Combination of Cognitive Behavioral, Empowerment Education, social learning, social net work approaches.	Used in stimulant, alcohol and opiate users
Self Help Approach	Social Networks/ social support/ peer support	Alcohol and opiate users

Principles for Effective Substance Use Disorder Treatment

Inter individual variance has been linked to the efficacy of outcome in substance use disorder treatment. But certain issues have universal applicability and should form the basis for the management plan. The guiding principles for effective intervention according to NIDA (1999) are:

- No single treatment is effective for all individuals: The treatment should be culture and gender specific, and geared towards addressing individualized needs of the patient.
- Treatment must be readily available: Patients entering treatment from waiting lists generally have poorer outcomes.
- Treatment to be effective should attend to the multiple needs of the patient and include case management services: To be effective, treatment must address the individual's drug use and associated medical, psycho- logical, social, vocational, and legal problems.
- Counseling and other behavior treatment are critical components of substance use disorder treatment: The treatment which focuses on motivation, relapse, life style change and problem solving ability yields better outcome results.
- Pharmacological intervention when combined with psychosocial intervention has proved to be more efficacious.
- To be successful, treatments must address aspects of the patient's post-treatment environment and offer a continuum of care.

- Patient's progress in treatment should be closely monitored, particularly substance use and treatment plans modified as needed.
- Treatment does not need to be voluntary to be effective. Patients who enter treatment out of coercion fare equally well in terms of outcome.
- Retention in treatment is positively linked to the outcome. It is fairly established in substance use disorder treatment that the longer the retention in treatment, better the outcome. Research has shown that treatment duration (at least 3 months) is related to better outcome.
- Treatment to be effective should be flexible and strive for quality improvement.
- Complete abstinence from substance use is a long term process and may require multiple episodes of treatment.

Challenges

Nobody can undermine the role of psychosocial interventions in the management of substance use disorder but there are inherent challenges in the effective delivery of these interventions.

1. Poor treatment retention: It is the patient and not the therapist who invariably controls the duration and intensity of treatment because the patient is usually free to drop out at any time or fail to comply with the expectations of their therapists (e.g. keep appointments, take medication, and practice skills). Dropout and non-compliance rates are typically quite high and, in many programs, the amount and duration of treatment actually received by clients are well below the desired intervention.
2. Efficacy is linked with patient characteristics: Many studies have found differences between the intake characteristics of patients who do well or poorly following treatment of various kinds. Better outcomes have been associated with higher education and social class, higher social stability and social support, lower severity of drinking/drug problems, higher motivation, less psychopathology and a variety of specific psychological traits.
3. Personal characteristics of therapist affect the outcome: There are indications that the therapist is a significant factor in determining treatment outcome for psycho-social interventions. The possibility that patients could do better with some therapists than with others makes it difficult to replicate. A consistent finding from literature is that treatment outcomes are best for therapists who have strong interpersonal skills such as "empathy" and "ability, to forge a therapeutic alliance" with clients. This is consistent with the conclusions based on the results of studies of behavioral self-control treatment. It has been concluded that clients seen by therapists with low levels of empathy fare worse than those in self-directed groups, while clients seen by therapists with high levels of empathy do better than in self-directed groups.
4. Matching treatment expectations: What works better for which type of patient is difficult to predict, as individuals approach treatment services and enter treatment programs with

different expectations of what the therapeutic process will entail. The extent of the differences between what the patient expects and what they receive is likely to interfere with progress or reduce treatment adherence. Matching a drug abuse treatment patient with the right type of treatment program is a much-discussed but elusive goal for drug abuse treatment providers. Project MATCH, a large, multi-center study for the treatment of alcoholism that used cognitive-behavioral therapy, motivational enhancement therapy and 12-step methods, found no evidence that matching is a viable treatment strategy. Substance use disorder has been recognized as a multi-dimensional problem which affects an individual's health, psychological and social condition. The effective management of this problem requires modifying all the affected aspects of the individual's life. It has been proven that when used in combination, pharmacological and psychosocial interventions are complimentary to each other and are more effective than either alone. Psychosocial intervention has been used as a stand alone intervention for problematic substance use and in management of abuse of certain substances where scientifically established pharmacotherapy is not yet available. The specific approach is also related to one's theoretical orientation skills and resources available. Certain approaches are specific to certain groups, for e.g. brief intervention for harmful and hazardous alcohol users, multi-systemic approach for adolescents and net work therapy for patient/ individuals who are poorly motivated to seek treatment. Certain approaches are also specific to certain phases of treatment. Overall, both patient and therapist variables are important in determining the success of a particular intervention.

Suggested Reading:

1. Babor, T.F. and Higgins-Biddle, J.C. (2001) Brief Intervention for Hazardous and Harmful Drinking: A Manual for use in Primary Care. World Health Organization, Document No. WHO/MSD/MSB/ 01.6b.
2. Beckman, L.J. (1980) An attributional analysis of Alcoholics Anonymous. Journal of Studies on Alcohol, 41:714-726.
3. Borduin, C. M., Mann, B. J., Cone, L. T., Henggeler, S. W., Fucci, B. R., Blaske, D. M., & Williams, R. A. (1995). Multi-systemic treatment of serious juvenile offenders: Long-term prevention of criminality and violence. Journal of Consulting and Clinical Psychology, 63:569-578.
4. Brown, T. L., Henggeler, S. W., Schoenwald, S. K., Brondino, M. J., & Pickrel, S. G. (1999) Multi-systemic treatment of substance abusing and dependent juvenile delinquents: Effects on school attendance at post treatment and 6-month follow-up. Children's Services: Social Policy, Research, and Practice, 2:81-93.
5. Burke, B.L., Arkowitz, H., Menchola, M. (2003) The efficacy of motivational interviewing: a meta-analysis of controlled clinical trials. Journal of Consulting and Clinical Psychology, 71(5), 843–861.
6. Condelli, W.S. and Hubbard, R.L. (1994) Relationship between times spent in treatment and client outcomes from therapeutic communities. Journal of Substance Abuse Treatment, 11:25-33.
7. Deas, D. and Thomas, S.E. (2001) An overview of controlled studies of adolescent substance abuse treatment. American Journal of Addiction, 10(2):178-89.

8. Donovan, J.M. (1986) An etiologic model of alcoholism. American Journal of Psychiatry, 143(1):1-11.

9. DeLeon, G: (1994) The therapeutic community: toward a general theory and model. Therapeutic Community: Advances in Research and Application (NIDA Res Monogr No 144). 16-53.

10. De Leon, G. (2000) The Therapeutic Community: Theory, Model, and Method. New York: Springer Publishing Company.

11. Ferri M., Amato, L. Davoli, M. (2006) Alcoholics Anonymous and other 12-step programmes for alcohol dependence. Cochrane Database Syst. Rev, Jul 19; 3: CD005032.

12. Galanter, M. and Kleber, H.D, eds. (2004) The American Psychiatric Publishing Textbook of Textbook of Substance Abuse Treatment.3rd ed. American Psychiatric Publishing Inc. Washington, DC.

13. Galanter, M., Dermatis, H., Glickman, L., Maslansky, R., Sellers, M., Neumann, E., and Rahman-Dujarric, C. (2004) Journal of Substance Abuse Treatment, 26(4): 313-318.

14. Higgins, S.T., Budney, A.J., Bickel, W.K., and Badger, G.J. (1994) Participation of significant others in outpatient behavioral treatment predicts greater cocaine abstinence. American Journal of Drug and Alcohol Abuse, 20(1): 47 - 56.

15. Lee Gartner and David Mee- Lee, eds (1994) The Role and Current Status of Patient Placement Criteria In the Treatment of Substance Use Disorders, Treatment Improvement protocol series(13) , Substance Abuse and Mental Health Services Administration (SAMHSA) .

16. McGovern, M.P, Bonnie, R., Wrisley, B.A. and Robert, E., Drake. (2005) Special Section on Relapse Prevention: Relapse of Substance Use Disorder and Its Prevention among Persons with Co-occurring Disorders Psychiatric Services 56:1270-1273, October, American Psychiatric Association.

17. Marlatt, G. A., Gordon, J. R. (1985) Relapse Prevention. New York: Guilford Press.

18. Mayet, S., Farrell, M., Ferri, M., Amato, L., Davoli, M. (2004) Psychosocial treatment for opiate abuse and dependence. The Cochrane Database of Systematic Reviews 2004, Issue 4. Art. No.: CD004330. DOI: 10.1002/14651858. CD004330.pub2.

19. McLellan, A.T, Arndt, I., Metzger, D., Woody, G., O'Brien, C. (1993) The effects of psychosocial services in substance abuse treatment. Journal of the American Medical Association, 269, 1953-1959.

20. Miller, W.R., Zweben, A., DiClemente, C.C. & Rychtarik, R.G. (1994) Motivational enhancement therapy manual: NIH Publication No. 94-3723. Rockville, MD: NIAAA.

21. Miller, J.M. Brown, T.L. Simpson, N.S., Handmaker, T.H., Bien, L.F., Luckie, H.A., Montgomery, R.K., Hester, J.S., Tonigan. (1995) What works? A methodological analysis of the alcohol treatment outcome literature. In: Handbook of alcoholism treatment approaches. R.K. Hester and W.R. Miller (eds). Needham Heights: Allyn and Bacon. p. 12–44.

22. Najavits, L.M., Weiss, R.D. (1994) Variations in therapist effectiveness in the treatment of patients with substance use disorders: An empirical review. Addiction, 89:679-688.

23. National Institute on Drug Abuse. (1999). Principles of drug addiction treatment: A research-based guide. NIH Publication No. 99-4180.

24. Ogborne, A.C. (1978) Patient characteristics as predictors of treatment outcome for alcohol and drug abusers. In Y. Israel et al. (eds.) Research Advances in Alcohol and Drug Abuse. Vol. 4. New York: Plenum Press.

25. Pal, H., Yadav, D., Jha, A.K. (2003) Brief Intervention: A manual for Practice: National Drug Dependence Treatment Centre, All India Institute of Medical Sciences.

26. Parks, G. A. and Marlatt, G. A. (1999) Relapse Prevention Therapy for Substance-Abusing Offenders: A Cognitive-Behavioral Approach in What Works: Strategic Solutions: The International Community Corrections Association Examines Substance Abuse edited by E. Latessa. Lanham, MD: American Correctional Association, p. 161- 233.

27. Project MATCH Research Group: (1997) Matching alcoholism treatments to client heterogeneity: post treatment drinking outcomes. Journal of Studies on Alcohol 58:7-29.

28. Roberts, G., and Ogborne, A. (1999) Best practices: substance abuse treatment and rehabilitation, Office of alcohol, drugs and dependency issues. Health Canada, http://www.hc-sc.gc.ca/hppb/alcohol-otherdrugs.

29. Robert J. Meyers and Daniel D. Squires. (2003) The Community Reinforcement approach A Guideline developed for the Behavioral Health Recovery Management project, University of New Mexico Center on Alcoholism, Substance Abuse and Addictions Albuquerque, New Mexico.

30. Roozen, H. G., Boulogne, J. J., van Tulder, M. W., van den Brink, W., De Jong, C. A., & Kerkhof., A. J. (2004) A systematic review of the effectiveness of the community reinforcement approach in alcohol, cocaine and opioid addiction. Drug & Alcohol Dependence, 74(1):1-13.

3

A Model of Brief Intervention

Anil Malhotra, Sameer Malhotra*

Introduction

Substance (tobacco, alcohol and illicit drug) abuse is a major problem worldwide and India is no exception. Substance abuse is associated with significant morbidity and mortality and contributes to global burden of all disease. It has significant impact not only on the individual sufferer, but also on the family and the society.

On one hand, there are challenges in dealing with the problem of substance use viz., low motivation and awareness on the part of the user, poor help-seeking and high relapse rates despite attempts to quit; and on the other hand, there are limited resources, especially in the developing world, to effectively deal with this major issue.

Against this backdrop, brief interventions in substance abuse provide a viable option in the form of cost-effective and time-efficient psycho-social strategies that aim at reduction of substance use and/or harm related to substance use. They are grounded in the scientific principles of harm reduction, stages of change, motivational interviewing and feasibility of community-level delivery.

Theoretical outline of the concept:

In the context of psychoactive substance abuse, brief interventions can be defined as a group of strategies which aim at reduction of substance use *(demand reduction)* and/or harm related to substances *(harm minimization)*, in a cost-effective and time-efficient manner, by imparting brief or minimal advice/counseling to the users of alcohol, tobacco or other drugs.

Screening and brief interventions aim to identify current or potential problems with substance use and motivate those at risk to change their substance use behavior.

It must be borne in mind that brief interventions are not intended to treat people with serious forms of substance dependence. For the latter, extended or intensive interventions for treatment by experts are used, which extend from months to years and consist of relapse prevention strategies conducted in inpatient or

* Anil Malhotra, PhD, Professor of Clinical Psychology, De-Addiction Centre, Post Graduate Institute of Medical Education and Research, Chandigarh.

* Sameer Malhotra MD, MNAMS, Sr. Consultant Psychiatrist, New Delhi.

outpatient settings e.g. coping skills therapy, cue extinction, contingency contract, recovery training and self help, etc.

Certain studies have compared effectiveness of brief interventions with extended counseling, and found the former to compare quite favourably with the latter, particularly in subjects with mild problems of substance (alcohol) dependence. However one must bear in mind the level of drug dependence and associated complications; and should not conclude that brief interventions are as effective as extended counseling for severe dependence.

There is strong evidence for effectiveness of brief interventions in primary care settings for alcohol and tobacco abuse, and growing evidence for effectiveness for abuse of other substances. Research also suggests an effective and feasible role of culturally appropriate brief interventions in primary care settings for substance use other than alcohol. Studies supporting effective role of brief interventions are available regarding cannabis, benzodiazepines, amphetamines, opiates and cocaine.

India, with a large population size and prevalent primary health care infrastructure, presents a fertile ground for application of these strategies. PHC doctors and health care professionals could be sensitized and trained in this direction to initiate the process (through assessment and brief intervention) and appropriate referral of clients to treatment agencies.

Actual Intervention

Brief interventions do not consist of a single technique or strategy; rather, they consist of a heterogeneous group of strategies (e.g. simple advice of 5 minutes, counseling session of 15-30 minutes, providing just self-help manual, etc.). They share certain similarities like: (i) brevity (less than 6 hours of contact and often 1-4 hours only; even 5-minutes of sensitively handled advice can be useful), (ii) relatively less professional expertise required and feasibility of training primary health physicians to deliver this service and (iii) goals and targets in terms of reduction of harm related to the substance use (and not only the use of substance).

Primary health physicians, with appropriate training and skills, can be helpful in delivering community based brief interventions. The patients/clients suited for this type of intervention include the ones with early stage or mild/moderate level of substance use in the community, those with inadequate awareness of the potential/actual gravity of the substance use problem, those with physical complications presenting in general medical practice.

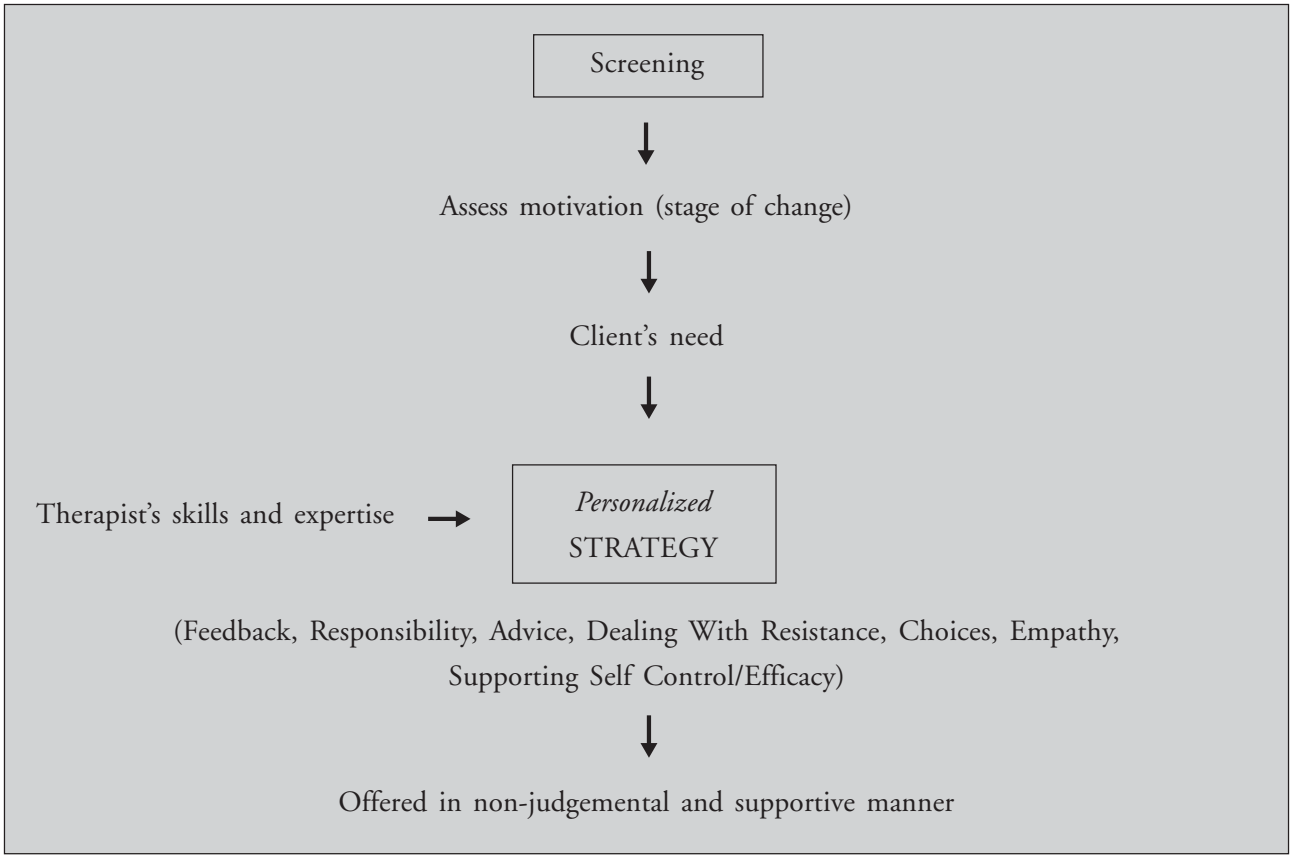
Basic scheme of community based brief interventions involves the steps of:

i) Identification (screening through proper medical history, use of simple screening instruments/ questionnaires, simple feasible laboratory tests, obtaining medical history): Screening helps in providing personal feedback about the substance use related risks to individuals with potentially harmful/harmful substance use, which can prompt them to consider changing

their substance use behaviour. It also aids the therapist/professional in devising an appropriate need based intervention.

ii) Intervention: Different sub-settings and interventions can be utilized within community based brief interventions. These include primary health centre (PHC) level, general hospital wards, community health programmes, media promoted programmes, and even counseling merely aimed at referral to the site of intervention etc.

Figure 1: Scheme of Community Based Interventions



Brief assessment screening helps to understand the client's drug/substance use pattern and circumstances, associated risk behaviours, existing or potential harmful effects, subject's awareness of such issues and his/her motivation for change.

Through screening, people with potential or actual substance related health problems are identified. Screening procedures involve the use of short, quick and easy instruments/questionnaires as well as certain feasible laboratory tests [for eg. Liver Function Test and Mean Corpuscular Volume (MCV) for alcohol dependent patients]. Some of the examples of screening instruments include:

CAGE Questionnaire: widely used brief and straightforward instrument for screening alcohol abuse. It includes 4 questions pertaining to:

'C' (*cut down*): feeling the need to cut down on one's drinking,

'A' (*annoyanc*e): being annoyed by people's criticizing one's drinking behaviour,

'G' (*guilt*): ever having felt bad or guilty about one's drinking, and

'E' (*eye opener*): ever having had a drink first thing in the morning to steady one's nerves or to get rid of a hangover. It was considered by the developer of the instrument that if 2 or more apply in an individual's case, it suggests alcohol abuse.

MAST (Michigan Alcoholism Screening Test): screening instrument to identify alcohol use disorders and alcohol-related disabilities. Original list comprises of 25 true or false questions. Briefer versions of MAST are also available.

FTND: Fagerström Test for Nicotine Dependence. Permits assessment of the degree of dependence based on 6 questions, with scores >7 being associated with very high dependence.

ASSIST (the Alcohol, Smoking and Substance Involvement Screening Test) developed by the WHO to identify persons with hazardous or harmful use of a range of psychoactive substances. It consists of 8 questions and provides information on the individual's use of substance(s) during lifetime and over the last 3 months, substance use related problems, risk of current or future harm, dependence and injecting drug use. The specific substance involvement scores (low/moderate/high risk in relation to alcohol and all other substances) can then be linked to an appropriate intervention for each patient.

Assessing the Readiness to Change:

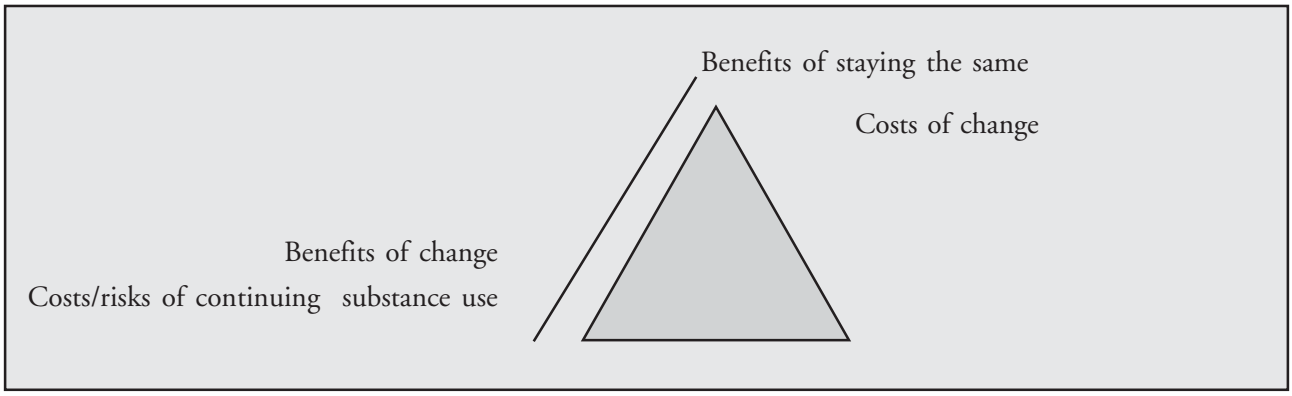
The model for stages of behavioural change developed by Prochaska & DiClemente (1986) can be utilized in understanding how people change their behaviour and in assessing the individual's readiness to change a particular behaviour. This model, which describes the natural processes by which people change with (out) treatment, could be utilized across diverse problems include substance use or other lifestyle behaviours, wherein a change in behaviour or attitude needs to be addressed.

The model includes the following stages of change:

- *Precontemplation* : when one is not really thinking about changing. An individual substance user is likely to be in this stage if, for e.g. one is happily continuing with substance use without any worries about its use, does not want to change substance use behaviour, is unaware or unwilling to accept that the risks/potential risks/problems of his/her substance use, or believes that advantages from substance use outweigh its disadvantages. It suggests that the individual is not intending to change his/her drug using behaviour in the foreseeable future and is therefore unlikely to respond to advice to change one's behaviour. Nevertheless, one may be receptive to information regarding the risks associated with pattern/level of substance use, which may in turn aid in recognizing the risks associated with substance use and in thinking about at least cutting down one's use.

- *Contemplation*: when a person is thinking about reducing or stopping substance (drug) use. This is the stage in which one has started considering pros (good things) and cons (not so good things) of continuing substance use vis-à-vis discontinuing/reducing it with resulting ambivalence about one's drug use. The person has some awareness of the problems associated with drug use (please refer to figure 2). He/she may be willing to make a change but may not know how to make the change or may not be confident about one's ability to change. One may intend a change in the next 6 months, for example. The therapist's role in this stage is of paramount importance and consists of tilting the balance towards the side of early change of behaviour, thereby taking the individual (substance user) into the next stage of change. Interventions in this stage focus on providing information about substance related risks, advice to reduce/stop substance use, and helping the individual to talk about the good and not so good things about their current substance use pattern. The individual can be encouraged to find and talk about his/her own reasons to reduce/quit substance use. The substance user (patient) in this stage could be encouraged to visualize his/her ambivalence about substance use as a balance with reasons for maintaining the same pattern/use of substance use on one side and reasons for change on the other. The patient could also be encouraged and helped in drawing a table listing the short and long term benefits and costs of continued substance use. The individual may help in recognizing their strengths and ability to change. The therapist may also be suggested a range of strategies to choose from, to help in the process of changing the substance use behaviour.

Figure 2: Decision Balance



(adapted from WHO: Brief intervention for problematic substance use: guidelines for use in Primary Care, 2003)

- *Determination/Preparation*: when the person has resolved the ambivalence and is ready to participate in action-oriented intervention. During this stage one also makes a choice from the available options and finalizes a concrete plan of action.
- *Action:* when one takes overt behavioural steps towards changing (reducing/stopping) the drug use behaviour; for example, coming to therapist for counseling sessions, completing home assignments, and reducing/stopping substance use. Individuals may benefit from continued encouragement and support to maintain their decision. Interventions in this

stage would include negotiating aims and goals for changing risky substance use behaviours together, suggesting a menu of options to choose from, helping them to identify situations and states likely to trigger/precipitate relapse, and discussing with the patient their plan for action to reduce/stop substance use.

- *Maintenance:* After the period of intensive therapy in the action stage is over, some milder amount of action is continuously required to maintain the changed behaviour; otherwise there is a risk of relapse to previous maladaptive behaviour.
- Either *Termination or relapse*: Successful observance of maintenance leads to recovery when the actions/efforts can be terminated altogether. Failure of maintenance phase leads to relapse. The therapist should bear in mind that relapses are common and should not get disheartened from the same. In fact the therapist should be prepared to deal with relapses and encourage the client/patient to prevent and effectively deal with the same.

The substance user needs to be ready, willing and able to change, in order to actually change one's substance use behaviour. Importance and confidence are addressed in interventions to encourage patients to change their behaviour. Visual analogues or rulers can be used to somewhat quantify the readiness and confidence levels separately.

The *intervention* is based on the information derived from screening and assessment methods as discussed above.

The components of the intervention could be understood through the principles underlying brief interventions.

The acronyms FRAMES and DARES (motivational interviewing) have been used to understand these principles.

FRAMES:

F: *Feedback*: Following an appropriate assessment (as mentioned above), feedback is provided to the subject on his/her pattern/level of substance use, existing or potential harmful effects, awareness of these issues along with certain laboratory parameters (e.g. Blood test for liver enzymes including GGT for alcohol users, urine screen for opiates), keeping in mind his/her motivation to change. Feedback may also include a comparison between the patient's substance use patterns/problems and the prevailing patterns and problems experienced by other similar people in the population.

R: *Responsibility*: An emphasis is laid upon the person that to think and decide about the need for change in substance use is solely the individual's personal responsibility.

A: *Advice*: Based on the assessment, the physician or the therapist gives a direct professional opinion or clear advice to the person regarding the harms associated with continued substance use to make changes in substance use in the direction of a specified goal e.g., 'moderation' or 'quitting'.

M: *Menu:* The subject is provided information regarding an array of options or a menu of the various alternative ways/strategies to reduce/stop substance use. Providing choices reinforces the sense of personal control and responsibility for making the change and can thereby help in strengthening the motivation to change. For example, keeping a diary for substance use (mentioning details viz., where, when, amount, with whom, why); helping patients to prepare substance use guidelines for themselves; identifying relapse precipitants-high risk situations and strategies to avoid them; providing information on self help resources and written information, reading pamphlets; attending counseling session(s) and follow up; identifying healthy enjoyable activities and life style changes that could replace drug use viz., hobbies, exercises, sports, spending time with family and visiting sober friends; providing information on specialized treatment centres or professionals; putting aside the money they would usually spend on drug use for something which is constructive, healthy and satisfying.

E: *Empathy*: The therapeutic style of warm, reflective listening and an understanding approach is an important component of effective brief intervention. The therapist communicates respect to the client, encourages exploration, reinforces the adaptive statements made by the client and avoids confrontation to prevent resistance.

S: *Self-efficacy*: The therapist endeavours to booster client's sense of self-efficacy or optimism or perceived control and confidence. This is in absolute contrast to the philosophy of 'powerlessness' promoted by fellowship groups like Alcoholics Anonymous. It is considered particularly helpful to elicit self efficacy statements from patients as they are likely to believe what they hear themselves say.

When a therapist imparts brief intervention to a given client, all the above mentioned elements need not be compulsorily present. Any one or more of these may need to be employed depending on the client's needs as well as the therapist's expertise and skills *(also refer to figure 1)*.

Motivational Interviewing (Miller and Rollnick, 1991): is a directive, client centred style of interaction focused at helping the client to explore and resolve the ambivalence about one's substance use and thereby move through the stages of change. There are five principles which guide the practice of motivational interviewing (*acronym DARES*). These include:

D: Develop discrepancy

A: Avoid argumentation

R: Roll with resistance

E: Express empathy

S: Support Self-efficacy

The practical strategy of motivational interviewing using the DARES approach is discussed in the next chapter.

Skills Required for Intervention

The skills required on the part of the therapist include:

- Empathy, patience, ability to understand drug/substance use problem from medical, psychological and social perspectives.
- Ability to identify and assess the level and pattern of substance use problem and the subject's/ client's readiness to change/stage of change. This includes knowledge and ability to use screening instruments.
- Ability to sensitively, sensibly and tactfully address the issue, linking screening to appropriate interventions.
- Ability to deal with resistance: through reflective listening, non-confrontational approach, roll with resistance and other elements mentioned above as the principles underlying brief interventions.
- Ability to rationally understand the scope of brief interventions and need-based appropriate referral of cases to appropriate agencies.

Greeting, listening, conversational and negotiating skills (to change risky drug use practices) are useful in the process. Avoid the use of labels viz., 'alcoholic', 'drug addict', criticism and blame.

Empathic communication and encouraging stance supporting self confidence and efficacy are important common elements of FRAMES and DARES.

'Open ended questions', 'affirmation', 'reflective listening', 'summarizing' (OARS) and 'eliciting change talk' are the 5 specific skills used in motivational interviewing. 'Eliciting change talk' involves the use of OARS to guide the client in presenting arguments and rationale for changing one's substance use behaviour.

Open ended questions provide a scope for the client to speak and put forth his/her perspective in greater detail. It aids in building communication with the client and providing insights into the client's perspective. For eg. the client can be asked about the benefits that one derives from one's substance use and also about one's concerns about one's substance use, encouraging the client to speak and present one's perspective. Other questions viz., 'how do you feel about your substance use' 'what would you like to do about it' 'what do you know about it' can be asked.

Affirmation includes statements suggesting appreciation and attempts at understanding the client's problems and perspectives, helps in establishing rapport. For example, statements from the therapist appreciating the client's strengths and efforts to change (viz., congratulating the client for making a visit, appreciating the efforts to speak about one's substance use, affirmation of self motivating statements), help in building confidence and boosting readiness to change.

Reflective listening involves the use of statements by the therapist reflecting the client's underlying meanings and feelings as well as the words used by the client. It reflects an attempt of the therapist to

understand the client's problems and perspectives, and thereby conveys that the therapist understands what is being said and can also be used to clarify what the client means. It can be used to emphasize ambivalence about one's substance use behaviour, to encourage greater recognition of one's problems and concerns, and to reinforce statements that indicate the client is thinking about change.

Summarizing provides an important way of putting together and conveying what has been said during the discussion and prepares the client to consider a change. It enhances the power of reflective listening. It also provides a scope of choice to the therapist with regards to inclusion and emphasis on certain issues over others.

Eliciting change talk: helps in resolving ambivalence and helps in enabling the client (patient) to present arguments for change. It involves recognizing the disadvantages of staying the same, recognizing the advantages of change, expressing optimism about change and expressing the intent to change. Clients/patients are encouraged for clarifications and elaborations regarding their statements and their goals and values are explored to find the discrepancies between their values and current substance use.

Steps in the Intervention:

Assessment (screening) and intervention are two important steps in brief intervention for substance use.

Awareness and knowledge about other services and networking with such services/agencies can help to strengthen the intervention. Networking with services providing social and moral support and job opportunities to clients and their families; with treatment facilities addressing physical complications; with de-addiction centres, psychiatrists and experts in the field of substance abuse treatment; with financial support and legal support providing agencies are useful. Role of health and social care agencies as well as media is also important.

Linking screening to appropriate interventions:

Gravity of substance use problems and the stage of change help in determining the choice of strategy. Those with low risk range of substance use behaviours, could be helped through brief feedback and offered information. Manuals, self-help guides, pamphlets are also helpful. The ones with moderate risk could be helped through a realistic feedback (including their test results) and brief intervention including elements of feedback, responsibility and clear advice. Feedback through brief interventions in those at high risk (including frequent injecting drug use), opens the door for more intensive treatment.

Problems and Challenges that one may face during Intervention:

Resistance to change one's substance use behaviour despite the underlying risks, low and/ fluctuating motivation, poor awareness and inadequate help-seeking, negative/biased views and relapse to previous patterns of substance use are some of the common challenges. Client's resistance can be approached through a non-confrontational, skillful and empathic approach. Therapist's knowledge and understanding of substance use behaviors, the cycle of change and associated challenges can help in better preparation, anticipation and

skillful approach. Those with severe substance use problems and associated complex issues should be appropriately referred to specialists and specialized centres.

Understanding the limitations of brief interventions is quite important. Brief interventions provide useful tools to initiate a process of positive change in substance use behaviors and address some of the problems of substance use, but should not be viewed as complete holistic solutions/remedies or replacements for extended and intensive treatments through specialized experts and treatment agencies.

Summary:

Brief interventions seem to be cost effective and time efficient modalities of psychosocial interventions with feasibility of community level delivery, aimed at identifying current or potential problems with substance use and to motivate the ones at risk to change their substance use behaviour. It helps in providing a realistic feedback correcting the misconceptions regarding substance use, feedback regarding the associated potential/ actual harms/risks and their management, encourages client's (patient's) participation, motivation and optimism and helps in the process of change in substance use behaviour. In the process, the substance using client (patient) gets some insights into his/her current condition and the alternatives in hand which include harm minimization, demand reduction or abstinence from substance use, focusing on overall improvement in quality of life. An empathic, non-judgemental, non-argumentative, non-threatening and reflective approach is utilized in the process of screening and intervention. Statements and resistance from the client (patient) are handled sensitively and sensibly in a non-confrontational skillful manner encouraging motivation towards changing substance use behaviour. Even a single brief session may act as an eye opener and motivation enhancer. Brief interventions should not be viewed as complete solutions to the substance use problem and are not adequate enough to handle complex issues and severe dependence problems. Brief interventions provide a method of health promotion and disease prevention with primary care patients/clients.

Suggested Reading:

1. Babor, T.F. & Higgins-Biddle, J.C. (2001) Brief Intervention for Hazardous and Harmful Drinking: A Manual for use in Primary Care. World Health Organisation, Document No WHO/MSD/MSB01.6b
2. Baker, A., Boggs, T. G. & Lewin, T. J. (2001) Randomised controlled trial of brief cognitive–behavioural interventions among regular users of amphetamine. Addiction, 96:1279-1287.
3. Bashir, K., Kingh, M. & Ashworth, M. (1994) Controlled evaluation for brief intervention by general practitioners to reduce chronic use of benzodiazepines. British Journal of General Practice, 44:408-412.
4. Bien, T.H., Miller, W.R. & Tonigan, S. (1993) Brief intervention for alcohol problems: A Review. Addiction, 88:315-336.
5. Copeland, J., Swift, W., Roffman, R. & Stephens, R. (2001) A randomized controlled trial of brief cognitive–behavioural interventions for cannabis use disorder. Journal of Substance Abuse Treatment, 21: 55-64.
6. Cordoba, R., Delgado, M. T., Pico, V., Altisent, R., Fores, D., Monreal, A., Frisas, O. & Lopez del Val, A. (1998) Effectiveness of brief intervention on non dependent alcohol drinkers (EBIAL): a Spanish multi-center study. Family Practice,15(6): 562-588.

7. Heather, N. (1996) The Public Health and Brief intervention for excessive alcohol consumption: the British experience. Addictive Behaviours, 21: 857-868.

8. Lang, E., Engelader, M. & Brook, T. (2000) Report of an integrated brief intervention with self defined problem cannabis users: Journal of Substance Abuse Treatment, 19:111-116.

9. Maisto, S. E., Conigliaro, J., McNeil, M., Kraemer, K., Conigliaro, R.L. & Kelley, M.E. (2001) Effects of two types of brief intervention and readiness to change on alcohol use in hazardous drinkers. Journal of Studies on Alcohol, 62(5): 605-614.

10. Malhotra, A., Malhotra, S. (1997) Relapse prevention in substance abuse: Concept of relapse-I. Indian Journal of Social Psychiatry, 13:83-85.

11. Malhotra, A., Malhotra, S. (1997) Relapse prevention: Strategies II. Indian Journal of Social Psychiatry, 13: 85-92.

12. Malhotra, A., Malhotra, S., Basu, D. (2001) Relapse prevention: Social and cognitive approach. Bengal Journal of Psychiatry , 10: 79-87.

13. Malhotra, A., Malhotra S. (2003) Psychosocial interventions in the management of substance use disorder. Indian Journal of Clinical Psychology, 30(1-2): 13-23.

14. Malhotra, S. (2004) Tobacco use among drug dependent patients in treatment setting. In: Proceedings of the workshop on assessment of role of tobacco as a gateway substance and information available on evidence relating to tobacco, alcohol and other forms of substance abuse (sponsored by WHO, India and Ministry of Health and Family Welfare, Govt. of India) (A Dhawan ed), pp. 50-57, New Delhi: Centre for Behavioral Sciences, All India Institute of Medical Sciences.

15. Malhotra ,S., Dhawan A., Prakash B. (2002) Social support in treatment seeking heroin-dependent and alcohol-dependent patients. Indian Journal of Medical Sciences, 56: 602-606.

16. Malhotra, S, Malhotra, S., Basu, D. (2002) Help-seeking in relapsed alcohol dependent patients: triggers and barriers. Indian Journal of Social Psychiatry, 18:17-28.

17. Miller, W.R. & Wilbourne, P.L. (2002) Mesa Grande: a methodological analysis of clinical trials of treatments for alcohol use disorders (review). Addiction, 97 (3): 265-277.

18. Miller, W., Rollnick, S. (2002) Motivational interviewing. 2nd Edition. Guilford Press: New York and London.

19. Prochaska, J.A., DiClemente, C.C. & Norcross, J.C. (1992) In search of how people change. Applications to addictive behaviour. Am. Psych.47: 1102-1114.

20. Saunders, B., Wilkinson, C. & Phillips, M. (1995) The impact of a brief motivational intervention with opiate users attending a methadone programme. Addiction, 90: 415-424.

21. Senft, R.A., Polen, M.R., Freeborn, D.K. & Hollis, J.F. (1997) Brief intervention in a primary care setting for hazardous drinkers. American Journal of Preventive Medicine, 13 (6): 464-470.

22. Stephens, R.S., Roffman, R.A & Curtin, L. (2000) Comparison of extended versus brief treatments for marijuana use. Journal of Consulting and Clinical Psychology, 68(5): 898-908.

23. WHO Brief Intervention Study Group. (1996) A randomized cross – national clinical trial of brief interventions with heavy drinkers. American Journal of Public Health, 86(7): 948-955.

24. WHO ASSIST Working Group. (2002) The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): Development, reliability and feasibility. Addiction, 97: 1183-1194.

25. World Health Organization. (2002) The world Health Report 2002. Reducing risks, promoting healthy life. WHO. Geneva.

4

Enhancing Motivation To Change: Steps In Practice

Vivek Benegal, S.Bala Shanthi Nikketha*

Example 1:

X is a 20 yr old student who has been smoking cannabis for the last three years. His grades at college have been dropping. His parents have observed him to be distracted and isolated. He has been brought to you and his response to seeking help is as follows:

"I don't have a problem. I'm fine. Difficulties at college have nothing to do with cannabis. Smoking cannabis will not cause harm. It's a herb. Come on, all of them do it and it helps me to play music and paint."

Example 2:

Y is a 35 yr old gentleman who has been dependent on alcohol for the last 10 years. He has been referred to you for management of alcohol dependence. When you start discussing relapse prevention strategies, his response is as follows:

"I will not touch alcohol hereafter. After all this trouble, you think I will go back to that hell. There is no need for this discussion. When I say I have made up my mind, I will certainly quit alcohol. My will power is very strong. Alcohol is a public health problem. I'm sure you would have seen a lot of people getting addicted to it, so why can't the government ban it? There is a bar in every street and this will make people drink."

Introduction

Motivating people to change from using alcohol and drugs to quitting is a challenging task. A perceived absence of this desire to change and frequent lapses can often be a source of frustration for those trying to help persons with substance use disorders. The current chapter is an attempt to sensitize the readers to the concept of motivation enhancement therapy and provide some handy tips to facilitate the process of change.

Research on substance dependence treatment has consistently shown that brief and timely interventions are more effective than long-term intensive therapies. Similarly clinical trials have demonstrated that brief interventions containing some core concepts of change are effective when compared to the absence of treatment. Therapeutic interventions comprising of some or all of the motivational elements have lead to better

* Vivek Benegal MD, DPM, Associate Professor, Department of Psychiatry, NIMHANS, Bangalore.

* S.Bala Shanthi Nikketha MPhil (PSW), Psychiatric Social Worker, Deaddiction Centre, NIMHANS, Bangalore.

involvement in treatment and reduction of drug related problems among substance users. Motivation enhancement therapy is employed as an adjunct to other forms of psychosocial and pharmacological interventions among substance users.

Understanding motivation:

Motivation in the past was commonly understood as the client trait, or a state with which one seeks help. Poor motivation was perceived as part of denial attributed to the nature of the person's illness (substance dependence) and also his/ her personality type. However there has been a shift in understanding motivation. The factors that contributed to this shift include the finding that all substance users do not strictly fall into certain personality types. Defense mechanisms like denial are employed by both substance users as well as non-users. It was also observed that not all people who have a problem with alcohol and drugs reach an ultimate phase of helplessness and loss; many of them opt for recovery and abstinence midway through. The decision to change from a user to a non-user is influenced by significant life events. This realization further threw light on the impact of one's external environment on his/ her desire to change. Motivation was viewed as an interplay between a person and his/her environment. Several aspects of a person's environment is said to mediate his need for change. Research on therapist effects has also shown that therapist characteristics contribute a great deal to dropout from treatment, conventionally regarded as a common index of motivation.

Thus, motivation can be induced and influenced. Motivation is recognized as the result of an interaction between the substance user and those around him/her. This means there are things a therapist can do to increase motivation for change.

Motivation, then, can be understood not as something one has, but rather as something one does. It involves recognizing a problem, searching for a way to change, and then beginning, continuing and complying with that change strategy.

What is Motivation Enhancement Therapy?

Motivation Enhancement Therapy (MET) is a systematic approach to evoke change in individuals. It is based on motivational psychology. The intervention is designed to produce internally motivated change through mobilizing the substance users internal resources favoring change. Thus the intervention is brief and best used during the client's first contact although repeating it during subsequent sessions may prove beneficial. It is particularly useful when contact with the client is limited to one or few sessions. Treatment outcome research supports MET strategies as effective in producing change in problem drinkers.

Initial responses of persons not ready to change:

"Drinking alcohol is not my problem."

"Cannabis is a herb so smoking ganja is good, I will not stop using."

"I drink because I have aches and pains after a hard day's work."

"I'm different from others so I fix brown sugar; I cannot stop using."

"Why should I stop?"

These would be few common responses to the idea of abstinence or quitting one's drug of choice. Despite patient listening and repeated advice you may find that substance users are determined not to change. Acknowledging the presence of a drug related problem would be the first step in building motivation. You need to help your client take this first step.

Why people do not change and what makes them change?

Familiarizing yourself with the basics of the change process becomes a prerequisite for you to help the client take his/ her first step. When change is suggested most of us feel afraid of it, we get confused and overwhelmed or stop thinking of it and discard the idea. This happens due to the lack of proper analysis of the change. We fail to consider all aspects of the proposed idea. Substance users are no exception to this. They tend to get confused and the result is their resistance to help seeking, and denial of the problem. The following are a few factors that operate behind a person when he/she considers change.

"Do I need to change?"

When a person views a significant difference between all his current problems due to substance intake and a possibility in redressal of these problems when he quits.

"Is this change possible?"

When the same person perceives that giving up alcohol will be beneficial and he is capable of doing it within a stipulated time.

"Can I do it?"

The sense of ability to actually take actions to stop drinking alcohol.

"I want to stop drinking."

Does the person say things about his desire to stop taking alcohol.

Why is it easier for some people to change when compared to others? / When do people change?

Motivation enhancement therapy extensively supports the *Stages of change: Transtheoretical model.* The stages of this model were discussed in the previous chapter. We provide here practical approaches that can be followed in each of these stages.

Stage of the cycle	What will help	What can you do
Precontemplation: People do not consider change. They let their drinking behaviour persist.	Information about the client and the problem. Help the client ventilate feelings about the problem. Impact of the problem on people around.	Avoid confrontation. Educate about alcohol and drugs; focus on rapport building. Encourage and appreciate any expression of the desire to quit alcohol.
Contemplation: Acknowledges that there is a problem. Considering costs and benefits of changing the drug taking behaviour	Assessment of the client's feelings and cognition about his/her drinking / drug use behaviour.	Facilitate the analysis of pros and cons. Help in realistic appraisal of the good and bad things about doing drugs/ alcohol.
Determination/ Preparation: Making decision to quit drug/ alcohol and do something to it.	Choosing to give up drugs and committing to specific goals	Reaffirm person's ability to make the change.
Action: Takes action to stop the drinking behaviour.	Achieving the goals by taking concrete steps.	Help him/her lay a definite plan of action
Maintenance: Sustains the modified behaviour of drug free living	Continuing to take the steps and strengthening commitment to give up alcohol.	Try to involve a significant other.

As you may observe the motivation cycle begins with pre contemplation and terminates in the maintenance phase. Some of your clients will find it easy to move ahead through these stages when compared to others. The ability of a person to pass from one step to another or, in other words, readiness to change depends on the stage at which the client is currently in, and on his/her ability to perform the ascribed tasks. You may have a few people with good motivation who have already made the decision to stop the substance (determination/ preparation) coming to you, while on the other hand you may also have people who do not think substance use is a problem (pre contemplation) and have been forced into treatment by a significant other. People usually move from one stage to another. You cannot usually get people to jump stages. The therapist plays the role of a facilitator and enabler. The skills and techniques you employ in talking to the client will also determine his or her movement through these stages.

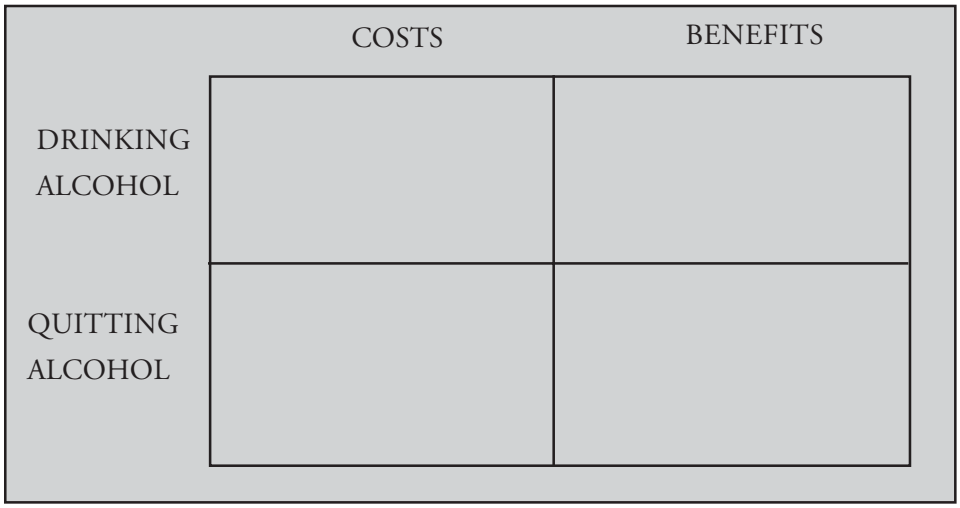
Motivational Interviewing:

Motivational interviewing is assisted by motivational balance exercise. To help a person make the decision of change it would be a useful exercise to encourage him/her to consider the pros and cons of changing and

continuing to use the substance. This will help him/her understand the need for change after weighing the costs and benefits. To facilitate change from using to not using the substance, you have to tip the balance so that the positives of quitting outweigh the negatives of continuing substance use. This, could, in turn enhance the person's commitment to change. The example provided below is for a person with alcohol dependence.

Things to do with your client:

Ask him/her to write the reasons he thinks of in the four boxes.



You may draw a 2x2 table with examples to initiate the exercise. Once the client is through with it, do the following……

1. Encourage him/her to compare the costs to the benefits.
2. Ponder if the costs are worth the benefits.
3. Ask him/her to enlist the reasons why he actually wants to stop drinking alcohol.

How can one get people to listen and consider change?

The process of helping a client to give up alcohol and drugs by enhancing his motivation occurs in two phases:

The first phase is all about building the person's motivation to change. This is where the motivational balance gets tipped in favor of stopping the drug taking behaviour. Decisional balance can be employed to do this. The process of tipping the balance is very crucial for the success of therapy and retention of the person in treatment. Different strategies have been identified to ease this process. Your ability to bring about change in the person depends on your skills in using these strategies.

The second phase encompasses steps in strengthening the person's commitment to give up alcohol or drugs. Here there is a consolidation of targets and a definite action plan is evolved. A significant other is looped into the treatment plan.

The basic principles of motivational interviewing include the following:

Expressing empathy:

To feel with your client and to communicate that you understand and care are the most salient features of MET. This will tell the client that he/she is not at the receiving end. You need to skillfully play the role of a supportive companion and knowledgeable consultant. MET is more of your listening than telling.

A few practical strategies are described below:

Listening with empathy:

Why do this?

Your response to self-motivational statements of the client is important for the further course of therapy. You need to listen carefully to what the client is saying and reflect it back to him/her or her in a slightly modified or reframed way. This is called reflection. Reflection helps to:

- Encourage clients to talk and express themselves better.
- Build a working therapeutic alliance and
- Understand what the client really means.

How to do it?

Reflective listening need not be your only means of response to the client. It is one among the other important strategies that MET employs. It requires alert listening and constant attempt to understand what your client actually means. You also need to pay attention to the nonverbal language of the client.

Few examples of reflection are given below….

Client: *"My parents are always behind my back; they think I always do drugs."*

Judgement: *"They are your parents and they could be concerned. What's wrong with that?"*

Questioning: *"Why do you think they do that?"*

Reflection: *"So your drug use has been getting you into trouble with your parents. You seem to be annoyed with their reaction?"*

Client: *"If I stop drinking, what am I supposed to do for friends?"*

Advice: *"I guess you need to keep the company of non-drinking friends."*

Suggestion: *"You can tell them that you have quit alcohol but still wish to see them."*

Reflection: *"It's hard for you to imagine living without alcohol."*

You need to keep in mind that when you try to reflect client's meaning and feeling, there will be some guessing involved. You need to keep this guess as close as possible to the client's statement. Sometimes when you markedly differ from what the statement means, resist the temptation to defend. Instead you can ask for more information without probing. *"Tell me some more, so that I will understand better."*

Questioning:

Asking questions is an important therapist response in MET. Instead of prescribing to the client, you may question regarding clients' feelings, reactions, ideas, concerns and plans and respond appropriately.

Affirmations:

Why do this?

You need to affirm, reinforce and compliment your client. This enables:

- Strengthening of rapport
- Enhancing empowerment and self-determination
- Eliciting self motivational statements
- Building client's self-concept.

How to do it ?

"Thanks for listening so carefully in the session."

"*I appreciate your strength in recognizing the risk here and your initiative to do something about it."*

"You really have some good ideas for how you might change."

"You've been through a lot together and I admire the love and commitment you have had in going through all this together."

Summarizing:

It would be useful to summarize periodically during the session and at the end of the session. Repeat client's self-motivational statements in the summary. Your summary can also include client's reluctance or resistance. Summary will let the client listen to his own doubts and affirmations on the need for a behavioral change.

Develop discrepancy:

Throwing light on the discrepancy between where your client is currently and where he/she aspires to be can induce motivation. You can do this by assessing personal risks involved in doing drugs.

Presenting personal feed back:

Why do this?

The first MET session is usually focused on giving a personalized feed back to the patient. You can use any objective evidence such as biochemistry reports. You need to go through each of the test report with reference to the normal range. This is done to elicit self-motivational statements from the client. Again therapist responses to client reaction to the discussion is crucial.

How to do it?

You can use reflective listening.

"That does not seem right to you."

"This is not what you expected to hear".

"A lot of reasons to think about making a change."

The other effective method of generating dissonance in your client is the motivational balance exercise. Here you help the client learn the pros and cons of his substance abuse.

Eliciting self motivational statements:

Why do this?

People tend to believe and value what they say. When you subtly suggest change to a substance user there is a probability that he/she will start realizing the need for change. This can be more effective in producing change when compared to a coerced change. Direct confrontational statements like *"you have to change because you have been a trouble to your family"* or *"you need to change as you are addicted"* will only produce counter reactions resulting in resistance. To avoid this process you need to induce clients to verbalise statements that can be self-motivating. Self-motivational statements can be based on the following:

- Being open to inputs about effects of alcohol
- Acknowledging potential problems about alcohol use
- Expressing need and optimism to change.

How to do this?

This can be done by open ended questioning. You can use one of the following:

- *"What brings you here; how can I help you?"*
- *"I assume that since you have come here, that you are concerned about your drinking; can we talk about your concerns?"*
- "*How has your drug use changed over time? Tell me what you have noticed, has it been bothering you in any way?"*
- *"What do people around you say about your drinking? What do you think are their concerns?"*

As the client is engaged in the process you can start helping him/her with self-evaluation of personal drug use. Areas such as increased tolerance to drug intake, physical impact, intensity of dependence, impact on family and sexual relationship, job and mental abilities can be explored.

The 5 Rs can also be used to develop discrepancy an enable the client contemplate change. The 5 Rs represent the following:

- **Relevance:** What is the personal relevance of quitting substance for the client?
- **Risks:** What are the potential negative consequences of using substance for the client?
- **Rewards:** What are the potential benefits of stopping the substance for the client?
- **Roadblocks:** What are the barriers in quitting the substance and elements in treatment that may help in handling the barriers.
- **Repetition:** The motivational intervention should be repeated every time the unmotivated client visits you.

Avoid argumentation:

Argument leads to resistance. Attempts to label a client need to be avoided. *Reframing* can be used.

Reframing is a strategy by which therapists invite clients to examine their perceptions in a new light or a reorganized form. New meaning is given to what is said. A spouse's reaction of *"I'm right and I told you so!"* can be recast to *"You've been so worried about him/her and you care about him/her so much"*. Client's admissions of being able to hold their liquor - to be able to drink more than other people without looking or feeling as intoxicated can be reframed as being a risk factor...the absence of a built in warning system that tells people when they've had enough. Thus good news becomes bad news. Other reframes are:

- *"Drinking as a reward - You may have the need to reward yourself on the weekends for successfully handling a stressful and difficult job during the week.....The implication is that there are other ways to handle issues without going on a binge."*
- *"Drinking as an adaptive function - Your drinking can be viewed as a means of avoiding tension or conflict in your marriage. It tends to keep things as they are. It seems like you have been drinking to keep your marriage intact. Yet both of you are uncomfortable with this arrangement"*. The implication here is that the client cares about his marriage and has been trying to keep it together but needs to find more effective ways to do it.The general idea of reframing is to place the problem behaviour in a more positive light, which can itself have a paradoxical effect (prescribing the symptom), but to do so in a way that causes the person to take action to change the problem.

Roll with resistance:

Resistance to change is not dealt with head on, but the therapist moves on with it. The client is encouraged to think of the problem differently. He/she is never forced to make a decision.

Dealing with resistance:

Why do this?

Client resistance could be your rightful problem. How you respond to it could be a defining characteristic of your therapeutic style in MET. Failure to comply with therapist instructions and signs of resistance like arguing, interrupting, side tracking or denying the problems are predictive of poor outcome.

How to do this?

When met with resistance you need to keep in mind the following:

Never meet resistance head on. Never challenge or confront.

Remember your aim is to bring out self-motivational statements from the client.

Some techniques…

Simple reflection	Simply reflect what the client is saying
Amplified reflection disavow what he said.	Reflect with exaggeration to a point where the client is likely
Double sided reflection	Reflect it back with the other side of the client's statement.
Shifting focus	Shift away from the problematic issue.
Roll with it	Move with resistance instead of opposing it.

Examples:

Amplified reflection	Client: *"I am not addicted to alcohol.* *Therapist: So as far as you are concerned you have not had any problems with alcohol".* C: *"Well I cannot say that exactly".* T: *"So you think that alcohol is a problem but you don't want to be called an addict".*
Double sided reflection	C: *"I can't quit because I will offend my boss if I say no".* T: *"You can't imagine how you could not drink, and at the sametime be working for your boss".*
Shifting focus	C: *"I just can't stop, as all my friends are using".* T: *"You are thinking too far ahead, lets first work on things we have at hand. You can think of stopping and what you can do about it later".*
Rolling with resistance:	C: *"But I will not stop drinking".* T: *"Well, by the time we are through with this session you may decide that it's not worth the effort to quit. Its tough to do so. That decision is entirely yours".*

Another way of breaking persisting resistance and disengagement during initial sessions is using *gentle paradox* to evoke self-motivational statements.

A few examples….

"I'm still not very convinced that you are really concerned about your drinking. It appears as if you are happy with what you have been doing".

"So drugs are really important to you; so tell me, what is it about drugs that you really cannot let go of?"

Support self-efficacy:

Client's ability to change is emphasized in therapy. Instillation of hope for change occurs.

The following will guide in ensuring self-efficacy of the client.

Is your patient ready to work on making changes (quit alcohol/drugs)?

Your previous efforts to motivate the client should necessarily culminate in his movement from precontemplation to the action stage of the motivational cycle. The second phase of MET focuses on consolidating the client's commitment to change. The time you choose to ask for this commitment and act on it is crucial. The determination stage is where the balance gets tipped in favour of change from contemplation. You may observe that this shift is not permanent and if action is delayed, determination could be lost. Hence identification of this readiness to change is significant.

There are some observable changes during the session which indicate that your client is ready……

- He/She stops resisting and raising objections
- Asks fewer questions.
- Appears more settled, unburdened, resolved and peaceful.
- Client makes self-motivational statements indicating an openness to change.
- Begins imagining how life might be after change.

On the other hand you may feel that few clients are still not convinced as to why they need to make changes. While handling such people it would be a bad idea to insist on decision making. You need to further explore their ambivalence and fears about quitting alcohol/drug. It is wise to delay decision making and planning for such people.

Some indicators that will guide you in recognizing these people:

- Irregularity with appointments.
- Absence of any prior discussion on feelings related to his/her coerced help seeking process.
- Hesitation on any further scheduling of appointments.
- Being guarded during sessions
- Perceiving help offered as degrading instead of an opportunity for better living.

The following strategies might be of help when you are helping the client move from stage 1 to stage 2 of motivation enhancement therapy, where the change plan and client self efficacy are the core ingredients.

Speaking about the Plan:

Begin with *summarizing* the reasons for change your client has given so far. This as already explained will include client's ambivalence.

After this you may use *key questions* such as *"I wonder what you think of your drug use at this point"?*

"What's your plan; what can you do"?

"Now as you have come this far, I wonder what you may do about your concerns"?

The client may by himself or herself express the decision to change or you as therapist may trigger it off with a key question. The goal of this phase is to encourage clients to come out with ideas about change and a plan to change. But it is important to note that a therapist will not prescribe a plan of change. He/she is instrumental in the process but will not lay down the plan.

The client is responsible:

Client's freedom of choice has to be emphasized in all your sessions. The onus of change needs to be placed on the client rather than being a therapists responsibility. Statements like :

- *"Its up to you to do something about this".*
- *"No one can decide for you".*
- "*No one can change your drug use, only you can do it".*

What happens-Action and No action:

A useful strategy is to ask the client (and significant other) to anticipate the result if:

- The client continues to drink alcohol as before.
- Generate a written list of possible negative consequences of not changing, anticipated benefits of change.

The client's fears about change also need to be analysed. A formal decisional balance may help.

What should the client do?

Often client and his/her significant other might ask you for information and advice. As far as information is concerned try and give specific and accurate information to the question posed. You also need to periodically check for the responses at the receiving end.

Questions like

- *"Does that make sense to you"?*
- *"What do you make of it"?*
- *"Does that surprise you"?*

Your advice on stopping drugs will also be sought. It is appropriate to give your best advice but client self determination and responsibility should be underlined. A few examples of handling these questions…….

"I can certainly tell you what I feel, I will be glad to do that but ultimately you need to make the choice".

"I'm not sure I should tell you. Certainly I have an opinion but you have to decide for yourself how you want to handle your life".

With this opening you may advise the client on:

- Changes in his drinking/ drug use behaviour.
- Need for the client and significant other to work together.
- General changes that are to be made in order to support sobriety

When questions regarding the ways to change are posed, it would be useful to turn the question back without indulging in prescription of specific strategies. You may not have answers to all queries, don't hesitate to convey that you will look up and get back to the client.

Emphasizing abstinence:

Your practice of MET with a client makes him or her the decision maker towards change.

But all your clients should at some point be given a rationale for abstinence from alcohol. You should however not prescribe but commend abstinence.

The Change Plan Worksheet

A change plan worksheet (CPW) can be used here to help specify the client's action plan. The information needed for the CPW should emerge through the motivational dialogue described below.

Change Plan Worksheet

- *The changes I want to make are:*
- *The most important reasons why I want to make these changes are:*
- *The steps I plan to make in changing are:*

- *The ways other people can help me are:*
- *I will know that my plan is working if:*
- *Some things that could interfere with my plan are:*

Recapitulating

Towards the end of the commitment process as one senses that the client is moving toward a firm decision for change, it is useful to offer a broad summary of what has transpired.

Asking for Commitment

After you have recapitulated the client's situation and responded to the additional points and concerns raised, move towards a formal commitment to change. The client is to commit verbally to take concrete, planned steps to bring about the needed change.

"Are you ready to commit yourself to doing this?"

As you discuss this commitment other points also need to be covered:

- Clarify what exactly the client plans to do.
- Reinforce what the client and significant other perceive to be the benefits of change and the consequences of inaction.
- Ask what concerns, fears or doubts the client may have that might interfere with the client carrying out the plan.
- What other obstacles might be encountered that could divert him/her from the plan. How could one deal with this?
- Clarify the significant other's role in helping the client make the desired change.
- Make an appointment for follow up visits

Summary:

Motivation enhancement therapy serves as an effective means of initiating, executing and sustaining change in persons with substance use disorders. The efficacy of the approach is widely realized because of its brief and comprehensive nature. As the intervention is based on motivational interviewing skills and techniques it can be used in various settings. Motivational interviews are not viewed as a single longitudinal therapeutic intervention. They are, rather, cross sectional interviews conducted with the client in combination with other therapeutic interventions. Repetition of motivational interviews during every session with the client has yielded better outcomes by increasing the person's engagement in treatment and reinforcing the commitment to change.

Suggested Reading:

1. Miller, W. R., Rollnick, S. (2002) Motivational Interviewing: Preparing people to change addictive behaviours, 2nd Ed. New York:Guildford Press.
2. Project MATCH. (1997) Matching alcoholism treatments to client heterogeneity: Project MATCH three-year drinking outcomes. Alcoholism: Clinical and Experimental Research, 22(6):1300-1311.

5

Preventing Relapse

Prabhat Chand

Introduction

Substance use disorder is a chronic relapsing condition. During the course of treatment, relapse is a rule rather than an exception. The term ***lapse*** refers to the initial episode of alcohol or other substance use following a period of abstinence, whereas ***relapse*** refers to failure to maintain behavior change (substance-free state) over time. It is a state in which an individual returns to a continuous pattern of taking a substance, after a period of abstinence. Similarly relapse needs to be viewed as a process i.e. as a series of maladaptive changes that eventually lead to the act of taking substances. In the process, indicators or warning signs appear prior to the individual's actual substance use.

Precipitants of Relapse

For preventing relapse in a client, one needs to understand relapse precipitants. The common relapse precipitants are shown in the accompanying box:

Common Relapse Precipitants

MOOD STATES

- Positive mood (excessive happiness)
- Negative mood (sadness, frustration)

BEHAVIORAL

- Impulsivity
- Poor coping skills

COGNITIVE

- Overconfidence (self-perception of ability to cope with high-risk situations)

ENVIRONMENTAL

- Peer pressure
- Loneliness / no engagement
- Lack of social support/ constant criticism by family

PHYSIOLOGICAL

- Craving

Long lasting withdrawal symptoms (sleep disturbance after stopping alcohol, pain after stopping opioids)

Chronic physical pain

PSYCHIATRIC CONDITIONS

Anxiety disorder

Mood disorder

Psychoses

Unrecognized depression/anxiety disorders

Interventions to Reduce Relapse

The interventions to reduce relapse are an essential part of the treatment programme. Once the detoxification is over, the main focus should be on this aspect of management

A. Identifying and Handling High Risk Situations

One can ask for the description of past relapses and the situations where the client feels the risk of restarting the substance is very high. Actually these are the situations in which the client might not be aware of in the past or not thought of. It is like preparing a soldier before going to the battlefield. The better the preparation, lesser is the chance of relapse. High risk situations may vary from person to person. Situations which trigger feeling of loneliness and isolation may be high-risk for one person whereas attending a party, social pressure or need to be seen as confident by friends may be high risk for another. These situations can trigger craving for the substance in an individual.

Common Situations where a Person can Develop Craving

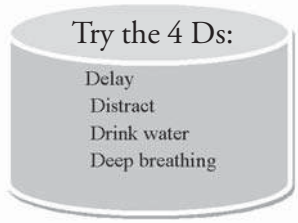
- The sight of a bar, especially the one the person used to frequent before
- Meeting friends with whom one was using drugs, passing by usual hangouts
- Peer pressure
- Parties
- Saturday nights/ weekends
- Some environmental cues like eating non-vegetarian food
- Being home alone
- Family conflicts
- Job stress, other stresses, fatigue
- Having a lot of unscheduled time can lead to boredom
- Negative emotions like frustration, sadness, depression
- Positive emotions such as happiness, excitement, a feeling of accomplishment (desire to celebrate)

Making the client aware of those situations which trigger craving is very important to prevent relapse.

B. Handling Craving

There are different ways to address these issues. As has been discussed, the idenfication of triggers or precipitants is the most important step in dealing with relapse. Described below are a few common ways effective in handling craving.

Postponement (Urge Surfing):



Craving is like a wave and episodes of craving are time-limited. Rather than increasing steadily until they become unbearable, they usually peak after a few minutes, and then die down like a wave. The waves of craving become less frequent and less intense as one learns how to cope with them and with progress of time.

At the time of intense craving the recovering individual can call a sober or abstinent friend and tell them he/she feels like taking a drink/using a drug, and needs help not to do so. Similarly, recall negative consequences of returning to substance use - losing one's job, broken family relationships, etc.

One advice that works very well in clinical situations is that of **HALT**. If one avoids these situations, the likelihood of craving decreases.

HALT

C. Drink Refusal Skills and Assertiveness

One of the common situations of relapse is peer pressure during different occasions and situations. One should be aware of pressure tactics, usually from friends.

Beware of Pressure Tactics

Pleading:	"*Please give me company just for a few minutes.*"
Reassuring:	*"It's ok, I'll talk to your family so they won't be angry with you."*
Anger:	"*Look, I'm drinking, but nothing has happened to me.*"
	"So you mean to say I'm bad and you are a reformed person."
	"So you want to avoid me."
Ridicule:	*"Are you planning to build an estate with all the money you have saved."*
Challenging:	"*Are you a slave to your wife?*"
	"Aren't you the earning member? Don't you have the right to spend your own money the way you want to?"
Threatening:	*"So you don't want our friendship."*
	"We will expel you from our group if you don't drink with us anymore."

Refusal skills are a specific set of skills which are related to dealing with social pressure. Hence it needs a strong body language and confident tone of voice from the person while refusing to drink/use a drug. In this situation one has to respond rapidly as the delay is likely to increase the urge. Many patients feel uncomfortable or guilty about saying "no" and think they need to make excuses for not using. Saying things like *"maybe later," "we shall see,"* just makes it likely that they will be pressured again to use. This allows for possibility of future offers. So "No" can be followed by changing the subject, suggesting alternative activities, and clearly requesting that the individual not offer alcohol or other drug again in the future. For e.g. *"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".*

Some Common Drink Refusal Statements

"No thanks, I have stopped drinking."

"Let us have tea of coffee instead."

"I am taking medicine and I can't drink on it."

"I have an important engagement."

"I have to get up early."

"I have to work a double shift tomorrow."

"I have a headache."

"I was just leaving."

One of other ways to learn and master it is through role play. Individual role play between substance user and therapist is one of the best ways to enhance drink refusal skills. In role play, the client and therapist enact potential relapse situations, and the client rehearses what he/she will say in such situations.

Another important component is learning to be "Assertive." Assertiveness is the ability to insist and stand up for one's own rights, without hurting others or violating their rights. People with substance use are seen to be unassertive and thereby frequently land up in a situation where they either flee from the situation or more often find it impossible to refuse the offer. Sometimes it is useful if the person is constantly pressured to leave the place by saying politely, *"I can see that you won't take no for an answer, so I am leaving."* This will show the friend that the recovering person is determined to stay abstinent.

D. Dealing with faulty cognitions like overconfidence, helplessness, etc.

A person's faulty thought very often becomes a problem for him/her and leads to a relapse. A simple example is:

"I can stay away from alcohol. Nothing can tempt me." The consequence is - going to parties where alcohol may be available, telling myself *"I will go, but I'll not drink."*

The person needs to recognize that this thought is a red flag or a dangerous thought and consciously needs to tackle it. One of the ways to challenge it is as follows:

Challenging Thoughts (overconfidence as in the above situation)

- *"What proof do I have that nothing can tempt me?"*
- *"What happened before?"*
- *"Every time in the past when I did something like this, I ended up drinking continuously. So what's the point in entertaining such thoughts again?"*

Similarly another example very often one comes across is that:

"My life has no meaning, it is so bad that I need a break."

Recognize it's a Red-flag Thought

Challenge these thoughts:

- *"Even if my life is bad, will reusing drugs really give me the break I need?"*
- *"Or will my life become more 'bad' than before?"*
- *"What happened before when I was using drugs?"*
- *"Even if I succeed in forgetting my troubles for a while, how long can I forget? For a few hours, until the effect lasts."*
- *"And after that? Should I go on using the drug to forget everything?"*
- *"What useful purpose does that serve, except to ruin my health and family, and put me in an even worse position than I was before?"*
- *"Think of other ways in which I can take a break: go home immediately, share with my family, just relax by reading a book, or resting for a while?"*

Similarly there are other thinking errors like catastrophizing [e.g. *"After all these months of abstinence, I used the drug again, so there's no use. I can not recover again"*], jumping to the conclusion that *"I am a useless person because of my alcohol addiction"* etc. Very often it is better to practice how to handle these in a work sheet (written down). The basics are what are described in the above box i.e. Listing relapse related thoughts, stating what is wrong with it and challenging and creating new statements.

E. Handling Negative Mood States

Negative mood states like anger, anxiety, fear, depression, guilt, getting upset or bored easily, irritability, tiredness, restlessness, etc. are associated with relapse. Some people suggest that addicts frequently relapse as a result of joylessness in their lives. A few ways to handle this are:

- The first step is to be aware of one's self-defeating thoughts and depressed mood.
- Realizing the adverse consequences of these negative thoughts.
- Creating opposite (positive) thoughts, challenge negative thoughts.
- Ignoring negative thoughts, not responding to them.
- Accepting oneself as one really is, with strengths as well as limitations.
- Having realistic self-expectations.

F. Assess for coexisting Psychiatric Disorders

Very often the person needs to be assessed for an independent psychiatric disorder. These can have an influence on a person's judgment, motivation and functioning with regard to substance use. Common co morbid disorders are Depression (Mood disorders) , Anxiety disorders (Panic Disorder, Generalized Anxiety Disorders), Schizophrenia, Somatoform disorders or Insomnias. It is important to get these details and treat these conditions effectively. That in turn will help immensely for controlling substance problems. These conditions mostly need pharmacotherapy and one should not hesitate to treat them effectively.

G. Having a Balanced Life Style

In addition to identifying and managing high-risk relapse factors, recovering individuals often need to make more global changes to restore or achieve a balance in their lifestyle. Developing a healthy lifestyle decreases the level of stress. The client's lifestyle can be assessed by asking about his/her daily activities, how he/she spends time, sources of stress, balance between pleasure and external demands , time spent in exercise/ relaxation patterns, interpersonal activities and religious beliefs.

Healthy Life Style Tips

- Attitude is the key – be positive!
- Begin and end your day with prayer and/or reflection.
- Believe in yourself – that you will get through your treatment, your hurdles, big or small.
- Cultivate a best friend whom you can really trust.
- Stay away from negative people who constantly criticize. Minimize peer influence that is adverse.
- Spend time with family and children.
- Take a healthy balanced diet rich in fruits, germinating grams etc. Follow a regular fitness regimen.

- Get sufficient sleep.
- Plan your time effectively. This will minimize the stress and confusion brought on by last minute hassles.
- Pursue a hobby – something you have always wanted to do. Take time out for recreation.
- Read a humorous book. Exchange jokes with a friend. Watch a funny movie. Remember, laughter is truly the best medicine!
- Practice Relaxation Technique (deep breathing).
- Be regular to job or work.

Use of Pharmacological Agents as an Adjunct to Psychosocial Treatment

It has been well know that a combination of pharmacological and psychosocial treatment work better than any one modality. So the therapist should use a specific pharmacological agent to decrease craving or to replace the harmful substance in the treatment of substance abusers. Brief details regarding the pharmacological agents are provided in the appendix. The reader may obtain more information on pharmacotherpy from a standard text book.

Role of Family in Relapse Prevention

Family plays an important role in preventing as well as helping the person remain alcohol/drug free. This issue has been dealt in detail in a separate chapter in this manual. A few important tips that one needs to tell the spouse or other family members include:

- Realize that alcohol/ drug dependence is a disease, and not a moral weakness or a lack of willpower.
- Do not argue, quarrel, justify his/her use of substance, or take up the responsibility of covering up for the consequences of substance use.
- Do not suspect. For example, don't start questioning whether he has had a drink/used drugs or not, especially when he comes home after the day's work. Do not make phone calls to his friends, or colleagues to check if he is drinking/using a drug.
- Pay extra attention to his needs – nutrition, medications, health.
- Do not discuss his previous drinking/drug use problems with others.

Arranging Follow ups

Relapse prevention as described at the beginning is a process and is ongoing. The importance of this is more obvious while the patient comes for follow up. One needs to check how he/she is handling the urges or any physical/emotional disturbance following stoppage of substance. The ways in which the recovering

person is managing time, job, family relationships etc need to be discussed. Similarly any high risk situation he/she has faced recently and how have they coped also need to be addressed. The therapist can ask appropriate questions to understand both recovery and relapse.

If abstinent:	If a lapse:
"What were the high-risk situations / warning signs you faced since your discharge/last session, and what did you do to deal with them?" *"What were the consequences of your successful dealing with the triggers and relapse cues? (e.g. you felt good about yourself, your family relationships improved, etc)"*	*"Where?"* *"How?"* *"What were you thinking and feeling?"* *"What were your expectations about what alcohol use would do for you?"* *"What will happen if you continue to drink/use drug?"*

Following identification of the triggers and of salient consequences, the patient should be engaged in problem-solving and the methods of relapse prevention. One can discuss what the person can do between now and the next session, so that lapses do not recur.

- *"What did you do on the days you did not drink /use substance that kept you from lapsing?"*
- *"Which of the coping skills you have been practicing might be especially useful?"*

Conclusion

There are a variety of different models described in literature. What we have tried to put here are the practical tips on how to help a person prevent relapse through counseling in a short and effective manner. The whole aim is to help the person to maintain the change over time and address the most common risks (high risks) for relapse. While follow-up is very important to ensure that relapse risk is minimized, there are no specific time limits. Follow-up needs to be frequent in the first three to six months as the chance of relapse is very high. The other aim of the whole process is to enable the person to identify the relapse events and strengthen the person's ability to handle such situations effectively.

Prabhat Chand MD, DNB Assistant Professor, Department of Psychiatry, National Institute of Mental Health and Neuro Sciences, Bangalore.

Suggested Reading :

1. Marlatt, G.A., Gordon, J. R. (1985) Relapse Prevention. New York: Guilford Press.
2. Daley, C.D., Marlatt, G. A. (2005) Cognitive and behavioral therapies. In chapter 51, Substance Abuse-A comprehensive textbook. Eds. Lowinson JH, Ruiz P, Millman RB, Langrod JG:723-732.
3. Relapse Management. Developing Community Drug Rehabilitaion and Workplace prevention Programmes. Assessed on 25.10.07 http://www.wesouthasians.org/html/modules/home/leaf8.pdf

4. Burke, B.L., Arkowitz, H., Menchola, M. (2003) The efficacy of motivational interviewing: a meta-analysis of controlled clinical trials. Journal of Consulting and Clinical Psychology, 71(5):843–861.

5. Waller, T. and Rumball, D. (2004) Treating Drinkers and Drug Users in the Community. Blackwell Publishing : Addiction Press.

6

Follow Up and Aftercare Issues in Persons with Substance Use Disorder

B M Tripathi, Amardeep Kumar*

Introduction

Substance use disorder is a chronic relapsing condition and a single episode of treatment seldom leads to long-term abstinence from drug. This emphasizes the need for some form of continuing care- also referred to as aftercare- following completion of an initial phase of treatment. The aftercare issues include enhancing retention in long-term pharmacological treatment, addressing individual psychosocial needs, enhancing family and social support and looking after the medical needs of the patient so that better community integration can take place.

Various treatment modalities available for long-term substance-use treatment include long-term pharmacotherapy and psychosocial interventions. While effective long-term pharmacological treatments are available for alcohol and opioids, there is no effective pharmacological treatment available for substances such as cannabis, stimulants and cocaine. Various psychosocial interventions are available depending upon the programme structure which includes self help groups such as Alcoholic Anonymous (AA) and Narcotic Anonymous (NA), Therapeutic Communities (TCs) and various kinds of individual and family interventions. Individual level psychosocial interventions include motivation enhancement treatment, relapse prevention treatment, contingency management (CM), and cognitive behavioral therapies (CBT). Despite the potential benefit of such interventions, many substance-dependent individuals either do not attend any continuing care or stop attending after a relatively small number of sessions. While self-help groups such as AA and NA, TCs, motivation enhancement, relapse prevention and working with families have been addressed in other chapters, this chapter will focus on some individual level interventions such as CM and CBT. It has been found that such interventions help in better retention of patients on long-term pharmacotherapy, address the individual psychosocial needs of the patient, help in community reintegration and are among the available treatment options for persons using substances such as cannabis, stimulants and cocaine. However, it is not clear which treatment modalities will benefit the individual patient the most. Experience with methadone maintenance program indicated that the major factor governing outcome in substance use disorders is the length of time in treatment. Thus, to retain the patient in treatment for a longer period, addressing follow up and various aftercare issues are required.

* B M Tripathi, MD, Professor, Department of Psychiatry, National Drug Dependence Treatment Centre, All India Institute of Medical Sciences, New Delhi.

* Amardeep Kumar MD, Ex- Senior Resident, Department of Psychiatry, National Drug Dependence Treatment Centre, All India Institute of Medical Sciences, New Delhi.

Some Interventions:

A. Contingency Management

Contingency Management (CM) treatments are based upon a simple behavioral principle- if behaviour is reinforced or rewarded, it is more likely to occur in the future. These behavioral principles are used in everyday life. CM as a strategy is used in substance abuse treatment to encourage positive behaviour change (i.e. abstinence) in patients by providing reinforcing rewards when patients meet treatment goals and by withholding those rewards or providing punitive measures when patients are engaged in undesired behaviour (Figure 1). The reinforcing or punishing consequences may be contingent on objective evidence of recent substance use such as urine screening, or behaviour important in the treatment process such as compliance with a medication regimen or regular clinic attendance. Often, clinicians implement CM procedures through written contracts that detail the desired behaviour change, duration of intervention, frequency of monitoring, and potential consequences of patient's success or failure in making the agreed upon behaviour change. This treatment can be used for the following purposes in substance users-

1. *Reinforcement of Abstinence*

a) For licit substance use such as alcohol- It works by providing tangible reinforcers to clients, contingent on negative breath-alcohol tests or as reported by family members/ close relative. The reinforcer may be shelter, employment, food, clothing etc., as feasible in a given circumstance.

b) For illicit and polydrug use- For such interventions, patients submit urine specimens several times weekly to be screened for evidence of drug use. When the specimens are negative for drug use, patients receive reinforcers, such as take home buprenorphine-naloxone combination tablets or methadone tablets (as available), increases in clinical privileges (such as not waiting longer), money, and vouchers exchangeable for retail goods. In many programs that use vouchers as reinforcers, the value of the earned vouchers escalates as the patient demonstrates consecutively longer period of abstinence. Submission of samples showing drug use results in no reinforcer and sometimes a punishment (i.e., the voucher amount decreased to a lower value or loss of take-home privileges).

2. Reinforcement of medication compliance- In addition to direct reinforcement of abstinence, CM has also been used to reinforce compliance with medications such as disulfiram, naltrexone, buprenorphine and methadone. For such purposes, patients receive reinforcers such as take home privileges, clinical privileges or vouchers contingent upon the regular use of medication as evidenced objectively by negative urine screen for substances and/or information from family member/close relative.

3. Reinforcement of treatment attendance- For this purpose, the reinforcers are provided for regular treatment attendance such as participating in regular programme activities.

4. Reinforcement of other treatment related goals- For such purposes, therapists usually use vouchers or other rewards to reinforce not only abstinence but also other non drug-related treatment goals, such as attending a medical appointment if the goal is to improve health, taking one's child to school if the goal is to improve parenting, applying for a job if the goal is to obtain employment. Patients receive vouchers or agreed upon reinforcer when they present documentation verifying that they have completed a designated activity. Thus, reinforcing compliance with treatment related activities may encourage patients to acquire new skills and overcome psychosocial difficulty associated with substance use.

General Principles in CM Interventions

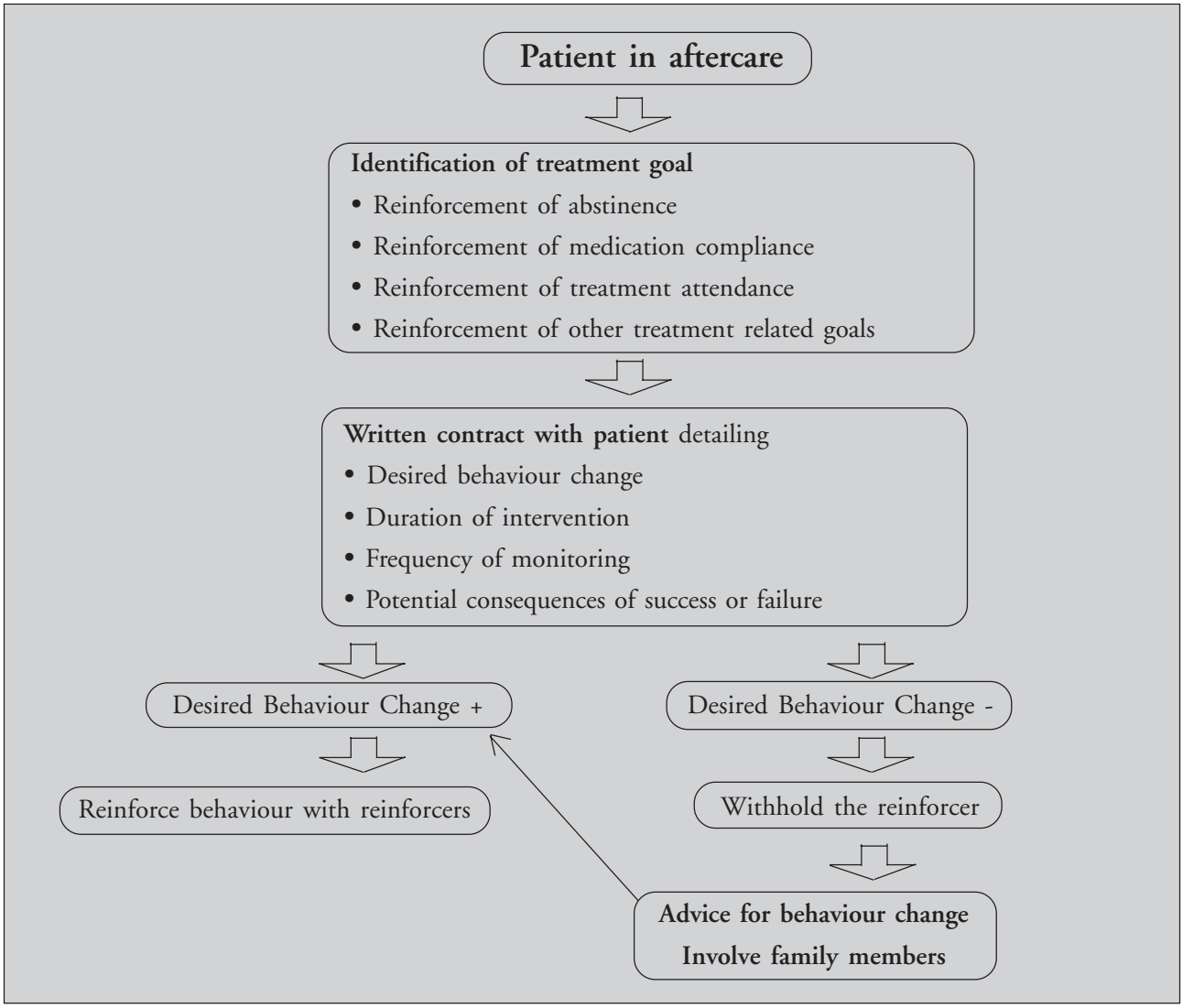
1. Arrangement for regular testing to ensure that the patient's use of the targeted substance is readily detected.
2. Provision of agreed upon tangible reinforcers by the clinician when abstinence is demonstrated.
3. Withholding of designated incentive from the patient when substance use is detected.
4. Clinician's assistance to the patient in establishing alternate and healthier activities (e.g., a better paying job, improved family relations, enjoyable social and recreational activities) to compete with the reinforcement derived from the substance-abusing lifestyle.

Limitations

1. Proper implementation by treatment staff – Patients should be monitored frequently and provided reinforcers consistently by treatment staff for CM to be effective in non-research based settings. Imparting training to the treatment staff is required for successful outcome.
2. Objective evidence for substance use- Use of CM in alcohol use disorder is limited due to absence of technology available to detect last alcohol use in the previous 2-3 days. Most CM interventions targeting drug abstinence screen patients twice or thrice weekly as most drug testing procedures can detect drug use over a 2- to 3-day period. However, alcohol testing is less sensitive, as breath alcohol tests can only determine whether a person has consumed alcohol over the past 4 to 12 hours. Thus, submission of negative samples confirms abstinence for only a relatively brief time period.
3. Reinforcement of other treatment related goals- The efficacy of CM for such purposes is limited as this goal requires a more comprehensive approach.
4. Length of treatment- Follow up studies on efficacy of CM have demonstrated beneficial long-term effects but have also found evidence of relapse in about the same proportion as is seen with other psychological treatments for substance use disorder. Evidence on optimal length of treatment and use of reinforcers to improve long term outcome is limited, as also the concern over the cost of providing reinforcers. For this reason, it is advisable to maintain

the initial treatment gain by changing from more contrived reinforcers (e.g., vouchers) to more naturally occurring reinforcers (e.g., obtaining and maintaining employment) as well as by altering schedules from continuous reinforcement during initial treatment to more variable reinforcement schedules as the treatment progresses.

Fig:1 Contingency Management



B. Cognitive Behaviour Therapy (CBT)

CBT primarily focuses on individuals' thoughts and behaviours. This therapy is based on three theories of substance use namely relapse prevention (See chapter Preventing Relapse), cognitive therapy and behavioural learning theory. CBT is a structured, directive, focal time-limited approach (12 to 24 sessions) and has strong empirical support for use in the treatment of substance use disorder. Several studies have demonstrated that CBT's effect is durable and that continuing improvement may occur even at the end of treatment. All cognitive theories make the following assumptions:

1. Substance abuse is mediated by complex cognitive and behavioral process.

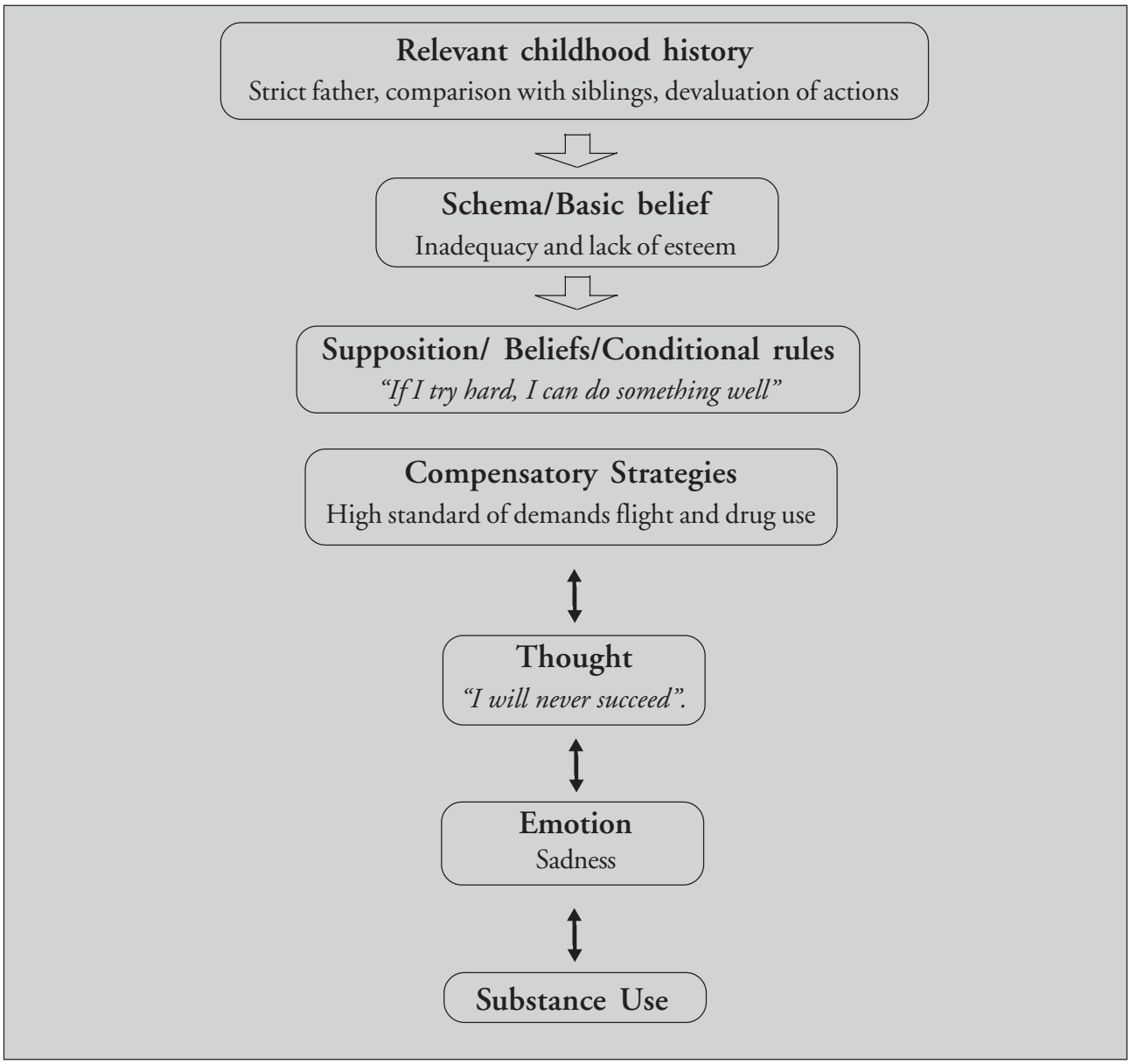
2. Substance abuse and associated cognitive-behavioral processes are, to a large extent, learned (social learning theory explaining modeling, operant conditioning explaining positive and negative reinforcement of substance use and classical conditioning explaining cue-related craving).
3. Substance abuse and associated cognitive-behavioral processes can be modified, particularly by means of CBT.
4. A major goal of CBT for substance abuse is to teach coping skills to resist substance use and to reduce the problems associated with substance abuse.
5. CBT requires comprehensive case conceptualization that serves as the basis for selecting specific CBT techniques.
6. To be effective, CBT must be provided in the context of warm, supportive, collaborative therapeutic relationships.

There are many different CBT approaches for substance use; some have attended mostly to cognitive processes, some have attended mostly to behavioral processes, and others have been equally attentive to both. Regardless of specific therapeutic techniques, certain principles are common to all CBT substance abuse treatments. These principles include:

1. *Case Conceptualization-* It needs one to understand that each substance abuser is unique. While some may have less impairment in various psychosocial domains, others may have significant impairment in these domains (homelessness, joblessness). For some users, co-morbid psychiatric illness such as depressive disorder, anxiety disorders are associated with substance abuse. As CBT has been found useful for all of the above mentioned situations, it is important to conceptualize each case on its individual basis so that the therapy can be made flexible according to the patient's needs. Case conceptualization involves the assessment of patients' backgrounds, presenting problems, psychiatric diagnoses, developmental profiles, and cognitive-behavioural profile. It should also look into factors leading to initiation and continuance of substance use. Several methods have been developed to organize information for such purpose; most commonly used being functional analysis of substance use behaviour (Figure 2). A good case conceptualization is necessary for good outcome as the selection of therapeutic technique and timing follows directly from it. However, it is also important to consider motivation to change (see chapter 'Enhancing Motivation to Change') before determining the timing and technique of CBT.
2. *Collaboration-* This is a very important principle in any CBT. However, for substance abuse it should be highly collaborative, supportive, and empathetic.

   Substance abuse patients have very high treatment dropout rates and they tend to invoke more negative responses in therapists than many other patient populations. Many therapists feel that they cannot compete with substances that provide more intense and immediate effects than therapy. Many find it difficult to relate with the life situation of the patients.

Fig 2: Functional Anaylsis of Substance use Behaviour



Thus, therapists are strongly encouraged to directly confront their thoughts about patients who abuse substances i.e., rather than thinking, *"This drug addict will never change",* they are taught to think, *"If I am patient, this person may eventually make some important changes".* They are also encouraged to use the technique of active listening and role playing rather than lecturing patients. Discussion of appropriate non-substance related problems by patients are encouraged. Regular feedback about patients' response to therapy is encouraged by asking questions such as, "*What was most and least helpful about our talk today?"* and *"How will you implement what we have talked about?"*

3. *Psycho-education-* This is a routine component of CBT. One of the major goals of treatment approach is to teach patients a new way of thinking that can be applied in resolving current symptoms and in managing problems that will be encountered in future. Early phase of

CBT incorporates significant psycho educational efforts. Areas for education includes the physiological effects of particular substances, high-risk behaviours, the impact of substance use on the family, dual diagnosis, and psychological models for understanding substance use. Therapists offer opportunity for patients to learn more by means of brief lectures, written materials, videotapes, or workbooks on a variety of topics. Long lectures are inappropriate.

4. *Structure-* This includes setting the agenda, checking the patient's mood, bridging from the last visit (including a review of substance use, urges, cravings, and upcoming triggers), discussion of problems (including potential coping strategies and skill building activities), frequent summaries, the assignment and review of homework, and feedback from the patient about the session.
5. *Attention to the multiple needs of patients-* CBTs for substance abuse emphasizes the need for addressing serious life problems of patients' which include health, legal, employment, family and housing problems by referring the patient to appropriate services, for example, providing basic information and referrals to self-help groups for patients needing them. Thus, the therapist must be familiar with community resources, including legal services, detoxification centres, HIV testing sites, and self-help groups.
6. *Monitoring substance use-* CBT therapists actively monitor the type, quantities, and routes of recent substance use at each treatment session. While self-report is the most common method used, urine and breath analyzer tests provide more objective data. Regardless of the method chosen, asking patients about substance use at each session is an essential component of CBT and the accuracy of self-report is enhanced when confidentiality is assured.

Specific Techniques of CBT

Although there are many different CBT approaches for substance use, there are several strategies common to most of them which includes functional analysis of substance use and coping skills management.

Functional analysis of substance use- Functional analysis (or chain analysis), is defined as "the identification of important, controllable, causal functional relationships applicable to a specified set of target behaviours for an individual patient". For the purpose of substance use the goal of analysis will be to understand the variables that are controlling the substance use and use this information for coping skills training on individual basis. The initial step is to help the patient recognize the triggers and reinforcers of substance use and skills needed to intervene in this process. The chain of events is usually composed of exposure to triggers for substance use, responses to these triggers, acquisition and actual use of the substance, and the positive and negative consequences of use. The method used is usually through open-ended exploration of patients' substance use history (e.g., determinants of substance use, patterns of use, common thoughts and feelings associated with urges to use, reasons for using substances).

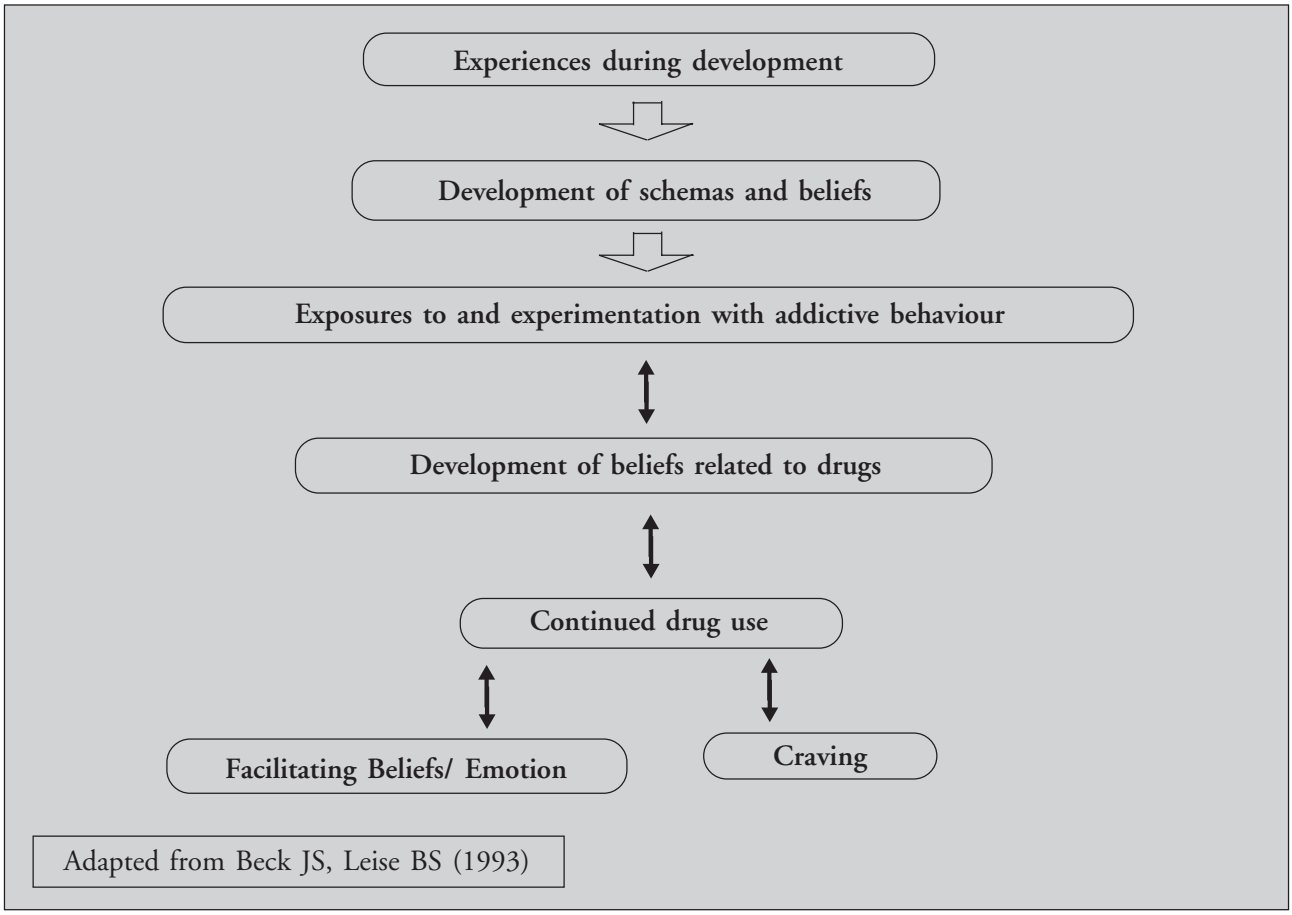
Coping skills for managing the antecedents of substance use- Once the functional analysis is complete, patients are taught coping skills either to prevent substance use or prevent relapse to substance use. There

may be different types of antecedents present in individual patient which includes social, environmental, emotional, cognitive, and physical factors.

Social Antecedents

These include attending social events such as parties or festivals where people use substances, peer influence through pressure or conditional association with substance use. Usually substance abusers develop a network of family, friends and coworkers with whom they have used substances in the past. For such antecedents, the coping strategies taught to the patient are lifestyle changes, enhancing social support and refusal skills. Lifestyle changes may range from informal discussions of lifestyle options to formal planning of, and participation in activities together. Other techniques include contracting to engage in new activities that are incompatible with substance use (e.g., exercise, meditation), referring patients to external resources to develop alternative pursuits (e.g., helping patients sign up for volunteer work), and identifying healthy activities. Social support enhancement strategies include minimizing contact with people who use substances, and developing a new social support network that is supportive of abstinence. For refusal skills, patients are taught role playing to practice refusing offers of substances, educating patients about passive, aggressive, and assertive communication style, anticipating consequences of refusal, and paying attention to body language and nonverbal cues.

Fig 3: Cognitive Behaviour Therapy



Environmental Antecedents

These include external substance-related cues (e.g., advertisements for alcohol, the smell of alcohol) and general cues that have come to be associated with substance use through classical conditioning (e.g., money, times of day). For such antecedents, patients are taught cue exposure treatment (CET) and decision-making skills. CET involves repeated exposure to the environmental cues associated with substance use (e.g., drug-related paraphernalia, photographs of high-risk locations, and depictions of actual drug use), with the goal of decreasing responsivity (e.g., cravings, substance-related thoughts) to these stimuli. In decision-making skills treatment the focus is on the decision chain leading to drug use, including identifying "seemingly irrelevant decisions" that increase the risk of relapse, such as, *"I can work in a beer bar/pub."* Strategies include identifying examples of poor decisions (e.g., keeping substances in the house), recognizing associations between decisions and exposure to high-risk situations, challenging cognitive distortions that encourage risky decisions, and practising safe decision-making.

Emotional Antecedents

These include patient's feeling of reductions in negative emotional states such as anxiety, low mood or increase in positive affect such as joy, excitement with substance use acting as triggers for relapse. CBT strategies for coping with emotional triggers focus on how to regulate and tolerate emotional states to decrease the risk of substance use. These include change strategies and acceptance strategies. Change strategies include challenging distorted thoughts that fuel negative affect, completing daily thought records, and using positive coping statements (e.g., *"I can handle these feelings without using").* Behavioral strategies include activities to decrease the intensity of negative affects such as distraction, engaging in pleasurable activities, self-soothing, acting opposite of emotions and relaxation strategies. Acceptance strategies focus on increasing tolerance for negative emotional states, decreasing emotional avoidance, and encouraging acceptance of emotional experiences.

Cognitive Antecedents

These include drug-related beliefs (e.g., *"Using drugs improves my mood"*), automatic thoughts (e.g., *"Drink"!*), and facilitating beliefs (e.g., *"I can handle one peg")* that increase the risk of lapse and relapse. These cognitions often derive from core beliefs about self (e.g., *"I'm vulnerable"*) and resulting rules that a person has developed for survival (e.g., *"If I let myself feel my emotions, I'll fall apart"*). The strategies include modifying automatic thoughts and drug-related beliefs and modifying conditional assumptions and core beliefs. The initial step in modifying automatic thoughts is to help patients identify their automatic thoughts and drug-related beliefs and to recognize that they may not be completely accurate. Patients are taught to identify logical errors in their thinking that may trigger substance use (e.g., ignoring evidence that substance use is becoming problematic, exaggerating their ability to quit, overemphasizing the positive aspects of substance use, devaluing non-substance-using friends and activities, and believing that life without substance use is boring). A variety of cognitive restructuring techniques can be used to modify distorted automatic thoughts and drug-related beliefs, including examining the evidence, considering the alternatives, keeping

daily thought records, using a cognitive continuum and surveying others. In addition, patients can create cards on which they can write their common automatic thoughts and effective challenges to them. Patients can refer to these when confronted with high-risk situations that trigger these cognitions. A later step in cognitive therapy is to identify and modify patient's conditional assumptions and core beliefs that are fueling negative automatic thoughts. Techniques available for identifying core beliefs include looking for central themes in patients' automatic thoughts, recognizing core beliefs that are expressed as automatic thoughts, Socratic questioning, and the what-if method. Once patient's core beliefs have been identified, strategies for modifying these beliefs include examining advantages and disadvantages, historical tests, keeping a daily log of evidence that supports and contradicts the core belief, and conducting behavioral experiments to test the conditional assumptions associated with core beliefs.

Physical Antecedents

These include substance use to control cravings, withdrawal symptoms and non-specific conditions such as headache. Techniques include distraction, urge surfing and focus on consequences. Distraction techniques include physical exercise, talking with someone, snapping a rubber band on their wrist, relaxation strategies and thought stopping. Urge surfing is done by focusing attention on the experience of craving and describing the associated physical sensations, feelings and thoughts in an objective way. This helps in increasing acceptance of craving as a time-limited normal experience that patients can manage without using substances. Focusing on consequences, an analysis of advantages-disadvantages is helpful in identifying the pros and cons of abstinence and continued drug use. Another strategy involves recalling the negative consequences of past substance use in order to make disadvantages of giving in to the craving more salient.

General Principles in CBT

1) An emphasis on functional analysis of drug use within the context of its antecedents and consequences, and
2) Skills training, through which the individual learns to recognize the situation or states in which he or she is most vulnerable to substance use, avoid those high-risk situations whenever possible, and use a range of cognitive and behavioral strategies to cope effectively with those situations if they cannot be avoided.

Limitations

Despite the emerging empirical support for use of CBT in drug-dependent populations, there are some limitations which need to be addressed. CBT is a comparatively complex approach, and training clinicians to implement this approach effectively can be challenging. Strategies for addressing these issues include greater emphasis on understanding the mechanism of action of CBT so that ineffective components can be removed and treatment delivery can be simplified and shortened and perhaps even accomplished by computer or other automated means. Strategies for enhancing acceptance and effective implementation of CBT by the clinical community are also needed.

Summary and Conclusion

Substance dependence is a chronic, relapsing condition and after a single episode of treatment some form of continuing care, also referred to as aftercare- is required to address various issues. These include enhancing retention in long term pharmacological treatment, addressing individual psychosocial needs, enhancing family and social support and looking after the medical needs of the patient so that better community integration can take place. Available approaches for individual level intervention includes contingency management (CM) and cognitive-behaviour treatment (CBT) which have been found effective in better retention of patients on long-term pharmacotherapy and in addressing the individual psychosocial needs, thereby enhancing the retention in treatment leading to improved outcome. CM treatments are based upon a simple behavioral principle- if behaviour is reinforced or rewarded, it is more likely to occur in the future. CM has been found to be useful in reinforcement of abstinence, medication compliance, treatment attendance and other treatment-related goals such as improvement in health, parenting responsibility and gainful employment. However, its limitations include the challenge of effective implementation by treatment staff, length of treatment, cost of treatment and effectiveness in achieving other treatment related goals. CBT is based on the theory of relapse prevention, cognitive therapy and behavioral learning theory and focuses on individuals' thoughts and behaviour. It has a structured, directive and focal time-limited approach (12 to 24 sessions). The effect has been found to be durable and efficacy persists even after the end of treatment. The central principle includes an emphasis on functional analysis of drug use within the context of it's antecedents and consequences and skills training through which the individual learns to recognize the situation or states in which he is most vulnerable to substance use; avoidance of those high-risk situations whenever possible and use of a variety of cognitive and behaviour strategies to cope effectively with those situations if they cannot be avoided. These strategies include lifestyle changes; social support enhancement and refusal skills for social antecedents, cue-exposure treatment (CET) and decision making skills for environmental antecedents; change strategies and acceptance strategies for emotional antecedents; modifying automatic thoughts and drug-related beliefs and modifying conditional assumptions and core beliefs for cognitive antecedents; distraction; urge surfing and focus on consequences for physical antecedents. However, CBT is a comparatively complex approach and training the clinician to implement this approach effectively can be challenging.

Suggested Reading:

1. Najavits, L. M., Liese, B. S., Harned, M.S. (2005) Cognitive and behavioral therapies. In chapter 47, Substance Abuse- A comprehensive textbook. Eds. Lowinson JH, Ruiz P, Millman RB, Langrod JG; pp 723-732.
2. Higgins, S. T., Petry, N. M. (1999) Contingency management- incentive for sobriety. Alcohol Research and health, 23(2):122-27.
3. Carroll, K. M., Onken, L. S., (2005) Behavioral therapies for drug abuse. Am J Psychiatry, 162, 1452-1460.
4. Da Silva, C.J., Serra, A. M., (2004) Cognitive and cognitive behaviour therapy for substance use disorders. Rev Bras Psiquiatr; 26 (Suppl 1:,33-39.

5. Mayet, S., Farrell, M., Ferri, M., Amato, L. and Davoli, M. (2004) Psychosocial treatment for opiate abuse and dependence. Cochrane database of systematic reviews, Issue 4

6. Beck, J. S. and Leise, B. S. (1993) Cognitive Therapy. In: Clinical Textbook of Addictive Disorders 2nd ed Frances RJ, Miller SI, editors. New York :Guildford Press; 547-573.

7

Working In Groups: Helping Substance Abusers and Their Families

Thirumagal.V*

Introduction

Group settings offer an ideal opportunity to reach out to substance abusers and their families. Group based interventions can be designed to achieve a range of outcomes:

- Awareness and sensitization about substance abuse problems
- Identification of substance abuse disorders
- Initiation and maintenance of behavior change in relation to substance abuse
- Reduction of harm related to substance abuse

Group interventions have in-built strengths as participants are able to :

- Meet and interact with others with similar problems
- Listen to and learn from experiences of others
- Talk about past experiences and feelings to find relief
- Identify problem areas and initiate realistic problem solving
- Feel more confident and increase optimism by working alongside others

Group based interventions are especially appealing in resource restricted settings as the services of trained staff (which is in short supply) can be utilized to reach out to more number of beneficiaries when compared to one to one interventions. Based on a review of numerous outcome studies, Roberts and Ogborne (1999), recommended that group based interventions are to be 'preferred' as these are just as effective as individual treatment while being less expensive. Studies also indicate that out-patient programs can work just as well as in-patient programs and short term interventions can be effective though many clients do need residential treatment. Group based approaches that address issues such as identification of high risk situations, refusal skill training, social skill training that helps strengthen relationships have been found to be associated with successful outcomes. In a review of 22 studies in 2003, O'Farell and Fals-Stewart showed that marital and family therapy increased abstinence and improved relationships. A qualitative research report from Chennai, India, highlighted the value of family interventions from the point of view of therapists and family members of drug dependents.

* Thirumagal. V, MPhil, Consultant, TT Ranganathan Clinical Research Centre, Chennai.

Components of intervention

Group interventions for substance abusers and their families are designed to meet different objectives and the intervention needs to reflect this. The following table presents the framework of group based intervention for both the groups. Depending on the need, the implementing physician can modify the same even while ensuring that the core elements are retained.

	Substance abusers	**Family members of substance abusers**
Number of sessions	3- 8 sessions	2- 4 sessions
Frequency	Twice a week	Once a week
Duration of sessions	1- 2 hours	1 hour
Issues addressed	- Recognizing damages caused by substance use in different life areas - Accepting powerlessness and need to abstain from substance use - Making changes in life style to support drug free lifestyle - Utilizing different services to maintain abstinence	- Receive information about substance abuse and treatment to make sense of what is happening to the substance abuser - Making changes in the way they feel, think and act to reduce dysfunction caused due to substance abuse
Structure of group sessions	-Interactive inputs to present information-Group work to internalize information received as well as skill training	- Interactive inputs to present information - Group discussions to internalize information received
Other supportive	Individual assessment	- Al-anon meetings
Components in addition to group sessions	- Detoxification - Pharmaco- therapy (including disulfiram, naltrexone or other medications) - Alcoholics Anonymous meetings - Referral for other services	- Referral for other supportive services
Personnel to carry out the intervention	Medical Officer and social worker / psychologist / health worker with adequate training	

Suggested session plan with topics for interactive inputs and group activity (in italics) is presented below:

Session plan for substance users

Session 1 :

Substance use disorders - symptoms and progression
Identifying and sharing about few of these symptoms

Session 2 :

Possible impact on one's physical and mental well being, work, financial situation and family and social relationships *Group discussion to list damages in one's own life*

Session 3 :

Staying drug free – how does one make it happen?
Planning and presenting one's daily routine to support a drug free life style

Session 4:

Recognizing and managing relapse cues
Identifying one's own cues and plan to handle these

Session 5:

Handling invitations to try drugs and other high risk s ituations
Role play on refusal skills

Session 6:

Handling stressful situation without resorting to drug use
Group discussion on healthy ways of handling stress

Session 7:

Developing relationships – communication and strengthening relationships
Identifying relationships that need to be strengthened and listing efforts they need to make

Session 8:

Utilizing other resources to stay drug free – pharmaco-therapy, self help group meetings, spirituality etc
Sharing in group about recovery plan

Session plan for family members of substance users

Session 1 :

Facts about substance abuse disorders
Recognizing symptoms of substance abuse in their loved one and sharing in the group session

Session 2 :

Information about recovery from addiction and relapse
Sharing in group about the unsuccessful attempts made to control loved one's substance use and accepting one's unmanageability

Session 3 :

Co dependency traits
Identifying dysfunction in one's own life due to loved one's substance use

Session 4 : Recovery issues for family
Sharing in group about how one can cope with least amount of dysfunction

Suggested Resources to Plan Inputs for Sessions:

Follow-up Services:

Telephone call, letters or personal visits wherein clients can be helped to review progress and receive encouragement and support to maintain drug free life style

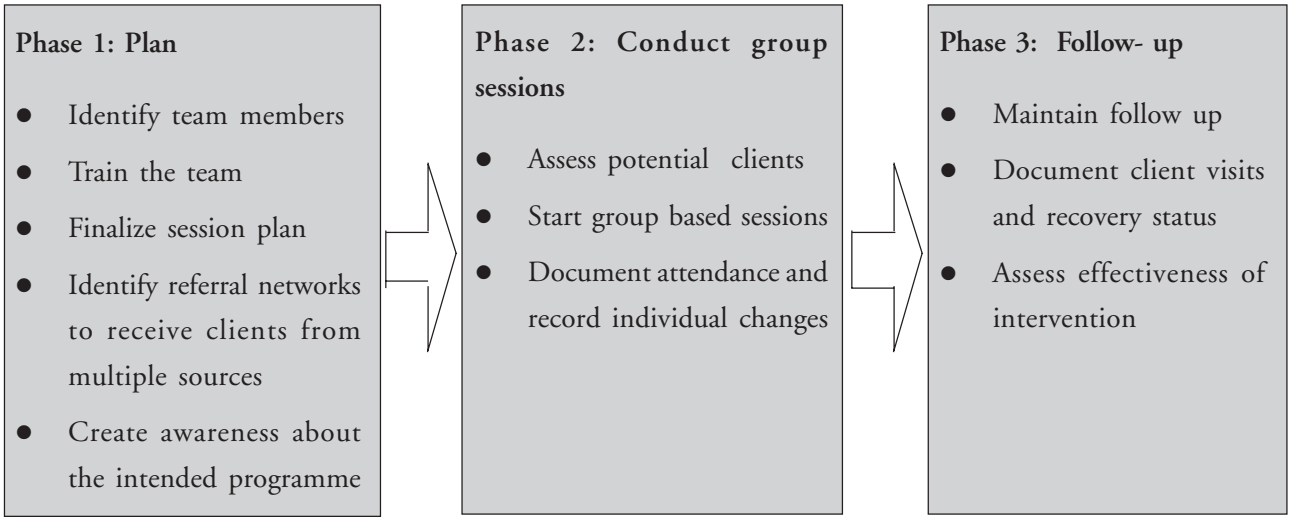
Knowledge:

- Assessment of substance abuse
- Short and long term effects of different drugs, symptoms of substance abuse, withdrawal symptoms andit's management
- Different treatment approaches, recovery and relapse prevention
- Impact on family and family recovery issues

Skills:

- Being 'empathetic' and establishing a 'helpful, non-confronting relationship'
- Public speaking and group presentation skills
- Able to motivate participants to talk openly, interact and work together to support each other in making meaningful changes in life
- Networking skills to work with agencies :
  - to receive client referrals (from trauma care units, other physicians and social service agencies)
  - to refer clients who need additional help (psychiatric help, addiction treatment centers and STI and HIV related services, legal assistance etc)
  - Recording and documentation skills

Steps in Intervention:



Problems and challenges

1. Inadequate number of clients: Making the programme known by conducting awareness programmes in the community, giving out press reports, distributing pamphlets and fine tuning networking can generate more referrals. Conducting sessions with lesser than 5 clients reduces the effectiveness and increases the cost.

2. Drop-outs: Clients may not complete the number of sessions and discontinue mid way due to lack of motivation or difficulties related to time off from work. Often clients feel that they can manage on their own and do not need additional help. Contacting the client and inviting him/ her to complete the programme may bring him/her back or at least motivate him/her to return for help if and when they relapse.
3. Drunk or under influence of drugs during the sessions: The client needs to be met in private and requested to come back for the next session in a sober state even while letting him/her know that he/ she cannot be part of the current session. Participation cannot be permitted as he/she does not profit by attending the sessions and can, moreover, set a bad precedent for the client as well as others in the group.
4. Relapses during or on completion of the intervention: Relapses do not necessarily mean a failure of the treatment intervention. For many clients a return to drug use helps them identify areas that they need to address and most clients go through treatment programmes more than once before they are able to establish long periods of sobriety. If the intervention makes clients more aware of their substance use, helps them reduce negative impact or avoid risks arising out of drug use and increases motivation to work towards a drug free life style, it needs to be seen as a positive outcome.

Pictorial Representation of the Intervention

The intervention process is explained using a fictitious case study of Raju to highlight the services required at different phases of recovery and the possible outcomes.

First phase – *Assessment and Preparation of client*

- Screening to assess level of dependence of client
- Explaining rationale of intervention and what client and family are expected to do
- Motivating client by showing how treatment can help
- Referral for detoxification or medical support if needed

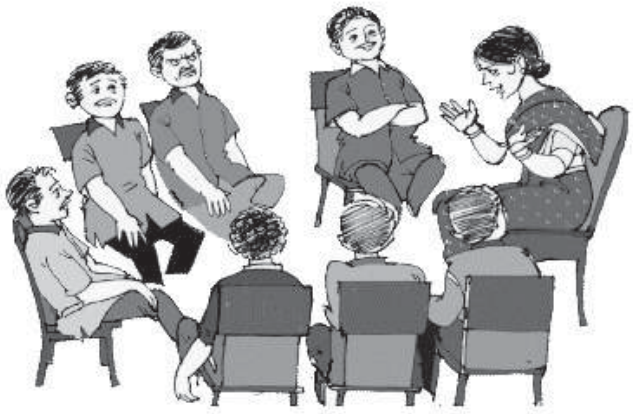
Raju, a 35 year old painter, was referred after an accident. Assessment showed moderate level of dependence. Raju was helped to see that quantity and frequency of alcohol and cannabis had increased in spite of two earlier attempts to give it up and was causing problems related to finances and work. Raju and his wife agreed to attend group sessions which were held during weekends and also meet the doctor once a week for the next one month

Second phase - *Participation in group sessions*

- Receives appropriate information in lectures
- Attends group discussions to internalize messages
- Develops recovery plan

Raju was able to recognize symptoms of substance dependence and understand that he needs to stay off alcohol and cannabis. He is able to identify relapse triggers and makes plans for alternative ways of coping. He decides to avoid drinking colleagues during the weekends. "They report to work on time on Mondays but this does not happen with me as I just go overboard", he reasoned. He decided to handle the boredom during his off days between painting contracts by watching movies, visiting his parents or doing odd jobs around the house. He learnt that eating on time, handling anger and getting adequate rest was important. He was also given the addresses where Alcoholics Anonymous meetings were held.

His wife Rani also benefited from these sessions. While she previously viewed alcohol and drug use as an act of defiance and lack of concern for her, she could now recognize his loss of control and sense his helplessness. She saw how her own lifestyle had progressively deteriorated. "What he did with alcohol I did without it in anger and despair", she said.



Third phase - *Follow up and stabilization of recovery*

- Periodic visits to the physician to review progress
- Prevent relapses by preemptive moves or timely help in case of relapse

Raju enjoyed the fortnightly visits to the physician. He felt good talking about the small little successes - bringing his weekly wages back home in full, feeling energetic at work all through the day, his mother's smile when he visited her without drinking. The assurance he received from the physician when he was anxious and encouraging words when he was frustrated about set backs was of great help. Once he took a few puffs of cannabis and also had an intense craving to drink. Meeting the physician helped him handle the craving and move ahead.

Instead of being preoccupied about his substance use, Rani focused on maintaining a routine for herself and desisted from making comments about the past. By following the 'one day at a time' principle she found that she could reduce her stress levels and relate more easily to her husband. Raju found in her a confidante to whom he could talk to when he had a craving and felt good when she drew his attention to positive changes he had made.

Raju has been sober for a year now and is a much happier man. He continues to remind himself that staying sober is extremely important and has made a decision to get in touch with the doctor at the slightest hint of trouble.

Summary

Group based interventions can be effective with substance abusers and their families. Assessing and preparing the client to attend the required number of sessions is the first step. Presenting information, helping them share in a group setting and skill building sessions help them understand their substance use and make meaningful changes in their lifestyles. Maintaining follow up to provide support to help clients stabilize recovery is also essential.

Suggested Reading

1. Aditi, G. and Thirumagal, V. (2004) Effectiveness of family therapy programme in an addiction treatment center. Paper presented in conference on 'Social problems in India, Perspectives in Intervention', T.T.Ranganathan Clinical Research Foundation, Chennai.
2. Jayaraman,R., Kanagam.U. (2005) Personal recovery tools for the drug dependent, T.T. Ranganathan Clinical Research Foundation, Chennai.
3. Ranganathan, S., Jayaraman, J. and Thirumagal, V. (2002) Counseling for drug addiction Individual, Family & Group: a field guide for trainers and service providers, Ministry of Social Justice and Empowerment, Government of India and United Nations International Drug Control programme, Regional Office of South Asia, Delhi.
4. Roberts, G., Osborne, A., Leigh, G., and Adam, L. (1999) Best practices – Substance Abuse Treatment and Rehabilitation, Office of alcohol, drugs and dependency issues, Health Canada, Ontario.

8

Family Interventions For Substance Use Disorders

Suman L N, Manoj Kumar Sharma*

Introduction

The family is a system and consists of subsystems within its boundary. The subsystems include the marital dyad, the sibling subsystem and the parent-child subsystem. Change in one part of the system leads to changes in other parts of the system. Substance abuse affects every member of the family system in a devastating manner. It adversely influences the family emotional climate, family identity, family tasks and relationships among the family members. Family interventions focus on bringing about a favorable change in all the subsystems in order to help the family recover from the trauma of widespread negative consequences of substance use on the family. Very often, a family crisis brings the patient into treatment. For e.g., the substance user is stigmatized by society and may find it difficult to get a suitable groom for his daughter unless he abstains from substances and changes his image. This forces many individuals to seek help. Empirical research has indicated that including the family in the treatment program increases the chances of better treatment engagement by the patient and favorable outcomes. Family interventions include marital therapy for the patient and his/her spouse and family therapy which includes the children of the substance user along with their parents. Family therapy is also carried out with unmarried patients and their parents.

Intervention

Phase of Intervention:

1. *Screening and Assessment*

- Alcohol and drug use history (use of alcohol and drugs, mode of use of drugs, quantity used, frequency, pattern of use, alcohol / drug combination, craving and legal complications).
- Medical History
- Family & personal history (marital status, alcohol or drug use by parents, sibling, relatives, alienation from family, drug using friends, domestic violence and history of other abuse, school, occupation and sexual history)
- Cognitive functions (Assessment of attention, concentration and memory).

* Suman L. N, M Phil, PhD, Associate Professor, Department of Mental Health and Social Psychology, National Institute of Mental Health and Neuro Sciences, Bangalore.

* Manoj Kumar Sharma, M Phil, PhD, Assistant Professor, Department of Mental Health and Social Psychology, National Institute of Mental Health and Neuro Sciences, Bangalore.

2. *Assessment of Impact of Substance Abuse on Client's Family*

- Consideration of the family from the client's point of view.
- Assessment of family member's effectiveness of communication, supportiveness or negativity, parenting skill, protective and risk factors. conflict management and understanding of addictive disease.

3. *Intervention:*

Engagement / motivation : It involves developing therapeutic alliance, reducing negativity and resistance among the family members, improving communication, enhancing optimism and developing motivation for change.

Behaviour change : It focuses on developing and implementing individualized change plan / changing the drug using behaviour / developing the relational skills (example : improving communication, coping behaviour of spouse / children and parenting skill).

Generalization / Termination : It deals with maintaining / generalizing the change in the personal area, preventing relapse to drug, enhancing social support for change and planning of booster sessions to maintain the behavioural changes.

Who Carries Out Therapy:

Therapy is generally carried out by trained mental health professionals (Clinical Psychologist, Psychiatrist and Psychiatric Social Workers). These mental health professionals must have exposure/ training in family therapy. It is useful for medical officers to network with trained professionals who provide such services. When such professionals are not available it would be useful for the physicians to be aware of family dynamics and basic interventions.

When : Family therapy can be planned for those families who present with any of the following:

a) History of difficulty in coping with alcohol / drug related situations, expressing distress, disagreeing, making requests for change, difficulty in listening to and understanding the other's communication and solving the problems productively as a couple.

b) Family members have started avoiding or criticizing the alcohol or drug users, or indulge in verbal or physical aggression.

c) Spouse has taken extra responsibilities to support the family. It leads to his/her decreased involvement in pleasurable activities or development of affective disturbance.

d) Children also show difficulty in coping with common developmental stressors and have started using alcohol as a primary coping behavior.

Number of Sessions: Minimum 10 to 20 sessions over a period of 3 to 6 months are recommended. These sessions can be carried out with a patient and his/her family. The sessions are carried out by one therapist and in some cases with a co-therapist.

Skills Required:

Learning to join the family. The primary skill that the therapist must have is to join the family by developing a therapeutic alliance with all the participants by listening/empathizing and taking into consideration each person's point of view.

It is composed of three broad actions : making contact, balancing interaction and moderating intensity.

Making contact: It is the first step in creating a strong relationship with the family. The therapist can make contact with family members in a number of ways, example by introducing himself/herself to each person who has come to the session, asking their names and then using their names while interacting with them. The therapist can assess reasons for the present contact from each member of the family.

Balancing interaction : It means giving everyone a chance to have a say about the family problems. It can be achieved by setting ground rules for each session. These rules include (a) Only one person in the family talks at a given time, (b) Each family member will speak for himself/herself (c) Involving the silent or quiet member in the discussion by asking direct questions (d) Curtailing monologues of family members by asking questions, making comments or by telling the person to stop so that others would get a chance to contribute to the session.

Managing Emotions : This is one of the key ingredients in family intervention. Several techniques can be used to reduce emotional intensity in a family session. It can be in the form of setting ground rules and asking everyone to speak only to the therapist . In some cases individual sessions can be planned for a family member who may be in severe emotional distress.

Formulation of Goals : It deals with the ability to negotiate mutually acceptable goals for treatment. These goals serve as a framework for the rest of the treatment. Each session should work towards achievement of the goal the therapist has set with the family.

Process : It is the ability to attend to the interpersonal process in families as well as the content of the problems. Process means pattern of interaction among family members. For example, attending to process means that the therapist tries to figure out how a client's family solves (or does not solve) a conflict, rather than getting preoccupied with what the conflict is about.

Steps in the Intervention:

Assessing and Engaging the Family: Families can be at different stages of coping when a client seeks help for substance abuse. For example, they may have tried all kinds of solutions for the management of the problem. Despite these efforts, the problem might have escalated over time, leading to loss of hope, depression and anxiety among family members. The therapist can acknowledge and validate their efforts to find solutions and the difficulties they have encountered, use reflective listening to talk through any feeling of anger, guilt, fear and frustration and provide self-help material.

Making a therapeutic contract: In the initial session, explain the rationale that family therapy is an opportunity to work out ways of helping the substances users as well as elicitation of solutions for various family problems. Allow time in your initial meeting to get to know each person and their relationship with each other. In your first meetings with the family, work out ground rules for communication. Explain that good communication will help to rebuild trust and ensure that everybody understands each other. Emphasise the importance of one person speaking at a time. In subsequent sessions use of other communication skills such as positive statement, positive specific request and active listening can be encouraged.

Talk about Change: If you have already started work with the client, help him/ her to update their family about treatment. Allow time for them to ask you or your client questions about his treatment progress.

Encourage each person to express his or her hope / expectation and apprehension about what can / cannot be achieved in family therapy. Reflective listening / summarizing / reframing can be used to explore goals at treatment as well as to tackle their apprehensions about the client.

Rebuilding Trust and Resolving Conflict:

Trust among family members can be built up by focusing on existing strength in the family relationship. Following questions can be asked to address this issue

To the family : *"Tell me about a time when you had success in dealing with substance abuse".*

To a Parent : *"Tell me about a time when you felt proud of your son/daughter".*

To the Client : *"Tell me about a time when your family helped you".*

Supporting and Rewarding Behavior

Help the family in creating a list of safe situations (it includes activities, places and people that are incompatible with drug and alcohol use) and risk situations (it includes activities, place and people that are likely to make it hard for the client to resist urge) by using open ended questions.

Family can be helped to promote client participation in safe activities. It can involve a written schedule of activities for each day and reviewing the progress at regular intervals.

Monitoring and Responding to High Risk Stuations:

Help the family in identification of high-risk situations and their management. In cases where the family has lost trust due to past failures, engage them to talk about lapse, expressing concern for each other, use time out in response to angry feelings and help them to work together to build a new relapse prevention plan.

Other Issues can also be taken up for Intervention:

Enhancement of coping behaviour of partner : Spouse coping skills include learning new ways to discuss drinking and drug use situations, learning new responses to the partner's drinking or drug use in the form of physical, psychological and sexual violence. Partners can be trained to manage these type of abuse. High risk sexual behaviour among drug using partners and the likely vulnerability of the spouse to STDs and HIV may require focus.

*Enhancement of interaction / problems solving skill*s between two partners for both substance use and other issues is helpful in decreasing mental conflicts as well as increasing positive exchanges among partners. Initially alcohol/ drug related topics can be used to introduce communication and problem solving skills. Such topics include how the couple could manage in a situation where alcohol or drug is present, how the partner could assist the alcohol/drug user in dealing with the craving or what the couple will tell family and friends about treatment. In the subsequent sessions, various issues in the form of how to improve parenting skills or involvement in family rituals can be discussed.

Enhancement of social support to drug users and partner : Clients are helped to identify interpersonal situations and persons who are associated with drinking / drug use and are also helped to identify potential social situations and people who would be supportive for drug free lifestyle. These people can be involved in the intervention.

Enhancement of coping behavior of children : Problem solving and stress management skills can be use to enhance feeling of well being among these children.

Termination of Session can focus on:

- Emphasizing change made during therapy. How is the new family different from the old family?

- Plan for problems! What stressors and problems can the family members anticipate? How will you handle them in a way that will keep them on track with the changes you have made.
- Booster sessions helps the family to maintain the change.

Problems and Challenges Faced:

1. Long term substance use leads the user to significantly neglect the roles within the family context . This often leads to feelings of shame and guilt especially in relation to their children. As a result, many patients give consent for marital therapy but not family therapy as they feel unable to face the 'loss of respect' from their children which may manifest during the therapy sessions. In such cases, the approach has to be explained to the client in detail, and he/she has to be made to understand that it is not confrontational nature.
2. The marital commitment of the spouse may have reduced over time; this can lead to indifference and lack of involvement in the treatment program. Spouses who are contemplating separation or those who have relocated to their parents' home, are poorly motivated for marital/family therapy. This requires meeting the spouse in an individual session and examining the possibility of reconciliation with the patient.
3. In some cases, consent for marital/family therapy is refused by the parents of the spouse, on her behalf, as they feel that the focus of treatment should remain on the patient and not the long suffering family members. In such a scenario, the rationale of the approach may have to be explained to the relatives and they will have to be reassured that the focus would not shift to the spouse or children.
4. Marital therapy may not be successful if the patient is currently having an extramarital affair and his/her commitment to improving the marital relationship with spouse is poor. This is also true especially in the case of male patients who have more than one wife. Very often the therapist may not be aware of these issues and may be puzzled by the poor outcome. Therapists must enquire in detail other heterosexual relations of the patient before planning marital therapy. Therapy may face another hurdle if the patient is having a homosexual relationship and is not willing to disclose it to his spouse.
5. Marital therapy can become challenging if the patient and his spouse have a consanguineous marriage. In such cases patient and the spouse refuse to consent as they do not want to involve the family elders. It has to be explained to the spouse that consenting for therapy would not constitute an affront to her elders.
6. Family therapy is especially challenging with joint families which protect the patient and make a scapegoat of the patient's spouse. These families reinforce the patient's addictive behavior by blaming the spouse for his condition. There is frequent 'ganging up' which often demoralizes the spouse and makes her powerless to assert herself.

7. In the joint family setting, there may be more than one substance using individual. If only one is motivated for treatment and the other is uninvolved, the success of therapy may be compromised. The same is true of couples who are both substance dependent. If both are motivated for therapy, the likelihood of a favorable outcome is enhanced. In such cases, it is advisable to motivate all the substance using family members to abstain from alcohol/ drugs and cooperate with each other to make the treatment effective.
8. Severe family pathology involving marital/domestic violence, child sexual abuse or incest are often 'family secrets' and the patient's spouse and children may be afraid that therapy sessions would bring such issues out in the open. This apprehension leads to decline of consent for marital/family therapy. A sensitive approach is required to overcome such fears and a protective strategy for the spouse/child will have to be planned separately.
9. Adult children of alcoholics are often resistant to family therapy as a result of anger and hostility against their substance using parent. This is especially true of sons who frequently decline to participate in family therapy sessions. Individual sessions would be required with them initially to make them understand the benefits of the approach. It has been noted that they often give consent if they perceive that the approach would help their mothers.
10. Women substance users are greatly stigmatized and often have poor support systems as they are perceived by others as being morally deficient. Often, they do not receive emotional support from their spouses (who may be substance users themselves) or their children. Some are abandoned by their spouses who remarry and set up separate families. In such cases, marital/family therapy may not be possible even if it is indicated. These women may require to be placed in shelters. Some may be accepted back by their parents/siblings but empowerment of these women is critical for their survival and dignity.

Family based interventions, when carried out effectively lead to improved interpersonal relations among family members, better coping strategies and more involvement in family matters by the patient. This also leads to decline in substance use behaviors and fosters cohesiveness. However, this approach does not address the needs of individual members. For e.g., the son of a patient may be so distressed that he may require individual therapy before he is included in family therapy sessions. Further, the approach may fail if all the members do not adhere to the goals of therapy or sabotage the sessions by making one member a scapegoat.

Diagrammatic Representation of the Intervention:

Screening and assessment
(Alcohol / drug use history, family / personal history / cognitive function)

↓

Assessment of impact of substance abuse on client family
(Communication skills, supportiveness, parenting skills, protective factor & risk factors, conflict management)

↓

Working with families - skills
(Learning to join family, making contact, balancing interaction, managing emotional intensity, formulation of goal and attending to process)

↓

Interventions

- Engaging / motivation
- Behaviour change
- Generalization / Termination of treatment

Tools to be used for Intervention:

Scales for Family Assessment

Marital Dyad	The Marital Quality Scale: This scale was developed by Shah (1995) at NIMHANS The Dyadic Adjustment Scale: This was developed by Spanier (1976)
Scales to assess family environment	The Family Environment Scale: This was developed by Moos and Moos (1976) Family Interaction Patterns Scale: This was developed by Bhatti et al (1986) at NIMHANS.
Scales to assess interpersonal violence	The Conflict Tactics Scale: This was developed by Straus (1979)
Scales to assess parent-child relationships	Parental Bonding Instrument: This was developed by Parker, Tupling and Brown (1977) Parent- Child Interaction Questionnaire-Revised: This was developed by Lange et al (2002)
Scales to identify children of alcoholics	Children of Alcoholics Screening Test: This was developed by Pilat and Jones (1983) Screening Interview for Identifying Teenagers with Problem Drinking Parents was developed by Biek (1981)

Summary:

The family is a system and consists of subsystems within its boundary. Change in one part of the system leads to changes in other parts of the system. Substance use affects every member of the family system. Family intervention targets these various subsystems (individual, spouse, children) to bring change in the family. These interventions involve assessment, engaging/motivating family members for behaviour change and generalization of the learned behaviors. It also targets the coping behaviour the of spouse, communication skills, children's behaviour and domestic violence. Family intervention leads to improved interpersonal relations among family members, better coping strategies, more involvement in the family by the patient and decline in substance use behaviours.

Suggested Reading:

1) Bhatti, R.S. Subbakrishna, D.K. and Ageira, B.L. (1986) Validation of Family Interaction Patterns Scale. Indian Journal of Psychiatry, 28: 211-216.

2) Biek, J. (1981) Screening test for identifying adolescents adversely affected by a parental drinking problem. Journal of Adolescent Health Care, 2: 107-113.

3) Lange, A. Evers, A. Jansen, H. and Dolan, C. (2002) The Parent Child Interaction Questionnaire-Revised. Family Process, 41: 709-722.

4) Parker, G; Tupling, H and Brown, L.B (1977) A Parental Bonding Instrument. British Journal of Medical Psychology, 1-10.

5) Pilat, J.M and Jones, J.W (1983) Identification of Children of Alcoholics: Two empirical studies. Alcohol Health and Research World, 9: 27-36.

6) Shah, A (1995) Clinical validity of Marital Quality Scale. NIMHANS Journal, 13: 23-31.

7) Spanier, G.B (1976) Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. Journal of Marriage and the Family, 38: 15-28.

8) Straus, M.A (1979) Measuring intrafamily conflict and violence: The Conflict Tactics Scales. Journal of Marriage and the Family, 41: 75-88.

9

Improving Extra-Treatment Support

(Including Peer-Led Groups)

Atul Ambekar, Deepak Yadav, Alok Agarwal*

Introduction

The treatment of drug dependence has seen remarkable developments over the years with the availability of several effective alternatives, which include both pharmacological and non-pharmacological approaches. However, the effectiveness of these alternatives depends upon the model through which the services are delivered as the treatment seeking and service utilization rates vary considerably. In our part of the world, a long duration of time is lost before drug users access various treatment services. During this time they are exposed to several health risks, including HIV/AIDS (UNODC, 2004). The reasons behind treatment non-seeking have been researched in India and have been found to be lack of motivation, stigma attached to the substance use and lack of understanding about the nature of the illness (Pal et al, 2003). Reaching the out-of-treatment population is indeed a challenging task and can be made possible by a partnership with current users – 'peers' – involving them as volunteers to facilitate treatment entry for their drug using peers. In this chapter we briefly present overview of two "Extra treatment" approaches. One of these, Peer Led Intervention could be an effective approach to bring drug users into treatment (i.e. to be used *before* actual treatment). Another important issue we discuss is that of Occupational Rehabilitation, once the treatment has begun (i.e. *during* or *after* actual treatment). Finally, we also briefly discuss spiritual and faith based interventions as an 'extra' modality which could improve the outcome of the treatment.

Unaware

↓

Aware

Concerned

Knowledgeable

Motivated to change

Practicing trial behaviour change

Practicing sustained behaviour change

* Atul Ambekar MD, Assistant Professor, National Drug Dependence Treatment Centre, All India Institute of Medical Sciences, New Delhi.

* Deepak Yadav MSW, Supervising Medical Social Science Officer, National Drug Dependence Treatment Centre, All India Institute of Medical Sciences, New Delhi.

* Alok Agarwal MD, Senior Resident, National Drug Dependence Treatment Centre, All India Institute of Medical Sciences, New Delhi.

Peer Led Intervention

Theoretical Outline

Behaviour Change Communication (BCC): To achieve change in risk-behaviours, the peer led intervention proposed here adopts an approach based on behavior change communication (BCC). BCC is an interactive process with communities to develop tailored messages and approaches using a variety of communication channels to develop positive behaviours, promote and sustain individual, community and societal behaviour, and maintain appropriate behaviours. The basic framework for bringing a change in behaviour is based on the following hierarchy:

The framework is used to:

- Increase perception of risk-behaviour.
- Develop the skills and capabilities of drug users to promote and manage their own health and development.
- Foster positive change in behaviour as well as in knowledge and attitudes of drug users.
- Work in partnership with families, schools, health services and communities to influence the social norms and policy environment.

Components of the Intervention

The model intervention should take place in two phases: preliminary phase, and the intervention phase, each with a separate set of objectives and activities.

- ***Preliminary Phase:***

The preliminary phase deals with the setting up of basic mechanisms for implementation of the peer-led intervention. This phase should begin with the assessment of the drug use situation from existing data. The objectives are to train the manpower required in the programme and to strengthen the existing referral system in the community.

Activities

1. Create/strengthen the Existing Referral System in the Community

Since the drug user needs different kinds of services at different times in her/his drug-using career, a wide range of services need to tapped and inter-linked. These include health and social welfare agencies. Health agencies include services for tuberculosis, STI clinics, voluntary counselling and testing centres and detoxification and rehabilitation services. Social welfare agencies, micro-credit facilities and vocational training centres in existence are similarly networked as referral centres.

2. Recruitment and Training of the staff for Peer-led Intervention

The staff for this peer-led intervention would consist of

- Trainers/Supervisors - non-drug users
- Peer outreach workers (POWs) - ex-drug users

Trainer/Supervisor: The role of a trainer/supervisor in this intervention should be to motivate substance users to enter the treatment net and to supervise, interview, assess and train peer outreach workers. In this model intervention, it is proposed that the person to be given this responsibility should be either a Medical Officer (from psychiatric or non-psychiatric background) or a Social Scientist (e.g. medical social service officer or psychologist). The person should have experience of working in the area of drug use treatment. It is important that the person should be able to communicate with the local population as well as the higher authorities.

The trainer/supervisor would select the peer outreach workers, train them in various skills required to implement the intervention and is also expected to supervise the activities of the POWs. The trainer should also interact with key stakeholders within the community and ensure that the programme runs smoothly.

Peer outreach worker: In this model, peer outreach workers are proposed to be selected from within the substance using population. However, for this intervention the person selected should be an ex-drug user who has been abstinent for at least 2 years without suffering a relapse in the substance use habit. The trainer must be reasonably sure that the outreach worker would not relapse into drug use after coming into contact with the drug using peers. The person should have some formal education, should be able to communicate freely with both the supervisors and with the substance users.

In the proposed model, the most important characteristic of the peer outreach worker is the ability to work with drug users and having a peer status within the drug using groups. As a result, the worker should be able to command respect and develop trust and credibility within the target population. It also ensures that the worker has an understanding of drug use norms and has experience of problems and difficulties associated with drug use and drug treatment. Another important consideration should be the ability to educate effectively (trainability and training ability). Also, the person should possess effective interpersonal skills, strong motivational skills and leadership skills and the ability to work in a team.

After training, the peer outreach workers should start working in the community in the form of outreach teams. It is safer for peer outreach workers when negotiating hidden populations to work in pairs.

• *Implementation Phase:*

The Implementation Phase should deal with the activities related to the delivery of the services modeled in the intervention. In this phase, the peer outreach workers would identify groups of users, establish contact with them and then identify and recruit volunteers from that peer group and with the help of the trainer, educate the recruited current user (volunteer) for risk-reduction related to drug abuse and HIV. In this phase

the selected peer volunteers are trained using behaviour change communication methodology. The trained volunteers are thus brought closer to the services, provided appropriate referral services and finally, to ensure sustainability, are encouraged to form self-help groups.

Activities

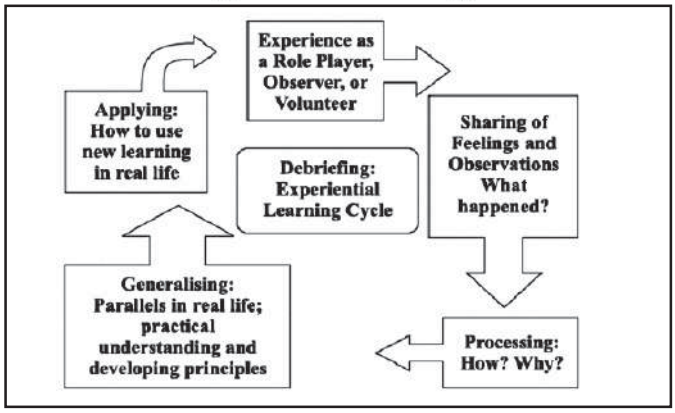
1. Identify groups of drug users in the field
2. Identify and contact the drug users who are suitable for the proposed intervention
3. Motivate the drug users for recruitment into the intervention as peer volunteers
4. Enroll current drug users into the intervention and to train them as peer volunteers
5. To provide assistance to drug abusers in formation of self help groups and referral to treatment whenever required

The POWs identify the locations where drug users congregate to procure/use drugs. Once the locations are identified, the peer outreach workers (POWs) should start visiting the places, observe the drug users' behaviours and attempt to establish a rapport with them. The drug users are then informed about the intervention and offered training as peer volunteers. Those who volunteer for the intervention and sustain interest in the same should be trained according to the training model proposed here.

Peer volunteers should be trained in batches of 10-12 to focus intensely on each person. Each peer volunteer should train members of his/her peer group after each session. The trainees should be matched with the pattern of drug use and level of risk behaviour shown. Care should be taken to ensure that the group of peer volunteers selected for a particular training schedule is as homogenous as possible (for e.g. avoid mixing IDUs with non-IDUs).

In this model, interventions in reducing substance use practices and risk taking behaviours are proposed as a set of seven half-day, once-weekly, training and interactive knowledge and skill building sessions, using behaviour change communication, participatory training and learning action tools. Training of recruited current users/peer volunteers should provide knowledge about problems faced by drug users – with a focus on health hazards, introduction to risk behaviours related to injecting drug use, sharing drug paraphernalia, unsafe sex, and risks associated with drug overdose.

Fig 1. Training



The trainees should also be taught strategies to minimize risk behaviour related to drug use and HIV/AIDS in the context of the current user's reality. Knowledge should also be provided about social consequences of drug use, self-help/support groups, and about relapse, recognizing relapse and relapse prevention.

The training sessions should aim to impart life skills, communication skills, leadership skills, decision making skills, problem solving skills and skills for motivating and training others among the participants. The training should also attempt to develop among the volunteers, sensitivity to the problems faced by family and other users, commitment to train others in the peer group and role model risk-reduction behaviour. Careful attention should be paid to the experience of each trainee as he/she attempts trial behaviour change and experiences training his/her peer-group members. Throughout the training, the peer volunteer should be encouraged into *playing the role* of a person practicing safe, risk-free behaviour *(acting as if).* The use of debriefing through the *experiential learning cycle* should be relied upon throughout the training (see attached figure).

At times, it has been observed that some peer volunteers are shunned by their own peers who do not identify any more with the changes shown by the peer volunteers. Such peer volunteers often feel grateful for the support given to them by other peer volunteers in the training group because of which they are able to deal with their grief and separation. Thus, in this model it is proposed that the trainers/POWs should encourage formation of cohesive bonds between the peer volunteers during the training period. Networking peer volunteers in this manner helps in building a support system for maintaining the newly formed health-seeking behaviour.

How the Intervention Works

Since peer volunteers come from within the substance using groups, the behaviours that they role model are expected to have greater impact on the behaviour of their peers as compared to any other form of educational intervention. The trained peer volunteers are expected to inculcate healthy norms within their peer group and to help in recruiting other substance users into the intervention. Even after the completion of training, the peer outreach workers should remain in contact with the peer volunteers and keep providing the booster training. They should also keep motivating the peer volunteers to form self-help groups, and to seek help from a facility in the organized and formal sector available in the community.

Support Groups or Self Help Groups

The need for support groups or self help groups is felt by recovering drug users. Such support coming from peers with whom drug users identify themselves is often seen as a strong motivating factor for seeking

recovery. It is seen that there are sufficient resources available in communities to start support groups. A coordinated effort is required to establish and set-up support groups with the networking of non-governmental organisations (NGOs), community based organisations (CBOs) and the religious institutions on the one hand, and drug treatment centres on the other.

Problems and Challenges

1. *Safety of the outreach team* - Sometimes the peer outreach workers can encounter hostility towards them while establishing contact with drug users. The POWs should take appropriate security precautions and should leave the site in such cases. Another important aspect of safety of outreach workers is the risk of relapse into the drug use habit on meeting the drug using persons. Working in pairs also helps POWs resist the temptation to relapse into drug use.
2. *Ethical considerations* – the peer volunteers may be exposed to individuals with higher risk. Such interactions rather than creating a new consensus around risk reduction and disclosure goals, may create negative role models for the volunteers who may then follow their behaviours and increase risk for themselves.
3. *Negative connotations of messages* – When aiming for behaviour change, it is plausible that messages designed to motivate the protection of others would be less well attended to and less likely to motivate behavior change than would messages about protecting one's own health. For e.g. such messages might make individuals living with HIV feel bad about themselves by making salient the fact that their past behavior may have put some of their partners at risk and that their future actions could threaten others.
4. *Confusion between options* – Previous research indicates that peer-interventions work best when part of a larger basket of services. Although this approach allows individuals to select the strategies that best fit their personal situation, presenting participants with multiple options may decrease, rather than increase, the adoption of effective risk reduction strategies. New evidence suggests that providing multiple HIV risk reduction recommendations may interfere with the adoption of maximally effective strategies.
5. *Barriers to communication* – barriers can appear at several different levels. Specifically, barriers exist on three levels:
    a. *Intrapersonal* – or within oneself
    b. *Interpersonal*– between two people
    c. *The community at large* – the larger environment around oneself

Summary of the Intervention

Peer-led interventions are outreach based models of substance abuse treatment based on the premise that the change in behaviour of any individual within a drug using group is largely determined by the

attitude of the fellow drug users towards the same. In this intervention model, current and ex-drug users are utilized as the primary agents of change within the drug using population. The proposed intervention consists of two phases- preliminary phase and the intervention phase. The preliminary phase deals with the setting up of basic mechanisms for implementation of the peer-led intervention while during the Intervention phase the peer volunteers are trained in a systematic fashion and knowledge and skills regarding treatment seeking and risk-reduction strategies are imparted. The peers then extend this knowledge to their drug using groups thus multiplying the impact of the intervention. The intervention also gives adequate emphasis to the establishment of self-help groups among the drug users and aims to integrate the initiative with other health and developmental programmes(UNDOC, 2005).

Steps in peer led intervention

- Select and train staff (trainer, outreach workers)
- Create a referral system in the community

Identify and motivate current drug users (peer volunteers)

↓

Train peer volunteers

↓

- Provide referral services to those who need them
- Create self help groups of drug users

Occupational Rehabilitation

Treatment needs of patients with substance use are unique and must be addressed by individualized intervention. Treatment when tailored to individual needs, can enable the patient to control their condition and live normal, productive lives. Unemployment and substance abuse disorders may be intertwined long before an individual seeks treatment. While it is well known that substance use leads to deterioration in occupational functioning, it has also been seen that enhanced occupational functioning leads to a decrease in substance use. The issue of occupational rehabilitation is also important to facilitate integration into society and prevent relapse. The unemployment rates of people with substance abuse disorders have been found to be much greater than those of the general population. Employment status also helps in retention in treatment and reduces the likelihood of relapse . Employment also can help decrease criminal behavior. A legal source of income by a recovering patient facilitates structured use of time, and improved self-esteem and interpersonal relationship, which in turn may reduce substance use and criminal activity. Research has shown that the best predictors of successful substance abuse treatment are:

- Gainful employment
- Adequate family support
- Lack of coexisting mental illness

Substance abuse disorders are a barrier to employment. Therefore it is imperative that vocational services should be incorporated into substance abuse treatment. In a developing country like India, owing to large

scale unemployment and resource crunch, gainful employment for recovering patients is a challenging task. With the stigma of drug use the patient either is not provided a job, or if in a job, are generally underemployed. Demonstration projects in India have shown the utility of occupational rehabilitation in improving recovery among substance users.

Planning Occupational Rehabilitation

While planning vocational rehabilitation, the following conditions need attention, and the individual should be cautioned against:

- Active drinking or substance use by other employees.
- Pay day (i.e., money management)
- Working on rotating, night shifts.
- Seasonal work.
- Lack of supervision
- Working excessive overtime.
- Excessive labor-intensive job.
- Drug availability near the place of work
- Access to marketable goods or petty cash
- Receiving cash tips
- Too much free time on the job
- Too much pressure on the job
- Job dissatisfaction or boredom
- Required business meetings, dinners, and parties where use of substance is expected.

Challenges to Occupational Rehabilitation

Unemployed individuals in substance abuse treatment programs face many challenges and obstacles in obtaining and keeping jobs. The barriers they face may exist within themselves, in interpersonal relations with others, or in coexisting medical and psychological conditions. Barriers also stem from society, scarcity of lower level jobs, and prejudice against employing people with substance abuse disorders. The initial period of recovery where the patient has to make frequent visits to hospital for follow-up makes the situation further complicated. As a result, they are left with two choices: being idle while on treatment, or to drop out from treatment to meet the economic demands. The post detoxification phase is generally associated with increase in expectation by family members; economically burdened by the individual's substance use they expect the patient to reassume the economic role as early as possible.

Spiritual and Faith Based Interventions

The need for an additional modality of intervention that would improve *quality of life*, reduce *craving*, *protracted withdrawals, severity of addiction* and *retention* is perceived. Since craving, stress, negative emotional states, interpersonal problems are universally accepted predominant relapse factors, spiritual and faith based interventions have been felt as a viable intervention that could possibly strengthen the expected outcome.

Spirituality has been viewed as an important adjunct to enhance treatment outcome of substance use disorder treatment. Miller in 2003 noted that many factors point to spirituality as an antidote to addiction: as a preventive, a treatment, and a path to transformation. Introspection, self-help movements, pursuit of the inner child, and various 12 Step approaches have a widespread impact. Undeniably, the 12 Steps of AA are explicitly spiritual in the areas of: gaining awareness of a "higher power" beyond oneself, turning over one's will to and asking for help from the higher power, confessing and making amends for wrongs, practicing prayer and meditation and seeking to conform oneself to the will of the higher power. The use of spiritual concepts in the treatment of alcohol and drug addiction is seen as the clearest demonstration of the value of spirituality and this construct is seen as the central curative factor in recovery. Research has shown that spirituality has played a role in maintaining treatment gains, and that recovering individuals apparently show more evidence of spirituality than those who relapse . Meditation of various kinds has been found to be helpful in the prevention and treatment of addictive behaviors. Thus, if patients display an inclination to join one of the spiritual approaches / programmes it should be encouraged by the treatment team. A detail description of 'how to' of spiritual approaches is beyond the scope of this document.

Suggested Reading:

1. Aron A., and Aron, E.N. (1980) The transcendental meditation programs effect on addictive behavior. Addictions and Behavior, 5: 3-12.
2. Borman,P.D and Dixon, D.N. (1998) Spirituality and the 12 steps of substance abuse recovery. Journal of Psychology and Theology, 26: 287-291.
3. Gelderloos P, Walton KG, Orme-Johnson DW, Alexander CN (1991) Effectiveness of the Transcendental Meditation Program in Preventing and Treating Substance Misuse: A Review. International Journal of Addictions March; 26(3): 293-325.
4. Gerstein, D.R., Johnson, R.A., Harwood, H.J., Fountain, D., Suter, N., and Malloy, K. (1994) Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment (CALDATA). Sacramento, CA: California Department of Alcohol and Drug Programs.
5. Jarusiewicz, B. (2000) Spirituality and Addiction: Relationship to recovery. Alcoholism Treatment Quarterly, 18(4): 99-110.
6. Koski- Jannes,A and Turner N.(1991) Factors influencing recovery from different addictions. Addiction research, 7 (6): 469-492.
7. Marlatt, G, A and Marques, J.K. (1977) Meditation, self control and alcohol use. In R.B Stuart (Ed), Behavioral self management strategies, techniques and outcomes. 117-153. New York: Brunner/ Mazal.
8. Miller, W.R. (2003) Spirituality as an antidote for addiction. Spirituality and Health. New York, NY. Http://www.spritualityhealth.com/newsn/items/articles/item_6651.html.
9. Pal HR, Yadav S, Joy PS, Mehta S, Ray R. (2003) Treatment nonseeking in alcohol users: a community-based study from North India. Journal of Studies on Alcohol, 64(5):631-633.
10. Schottenfeld, R.S., Pascale, R.; and Sokolowski, S. (1992) Matching services to needs: Vocational services for substance abusers. Journal of Substance Abuse Treatment. 9(1): 3-8.

11. UNODC (2004) The Extent Pattern and Trends of Drug Abuse in India. National Survey (Ray R). United Nations Office on Drugs and Crime, Regional Office for South Asia, New Delhi.

12. UNODC (2005) Reducing risk-taking behaviour among young drug users in South Asia - Field Manual (Sethi HS, Ambekar A, Pant S, Ray R) United Nations Office on Drugs and Crime, Regional Office for South Asia, New Delhi.

13. Zemore, S.E and Kaskutas, L.A.(2004) Helping, Spirituality and AA in recovery. Journal of Studies on Alcohol, 65:383-399.

10

Community Level Interventions: Role of Medical Officers

"Community as Teachers and as Healers"

R. Dhanasekara Pandian, E. Sinu

Introduction

The role of the medical officer in the community is specially to offer "primary care" to a large group of people in addition to his/her role in curative and rehabilitative services. In recent years the role of promotive health is increasingly being recognized. People are being empowered to protect their own health.

Role of Medical Officer in Community level Interventions: In a broader perspective, it refers to a process which comprises of a range of activities designed by medical officers along with their team to bring about a change, by striking a balance between community problems, community needs and community resources. Medical officers can directly or indirectly work with community. He / she can work directly through health programmes and indirectly through formal or informal services.

Levels of Community Prevention:

1. ***Primordial Prevention***: Here the efforts are directed towards discouraging adults and children from adopting harmful life styles. It aims at preventing, or ameliorating the emergence of risk factors/ vulnerable groups. For e.g impulsivity in children, conduct disorders, childhood maltreatment, adult – role modeling in the family are some risk factors for later development of substance use disorders. People in some areas of work like painting, carpentry, construction work, driving, heavy machinery, tourism industry, night shift working hours, monotonous nature of work, work involving high demand, risky work, are all at a greater risk of developing drug and alcohol dependence. Taking appropriate action in this vulnerable group, addressing their cultural beliefs, attitude towards alcohol and drugs, and use expectancies would be a kind of primordial prevention for them. Basically it focuses on individuals at specific risk.

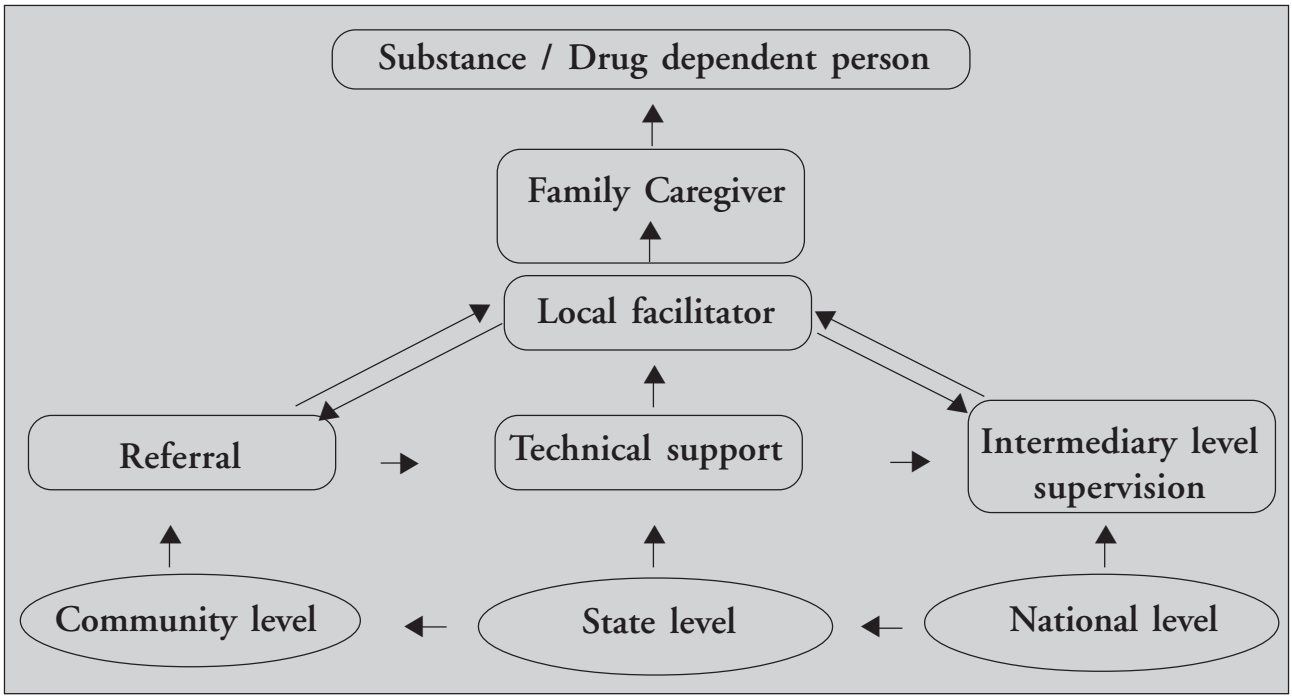
* R. Dhanasekarapandian, Ph.D, Assistant Professor of Psychiatric Social Work and Consultant, De-Addiction Centre, National Institute of Mental Health and Neuro Sciences, Bangalore.

* E. Sinu, M.Phil (PSW), Psychiatric Social Worker, De-Addiction Centre, Department of Psychiatry, National Institute of Mental Health and Neuro Sciences, Bangalore.

2. ***Primary Prevention:*** It refers to a set of actions taken prior to the onset of drug dependence, which minimises the possibility of occurrence or development of dependence. It may be accomplished by measures designed to adopt healthy life style, improving emotional well being, and improving quality of life by implementing specific protective measures like "smoke free environment". Educating youth in the community, children in schools through effective programmes also constitutes primary prevention.
3. ***Secondary prevention*:** Here action is taken to halt the progression of dependence at its incipient stage and to prevent further complications. The specific interventions like case finding, screening, referrals are some forms of secondary prevention. Some industries have employee assistance programs and workplace prevention programs. Medical officers, social workers and labour welfare officers are trained to provide de-addiction related services in these settings. At present some of the government and private concerns are implementing workplace prevention programmes in India.
4. ***Tertiary prevention:*** This includes treatment of persons with dependence and their rehabilitation. At this stage, treatment usually needs to be more intensive, and relapses are common.

Community Based Intervention: In this context, community based intervention programmes are set up within the community. They are owned by the community, formed in response to the expressed needs of the community, and they mobilize resources available within the community. In this process there is a need to include various stakeholders which may include schools, hospitals, employers, workers, groups, relevant government agencies, non-governmental organizations and community volunteers. Linking these various groups in the treatment and rehabilitation services would enable the community to play its role and provide opportunities for extending its support.

Fig 1: Community Based Approach



In community based intervention, the first step is to educate the community on issues pertaining to addiction and recovery. Medical officers, social workers, programme planners and other staff must actively participate in public awareness campaigns and outreach programmes with a special mission to convey pro-rehabilitation messages. A community must be convinced that the programme's ultimate objective is to reduce prevalence of drug use in the area. Hence, the public needs to understand issues like the prevalence of addiction, severity of addiction, effects on lifestyle, how addiction affects families, what rehabilitation programmes are available for persons with addiction, what such person actually experiences when returning to the community and why they relapse. What is most expected of them is to be able to interact in a supportive manner with recovering individuals and their family members.

Community Involvement: Substance use is usually seen as an individual or family disease. It should be viewed as a community issue. The whole village / local community needs to be sensitized and the importance of dealing with the problem needs to be strongly emphasized. Any program in the community becomes successful only when the community itself takes "ownership" and responsibilities of the programs.

Components of Community Level Interventions

1) Effective recognition of substance use related disorders.
2) Public education of substance use related disorders: nature, symptoms, causes, treatments available, treatment centers, risk factors, and vulnerable groups.
3) Through public health education, awareness can be brought about among people in prevention of substance related disorders in the community; thereby, entry into hospital can be minimized.
4) Focused group discussion with individuals in order to achieve positive health thereby improving overall community health.

Role of Medical Officers in Preventing Substance Use at Community Level

1. Integration of de-addiction related services in their routine clinical practice.
2. Collaboration with various other service organizations.
3. Sensitization of non-governmental organizations (NGO's).
4. Conducting community health camps for mass education and mass detoxification services.

5. Integration of de-addiction related services for persons with substance use disorder under District Mental Health Programme.
6. Working with self-help groups and local communities
7. *Using mass media* to counteract popular myths associated with alcohol and drug use and their treatment.
8. *Conducting awareness programs* at schools and colleges on impact of alcohol/drugs on health, family and career and emphasis on healthy life-style.
9. *Training* health educators, ANM's, anganwadi workers, lay-volunteers on addiction related issues.
10. *Maintaining inter-sectoral coordination:* Close coordination must be maintained with organizations like health department, education department, and law enforcing authorities.
11. *Acting as a case manager:* The role of case manager in the community is to ensure the continuity of care and integration with other treatment services. This becomes especially important for managing specific problems such as HIV, tuberculosis, hepatitis which are common health problems among alcohol and drug users.
12. *Providing after-care services*: 'Aftercare' refers to services that help recovering drug dependent persons to adapt to day-to-day community life. Aftercare services provide a safe environment for long term continued support.
13. *Facilitating community based meetings:* Medical officers can play an effective role in facilitating community based group meetings at local schools, library, and public or community hall.
14. *Working with volunteers:* Volunteers from the local community can play a significant role in recovery of a person with substance use disorders by ensuring their regular follow-up. They should have the ability to listen and empathize with persons with substance use disorders. Medical officers can orient volunteers from the community on alcohol and drug dependence. Senior recovering addicts may be involved as "companions" and "mentors" to recovering addicts in the programme.
15. *Working with Non Governmental Organizations*: In most developing countries the NGO's may offer unique services that the government cannot undertake. Since different organizations have different groups of people as their members, linkage with them will expose the programme to a greater number of people in the community. NGO's can help to create opportunities for clients to participate in a variety of healthy activities because each of them has their own strengths and resources. Youth clubs may include clients in recreational activities.

NGO's working on drug and alcohol related issues may involve clients in their public awareness campaigns, and other charitable organizations may hold some kind of fund-raising activity for the community program.

16. *Working with Government Agencies*: Schools, hospitals, welfare and labour department can be involved in community programs.
17. *Enhancing Community Linkages*: Alcohol and drug related rehabilitation programmes need various community linkages to recruit clients, to gain support of the families and the community, to reduce the negative public attitude towards recovering addicts, to help clients get various services from other sources and to get more financial and other support. A good community linkage enables a programme to render more comprehensive service to its clients and ensure continuing support when they go back to the community.

Skills Required for Medical Officers

1. Knowledge: Thorough knowledge of how the community works, nature of the community and its cultural beliefs, knowledge about various practices, needs of the community and problems prevailing in the community.
2. Understanding the range of human needs.
3. Ability to acknowledge the impact of substance on individual, family and community.
4. Skill in transferring the knowledge to others.
5. Positive attitude.
6. Awareness of various de-addiction treatment services.
7. Skill in predicting probable responses to possible lines of action while addressing the substance use problems.
8. Skill in initiating community activities.
9. Skill in resolving group conflicts.
10. Good communication skills and interpersonal relationship with local formal and informal leaders.
11. Being patient –friendly and community-friendly.
12. Ability to lead and to work with other team members.
13. Democratic leadership and administrative skills.

Harm Minimization:

Harm minimization includes a set of strategies to reduce the harm an individual is likely to face as a consequence of drug abuse, including sexually transmitted diseases (STD), risk of HIV infection, hepatitis, and so on.

Methods of Reducing Vulnerability to STD/HIV:

a. Abstain from sex after alcohol/ drug use.

b. If abstinence not possible have non-penetrative sex.

c. If sex is penetrative, use protective measures like condoms .

d. Avoid having sex with commercial sex workers and multiple sex partners.

e. Reduce number of sex partners and number of sexual intercourse after alcohol/drug use.

NIMHANS Experience in Providing Community Level Interventions

1. *Model District Program*: De-Addiction Centre, NIMHANS in a programe supported by WHO, started a Model District Programme for prevention of alcohol and drug related problems in 1999. The main aim of the project was to evolve preventive strategies for drug and alcohol related problems in the community. The objectives of the Model District Programe were:

   - Early recognition of the substance users,
   - Offering preventive counseling,
   - Community –level education for population at risk.

   The project was carried out in Mandya Distrct of Karnataka state, India. As a preliminary step towards this model district programme, NIMHANS conducted orientation programs for medical officers, the education and welfare sectors, and other service organizations working in the district on identification of high risk drinkers, early stage problem drinkers and medical and psychosocial interventions for them.

   The program found that detection rates of drug and alcohol use was extremely low by medical officers. It demonstrated that training could improve the knowledge and sensitivity of these doctors in identifying and intervening for alcohol related problems more effectively.

2. *Out reach- camp approach:* Several government and international agencies recommend that substance use has to be dealt with primarily as a community problem. Community level intervention strategies would involve community leaders and local volunteers. Thus Community level interventions de-emphasise the medical model and focuses more on psychosocial model. Activities in the community include prevention, education, health promotion and harm reduction. The camp approach basically involves mobilization of local resources, involving the family, local community, and decentralization of service delivery. Especially at the village level, where deputing professionals to villages, building new hospitals, opening extension or special clinics may be difficult, providing services through camps in villages may be more viable modes of intervention at the community level.

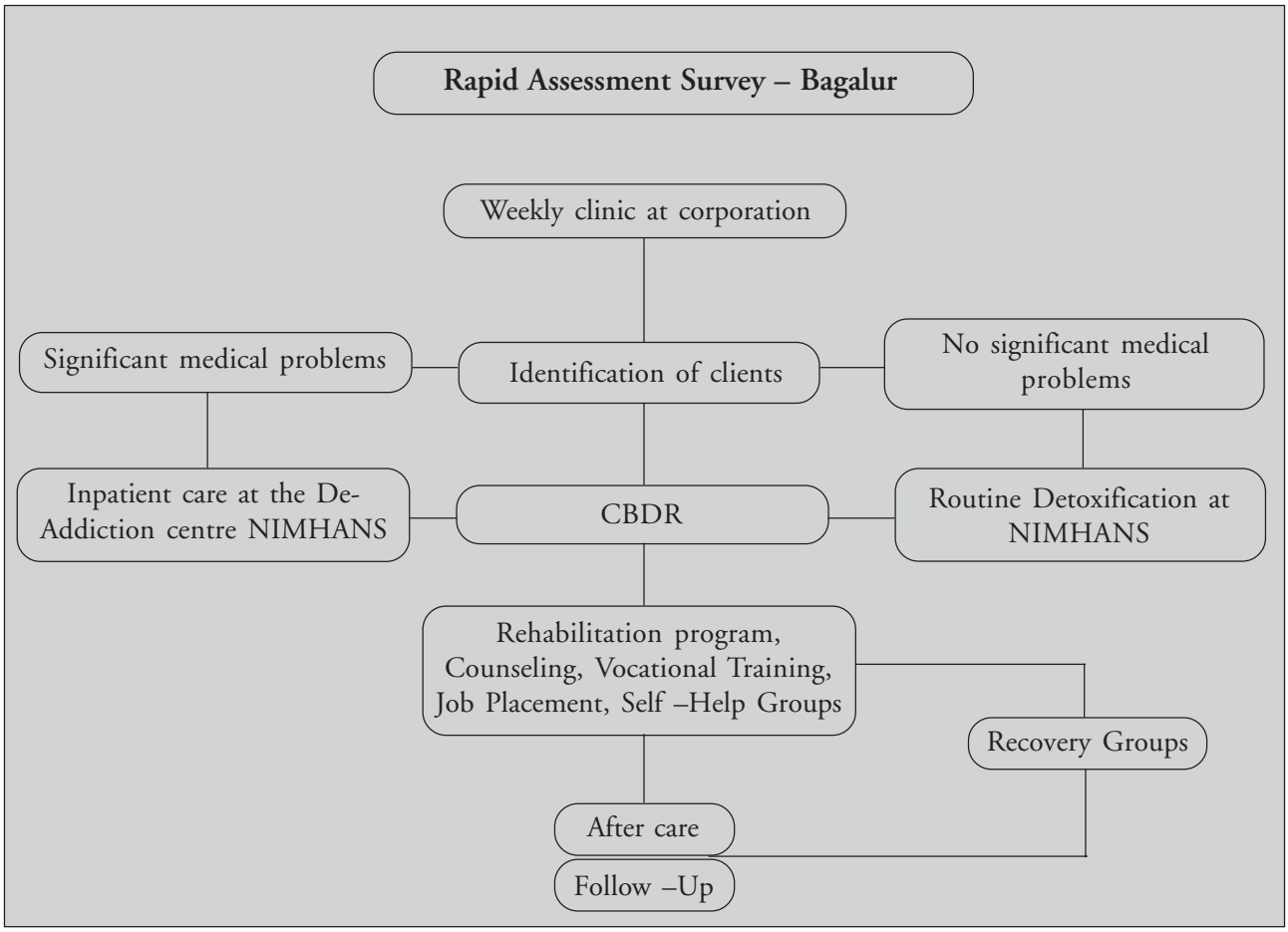
In India, rural camps have produced significant results for problems such immunization, eye care, dental care and other general health care. Many NGO's have initiated the camp approach to address substance related issues in the community. In these camps people are expected to stay for detoxification process and undergo other intervention programs. The advantages of the camp approach are:

- Services are brought to the door step of community
- Professionals are called to offer their services in the camp
- Medical and other psychosocial interventions are provided at free or at a low cost.
- Selection of common place for venue of camp which is accessible to all nearby villages.

Involvement of the community in action requires a lot of time, energy, and, above all, sustained commitment. It is not a one time effort. Sensitization and preparing the community is the first step in conducting such camps.

3. *Network meetings:* The medical officer can initiate network meetings with various de-addiction related service organizations working for the welfare of persons with alcohol/ drug abuse. This important activity will bring together various organizations working in

Fig. 2: Community Based Drug Rehabilitation Model: NIMHANS



the area of substance abuse for information exchange and continuing professional training. The network can facilitate sharing of experiences, plan for future activities and periodical meetings. Such network also can take up many common issues related to better quality of de-addiction service delivery.

4. *Community based drug rehabilitation project:* Under this project, 50 persons with alcohol and drug abuse from Old and New Bagalur, Lingarajapuram, Bangalore were treated, with either in-patient or out-patient detoxification, intensive counseling and after care. The follow-up was done at the corporation clinic at Bagalur where out patient groups were run and all the patients were also contacted through home-visits. The emphasis was not only on maintaining the clients drug free but also on ensuring that they were occupationally employed and crime free. This community based comparative study on CBDR program was found to be very successful.

5. *Supported employment for recovering addicts:* Some of the recovering alcohol/drug dependents were referred to the Department of Pychiatric and Neurological Rehabilitation at NIMHANS. Under this program they were paid as per the Minimum Wages Act. During the sheltered work they were taught work conditioning, work behaviour, savings and drink refusal skills. They were encouraged to seek employment outside after 3-6 months of sheltered employment. This program was found to be effective in improving the quality of life of the alcohol/drug dependent.

6. *Workplace Prevention Program:* NIMHANS in collaboration with Karnataka State Road Transport Corporation (KSRTC), Motor Industries Company limited (MICO) and other organizations carried out workplace alcohol / drug abuse prevention program. This included formulation of a company policy on alcohol and drug abuse and prevention and treatment program for its employees. The KSRTC program showed significant benefits for treated employees-reduction in substance use, improved family functioning and enhanced productivity.

Conclusion:

On the one hand, medical officers have an important role at the community level in addressing substance use disorders through screening, case-identification, diagnosis, early treatment and providing need based interventions. On the other, they have a critical role in being key agents for primary prevention because of their proximity and influence in the community. Ensuring health promotion in the community will surely minimize later development of alcohol and drug problems

Suggested Reading

1. Chavan, B.S., Gupta, N. (2004) Camp Approach: A Community-Based Treatment for Substance Dependence. The American Journal on Addictions, 13:324-325.

2. International Labour Organization (2002) Developing Community Drug Rehabilitation and Workplace Prevention Programmes. Partnerships for Drug Demand Reduction in India. Murthy P (ed). Ministry of Social Justice and Empowerment, Government of India, United Nations Drug Control Programme Regional Office for South Asia, International Labour Organization, European Commission. Publication of the Project AD/Ind/94-808.

3. Lal, R. (2005) Substance Use Disorders. Manual for Physicians. National Drug Dependence Treatment Centre, New Delhi.

4. Ranganathan, S. (1996) The Empowered Community - A Paradigm Shift in the Treatment of Alcoholism. TT Ranganathan Clinical Research Foundation, Chennai.

5. Ranganathan, S. (1998) Community Based Treatment. Accessed at: http://www.wesouthasians.org/html/modules/home/south1998/ddch9.pdf

11

Psychosocial Interventions- Opportunities and Challenges

Vani Kulhalli*

Introduction

Doctors live and work in a variety of settings- public health, private practice, rural care, human resource groups…the list is endless. A doctor plays various roles-that of a medical officer in a hospital, family physician in the community or medical advisor in large factories and firms. At all these places he/ she is required to deal with problems of substance use. Everywhere the doctor is the 'first point of contact'. He/she is also often the PREFERRED person for intervention.

According to the National Mental Health Programme (1982), primary care doctors have been given the responsibility of treating mental illnesses, including substance abuse disorders. In order to be an effective healthcare provider, the medical officer has to be well versed in the diagnosis, treatment and rehabilitation of persons with substance abuse.

This chapter will review the opportunities and challenges for doctors treating persons with substance use problems.

Current Practice

Persons with substance abuse are frequent users of healthcare services. This is mainly because they suffer from many more medical complications than the non-substance using persons. However, they usually do not get any specific interventions with regard to drug-alcohol use problems. The most common situations for giving drug-related advice/ treatment would be:

- Where patients request such treatment
- In those having serious complications arising out of substance use
- In those arriving in emergency, and suspected to have recently consumed a drug
- In those posted for surgery/ invasive tests and having a history of substance use

Under these circumstances, they usually receive care for the withdrawal symptoms, for example, a brief course of benzodiazepines to tide over alcohol withdrawal. Some persons may receive drugs like disulfiram

* Vani Kulhalli MD, Consultant Psychiatrist, Mumbai.

or naltrexone to help them to quit, but it is very infrequent for them to routinely receive psychosocial interventions. When medical officers treat routine medical problems, in a way they are also offering services for persons with substance abuse. Some medical officers go beyond this routine practice by working in de-addiction facilities, non-governmental organizations, etc.

Some practice patterns actually contribute to the drug abuse problem. For example, the widespread practice of prescribing sedatives for any insomnia or psychological discomfort leads to addiction to these drugs. The popular perception among doctors, imbibed during training, that a certain amount of alcohol on a daily basis prevents cardiac disease, makes them complacent in treating persons with problem drinking. From their experience, medical officers are aware that it is hard to motivate persons to stop further drug abuse and relapses are many. It is also essential to learn simple interventions, which can be effectively used in routine practice.

In daily practice, there is immense potential for incorporating simple de-addiction interventions. The 'advice to quit' itself has been found to be highly effective in a substantial number of cases, particularly in tobacco cessation. Somehow, it does not get used frequently. The common approach used is to scare the patient by informing him/her of the worst consequences of continued drug use. This has now been replaced by different techniques, discussed in earlier chapters , which need to be popularized among primary care doctors.

Whether to offer interventions as part and parcel of routine practice or as a specific intervention is entirely up to the medical officer. However the need for competence does not change. Just because a medical officer decides not to delve much into substance abuse problems, they do not go away. They always form a substantial part of any practitioner's work. The need of the hour is for the family physician to equip himself/herself with the tools to provide psychosocial interventions.

The Changing Framework of Patient Care

During their training in medicine, doctors are oriented to the medical model of disease and treatment. However, in practice they have to adapt to a complex situation, where the interventions have to necessarily involve psychological and social concepts. Thus even though doctors may have an almost perfect technical knowledge about drugs of abuse, they begin to feel inadequate in managing disorders in the real world. The curriculum is such that a medical student can recite by-heart all the stages of alcohol-induced liver disease, but is at a complete loss to decide how to help the patient to quit alcohol!

In an ideal situation, following medical treatment, the patient can avail of psychosocial interventions from specially trained professionals. In India such services are available in many urban centers and the medical officer can organize referrals to them. However if the patient refuses to visit these centers or in areas where such service is not available, the responsibility of psychosocial interventions falls upon the medical officer. Thus, doctors are expected not only to examine the patient, give medicine, but also to provide 'guidance'. Traditionally the family physician has been designated as 'Physician and Surgeon'. However, in the current world, this will be replaced by the term 'Physician, Surgeon and Counselor'.

In all this, the patient is no longer a passive recipient of interventions. In urban areas patients often come with printouts from internet sources or with information gathered from friends and relatives. The medical officer cannot assert his/ her authority as 'the intelligent professional' and enforce his/ her views about treatment. Patients often view the doctor as a 'service-provider' as against the erstwhile view of a 'helping professional'. The doctor now informs and explains to the patient the various treatment options available and carries out those chosen by the patient. Now, collaborative teamwork between doctor and patient is the accepted norm for work in healthcare.

Thus, the work of a medical officer has become far more complex and demanding. But through learning and practice one can manage this challenge.

Opportunities

Epidemiological surveys place the total percentage of drug use to almost 60% (lifetime, including tobacco use) of the population. Alcohol use is rampant, to the extent of around 30% of the population, with third of users being dependent. Besides there are persons using other substances, too. If we compute the absolute numbers, 30 million persons require intervention for alcohol use alone! These large numbers speak of a voluminous opportunity.

The Indian population is in a stage of transition in terms of healthcare. This means that from believing that symptoms are caused due to spirits/ curses, more and more Indians now know that they are due to disease. Thus a larger proportion of the population would be approaching doctors for their problems. As compared to other mental health problems, the disease model is more readily accepted for substance use disorders. So the number of persons seeking help is going to increase steadily, in the coming years.

Certain areas have been grossly under-explored. These form new opportunities for the medical officers desiring to work in the area of substance abuse. They are as follows:

Healthcare Organisations

Even if healthcare facilities are the most frequent sites for intervention, they are woefully inadequate in their care of the person with substance abuse. Frequently, patients make several visits to hospitals and specialists, but fail to get adequate inputs regarding drug and alcohol problems. Although this appears counterintuitive, it is true. There is also low awareness about the scale of addiction to prescription drugs like sedatives as well as to tobacco. This area of work holds immense promise as patients would accept interventions with minimal fear of stigma and the service can be sustained by internal referrals.

Employee Programmes

Even at low levels of use, drugs can cause impaired work efficiency and judgment. At worksites this manifests as high accident rates, low productivity, absenteeism, larger medical bills (for reimbursement), higher insurance premiums and disciplinary problems. Under the Factories Act, every such organization is

supposed to provide for medical interventions including an in-house medical officer. This medical officer can initiate drug abuse prevention and treatment programmes. Such programmes are not yet as common as they should be, although they have the potential to cut losses of industries by very large margins.

Schools and Colleges

Recent studies have shown that the age at which substance abuse begins, is falling steadily. It is now commonplace for doctors to encounter youngsters aged 14-15 years who use tobacco or alcohol regularly. They require educational interventions to prevent the use of any drugs altogether or failing that, to quit as soon as possible. Programmes for youngsters can be implemented effectively through schools and colleges or organizations such as Rotaract Clubs or hobby clubs. School and colleges invariably have 'on-call' community based medical officers/ pediatricians, and they can implement or organize such programmes.

Women's Health Clinics

Studies done over the last twenty years have clearly established that the use of tobacco, alcohol and other drugs among women in India is increasing steadily. This is applicable to all sections of society, both urban and rural. Pregnancy and related interventions are the commonest (and sometimes the only) reason for women to come in contact with the organized healthcare system, so antenatal clinic provides good chance for drug abuse interventions. Menopause clinics, weight-reduction centers, breast cancer clinics, also offer opportunities for drug abuse interventions. Any medical officer manning such a service, can start monitoring clients for drug abuse and offer interventions at his/ her clinic.

Starting a Programme

Step 1- NEEDS ASSESSMENT

One must try to estimate the percentage of the target population who would require a drug intervention programme. One must also try to find out what proportion of them would readily accept the program and what are their views about such programmes. This can be done easily by use of simple methodologies. This step is vital to proper planning and execution of programme, as it allows you to decide whether to have the program, to what extent and of what type.

Step 2- RESOURCE PLANNING

One needs to make an estimate of funding, space and manpower. Some medical officers, also avail of specialized training at this stage. In a private set-up, the medical officer also needs to estimate the cost to the patient, as in a fee for service model.

Step 3- EXECUTION

One has to convince the stake-holders that such a programme is essential. Referral sources like employers, teachers, community leaders have to be educated and informed about the programme. The public has to be informed through health promotion campaigns.

Step 4-GROWING AND EVOLVING

One needs to evaluate the programme to spot problems as well as successes as early as possible. Through continuous introspection the programme becomes sophisticated and effective.

Challenges and Problems

Medical officers who decide to participate or organize a drug abuse treatment programme, may face some challenges. These can be broadly classified as: Those related to

- DOCTOR HIMSELF/ HERSELF
- PATIENT
- COMMUNITY
- LOGISTICS/ ORGANISATION

Doctor Related Factors

Personality Factors

It is difficult to predict exactly as to what type of person will be successful in this field. Both men and women professionals are needed in this field. The person wishing to work in de-addiction needs to have following qualities

- Liking for the subject
- Tolerance of associated problems like frequent frustrations, stigma, difficult clientele
- Ability to work with poor infrastructure
- Courage to withstand the different pushes and pulls of the environment

Training and Knowledge

As discussed earlier, the current medical curriculum is grossly inadequate to equip the average doctor to coordinate a drug treatment programme. There are very few training programmes and these often require relocation and investment of substantial time and money, all of which a medical officer can seldom afford. Under such circumstances the medical officer wishing to choose this line of work needs to find ways to train himself/ herself. This can be done at a very basic level by reading up regularly and attending CME programmes. The medical officer can also opt to work for a few years in a deaddiction facility, where hands-on training will happen automatically.

Patient-related

Most patient-related factors have been discussed in other chapters. These include lack of motivation, relapse, medical complications, multiple substance use, etc.

It is not realistic to expect that every person with substance abuse can be handled completely at the primary care level. A minority of them would require referral to a specialist. The following patients should be chosen for referral:

- Persons who do not improve despite your best efforts
- Persons who relapse frequently
- Persons who are using large quantities of substance- for example chain smokers/ those drinking alcohol continuously
- Persons with multiple substance use
- Persons with substance use and mental illness
- Pregnant and lactating women
- Persons with history of complications during previous attempts at deaddiction
- Patients who are difficult to treat either due to personality factors or family problems

What do Psychiatrists do?

Although the most visible complications of consistent substance abuse are medical, it is actually a behavioral problem. Because of their training in human behavior and mental disease as well as in medicine, Psychiatrists are uniquely suited to the treatment of substance use disorders. Typically the psychiatrist would:

- Use medications to assist in withdrawal and minimise complications
- Use medications to reduce craving and minimise risk of relapse

- Diagnose and treat mental illness if that is present. More than 50% of persons with substance use are known to suffer from mental illness, while around 70% persons with mental illness use substances regularly
- Employ specific therapies to treat the person as well as the family members

Some psychiatrists have special qualification in De-addiction Psychiatry (as a super-specialisation).

Community Related

Stigma

Persons with substance abuse as well as the doctors working with them are seen in a 'different' sort of way by the community. They may face active discrimination or even simply differential treatment not amounting to discrimination. This includes calling persons 'alcoholic' 'addict', not giving them jobs, regarding them as unreliable/ incompetent, etc. Sometimes, community members refuse to have drug intervention programmes as it is bad for their 'image'. This set of negative attitudes and behaviors is due to 'stigma'. Medical officers who choose to treat persons with substance abuse, must be aware of this and be prepared to deal with it.

Ways to Reduce Stigma in Your Community

PROVIDE INFORMATION- Through awareness programmes, provide information in a educational tone. Use unique methods like dramas, exhibitions, etc

INVOLVE COMMUNITY LEADERS- Enlist the support of important members of community in stigma-reduction programmes

SET AN EXAMPLE- By treating stigmatized persons respectfully, one can set an example to the community.

ADVOCACY- Be aware of the rights of your clients and support laws which protect them

One should also be aware of common myths about drugs and alcohol.

Local Circumstances

Substance abuse problems occur on the background of peculiar socioeconomic and political conditions. An astute doctor should practice with an awareness of the surrounding milieu. There is a high prevalence of personality problems amongst persons with substance abuse. The drug-tobacco-alcohol industry is a billion rupee business. A doctor who restricts interventions to medical treatment can probably (?) insulate himself/ herself from these effects, but the one committed to giving holistic care including psychosocial interventions cannot ignore their effects. It is, therefore, likely that professionals treating drug-dependent persons may come in conflict with these persons/ agencies.

Logistic Factors

Time

The typical medical officer is dealing one day with a flu epidemic, the second day with diarrhea plus the usual crowds of somatisers, coughs and colds, anxious mothers, etc milling around. In addition, one has to take care of mundane requirements of basic administration and family responsibilities. So is it realistic to expect that a medical officer would have the time and energy to perform psychosocial interventions for drug abusers?

The answer is-'Yes'. Contrary to popular perceptions, counseling does not take long time and empathy can be learned much like auscultation. Besides this, one can use simple techniques to provide proper interventions as a part of your regular practice.

Techniques to 'fit' Psychosocial Interventions in your Practice

Suspect and spot- Have a high degree of suspicion for drug abuse problems and be proactive in diagnosing them. Do not wait for the problem to declare itself in form of a complication

Attitude- Accept that your patient is not going to improve without psychosocial intervention. It is as important as dietary advice for diabetic. If you can find time to counsel a diabetic about diet, you can find time to do psychosocial counseling in a patient with substance abuse.

Learn and use- Learn to use counseling techniques and use them frequently. Soon you will become an expert and will be able to do 'micro-counseling' lasting few minutes at a time

Manage time- You may call the patient by appointment at a time when you are less busy, for example during morning hours.

Delegate- If you are feeling overwhelmed with the work load, do not hesitate to refer to or employ someone who will be able to do the work more easily than you

Cost

Whether one is self-employed or employed in an institution, every medical officer has to give due consideration to the economic sustainability of his/ her work. As we are trained to give medication, medical officers find it difficult to conceptualize the costs and funding of interventions, which do not involve prescriptions. Firstly, one may charge for psychosocial interventions by including their cost in the consultation fee. Secondly, including these interventions in your practice works out to be cost-effective for you because:

- It reduces case dropouts
- It brings more work as your reputation travels
- It reduces emergencies, which are disruptive to your personal life
- In healthcare institutions, it reduces the average length of stay per patient, which translates into better economic efficiency of the hospital.

Other Players

Majority of substance abuse programs are managed by non-medical persons like peer groups (Alcoholics Anonymous), charitable and religious organizations or social workers. One must be aware of such organizations and learn to network with them.

Physician Heal Thyself…

The prevalence of substance abuse among healthcare providers, particularly doctors and medical students is considerably higher than that of the general population (15-60%). Unfortunately, we still do not have a formal system to address this widespread problem in India. If you are using a lot of drugs or alcohol, do not hesitate to get help. If your colleague is having a problem, gently convince him/her to seek help.

As a medical officer, one's conduct in public can also have significant impact on the community. Some examples are-

1. Making statements in media supportive of drug or alcohol use

Example- *"Low tar cigarettes are safe", "regular alcohol use can prevent cardiac disease".*

2. *"Taking sponsorships from drug/ alcohol companies".*

3. Making certain statements to patients, inadvertently (as below)

"Even I use beer when I am upset".

"Only two cigarettes? That's not much anyway".

Medical officers should avoid such situations by remaining alert and committed to their profession.

Conclusion

Psychosocial interventions for persons with drug abuse are very effective but underused interventions. There are many challenges and opportunities for their application in India. Medical officers should educate themselves about these interventions and use them in their practice regularly.

Suggested Reading:

1. Patel, V. (2003) Where there is no Psychiatrist: A Mental Health Care Manual, Gaskell Publications.
2. Nadkarni, V. (1992) Drug Abuse and Demand reduction. A Focus on community based approaches, Mumbai: Tata Institute of Social Sciences.
3. Mehta, D. (1993) Treating Alcoholic Industrial Employees. Mumbai: Tata Institute of Social Sciences.
4. Gururaj, G. and M. Isaac, (2003) Psychiatric Epidemiology in India in Mental Health: An Indian Perspective. Ed- by S P Agrawal. DGHS, Ministry of Health and Family Welfare, New Delhi
5. Alexander, L. (2001) Creating an Employee Wellness Programme. Gloucestershire: Management Books Ltd.

6. Ewles, L. and Simnett, I. (2003) Promoting Health: A Practical Guide. 5th Edition Ed.. Pub. Bailliere Tindall.

7. Haghighat, R. (2001) A Unitary theory of stigmatization. British Journal of Psychiatry, 178: 207-215.

8. Wig, N. N. (1997) Stigma against mental illness. Indian Journal of Psychiatry, editorial.

9. Hammond et al. (2006) Secret Science: tobacco industry research on smoking behavior and cigarette toxicity. The Lancet, 367: 781-787.

10. Tripathi, B.M., Lal, R. (1999) Substance abuse in children and adolescents.. Indian Journal of Pediatrics, 66:569-575.

Appendix - 1
Pharmacotherapy in Addiction

Sreejayan K, Prabhat Chand*

Pharmacotherapy for substance abuse includes medications used to treat withdrawal following acute stoppage of the substance and for long term abstinence. Pharmacotherapy along with appropriate psychosocial interventions plays a significant role in preventing relapse.

Pharmacotherapy for addiction mainly consists of two categories:

1. Medications used in detoxification or management of withdrawal symptoms
2. Medications for relapse prevention

Alcohol

Detoxification/ management of withdrawal symptoms

Benzodiazepines are the mainstay of treatment for alcohol withdrawal symptoms. Alcohol withdrawal symptoms are of mild to moderate intensity in a majority of cases and characterized by insomnia, tremors, sweating and inner restlessness. In very few cases, it may be severe to the extent of producing a seizure (withdrawal seizures or rum fits) or altered sensorium (Delirium tremens). The withdrawal symptoms usually start 12 to 48 hours of the last alcohol drink.

Mainstay of management is pharmacotherapy and most of the cases can be managed on an out-door basis. Roughly for one unit of alcohol (30 ml spirits), 1mg of diazepam or 5mg of chlordiazepoxide is needed.

Drug	Dose	Trade name	Interval	Comments
Diazepam	10-40mg	Calmpose	6hr-8hr	Safe
Chlordiazepoxide	50-120mg	Librium	6hr-8hr	Safe
Lorazepam	4-12mg	Ativan	6hr-8hr	Safe even in liver disease

* Sreejayan K. MD, Senior Resident, Department of Psychiatry, National Institute of Mental Health and Neuro Sciences, Bangalore.

* Prabhat Chand

All the above medications are safe and can be used in 6-8 hour intervals in divided doses. Along with this, intramuscular injection thiamine 100mg/day for five days should be given followed by oral vitamin B complex for two weeks.

Drugs for relapse prevention

Disulfiram

Disulfiram, a deterring agent, is a commonly used drug for alcohol dependence.

Mechanism of action: Disulfiram acts by irreversibly inhibiting aldehyde dehydrogenase enzyme and leading to accumulation of acetaldehyde. This triggers an unpleasant reaction when alcohol is ingested and thus acts as a psychological deterrent to drinking alcohol.

This form of aversive therapy is effective in motivated and reliable patients who have good social support.

Disulfiram alcohol reaction: If the patient drinks alcohol while on disulfiram, he/she is likely to have flushing, headache, palpitations, dyspnoea, nausea, hypotension, and prostration. The reaction varies in intensity between individuals and usually occurs within 10 minutes of taking alcohol and reaches a peak at 20–30 minutes and lasts for 1–2 hours. The reaction is managed by supportive treatment.

Dose: Disulfiram is available as a 250 mg tablet, and is commonly prescribed once daily. It is to be administered only after the patient is educated about the disulfiram alcohol interaction and written informed consent is taken. Patients need to abstain from alcohol for at least one day before administration of disulfiram and for at least one week after cessation of treatment.

Side effects: Few patients report mild drowsiness. Persons should avoid any alcohol containing drink/ medicines while on disulfiram.

Contraindications: Psychosis, ischaemic heart disease, severe hepatic or renal disease, impaired cognitive function (post head injury, dementia etc.)

Naltrexone

Naltrexone is used as anticraving agent in alcohol dependent patients.

Mechanism of action: Alcohol consumption is thought to produce a feeling of well being brought about by the release of endorphins in the brain and stimulation of opiate receptors. Naltrexone competitively blocks opioid receptors and reduces the reinforcing and rewarding effects of alcohol.

Dose: Naltrexone is available as a 50 mg tablet and prescribed as one tablet a day.

*Side effects: A f*ew patients complain of altered taste in the mouth.

Contraindications: Severe liver disease, concomitant opioid intake

Acamprosate

A relatively newer anti craving agent used in the management of alcohol dependence.

Mechanism of action: It predominantly suppresses excitatory glutaminergic neurotransmitters and decreases craving.

Dose: available as a 333mg/tablet. If the person weighs <50kg, 4tablets in three divided doses is prescribed, if >50kg, 6tablets in three divided doses are prescribed.

Side effects: Diarrhoea occurs in a few patients but is reduced by taking medication with a meal.

Contraindications: It is a relatively safe drug except in persons with renal insufficiency.

Miscellaneous

Drugs that modulate serotonergic system and help in craving like ondansetron, topiramate and SSRIs are also used.

Summary of the most commonly used drugs for alcohol dependence

Name	Dose	Duration	Comments
Disulfiram	250mg/day	One year	Works best if patient is motivated, has good social support
Naltrexone	50mg/day once daily	Six months	Probably works better in persons with a positive family history of addiction
Acamprosate	4-6 tablets thrice day	Six months	Can be started during detoxification, least side effects

Opioids

Detoxification/ management of withdrawal symptoms

Opioid withdrawal is characterized by lacrimation, body aches, dilated pupils, diarrhea, sleeplessness and piloerection. The commonly used agents are **buprenorphine** and **clonidine**.

Buprenorphine

It is an opioid with partial agonist and antagonist actions.

Mechanism of action: Being an opioid, it acts by substitution and provides a comfortable withdrawal.

Dose: Buprenorphine is usually started at 4 to 16 mg daily in divided doses. It is useful to monitor the opioid withdrawal symptoms while titrating the dose. The dose has to be supervised and prescribed by a medical professional to prevent abuse. It is given in the form of sublingual tablets.

Side effects: constipation, nausea in a few patients.

Clonidine

Clonidine is used to control the autonomic arousal symptoms during the withdrawal state.

Mechanism of action: Clonidine is a centrally acting álpha 2-adrenergic antihypertensive medication that effectively decreases the noradrenergic hyperactivity associated with opioid withdrawal. It has been shown to reduce tremor, heart rate, and blood pressure, which are some of the important physical symptoms of opiate withdrawal.

Dose: Usually 0.3mg to 0.6 mg per day in divided doses (0.1mg in three divided doses initially). One needs to closely monitor blood pressure and heart rate during its initial administration. The dose can be varied according to body weight.

Precautions: The dose needs to be skipped if the blood pressure (systolic/lying) is less than 80mm Hg or pulse is less than 50/minute.

Use of clonidine alone is usually not enough to handle various symptoms of opiate withdrawal. Diazepam can be added for sleep disturbance and inner restlessness at a dose of 10mg every six hours for three days, after which it is tailed off over four days. Similarly NSAIDs e.g. Chloroxazone help in reducing body ache and joint pains commonly associated with opioid withdrawal.

Drugs for relapse prevention

Buprenorphine: Already described in previous section.

Dose: The use of this in lower doses i.e. 2-8 mg, one to two times a day has been found very useful in longer term maintenance. It works on the principle of harm minimization.

Precaution: To prevent abuse, this drug needs to be supervised and dispensed for short term i.e. not more than two to three days by the treating doctor.

Naltrexone

Mechanism of action: By tightly binding to opioid receptors without producing a psychoactive effect, naltrexone blocks the pleasurable effects of the opioids drugs, thereby discouraging opioid use and diminishing conditioned craving.

Dose: Naltrexone is available at 50 mg tablet and prescribed as one tablet a day

Precaution: Naltrexone cannot be given to individuals while they are taking opioids as it can precipitate an immediate opioid withdrawal syndrome. Hence before starting naltrexone, patients must be completely abstinent for at least 5-7 days from any opioids. In an ideal condition, urine toxicology screen should be done to confirm absence of opiates in body.

Side effects: No major adverse effects are reported except occasional dysphoric mood and change in taste sensation.

Nicotine

Management of withdrawal symptoms

Nicotine withdrawal does not have any specific symptoms other than irritability, restlessness and persistent desire to take nicotine. Recently, nicotine replacement therapy is commonly used to handle withdrawal symptoms and at the same time decrease craving.

Nicotine Replacement Therapy (NRT)

NRT is available in different forms like nicotine gums, patches, sprays etc. In India nicotine gums are presently available.

Mechanism of action: These agents contain nicotine that substitutes for the nicotine in the tobacco.

Dose: Scheduled dosing (e.g. 1/2 piece of 4-mg gum/hour), and 4-mg gum for highly dependent smokers) is more effective, however using ½ piece of gum p.r.n. in response to craving has also been used. The gum which is available in India contains 2 or 4 mg of nicotine that can be released from a resin by chewing. The nicotine is absorbed through the buccal mucosa. The gum is chewed and kept between the cheeks and gum (parking). The person needs to take the gum for 4-6 weeks after which it can be weaned. Two flavors are presently available, one for smokers and the other for chewers

Precautions: One need to be careful while using in pregnancy, lactation and peripheral vascular disease.

Side effects: These are safe agents without major side effects. Minor side effects are either of mechanical origin (e.g., difficulty chewing, sore jaw) or of local pharmacological origin (e.g., burning in mouth, throat irritation nausea, vomiting, hiccups, and excess salivation). Tolerance develops to most side effects over the first week.

Drugs for relapse prevention

Bupropion

Bupropion is the first drug to be approved for use in nicotine dependence. It is chemically unrelated to nicotine or other agents currently used in the treatment of nicotine addiction.

Mechanism of action: The exact mechanism is not known. Bupropion is a relatively weak inhibitor of the neuronal uptake of norepinephrine and dopamine.

Dose: 150 mg/day given as a single daily dose initially for three days, and then increased to the 300-mg/day target dose, given as 150 mg twice daily. There should be an interval of at least 8 hours between successive doses. One should advise the person to set a quit date for 1-2 weeks after beginning bupropion. Bupropion can be prescribed 150 mg b.i.d. for up to 6 months.

Precaution: Higher doses can precipitate seizures in patient having seizure disorder.

Newer drugs like **Varenicline**, a partial agonist of nicotine receptor is already available in the international market. This molecule, being an agonist looks promising in the management of nicotine dependence.

Benzodiazepines

The basic principle of benzodiazepine dependence is substituting the current drug with a longer acting benzodiazepine and slowly tapering out tapering at the rate of 5 – 10% every week. This helps in smoother withdrawal and minimizes any untoward complications like withdrawal seizures, confusion and altered sensorium. The benzodiazepine equivalents are given below

Benzodiazepine Equivalents

Drug	Dose equivalents	Half life	Rate of absorption	Usual adult dose mg/day	Dose Preparations
Diazepam	5	long	rapid	4- 40	2, 5, and 10mg tabs
Clonazepam	0.5	long	rapid	1-6	0.5,1, 2 mg tabs
Chlordiazepoxide	10	intermediate	medium	10 – 150	5,10, 25mg tabs
Alprazolam	0.25	intermediate	medium	0.5 – 10	0.25, 0.5, 1 ,2 mg tabs
Lorazepam	1	short	rapid	2-6	1, 2 mg tabs
Zolpidem	2.5	Short	Rapid	5- 10 mg	5 and 10mg tabs
Zaleplon	2.5	Short	Rapid	5 -10 mg	5 and 10 mg tabs

CANNABIS

Cannabis withdrawal does not have any specific treatment and needs to be handled symptomatically. At the same time no drug has been found to be useful in maintenance therapy.

Further Reading:

1. Williams S,H. (2005) Medications for treating alcohol dependence. Am Fam Physician. Nov 1;72(9): 1775-80. Review.
2. Okuyemi KS, Nollen NL, Ahluwalia JS. (2006) Interventions to facilitate smoking cessation. Am Fam Physician. Jul 15;74(2):262-71. Review.
3. Assanangkornchai S, Srisurapanont M. (2007) The treatment of alcohol dependence. Curr Opin Psychiatry. May; 20(3):222-7. Review.
4. Chand PK (2004) Current trends in management of alcohol dependence. Ind J Psychol Medicine,1: 33-46.
5. Chand PK & Isaac M. (2005) Management of Substance Use Disorder in Primary Care. In *Substance Use Disorders, Manual for Physicians* (Rakesh Lal ed) Published by AIIMS-WHO National Drug Dependence Treatment Center, AIIMS New Delhi (Chapter15 page no 1-12).

808
1

Appendix - 2
Assessing a Person with Drug Dependence

What is Assessment?

Assessment is the process of gathering information about the person's drug use patterns, and his/her drug-related as well as other associated problems in order to make decisions about intervention.

Why is Assessment Important?

Assessment helps us to:

- Understand the severity of the drug use problem and current situation
- Develop a clearer picture of the user's background
- Understand associated problems of the drug user
- Determine the circumstances in which the user sought or was brought for help
- Decide what intervention is likely to work for the person
- Anticipate effectiveness of intervention and its likely outcome.

What are the Steps in Assessment?

i. Intake

ii. Preparing an assessment report based on intake

iii. Assessment of motivation

iv. Deciding on type of intervention.

i. Intake

Intake refers to the actual procedure of collecting information in a standard and systematic manner. This information should be very sound, as the decisions about admission and intervention depend on a good assessment.

Issues in Interviewing for Intake Information

Whom to Interview?

i. *The drug user:* The user (client) himself or herself can provide much of the information pertaining to drug use. This information may not always be adequate or complete because the user:

   a. May not wish to share accurate information, often out of 'fear' (of victimization and ridicule), 'shame' (from revealing some of the aspects of drug use, such as stealing, or high-risk sexual behavior), or 'a feeling of anger' at being brought forcibly for treatment;

   b. May be unable to recollect all the information, e.g. behavior when intoxicated, physical problems such as fits or unconsciousness, or because he/she is very anxious and tense; and/or

   c. May be able to provide only his/her own perception of the problem. A detailed intake also looks at the way others perceive the drug user and drug-related problems.

A good intake and assessment procedure lays the right foundation for a successful treatment and rehabilitation program.

Very often, family members accompany the drug user and can be interviewed for additional information, or for clarification. If the client has come alone, it is desirable to call other informants at a later date.

ii. *Other family members:* This commonly includes parents, spouse, children or a relative. Family members may also be extremely upset, either because they have only recently come to know of the drug use, or because of its consequences - violence, health problems, etc. They may also be hesitant to provide information (out of fear of shame and stigma) or may have an inadequate knowledge of the problem (e.g. when the drug user has been staying in a hostel, or working in a different city).

iii. *Other sources of information:* Referring professionals or agencies, employers, police, legal reports, friends and colleagues may often be able to provide useful information for an intake assessment and should be contacted wherever possible.

Skills for Intake and Assessment

Some of the difficulties described earlier in interviewing clients (on account of fear, shame, anger or stigma) can be overcome in the following ways:

Helping the client to relax: A relaxed and trusting client is more likely to provide useful information than one who is nervous and on his/her guard. Explaining the purpose of the interview, expressing warmth

and concern, expressing encouragement and support, and instilling confidence in the client can help to establish a rapport.

Explaining the purpose: 'I will be trying to understand what the drugs do for you and the effects they have had on you and on others close to you.'

Expressing warmth and concern: 'I can understand how difficult things have been for you'. 'I am concerned about the state of your health.'

Instilling confidence: 'We will be able to work on solutions once I have understood the situation.'

Building trust and confidence: 'I would like to talk about some personal details concerning you. This information will be kept confidential.'

Similar strategies can be used with family members. In addition, a non-judgmental attitude (not taking sides as to who or what is right or wrong) will help in gathering information from the drug user and other informants.

Time and Setting

It is important to arrange and schedule a separate time slot for intake assessment. A period of about 45-60 minutes is usually required for an intake procedure. In some situations, the procedure may be carried out over two or more sessions (e.g. when additional people have to be interviewed, or when the client is uncooperative). Intake assessment should not be done when a client is intoxicated.

The evaluation should be carried out in a comfortable, well-lit room with adequate privacy. Interruptions such as others walking into the room or phone calls should be avoided.

Technique of Questioning

It is necessary to have a common set of information on all clients. However, the interviewer must learn how to obtain information without making it a question-answer session.

Styles of Questioning

Two styles of questions are important in eliciting answers. The first are *open-ended questions,* which often encourage the client to describe different aspects rather than simply say 'yes' or 'no'. At the beginning of the interview, open-ended questions are more useful and provide more information. For example, 'Tell me about your school days' is preferable to 'Did you like school?' The second question is an example of a closed question, to which a person only answers 'yes' or 'no'. The first question, an open-ended one, allows the person to narrate details from which information can be gathered about school performance, problems, relationships with peers etc.

Directive questions are useful towards the latter part of the interview, to focus the interview and get factual information, ensure completeness of information, or rule out important problems commonly

associated with drug abuse. Some examples are 'How much do you spend daily on drugs?' 'Have you ever injected drugs?' 'Have you had any kind of trouble with the police?' A 'yes' to any of these can be followed up by another open-ended question: 'Can you tell me more about that?'

Interview Styles

The communication skills of the interviewer, including the ability to build rapport, will affect the quality of information obtained. Non-verbal communication that sends the wrong signals (expressions of disinterest, boredom, lack of concern, sitting in a slouching position, frequently looking at a watch) can all prevent rapport building and thereby affect the quality of information.

Content of Intake Assessment

The staff conducting the interview should have an adequate knowledge of drug abuse and be trained in the procedure of conducting an assessment.

> What the mind does not know, the eyes do not see.

Personal details of the client

- Name, age, sex, address, educational status, occupation, living situation (alone, with family). Any other relevant information.
- Key persons for contact: It is useful to identify one or more persons (family member, friend, employer) who are potentially important for assessment, involvement in treatment and aftercare.
- Primary reason(s) for seeking help: Common reasons may include a serious health problem including abnormal behavior, threat of job loss, serious marital or family problems, or legal problems. Identifying these reasons is important, because they can be used later for increasing motivation.

Drug Use History

Age at first onset of drug use, personal reasons for initiating and continuing drug use, effects of use (including change in effects over time), change in quantity, route (for injecting use, sites of injection, frequency of injection, safety of injecting practices) and pattern of use, frequency of drug use, last use of drug. If the person is using more than one drug, these details must be obtained for each drug. Details of increasing consumption to intoxication, tolerance (need to increase the amount of drug used to get the desired effect), presence and nature of withdrawal symptoms need to be assessed.

Typical Features of Dependence include:

- Use despite having had definite physical and psychological harm
- Craving to use the drug
- Loss of control
- Tolerance
- Withdrawal symptoms
- Increase in time spent on drug use, procuring the drug, or getting over side effects
- Neglecting all other pleasurable activities because of drug use

- Details of drug-free periods, including reasons for drug discontinuation and reasons for restarting
- Acute and long-term effects of the drug. This should include physical (e.g. injury, accidents, jaundice, tuberculosis, fits, sexually transmitted diseases including HIV/AIDS), psychological (depression, anxiety, behavioral change), family, occupational, financial and legal consequences.

Past History

Details of significant physical, or mental problems need to be documented.

Treatment History

The client should be asked for details of previous treatment, including reasons for seeking treatment, kind of treatment sought, period of abstinence following treatment, level of functioning after treatment, aftercare including attendance at self-help groups and adherence to follow-up after treatment.

Family History

Details of family structure and details of individual family members, including a genogram (a family diagram illustrating relationships and other affected family members), are needed. Roles and relationships between family members, and level of support should be assessed. Family history of drug use, personality problems, psychiatric illness or criminality should be elicited.

Personal History

This includes relevant aspects of early development, including childhood and schooling problems and temperament, educational achievement, employment history, including stability and consistency in work and peer relations. Sexual history including high-risk sexual behavior and marital history, where relevant, should be obtained. Details of children, if any, must be sought. Enquire about recent lifestyle components, including leisure activities and social support.

Personality Prior to Onset of Drug Use

Stability of mood, level of emotionality, expression of anger and frustration, relationship with others, personal strengths and ability to handle stress -these and other points should be covered during intake.

Examination of Physical and Mental State

A physician should perform a detailed examination for physical illnesses/complications, and assessment of withdrawal. Assessment of the mental state should be carried out by a competent and trained professional.

ii. Preparing a Report Based on Assessment

Based on the information obtained during the interview, it will be possible to summarize the client's problem and identify different areas for intervention. The summary should include:

- Personal details
- Main drug of use and pattern of such use (dependence)
- Major consequences of drug use
- Significant past, treatment and family history
- Attempts at abstinence
- Last drug use
- Current problems (physical, psychological and social)
- Reasons for seeking help, and assessment of motivation.

iii. Assessment of Motivation

Motivation is the individual's desire to give up drugs.

Guidelines to assess motivation include:

- The client's expressed desire to give up drug use
- Reasons the person gives for the same (whether only because of family pressure, or out of concern of the consequences of continued use)
- Attempts made in the past to stop drug use
- The making of definite plans to change lifestyle

A low level of motivation does not necessarily mean that treatment will not be effective. However, a well-motivated individual is likely to do well in treatment. A good intake assessment itself will get the client thinking about the various problems emerging from drug use, and thus improve his/her motivation to change.

iv Deciding on Type of Intervention

This is the process of deciding what kind of intervention will be most effective for the client. If a junior staff member of the team is doing the intake assessment, it is advisable to discuss the case with a supervisor. Intervention decisions include the following:

Decisions on whether to admit the client or treat as an outpatient

This decision is based on consideration of the severity of the problem, past treatment failures, social support, the presence of severe craving in the person, as well as the admission regulations of the treatment center

Decisions on the need and type of detoxification (overcoming the effects of withdrawal)

For example, a client with significant alcohol dependence in severe withdrawal is best managed only with active medical support. A patient with a history of psychiatric disturbance should be under psychiatric care.

Setting up the Assessment Component

A comprehensive Assessment Component of the training program should ensure that there is:

- Adequately trained and informed staff to carry out the assessment
- An easy to use proforma for intake and assessment
- Adequate supervision of the staff
- A system of proper guidelines for admission, and a definition of the kind of problems the treatment center can handle and those it cannot
- Maintenance of individual case records. Ideally, case records should be computerized, but access to the information must be limited to maintain confidentiality
- Periodic review and improvement of the assessment procedures.

Summary

Intake assessment thus helps the counselor to understand not just the client's drug use patterns, but also to establish the context and consequences of use. It allows the counselor to assess the client's personal strengths and deficits. It helps to identify both the supports and the risks that the client is likely to face in the community. Intake counseling can provide the opportunity to establish a good working relationship with the client. A good intake assessment also helps to generate potential solutions to the problems that the client faces.

Acknowledgments

Principal Author : Dr. Sunil Mittal

Scientific Editor : Dr. Pratima Murthy

808

2

Recovery
Building a New Future

Introduction

Addiction affects practically every area of a drug abuser's life. It makes the person physically weak and run down. It interferes with education and messes up job prospects. It results in emotional scarring - the user is often torn by shame, guilt and fear of the future. Family relationships become weaker and lack emotional closeness and warmth. Socialization gets limited to alcohol- or drug-abusing peers and the drug user comes close to losing the regard and respect of others.

Does Recovery simply mean getting treated and being drug-free?

Receiving treatment and not using drugs is an essential step, but it is not enough for complete recovery.

What then is Recovery?

- Recovery is a process of change that takes place over a period of time. Undergoing treatment is just the first step in the recovery process and not an end in itself. The primary treatment program only stabilizes the client; the major part of recovery starts later. The recovery process proceeds differently for each client and the same client may find it easier to change in certain areas than others.
- Recovery requires giving up alcohol/drugs as well as initiating qualitative changes in lifestyle. Both these aspects of recovery need to progress hand in hand as they support, complement and sustain each other. Progress in one aspect without the other does not lead to complete recovery. For example, if the client is drug-free, but is demanding, irritable and does nothing worthwhile throughout the day, it means that he/she has not really recovered.
- Recovery does not occur automatically after treatment. It requires a conscious effort and continuing support for change. It is erroneous to believe that once abstinence is established after treatment, recovery in other areas will follow automatically. Simply recognizing problems will not lead to qualitative changes without the active, sustained effort of the client.

Recovery means a new way of life for the drug user. It not only involves giving up drugs, but also changes in his/her thoughts, behavior, functioning, relationships and lifestyle.

Responsibility for Recovery

The responsibility for recovery rests mainly with the client. While the client's motivation influences recovery to a large extent, professional help, family support and self-help groups are also important. Years of drug abuse alter the person's thoughts and behavior. The individual has to learn or re-learn how to live and become integrated in society. The intervention and support of others can make a big difference to the quality and tempo with which such changes can be made.

What does Recovery Involve?

Recovery involves working through many of the problems in the drug user's thoughts, behavior, functioning, relationships and lifestyle. To work through these problems while maintaining abstinence is not easy. The person's attitude, actions, reactions and responses need to change.

Abstinence - The Stepping Stone to Recovery

Being drug- or alcohol-free is the foundation on which recovery rests.

- A structured treatment program is necessary to strengthen the commitment to remain abstinent. It should help the person overcome denial, understand the damage caused by addiction and look forward to a meaningful future without drugs/alcohol.
- The client should understand the chronic, permanent nature of the disease and the need to completely give up drugs of all kinds as well as alcohol. Drugs that are medically prescribed must be used only under specific instructions by a physician.
- The client must follow a daily routine to sustain recovery and remain ever watchful of threats to his/her abstinent state.
- As abstinence is crucial to recovery, it may be necessary to slow down other aspects of recovery if action on those fronts puts the abstinent person at risk for relapse. For instance, accepting a challenging job assignment early in recovery ought to be discouraged as it may trigger a relapse - if the person will not be able to cope with the demands and st resses of the new job. Once abstinence has been established and coping strategies have been strengthened, he/she may be ready for such an assignment.

Five Pillars of Recovery

Complete recovery involves changes in five major areas of life: physical well-being, work routine, healthy relationships, personality changes, and meaningful leisure activities.

i. Physical Well-Being

Health, which is totally neglected during the days of drug use, becomes an important concern in the early part of recovery. While on the one hand continuing health problems can increase the person's frustration,

on the other hand an improvement in physical well-being can motivate him/her to greater efforts in other areas.

As a counselor, you can provide some common sense directives to help in the client's improved health:

- Establishing a regular meal routine with at least three balanced meals a day is important. Excessive smoking, too many cups of coffee or tea, and frequent consumption of junk food are to be avoided, as they reduce appetite and increase restlessness.
- Maintaining regular sleep hours (at least 7-8 hours every night) is necessary. While too much sleep can make the person lazy and dull, too little can make him/her tired and irritable. If medications are given to stabilize sleep patterns, care should be taken to prescribe medications with low addictive potential, and they should later be tapered off systematically.
- An exercise routine or a brisk walk of at least 10-15 minutes each day should be encouraged. Exercise keeps away dullness and lethargy, and improves physical fitness. Taking pride in physical fitness is a strong motivator to staying alcohol- or drug-free.
- Bathing daily, dressing neatly, shaving regularly etc. are activities that may seem commonplace. Yet, due to the client's dysfunctional lifestyle, even these need to be stressed upon.
- Physical problems like gastritis, neuritis, respiratory infections or needle abscesses may need to be treated. Drug abusers tend to postpone seeking help for health problems, and are irregular with medications even when they do. The counselor needs to be on his/her guard, for physical pain and discomfort can often trigger a relapse.

Complete Recovery involves changes in five life areas: Physical well-being, involvement in productive work, developing meaningful relationships, positive personality changes, and learning to enjoy life without drugs.

ii. Productive Work Routine

It is employment that gives the recovering client a sense of fulfillment as well as financial independence. It also does wonders for his/her self-esteem. If nothing else, it keeps away boredom and gives the client something to occupy themselves with. Many drug abusers are unemployed or employed well below their potential, without a sense of regularity and permanence. These clients need help and encouragement from the counselor to find employment opportunities and handle job interviews. Vocational training may also need to be considered.

Even when employed, the client may need the counselor's help to work with the right attitude, involvement and commitment. Poor interpersonal skills and poor judgment of one's ability can create problems in the workplace. Problems created during the days of active addiction - the memos, absenteeism records, etc. - may also need to be dealt with.

Work and financial stability are closely linked. Budgeting, prioritizing expenses, and saving a sum regularly, are part of the financial discipline that the client needs to follow.

iii. Meaningful Relationships

The few relationships that the client managed to retain in spite of the addiction need to be strengthened further. More than that, he/she also needs to learn to form new relationships. He/she needs to break out of the self-imposed social withdrawal and learn to relate to people again. But this aspect of recovery is easier said than done. The client may need some social skills training in this area. Starting conversations, communicating one's thoughts and expectations clearly, and handling conflicts are some issues that may need to be re-learnt.

The family is a readymade support system available in our culture. Family members can make the client feel wanted, and can also be a source of great happiness. Helping him/her work through family conflicts and clarifying his/ her role in strengthening family bonds can be beneficial. The user's relationships with parents, siblings, spouse as well as children need to be discussed, and concrete steps taken for improvement.

iv. Positive Personality Changes

Personality changes are indispensable to qualitative recovery. Negative personality traits have to be identified and worked on. Wishful thinking, impulsiveness, excessive and inappropriate expressions of anger, and indiscipline are commonly present. Presenting the client with information, through lectures or printed material, as well as providing testimonies of others in recovery can help him/her work through and change some of these undesirable responses.

It is equally important to focus on the client's positive qualities and achievements. It is on the strength of these positive qualities that he/she begins to view himself/herself as a valuable person, and it is these qualities that change the way others view him/her. Reviewing progress periodically, helping the client become aware of his/her personality strengths and building on them is very important for recovery.

Building a value-based lifestyle is essential to the user's continued recovery. A clear understanding of what is ethical and what is not, is important. Respecting others' needs and feelings, honesty, accepting responsibility, and above all not participating in anti-social and criminal activities influence the quality of recovery.

Many clients find that belief in a Higher Power gives them tremendous support. It can also add a sense of urgency and purpose to efforts to alter the client's personality traits. A routine of just repeating the serenity prayer reminds him/her of what he/she can and cannot do, thus making a difference to the way he/she deals with problems. The act of surrender to the Higher Power and asking for His help is a lesson in humility, even while increasing the client's confidence to cope with problems.

v. Experiencing Pleasure without Drugs

Learning to have fun and enjoy oneself without drugs/alcohol is something the client must do. As leisure and fun were always associated with alcohol/drugs, having fun differently now may seem strange. It will take a while before the client spontaneously participates in social activities and enjoys them.

Going back to the client's past history and identifying activities that he/she used to enjoy prior to addiction is a good starting point. A list of activities can be readily generated even otherwise - playing games, reading, meeting friends, music etc. Yet, even if he/ she has done it all before, effort is needed to revive these activities. For instance, it has probably been months since he/she showed up for tennis practice and the old partners may no longer be available. Reading books may be difficult as the client's attention span is shortened. He/she may have long ago lost touch with non-drug using friends and may not even know if they still live in the same town. For every activity, there may be some problems like these, which makes this area a difficult one to deal with.

The Counselor: The Catalyst in Recovery

The strength of the counseling relationship greatly influences the recovery process. The counselor's professional ability to identify problem areas and work with the client, is based on a good grasp of the issues involved in addiction recovery, along with an attitude that is helpful and optimistic.

The recovery period can be difficult for the client as it calls for developing insight into his/her problem, accepting responsibility for it and changing himself/herself. The supportive, non-judgmental relationship with the counselor is often the only source of support available to the client during this trying period.

Being sensitive to what the client wants to do, even while staying in tune with what is healthy and appropriate for the client and working in a sense of partnership with him/her, requires skill as well as patience and tolerance.

A fine sense of balance and judgment is often needed. Drug abusers carry over their obsessive traits into their recovery period and approach problems with an 'all or nothing' attitude. From being completely unemployed, the addict may swing to a fifteen-hour workday. Helping the client balance the different areas in his/her life, with adequate emphasis on each without overdoing any, is a skill indeed.

Recovery can be conceived of as a journey that the client undertakes. The unfamiliar terrain, the unexpected twists and turns, the need to respond differently to each, the effort it demands - all this can make it challenging and satisfying at the same time. The counselor works as the client's ally, prodding him/ her on when progress is poor and urging them to slow down when they go too far too soon. The appreciation and encouragement, along with caution and guidance, of the counselor can help the client go smoothly through their journey to achieve qualitative recovery.

Acknowledgments

Principal Author : Ms. V. Thirumagal, TTK Clinical Research Foundation

Scientific Editor : Dr. Pratima Murthy

808

3

Individual Counseling for Drug Dependence (Addiction)

What is Individual Counseling?

Individual counselling is the process of helping a person overcome problems through a professional relationship based on trust.

What do you need to know as a counselor for individuals?

To be an effective counselor you will need to know:

- Details about the client, as well as the influence of significant others (parents, spouse, employer etc.) on the individual and his/her problems
- The cultural and social background of the client
- About drugs of abuse, their physical, psychological and social consequences
- About treatment
- Techniques of good communication, improving motivation, problem solving skills and providing support.

What do you need to have to be an effective counselor?

In addition to basic knowledge of both the client and the problem, you need to have:

- A warm, genuine, understanding and caring attitude
- Respect for the client
- Objectivity
- Good communication skills.

What is good communication?

Communication consists of 'active listening' and responding.

Attentive listening is an important part of good communication. A good counsellor is a good listener.

Listed in the following box are some important dos and don'ts of effective listening and responding. These guidelines will help you in your communication with clients.

Dos and Don'ts of good communication

Do	Don't
• Make eye contact	• Interrupt
• Listen attentively (e.g. nodding)	• Generalize
• Summarize	• Be distracted
• Acknowledge emotions	• Be judgemental

When can you provide individual counseling?

Individual counseling can be carried out in different situations:

- Over several sessions with a client who is in a treatment program
- In the form of a brief intervention with a person referred for drug-related problems who has not yet entered a treatment program
- In a situation of crisis.

Counselling is not effective when the client is highly intoxicated or in severe withdrawal.

Daily counseling may be possible in an inpatient program. However, weekly counseling is more practical in an outpatient program. Follow-up counseling and monitoring is necessary on a monthly basis for at least a year.

Where can you counsel?

The place chosen for counseling must:

- Be comfortable for both the client and you
- Have some seating arrangement (counseling takes time)
- Ensure privacy
- Not have distractions (e.g. noise).

Specific Interventions in Drug Addiction

Assessing Motivation

Motivation refers to the desire in the client to change. Motivating a client to seek treatment means encouraging the client to change behavior by discussing the disadvantages of continuing substance use, advantages of stopping substance use, and conveying the hope that change is possible.

It is important to recognize that clients come to counseling in different stages of motivation:

a. Client may not have considered changing at all
b. Client may be considering change, but not be sure about wanting to change
c. Client has a desire to change and has made some efforts, with limited success
d. Client has achieved a period of abstinence
e. Client has had stable abstinence
f. Client has relapsed after a period of abstinence.

The specific objectives and techniques of intervention depend on the stage of motivation the client is at. These stages may not always be clear in the case of each individual, therefore, carefully choose the technique most appropriate for the individual in question.

a. A client who has not considered changing at all

Objectives:

- To establish rapport with the client
- To get the client to start thinking about potential advantages of abstinence
- To clarify doubts and fears about stopping substance use.

Techniques:

- Common responses from the client include embarrassment, surprise, hostility or denial. Avoid arguments or confrontation. Use language that is not stigmatizing (avoid terms like addict/drunkard)
- Determine why the client has come (e.g. pressure from family, threat of job loss)
- Acknowledge the client's thoughts, feelings, fears and concerns (e.g. worries about unpleasant withdrawal, not knowing any way other than alcohol or drug use to cope with low moods or anxiety)
- Give a positive and personal message (e.g. 'your abscesses will heal and not recur if you stop unsafe injecting practices', 'your liver damage will improve if you quit drinking')
- Educate the client about drug abuse lifestyle and infections (e.g. IV drug use, hepatitis and HIV, risky sex and sexually transmitted diseases)
- Discuss why it may be a good idea to consider stopping drug use (e.g. improvement in personal health, improved family relationship, improved social status)
- Get the person to think of why other people decide to quit substance use (e.g. success story of someone who has been able to stop with help)
- Discuss the risks of continuing substance use (e.g. risk of job loss, risk of abandonment by spouse).

Convey the hope that change is possible. Stress that addiction is not anyone's 'fault' and can be overcome.

b. A person who is considering change, but is still not sure

Objectives:

- To strengthen the desire to change
- To address the issues that come in the way of change in the patient.

Example of a 'balance sheet' of benefits and problems associated with substance use	
Benefits	**Problems**
• 'Numbs my senses' • 'Helps me belong tomy group of friends'	• 'Feel worse the next day' • Friends desert me when l run out of money' • 'Can't go to work when intoxicated, or having withdrawals' • 'Not able to support family' • 'Run into debts' • 'Family very upset' • 'Spouse threatening to leave' • 'Children not attending school properly'

Techniques:

- Discuss the benefits the client derives from the use of the substance as well as the problems. You could use a balance sheet approach (see above box). This often helps the client to contrast the problems emerging from substance use with the small and temporary benefits. The list of problems is invariably much longer
- Discuss the person's goals in life and the way drug use can interfere with these goals
- Explore the reasons for the client wanting to change (child reaching marriageable age, physical problems, career aspirations, and/or threat of loss of job or partner). Some may have presented themselves for treatment only due to pressure from family. Even when the person has come due to external pressures, it is worthwhile getting him/her to evaluate the advantages of changing their drug use behavior
- Discuss the client's fears about stopping drug use. Common concerns and examples of how to handle them independently are given in the table:

Techniques to Handle Client's Fears	
Concern	**Counseling Technique**
• Ignorance about treatment	• Explain the strategies of treatment available including stages of treatment, namely detoxification, counseling, strategies for long term abstinence, aftercare and follow-up
• Fear of withdrawal symptoms	• Explain that withdrawal symptoms are temporary and will generally disappear in a week to 10 days. Reassure that medical help will be available to manage significant withdrawal
• Fear of loss of friends	• Point out that most 'drug friends' stick together only to take drugs. Such friends never remain friends once the money runs out. Once drug-free, the client will be able to develop new friendships based on mutual trust and concern.
• Fear of handling negative emotional states like loneliness, sadness, anger	• Explain that there are many other alternative and safer ways of dealing with negative emotions. In the long run it is these strategies that help, while alcohol and drugs often worsen emotional states
• Worry about the vacuum there may be in his life without alcohol or drugs	• Emphasize the ways in which life will be better when drug-free or abstinent. Clarify that there are ways of filling this vacuum that the person will have to learn or re-learn

c. *A client who has a desire to change and has made some efforts, with limited success*

Objectives:

- To strengthen motivation
- To discuss a plan of action
- To provide a clear and firm message about recovery.

Techniques:

- Make supportive statements about the client's motivation to change (e.g. 'I am glad you have made specific plans for your future. Stopping drug use is definitely going to help in working on these plans.')
- Discuss strategies with the client (e.g. taking leave for admission, making time to come for counseling)
- Identify changes in lifestyle that may be needed (e.g. avoiding alcohol parties or drug-taking peers, daily exercise, learning a technique of relaxation like yoga)

- Structure a plan of action (e.g. decide on treatment as outpatient or inpatient, detoxification, attending groups in addition to individual counseling, evaluation of physical illness, modifications in work schedule and home life, as required)
- If you are a physician, carry out a detailed physical evaluation, provide medication for detoxification and long term treatment as appropriate. Treat any co-morbid medical problems or mental illness (or refer to a psychiatrist). If you are not medically qualified, liaise with the physician who will provide these services).

  Even if you are not medically qualified, it is important that you have some idea about medical interventions. The client will have faith in what you say as a counselor, so reinforcing the message of the treating physician is very important. If you are uncertain about any of the medical treatments, it is best to advise the client to seek clarification (e.g. 'I'm not sure about the side effects. You could ask the doctor at your next consultation or I could check it out with the doctor.')
- Make a contract with the client about concrete issues - e.g. date of quitting, keeping next appointment, how to contact if appointment not kept
- Emphasize the need for follow-up.

d. A client who has achieved a drug-free period

Objectives:

- To maintain abstinence
- To focus on behavioral change.

Techniques:

- Identify relapse triggers and ways of coping with them. Common relapse triggers include craving and external triggers such as advertisements, watching others drink or use drugs, going back to an environment where the client formerly used the substance, as well as negative emotional states. Help the client discuss the various ways of dealing with such triggers, and what might be most appropriate for the client
- There are changes a person has to make beyond just stopping drug use. Undesirable patterns of behavior displayed during drug use, often continue after stopping use. In alcohol addiction this is known as 'dry drunk behavior'. Help the client focus on changing these behaviors (e.g. hiding issues from the family, coming home late, flaring up at the slightest provocation, not participating in any family activities). Depending on the client's past strengths and abilities, help the client make decisions about behavioral change
- Support even minimal progress (e.g. 'You took home Rs. 1000 for the first time in 5 years! The pleasure on your parents' faces is something you can never forget', or 'Your act of

taking flowers for your wife is commendable. Remember, that little act tells a lot... conveying to her that you care...')

- Highlight any successful strategy used by the client (e.g. 'When your friends offered you a fix, you said that you were on treatment? Well done. It certainly takes courage to be frank about taking help. Moreover, the next time will be much easier', or 'You listened to your favourite music when the craving was strong? That is a very effective way of dealing with craving. You know it comes like a wave and reduces after some time. Distracting yourself is a good way of dealing with it.')
- Discuss alternative activities (especially what the client can do in the evenings which were earlier spent using substances): playing, exercising, spending time with family, watching television, supervising children, involvement in spirituality, are some alternatives
- Money management: With addiction come multiple financial difficulties, including debts and poor money management skills. Talk to the client about how to repay debts, match expenditure to earning, and plan for saving (e.g. opening a bank account, putting aside a fixed amount for a specific purpose like buying a vehicle or repairing the house)
- Record any high-risk situations the client has been in, for example, going to a party where alcohol or drugs were being used, going outstation which was previously risky, having any emotional stress that was difficult to handle. Find out the alternative ways in which the client dealt with these situations. If he/she had a lapse (substance use) in between, encourage them to be honest about it
- Make a follow-up appointment.

e. A client who has had stable abstinence

Objectives:

- To continue to identify high-risk situations
- To support self-growth.

Techniques:

- Help the client recognize his/her own high-risk situations and specific measures that have worked or not worked for each. Strengthen the strategies that work
- Encourage the client to focus on gradually improving themselves - in the context of self, family and occupation. This includes having a properly planned day, cultivating a hobby, developing safe relaxation and recreational activities, planning activities with family, improving communication, regularity and concentration at work, including handling work tension and relationships with co-workers
- Helping others with similar problems also boosts a person's self esteem. At this time the client may be encouraged to help others quit, while paying attention to his/her own personal growth.

f. A client who has relapsed after a period of abstinence

Objectives:

- To help the client handle relapse without slipping back entirely to the pre-treatment stage
- To learn from the relapse.

Techniques:

- Warn clients about the possibility of relapse in the early stages of counseling ('Like any other chronic disorder, relapses can occur even in drug addiction. It is important therefore to keep in regular contact, so this can be identified early and corrected.')
- Reduce the client's feelings of guilt or shame by focusing on the improvements made in earlier periods of success
- Help the client identify what strategies had worked earlier and urge: 'Let's try them again'
- Talk about the events that led to the relapse, and ways of overcoming them the next time around
- Plan ways of becoming drug-free (e.g. detoxification) and maintaining a drug-free status.

Crisis situations

There may be many kinds of crises for an addicted individual. These may be related to emotional difficulties, interpersonal conflicts, or life situations (death, separation, job loss etc). Earlier, the person coped with such situations by using drugs. As a counselor, in such crises you will need to help the client deal with the situation without drugs.

Objectives:

- To help the client handle crises without using any drug
- To help the client develop coping skills to handle the next crisis.

Techniques:

- Be supportive. Allow the client to express concerns and anxieties
- Help the client use problem solving techniques. Simple steps for problem solving include:
  - Identifying the problem
  - If there is more than one problem, prioritizing the problems
  - Deciding which problem to handle first
  - Listing all the possible actions to solve the problem
  - Looking at the advantages and disadvantages of each action
  - Deciding on the most appropriate action
  - Implementing action (If it works, use it in future. If it does not, try another approach).

If the client is very depressed or suicidal, appropriate professional help must be sought.

How Effective is Personal Counseling?

Experience in working on persons with addiction has shown that the more competent and empathetic the counselor, the greater is the likelihood of the client staying in treatment, returning for follow-up and modifying drug taking behavior. Empathy and a humane and caring approach are important attributes of a counselor. However, such a caring approach must be complemented with specific skills and techniques of individual intervention, for counseling to be effective.

Acknowledgments

Principal Author & Scientific Editor : Dr. Pratima Murthy, NIMHANS

808

4

The Family and Drug Addiction

The family is very important in a drug dependent person's life. Family members may be closely involved with several aspects of the addiction: family members' response to the addiction, their response to the dependent person and influence on the course of addiction, and their role in the individual's treatment and aftercare, which may either aid recovery or precipitate relapse.

Responses of the Family to Addiction

Many partners of drug dependent persons suffer anxiety, insomnia, tension and depression. Other family members often have serious social and psychological problems. They often feel a strong sense of guilt or anger and have a desire for vengeance, which they may take out on their children or colleagues at work.

An important factor is denial of the problem by family members. Denial is an unconscious process of blocking out reality. With regard to problems associated with alcohol and drug abuse, denial is manifested in one or more of the following ways; in the failure to:

- See the problem entirely
- Recognize the extent or severity of the problem
- See the connection between drug use and the problems it has caused
- Understand that the drug dependent person needs help in dealing with the problem.

Manifestations of denial include covering up for the addicted person, doing the work that he/she does not complete, paying the bills that he/she does not pay, rescuing him/her from various kinds of problems, e.g. legal problems, and generally taking up the responsibilities the person has abandoned. The family can also deny their own part in the addiction: *"I don't know where she gets the money to buy drugs.' 'He doesn't mean to hurt us.' 'Her performance will improve.' 'She just needs to snap out of it.'*

Denial lets everyone pretend that there is no problem. The longer denial goes on, the longer it takes before drug-using individuals change their behavior.

Responses to the Addicted Individual and Influence on the Course of Addiction

The partner or significant family member may either be supportive of the dependent person or show extremely unhelpful behaviors ('inducing' the individual to continue drug use). A supportive partner can greatly reduce damage, and be extremely helpful in treatment. The 'inducer' does not understand the dependent

person and responds by scolding constantly, imposing excessive surveillance, restrictions and threats all of which actually worsen drug use in the majority of cases.

Enabling behaviors

Often when family and friends try to 'help' the affected person, they are actually making it easier for the progression of the problem. This is called 'enabling'. It helps the dependent person avoid the consequences of his/her action. This in turn leads to continued drug use, with the knowledge that someone is always there for the rescue.

Common 'Enabling' (addiction maintaining) Responses

i. Lying or making excuses for the addicted person's symptoms (e.g. calling up the employer to say the person is 'sick')
ii. Taking the blame for the person's drug use or behavior
iii. Avoidance of the topic of drug use with the person out of fear of his/her response
iv. Paying the debts that the person is supposed to settle himself or herself
v. Lending money to the person
vi. Drinking or using drugs along with the person in the hope of strengthening the relationship
vii. Giving the person 'one more chance', and then another and another
viii. Simply threatening to leave and then staying on each time
ix. Finishing a job or project that the person failed to complete himself/herself.

Common enabling responses are mentioned in the accompanying box. If the family member answers yes' to most or all of these questions, he/she has not only been enabling the drug user, but has probably become a major contributor to the growing and continuing problem.

Role of Family in Treatment and Aftercare

The family's participation and encouragement during active treatment is very important. However, they are often extremely distressed and have often exhausted all their resources. Therefore, they need a lot of assistance and encouragement to be able to support the person in treatment.

The dependent person can also induce a sense of guilt in the family members, especially when not yet motivated to change. Some of the ways the drug user may induce guilt in a family include:

- Complaining about the quality of treatment
- Saying that he/she will die if the drug is not provided. Many family members feel helpless and secretly bring in the drug to the treatment facility, hidden in food and drink

- Threatening suicide if the family does not 'rescue' him/her from the treatment center
- Making unrealistic demands on the family: *'Set up a shop for me immediately', 'Find me a job'.*

In such situations, family members become even more helpless. Therefore, establishing a trusting relationship with them, providing support, educating them about withdrawal related behavior, aiding them in decision making, and helping them with problem solving and communication become extremely important. Only when they themselves change will they be able to support and facilitate change in the addicted person.

Denial and enabling behaviors on the part of the family also have to be discussed with the family. A trusting relationship with the counselor is an initial step in getting the family to recognize denial, discuss it, and learn to accept it. Discussion about enabling behaviors and ways of modifying them is also an important step in treatment. This will help the family put the responsibility for the consequences of substance use on the person using the substance.

Role of the Family in Aftercare

Treatment in substance abuse does not simply involve getting the individual to stay sober, but also includes helping him/her get back to their normal level of functioning. The following aspects need to be looked into.

Role structures

Drug dependence affects the user's role, status and functioning in the family.

The client's role within the family can be clarified by:

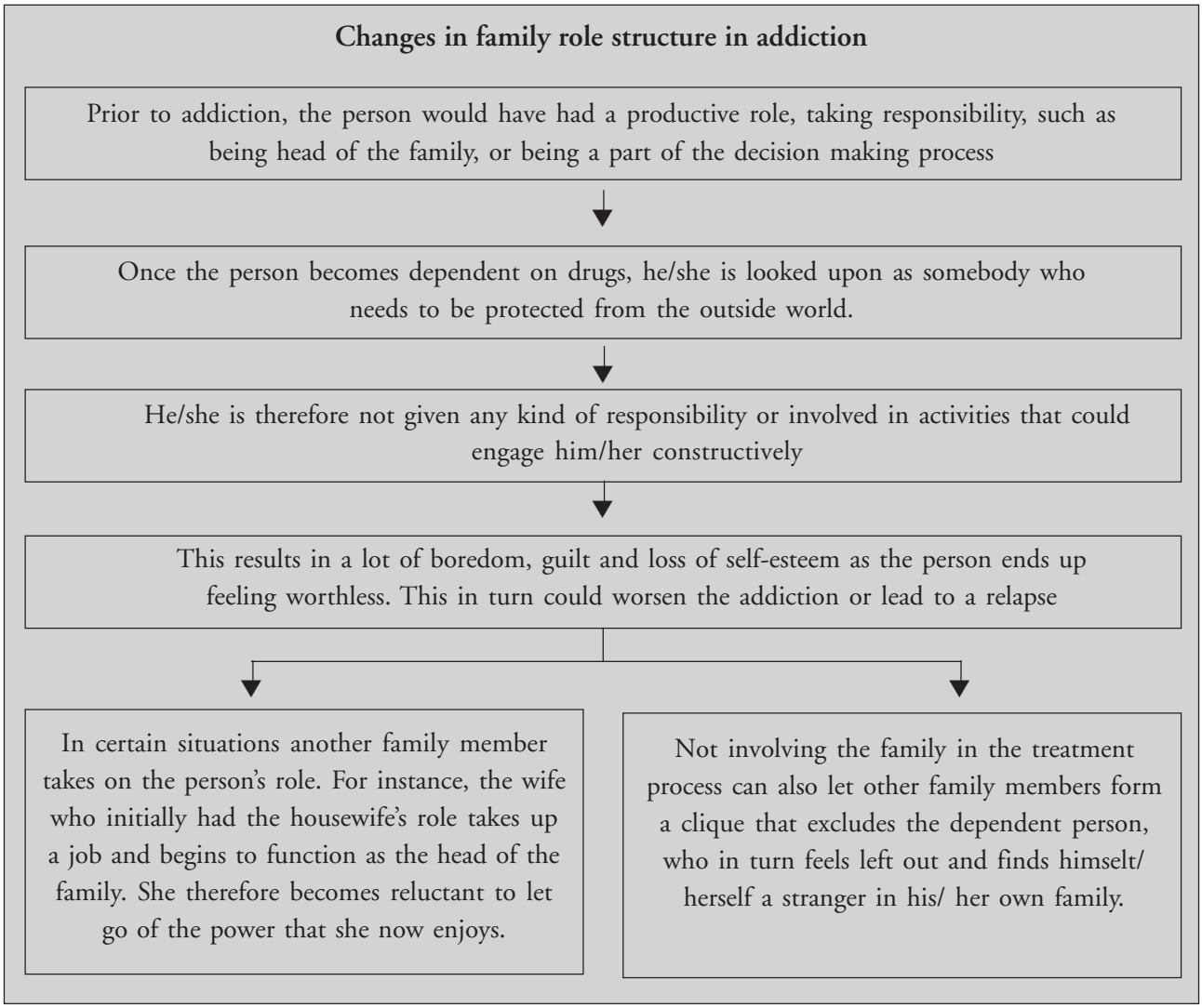
- Involving the family members and helping them work ***with*** the dependent person rather than ***for*** him/her.
- Getting the support of family members in normalizing the affected person's activities and helping him/her get back to their initial and full functional role.
- Educating the family on the need to reintegrate the person back into the family and facilitating this by involving the patient in the decision making and problem solving processes in the family.

Communication

The way the family members react to the individual and help him/her get back to their normal level of functioning is greatly affected by the communication patterns in the family.

- If family members have avoided direct communication with the individual during his/her addiction process, they find it difficult to change this pattern even when he/she is drug-free.

For example, children get used to asking for things from the dependent father through the mother and do not speak to the father directly even when is recovering.



- The family members also get into a pattern of bringing up past issues from when the dependent person used to create problems due to the addiction. This can affect the individual's sense of guilt and self-esteem.

Family members thus need to be counseled on appropriate communication.

Reinforcement patterns

Encouragement of the recovering person by family members plays a key role in the recovery process. At the outset, the family may have severely condemned the individual's behavior due to addiction. If they maintain this behavior during the process of recovery, they will actually increase the risk of relapse. Instead, complimenting the person on his/her efforts to recover will make them feel recovery is worthwhile and will adequately reinforce the recovery process. Verbal (acknowledgement, praise), non-verbal (a look of

appreciation, a pat or a hug) and material reinforcements (making the person's favorite dish) will all contribute in some measure to recovery.

Social support

Many families take the help of their support systems in the treatment of this illness. They often discuss the individual's problem with other relatives, who in turn offer 'advice'. This can be a source of resentment for the recovering individual and must be avoided.

Once the person begins treatment, the family members need to ensure that his/her support systems are strengthened. Significant people in the support system (e.g. friends, co-workers) must also encourage the person's attempts to be drug-free

When the individual is not amenable for treatment

Willingness for treatment often varies, depending on the level of motivation. Sometimes, even when the family is encouraging and supportive, the individual refuses treatment or is uncooperative. In such cases it is good for the family to:

- Develop problem solving skills
- Identify and stop enabling behaviors (covering up, making excuses, taking on responsibility for the consequences of substance use)
- Get the support of a self-help group
- Develop a sense of detachment.

There is also a need for hope that the drug dependent person will, at some crucial point, become motivated to accept treatment.

Acknowledgments

Principal Author : Ms. Maria Christine Nirmala, NIMHANS

Scientific Editor : Dr. Pratima Murthy

808

5

Family Counseling in Drug Addiction

Introduction

Families of drug-dependent persons face a number of problems including violence, disruption of family rituals, separation, divorce, inappropriate role models and economic difficulties. Addiction does not burst into the family the way a heart attack would; instead it creeps in slowly and silently, until it is finally detected and it is perhaps only then faced by the family. However, by that time it has left its mark on each family member.

Addiction (drug dependence) is not a condition which once treated can be completely cured. A chronic and relapsing condition, it is always likely to topple the individual back to the same situation of dependence if the individual and his/her family do not take adequate precautions.

Treating drug dependence therefore involves more than just getting the drug user to stop using drugs. It also involves counseling the family and thus improving family relationships and functioning.

Steps in Family Counseling

There are different steps in family counseling, which are carried out in the course of sessions with the client and his/her family. In an ideal situation, the counselor should follow the steps in the sequence given here; for instance, it is important to make a proper assessment of the impact of the client's drug use on the family, before counseling the family. In reality, families often come with different problems or expectations. The counselor will then have to be flexible, and select and use the appropriate intervention. Different sessions may address different issues and should be structured according to the needs of family members.

Stage 1: Ventilation

Addiction is often understood as a problem stemming from the lack of voluntary control. Family members often feel angry, disappointed and frustrated because they think the person takes the drug deliberately. The spouse and children of the drug-dependent person are unable to discuss the problem with anyone due to the stigma attached to such issues, and keep all their emotions bottled up. Very often, negative emotions towards the drug user are not expressed, and there is a lot of anger, hostility and resentment towards the person. The family member is often on the brink of 'giving up'.

Ventilation helps family members unburden their pent-up emotions and feelings. This intervention provides emotional support by listening, being sympathetic and non-judgmental, and acknowledging the

family members' feelings. It allows rapport to be built up with the family members so that further counseling becomes effective.

Process

Rapport building

- Introduce yourself
- Ask for general information like the individual's name, occupation etc., instead of identifying them only as the patient's relative
- Assure the individual of confidentiality.

Enquire about the problems that the family member has been facing and just allow them to talk.

The course of the interview is determined by the family member and what he/she would like to talk about. The counselor is basically supportive, listening and communicating understanding to the relative.

Stage 2: Assessment of the Problem

Addiction affects a number of areas in life. Before intervention, the counselor should have a comprehensive understanding of the impact of addiction on the family.

Process

The counselor needs to talk to available family member(s) on the following aspects:

- Knowledge about drug dependence
- The reactions of family members towards the drug user
- Changes in the roles played by family members
- The effect of addiction on the drug user's job
- Available social support that the family members have in terms of immediate family, friends and other tertiary support groups (like the church, self-help group etc.)
- The maintaining factors for drug use in terms of: craving, withdrawal, negative moods, peer pressure, coping with stress, handling pain, family problems and any others.

Family members' perceptions of these issues is useful to understand, as they may be quite different from the drug user's own perceptions. Such differences can be addressed in the intervention.

Stage 3: Psycho-education

Members of the family generally expect the drug-dependent person to have voluntary control over drug use. They need to be educated about the individual's problem as an illness that cannot be cured by will-power alone.

Process

Compare drug dependence with any other physical illness:

- Just as any physical illness affects your ability to function normally, e.g. your appetite, sleep and work, drug addiction too affects these functions.
- Drug addiction can be treated like any physical illness. However its treatment is not 'onetime', like treating cholera and malaria. It is rather an illness that needs life-long precaution and care, as with diabetes.
- The earlier the illness is identified and treated, the easier it is to control, similar to any other chronic illness.

Discuss the pattern with which the problem started in the client, right from first-use of drugs, and how it progressed.

Stage 4: Relapse Prevention

A tendency to relapse is typical of the nature of drug dependence. While the individual may be motivated to give up the drug when first seeking treatment, the will-power to stay sober is not sufficient by itself in the long run. The individual needs to be equipped with very practical strategies to handle high-risk situations. The family needs to provide support in these efforts.

Process

- Educate the client and his/her family members that drug dependence can be a chronic and relapsing condition, and that will-power alone is not enough for staying sober
- Make the family aware that they need to assist the individual in identifying common relapse triggers
- Educate both client and family members on how to handle these triggers.

Handling peer pressure

- Explain to the family that peer pressure is one of the most important factors leading to relapse

Family members often feel that the best solution is for the individual to avoid contact with drug users, and therefore prevent the person from meeting such friends. This does not solve the problem, and may even make the person defensive and hostile towards the amily. Every individual needs friends. Therefore such avoidance is not always possible.

- The individual thus needs to be helped to cope with peer pressure by teaching him/her skills of drug refusal, without affecting the relationship with drug-using friends.

Handling craving

Explain to the family that craving is one of the main problems of continuing addiction, and that the individual is likely to come across many situations that trigger craving. The family can help by:

- Encouraging the individual to express craving to them
- Not panicking, as craving can be handled in ways other than using drugs
- Understanding that the process of craving is temporary
- Giving him/her something to eat or drink. The craving is often reduced when a person's hunger or thirst is quenched
- Talking it through when craving occurs
- Distracting the individual by playing a game, reading, going to a movie, listening to music or going out to visit some relatives, etc.

(It is important for you as the counselor to help the family think of alternatives, rather than directly suggesting solutions. This will help the family accept responsibility for following them through).

Coping with stressful situations

Generally, dependent persons tend to use drugs as a way of coping with stressful situations. They need to re-learn adaptive coping strategies to deal with such situations. Coping strategies are of two types, emotion-focused and problem-focused:

- Encourage the family to listen supportively to the person. Getting emotional support from the family helps greatly in facing problems. This is emotion-focused coping
- For problem-focused coping, educate the entire family about the process of problem solving.

Using a systematic approach to problem solving lets people feel that they have control over problems in their lives. As the problems are put in a different perspective and significant family members become involved in finding a solution, the drug user in recovery feels unburdened and lowers his/her chance of relapse as a dysfunctional way of coping.

Stage 5: Substance-free Lifestyle

A person who has been spending most of their time getting, using or recovering from the effects of drugs, does not know what to do with himself/ herself, with the time and the extra money available after quitting drugs. This can be troublesome for the recovering user.

Process

a. Management of finances: Drug dependence is associated with many financial losses. During recovery the person is often confronted with financial difficulties of which he/she was earlier unaware. Encourage the family to work with the individual towards:

- Clearing debts
- Budgeting current expenses
- Investing for the future.

b. Management of time: Without the drug, the individual will be left with a lot of time on his/her hands. If this time is not managed wisely, it can lead to boredom, which may trigger a relapse. The family can help by:

- Helping the individual schedule activities
- Not letting him/her be alone too often
- Engaging the person in some mutually interesting activity.

c. Role functions: With progressive addiction, the drug user often reduces or stops taking responsibility and playing his/her role within the family. Another family member takes up his/her role. Once the drug user recovers, he/she may be keen to take on that responsibility or role again (for example, earning for the family, making decisions). Family members may be hesitant to restore these roles and responsibilities to the recovering user -because of a lack of trust, doubt, or because someone else has taken up that role. Defining (or redefining) the role of the recovering drug user in the context of the family is very important in order to reintegrate the person within the family.

- Discuss this issue very carefully and tactfully with the family
- Encourage both the client and the family to discuss the issue and try to understand each other's views
  - The client needs to be helped to accept the lack of trust from family members due to a number of experiences of broken promises
  - The family also needs to be counseled on the need to normalize the activities of the individual and encourage role responsibility
  - Both need to sit together with the counselor and establish contracts on what each needs to do

  (This issue cannot be handled through a one-time resolution, but is something that will recur and will need to be handled each time).
- Emphasize to the family the need for positive reinforcement of the recovering person
- Caution the family against constantly bringing up past issues and putting the recovering person down for all the problems that he/she had created in the past.

Stage 6: Coping with Relapse

Family members often find it difficult to accept that the process of recovery is uneven. They would like to believe that once the dependent person is admitted into a treatment program, he will remain drug-free for

life. A lapse or relapse may come as a rude shock. They are not prepared to deal with the situation, and feel hurt and betrayed.

Process

- Emphasize to the family that relapse is very common during recovery
- Stress the need for continuous and regular follow-up
- Advise the family to bring the individual to the treatment center at the earliest in the event of a relapse.

Handling crises and emergency situations

- If the drug user gets very violent and is a threat to the health and safety of the family members, advise them to take the help of neighbors or even the law.
- If the person is not motivated for treatment and repeatedly troubles or threatens them, teach the family members to set limits by not yielding to his/her threats, and to take the help of other resources to handle such threats.
- Encourage the family to keep in touch with the counselor even if the drug user is unprepared to change. There are critical times such as illness, withdrawal, or following threat of job loss, when the individual can be persuaded by the family to seek treatment. In the meantime, their contact with you will provide the family emotional support and the strength to cope.

Indications for referral to family therapy

In certain situations simply counseling the family may not be adequate, and referral to family therapy may be needed, if there is a specialized family therapy facility. Indications for family therapy include:

- Frequent relapses precipitated by interpersonal problems within the family
- Family problems that tend to maintain the dependence of the individual
- Non-compliance of family members with the counseling process.

Acknowledgments

Principal Author : Ms. Maria Christine Nirmala, NIMHANS

Scientific Editor : Dr. Pratima Murthy

808

6

Aftercare Services for Drug Dependence Persons

What is Aftercare?

'Aftercare' refers to services that help recovering drug-dependent persons to adapt to everyday community life, after completing earlier phases of treatment and rehabilitation. It provides an opportunity to address important issues and problems associated with abstinence and recovery. Aftercare provides a safe environment for continued support till it is no longer needed.

Why Aftercare?

The journey of recovery continues even after treatment and rehabilitation, and is long and steep. Since clients may take a year or even more to complete this last part of the recovery journey, they need support and guidance during this period.

Aftercare should:

- Be an integral component programed into a treatment and rehabilitation service
- Include training to prevent relapse and other crises
- Focus on reviewing and consolidating the gains made during treatment and aim at Whole Person Recovery (with strategies for being drug-free, crime-free and gainfully employed)
- Impart new skills for maintaining recovery, including help in handling everyday responsibilities, managing family and other relationships, making new friends, developing alternative recreational activities, adjusting to work and employment or acquiring/re-learning occupational skills, overcoming the stigma and shame of the past, and developing new insights.

Differences between Aftercare and follow-up

While an aftercare program does include follow-up procedures, mere follow-up is not aftercare.

	Aftercare	**Follow-up**
Definition	Planned services that help recovering drug - dependent persons to adapt to everyday community life	Monitoring and collecting information about clients after they leave a program
Focus	Support and guidance in relapse prevention, Whole Person Recovery, and developing new skills	Learning about clients after they leave a program

Issues in Aftercare

Aftercare includes working on:

a. Recognition, review and consolidation of treatment gains

b. Addressing the issue of drug-craving in terms of:

- Identification of drug-craving
- Identification of psychological and other cues that trigger craving
- Tracking of craving urges
- Anticipating situations that may lead to drug use
- Handling craving

c. Establishing a new social network by:

- Developing social and intimate relationships with non-drug using persons and peers
- Carrying out non-drug using 'fun' activities
- Establishing healthy social activities

d. Beginning or resuming new roles and responsibilities as:

- An employee, worker or student
- A family member
- A parent, son, daughter or homemaker
- A friend, colleague or co-worker

e. Lifestyle changes required for **Whole Person Recovery**. This includes helping the client handle work/employment, family and relationships, finance, as well as social and recreational activities, without resorting to drug use

f. Relapse prevention.

Aftercare should not be an afterthought.

Goals in Aftercare

Based on the aftercare issues outlined, the staff of the program should formulate a set of client goals. These should be in tune with the recovery model being used in the treatment and rehabilitation services. Well-defined goals provide a focus for both the client and the staff and also set criteria and standards for client entry into and completion of aftercare.

A good aftercare program also needs to be individualized. All clients differ as regards their individual problems, needs, and psychological as well as social capacities and resources. A flexibility that allows more individual choices, makes a program more attractive and effective.

The Place of Aftercare in the Treatment Process

Plan aftercare arrangements before discharging the client from the treatment and rehabilitation facility. Such a plan should specify the person(s) responsible for providing aftercare, the time, frequency, place and type of contact.

If your treatment program is new, with only a few clients having reached the aftercare stage, counselors should pay attention to each client's aftercare needs. When the group of clients grows, a more formal program of aftercare can be developed.

Who Provides Aftercare?

Although desirable, not all drug treatment centers need to provide for aftercare themselves. The aftercare component can be provided by a different agency in the community. For example, hospital-based detoxification-only programs may refer their 'graduates' to other rehabilitation programs that facilitate the rest of recovery.

Smaller rehabilitation programs may opt for a more flexible client-to-client approach for community reintegration (individualized aftercare). Alternatively, several rehabilitation services may share resources and set up a common central aftercare service, where they continue to provide individualized counseling but rely on the common program for group or larger activities.

The Aftercare Setting

Aftercare services may be offered on an outpatient basis by the designated staff of the treatment unit. Alternatively, aftercare may be offered in the community by trained community volunteers, or by an aftercare self-help group.

Aftercare Staff

i. Specially trained staff

A staff member or a committee should be designated to oversee the aftercare program. One or more experienced counselors can be trained to acquire the special competence required for the purpose. Other counselors and volunteers may be trained to assist in the program.

ii. Recovering addict counselors

'Senior' recovering addicts can form an effective part of the aftercare team, as they not only provide role models but can also be effective peer counselors and peer leaders.

iii. Volunteers

Volunteers from the community who are familiar with the process of drug dependence and recovery, who have the sensitivity and ability to listen and empathize, and the capacity to understand, may be trained to assist in aftercare services.

Aftercare Activities and Procedures

The Aftercare plan

Ensure that the aftercare plan:

- Specifies the person(s) responsible for providing aftercare
- Works out time, frequency, place and nature of contact
- Is systematically planned. Every session or activity must conclude with a mutually agreed plan for the next
- Is reviewed periodically and modified as required.

The Aftercare contact

You can plan various types of aftercare contact including:

- Personal meeting and interview (most preferable)
- Personalized letters to the client
- Personalized messages of care and concern
- Telephonic contact. Information may be gathered and advice, support and encouragement offered
- Structured or semi-structured questionnaires for the client to fill. Questions include frequency and evel of drug use, family and other interpersonal relationships, work and employment, finances, health, social and spiritual activities
- Home visits by counselors or volunteers.

Clear entry and completion criteria

Define clearly the criteria and standards for entry into and 'graduating' from the aftercare program. This maximizes benefit and reduces wastage of resources. Admit only those clients who are ready to use the service.

Components of Aftercare

i. Individual counseling

General Principles of Individual Counseling	
• Respect for the Client • Rapport • Confidentiality • Authenticity • Non-judgmental attitude • Warmth	• A thorough understanding of the basic nature of the problem and client's ability to improve • Ability to identify resources and utilize them for client's benefit

ii. Continuation of medications

Depending on the recovery model used by the treatment and rehabilitation service where the aftercare program is based, suitable clients may have been prescribed and maintained on certain medication to facilitate aftercare and recovery. Such medicines include:

- Antagonists (e.g. Naltrexone in cases of opiate dependence)
- Agonists that work as maintenance substitutes (e.g. Methadone, Buprenorphine in opiate dependence)
- Anti-craving medicines (e.g. Naltrexone or Acamprosate in alcoholism)
- Aversive drugs that cause an adverse reaction (e.g. Disulfiram in alcoholism).

The aftercare staff may need to supervise medication to ensure compliance. Decisions regarding when to start, change or stop these medicines are best left to the medical professional in charge.

iii. Psychiatric and medical treatment

Certain clients in aftercare may continue to receive psychiatric or medical treatment for co-morbid conditions. Such patients require:

- Monitoring of treatment and ensuring compliance
- Appropriate referral and contact with the treating doctors.

iv. Family counseling

Family counseling should be continued on a single-family basis in the treatment center setting or through a family support group outside the center, in the community. Counseling includes helping family members learn new strategies to cope and relate to each other, resolve conflicts and prevent relapse. They must also learn to overcome social stigma, shame, and pain and their own 'co-dependence'. In such situations, aftercare may involve family counseling, family groups, group fellowships and other activities. Even occasional home visits may be required to assess the living situation and to intervene.

v. Aftercare group

Those clients who show a certain level of readiness could be associated to form an aftercare group that focuses on common issues of aftercare. Such a group should be formally led by a trained aftercare staff member and could be co-led by a 'senior' recovering addict. Regular meetings should be held at least once weekly. Group therapy in such settings is a powerful technique of aftercare.

Self-help groups such as Narcotics Anonymous and Alcoholics Anonymous can also form a part of the network for aftercare support.

vi. Vocational rehabilitation

This 'employee assistance' component of the aftercare plan aims to reduce the difficulties that recovering addicts face in adjusting to regular work and employment (such as socializing with fellow workers, coping

with routine and monotony, coping with authority, not being able to speak up, etc.). Since vocational rehabilitation is crucial for recovery, any risks on the job can be risks to recovery. The aftercare staff might have to maintain contact with the employer, make non-intrusive visits to the workplace, intervene in crises on the job, conduct group discussions on job-related issues, and assist in job-or work-related decision making.

vii. Fellowship and community activities

Such activities wonderfully supplement group meetings by providing wholesome recreation and socializing among members. Meetings should be held regularly, preferably every week. To hasten social reintegration, guests should be invited from the community and attempts should be made to hold as many activities in the community as possible.

viii. Community-based meeting sites

Group meetings should preferably be held in locations within the community such as a school, library, public or social hall, place of worship, or any suitable place, rather than the rehabilitation center. This helps foster a sense of well-being, as it helps clients feel more like respectable members of the community than addicts.

ix. Networking and co-ordination

Close co-ordination must be maintained with similar as well as other social, medical, law enforcing, religious or other services and groups, to ensure prompt intervention at times of crisis or urgent client needs (such as for detoxification), client follow-up, vocational rehabilitation, or for any aftercare activity.

Aftercare Outcome and Evaluation

In order to develop and refine an aftercare program, close attention must be paid to the program's outcome data. The outcome information will help assess the effectiveness of the program and modify it suitably. Such evaluation will also identify staff training needs and the direction the program must take.

Setting up an Aftercare Program: Summary Steps

- Before starting an aftercare program, decide whether to 'own' the aftercare program or 'outsource' it.
- Set up an 'Aftercare Team' with one or more counselors, a manager or member of the treatment center's Board, and a recovering addict counselor (if possible). The Aftercare Team will carry out the planning, implementation and development of the aftercare program.
- Plan client-by-client individualized aftercare (for smaller treatment programs) or a larger, formal and structured aftercare program, as suitable.
- The Aftercare Team should:
  - Plan program components
  - Identify areas of staff training and capacity building
  - Estimate financial and other resources for the program and mobilize such resources
  - Carry out a periodic evaluation and review.

The client who successfully graduates from an aftercare service will have made substantial **Whole Person Recovery** to lead a normal life. Yet, the road to recovery does not end here, as recovery is a continuous journey. Though the risks of relapse decrease with the passage of time, relapse can still occur. The aftercare experience enhances the client's capacity to cope with this risk and make progress on a drug-free life.

Acknowledgments

Principal Author : Dr. Sunil Mittal

Scientific Editor : Dr. Pratima Murthy

808

7

Crisis Intervention Role of a Counselor

Introduction

Most drug abusers remain in danger of a relapse throughout their life. In addition to the craving, sudden, unexpected and painful events or situations can break the individual's normal pattern of functioning, and even act to push the abstinent person back into the vicious cycle of drug use. Any such painful event or situation that can disturb the person's normal functioning and emotional state is called a crisis.

This pamphlet will help you identify and intervene in such crises.

Not every problem is a Crisis

The recovering addict may face numerous problems, many of which may be solved by the client either alone or with help from the family. Thus, every problem should not be seen as a crisis. A crisis, as defined in this pamphlet, is a situation that cannot be solved with just the individual's usual problem solving resources.

Common Crisis Situations

For a recovering addict, crises may emerge from:

Family Situations: Lack of family support, fights between or separation of parents, violence at home, or physical illness in the family can give rise to crises for the abstinent user.

Economic Situations: Economic situations that can spark off a crisis include failure to find a job, loss of an existing job, pressure to repay debts, and the need to provide financially for the family, especially if the recovering addict is the breadwinner (e.g. children's school fees, medical expenses of a family member).

Personal and Social Situations: Problems resulting from previous drug use, for example, having to face legal action because of a previous theft/assault, or ostracism from the community because of earlier behavior, are also potential causes for a crisis.

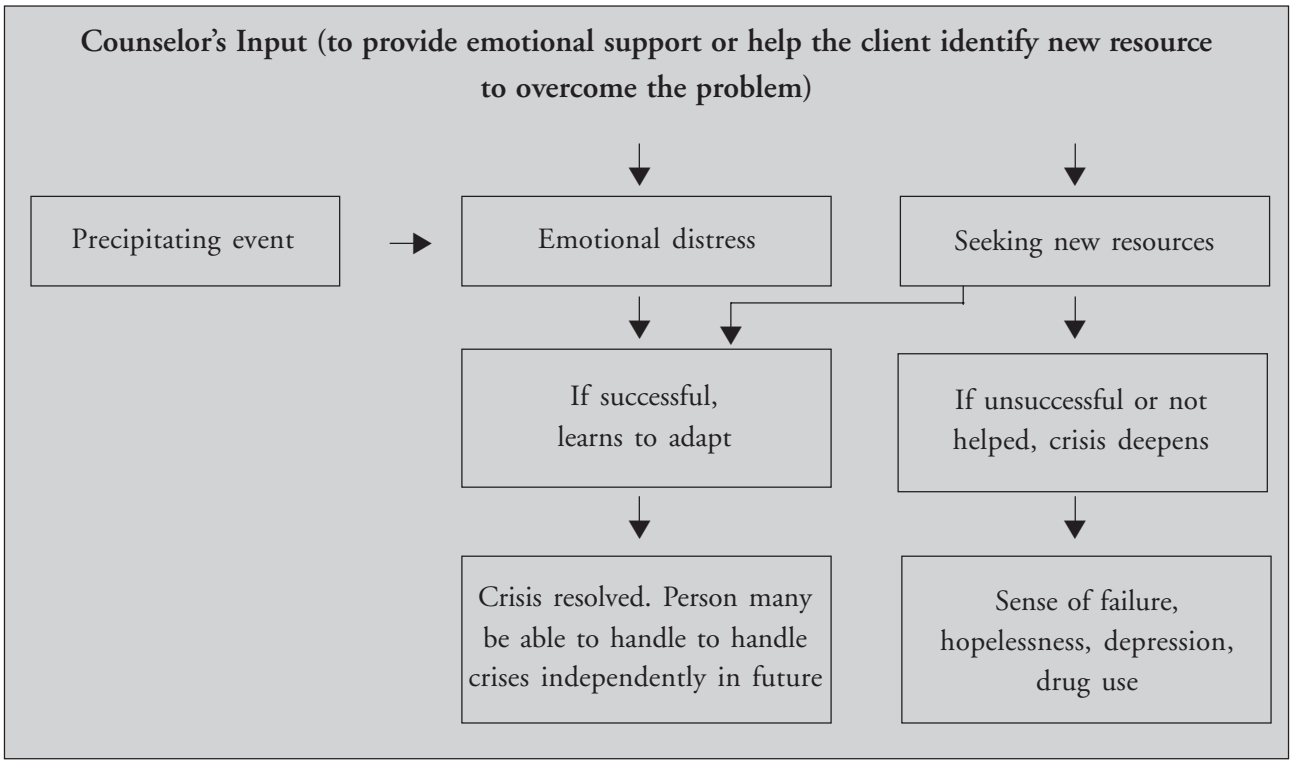
Interpersonal Crises and Life Events: Difficulties in relationships, within and outside the family, including romantic as well as peer group relationships, can lead to crises. Crises can also emerge from positive events like a promotion, marriage or birth of a child, or negative events such as death or separation.

What Happens After a Crisis

Following a crisis, anyone in such a situation can feel anxious, hurt, upset or angry. The recovering addict may try to deal with the problem by himself/herself or with the help of family. If the client does not have the skills to handle such a problematic event or situation, the crisis will deepen, emotional problems may worsen and the person even runs the risk of relapsing. If you as a counselor can intervene at the right time, and support and help the client develop the strength and appropriate skills to handle such crises, it is possible for him/her to overcome crises, learn new ways of adapting to problems and actually be stronger in facing similar situations in the future.

Timing of Intervention

Any crisis, and the possibility of relapse, usually lasts for 4 to 6 weeks after the distressing event. It is important for the counselor to provide help during this critical time to prevent breakdown, and restore adequate functioning. As a counselor, you may need to spend several hours with your client initially, and should always be available to your client during this period.



Responding to the Client's Needs

The client's psychological responses during a crisis may include feelings of:

- Loneliness and feeling lost
- Tension and fear
- Confusion, restlessness

- Being stuck, as if nothing works
- Helplessness
- Desperation that something must be done right away.

As a counselor, you must remember that:

- Anyone can have a crisis
- The crisis is temporary and will pass
- Emotional distress is common and does not mean that the person has any mental illness. (It is useful to convey this to your client.)

Supporting your Client in a Crisis

- Intervene at the appropriate time
- Be available
- Be supportive
- Reassure the client that this is a temporary phase
- Help the client with the Problem Solving Approach:
    - Assess the hazardous situation and precipitating factors responsible for the development of the crisis
    - Identify the maladaptive responses used by the person in dealing with the crisis
    - Evaluate the intensity of discomfort for the person and the potential for rapid deterioration
    - Focus on resolution of the crisis
    - Use every supportive device available, such as suggestion, reassurance, medication, modification of environment, and if necessary, brief hospitalization.

A Simple Problem Solving Approach

What is the problem?

Whom is it affecting? or Who is contributing to it?

Where did it happen?

When did it happen?

Why did it happen?

How can it be handled? If there are more ways than one:

- List the possible responses
- Discuss the pros and cons of each response
- Decide and act on the most suitable response
- Discuss the effectiveness of the action
- Rethink the most appropriate action.

After the Crisis

Once the crisis has blown over, or the recovering addict has been able to adapt to the new situation, you can reduce the time spent with the client, and encourage self-reliance. It is also useful to go over the episode in a review, and help the client strengthen his/her useful responses and change unhelpful responses to a crisis. This will make the client stronger and help them face any future crises more successfully.

Acknowledgments

Principal Author : Dr. H.S. Sethi

Scientific Editor : Dr. Pratima Murthy

808

8

Relapse Management

Treatment for addiction is seen as an end to all problems that the client faces. Family and society now expect the addict to live like any other individual, little realizing that recovery brings with it problems which can be as difficult and complex as those encountered during the days of addiction.

- Recovery means a new way of life for the client. The transition from a drug-using world to one that is drug-free calls for numerous adjustments. This may mean a lot of struggle and the period can be very stressful. Even issues that seem trivial to others, like finding ways to fill one's time or conversing with people, can appear difficult.
- The outside world continues to bombard the client with alcohol/drug related situations that he/she needs to guard against all the time. Brightly lit bars, peddlers and drug taking peers can tempt him/her to try drugs again.
- Though the physiological withdrawal symptoms are no longer present, psychological craving to use the drug again may set in suddenly, even weeks or months after the client has quit.

When he/she is unable to cope with the demands of change, resist drug related cues or handle the craving, relapse follows.

What is a Relapse?

Relapse needs to be viewed as a process - as a series of maladaptive responses that eventually lead to the act of taking drugs or alcohol. Changes at the levels of thought and feeling, shifts in attitudes and behavior patterns can be noticed before the client actually takes alcohol/drugs again.

Relapses vary in intensity. Some may reach out for help after a single incident of drug or alcohol use while others may go back to regular drug use, with some or all the drug related problems of the past. Irrespective of the intensity of the relapse, specialized intervention is called for.

Misconceptions about Relapse

- Relapse is **not a sign of poor motivation** as is generally believed. Most clients in treatment are motivated to give up drugs and alcohol and are willing to make changes in lifestyle to support their recovery. Yet, when they are unable to cope with the demands and challenges this entails, many relapse. We need to remember that relapses are equally if not more emotionally painful for the addict, as for disappointed family members.

- Relapse **does not signal failure of treatment.** It instead points to the need to refine or fine tune treatment plans. Addiction is to be viewed as a chronic disorder in which relapses are a natural part of the recovery process. It may not be possible to avoid relapses altogether but instead they can be used constructively to help the client work towards the goal of abstinence.
- Repeated relapses **do not indicate that there is no hope for recovery.** A closer search for previously unnoticed relapse triggers is called for. Depression or other underlying psychiatric problems, physical illness like diabetes or unresolved childhood or marital issues may need to be handled.
- Clients **need not hit bottom once again to ask for help.** Relapse actually brings with it a hugeload of guilt and shame. The client hesitates to approach the counselor and may instead continue to abuse drugs and alcohol to obtain relief from these feelings. Relapse also shakes his/her self-confidence and he/she may wrongly conclude that they will never be able to recover. The counselor may need to make the first move and encourage the client to take help. Postponing help may only permit him/her to sink deeper into drugs and make intervention more difficult.

While it is true that all clients do not recover, it must be emphasized that the majority do. So, the extra effort made to handle relapses is definitely warranted.

Issues to be Addressed

Relapse education is an essential part of the primary treatment program itself. While detoxification gives the client relief from the withdrawal symptoms that keep him/her chained to addiction, the following issues need to be addressed during psychological therapy:

- understanding the nature and intensity of problems caused by addiction and strengthening the resolve to abstain
- identifying high-risk situations for a relapse and making plans to handle it
- focusing on qualitative recovery by initiating lifestyle changes
- maintaining regular follow-up to sustain recovery.

When relapses take place in spite of these efforts, an especially tailored relapse prevention program is necessary. Through the program, clients can be helped systematically to resist craving, recognize and manage relapse warning signs and work through their recovery.

Planning a Relapse Prevention Program

Relapse prevention programs can be conducted on a regular basis. The program may be conducted on an inpatient or outpatient basis for 4 to 5 hours each day and run continuously for 4 to 7 days. However, relapse prevention programs can also be conducted for about 1 to 2 hours per week and last for a few months.

The program module includes lectures to present facts, group therapy and counseling sessions. Assignments or workbook activities can also be used to enhance effectiveness. Role-play sessions on refusal skills, assertiveness and communication skills are particularly useful.

Depending on the treatment center's resources, particularly the availability of skilled staff, the frequency, duration and the impact of the program can be decided upon. It is, however, extremely important to document efforts made to evaluate effectiveness.

Four Components of Relapse Prevention

A relapse prevention program essentially covers four major areas: stabilization, insight into the pattern of relapse, developing a recovery plan, and strengthening social support.

i. Stabilization

As part of stabilization, medical assistance may be necessary to ease withdrawal symptoms and help the client become drug-free again. As the first step in recovery, the client needs help to deal with the immediate crisis. Counseling sessions may be needed to sort out issues and get the client to focus on the task at hand - establishing abstinence.

ii. Insight into Relapse Pattern

Clients are helped to:

- identify the relapse triggers
- recognize the relapse warning signs and
- understand the relapse process.

a. Identify the relapse triggers

Listed below are some issues that clients in recovery find particularly difficult to deal with, which thus act as relapse triggers:

- stress related to work, finance or even boredom
- interpersonal conflicts related to family/friends
- strong positive or negative feelings like happiness, anger, grief or anxiety
- presence of drug/alcohol related cues in the immediate environment - conversations related to drugs, social events where drugs/alcohol are being openly used, news of a new drug or pusher
- repeated invitations to try 'alcohol' or 'drugs'.

b. Recognize the warning signs

When the client responds to these circumstances inappropriately or ineffectively, relapse warning signs set in. Relapse warning signs can be seen at three levels.

- Irrational thoughts - He/she may have recurrent thoughts of alcohol/drugs or try to justify its use. Even while recognizing the need to stay drug-free, the client can find himself/herself thinking, 'I can use just a little and exercise control'; 'Heroin is my problem so why can't I have some beer?'
- Unmanageable feelings - Due to an inability to handle feelings appropriately, he/she permits them to build up and intensify, making him/her uncomfortable. For instance, the client's unemployed status over a long period, say six months, may give rise to self-pity and a sense of worthlessness. The unexpressed anger may lead to severe resentment. The client may then be tempted to try alcohol or drugs in an effort to handle these feelings.
- Self-defeating behavior patterns - The client's over-confidence may lead him/her to take unnecessary risks like associating with drug-using friends. He/she may become casual in his/her efforts to maintain recovery - may skip/ reduce self-help group meetings or counseling sessions. There may be a progressive loss of daily structure; the client may not eat or sleep on time, may overwork or just be lethargic. When these unhealthy signs are not recognized and checked, the relapse process is set into motion.

c. Understand the relapse process

A series of seemingly irrelevant decisions build up to a relapse. One thing leads to another and the client gradually slips back into alcohol/drug use. The lack of social skills keeps him/her from making new friends, giving rise to boredom. This may lead him/her to visit drug-using friends and just watch them smoke a joint. The conversation may drift on to how fun drugs can be and he/she may start using all over again.

The client needs to revisit the past and piece together the relapse process to understand what initiated the relapse and why it all happened. This understanding is crucial to their future recovery so they can now see where they went wrong.

iii. Develop a Recovery Plan to Safeguard Sobriety

Based on a realistic assessment of the client's problems and resources a recovery plan is developed. Recovery plans need to address these aspects.

a. Handling relapse triggers - Stress management techniques, conflict resolution skills and appropriate ways of dealing with feelings need to be discussed.

b. Recognizing warning signs - Using a daily/ weekly inventory is an excellent way to make sure the client stays on track. By assessing himself/herself each day on what they set out to do and what they actually did is a good way to ensure self-introspection and growth.

   A daily routine with emphasis on timing and discipline is essential. Regular eating, sleeping and work habits as well as healthy leisure activities are very important.

   A regular follow-up regimen with the counselor also helps to identify relapse warning signs.

c. Dealing with craving to use - Reciting the serenity prayer, focusing on the benefits of sobriety, remembering the damage due to addiction as well as his/her powerlessness over drugs on a daily basis are all effective strategies. Use of self-motivating statements like, 'I can do it', 'Easy does it', 'One day at a time' can also be very helpful.

d. Improving lifestyle - Apart from staying drug- or alcohol-free, clients need to work towards improving the quality of their lives. Recovery plans should list goals and activities aimed at personality growth, healthy social relationships and a value based and productive lifestyle.

e. Medical help - This can be of great support in avoiding relapses. Use of disulfiram for alcoholics and naltrexone for drug abusers can be useful. Medications to handle depression, anxiety, obsessive thoughts etc. may also be needed.

iv. Strengthening Social Support

The counselor needs to make special efforts to increase the support the client receives from his/her family and friends. By providing a supportive family environment and helping him/her to become aware of the warning signs, family members can be of valuable assistance in preventing relapses.

Introducing the clients to self-help groups is very helpful. Apart from providing a readymade support base of non-drug using peers he/she also gets to meet appropriate role models who cope with life without drugs or alcohol.

Conclusion

It is not possible to treat alcohol and drug problems without addressing relapse issues. The counselor plays a key role in helping clients recover from relapse and reestablish their sobriety. The early period of sobriety can be difficult and the counselor needs to appreciate every progress made and support him/her through difficult times with messages of hope and optimism. In a way the counselor walks with the client as a guide, identifying pitfalls - some evident and some hidden - and teaching him/her much needed coping skills to overcome or sidestep each of them.

Acknowledgments

Principal Author : Dr. Shanthi Ranganathan, TT Ranganathan Clinical Research Foundation

Scientific Editor : Dr. Pratima Murthy

808

9

Prevention in the Community Role of a Community Worker

Introduction

When it comes to drug abuse, people within a community can be seen as belonging to three different zones. The three zones can be best compared to a traffic light. People in the green zone are those who do not use drugs presently. Those in the amber zone are the early users, who run a great risk of developing problems. Those in the red zone are persons who are addicted. People in the red zone need treatment that is expensive and requires a lot of effort, and relapses are frequent. Therefore, red zone strategies include detoxification and rehabilitation. Green zone strategies, which include awareness and education, reach a lot of people in the community. Amber zone strategies, including early identification and referral to treatment centers, are very effective, especially when the person is willing to work towards behavioral change.

This pamphlet addresses the role of the community worker in understanding the needs of the community and planning prevention of drug abuse.

Learn about the Community

It is useful to carry out drug abuse prevention work in a defined geographical area. The characteristics of the people in that community, including age groups, occupations, socio-economic status, and cultural practices help in planning a community program specific to their needs. It is important to be aware of the attitudes of the local government, local community leaders and to understand the 'needs' of the community.

Focus on the most vulnerable groups

At what age do people start using drugs in this community? In most cases, drug abuse begins around adolescence. How are the children and adolescents in this community spending their time: do they go to school, do they work, or do they stay at home, idle? How do they spend their free time: do they play, do they 'hang out'? How strong is the peer group? Do they use drugs with peers? What recreational activities do they have?

Know the social patterns

How closely knit or isolated are members of the community? Are neighbors friendly with each other? What are the formal and informal social networks within the community? Do they have contacts outside

the community? If so, what are they? What are the common activities that involve a lot of community members? How long have people been in the community? Do they move in and out? Is there frequent mobility?

Assess the strengths, resources and vulnerabilities of the community

What is the community proud of? How involved are people with community activities? Are they motivated to solve problems, or is the neighborhood experiencing rapid deterioration -increasing unemployment, growing problems with children? Has the community thought about drug and alcohol abuse as a problem? Have they considered possible responses?

The answers to some of these basic questions will shape the kind of community program that is required.

Define the Needs and Plan a Project

The following steps are useful in assessing needs, and then planning and initiating a community project to prevent drug abuse.

i. Carry out a Systematic Needs Assessment

- Identify the needs: What are the current problems faced by the community and what would constitute ideal community living? What does the community need to reach that ideal?
- Prioritize the needs: Decide which needs are most vital and can be met by your organization.
- Level the needs: Match the needs of all concerned - community needs, your organization's needs, needs of funding agencies (if any).
- Use a filter process: Decide which needs can be considered by your organization.

Who **needs** what **as defined by** whom?

Who are the persons in need of services?

- Out of school youth?
- Youth already experimenting with drugs?
- Youth using drugs in dangerous ways?

What are the needs of the community? For instance, do they need facilities to read and write? Do the children need a safe place to play? Do young men need alternative recreational activities for the evenings? What kind of health services are required? Do people need to develop skills to get jobs? How can their job opportunities be enhanced?

These needs are defined by **whom**? What are the different categories of people who can define the community's needs? It will not be feasible to talk to all members of the community. Therefore, we need

to identify 'key informants' and 'gate keepers' who have an understanding of the community because of their position (leaders, teachers, project planners in government, and local 'know-alls'), role in the community (non-governmental organization representatives), or their needs (community persons in need of services themselves).

ii. Plan the Project

- Decide what is important and what can be done, based on community priorities.
- Focus on the persons who use drugs and not on the drug itself.
- List out the resources needed for the program, what you (your organization) and the community can offer.
- Check the difference (between needs and resources available) and plan to raise the additional resources needed.
- Decide whether the drug abuse prevention and program can be a 'stand-alone' one, or it should be a component of another project that the community needs.
- List the immediate activities from the priorities identified.
- Monitor the program at every stage. Evaluate impact by deciding beforehand what your program aims to achieve.

iii. Mobilize the Community

Assess the existing degree of involvement among community members, and also gauge how much they will involve themselves in bringing about change. It is important to create active interest in your program among the community. Identify the right community members to participate in the program and give them well-defined leadership roles, so that community ownership for the program is developed from the start.

Potential community members who can be included in drug abuse prevention programs include:

- Youth groups
- Women's groups
- NGOs
- Community leaders
- Community workers
- Health professionals
- Police
- Policy makers
- Government officials
- Municipal officials
- Local counselors
- Social clubs like Lions, Rotary etc.
- Scouts and Guides
- NSS
- NSC
- Parent Teacher Associations

Effective community members are those:

- Who can empathize with drug users
- Have knowledge of substance abuse
- Have regular contact with drug users and the project staff
- Are well respected by the local community and have social, political or financial power that is important for drug abuse prevention
- Who respect differing opinions.

Techniques of involving key community members

- Discussion among focus groups is a useful way of involving key community members. In this method, about 6-8 potential members are brought together to discuss a specific issue. Their opinions, including points of agreements and disagreements, are recorded and are very useful in understanding the problems in the community, and in planning programs.
- Encourage formation of self-help groups. This could include groups of ex-users, groups of youth at risk, families of drug users, etc.
- Voluntary drug abuse prevention committees may be another effective strategy to prevent drug abuse in the community. These committees may plan programs for the community: e.g. recreational facilities for the youth, starting an employment agency in the community, setting up a counseling center for people in distress. These may be important measures to prevent drug abuse.
- Add on a drug abuse prevention component to existing programs in the community. In many communities there may be ongoing programs such as programs for adult literacy, self-employment, health and so on. Drug and alcohol prevention messages can very easily be incorporated into such programs.

Breaking the denial of the community

Members of the neighborhood might think that the problem identified by you does not exist or is not as significant as you have indicated. The denial of existence or significance of the problem varies from one neighborhood to another. Breaking through the denial by the community is a process not an event, and is tackled in several, at times overlapping, steps. This is achieved by:

- Creating awareness of the problem of drug abuse in the community and how it affects the community members and their children (increasing knowledge). At the end of this step, the community members will accept that there is a problem
- Encouraging participation of community members

- Selecting community members to work for the project
- Involving the community in project planning, implementation and evaluation, and giving them ownership of the project.

  At the end of these steps, the community members would have understood the problem and would have ownership of the project.
- Demonstrating change to the community as a result of project work, by sharing success stories of the project with other community members. This increases the understanding of the problem by a larger number of people in the community
- Facilitating evaluation of attitudes and attitude change in members of the community after getting involved in the project. Changing attitudes of community members is the goal of breaking the denial.

iv. Create Awareness

Create awareness about:

- The Problem
- The Responses
- The Resources

Awareness programs help to:

- Motivate people to come together for action. Targeted awareness can be conducted for parents, teachers, NGOs, community leaders, community members, government officials, administrators and policy makers

The Problem

- Reach high-risk groups like street children, injecting drug users, industrial workers, prisoners etc.
- Promote alternative strategies like sports and recreational activities to prevent drug abuse

The Responses

- Identify the problem and intervene early, as change occurs best with early intervention
- Provide information on treatment and rehabilitation
- Advocate a change in approach from only treatment and rehabilitation of addicts,which is expensive, to prevention, which is cheaper and reaches more people

The Resources

- Mobilize resources from funding agencies (industry, government, private andinternational agencies).

Techniques of awareness building

- Individual and group interviews
- Focus group discussions
- Films
- Slide shows
- Lectures
- Role plays
- Drama or street theatre
- Puppet shows

Prevention Activities

Certain principles are useful to remember when deciding on the techniques and methods of planned prevention. Some important principles are:

- Avoid mass awareness campaigns. Targeted interventions are more useful in drug abuse prevention.
- Focus on the positive aspects of not using drugs. This includes messages on saying 'NO' to drugs and resisting peer pressure.
- Provide factual information on drugs. Scare tactics (showing skulls and bones) usually do not work.
- Focus on healthy ways of having fun. This may include group activities like games, cultural programs or activity workshops.
- Education, including academic education, vocational training and value-based education, are useful techniques of prevention.
- Job placements and pre-job training are especially useful for high-risk youth.
- Harm minimization may be the first step to help youth at risk (e.g. providing information on clean injecting practices to youth not yet willing to give up injecting drug use).

Messages of Prevention

- Drug abuse is **preventable**
- Drug dependence is **treatable**
- Those not abusing drugs must protect themselves from pressure to use (e.g. peer pressure)

You can add to this list. Be innovative. Be sensitive to the specific needs of the community. Monitor your messages and make sure they are understood. If they are not, alter the message or the way it is conveyed.

The Humane Community Worker

In any program, it is the sincerity and warmth of the community worker that is crucial to success. In addition to developing good communication skills, here are some practical tips to gain rapport with the community, especially the drug user in need of help:

- A warm 'hello' at every meeting goes a long way.
- Establish rapport. Listen with interest and understanding. Do not moralize.
- For those not using drugs, strengthen involvement in sports and social activities not involving drugs.
- For the drug user, convey a positive message that giving up drugs is possible and a drug-free life can be healthier and happier.
- Use success stories of persons who have recovered to motivate the community and the drug user.
- Encourage attendance to self-help groups. For alcohol-and drug-dependents, Alcoholics Anonymous and Narcotics Anonymous groups are available in larger cities. Self-help groups can be formed in smaller communities.
- Encourage the community to support the drug user to get treatment and support his/her reintegration into the community.
- Involve the families actively. Convey the same message of hope.

Acknowledgments

Principal Author : Dr. H.S. Sethi

Scientific Editor : Dr. Pratima Murthy

Appendix 2 printed with permission from UNODC, ROSA, New Delhi

Developing Community Drug Rehabilitation and Workplace Prevention Programme
(AD/IND/94/808)

Ministry of Social Justice and Empowerment
Shastri Bhawan, New Delhi - 110 001
Tel : 23388580 Fax : 23384918

United Nations Office on Drugs and Crime, Regional Office for South Asia
EP 16/17, Chandragupta Marg, Chanakyapuri, New Delhi - 110 021
Tel : 24104970, 71, 72, 73 Fax : 24104962, 63 E-mail : fo.india@unodc.org

International Labour Organization
Core 4B, lllrd Floor, India Habitat Centre, Lodi Road, New Delhi - 110 003
Tel : 24602101 Fax : 24602111 E-mail : delhi@ilodel.org.in

European Commission
65 Golf Links, New Delhi - 110 003
Tel : 24629237, 38 Fax : 24629206 E-mail : eu@delind.cec.eu.int

National Centre for Drug Abuse Prevention
Ground Floor, West Block 1, Wing 7, Rama Krishna Puram, New Delhi - 110 066
Tel : 26173257, 26100058 Fax : 26173257 E-mail : contact@nisd.gov.in

Coordinated by : UNDCP, Regional Office for South Asia
Year of Publication: 2002

The original pamphlets can be accessed at *http://ncdap.nisd.gov.in/ncdap.php*

Appendix - 3

Alcoholics Anonymous (A.A.) at a Glance

What is Alcoholics Anonymous (AA)?

Alcoholics Anonymous is a voluntary, worldwide fellowship of men and women from all walks of life who meet together to attain and maintain sobriety. The only requirement for membership is a desire to stop drinking. There are no dues or fees for AA membership.

Current Membership

It is estimated that there are more than 100,000 groups and more than 21,00,000 members in 150 countries. In India, there are over 500 groups which hold over 750 AA meetings every week, inclusive of 25 meetings in large industrial organizations and group meetings in hospitals. There are over 10,000 members.

Relations with outside Agencies

The Fellowship has adopted a policy of "co-operation but not affiliation" with other organizations concerned with the problem of alcoholism. We have no opinion on issues outside A.A. and neither endorse nor oppose any causes.

How is AA Supported?

Over the years, Alcoholics Anonymous has affirmed and strengthened a tradition of being fully self - supporting and of neither seeking nor accepting contributions from non-members.

How AA Members Maintain Sobriety?

AA is a program of total abstinence. Members simply stay away from one drink, one day at a time. Sobriety is maintained through sharing experience, strength, and hope at group meetings and through the suggested Twelve Steps for recovery from alcoholism.

Why Alcoholics Anonymous is Anonymous'?

Anonymity is the spiritual foundation of AA. It disciplines the Fellowship to govern itself by principles rather than personalities. We are a society of Peers. We strive to make known our program of recovery, not individuals who participate in the program. Anonymity in the public media is assurance to all AA's especially to newcomers, that their AA membership will not be disclosed.

Anyone may attend AA Open Meetings

Anyone may attend open meetings of AA. These usually consist of talks by a leader and two or three speakers who share their experiences as it relates to their alcoholism and their recovery in AA. Some meetings are held for the specific purpose of informing the non-alcoholic public about AA. Doctors, clergymen and public officials are invited. Closed discussion meetings are for alcoholics only.

How AA Started?

AA was started in 1935 by a New York stockbroker and an Ohio surgeon (both now deceased), who had been "hopeless" drunks. They founded AA in an effort to help others who suffered from the disease of alcoholism and to stay sober themselves. AA grew with the formation of autonomous groups, first in the United States and then around the world.

What AA Does Not Do?

AA does not: Keep membership records or case histories….. engage in or support research.... join "councils" or social agencies (although AA members, groups and service offices frequently co-operate with them).... follow up or try to control its members……..make medical or psychiatric prognoses or dispense medicines or psychiatric advice... .provide drying-out or nursing services or sanitoriums…. offer religious services... .provide letters of reference to parole boards, lawyers, court officials, social agencies, employers, etc. housing, food, clothing, jobs, money or other welfare or social services….. provide domestic or vocational counselling.

Will AA Work for Everyone?

The AA programme of recovery from alcoholism, we believe, will work for almost anyone who has a desire to stop drinking. It may work even for those who feel they are being prodded in the direction of AA. Many of us made our first contact with AA because of social or job pressures.

But no matter how down-and-out an alcoholic may be, or how high he or she may be on the social and economic scales, we know from experience and observation that AA offers a sober way out of the squirrel cage of confused problem drinking. Most of us have found it an easy way.

Accessed at: http://www.karmayog.com/ngos/aa.htm

Alcoholic Anonymous contact:

E-mail : gsoindia@ysnl.com

Website : www.aagsoindia.org

Narcotics Anonymous (NA) at a Glance

Development

Narcotics Anonymous sprang from the Alcoholics Anonymous Program of the late 1940s, with meetings first emerging in the Los Angeles area of California, USA, in the early Fifties. The NA program started as a small US movement that has grown into one of the world's oldest and largest organizations of its type.

For many years, NA grew very slowly, spreading from Los Angeles to other major North American cities and Australia in the early 1970s. In 1983, Narcotics Anonymous published its self-titled Basic Text book, which contributed to tremendous growth. Within a few years, groups had formed in Brazil, Colombia, Germany, India, the Irish Republic, Japan, New Zealand, and the United Kingdom.

Program

NA's earliest self-titled pamphlet, known among members as "the White Booklet," describes Narcotics Anonymous this way:

"NA is a nonprofit fellowship or society of men and women for whom drugs had become a major problem. We … meet regularly to help each other stay clean. ... We are not interested in what or how much you used ... but only in what you want to do about your problem and how we can help."

Membership is open to all drug addicts, regardless of the particular drug or combination of drugs used. When adapting AA's First Step, the word "addiction" was substituted for "alcohol," thus removing drug-specific language and reflecting the "disease concept" of addiction.

There is no social, religious, economic, racial, ethnic, national, gender, or class-status membership restrictions. There are no dues or fees for membership; while most members regularly contribute small sums to help cover the expenses of meetings, such contributions are not mandatory.

Narcotics Anonymous is not affiliated with other organizations, including other twelve step programs, treatment centers, or correctional facilities. As an organization, NA does not employ professional counselors or therapists nor does it provide residential facilities or clinics. Additionally, the fellowship does not provide vocational, legal, financial, psychiatric, or medical services. NA has only one mission: to provide an environment in which addicts can help one another stop using drugs and find a new way to live.

Accessed at: http://www.na.org

How Does NA Work?

Addicts helping each other recover are the foundation of NA. Members meet regularly to talk about their experiences in recovery. More experienced members (known as sponsors) work individually with newer members.

The core of the NA program is the Twelve Steps. These "steps" are a set of guidelines outlining a practical approach to recovery. By following these guidelines and working closely with other members, addicts learn to stop using drugs and face the challenges of daily living.

Narcotics Anonymous is not a religious organization and does not mandate any particular belief system. It does teach basic spiritual principles such as honesty, open-mindedness, faith, willingness, and humility that may be applied in everyday life. The specific practical application of spiritual principles is determined by each individual. Recovery in NA is not a miracle cure that happens within a given period of time. It is a process, ongoing and personal. Members make an individual decision to join and recover at their own pace.

Accessed at: *http://www.naindia.org/*