The Treatment of Opiate Addiction Using Methadone

A Counselor Manual

STATE OF CALIFORNIA
DEPARTMENT OF
ALCOHOL AND DRUG PROGRAMS

October 1992

THE TREATMENT OF OPIATE ADDICTION USING METHADONE:*

A Counselor Manual

Michael J. McCann

Richard A. Rawson

Jeanne L. Obert

Matrix Institute on Addictions
Los Angeles, California
Richard A. Rawson, Ph.D., Director

UCLA Drug Abuse Research Center
Los Angeles, California
M. Douglas Anglin, Ph.D., Director

*This project was funded under contract #91-00201 from the state of California to Matrix Institute on Addictions and the UCLA Drug Abuse Research Center; R. Rawson, Principal Investigator, M.D. Anglin, Co-Principal Investigator.

PREFACE

This manual was written to facilitate training of new counselors and improve the quality of the counseling component of methadone treatment. It is hoped that this can be a useful tool for methadone program staff who are explaining treatment to new counselors or desiring to enhance treatment services with current counselors.

We have included a number of forms and appendix materials which may be helpful both in implementing some of the requirements of state and federal regulations and in counseling activities. The use of these forms is recommended, however they are not approved by the State and their use is not mandated.

The manual is an attempt to consolidate information in regulations, in the methadone literature and from colleagues in the addictions field into a useful and practical instrument. Portions of the manual include materials and excerpts from the works of other authors. We would like to acknowledge the following sources and contributors in particular:

"Education and intravenous drug use" by James L. Sorensen and Steven L. Batki in P.T. Cohen, M. Sande and P. Volberding (Eds.) San Francisco General Hospital AIDS Knowledgebase (CD ROM database). Wattham, MA: Massachusetts Medical Society, in press.

Enhanced Counselor's Manual by John Fairbank, Arthur J. Bonito, Michael L. Dennis, and J. Valley Rachal, Research Triangle Institute, 1991.

"Management of psychosocial sequela of HIV infection among drug abusers" by James L. Sorensen and Steven L. Batki in J.H. Lowinson, P. Ruiz and R.R. Millman (Eds.) Comprehensive textbook of substance abuse. Baltimore: Williams and Wilkins, 1990.

Methadone maintenance to abstinence by Stephen Brummett, Roland Dumontet, Laurie Wermuth, Marc Gold, James L. Sorensen, Steven Batki, Rome Dennis, and Richard Heaphy, Unpublished manuscript, University of California, San Francisco, 1986.

Motivational Interviewing by William R. Miller and Stephen Rollnick (Eds.) New York: Guilford Press, 1991.

In addition, we would like to thank the following individuals whose work has contributed in either a substantive or philosophical way to sections of the manual: Joan E. Zweben, Ph.D., J.Thomas Payte, M.D., Felipe G. Castro, Ph.D., George Woody, M.D., Walter Ling, M.D., Richard Resnick, M.D., Forest S. Tennant Jr., M.D., and Charles Charuvastra, M.D..

From the UCLA Drug Abuse Research Center we thank Michael Prendergast and Kirk Carroll who provided invaluable help in the literature search for this project.

This project was conceived and supported by the California Department of Alcohol and Drug Programs (Contract No. 91-00201). We particularly thank Virginia Backman for her input, direction, and encouragement which contributed to the quality of the manual and the enthusiasm of all involved.

Finally we thank Brigitte Koss for her help in preparing sections of the manual and special thanks to Lydia Corrales who worked tirelessly and cheerfully on the preparation of the manual from rough draft through final copy.

TABLE OF CONTENTS

CHAPTER I

INTRODUCTION AND OVERVIEW

Goals of the Manual

Methadone treatment for opiate addiction has been the subject of controversy for almost 30 years. The controversy has involved

- Physicians, therapists and paraprofessional counselors;
- Funding agencies, employers, and local, national and international politicians;
- Sociologists, clergy, law enforcement officials;
- Leaders of ethnic interest groups;
- Hundreds of thousands of addicts and their families.

Methadone has been the most praised and, at the same time, damned treatment modality for the treatment of addiction. It is the most widely used treatment and the most widely evaluated. Few other treatments in medicine, psychiatry, or psychology have created the furor that methadone has generated.

This controversy has resulted in much misinformation about the nature of methadone, the medication, and methods of treatment.

The purpose of this manual is to give counseling staff who work in methadone treatment centers accurate information about the treatment they are delivering. Historically, many counselors learn about methadone from their clients: the myths about methadone are much more entertaining and colorful than the facts, though there is an abundance of facts. Part of the reason for the controversy about methadone is that the myths have been much more widely circulated than the facts. It is our hope that this manual will encourage counselors who work with methadone patients to use the facts rather than perpetuate the colorful, but inaccurate, old wives' (or addicts') tales about methadone.

We view the creation of this manual as an important benchmark in the development of methadone treatment. As addiction treatment using methadone enters its fourth decade, the U.S. health care system is progressing through a revolutionary period of change, and the

spread of HIV disease continues. With intravenous drug use a major factor in the spread of HIV, the role of methadone in addressing this problem is far too important to be guided by myth and misinformation. One goal of this manual is to increase the understanding about methadone by informing those clinicians and professionals who provide the treatment with methadone.

A second purpose is to promote the improvement of addiction treatment using methadone. One factor contributing to much of the controversy about methadone is that it has often been poorly and ineffectively used. Policies that have guided the delivery of methadone treatment have been based on politics, economics, myth, and morality. It is time for treatment policies to be based upon sound medical practice and clinical care. As with all forms of medical or psychiatric care, methadone treatment is only as good as the protocols used and the people who provide the service. It is our hope that this manual will contribute to the upgrading of methadone treatment and the more humane and enlightened treatment of addiction.

Attitudes Toward Methadone

One of the most important starting points in developing a professional attitude regarding methadone treatment is understanding that methadone is a medication. It is neither a good medication nor a bad one. It is neither a sacramental cure nor an evil potion. It is simply a medication. If used appropriately, it can help people tremendously. If used improperly, it can harm them. The benefits and risks are dependent upon *how* the medication is used and not on the medication itself.

A second equally important fact is that methadone does not *cure* opiate addiction. Methadone treatment is designed to relieve opiate withdrawal symptoms and reduce the craving for illicit opiates. The rationale that has long been the basis for methadone treatment is that, if withdrawal symptoms and cravings can be reduced with methadone, addicts can be effectively engaged in rehabilitative activities.

Currently, there is a debate over whether methadone treatment should be viewed as solely a medical treatment. Proponents of this view suggest that, for many addicts, the benefits provided by the medication are sufficient that there is no need for rehabilitative services. The most extreme proponents of this "medication only" view contend that the treatment of opiate addiction is exclusively a medical matter and that counseling and rehabilitative services are an unnecessary added cost of delivering methadone treatment service.

Current FDA and California regulations regarding methadone treatment require that the treatment be delivered within an environment that offers supportive counseling and

rehabilitation services. The federal and state regulations are clear that methadone treatment must include services that address the broader psychological, vocational, legal, social, and medical problems of opiate addicts. Giving medication to control withdrawal symptoms and craving isn't enough. The treatment services that accompany the medication in methadone programs must provide the patient with a broader type of rehabilitative service.

The Authors' Perspective

The authors of this manual have had extensive experience in the delivery of methadone and other addiction treatment services. It is our belief that regulations requiring that methadone treatment include counseling and rehabilitative service are important and are in the best interest of patients and the health care system. However, we feel that one reason the services are sometimes viewed as unnecessary and costly is that there has been almost no definition of what these services should be designed to do. Are the counselors in methadone clinics supposed to be psychotherapists who conduct in-depth psychotherapy with patients? Should they be marriage and family counselors who address family and relationship problems? Are vocational issues critical enough factors that methadone program counselors should be trained as vocational counselors? With the advent of AIDS and increased attention to addicted mothers, would counselors be best trained as public health nurses who can coordinate care for multiple medical problems? In order to coordinate all of these issues, is it possible that the best credentials should be social work training that provides expertise in case management? What exactly is it that counselors in methadone clinics are expected to know and to do?

We hope that this manual can give some definition to the role that counselors serve in the addiction treatment modalities that use methadone. It is our belief that only if the role of the counselor is defined can people serving in that role determine whether they are providing adequate service. Similarly, unless there is some agreement about what is expected of counselors, training is difficult. Finally, unless counselors understand what function they play, it is impossible for patients to receive the greatest possible benefit.

Opiate Addiction and Treatment: A Brief History

The use of opiates—opium and substances made from opium—has been documented for centuries. In 19th century America, opiates were commonly used for pain control, in cough medicines, and in other forms of medications. Until 1900, use of and dependence upon these substances were historically viewed much as many now view the use of alcohol—with an uneasy mixture of toleration and disapproval. Between 1900 and 1910, however, the rate of addiction increased sharply, fueled in part by heightened international drug traffic. It was

in an effort to control this traffic that Congress in 1914 passed the Harrison Act. This act outlawed non-medical use of opiates, and Supreme Court decisions during the next seven years further narrowed even medical uses of opium products. With the Harrison Act, people who had become dependent on opiates had to seek alternative, nonmedical sources for drugs containing opiates. This elimination of the medical supply of opiates and criminalization of opiate use shifted narcotic addiction from the medical arena to the legal arena. At the same time, this law precipitated the need for treatments to assist those who were addicted to opiates but could no longer obtain them from their physicians.

In the 1930's, federal narcotic treatment programs were established at the U.S. Public Health Service Hospitals in Lexington, Kentucky, and Fort Worth, Texas. These two facilities were, for all practical purposes, the only federal treatment response to the needs of narcotics addicts until the 1960's. Between the 1930's and the 1960's, additional state and federal laws were passed that reinforced the view that narcotics addiction was a concern of the criminal justice system rather than the medical system. The majority of opiate users were much more likely to end up in jail than in treatment.

During the 1950's, under the leadership of Charles Dederich, a group of narcotics addicts founded Synanon, an organization established to provide a living environment in which narcotic addicts could help each other stay sober. Many of the original members of Synanon had extreme histories of narcotics addiction and criminal involvement. They adapted aspects of the Alcoholics Anonymous philosophy and developed a series of group therapies that became the foundation of this treatment approach. The aggressive and confrontational nature of the therapies they developed was seen as necessary to accommodate the lying, manipulative behavior, and sociopathy that were seen as fundamental to the personality of the narcotic addict. No professional involvement was incorporated into the Synanon system. In fact, the established medical/psychiatric community was viewed as the enemy. For years, established medicine and psychiatry had shunned addicts, tacitly supporting their classification as criminals. Synanon and other similar programs, which came to be known as therapeutic communities (TCs), felt that since the health care system was unwilling to provide help they would develop their own model.

As the decade of the 1960's began, there were essentially two "treatment" modalities in use–the federal approach, characterized by the Fort Worth and Lexington treatment centers, and the TC programs run by ex-addicts. The medical/psychiatric community provided little direction to either treatment philosophy. However, it was becoming increasingly clear that these two treatment approaches were inadequate to serve the needs of the increasing number of heroin addicts who lived in major U.S. cities, especially New York City.

The introduction of methadone

In the early 1960's, two researchers – Dr. Vincent Dole, an endocrinologist, and Dr. Marie Nyswander, a psychiatrist–began research on a new method of treating heroin addicts. Dole and Nyswander hypothesized that addicts could benefit from a type of treatment in which they were given a medication that could satisfy their craving, reduce their drug-seeking behavior, and allow them to lead productive lives. Dole, who had previously done considerable research on diabetes and the value of insulin, viewed the condition of the heroin addict as analogous to that of the diabetic. He and Nyswander thought it possible that heroin addicts were motivated by a biological need for opiates and that this need resulted from either an inborn deficiency or the effect of damage created by chronic administration of heroin. Regardless of the origin of the deficiency, they believed that a possible solution was to provide addicts with a medication that would satisfy their physical craving for opiates and decrease their drug-seeking behavior and the concomitant crime and antisocial behavior required to obtain illegal supplies of heroin.

In 1963, Dole and Nyswander began a project to evaluate methadone for the treatment of heroin addiction. They chose methadone because it was a long-acting medication that could be taken orally. Methadone was demonstrated to have a therapeutic effect of 24 hours (this property is known as half-life), which meant that methadone administration could be limited to once per day. This was a tremendous benefit over opiates such as heroin and morphine, which have half-lives of four to six hours and need to be administered three to four times per day. The fact that methadone could be administered orally also gave it tremendous advantages over opiates that were injected. These properties of methadone made it the choice of Dole and Nyswander for testing their hypothesis about the value of a medical treatment for heroin addiction.

The early methadone trials provided dramatically positive results. Addicts who had not responded to any other form of treatment began to make tremendous changes in their lives. Between 1964 and 1968, Dole and Nyswander treated 1139 patients. In August, 1965, they wrote a paper in which they cautiously supported the view that methadone could be an important new treatment. The media took this report and magnified the claims about methadone. Before long, the controversy about methadone was started and has continued to the present.

The methadone controversy

The controversy about methadone has taken many forms. However, a basic element of the controversy centers on the philosophical conflict between addiction treatment advocates from the therapeutic community philosophy and those from the criminal justice system, who view the notion of legally prescribed narcotics as immoral and in fundamental conflict with the goals of rehabilitation and sobriety. In spite of this controversy, the early successful reports on the value of methadone resulted in the rapid expansion of methadone treatment facilities

throughout the United States. During the Nixon administration, concern about the return of addicted veterans from the Vietnam War prompted a tremendous enthusiasm for methadone treatment services.

Unfortunately, much of the subsequent expansion was done with little attention to the quality of the treatment and safeguards against the inappropriate use of methadone. As a result, during the late 1960's and early 1970's, methadone treatment expanded very rapidly, but problems with methadone began to be reported.

One major problem has been the diversion of methadone from patients' supplies to the sales on the street. This problem gave support to the view that giving a narcotic medication to addicts will worsen the overall problem. Law enforcement opposition to methadone had been negative from the earliest research of Dole and Nyswander; evidence that methadone was being diverted from its prescribed uses added fuel to the fire of opposition.

The second major problem that surfaced during the first decade of methadone treatment was the chaotic manner in which the clinics were run and the smorgasbord of policies under which methadone was used. In some circumstances, methadone treatment was implemented with a knowledgeable staff, and the quality of the treatment was excellent. In other cases, methadone was used by untrained clinicians without adequate support services, and the outcomes were much poorer. An added problem was that the treatment philosophy of many of the paraprofessional ex-addict counselors in methadone clinics was adapted from their own TC backgrounds. Clinics that used these developed a type of hybrid treatment philosophy. This philosophy accepted that methadone could be useful for the temporary stabilization of addicts so that they could be rehabilitated. However, the philosophy also included the belief that patients should be detoxified from methadone at the earliest possible time, since patients in treatment with methadone were not truly "rehabilitated." Although methadone was accepted, the concept of ongoing maintenance without detoxification to a drug-free condition was not philosophically acceptable.

During the mid-1970's, increasing attention was given to pharmacologic alternatives to methadone. Naltrexone, an opiate blocker, and LAAM, a long-acting synthetic narcotic maintenance drug, were tested as potential replacements for methadone. Naltrexone was preferred over methadone because it was a non-addictive opiate antagonist that blocked all opiate effects and prevented detoxified addicts from becoming readdicted. LAAM was preferred over methadone because it would be taken only three times per week. This dosing schedule eliminated the need for take-home medication and thereby reduced the problem of diversion that was problematic with methadone. In addition, some researchers suggested that withdrawal from LAAM was less difficult than from methadone and would make detoxification to a drug-free condition easier.

The intense efforts to develop these and other alternatives to methadone were indicative of the strong ambivalence of policymakers toward methadone. Although it rapidly was

disseminated as a widely available treatment, there was discomfort about the philosophy of maintaining addicts in treatment with a substitute narcotic. As the concern over returning Vietnam veterans faded by the late 1970's, interest in and funding for addiction treatment began to decrease. In many parts of the country, government funding for treatment disappeared, and the promise for building a quality treatment system for addiction in the U.S. lost momentum. Addiction treatment became a service that received little attention and minimal support. Of all forms of treatment, methadone was the least popular from the public's perspective and was considered in many ways a societal embarrassment.

During the 1980's, attention in the substance-abuse field shifted away from heroin to cocaine. "Treatment" for the public became synonymous with the Betty Ford Center model of recovery. This model promoted the 12- step program of Alcoholics Anonymous. In this model, the only acceptable treatment goal was total abstinence from all drugs and alcohol. Proponents of this recovery philosophy were generally critical of methadone treatment, and many viewed the use of methadone as being virtually no better than the use of heroin. The contrast between the well-funded, middle-class hospital programs creating "healthy, sober, recovering people" and the poorly funded, lower-income, inner-city methadone clinics in which some patients continued to abuse drugs was used as an illustration of the ineffectiveness of the methadone treatment approach. During this period of the early and mid-1980's, views about methadone treatment reached all-time lows.

During the latter half of the 1980's, there was a dramatic rethinking about the value of methadone treatment. This change was a result of the AIDS epidemic. Research on the HIV virus indicated that a major factor in the spread of HIV was the sharing of intravenous equipment used by addicts. Some of the highest rates of HIV infection were reported among intravenous drug users in major east coast cities. It was clear from these data that measures were needed to rapidly engage a much larger proportion of intravenous drug users into treatment. Since methadone had been demonstrated to be a relatively inexpensive treatment that could be rapidly expanded, it immediately became a candidate in the fight against the spread of HIV. Because its properties were acceptable to a large number of intravenous drug users and it could retain large numbers of users in treatment for significant periods of time, methadone treatment rapidly expanded as a major strategy in the war on AIDS. Therefore, although public ambivalence over methadone as a drug-addiction treatment modality continues, there is much greater acceptance of methadone in AIDS prevention.

Methadone Myths and Misunderstandings

(Much of this section was excerpted or adapted from "Misunderstandings about methadone" by Joan Zweben, Ph.D., and James L. Sorensen, Ph.D.)

As previously discussed, there is a long history of inaccurate information regarding the dangers and problems with methadone treatment. It is important for staff members to have accurate information to adequately discuss these issues, and to be able to provide a medically sound rationale for the treatment they are using. It is often inadvisable to debate the value of this treatment. The issue is emotionally charged and frequently defies rational discussion.

To begin with, it is important that counselors involved in the use of methadone be aware of which aspects of methadone are fact and which are myth. We list below a number of the most commonly heard misconceptions about methadone and the accurate information regarding each issue.

"Methadone doesn't help patients; it simply substitutes one drug for another."

Methadone treatment is a form of drug replacement therapy. It does involve using a medication (methadone) to replace an illicit opiate (heroin and other illicit opiates). The fact that patients are maintained on methadone and are not drug free does not mean that they are not being helped. Heroin addiction is a life-threatening condition. People injecting heroin are using a drug of unknown potency, diluted with unknown chemicals, with equipment that may be infected with HIV or hepatitis, with no medical or psychological assistance to address physical, psychological, or other critical problems. Short-acting opiates like heroin produce tolerance and need to be used in increasingly potent amounts. They can only be obtained through illicit markets, and their high cost is often the impetus for involvement in crime to pay for the drug habit. Use of heroin and associated activities keep the addict heavily involved in the drug-addiction lifestyle and surrounded by drug dealers and other drug users virtually 24 hours per day. All of this makes it difficult for users to maintain employment or any semblance of family life while using illicit opiates.

Methadone is a controlled substance produced and distributed under close supervision and quality control. The medication is taken orally and therefore does not require intravenous administration. The 24-hour half-life of methadone means that the drug is only administered one time per day. This single daily dose eliminates the opiate craving for most patients and allows them to participate in recreation, employment, school, and therapy. Methadone treatment eliminates the need to inject drugs, which dramatically reduces the risk of HIV and other infections. Methadone treatment is provided in a context where medical and counseling services are made available to patients. The availability of these services promotes better health care and improved psychosocial function. Therefore, although methadone does involve drug replacement, there is a clear benefit to patients in treatment.

"Methadone keeps you high for 24 hours."

A properly adjusted dose allows the patient to function without sedation or intoxication. Patients on a stable dose of methadone often experience the onset of methadone within 45 to 60 minutes after they take their dose. Some experience a pleasurable sense of well being but quickly feel normal. On a stable dose of methadone, patients do not get high from the methadone, but stay stable and avoid the four-hour cycles of intoxication and withdrawal that accompany the use of short-acting opiates including heroin.

"People on methadone keep using drugs and alcohol."

Methadone is not a cure for addiction. It is a medication that reduces withdrawal symptoms and cravings. Just as insulin doesn't cure diabetes, methadone doesn't cure heroin addiction. Methadone is not a treatment for cocaine abuse, or for alcoholism. Currently, the counselor provides the most important treatment for addressing the problems of other drug and alcohol use. Studies have shown that the majority of patients on methadone substantially reduce their overall use of drugs and alcohol. In addition, clinics with well-run programs and well-trained staffs exhibit the least amount of alcohol and drug use. As we learn more about how to treat other substance-abuse problems, these new technologies can be added to our efforts with methadone patients. For now, however, it is clear that methadone treatment results in a very substantial reduction in illicit drug use but does not eliminate all use of drugs and alcohol.

"Patients on low doses of methadone do better in treatment that those on high doses."

There has long been a controversy about the "best" dose level for the use of methadone. Some so-called "low-dose" programs maintain a ceiling dose of 40 mg. Other programs allow doses to go to 80 or 100 mg. There have been extensive philosophical debates about the value of high-dose vs. low-dose programs. Outcome studies have demonstrated that patients who are maintained in programs with a mean dose of at least 60 mg. appear to function better, use drugs less, and stay in treatment longer than programs with lower dosing practices. The best guideline is for the physician to adjust the dose to meet the needs of the patient and to maximize his/her ability to discontinue heroin use and be retained in treatment. Some programs are beginning to measure methadone blood levels to determine whether patients are receiving adequate therapeutic doses of methadone. As these procedures are perfected, methadone doses may be determined using a combination of the patient's reports and blood-level monitoring to provide the patient with the most helpful dose possible.

"Methadone is worse to kick than heroin."

Because methadone has a longer half-life than heroin, withdrawal from methadone takes longer than withdrawal from heroin. Typically, addicts find the symptoms of withdrawal are

more severe with stopping heroin, but the most substantial withdrawal symptoms are over within the first three to five days. With methadone, the initial symptoms are frequently less severe, but they can last for ten days to two weeks. To the observer, the withdrawal does not appear tremendously difficult. To the addict, however, fear of the withdrawal creates a powerful anxiety. The long duration is an aspect of methadone withdrawal that is not always well tolerated. If the patient follows a medically supervised tapering schedule and post-methadone detoxification program, withdrawal from methadone can be accomplished without extreme discomfort.

"After people go off methadone they go back to using."

The value of methadone should be viewed as similar to the value of other medications. For example, many people take medications to reduce their blood pressure. These medications work extremely well and are a major treatment for hypertension. Most people who use them find that, if they stop the medication, their blood pressure goes up. The medication didn't cure the high blood pressure; it simply controlled it during the time the medication was used.

The same can be said for the use of methadone. It is not a cure. Many patients who are on methadone may make changes in their lives and build a support system that will allow them to stay sober when they complete methadone treatment. However, this post-medication success will only occur if there is a clear plan for continuing care; otherwise, relapses will occur and patients will need to be readmitted to methadone treatment. In short, opiate addiction is a chronic relapsing disorder, and methadone is a useful tool for accomplishing major progress.

"Pregnant women shouldn't take methadone because the baby will be born addicted."

Pregnant users who are in treatment with methadone deliver healthy babies. It is true that babies born to women on methadone sometimes experience some withdrawal symptoms during the first several days after birth. The symptoms are routinely treated by the baby's pediatrician and do not result in any long-term damage. In addition, babies born to women on methadone tend to have a slightly lower birth weight than babies of non-addicted control mothers.

The most important comparison, however, is not how these babies compare to non-addicted controls, but how they compare to babies of mothers addicted to heroin. Studies that have compared babies born to mothers in methadone treatment with babies born to mothers on heroin have demonstrated tremendous benefits from methadone. Methadone treatment allows the mother to be followed in prenatal care, receive nutritional supplements and information and often participate in parenting classes. The vast weight of evidence supports the use of methadone with heroin-addicted women to reduce risk of miscarriage, increase birth weight, reduce infection and HIV risk to the fetus, and generally produce a much

greater chance for a healthy baby. Dose levels for the mother should be adjusted by the physician to allow the mother to abstain from street drugs. There is no best-dose level for pregnant women.

Your role as counselor

During your work as a counselor in a methadone treatment program, you will hear many more myths and inaccuracies about methadone from patients, their family members and critics of methadone. It is important for you to take questions you have to the program director and program physician to get accurate information so that you can operate from a basis of knowledge not misinformation.

CHAPTER II

COUNSELING IN METHADONE TREATMENT

Treatment of patients with methadone requires a close team effort. The counselor should view his/her role as a team member within a medical/mental health/addiction treatment team and be in close communication with the medical staff of the clinic. Coordination of effort with the program physician and especially the nursing staff is essential. Programs in which the counseling staff or individual counselors view themselves as independent practitioners with "their own patients" become very poor treatment environments, and a "them" vs. "us" mentality is detrimental to the program.

The Role of the Counselor

Within the structure of a methadone clinic, the persons with most frequent and most regular patient contact are the dosing nurse and the counselor. The counselor has the responsibility of attempting to gain the confidence and trust of the patient in order to perform the following functions:

1. Coordinate the patient's treatment within the clinic so that the patient's best interests are served by the treatment team.

2. Educate the patient as to what choices are available, both during the treatment episode and in terms of longer rehabilitation goals.

3. Encourage the patient to attempt changes he/she wishes to make (vs. changes the counselor thinks should be made).

4. Be viewed by the patient as an advocate to help accomplish the first three goals.

Notice that absent from this description of the counselor's role is reference to "confronting" the patient. Counselors in drug treatment often mistakenly presume that a confrontational approach is the standard therapeutic method. While this may be so in residential treatment, in outpatient settings the value of confrontation needs to be weighed against the risk of the patient dropping out of treatment. Different settings require different approaches and in outpatient settings where retaining patients in the treatment process is a prerequisite for any therapeutic gains, confrontation too often results in losing patients. This is not to say that counselors should be passive. Addicts appreciate and usually need direction and benefit more from a directive approach as opposed to a non-directive, passive type of counseling.

Patients enter treatment confused, ambivalent, and out-of-control. Counselors who provide directive input, in a positive, helpful, and respectful manner can avoid the problems associated with either a confrontational or a non-directive style.

Building rapport

Counseling addicts is often considered by mainstream therapists to be extremely difficult, and, for many years, the job was usually done by recovering addicts who had very little formal training in how to "do therapy." There still remains a belief in some circles that counseling addicts is difficult, if not impossible, unless the counselor has experienced first-hand the same problems the patient is experiencing. This is not true of other mental health specialists. Therapists specializing in suicidal patients are not perceived as being more effective if they themselves have attempted suicide. Geriatric specialists do not need to be over a certain age to understand and deal with the problems of aging. Why, then, have recovering people gained the reputation of being better able to counsel addicts?

Part of the answer may be that for many years, very few people except recovering addicts were interested in helping other addicts. But a larger reason for the development of this perception may be that it is easier for a recovering person to:

Be non-judgmental about the use of illicit drugs and/or about being a member of the addict subculture

Provide a role-model for a "straight" lifestyle to which the patient can relate

Fully understand the inherent conflictual nature of addiction with which every addict struggles

Even without formal education, a recovering person can relate to an addict easily. And, if the addict as patient can listen to how the counselor achieved his sobriety, he/she can attempt to emulate the counselor's process. Problems occur, however, when there are differences in the experiences of the counselor and the patient. In these cases, strategies that worked for the counselor may not work for the patient. The "do as I did" philosophy works only when the intervention that worked for the counselor happens to work for the patient. Beyond this happenstance, counselors need to draw on methods they have been *taught* to achieve their goals successfully.

How can counselor-patient rapport be established by a counselor who cannot say, "I've been there; I understand; trust me?" It is important to remember that communicating consists of both talking and listening. If the patient perceives that you are not caring or interested in helping or that you are being judgmental and imposing your beliefs and values, a positive helping relationship will not occur. In *Theory and Practice of Counseling and Psychotherapy*

(1982), Gerald Corey aptly describes the factors that contribute to the development of a therapeutic bond. In summary,

"Therapists' degree of caring, their interest and ability in helping the patient, and their genuineness are factors that influence the relationship. Patients also contribute to the relationship their motivation, cooperation, interest, concern, attitudes, perceptions, expectations, behavior, and reactions. Counseling or psychotherapy is a personal matter, and evidence indicates that honesty, sincerity, acceptance, warmth, understanding, and spontaneity are basic ingredients.

The effective element in therapy is the therapeutic relationship. The therapist's respect and concern for patients become powerful influences on their behavior, and therapist provides a model of a good personal relationship that patients can use for their own growth. The central ingredients of empathy, warmth, and genuineness do not merely represent 'techniques' of psychotherapy or counseling, but interpersonal skills.

What are the basic characteristics of a therapist that lead to constructive personality and behavior change in the patient? Truax and Carkhuff (1967, p.25) found three main sets of characteristics: accurate empathy, nonpossessive warmth, and genuineness. Most therapeutic approaches emphasize the importance of the therapist's ability to be an integrated, mature, honest, sincere, authentic, and congruent person in therapeutic encounters; to provide a safe, non-threatening, and trusting climate by demonstrating nonpossessive warmth for patients, which allows them to engage in deep and significant self-explorations; and to be able to grasp the internal frame of reference of patients' experience and deeply understand their meanings."

In the Matrix manual outlining an intensive outpatient model of addiction treatment, Rawson, Obert, McCann and associates further describe the difficulties inherent in establishing rapport with addicted patients:

"The mental health field has a bad track record in treating addicts. In part, this is due to the fact that most mental health professionals don't understand that addicts' behavior often can be personally offensive to counselors. Many addicts come to treatment hostile, suspicious, and resistant to taking direction. They demonstrate immature, self-destructive, impulsive, and oppositional behavior and the counselor's job is to work with them, often with little thanks or appreciation. Relapse is discouraging, underlying pathology is frequently evident, and the impact of the addiction on career, family, and relationships may make the situation appear hopeless. This litany of problems often makes it difficult for the counselor to stay positive and focused on treatment.

In response to this large array of problems, the counselor often becomes overwhelmed and discouraged. This can translate into impatience, and impatience can change "giving direction" into "giving orders." If this occurs, the counselor can become judgmental and lose objectivity. If the patient doesn't comply, the counselor becomes discouraged; if the counselor becomes more strident, the patient becomes more oppositional, and the entire situation deteriorates.

The counselor can never lose sight of the fact that he/she is the professional delivering a service. Unless the counselor stays focused on that, the treatment episode will certainly be one more in a series of failures experienced by the addict. Rather than providing help, "treatment" may exacerbate the addict's self-contempt."

Coordinating the treatment

Most patients will agree that the goal of methadone maintenance treatment (MMT) is to reduce or eliminate illicit drug use. They may also agree on the goal of reducing or eliminating the use of alcoholic beverages. However, they may not be able to understand how the program procedures and rules are designed to help them achieve this goal. The counselor needs to help the patient understand the need for the various hoops he must jump through to get what he thinks he needs. A system with rules and requirements may elicit a very oppositional response from patients whose lifestyles run counter to societal rules and norms. Even being asked to sit down in a room with a counselor may seem to the patient like an infringement instead of a helpful activity. It is important for counselors to be sensitive to what is viewed as helpful by the patient and to plan treatment that is viewed as relevant to their circumstances.

Regulating the dose

A very sensitive issue to MMT patients is regulating their dose of methadone. Patients tend to see their physical and psychological well being as being directly related to their medication. By entering treatment and relinquishing control of their dosing regimen, they immediately feel very vulnerable and sensitive to issues of dose changes. Often they blame the dose level for all kinds of physical and emotional problems. It takes patience and sensitivity on the counselor's part to understand the vulnerability and to help the patient sort out the issues. Programs or professionals that attempt to control the patient's behavior by manipulating dose changes further confirm the patient's suspicion that the system is working to impede getting his/her needs met. As take-home doses are granted and/or rescinded, as dose levels change and as ancillary medications are prescribed, the counselor needs to work to help the patient understand why and how these maneuvers are being made in the interest of assisting him/her to control or eliminate illicit drug use.

Educating the patient

To provide patients with information about what options are available to them, it is critical that counselors be knowledgeable of and familiar with the entire range of medical and non-medical interventions to help patients curtail and/or eliminate drug and alcohol use. While the counselor cannot make the final determination, he/she can serve as a coordinator between medical staff and patients and can suggest possible interventions to be explored. Patients who are confused about their medical treatment or unhappy with their options will often be more understanding of the treatment team decisions when they have had a chance to listen and be listened to by an educated, concerned counselor.

Giving patients choices is a fundamental and critically important part of the counselor's job. Addicts may not be aware of lifestyles that are available to them as recovering people. Counselors need to find ways to expose recovering addicts to others who have made similar lifestyle transitions and who can encourage and support them while they are MMT patients.

In a chapter titled "Motivational Intervention with Heroin Users Attending a Methadone Clinic" from Miller and Rollnick's book Motivational Interviewing (1991), Bic Saunders, et. al., describe a "cluster of useful strategies that (can) be deployed in therapeutic work to test out, assess and augment a client's potential for change." They used the following agenda in their sessions to guide the "motivational interventions":

- Assess the patient's perception of the good things about heroin and other drug use.
- Help the patient create an inventory of the less good things about the behavior.
- Elicit the patient's current satisfaction with his/her lifestyle, vis-a-vis that previously envisaged and that anticipated for the future.
- Have the patient enunciate which, if any, of the elicited problems are of real concern.
- Compare and contrast with the patient the benefits and costs of continuing the behavior (a type of cognitive review of the current situation).
- Work with the patient to reflect on areas of greatest concern and discrepancy. Try to elicit from the patient his/her discomfort with the current behavior (an emotional review of drug use and related problems.)
- Elicit and agree on future intentions regarding the behavior.

One technique that can be useful in clarifying for the addict why he/she has decided to enter treatment is to spend a session creating a list of "good things about heroin" and "bad things about heroin." Following this list, it can be helpful to create a list of "good things about

treatment" and "bad things about treatment." Often these lists will help the addict express his/her concerns about stopping drug use as well as negative feelings about entering treatment. The balance sheet from this comparison, however, usually provides a basis for choosing the benefits of treatment. The exercise can often demonstrate to the patient that although treatment does have some drawbacks, the payoffs are much greater than continued heroin use.

This exercise can provide the counselor with an idea of some of the patient's concerns about giving up his/her current lifestyle and about fears concerning treatment. Some of the fears may be inaccurate (e.g., "If I use while I'm in treatment, I'll get kicked out" or, " I'll never be able to leave this city for a time because I won't be able to get methadone"), and the counselor can educate the patient about this inaccuracy. Other issues may be realistic concerns (e.g., "If I can't get to the clinic on time, I won't get dosed" or, "I think the methadone will help with my heroin use, but it won't help me with cocaine"), and the counselor may be able to provide some options that can help alleviate them, including some that can be incorporated into treatment plans.

Early intervention can establish rapport between the counselor and the patient. The counselor can intercede at appropriate intervals with information about options. This provides an excellent format for suggesting options without appearing to be confrontational or giving advice. The counselor can present options by saying something like, "When another patient I was working with was in that same situation, he chose to use Antabuse to help him get through a difficult period." By presenting options and educating patients on choices, the counselor demonstrates respect and empowers the patient with the right to decide to change.

Encouraging the Patient

Once patients trust their counselor and have decided there are some changes they would like to make, the work becomes focussed on the new goals. Many MMT patients have not experienced any system as working in their favor; they do not understand functioning within limits or using the system to get their needs met. Counselors need to work gently but consistently within the limits and demonstrate how patients can use the treatment system (within the clinic and beyond) and the social system (beyond the clinic) to assist in attaining their goals.

Questions can be used to show curiosity about a patient's reaction to suggestions: "Would it be useful to spend a few minutes looking at this whole question of what is a safe level of consumption?" or, "I wonder: how does this apply to you?" Asking questions tells the patient you are not looking for a certain response or being judgmental. It allows the patient to make choices, and helps avoid building resistance. By asking what the patient would like to do next, what might happen as a result of this choice, when might be a good time and what

concerns there are, the counselor evidences the belief that the patient can and will be able to follow through on choices.

Counseling Sessions: Common Formats

There is very little research evidence on which types of counseling sessions are most effective with MMT patients. Different counselors will prefer different strategies. There are, however, some common-sense principles that apply to most counseling situations with MMT patients.

Individual sessions

In some areas of substance abuse counseling, it has been documented that use of individual sessions will increase the retention of patients in treatment. These sessions allow for the development of a one-to-one relationship between the counselor and the patient.

Individual sessions allow the patient to discuss issues that are personal, embarrassing, intimate or simply are the patient's choice not to divulge to other patients. The frequency of these sessions depends on the individual (as discussed in later sections). However, the counselor should attempt to maintain a balance between the extremes of requiring the same number of sessions for all patients and seeing some daily and others not at all.

Clearly, some patients will desire, and require, more counseling sessions than others, but it is unwise to have a small number of patients monopolize the counselor's time while others feel excluded. It is often necessary to reach out to some patients to encourage attendance at counseling sessions. Effective counselors develop a positive style of requesting that patients stop in for a check-up, which promotes the patients' view of the counselor as a concerned ally and avoids policies that force unwanted counseling sessions.

Group therapy sessions

Groups can be useful forums for discussing issues of common concern. Special-topic groups such as women's groups, groups with HIV concerns, parenting groups, or job club groups can all be helpful forums for MMT patients. They can provide peer support and reinforcement for making positive change. It is important for the group to have clear goals and purposes, however; open-ended and whatever-is-on-your-mind groups are often much less productive.

Groups without a purpose or theme can turn into general "bitch sessions" or confrontational sessions. These can become volatile and potentially dangerous. Group leaders should avoid

"war stories" in which drug use and related behavior are glorified. Also, extensive explicit discussions of drug use episodes should be avoided; these can be triggers that precipitate cravings and even relapse. It is also important for the group leader to stay in control and direct the group into productive areas of discussion.

Family therapy

Recent research has demonstrated that the participation of family members in the treatment of methadone patients can increase retention and help reduce drug use during treatment. Involvement of family members in constructive family groups or in conjoint sessions with patients may help address issues of importance in recovery planning. Educating family members about methadone and the treatment process can reduce their resistance to the treatment program and encourage their support.

12-step programs

Although the counselor cannot "conduct" 12-step groups as part of treatment, the encouragement of patients to participate in 12-step programs is strongly recommended, and some clinics have 12-step groups on site. The 12-step programs of Narcotics Anonymous, Cocaine Anonymous and Alcoholics Anonymous can be a valuable source of support for patients, but patients need to be given some education about 12-step groups in the context of MMT. Historically, 12-step programs have viewed patients on methadone as "not in true recovery," since they are using a medication and are not completely drug-free. This attitude has led to experiences in which methadone patients were ostracized from the 12-step program.

Recently, however, many 12- step groups are much more accepting of methadone patients. Meetings held on-site should be supportive of methadone program involvement. Patients using community 12-step meetings may find they prefer to avoid discussing their methadone use so that they can use the 12-step resources without producing controversy.

Counseling sessions - practical considerations

Most MMT patients enter treatment with their lives very much out of control. Most view the primary benefit of treatment as the medication; most view counselling of any type as a secondary issue, and most do not have the middle-class experience of attending scheduled therapy sessions. Therefore, attendance at these sessions is likely to be poor unless certain considerations are made.

- Schedule sessions around dosing times. If patients can receive their dose and their counseling at the same time, attendance will be facilitated.

- Don't substitute informal "dosing window check-ins" for counseling sessions. Counseling needs to occur in a setting that ensures privacy.

- Avoid lengthy waits for counseling appointments. Methadone patients are not known for their tolerance in waiting for an appointment. Also, having patients waiting around for services can lead to loitering, informal "groups" in the waiting room or outside, and possibly the opportunity for drug dealing and other illegal activities.

- If patients bunch up for sessions, try to make sessions brief or have another counselor help out. Avoid creating crowds: strive for smooth patient flow and limit informal groups.

- Counseling intoxicated or belligerent patients is not helpful or beneficial to the patient and may increase the risk of violence (see Detoxification chapter, The Belligeremt Person, pg. 100). Medical or supervisory staff should be consulted to assist in handling these situations.

Professionalism

Paraprofessional counselors

The counselor in a methadone program is a professional within the health care system. He/she is paid a salary for providing patients with a set of services. Historically, many counselors have entered the position of counselor without a clear understanding of how a professional counselor differs from a friend. Many paraprofessional counselors who have not had formal training in counseling have often felt confusion and a split loyalty between the rules of the clinic and the needs and requests of patients. Since many paraprofessional counselors have entered this career with their own personal history of addiction and recovery, they often feel uncomfortable being viewed as a member of "the system" rather than as one of the "homeboys." Often the paraprofessional counselor feels that he/she has more in common with the patients than with doctors, nurses, and the counselors who have no personal history of addiction. It can be difficult to make the adjustment from being "one of the boys" to being a member of a professional healthcare team. This task is particularly difficult when the role of the counselor includes serving as an advocate for the patient. It sometimes can be hard to see the line between being the patients' advocate and the patients' friend.

The relationship between a counselor and a patient is professional. There are boundaries in this relationship which preclude many types of interactions. The relationship can not be nonprofessional in the sense of being personal or a friendship. Being friendly in the context

of a professional relationship is very different from being a friend. One socializes with friends, confides personal feelings or problems with friends, and engages in variety of activities with friends. The counselor's relationship with the patient, however, should not involve socializing, discussing the counselor's personal life or problems, and should be restricted to within - clinic interactions focused on the goals described in the treatment plan. Sometimes staying within professional boundaries can be difficult. Counselors should remember that patients who become confused regarding the nature of the relationship may become uncomfortable confiding with them or may unrealistically expect counselors to behave as friends and then feel embarrassed or rejected when the limits are finally set down.

Professional counselors

Professionally trained therapists who become counselors in methadone programs typically do not have to wrestle with the role conflict experienced by the paraprofessional counselor. They have training in professional standards of behavior and ethics. However, many experience a different type of problem. Most professional therapists who work in methadone programs enter the job with some theoretical framework that defines their treatment orientation. Therapists trained as psychologists may enter with behavioral, psychodynamic, or psychoanalytic training. Those with marriage and family counseling training may enter with a family systems orientation. Those trained as certified addiction counselors may enter with a strong belief in the 12-step recovery model.

Regardless of their orientation or training, all trained therapists typically enter the field of methadone treatment with a much better understanding of schools of therapy than of the needs of methadone patients. Historically, the result has sometimes been that professional therapists will do the type of therapy of which they are knowledgeable, often without regard for the tangible, present needs of the patient.

Individual therapy, group therapy, in-depth therapy, and cognitive therapies are sometimes conducted without any clear connection between the therapy process and the needs of the patients. Often there seems to be the assumption that "therapy is good" without a real consideration of who the patients are or what their needs are. Hence, when patients are resistant to counseling sessions, this resistance is viewed as denial or lack of motivation. In some cases, the patients protestations that the counseling sessions are irrelevant and unhelpful may bear closer consideration. There is a need for counselors to deliver a service that meets the needs of the patients.

Counselor as team member

Throughout this manual, reference is made to the counselor as a member of the treatment team. This concept is central to the professional role of the counselor in the methadone clinic.

Keeping this concept in focus is critical to both paraprofessionals and professionals. One of the most detrimental things that can happen to patient care within a methadone clinic is the development of an "us" vs. "them" split among the staff. This split can take a number of forms: recovering staff vs. non-recovering staff, counseling staff vs. non-counseling staff, or simply one clique vs. another clique. Such splits are extremely damaging to the staff and interfere with the delivery of quality treatment to patients.

Professionalism for a counselor in a methadone clinic involves a team approach to the delivery of treatment. A counselor who operates in opposition to the clinic rules, or to the treatment guidelines created by the treatment team, is committing a severe breach of professional behavior. No matter how well a counselor knows the needs of his/her patients, the treatment activities must stay within the boundaries of professional behavior. There are no exceptions. Heroin addicts can be a difficult group of patients to treat. They can split staff and promote conflict between staff members. Only by adherence to a clear set of professional standards, open communications between staff within a clinic, and a team approach can a high-quality treatment service be delivered.

Ethics

Each treatment center that uses methadone should have a clearly stated set of guidelines outlining the standards of behavior expected of counselors. These standards should address issues such as guidelines for contact with patients outside the clinic, acceptance of gifts from patients, use of staff automobiles to transport patients, loans and business transactions between staff and patients, and circumstances justifying staff home visits to patients. All programs should have a policy prohibiting sexual contact between staff and patients under all circumstances.

Confidentiality

The treatment records of patients in methadone treatment are closely guarded by state and federal confidentiality laws. Information cannot be given to any person or agency without a patient's written consent. This restriction includes both written and verbal information. The restriction applies to social-welfare and law-enforcement agencies, as well as to family members and friends. This confidentiality is critically important to the credibility of the treatment agency. Violation of this confidentiality by a clinic staff member is an ethical and legal violation.

The confidentiality does not apply within the clinic setting. Information provided to a counselor is accessible to other members of the treatment team, and the counselor should never be in a position in which he/she agrees to conceal information from other members of the treatment team. Attempts by patients to restrict information in this manner or use other manipulations that jeopardize the professional integrity of the counselor and interfere with the functioning of the clinic should be immediately discussed with supervisory staff.

There are some situations in which the confidentiality principle is overruled.

1. Tarasoff. The Tarasoff case was an important legal precedent in which it was established that a therapist had a legal duty to warn a third person if a patient stated an intention to harm that person even if that statement was made within a counseling session.

2. Child or elder abuse. If information is discovered in a counseling session or by observation of physical abuse to a child or elder person, appropriate social-welfare agencies must be notified. Counselors should be very clear on the policy of their clinic regarding this duty. There are wide variations in the definition of abuse or neglect. If this principle is defined too broadly, virtually all patients in MMT treatment or applying for treatment could be considered reportable. The clinic policy on this issue should be clear and the policy should be followed consistently by all staff.

3. State or federal inspections. Representatives of authorized governmental agencies may have access to treatment records in order to perform inspections or audits of programs.

4. Court orders. In some instances the courts can order programs to relinquish either information about a specific patient or the entire patient file. Every request from a legal source (attorney, district attorney) to obtain patient information does not warrant a suspension of confidentiality. Counselors should be extremely careful in dealing with these requests.

In all cases where the confidentiality of patients is to be breached for mandatory reporting, the counselor should consult supervisors prior to filing such reports. Special restrictions may apply to information surrounding HIV/AIDS issues. Changing regulations regarding this aspect of confidentiality requires consultations in all cases.

Counselor Burnout

Most counselors are at high risk for burnout. There are some safeguards that can reduce the likelihood of burnout.

Take care of yourself. As in any other caregiving occupation, it becomes impossible to function effectively if the caregiver does not take adequate care of himself or herself, physically and emotionally.

Avoid adversarial relationships with patients. It is very easy to get drawn into the role of being the enforcer for the system; in fact, many patients will view the counselors as such, no matter what. Counselors who follow the preceding suggestions in this section for dealing with patients as an advocate should find it easier to stay out of the enforcer role.

Do not function outside your training. Many patients are good candidates for psychological treatment beyond counseling. However, there is frequently not enough time or trained personnel available to provide formal therapy to MMT patients at the clinic. Such therapy should not be provided in place of the type of counseling described in this manual. MMT counseling as such is not therapy but is a critical component of the treatment episode, without which the likelihood of successful treatment is severely diminished.

Giving or referring patients for additional therapy can often be helpful, especially after the initial need to focus on achieving stability in MMT. For patients with family issues, family therapy can be extremely beneficial. Patients needing to better understand themselves and their emotions can benefit from psychodynamic or Gestalt therapy. Rational - Emotive therapy or reality therapy may help patients needing to learn to control their emotionality. Referrals can be made for specific therapeutic needs as well as for help with vocational problems, housing problems, legal issues, special medical concerns, etc. Programs with resources to offer these specialized services can provide them on-site, but counselors in most programs need to have up-to-date knowledge of the resources available in the community in order to refer patients appropriately.

Appendix

Chapter II

Table of Contents

Heroin Use Vs. Treatment

A Sample Form

List as many of the following as you can think of.

Good things about heroin use	Bad things about heroin use
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Good things about treatment	Bad things about treatment
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Summarize your feelings about stopping heroin and entering treatment. _____

_____

_____

_____

CHAPTER III

METHADONE MAINTENANCE

This is the longest chapter in this manual. The reason is that methadone maintenance is the treatment modality that requires the greatest understanding of the rationale and regulations surrounding its use. As discussed previously, it is probably the most controversial approach in the field of substance abuse treatment. For these reasons, you need to have a clear understanding of the rationale, procedures, regulations and patient care guidelines for delivery of methadone maintenance treatment.

Description and Philosophy of Methadone Maintenance

Elements of methadone maintenance include:

1. Administration of methadone at relatively stable dosage levels;

2. Treatment duration in excess of 21 days;

3. Provision of counseling and medical services.

The initial goal of methadone maintenance is to free the addict from the periodic withdrawal that prompts regular use of illicit opiates. Patients who are thus freed from dependence on illicit drugs will, it is hoped, disassociate from people and places that involve drug use and crime, deal with their problems, establish new life styles, and enjoy a higher quality of life.

While counselors should provide support and direction to patients who are interested in tapering off methadone, it is not realistic or therapeutically beneficial to direct all patients towards the immediate goal of getting off methadone. To do so can suggest that what the patient is doing to deal with his or her heroin addiction is at best temporarily acceptable. The focus upon getting off methadone maintenance implicitly conveys a negative attitude about the treatment. The patient who is not ready or able to withdraw from methadone is then left with the choice of being in a "bad" treatment or of returning to heroin use.

Clearly, as we have noted in the previous chapters, there are some trade-offs for the benefits. They include:

- It is addictive. Daily dosing and sometimes daily program attendance is necessary. Missing a dose can result in discomfort.

- It may be inconvenient. Dosing only occurs at certain scheduled times.

- It restricts travel. There are limitations on how much methadone can be taken out of the clinic. It may be necessary to arrange for dosing at other clinics when out of town.

It is not a perfect solution. (But, the same can be said for many other treatments for medical problems. Medications have side effects. Kidney dialysis is restrictive and inconvenient.)

Despite these problems, counselors working in methadone maintenance treatment can help people overcome the more serious problems associated with illicit drug use by supporting the achievements of getting on methadone instead of focusing on its drawbacks or suggesting that recovery can begin only after one is off methadone. With illicit drug use stopped, the patient and counselor can work together to establish a recovery plan that will work for the patient both while he or she is on methadone maintenance and afterwards.

Criteria for Patient Acceptance

Because methadone is a powerful and addictive medication, there are restrictions on who may receive it. People for whom methadone maintenance is not appropriate includes those who are not addicted to illicit opiates, who have not been addicted for long enough, or who have not tried other treatment approaches (such as detoxification). Because you are usually involved in initial contacts with prospective maintenance patients and help determine whether they meet eligibility criteria, it is important that counselors understand admission requirements, help eligible applicants collect necessary documentation and, identify the ineligible and redirect them to other treatment. Even if your program has a separate intake counselor or intake department you should have a comprehensive knowledge of this process.

There are specific state and federal regulations regarding admission criteria for methadone maintenance. Counselors should refer to these regulations and contact appropriate regulatory agencies if necessary for information, assistance, or interpretation. Discussion of regulatory issues here is not meant to be a statement or an interpretation of these requirements.

Some of the issues dealt with in the regulations include the following:

1. Documented history of at least two years of opiate addiction. This is usually acquired through legal records for narcotics violations, or treatment records from previous treatment efforts.

    a. "Documented" usually means that written records of the required history (as opposed to telephoned information or personal testimony).

    b. Treatment records can be obtained by telephone after the patient signs a release of information. The counselor can record information to verify history and then follow up by mailing a request along with the signed release.

    c. Arrest records usually consist of either an actual "rap sheet" or of a letter from an acceptable authority, such as a parole or probation officer, indicating dates and conditions of arrests.

    d. The program physician can make an exception to the two-year history requirement on the basis of a "life or health endangering situation" with prior approval from the State. Although counselors can not make this determination,

it is important to be aware of this option so that individuals who might qualify are not turned away for failure to meet the two-year history requirement.

Patients who present significant or unusual medical complaints or physical appearance should be seen by the physician. Some examples of circumstances indicating a physician evaluation are HIV positive, critical illness, recent hospitalization for non-addiction related problems, suicidality, yellowish appearance, or sores, boils, or abscesses. Counselors are not expected to make medical decisions. However, when presented with medical complaints or information, the counselor can play a vital role on the treatment team by seeking help from, and passing along information to, the medical staff.

2. Confirmed history of two or more unsuccessful attempts to detoxify from illicit opiates. Detoxification histories typically consist of treatment records or records of incarceration for narcotics violations. As with the two-year history requirement, these are usually treatment records or "rap sheets," or letters from acceptable sources within the treatment, legal, or penal establishments describing periods of treatment or incarceration.

3. One year of addiction prior to admission. Counselors should consult appropriate regulations for the definition of what constitutes "one year of addiction." Counselors should be aware that only the physician can determine the one year of addiction requirement.

4. Evidence of current narcotic dependence, including early signs of withdrawal. Although the physician will document current dependence and signs of withdrawal, it is important for counselors to know some of these indications. Again, as one of the initial contacts during the intake process, the counselor may play an important role in determining eligibility or may help others on the treatment team by passing along observations and information.

   a. Needlemarks are one possible indication of current narcotic dependence. Old tracks and scars do not indicate current dependence. Fresh marks (pink or recently scabbed) indicate recent I.V. use. These fresh marks suggest the possibility of opiate dependence, but are not conclusive. They may be injection sites for other non-opiate substances such as cocaine, or they may be opiate injection sites but the person might not yet be addicted.

      The absence of needlemarks may not be significant if the person is reporting non-I.V. use (smoking, snorting, or oral). If the person is using prescription opiates, copies of prescription labels can facilitate the documentation process.

Being under the influence (pinpoint pupils, sedation) doesn't necessarily mean a person is addicted; and a dirty urine can result from using just one time.

b. The onset of withdrawal is related to the specific opiate to which a person is addicted. Different opiates stay in the system for different lengths of time. For a long-acting opiate like methadone, it would take about 24 hours after the last dose before a person addicted to it would show signs of withdrawal. For codeine, it would only be a few hours. Heroin withdrawal begins after 4-8 hours.

Because a person must exhibit signs of withdrawal in order to enter methadone maintenance treatment, counselors who talk to prospective patients should be clear in advising would-be patients in matters regarding time of last use prior to program entry. (E.g., "make sure you don't use anything after midnight tonight. You won't be able to get dosed unless you're just starting into a little withdrawal.") Counselors should allay the addict's fears that he/she needs to be sick. Let the person know that it is only necessary to be in the very beginning phase of discomfort.

Withdrawal, even in the absence of needlemarks, clearly indicates addiction. The most common signs of opiate withdrawal are:

- runny nose
- eyes tearing
- chills
- yawning
- goose flesh
- large pupils
- sweating
- diarrhea
- nausea

Because cravings and irritability are also associated with withdrawal, counselors need to be sensitive to the fact that this requirement for treatment entry may significantly restrict counseling activities during intake. The patient will most likely be focused on "when do I get my dose?" and may not be cooperative or interested in history taking, treatment planning, program description or other matters. Attempts to accomplish non-essential aspects of intake might antagonize the patients and impede establishment of a therapeutic relationship. On the other hand, understanding the patient's discomfort and help in expediting the intake process can do a lot to get a therapeutic relationship underway during the intake process.

c. The counselor should alert medical staff or seek assistance from supervisory staff if there are concerns surrounding these requirements. Concerns might include: the patient is under the influence; there are no fresh needlemarks; there are no apparent signs of withdrawal despite self-report of more than 12 hours since last heroin use; there is extreme withdrawal precluding normal intake processing.

5. Exceptions to two-year history and two detoxification requirements. There are exceptions to these requirements (e.g., pregnant addicts) which are described in the regulations. Counselors should refer to state and federal regulations regarding these. Procedures for granting exceptions vary depending upon whether the program is in compliance or noncompliance with State regulations. Counselors should consult with appropriate supervisors or regulatory agencies for clarification.

6. Exceptions to requirements of a one-year period of addiction prior to admission and signs of current opiate dependence are also described in the regulations. Counselors should again refer to regulations or consult appropriate agencies for clarification of these exceptions. Counselors should be aware that determination of exceptions is the physician's responsibility.

   In cases where there are no signs of current physical dependence to opiates, counselors should present the option of naltrexone treatment (see this chapter, Aftercare Issues). Even though patients may qualify for methadone maintenance, naltrexone might be preferable and more appropriate in some cases. Patients who express interests or who would like additional information should be referred to a supervisor or the medical staff.

7. Plan for next contact or referral. A discussion of maintenance eligibility requirements should end with a plan for the next contact or specific referrals. Things should not be left open or hanging, nor should the initiative for making another contact be left with the patient. Before the patient leaves there should be:

   a. An appointment to see the physician, followed by another appointment with a counselor;

   b. Another appointment with the counselor, if necessary, to continue intake procedures (e.g., acquiring documentation of addiction history);

   c. A plan for acquiring necessary documentation for admission;

   d. Provision of information or referral to other treatment. For example, methadone detoxification programs, residential programs, drug-free counseling, self-help directories.

At all times, it should be clear both to you and to the addict what is going to happen next and when. If possible, you should follow-up by phone with individuals who are referred elsewhere. As a counselor, you should be proactive in engaging addicts in treatment. In cases where a person fails to return for scheduled counseling or physician appointments, should call and reschedule appointments; too often in addiction treatment, counselors fail

to seek out individuals who do not keep appointments. Those who fail to return are often characterized as unmotivated or are simply ignored.

Considering that addicts are generally out of control, as well as the power of heroin addiction, it should not be surprising that many addicts do not return for appointments or arrive at non-scheduled times. You should not view calling someone to reschedule an initial contact and being flexible in appointment times as unusual or extraordinary. Rather, this should be normal and expected service you provide to addicts seeking treatment.

(A recommended checklist to assist counselors in determining eligibility for methadone maintenance is provided in the Appendix to this chapter.)

Patient Orientation and Consent

New patients must be advised on some specific issues related to methadone, program rules and procedures, and patient rights. Since it is often better to forego discussion until the patient has been on the program a few days and feels comfortable this information may be provided in the form of a patient handbook and discussed to ensure understanding. In discussing program rules, it is important that you not assume an authoritarian or disciplinary stance. Talk about rules and procedures in a way that emphasizes positive therapeutic aspects. For example, urine testing can be described as a tool to help patients stay clean, rather than a means of catching them dirty.

Needs Assessment

Before you can develop a treatment plan for a patient, you need to do a needs assessment. Areas to be assessed include drug and alcohol use; medical, social, psychological, educational; and vocational rehabilitation; and employment. In completing the first three sections of the Needs Assessment (drug use, alcohol use, and medical history), you should review the medical evaluation, which covers areas regulations require the physician to evaluate. Further investigation of problems identified by the physician may promote a more thorough needs assessment and a better treatment plan. (A Worksheet for Needs Assessment and a Needs Assessment form are included in the appendix.)

Using the needs assessment form.

The Worksheet for Needs Assessment form should be completed after the patient has become physically comfortable, and you have established a relationship of trust, but, soon enough so that problems can begin to be addressed. Generally this would be about the third week of treatment (treatment plan needs to be done within 4 weeks). Read the instructions on the worksheet form aloud and encourage the patient to answer all questions honestly and completely. Reassure the patient that the purpose of the assessment is to help determine areas where help is needed. Tell the patient that answers to needs assessment questions will not be used for any other purpose except to help you design a treatment program and that information about drug and alcohol use or other matters will not be a basis for disciplinary or punitive action.

Evaluating the Worksheet form.

The Worksheet form is designed to help you collect information in order to make some general assessments of need in seven areas. After the patient completes the form, the counselor should review it for completeness, ask the patient questions to clarify answers if necessary, and then complete the Needs Assessment form. Problems or goals within each area of assessment should be indicated in this section. Medical or psychological problems which have developed since the physical exam should be brought to the attention of the medical staff, and the form should be reviewed by a clinical supervisor. This information is then used to develop the patient's treatment plan.

In completing the first three sections of the Worksheet (drug use, alcohol use, and medical history), you should review the medical evaluation, which covers areas regulations require the physician to evaluate. Further investigation of problems identified by the physician may promote a more thorough needs assessment and a better treatment plan.

Needs assessment areas

Drug Use. Review medical evaluation. Considerations in evaluating presence of problem:

- Any current regular drug use (particularly long-term, or heavy)
- Any that patient feels is a problem

(Additional assessment instruments can be used to help evaluate drug problems (Cocaine Problem Severity Index; Amphetamine Problem Severity Index; Addiction Severity Index are included in the Appendix.)

Alcohol. Review medical evaluation. Considerations in evaluating presence of a problem:

- Daily drinking
- Binge drinking
- Regular heavy drinking
- Drinking-related arrest
- Self-report of problem

(Additional assessment instruments in the Appendix: MAST and Alcohol Intake Pre-Screening Instrument.)

Note: In assessing problems with non-opiate drugs or alcohol, don't forget that opiate addicts tend to minimize, feeling that anything less than regular, daily chronic use in the manner of opiate addiction is not a problem, and certainly not an addiction. You may need to discuss other than tissue-dependent types of chemical dependencies to put drug and alcohol use in proper perspective (see later in this chapter, "Dealing with alcohol and other drug use").

Medical History. Review medical evaluation. Considerations in evaluating presence of problem:

- Recent hospitalization
- Self-reported problems
- Currently taking medications

You can be an important liaison with the medical staff and should refer patients to medical staff if the need arises or if there is some doubt regarding need. You can also encourage and monitor the patient's medical care with practitioners outside the methadone clinic.

Social/Social Services

- Amount of drug/alcohol use in social environment
- Unemployment
- Dependence upon illegal sources of income
- Eligibility for public assistance
- Need for housing
- Legal problems

Psychological History Status

- Problem within past 30 days
- Any previous treatment history

Education

- Failure to complete high school
- Desire to return to school

Vocational

- Unemployed or disabled
- Interested in job training

In performing needs assessment you should prioritize the patient's needs. For example, suicidality or some medical problems would take precedence over educational or vocational needs.

Treatment Planning

(Much of the material in this section has been excerpted or adapted from the Enhanced Counselor's Manual, published by Research Triangle Institute, 1991. The authors are John Fairbank, Arthur J. Bonito, Michael L. Dennis, and J. Valley Rachal. The manual was sponsored by a NIDA grant.)

The treatment plan should be developed after the patient has stabilized on methadone (i.e., when he/she no longer has withdrawal complaints or is experiencing any sedative effects of methadone) or within four weeks, whichever is sooner. The treatment plan charts the course of counseling. It allows you and the patient to establish concrete goals for treatment.

It is important that the patient participate in the development of the treatment plan;

- **Patient involvement can provide you with important information about the desirability, feasibility, and ease with which various treatment strategies can be implemented.**
- **Involvement can increase the patient's motivation to participate and continue in counseling.**
- **It better ensures that the goals have been mutually determined.**
- **It can boost the patient's morale, and sense of mastery over problems.**

Identify possible short and long-term goals and objectives for each target problem.

Review each problem covered by the needs assessment as well as any other areas which have been uncovered. Identify specific goals and objectives for each problem area. Specifying treatment goals allows you and the patient to fully understand the purpose of counseling, permits you to assess whether the treatment team has the skills and/or resources necessary to assist the patient in attaining specific goals, and guides the development and revision of treatment plans.

Most treatment plans contain both long-term and short-term goals and objectives. Long-term goals usually represent the ultimate outcome to be achieved by treatment. For example, a methadone patient who uses cocaine might desire to achieve total abstinence from illicit drugs-- a long-term goal that may require significant time and effort to achieve.

Counselors have long recognized that a key to helping patients achieve long-term treatment goals and objectives is the ability to develop a graduated series of challenging, but clearly obtainable, short-term goals, which in principle should lead to attaining the desired long-term goal. Short-term treatment goals are especially important for individuals with severe and chronic problems--precisely the kinds of problems facing long-term drug users.

For example, for a patient who is currently unemployed, an appropriate long-term goal is to find a job and maintain steady employment. However, this may take an uncertain and prolonged amount of time (weeks or months). Linking the measurement of treatment progress to the attainment of shorter-term goals that permit a realistic daily look at treatment progress, providing almost immediate feedback on goal achievement, and fostering a sense of accomplishment in both the patient and counselor are good short-term goals. A reasonable first short-term goal for the unemployed patient might be to ask him/her to bring to the next counseling session clippings from the newspaper want ads section of one to three jobs to follow up on. You can discuss the appropriateness of the job in view of the patient's skills and experience, then work together through the application process. Further short-term goals that build on the earlier success might be to have the patient apply for one or more jobs per week, then follow-up with at least one formal job interview within two to three weeks.

Similar strategies can be developed for all potential problem areas, including drug and alcohol abuse, medical and psychological problems, legal problems, and family problems. An example is a case in which the patient indicates family problems or a desire for marriage and family counseling. Through extensive probing about specific kinds of family problems you might find severe deficits in the patient's ability to communicate effectively with family members. In this case, you and the patient might decide that communication problems constitute an appropriate target, and that an important long-term goal is to improve the patient's ability to communicate effectively with family members.

In communicating with family members, several meaningful short-term goals may be identified. These might include completing a three-session educational minicourse in the topic of effective communication skills, participating in several counseling sessions together with family members to discuss ways of improving communication, and completing "homework" assignments that require completion of tasks that target specific interpersonal communication problems.

Introducing treatment planning

Patients may have vague ideas about what is supposed to happen in counseling. They may fear the unknown or have negative expectations based on previous counseling experiences in methadone treatment where "counseling" consisted of solely of disciplinary actions for violating program rules. The manner in which treatment planning is introduced can set the tone for counseling.

Sample Script

The following is a script that can be useful in introducing treatment planning. Counselors should try to convey the contents of this script in personal style so that it sounds natural:

"As you know, drug use and the problems that go along with drug use are difficult to change. It's certainly not news to you that changing behavior related to drugs and other problems is a difficult task. One thing we know, however, is that when you are faced with a difficult task, you are much more likely to succeed if you have a plan than if you have no plan at all. What we are going to do now is work together to develop a plan for your treatment while you are on the program."

"You and I will need to do several things in order to develop a useful plan. First, it is important that you and I work together to develop this plan because it will serve as the blueprint for what we will be doing when you come to counseling over the next 6 months. It is very important then that the plan we develop include problems that are important to you. If your treatment plan only includes things I think are important, then I can tell you now that it probably will not be very useful. One of the things we will use to develop this plan is the information you provided the other day when we did the structured assessment of your needs."

"The second part of developing this plan is that you and I will establish some goals for each of the problems you decide to work on. This is never easy, and what it will require is that you and I roll up our sleeves and go to work to try and determine reasonable long and short-term objectives for each problem. Basically, we will try to answer these questions: Where do you want to be 6 months from now regarding these problems? Where do you want to be in a couple of weeks? And where do you want to be tomorrow or the next day?"

"Thus, what we are going to do today is identify problems that we will work on and plan your goals. It is never an easy task, but it is very important. Any questions? OK. Let's get started."

Deciding on a specific treatment plan.

The basic procedure for generating an initial treatment plan is to systematically evaluate the appropriateness and utility of a range of treatment alternatives for each target problem. Some of the key factors that enter into the decision on what treatment plan to implement with what patient are the following:

- Assess the likelihood that a particular treatment approach will produce a particular effect or outcome based on your past relevant experiences with other patients with similar problems and personal characteristics.

- Estimate the likelihood that a particular treatment strategy can be implemented in its optimal form. This judgment requires an understanding of the availability of resources and an appreciation of potential **structural** barriers that might impede the patient from participating in treatment (e.g., transportation, financial, or child care difficulties). In addition, this component of treatment planning requires an understanding of the **personal** liabilities and weaknesses of the patient, the treatment team, and the range of community resources that affect the ability to deliver services to the patient. Issues such as patient motivation and counselor knowledge and competence with a particular procedure are relevant here.

- Each treatment alternative must be considered in terms of its personal consequences for the patient and the counselor. These personal consequences include ethics, level of effort, time commitment, finances, impact on family and significant others, and emotional and physical side effects.

Selecting the optimal initial treatment plan involves comparing the overall expected outcomes of each alternative given the particular short and long-term goals previously specified. Thus, in the example cited above, the counselor has generated a list of potential tactics for treating the family communication problems identified by the patient. The next step is for the treatment team and the patient to consider the potential outcome of each of these options separately, as well as contrast to the expected outcomes of other alternatives.

Personal, family, and environmental variables that would effect each option should be considered in the course of this decision-making process. The counselor might conclude that conjoint family counseling is the most powerful technique for improving communication within this patient's family. However, it may not be feasible for the patient's children to attend counseling sessions at the times available to the patient and his/her spouse. Thus, although the counselor might consider marital counseling (without the children) to be potentially less efficacious than conjoint family therapy for this particular problem, marital counseling might be the most viable treatment alternative that is available.

Summary of important points in treatment planning

- Perform needs assessment.
- Develop plan with patient after stabilization or within 4 weeks.
- Get patient participation in treatment planning.
- Identify short-term and long-term goals and objectives.
- Select realistic strategies for goal attainment.
- Review treatment plan at least every 90 days; note progress or lack of progress and revise if necessary.
- Consider dose level appropriateness in treatment plan review. (Note, the consideration of the dose level does not suggest that dose reduction need be a goal. It may be that dose increase could be a more appropriate goal in cases where patients are continuing to use illicit opiates.)

Sample treatment plan.

(A sample treatment plan form is provided in the chapter appendix.)

Counseling Issues

General issues regarding counseling are discussed in Chapter II. This section deals with some counseling issues which are specific to the methadone maintenance program and suggests some general topics for counseling.

Frequency and duration of counseling.

There are no specific requirements regarding the frequency or length of counseling sessions. In some cases programs may have contractual obligations (e.g., with a county drug office) to provide counseling at some specific frequency. Counselors should consult with supervisors for guidance. In most cases, however, sessions should be scheduled at least twice a month and should last at least 30 minutes. A guiding principle should be that the frequency or length should not be such that the counseling sessions are burdensome or aversive to the patient. Unnecessarily frequent or long sessions might engender a negative attitude toward counseling (which impedes the counseling effort). At the opposite extreme, sessions should not be so infrequent or brief as to be ineffective. It is difficult to provide effective input and monitor progress if sessions are more than a month apart or merely as brief "how are you doing?" check-ins. These "dosing window" interactions may allow for more frequent contact but do not constitute counseling sessions. It is unlikely that patients would speak freely or in sufficient depth on many topics in public areas where brevity and superficiality generally characterize conversations.

When counseling sessions are scheduled less than twice a month, it is advisable to justify this relative infrequency of contact on the patient record. Patients who are seen less than twice monthly should be:

- abstinent from illicit drugs
- not abusing alcohol
- employed, in full-time education, or engaged full-time in homemaking activities
- regularly attending the clinic
- without legal problems
- without significant health problems
- making progress towards treatment plan goals
- attending scheduled counseling sessions

Counseling sessions should be scheduled more frequently during periods of crisis or difficulty. Be flexible in scheduling patients during such times in order to accommodate the patient.

Brief, frequent, contact (perhaps scheduled at dosing time) can be helpful and practical during times when more contact is needed.

Always write counseling notes soon after the session to ensure completeness and accuracy of records.

Some suggested counseling techniques.

Counseling does not have to involve specific techniques. It can consist of general or specific advice, information, or support related to treatment goals. However, two counseling techniques that can be used to more efficiently and effectively attain methadone treatment goals are contingency contracting and problems solving.

Contingency Contracting.

Contingency contracting links patient behavior to specific rewards, sanctions, or loss of privileges. The most common type of contract involves the opportunity to earn take-home doses if a specific goal is achieved within a specified time. Other reinforcers might be the availability of additional or more favorable dosing times, access to ancillary clinic services, or involvement in advanced, higher-status treatment groups.

Counselors can take advantage of the powerful incentive of take-homes by explicitly specifying behavioral requirements (refer to regulations for requirements) for take-homes in a contract. For example, in addition to clean urines, enrollment in school or gainful employment could be specified as conditions of take-home privileges. (Note that the physician ultimately makes a determination of take-home status.) The explicit statement of such requirements within a contract can help patient compliance. (A sample "take-home treatment contract" is shown in the appendix to this chapter.)

A "Treatment Contract" that is not specific to take homes is also included in the chapter appendix. The format of this contract lends itself to the provision of rewards for positive behaviors. Counselors should take care to specify realistic behaviors within reasonable time frames. Rewards should also be reasonable. Basic clinic services such as counseling sessions or physician visits should not be held out as contingent rewards.

Contingency contracts that specify negative outcomes (punishment, loss of privileges) are not as useful as those involving rewards. Counselors should be careful not to impose unrealistic demands and must consider the general effects that imposing sanctions may have on the therapeutic relationship. An exception might be a situation where treatment termination is a possibility. In this case a Probation Treatment Contract, specifying conditions necessary to avoid termination, might be useful. (A sample probation contract, adapted from George Woody, is included in the Chapter appendix.)

Contracts that involve dose levels are not only inadvisable but are outside the realm of the counselor's activities. Dosing issues are a medical decision.

Problem-solving.

(The following section has been excerpted or adapted from the Enhanced Counselor's Manual, published by Research Triangle Institute, 1991. The authors are John Fairbank, Arthur J. Bonito, Michael L. Dennis, and J. Valley Rachal. The manual was sponsored by a NIDA grant. Excerpted passages are in quotes.)

"Mental health professionals have long observed that drug users often have histories of poor problem solving, acting impulsively when confronted with problems and failing to consider either the consequences of their actions or the possible range of alternative solutions. Deficits in effective problem solving among drug abusers often lead to unsatisfactory solutions, especially when drug or alcohol use is the solution for coping with problems. Clearly, patients who rely on drug use as a strategy for coping with situational and emotional problems are at increased risk for continued drug abuse and relapse following treatment. Recidivism (i.e., relapse) among heroin addicts is especially likely when they do not have the problem-solving skills necessary to cope with the stress of low-status employment, specific situations of the nondrug world, recreational drug use by straight co-workers, and the effort of maintaining gains made in treatment.

The goal of problem-solving counseling is to teach patients to adopt a multi-step approach toward resolving problematic life situations. Components of problem-solving counseling include: a) problem orientation, b) problem definition, c) generation of alternative solutions, d) decisionmaking, and e) implementation and monitoring.

The initial session(s) of problem-solving counseling should focus on providing the patient with information on the rationale of problem solving and its relevance to his or her situation (family problems, depressed mood, etc.) When the initial treatment plan has been completed, it is advisable to dedicate at least one counseling session to presenting the rationale for problem-solving counseling.

The following is an example of a rationale for introducing problem-solving counseling that has been adapted from Nezu et al., (1989):

> The basic counseling approach that I am recommending is called "problem solving." According to this approach, people can abuse drugs if they have difficulties coping with stressful life problems. Some people have difficulty coping because they never learned how. Others have difficulty because of the overwhelming severity of the problems themselves. At times, the way that we think about these problems can also lead us to drugs. For example, if we believe that we can't do anything to change a problem--that no matter what we try, nothing ever works--we probably won't feel like solving the problem. This in turn may lead to more problems and stress. The general upshot of this vicious cycle might be drug use, especially if the consequences of not solving the problem are severe. Another difficulty that people may experience relates to poor or ineffective problem-solving skills. For example, in trying to solve a problem, we might fail if our goals are too high, or if we don't think of enough options, or if our decisions are poor about which solutions might be effective. According to this counseling approach, many skills are involved in effective problem solving. Basically, the purpose of this approach is to help you to learn these skills in order to cope better with problems related to drug use. We will be focusing on five major skills: what we think about problems in general; how we define problems and set goals; how we think of various solutions to real-life problems; how to make decisions; and how to evaluate the success of our attempts. Throughout our sessions together, we will be focusing in learning more effective ways of coping with difficult and stressful current and future problems.

- Adopting a problem-solving orientation. Drug users commonly believe that their problems in life are so massive that the problems are unresolvable. In addition, it is not uncommon for clients in methadone programs to believe that they possess few skills for solving problems. Consequently, when confronted with problems, they typically react impulsively and negatively.

  A more rational orientation to problems in living and problem-solving as a means of coping can encourage patients to:

  - accept problems as a normal part of living,
  - believe in their ability to solve problems effectively,
  - label distress as a cue that a problem exists,
  - inhibit the tendency to respond automatically or impulsively,
  - develop the ability to think things through carefully, and
  - recognize that resolving a problem often takes considerable time and effort.

Some patients, especially those who are unable to stop and think because of runaway anxiety, may benefit from relaxation training. Once the patient is able to calm down, he/she can begin to think things through logically and carefully.

- Defining problems objectively. Patients often come to methadone programs with unspecified, vague, or very general complaints, (e.g., "my nerves are shot and I need some help," "my old man/lady is driving me nuts"). An important component of problem-solving counseling is to help the patient to develop skills that will enable him/her to get beyond these complaints to the problem(s) at hand. A major function of the treatment plan was to identify and clarify problems in specific problem areas. That process can serve as a model of how to teach patients to be able to define and formulate problems in an objective manner that opens them up to specific solutions. As noted by Nezu et al. (1989), this can be done by showing the patient how to do the following:

    - seek all available information about the problem;
    - differentiate relevant from irrelevant information, and objective facts from unverified assumptions and interpretations;
    - identify factors that actually make the situation a problem;
    - set realistic problem-solving goals aimed at those factors.

This can be facilitated by asking "who, when, where, and why" questions about each problem: Who is involved? What happens (or does not happen) that bothers you? When does it happen? Where does it happen? Why does it happen (i.e., known causes or reasons for the problem)? What is your response to the situation (i.e., actions, thoughts, and feelings)?

This is an excerpt from a transcript of a counseling session that deals with the issues of problem definition and formulation:

Counselor: Tell me again what happened when the nurse gave you your methadone today.

Patient: She insulted me. She threw the cup at me. I tell you, the woman hates me.

Counselor: You are telling me that the nurse told you that she hates you.

Patient: No. she didn't say that. She didn't have to. The way that she threw the cup at me was clear enough. It makes me mad. She wouldn't treat a dog that way. It's insulting.

Counselor: Describe the circumstances at the dosing station this morning.

Patient: Well, as usual, it was busy. There were more folks in line than usual, though. Only that nasty nurse was on duty.

Counselor: Describe exactly what happened when you received your methadone. As we've discussed before, give me a brief, clear, and accurate description of the event itself, with no interpretive language.

Patient: After waiting about 20 minutes, I finally got to the front of the line. She gave me the cup and ordered me to drink it fast.

Counselor: She ordered you? What did she say exactly?

Patient: Dave, quick, down the hatch, we're busy today (patient laughs).

One of the things that occurred in this dialogue was the evolution of the patient's emotional, exaggerated, and overstated description of a problematic interpersonal interaction to a brief description of the event itself with no speculation as to hidden meanings. Frequently, counselors choose to begin the process of problem definition training by focusing on examples of recent problems of relatively minor significance to the patient. Once the patient has demonstrated that he/she can define minor problems accurately, then he/she is ready to advance to the more difficult task of defining and formulating problems of a more severe nature.

- Generating alternative solutions. At this stage, work with the patient to generate a range of possible solutions to problems by using brainstorming techniques. In the following passage, Nezu et. al. (1989) provide an excellent rationale for the importance of this process to effective problem solving:

> Training patients to develop a range of coping options is based on the premise that the availability of a large number of alternative actions will increase the chances of eventually identifying an effective solution. Often patients expect that there is one right answer for each problem and that therapy, or the therapist, will provide it for them. Moreover, in trying to find the right solution to a problem, patients sometimes believe that the first idea that comes to mind is the best one. Therefore, in order to maximize problem-solving effectiveness, the therapist needs to convey to patients the necessity of generating as many different options as possible."

The key aspects of brainstorming are quantity of ideas and deferment of judgment:

- Generate as many ideas as possible.
- Don't criticize ideas at this stage of problem solving.

Patients often complain that they can't brainstorm because they can't imagine that there are other solutions to their problems. Be persistent, tenacious, and patient. Hang tough with attempts to avoid this essential aspect of problem solving. Don't willingly or passively accept standard complaints that "I can't think of any other solution to this problem. Besides, if I could, I wouldn't need to come see you twice each week." Resist the temptation to buy into a patient's insistence on helplessness in this regard. Encourage creativity.

Patients also often have difficulty generating alternatives without immediately evaluating and rejecting them. Don't let your patients off the hook with this aspect of brainstorming either. Counselors must encourage patients to avoid rejecting any option before all possible alternatives have been generated. Through repeated practice and reinforcement, you should work with the patient to generate as long a list as possible of alternative solutions before proceeding to the next stage, when decisions are made.

- Developing decisionmaking skills. At the decision-making stage, you teach the patient to predict which alternative solutions are worth pursuing and then take action. Discuss each potential solution with the patient and encourage him/her to anticipate the likely long-term consequences of each alternative and evaluate the usefulness of each of these consequences for resolving the problem situation.

Resnick and Jordan (1988) have noted that when patients have difficulty choosing among the alternatives, it is often helpful to have them assign weights (scores) to the positive

and negative consequences to estimate their relative importance. Positive consequences could receive scores from 1 to 100, while negative consequences could be assigned scores from -1 to -100. For instance, although one alternative may have a longer list of positive consequences, it may also have more important drawbacks, while another alternative has fewer important drawbacks and a greater number of important gains. Although a patient is unlikely to base his/her final decision only on the total score obtained from the weightings, going through the process may help the patient to decide what factors are most important in deciding on a course of action.

- Implementing solutions and monitoring effectiveness. At this stage, you encourage the patient to carry out the selected course of action. Some patients are likely to need considerable encouragement at this stage of problem-solving counseling, given that many of the men and women in treatment for drug abuse are avoiders. To provide this encouragement, show the patient how to engage in the following behaviors:

    - How to observe the consequences of his/her actions.

    - How to match the real outcome of the solution against the expected/predicted outcome.

        - If the match is satisfactory, the problem has been resolved.

        - If the match is unsatisfactory, you and the patient should reexamine each of the preceding steps in the problem-solving process to determine what to do next. Was the problem defined adequately? Were enough alternative solutions generated?"

Summary.

Problem-solving is a skill that patients can learn to use effectively to cope with a variety of problem situations. Whether it is learning how to resolve a conflict with an employer, control explosive anger episodes with one's family, or avoid the places and people associated with drug abuse, the goal is to teach the patient practical and flexible problem-solving skills. As counseling approach to narcotics abuse, problem-solving shapes new, more adaptive behaviors for coping with situations or emotions that may trigger episodes of drug use. (cf. Childress, McLellan, & O'Brien, 1985).

Cognitive/Behavioral Techniques.

These techniques emphasize information and behavior change as ways of dealing with problems as opposed to seeking insight into problems or exploring underlying or historical causes. These practical, straightforward approaches sometimes require that you be directive with the patients, especially those who resist change or lack insight into themselves. You may need to prompt appropriate behavior and reinforce small movements toward positive change. Oftentimes the insight, motivation, or attitude changes will follow the behavior changes. Some behavioral techniques include the following:

- Behavior rehearsal and modeling. This involves role-playing circumstances so that the patient can practice appropriate and effective ways of dealing with difficult situations. For example, the counselor can assume the role of a drug dealer and ask the patient to respond to a chance meeting in a park. The counselor, and patient could then switch roles and the counselor could model effective ways of turning down offers to sell drugs. This technique can be used to provide concrete direction for dealing with a variety of interpersonal situations.

- Shaping and reinforcement. Shaping refers to a learning process wherein small improvements or changes in behavior, that are headed in the direction of a treatment goal are rewarded. For example, a process of shaping a person to get a job might involve initially praising the person for looking at want ads, then for bringing the ads in to discuss with the counselor, then for choosing some possible ads to call on, then for calling, and finally for submitting an application. The person who is simply encouraged to "get a job" may not know what to do in order to achieve this goal. Breaking the task into smaller pieces and rewarding (praising) the accomplishments of each step toward the ultimate goal can facilitate success.

Some suggested counseling topics

Stress management. Addicts often use drugs to the exclusion of other responses to stress. Moreover, stress can precipitate withdrawal in opiate addicts; this stress-induced withdrawal can further reduce the likelihood of the addict's finding new ways to deal with problems. A "Recognizing Stress" checklist from Rawson et al., 1991, (see appendix to this chapter) can help in identifying the presence of stress by looking at some of its common manifestations.

Stress management involves first identifying the presence of stress and then taking action to deal with either the stress or the stressful situation. This can be done with the help of the counselor, particularly through the application of problem-solving techniques. Other methods include improving personal habits (see leisure, diet and nutrition, and exercise, below), discontinuing the use of all mind-altering chemicals, and working on self-relaxation techniques.

The following exercise in relaxation is adapted from a description in Methadone Maintenance to Abstinence: The Tapering Network Manual, (Brummett et. al, 1986).

An Exercise: Relaxation (The counselor reads the following)

During periods of stress you may feel anxious, nervous, have aches and pains, and be physically uncomfortable. One thing that can help is called "body work." This means gaining a new awareness of the stress you are experiencing, and finding new ways to alter your reactions to it. Body work may include relaxation exercises, biofeedback techniques, acupuncture, massage , and exercise. We cannot always control all of the stressors (the job, people, events in our lives), but we can alter the ways we react to them.

Relaxing is more than "kicking back", or watching T.V. It is a skill which involves releasing all of the tension and anxiety from your body. With practice you can get better at it, and use self-relaxing to counter tension and anxiety, to facilitate sleep, or as a daily "dose" of stress relief.

There are so many pressures and distractions in everyday life that it's easy to loose touch with how we're feeling. It's easy to get divorced from our bodies. I'd like to do a brief exercise now that will help you to get in touch with yourself. I'd like you to be meditating and breathing deeply and easily, not just up in your chest but all the way down into your abdomen. Breathe deeply and easily and close your eyes. Imagine that you're in some comfortable place, perhaps walking in the woods, or walking along the seashore. Walking over the beach, walking over the sand, listening to the sound of the waves as they roll onto the shore and then wash back out to sea. Find a comfortable place, sit down on the sand facing out to sea. Breathe deeply and breathe easily. Breathe all the way down into your belly, watch the waves as they crash on the shore and then slowly roll back out to sea.

You think to yourself, this is my time. You don't let thoughts of what you should have done earlier or what you have to do later intrude upon you and if these thoughts do arise, you let them drift through your mind the way the clouds drift across the sky. Breathe deeply, breathe easy, breathe all the way down the belly. Now I'd like you to focus your awareness, focus all your awareness up on top of your head, all the way up on top of your head. We're going to guide our sense of awareness down through our entire body letting go of the tension as we find it. We'll check for tight places, we'll check for tension, we'll check for hurt places, and if we find any of these, we're going to breathe them out. We're going to release the tensions as we release our breath.

Breathe deeply and breathe easily, breathe in rhythm with the waves, as they roll on into shore and then roll back out to sea. Your awareness is focused up on top of your head. All the way up on top of your skull. We're going to guide it down through our bodies, we're going to do a "systems check." We're going to breathe out the tensions and hurts. Breathe deeply, breathe easily, breathe in time, with the rhythm of the waves. You hear the sound of waves, (perhaps you hear the sound of traffic off in the distance). You hear the sound of the gulls overhead and you breathe. Guide your awareness down over the top of your skull. Down, down across your forehead and your temples, down across the crown of your skull. Breathe deeply, breathe easy. Guide your awareness down, down over your eyes, down and past your ears, down over the back of your skull. Your awareness flows down your cheeks,

to your abdomen. Guide your awareness down over your shoulders, down your upper arms, across your elbows. Down through your forearms, over the wrists, down into your hands, to your fingers. Breathe deeply, breathe easily, your hands are limp and loose and relaxed. You guide your awareness down through your shoulders, over your collarbone, down across your shoulderblades, down over your chest, across your ribs, down your back. Breathe easily, breathe deeply. Your awareness flows down your ribs, over your abdomen, down the small of your back, across your hips, and your buttocks, down through your thighs, across your knees. Breathe easily, breathe deeply. Your awareness flows down, down to your calfs, over your shins, down, down to your ankles, down into your feet, down through your toes. You breathe deeply, breathe easy. You're releasing any tension that you found. Any tight places, any hurts that you've found have flowed out. Feel comfortable, feel relaxed, your whole body feels good. Take a moment just to be with yourself. Say hello to your body and to yourself. Now slowly, slowly bring your attention into the room and when you're ready, slowly open your eyes and return.

This is a progressive relaxation exercise and you should do daily, if possible. Sit in a comfortable place, close your eyes, do the systems check. Breathe comfortable, breathe easily, you remember that this is your time, try not to let thoughts of what you should have done earlier or what you must do later intrude. If these thoughts do arise, let them drift through your mind, as clouds drift across summer sky. Remember how you let the tension go. Remember how you let go of the tightness. You are able to do that with any part of your body that you choose to. Breathe easily, breathe deeply, breathe comfortably. Your whole body is limp and loose and relaxed and you feel good. Take a moment just to be with yourself and then when you're ready, bring your attention back into the world. When you're comfortable, slowly open your eyes.

Leisure. When addicts stop using and drinking, they need to work at incorporating leisure activities into their lives. For many, drug and alcohol use either constituted leisure activities or consumed so much time that other activities were impossible. Many long-term users have little leisure experience to fall back on and may need help with even ordinary recreational activities such as going out for a pizza, taking a walk, or reading a newspaper.

A "Recreational Activities" list is included in the Appendix to this chapter. Review it with patients to help them pick out potential activities. Have the patient pick at least three possible activities to try out.

The importance of staying busy in recovery is summarized in a "Staying Busy" handout in the appendix. Review this with the patient to underscore the importance of leisure activities.

Diet and nutrition. Most heroin addicts do not pay much attention to diet and nutrition. After entering methadone maintenance, many patients continue poor eating habits. People who are accustomed to using powerful drugs to alter the way they feel may not initially appreciate the more subtle effects of a healthy diet. Part of the change in lifestyle out of illicit drug use and into recovery involves letting go of old ways and learning new habits.

Brummett et al. (1986) advise the following:

> If one has never given much attention to health and nutrition, a way to begin is to pay attention to bodily feelings--breathing, what it feels like to eat good food, get a good nights sleep, get rid of tension in the body by sleeping, having sex, stretching or exercising. The next step is to educate oneself about good eating habits. We can begin slowly to replace the junk, caffeine, and nicotine in our diets with food that will make us feel better. Nutritionists recommend whole grains, fresh fruits and vegetables, and suggest that the following be avoided: sugar, white flour, coffee, salt, alcohol, and junk food. Many also stress the importance of eating breakfast. It is wise to not expect to change every part of your diet overnight or to feel euphoric because of it. A healthy diet should produce slow, steady positive results in the way we feel. Avoiding hunger by eating three meals a day plus healthy snacks in between when needed can help us to feel nourished--physically and emotionally.

To evaluate the patient's eating habits, use the "Nutrition" handout (in the appendix) and ask for a listing of what the patient has eaten recently. Discuss good nutrition with patients and re-evaluate nutrition regularly while working to improve eating habits.

Exercise. Another aspect of a new healthy lifestyle is exercise. Exercise does not have to involve team sports or expensive equipment. Taking a brisk walk on a regular basis can constitute an exercise program. Some patients reject the need for exercise because they have strenuous jobs. In these cases, point out that exercise is different from exertion. Exercise should be enjoyable and stress relieving; it can help release the tension of a physically demanding job.

Explain to patients that exercise can promote the production of endorphins, natural morphine-like chemicals. Patients who have had difficulty during periods of opiate abstinence may find the potential to increase endorphin levels through exercise a way to help prepare for and deal with being off methadone in the future.

Review the "Exercise" handout (appendix) with patients. Encourage them to engage in some sort of exercise activities. Try "shaping" patients who are resistant. Perhaps a patient will agree to a short walk by parking a block away from the clinic before the next counseling appointment. Counselors should reinforce any small steps towards a new, healthy lifestyle.

Vocational and educational activities.

Many methadone patients enter treatment unemployed and with meager employment histories. Counselors should address vocational needs during needs assessment and incorporate vocational counseling into treatment plans. A "Sources of Support" instrument is included in the appendix to facilitate the assessment of vocational needs. This is a section from the Individual Assessments Profile designed by Research Triangle Institute.

It is important to consider and deal with barriers to vocational training and vocational opportunities. Some of these barriers include:

- discrimination against recovering addicts for both real and perceived reasons
- lack of program-level commitment to vocational rehabilitation
- potential loss of welfare benefits, particularly medical benefits
- lack of childcare and transportation
- lack of training and/or marketable skills
- significant gaps or lack of employment histories
- lack of client motivation/self-esteem
- lack of staff training in the delivery and use of vocational services

Counselors should consider each of these barriers as they may apply to each patient. Programs may choose to have a counselor who specializes in vocational training and programs should develop liaisons with state offices for vocational rehabilitation. Using existing resources for vocational training through these state offices can greatly facilitate this area of counseling.

Problem-solving techniques can help patients move through the process of finding potential jobs in want ads, making calls, and deciding upon where to submit applications. Behavior rehearsal can be used to practice telephoning to inquire about jobs, requesting an employment application, and interviewing for jobs. Rehearsal can greatly help in improving the patient's skills and as a result increase confidence and self-esteem.

In dealing with educational needs, be aware of resources for adult education and vocational training. Patients who express a desire to resume educational activities will often need specific directions and support from counselors to carry through.

Take Home Doses

State and federal methadone regulations clearly describe requirements surrounding self-administered take-home dosages of methadone. As a counselor, you are the person primarily responsible for explaining and invoking these regulations. You should be familiar with them and communicate with administration and medical staff regarding take-home issues.

The matter of take-home doses is important from two perspectives:

- Diversion of methadone. There is a concern that methadone intended for a patient will be diverted to another person.

- Patient incentive. Take-homes are a major incentive to patients in methadone maintenance treatment. Each take-home represents one less early wake-up, drive through traffic, search for a parking space, and wait in a dosing line. To some degree, treatment goals can be more successfully attained through their connections to take-homes.

  Treatment goals related to drug and alcohol use are clearly related to take-homes, but counselors also have the option of linking other goals to this incentive if this is within the program protocol. For example, because take-homes are justified only on the basis of daily attendance being incompatible with gainful employment, education, and responsible homemaking, treatment-plan goals pertaining to these areas can be specifically tied to take-home level. Other clinical goals may be tied to take-homes if a program chooses to do so in its protocol. (Some applications of take-homes as incentives is discussed in the previous section on contingency contracting.)

Explaining and enforcing take-home regulations.

You should explain take-home regulations to new patients during orientation. The regulations should be explained in a positive manner. Stress the opportunity to earn take-homes as a result of progress versus the sanctions on take-homes related to drug use and other program rule violations. Always try to position yourself as someone who is there to help the patient.

In explaining the take-homes regulations, make sure to discuss such requirements as:

a. Need for a locked box.

b. Adherence to program requirements and dose limitations.

c. Step level schedule.

d. Exceptions in cases of physical disability or exceptional circumstances.

e. Restricting take-home privileges.

f. Revoking take-home privileges.

g. Restoring take-home privileges.

When it becomes necessary to enforce regulations, you are put in what often is an uncomfortable position. Some patients may feel rejected or mistrusted and may become angry. Others may apply pressure to "look the other way" or give them one more chance. You need to sustain professionalism through such periods. Be clear that decisions regarding take-homes are not personal and are within the counselor's discretion. Emphasize, instead, that the regulations are clear and that as a counselor you are not making a decision but explaining a requirement. You should then emphasize that you can help the patient in dealing with the problem(s) that resulted in the loss of or failure to earn take-homes.

When a counselor overlooks a violation of take-home regulations or inappropriately facilitates the earning of take-homes, he/she may receive thanks and appreciation from the patient; but more important are such effects as the following:

- diminished respect for the counselor
- assurance of future requests for "special" treatment and rule bending
- negative role-modeling with regard to honesty and fairness
- signals to the patient that his/her behavior does not carry consequences
- undermining of the rehabilitation process

Exceptions.

In addition to the exceptions in cases of physical disability or exceptional circumstances, there are additional exceptions in the case of terminal illness. In this case, the program can waive the take-home schedule and some requirements. You should refer to the regulations or consult with a supervisor or approval regulatory agency for guidance in these cases.

Urine Testing

Patients in methadone maintenance treatment are required to submit a urine specimen for a drug screen at least every 30 days. Urines are collected on a random basis and screened for methadone and its primary metabolite, morphine, codeine, amphetamine, methamphetamine, phenobarbital, and secobarbital. Other drugs may be screened at the program's discretion. Given the high level of cocaine/crack use it is strongly advised that urines be screened at least periodically for cocaine.

Rationale.

Urine testing allows several things. First it enables the program to determine whether a patient has methadone in his/her system; it is a deterrent to methadone diversion. Testing also may uncover use of illicit or unauthorized drugs.

Most importantly, however, testing provides the patient with an additional tool to prevent drug use. This purpose of testing is the most positive and usually the least obvious to the patient. Testing should be presented to the patient as primarily something that can assist in treatment, as opposed to a mechanism of surveillance necessitated by an assumption of the patient's dishonesty. Patients are out of control when they enter treatment and need to impose structure around their behavior in order to stay off illicit drugs and move forward in the recovery process. Urine testing is one aspect of this structure.

Interpreting urine results.

Urine results are usually reported as negative or positive. Negative indicates the absence of a drug, positive indicates the presence of a drug. Positive tests for illicit drugs are "dirty" tests. In most cases these results reflect the presence or absence of drug use but sometimes lab error or a medical condition can account for a test result.

- Negative for methadone and methadone metabolite: This usually means that the patient has not taken methadone recently (within about three days of the test). This result can also indicate that the patient has submitted the urine of someone not on methadone.

- Positive for methadone only: This means that there is methadone in the urine specimen but no methadone metabolite. The methadone metabolite is the result of the body's processing of methadone. Methadone needs to go through the system in order for the methadone metabolite to be found in the urine. This result suggests

that some methadone was put directly into a urine specimen of a person who had not been taking methadone. A patient using someone's urine who was not on methadone might try to make the specimen appear to be that of a person taking methadone by perhaps spitting a small amount of his/her dose into the urine bottle. The methadone would be detected in the urine specimen but there would be no metabolite as it has not gone through the patient's system.

- Positive for methadone metabolite only: This result indicates a very small amount of methadone in the person's system. This result might mean that the person has not ingested his/her dose the previous day or that the person is on a very low dose. This result should promote closer supervision of dose ingestion by the nursing staff and an examination of take-home eligibility if the urine were collected following a day the patient had received a take-home.

- Positive for methadone and methadone metabolite: This indicates that the patient is taking methadone and has taken his/her dose on the day prior to testing.

- Morphine positive. Heroin is converted into morphine in the system. A morphine-positive result most likely indicates either morphine or heroin use. Codeine is also metabolized into morphine and may result in a morphine positive result. It is more likely, however, that the codeine will be detected as "codeine" or "codeine and morphine" with codeine in greater proportion.

- Codeine positive. This result not only reflects codeine use but may also reflect heroin use, because heroin contains a small amount of codeine. It is more likely that heroin will be detected as morphine and codeine with a greater proportion of morphine.

- Summary: Heroin = morphine, or morphine/codeine; codeine = codeine or codeine/morphine.

Other test results are generally self-explanatory. Most drugs will be detected within 72 hours of use. Some drugs, like marijuana or PCP, are stored in the body's fat and can be detected up to several weeks after last use. Drugs used in large quantity or over a long period of time are more likely to be detected for a longer time subsequent to use. "Qualitative" tests indicate the presence or absence of a drug or its metabolites in the body; "quantitative" tests indicate the amount of a substance in the body. Quantitative tests are not necessary for the methadone program urine screening.

Occasionally a test will be reported as having "low specific gravity." This means that the specimen is rather "watery." This can indicate the patient had drunk a lot of fluid just prior to the urine tests, or that the specimen was diluted with water.

Poppy seeds (even as little as a teaspoon) can result in a morphine positive test. Methadone patients should be advised against eating poppy seeds to avoid possible dirty tests.

Dealing with a positive urine test

An unexpected positive urine is an extremely significant event in treatment. It might mean that there has been an occasion of use or it might indicate a return to chronic use. In response to a positive result:

a. Re-evaluate the period of time surrounding the test. Were there other indications of a problem such as missed appointments, unusual behavior, discussions in treatment session/group, or family reports of unusual activity?

b. Don't confront the patient. Rather, give him/her the opportunity to explain the result. For example, "I received a positive test from the lab on your urine test from last Monday. Did anything happen that weekend you forgot to tell me about?"

c. Don't get into a discussion about the validity of the results (e.g., the lab made an error, the bottle was mixed up with another patient's). Move on to other issues.

d. Regardless of the patient's explanation, or lack of explanation, be assured that there was at least one instance of drug use. It might be necessary then to temporarily increase the frequency of testing to determine the extent of use.

Some patients will admit to the drug use. This honesty should be reinforced and cited for its therapeutic importance. This interaction may occasionally result in admissions of other instances of drug use that had gone undetected.

Sometimes a patient will respond with a partial confession of drug use. For instance, he/she ran into an old connection but didn't use. These partial confessions are often the closest the patient can get to actually admitting drug use. You need not attempt to elicit the entire confession but may assume that there was drug use and move on to other issues.

Occasionally, a patient will react angrily. Typically there is an accusation of lack of trust on the counselor's part and indignation at the suggestion of drug use. (These reactions may be very convincing and may cause the counselor to initially react defensively.) Inform the patient of the necessity of discussing the positive urine result and that the questioning is in his/her best interest. You should attempt to move on to other issues. At some other time, the topic of truthfulness should be discussed and the patient given an opportunity to discuss the urine result.

If there are repeated positive test results, it may be necessary to be somewhat confrontational. Even if the patient denies drug use, you must proceed as if there were use.

Your confidence and certainty of the result are critical at this point and may be instrumental in inducing an honest explanation of what has been happening. In all cases you must proceed with necessary actions regarding take-homes.

Falsified specimens.

Occasionally, a patient will attempt to conceal drug use by tampering with a specimen. This includes submitting watered-down urine, a substance (usually tapwater) other than urine, or sometimes someone else's urine. The tampered specimen is usually obvious by appearance (clear, lacking in yellow coloration) or temperature (bottle too cold to be body temperature) or indicated by a "methadone only" or "negative for methadone and methadone metabolite result." At the time the specimen is given, the patient should be taken into a private setting and asked why he/she has given a false sample. The patient can either discuss what happened or give another sample. If there is a recurring problem with a patient it may be necessary to observe him/her giving the sample.

Falsified specimens are an indication of drug use. Patients who are involved with specimen tampering rarely admit it. This is a critical situation in treatment and may signal a serious relapse. The drug use, combined with the concealment of the truth, may reflect a breakdown of the therapeutic process. Observing the patient while he/she is providing the specimen is a last resort attempt at establishing what is actually happening with regard to drug use and also at encouraging truthfulness.

A much less serious instance of urine tampering is the patient attempting to avoid giving the specimen altogether. Patients who claim that they are unable to urinate ("I just went before I got here."; "Can I give it to you next time?"; "I just can't go.") or those who seem overeager to get to the lavatory to establish an empty-bladder alibi may be trying to conceal drug use. It may be necessary to offer the patient water or other beverage and ask him/her to wait until urination is possible or return later the same day. If the patient fails to submit a specimen you must proceed as though a dirty test were given.

Observed urines.

If a situation warrants observing a urine, ask a supervisor for approval and direction. This is an uncomfortable exercise and may be humiliating for the patient. It should be explained to the patient that urines are observed occasionally in order to establish, with certainty, the validity of the urine test. If the patient gives hot, cold, or clear specimens, he/she should be told that there was some uncertainty about the recent specimen. Be non-accusative. Try to make the patient comfortable but avoid tension-relieving jokes that might communicate the wrong message about the seriousness of what is going on.

It is not necessary to literally observe urination. Being in the lavatory deters the activities involved in falsifying a specimen (e.g., pouring another liquid into the specimen bottle, using hot tap water to heat up the specimen container). It may take some time before the patient is able or willing to urinate. Take your time. It may be necessary to return to the office for more beverages and try again.

It is important to view observation as a therapeutic activity. It may be the only meaningful patient-counselor interaction that is occurring if there has been an interruption of the recovery process. In many cases, observation will move the patient back on track and prompt a truth telling.

Observing urine testing is a last resort for patients who are struggling with the recovery process. If it succeeds in documenting drug use and allows the patient and counselor to begin dealing with it, it will have served a valuable function.

Dealing With Opiate Use

Opiates include heroin, morphine, codeine, oxycodone (Percodan), hydrocodone (Vicodin), hydromorphone (Dilaudid), meperidine (Demerol), propoxyphene (Darvon), and pentazocine (Talwin). Patients sometimes continue other opiate use after entering treatment or they relapse to opiate use during the course of treatment.

Indications of use

- Urine tests. Urine tests are discussed above.

- Arm checks. Arm checks should be performed periodically, particularly if there is a suspicion of urine tampering or indications of use not reflected by urine. Arm checks should be performed routinely by nursing staff, but counselors should be trained by medical staff in recognition and interpretation of needlemarks. An armcheck should be performed matter-of-factly and requested in a non-threatening manner such as "let's see how your arms are looking today." Patients are usually very willing to point out needlemarks at admission in order to document evidence of current use. If the counselor has an opportunity to ask new patients to see marks, he/she can acquire greater familiarity with needlemarks and also find out where patients tend to inject. The latter information may be useful at some later time when the armcheck may be necessary to document heroin use.

- Old marks and scars. These are not relevant to current use. These scarred or discolored areas are sites of past injection and reflect long-term, heavy use.

- Fresh and recent marks. These appear as either pink areas or as scabbed over areas. Injections within 24 hours will appear as tiny pink dots. Between 24 to 72 hours these dots will scab over. The most likely areas to observe needlemarks are: the antecubital spaces (the insides of the elbow, the "pit"); the forearms, wrists, or hands; less often marks may be found on the feet, legs, or neck. Counselors would normally not perform needlemark checks anywhere except the arms.

  Doing an arm check can cause a counselor some discomfort, and can feel like an inappropriate personal intrusion. However, there are times when the critical issue in counseling is the identification of drug use and sometimes the armcheck is the only way

to do so. In these cases, the arm check is a necessary procedure in helping the patient to begin dealing with drug use and the problems that are contributing to the use.

- Prescriptions. Patients sometimes present prescriptions from outside physicians for pain problems or coughs. It is advisable to have the program physician review such prescriptions to advise on the necessity of opiate-containing medications. In many cases over-the-counter remedies or non-opiate medications may be equally effective. In cases where patients are seeing outside physicians or dentists, it may be helpful to provide patients with an introductory letter informing the practitioner that the patient is on methadone and offering some general guidelines. A sample letter is shown in the following pages. (Ref. Zweben and Payte 1990.)

Sample letter to physicians and dentists treating patients on methadone maintenance

Dear Dr._____:

The bearer of this letter is a patient in a methadone maintenance treatment program. Methadone-maintained patients occasionally need treatment for medical, psychiatric, surgical, and dental conditions. Health professionals are not always familiar with addictive disease and the various forms of treatment, including methadone. In some cases the reaction to methadone-maintained patients is based on fear, anger, prejudice, disgust, or other negative subjective responses, none of which contribute to providing quality health care. Many patients are reluctant to provide information to health professionals about their addiction and treatment with methadone because of previous bad experiences. The purpose of this letter is to describe the most common problems encountered and to offer any assistance we might be able to provide.

Addiction is now widely accepted to be a disease or a group of diseases. Addictive disease can be characterized as a chronic, progressive, probably incurable, and often fatal disorder. The principal diagnostic features are obsession, compulsion, and continued use despite adverse consequences (loss of control). Our program provides counseling services to help the patient make the life-style changes needed to address the many dimensions of this disorder.

Methadone has been used in the treatment of opiate dependence for about 25 years. Its long-term administration has been found to be both effective and safe. Methadone-maintained patients develop nearly complete tolerance to the analgesic, sedative, and euphorigenic effects of methadone at an established maintenance dose. Tolerance doe not develop to the effect of preventing the onset of the abstinence syndrome. Methadone has a half-life in excess of 24 hours. It has a relatively flat blood plasma level curve that will prevent the onset of the abstinence syndrome for more than 24 hours without causing any sedation, euphoria, or impairment of function.

The management of pain in a methadone-maintained patient is the most common problem we encounter. Because the patient is fully tolerant to the maintenance dose of methadone, no analgesia is realized from the regular dose of additional analgesia. Nonnarcotic analgesics should be used when pain is not severe. In the event of more severe pain, the use of opiate-agonist drugs is appropriate. The dose of an opiate-agonist drug may need to be increased because of the cross-tolerance to methadone. Also, the duration of analgesic may be less than usual. Opiate-agonist antagonist drugs such as pentazocine (Talwin), butorphanol tartrate (Stadol), and nalbuphine hydrochloride (Nubain) should never be used in a methadone-tolerant person. Severe opiate abstinence syndrome can be precipitated by drugs of this type.

The administration of opiate-agonist drugs should be closely supervised in terms of quantities and duration. Prescribing for self-administration by the patient should be avoided. If it is absolutely necessary to prescribe for self-administration, the amount should be for no more than 24 hours and refills carefully controlled. Similar precautions are indicated in the prescribing of sedative-hypnotic and central nervous system-stimulating drugs. The abuse potential of all benzodiazepines is high.

At times admitting physicians are tempted to treat the opiate dependence itself. This is usually attempted by doing a graded reduction of methadone dose. If successful, the graded reduction may result in a reduction or elimination of the physiologic dependence, but it has no effect on the disease itself. Even after the methadone treatment is discontinued, significant signs and symptoms of abstinence may persist for several weeks. The relapse rate associated with detoxification alone approaches 100%. A relapse to street or illicit drugs increases the risk of overdose, hepatitis, AIDS, and a host of other biomedical, psychosocial, and legal complications.

Under some circumstances an intervention can be accomplished during a hospital stay for other conditions. Such a process should involve experienced professionals with a strong emphasis on continuity of care on discharge.

If you have any questions or concerns about our mutual patient in relation to methadone or drug dependence, please call us. We would be delighted to hear from you.

Sincerely,

Counseling Approaches

We have discussed some counseling approaches for dealing with illicit opiate use in Chapter II and earlier in this chapter. Contingency contracting is built into methadone maintenance treatment by virtue of take-home regulations. Contingencies for acquiring and restoring take-homes should be made clear to the patient. Other methods are described in the next section on other drugs and alcohol use. In addition, you may need to focus on general issues involving stress and lifestyle that might contribute to illicit opiate use, using methods described earlier in this chapter.

Dealing with continued drug or alcohol use can be very difficult and all too common. Zweben (1991) offers the following to help counselors in approaching such patients from a realistic perspective. She also describes two cases of positive change with chronic users.

The patient who continues to use heroin, alcohol, or other drugs problematically is a frequent source of frustration for counselors. It is common for counselors with a limited repertoire of clinical skills to fall back on power tactics when initial efforts meet with resistance. It is important to remember that many patients have long histories of drug use and are deeply embedded in the drug culture; it is unrealistic to expect rapid responses to treatment. Nonetheless, the pursuit of a blend of clinical exploration and appropriate limit-setting can prove to be beneficial, as in the following case report:

John is a 35-year old multiple drug abuser who was involved with one drug or another since the age of 16. At the time of admission to MMT, he had been using heroin for nine years and was also using marijuana regularly. He had made a previous treatment attempt but stated that he never felt any therapeutic effect from methadone in that program because of their policy to maintain a ceiling dose of 40 mg. At the time of the current admission, his dose was quickly raised to 80 mg. However, he continued to test positive for opiates and reported an inability to stop his heroin use. He routinely avoided his counseling appointments and complained about methadone when he did appear. At the same time, he would express guilt at not being able to stop using heroin. He was quite frightened at the notion of losing the sedation he had created since early adolescence, fearing the long-suppressed affect he had avoided for nearly two decades. He attributed his avoidance of counseling sessions to the same thing.

Gradually he began expressing a growing desire to decrease his heroin use. After attending the program for nine months, he was again referred to the physician who raised his dose to 100 mg. Shortly after that he provided his first clean urine test since entering the program. Although still using heroin episodically, he reports being able to "feel" the methadone for the first time. His nocturnal withdrawal symptoms are diminishing, his insomnia is less severe, he is beginning to attend Narcotics Anonymous meetings, and he is showing up for counseling more consistently. Most importantly, he states that for the first time he can imagine attaining a drug-free lifestyle. He has a long way to go yet in his recovery, but he has finally made a start.

An important feature of this counselor's work was probably a willingness to build on small gains to develop the patient's motivation for abstinence, initially manifested by his gradual admission of guilt over continued heroin use. One may expect the client's fear of experiencing feelings to be a recurrent theme. Although some patients report that methadone dampens their feeling states,

Another counselor demonstrated one way of addressing this issue:

Rachel had a long-term history of using a variety of drugs, but had settled on heroin for the past seven years before admission to MMT. She had gradually reduced her heroin use, but was still using regularly. The counselor utilized the technique of Gestalt dialogues to encourage "Clean Rachel" to talk with "Dirty Rachel." Gradually these two separate self-images began to be clarified, along with the patient's ambivalence about stopping heroin use. The patient conceded the year 1989 to "Dirty Rachel," but that seemed to give her renewed energy for 1990. During the first half of 1990, she was able to gradually increase the length of clean time, claiming weeks and then months for "Clean Rachel." Receiving take-home doses for the first time increased the vigor of "Clean Rachel", who claimed 1990 for herself and is able to examine for the first time the negative self-images that have pervaded this and many other areas of her life.

These vignettes illustrate the importance of maintaining a long-term perspective and an appreciation of the extent to which many MMT patients do not believe a better life is possible for them. This view is reinforced by a history of physical and/or sexual abuse and parental alcohol and other drug abuse, which often makes a drug-free lifestyle seem unachievable. As a counselor you must work gradually to install hope and to address resistances, such as the reluctance to commit to abstinence to avoid another treatment failure experience.

Dealing with Alcohol and Other Drug Use

Some of the regulatory requirements related to drug and alcohol use are covered earlier in this chapter in the section on take-homes. This section deals with more general and clinical issues in the use of non-opiate, illicit drug use and alcohol use.

Classes of drugs

Stimulants. The most common stimulants are cocaine, crack, rock, freebase, methamphetamines, crystal, crank, and, in some areas ice. These drugs produce increased arousal accompanied by a sense of confidence and euphoria. As use continues over a prolonged binge, the user may become irrational, agitated, and paranoid. Patterns of use can vary from occasional weekend use to binges lasting several days. The stimulant user may appear at the clinic in a state of hyperactivity, agitation, or exhaustion. Patients with extreme stimulant addictions may miss dosing due to exhaustion or an inability to interrupt binge episodes.

Stimulants, particularly cocaine, can be used in combination with heroin (speedball). They can be snorted, injected, smoked, or eaten. Because there is no built-in overdose limit (as with heroin) to the amount of stimulants that a person can take, users often ingest large amounts over long periods of time. If they are using IV, this results in numerous injections and increased risks of the medical consequences associated with IV drug use.

- Indications of use: urine tests that are positive for cocaine or amphetamine; weight loss; numerous needle marks; exhausted appearance; missed clinic appointments; hyperactivity; talkative, agitated or paranoid behavior; increased financial, vocational, or relationship problems.

- Stimulant addiction: Heroin addicts often presume that an addiction only exists if a drug needs to be taken all of the time. Because the pattern of addiction associated with stimulant use need not involve uninterrupted drug-taking in order to avoid withdrawal, it is common for opiate addicts to deny addiction. Stimulant addiction is characterized by regular episodes of out-of-control use despite increasing negative consequences associated with use. (This type of addiction is discussed in the next section of this chapter).

- Interactions with methadone: No interactions with methadone, but the person using stimulants runs the risk of developing a separate new addiction that would not be helped by methadone.

Sedatives, hypnotics, tranquilizers. These are generally called "downers." They are usually prescription drugs designed to reduce anxiety or facilitate sleep. When abused, they induce a sedated, intoxicated state that may eventually result in sleep. The most commonly abused drugs in this class are: the benzodiazepines (Valium, Xanax, Ativan, Halcion, Dalmane, Restoril, and others), barbiturates (phenobarbital, seconal, nembutal, Fiornal, Tuinal), and sleeping pills such as Placidyl, Doriden, quaaludes (no longer available in the U.S. through prescription), and chloral hydrate. All are normally taken in pill form but can sometimes be injected.

Patterns of use can vary from occasional use to physical addiction. An addiction to these drugs would not be alleviated through methadone. They are not in the same class of drugs with opiates, and an opiate addict could develop a second addiction to these drugs.

- Indications of use: urine tests positive for benzodiazepines or barbiturates; intoxicated appearance without the odor of alcohol (or with negative breath alcohol test); in some cases complaints or anxiety and insomnia coupled with requests to see program physician or coupled with prescriptions from outside physicians.

- Sedative-Hypnotic addiction: Addiction to these drugs is similar to opiate addiction, in that there is a tissue dependence, or physical addiction, resulting in a need to maintain a sufficient amount of the drug in the system at all times in order to avoid physical withdrawal. The consequences of an abrupt discontinuation of these drugs can be a life-threatening withdrawal syndrome including seizures. Medical intervention is always necessary in cases of addiction to these drugs. Counselors should never advise patients addicted to these drugs to stop on their own. Short of physical addiction, patients may have a dependency upon these drugs resulting in periodic intoxication, or abuse associated with access to the drugs.

- Interactions with methadone: Because both sedative/hypnotic drugs and methadone depress the heart rate and breathing, there is an increased risk of overdose from this combination of drugs. A tolerable amount of Valium, for example, for a person who is not on methadone may be a dangerous amount for the same person on methadone.

Marijuana, Hallucinogens. These include marijuana, hashish (hash), LSD, ecstasy, peyote, and mushrooms. The significance of the use of these drugs has historically been downplayed by both patients and treatment staff. Opiate addicts and staff often fail to see significant detrimental effects resulting from use of these drugs, and staff sometimes feel uncomfortable confronting their use because of their own use. However, there are

detrimental effects related to the use of these drugs, ranging from addiction, to impairment of functioning, to impedance of the achievement of higher quality of life.

- Indications of use: urine tests positive for THC (tetrahydrocannabinol, the active ingredient in marijuana and its derivatives), bloodshot eyes and the odor of marijuana, unusual behavior and expressions of strange ideas. Except for THC, urine tests will not detect other hallucinogen use.

- Marijuana addiction: Addiction to other drugs in this class is extremely rare. Marijuana addiction is not uncommon but it is not often identified by the user as an addiction. However, the daily marijuana or hash smoker will experience a withdrawal syndrome characterized by roughly 30 days of irritability, insomnia, and craving. Moreover, after discontinuing for 30 to 60 days, many of these addicts become aware of the cognitive impairment and reduced motivation caused by chronic marijuana use.

- Interaction with methadone: There does not appear to be any interaction with methadone.

Other drugs. PCP and "designer" drugs are also an issue for the MMT patient.

- PCP (phencyclidine, angel dust, sherms, or sometimes inaccurately called THC) affects users at different times as a stimulant, hallucinogen, analgesic, or sedative. Although the strange hallucinogenic effects accompanied by violence are most commonly reported by the media, the PCP addict usually reports stimulant effects and uses in a pattern similar to that of the stimulant addict. However, although the PCP withdrawal syndrome is very similar to that of stimulants, it does produce a variety of other effects unlike those of stimulants. PCP is definitely addictive; it can be snorted, smoked, eaten or injected. It is fat soluble, so it takes a while to leave the system and will show up in the urine for a couple of weeks following use.

- Designer drugs are synthetically manufactured substances that mimic other drugs (e.g., synthetic opiates) or produce new effects (e.g., ecstasy). These may not be detected through urine screening but may produce effects similar to known substances. If effects of a designer drug were to mimic opiates, then approaches to the use should be similar to approaches to known opiates.

Alcohol. Alcohol use is often a problem with methadone patients. There is a widely-held misconception that methadone increases alcohol use. However, a study by Anglin and his colleagues found that increased alcohol consumption was associated with periods of not using heroin, rather than using methadone. Programs have often been inappropriately tolerant of patients' drinking because alcohol does not show up on urine

screens, because it is legal, because "it's better than using heroin", or because of staff's own use of alcohol.

Patterns of alcohol use can range from occasional episodes to daily heavy drinking. Dependence can vary from periodic use that cannot be controlled, moderated, or stopped, to physical dependence that cannot be stopped without significant and dangerous withdrawal.

- Indications of use: sedated, intoxicated appearance, alcohol odor, positive breath test for alcohol. It is highly advisable that counselors use breathalyzers to determine irrefutably if a patient is under the influence of alcohol. Programs can improve treatment by randomly breath-testing all patients weekly and breath-testing patients who blow a positive test before each dose.

Standard explanations patients offer for positive breath include:

"*I just used some mouthwash.*" Mouthwash with alcohol will result in a positive breath test if the test is given very shortly (less than 15 minutes) after the mouthwash is used. However, rinsing out the mouth with water will eliminate this test result.

"*I used Nyquil* (or other cold medicine with alcohol.") An ingestion of Nyquil or similar cold medicine within an hour or two prior to breath testing may result in a low positive test. Patients should be advised against these medications and reminded that only very low readings can be explained by these cold medicines.

"*I only had a couple of beers.*" The level of the breath test result is related both the amount and recency of drinking. "Only a couple of beers" would account for a relatively low reading if the drinking occurred more then two hours prior to testing. An admission of any drinking prior to morning dosing brings the question of alcoholism into the picture.

Generally, the excuses can be ignored. Your response should be to closely monitor the patient for further evidence of drinking. You need not explicitly reject the patient's excuses but should proceed with the possibility that the patients has a drinking problem, and intensify monitoring.

- Indications of addiction: Physical addiction to alcohol is characterized by a need to maintain alcohol in the system to prevent physical withdrawal. As with sedative-hypnotics, abrupt discontinuation of alcohol can be dangerous in cases of physical addiction; medically supervised withdrawal is necessary in these cases. Repeated positive breath alcohol tests, particularly in the morning, indicate physical addiction. The Alcohol Intake Prescreening Instrument to assess physical dependency is included in the appendix to this chapter.

- Interaction with methadone: As with sedatives/hypnotics, there is an increased risk of overdose due to the combined depressant effects of alcohol and methadone. Similarly, patients may develop a dual addiction to alcohol and opiates.

  Alcohol interferes with the metabolism of methadone. A patient who is drinking may be either over-medicated or sick as a result. Because alcohol initially slows down the breakdown of methadone, the patient may feel sedated, as if the dose were higher that it actually is. However, after a while the metabolism of the methadone will be speeded up due to an increase in liver-enzymes caused by alcohol. This will result in a feeling of the dose being lower than it actually is or of its wearing off to soon. Patients who abuse alcohol are often motivated to reduce or stop drinking when they are told that the alcohol is in effect "cutting your dose."

Episodic chemical dependencies

Heroin addicts have no trouble understanding physical addiction. They have experienced tissue dependence with opiates and can recognize the same sort of addiction when it occurs with other substances, such as Valium or alcohol. However, they are often reluctant to describe chemical dependencies that are less than tissue- dependent as being "addictions" or even "problems." As a counselor, you need to be clear on the nature of episodic chemical dependencies in order to avoid minimizing the patient's problems and inadvertently participating in the patient's denial.

The key factor in the patient's minimizing of episodic drug or alcohol use is in the statement "but I don't need to use (or drink) all the time" or "I only use or drink on the weekends." Drug problems are understood to be like heroin addiction or else they are not actually problems.

You must be able to help patients identify the existence of problems associated with episodic drug or alcohol use. A useful approach is to examine the consequences of the drug or alcohol use and to probe the patient's attitude about the use. For example, does the patient sometimes wish that he/she was not using a particular substance but then at other times rationalize "one more time?"

To determine whether there is a problem, ask the patient to list the positive and the negative consequences of use. For the weekend cocaine user, positives might include: good times, euphoria, sex, and something to do. Negatives might be: fatigue, job loss, relationship problems, being broke, paranoia, depression, getting arrested. Hopefully, this person could be encouraged to see that the negatives outweigh the positives.

A person who continues to use despite mounting negative results is out of control. In this case, the addiction is not reflected by a need to use in order to avoid being sick; rather, it is characterized by an inability to not use in certain circumstances. Cravings mount, thinking becomes irrational, and using or drinking occurs. (The Cocaine Problem Severity Index may be useful in determining the extent of a cocaine problem; see appendix.)

One way of explaining these types of addictions is in light of the higher brain versus the lower brain. The higher, rational, brain decides to stop using; the lower, pleasure-center part of the brain becomes triggered by people, places and circumstances that had been associated with drug and alcohol use. The weekend cocaine user's higher brain decides to quit on Monday, but on Friday as he gets paid, sees his using friends, and the lower brain becomes triggered, craving occurs, and use follows.

This type of an explanation can help patients see that it is not so much that they don't use cocaine from Monday through Thursday but that they are unable to avoid using on Friday. The fact that a part of the brain is responsible for this helps in introducing a physical aspect to the addictions. (Handouts developed by Rawson and his colleagues explaining the process of addiction to cocaine are included in the appendix to this chapter.)

Counseling approaches for dealing with non-opiate drug use or alcohol use

Detoxification. In cases of physical addiction, the initial treatment need will be medically supervised withdrawal. Patients in this category should be referred to medical staff. Counselors should remain integrally involved with their patients throughout the detoxification. You should help them remember days and times of medical visits, check with medical staff to monitor compliance and progress, and provide encouragement and support in daily counseling sessions throughout detoxification. Following detoxification, you should deal with the patient's drug and alcohol problems in the same way as with episodic users or drinkers.

Avoiding triggers. A practical, straightforward approach to these drug and alcohol problems can be very effective: avoiding the triggers that cause them. Some patients expect or prefer an approach that looks for the "real" reasons for their using or drinking, and counselors sometimes oblige. Too often, however, counselors lack the training to probe psychodynamic or family-history issues that theoretically have resulted in chemical dependencies. Moreover, in many cases the resolution of these deeper issues does not result in changes in drug and alcohol use.

The approach suggested is based upon the premise that the brain will react to drug and alcohol triggers, craving will occur, and drug and alcohol use will continue. To help patients, the counselor needs to investigate the pattern of use:

- When does the use occur?
- With whom does it happen?
- Where does it occur?
- What circumstances (e.g., money, sexual arousal, anger) trigger cravings?

For a weekend cocaine addict, triggers might be:

- When: Friday night
- With whom: Friend from work
- Where: Outside bar
- What circumstances: Payday, after 3 or 4 drinks, argument with wife.

The counselor should ask questions surrounding recent use and typical using situations. (External Trigger Questionnaire and Internal Trigger Questionnaire are included in the appendix to this chapter.) After thoroughly investigating the pattern of using/drinking, you can use the Trigger Chart (see appendix) to clearly indicate the safe vs. risky situations related to the using.

It should be emphasized that will power alone cannot prevent continued drug or alcohol use. Because the brain has been affected, changes in behavior need to occur in order for changes in drug or alcohol use to follow.

Relapse prevention. Just as drug and alcohol use occurs predictably, relapse can be predicted. Patients should be taught the concepts of relapse prevention. They can learn to identify changes in thinking, emotions, and behavior that signal a return to old ways. The idea of "recovery"--as opposed to just not using or drinking--is also relevant here. Patients should be encouraged to try new leisure activities, work on goals and values, attend 12-step meetings, and generally develop a higher quality of life.

Handouts dealing with relapse prevention are included in the appendix. The handouts can be used to provide a framework for discussing some of the important issues in relapse prevention. They should be used in a casual versus formal, teacher-like way. The overriding message from the counselor should be that the counselor will help in figuring out ways to facilitate staying clean and sober.

If relapse does occur, you and the patient should discuss in detail the events leading up to it. Drug or alcohol use doesn't "just happen," as is often the initial explanation. Understanding how a relapse happened is the first step in preventing further instances of use. A Relapse Analysis form (see appendix) can help the patient identify the circumstance

that led to the relapse. A plan for preventing future relapses can then be formulated. Ask the patient what he/she would have done differently to prevent the relapse and what can be done in the future if similar circumstances come up.

Antabuse treatment. Antabuse or disulfiram is a medication sometimes used to treat alcohol problems. When a person who is taking Antabuse drinks, he/she becomes very sick. The purpose of Antabuse is to prevent drinking. Because the person on Antabuse knows he/she will become sick, drinking usually stops and alcohol cravings diminish or disappear.

Some patients request Antabuse because it helps them to not drink. Others may be prescribed Antabuse as a condition of staying on the methadone program because they are abusing alcohol. Counselors who are working with patients who are taking Antabuse need to know some basic information about Antabuse and work closely with the medical staff.

Facts about Antabuse

- A person must have no alcohol in the system before beginning Antabuse treatment; otherwise, the medication will cause sickness. Usually, 24 hours since the last drink and a negative breath-alcohol test indicate readiness for Antabuse. (Some common sources of alcohol, apart from alcoholic beverages are: cold medicines, mouthwash, some salad dressings, and wine sauces if not cooked.)

- If a person does not have alcohol in his/her system, the medication usually will cause no effect.

- Some people report a metallic or garlic taste during the first few weeks of Antabuse treatment.

- Alcohol in any form can cause a reaction because Antabuse interrupts the metabolism, or breakdown, of alcohol, resulting in a build-up of toxins in the person. The severity of the reaction is related to the amount of Antabuse in the system and the amount of alcohol taken.

- The results of drinking on Antabuse can be of a severity to require medical attention.

- Some patients fail to take the Antabuse regularly or plan to take it when they feel a need to. This does not work. The medication should be taken daily.

- Some patients avoid taking Antabuse so they can continue drinking. If you notice evidence of drinking with a patient who is supposed to be taking Antabuse, notify the nursing staff. Some patients may need to take their Antabuse at the dosing window. Still others may have the Antabuse mixed in with their methadone dose to assure compliance.

Counselors should recognize that Antabuse allows sobriety but does not ensure "recovery." Patients on Antabuse should be encouraged to avoid alcohol-related situations and to explore reasons behind their drinking, to investigate new ways of coping with problems, and work on developing new leisure activities and a higher quality of life.

Tapering Off Methadone

(Much of the material in this section has been excerpted or adapted from Methadone Maintenance to Abstinence: The Tapering Network Project Manual, unpublished manuscript, University of California, San Francisco, 1986. The Authors are Stephen Brummett, Roland Dumontet, Laurie Wermuth, Marc Gold, James L. Sorensen, Steven Batki, Rome Dennis, and Richard Heaphy. The manual was sponsored by a grant from the National Institute on Drug Abuse).

In the current state regulations the ultimate goal of treatment is to eliminate dependency on all drugs, including methadone. Some patients on methadone maintenance will ask to be taken off the treatment. Long-term opiate users, however, face multiple barriers to successful tapering off. Many have not been drug free since adolescence, and by adulthood the drug use has had a marked impact on lifestyle, self-esteem, brain chemistry, and psychological and social functioning. Most patients lack confidence in their ability to taper off successfully and fear losing all they have gained while in maintenance--including jobs, relationships, money and health; indeed, many attribute their current success and control over their lives to being on methadone. Spouses and other family members may also fear relapse enough to dissuade the patient from tapering off.

Many fears surrounding tapering off are well founded, since most patients who attempt to detoxify from methadone are unsuccessful. It is important for counselors to provide good advice to patients who are considering tapering off, to help those who are, and to provide direction to patients who are unable to successfully complete an attempt.

Evaluating readiness.

Patients who express a desire to get off methadone should be evaluated for readiness. The timing of an attempt to taper off is important. In some cases, it is better to advise patients to delay until a time when factors that promote successful outcome are in place. Counselors should not automatically, approach a desire to get off methadone as a good idea (only 10% to 20% successfully achieve long-term abstinence). Getting off methadone too often translates into getting back on heroin.

A Tapering Readiness Inventory is included in the chapter appendix. You should go over it with any patient who is considering tapering off. In discussing the Readiness Inventory, you should stress that there are no assurances of success or failure. There are, however, some indications of a greater or lesser likelihood of success.

Pharmacologic adjuncts.

Many patients benefit from additional medication over the course of tapering off (particularly when dose levels go below 15-20 mg.); most need medication to help with the first 7-14 days after the final methadone dose. The counselor should discuss the patient's tapering-off plans with the medical staff and monitor the patient's medical appointments.

Preparing the patient.

Patients and family members should be made aware of the difficulty and problems associated with tapering off. These are some problems and suggested ways of discussing each with the patient and family:

- Craving. Craving is an important, common, and dangerous problem with tapering off. People giving up methadone may find that they are craving for a variety of substances, some of which they haven't wanted in years. Drug craving is to be expected. The most effective way to overcome craving is to develop the ability to deal with stress without using drugs before beginning a taper. Then you (the patient) will be confident that you can deal with the desire to use drugs. It's also helpful to have someone you can talk to about the craving. When all else fails, hang in there just a little longer; take things a step at a time. As the saying goes: "By the mile life's a trial, by the yard life is hard, but by the inch life's a cinch!"

- Anxiety. Anxiety is natural and to be expected. Getting off methadone is a big step. It's natural to worry, to feel unsure, even to experience a sense of doom occasionally. During periods of stress, even at high methadone doses, you may experience withdrawal symptoms. This is known as "pseudowithdrawal," and is eased when you relax.

- Emotional unsteadiness. When coming off methadone, a person may go from feeling very happy to very sad in an instant. Thoughts may intrude themselves into your consciousness. This is a natural part of withdrawal, related to both chemical changes and to the significance of the event. It is helpful to have a mental health professional available, like a clinic doctor or counselor, who can assess the seriousness of the mood swings and help you deal with them.

- Impatience. With all that people go through in withdrawal, it's not surprising that they don't have a great deal of tolerance for frustration during this time. They may seem to have a short fuse or not want wait for anything. This becomes dangerous only when people try to "con" themselves by saying things like "this tapering is so difficult, I want to hurry up and get it over. I'm going to quit methadone now, rather than tapering off slowly." That kind of thinking is a sign that you are in trouble. That's a time when it is helpful to have a close friend or counselor who can help you check out your thinking.

- Withdrawal Symptoms. Because methadone is a longer-acting narcotic than heroin, the withdrawal symptoms will not be as severe but they will last longer. Every ex-addict knows what these involve--aches, problems with sleep, diarrhea, runny nose, teary eyes. To nonusers, these are best compared to having a very bad case of the flu. The best ways to deal with these symptoms are to be in good health in the first place; to eat well; to exercise; and to use nondrug aids like acupuncture, massage, hot baths, and vitamins. Try these activities. They will help relieve symptoms without the use of illicit drugs. If you are receiving medication from the medical staff to assist with the detox, make sure to follow medical direction and stay in close contact with the staff monitoring your progress and adjusting medication.

- Old aches, new pains. Some people compare being on methadone to being in a protective cocoon, where experiences are buffered by the medication. Coming off methadone exposes you to new experiences, not all of which are good. For example, as the dose comes down, a person may experience pain around an old bullet wound--pain that he/she didn't feel when at higher doses of methadone, or didn't notice when using heroin. Another frequent source of problems is the teeth, which may ache. These are natural problems of living clean as an ex-addict, and you should get them checked out medically to see if there is a solution.

- Isolation. One natural reaction to all this stress is to cut ties with the outside world. This is not generally a healthy reaction. Just as it is not wise for a depressed person to be alone, a tapering off addict alone is in bad company. People tapering off from methadone can seek out consolation from people who do not have a drug problem; people in their support system can offer reassurance. Silence is the enemy of recovery.

Counseling strategies to facilitate tapering off.

As the dose decreases, the frequency of contact needs to increase. In a sense, the "dose" of counseling contact must offset the reduced dose of methadone. During the final two weeks of tapering off, daily visits are advisable. Some important daily rules for patients who are tapering off are:

- If things get super-rough, hang on just a little longer. Every minute you hold on in the face of misery or panic makes you stronger. Then hold on just another five minutes, and keep hanging on! Eventually, you will make it.

- Try to remember, always, you're not the Lone Ranger. Everything you are experiencing, no matter how weird, others have experienced and survived.

- Don't hang out with drug users. You will get their vibrations, and you yourself will get the craving again.

- You can never use drugs again, not even once. An ex-addict can never use a narcotic again, not even that innocent-looking little codeine pill the dentist wants to give you. Your body is abnormally sensitive to narcotic drugs, and can never have them again, not even once. Don't ever forget this, or you run the risk of wasting many years and many tears.

- If you are married, both of you have some major readjusting to do as you awaken from that narcotics dream. The "real you" is going to appear, and your mate has some shocks ahead as she or he finds out who you really are. This will cause a lot of strain on your marriage. At times one or both of you may suddenly feel that you are with a total stranger, or that you really had nothing in common except drugs, and now that you're drug free there's nothing holding you together. But relax. If you are married, you are much more to each other than just drug partners. Take it easy, be patient, tolerant, and always loving, and things will eventually be better than ever between you.

Some general advice to patients who are taping off involves learning to manage stress, and watching diet and nutrition, and exercise.

General Support. As a counselor, don't underestimate your contribution of ongoing concern, empathy, and support. The patient's physical discomfort and anxieties will increase as the "taper" proceeds, and your reassurance and sympathetic ear will be needed. Give patients a realistic expectation regarding this and dissuade them from self-medicating with alcohol, street drugs, or prescription drugs acquired outside of the program.

You need to be flexible during this time, sometimes seeing patients at times when appointments are not normally scheduled, accepting phone calls at any time, and maintaining a positive focus throughout. It can feel as though the patient is "bothering" or "demanding," but in fact he/she is simply seeking out help from the counselor instead of the connection. View these patient contacts positively; don't discourage them or display impatience or annoyance in reaction to them.

Monitor progress, regulate, or abort the taper.

Regularly review withdrawal symptoms with patients to monitor progress, discuss problems, and have a basis for referring them to the medical staff. (A Withdrawal Rating Sheet is in the chapter appendix.) Patients who report severe or persistent withdrawal should be advised to slow down the tapering-off process or possibly discuss a temporary dose increase with the medical staff.

Most patients who become impatient and wish to speed up the taper or terminate methadone to "get it over with" should be dissuaded. In some cases it might be possible to

refer patients to inpatient detoxification or discuss an abrupt discontinuation with the medical staff if they are equipped to handle this with other medications such as clonidine.

Advise aborting the taper if the patient resumes heroin use. Patients are frequently unwilling to admit to heroin use during a tapering attempt for fear that they will not be allowed to proceed with the plan. Counselors should emphasize that the person who is decreasing methadone while increasing other opiate use is going nowhere in terms of a detox. Moreover, the resumption of heroin use prior to a total discontinuation of methadone does not predict a successful post-methadone heroin abstinence.

If a patient admits to using heroin, ask to see the needle mark. Advise the patient about the danger of re-addiction to heroin and consider putting the taper on hold until another time. If the patient insists on continuing the taper, perform daily arm checks. If any new marks are observed, inform the patient that the taper is not working, inform medical staff, and reassure the patient that another attempt can be made in the future.

If the taper is stopped, discuss the following issues with the patient:

- Something has been gained from the attempt. The patient now understands more about what is involved in tapering off methadone then he/she had previously known.

- Remind the patient that the taper has resulted in a lower maintenance dose (if this is the case).

- Examine what went wrong with the attempt. Was the tapering too fast? Was the patient not being honest about his/her level of discomfort? Were things too stressful at work or at home? Was there too much drug use in the patient's environment?

- Discuss a plan for dealing with tapering off differently in light of problems with this attempt.

Aftercare Issues

The abstinence syndrome.

Patients should be prepared for a period of continued discomfort and emotional difficulty following cessation of methadone. Particularly in the initial 30 days following the last dose, patients will experience weakness, tiredness, irritability, anxiety, or insomnia. A continued low-level withdrawal syndrome accompanied by opiate cravings can be expected. Assure patients that periods of discomfort are normal and to be expected for up to 90 days following the last dose of methadone.

Naltrexone.

The risks and uncertainties of the post-methadone period can be eliminated by going on the opiate blocker naltrexone, an oral prescription medication, that blocks the effects of opiates, making it impossible to get "high" or readdicted. Naltrexone itself is not abusable or addictive. All patients who taper should be informed of the availability of naltrexone and provided with written materials explaining it (a Naltrexone Information sheet is provided in the appendix to this chapter).

Because naltrexone provides pharmacologic insurance against becoming readdicted while dealing with some of the difficulties encountered when off methadone, patients who transition from methadone to naltrexone may experience less anxiety about being off methadone. Delivering naltrexone treatment is difficult, however. Few patients are able to successfully begin naltrexone treatment, and many do not continue with it long enough. A guide to naltrexone treatment is beyond the scope of this manual. However, these are some key points regarding naltrexone treatment:

- A period of being totally opiate-free is necessary prior to beginning naltrexone. Otherwise it will cause a sudden severe withdrawal syndrome.
- Naltrexone is non-abusable, non-addictive.
- It is usually taken once per day.
- It blocks all opiates, not just heroin.
- Patients who take naltrexone report feeling better, sooner during the first several weeks off methadone than those not taking naltrexone.

- Patients on naltrexone generally report an absence of craving.
- After a period of taking naltrexone, many patients discontinue without adequate preparation. Patients should be warned about this tendency in advance.
- Patients should commit to taking naltrexone for a period of 6-months plus one month for each year of addiction.

12-step groups.

Just as all patients tapering off of methadone should be advised of naltrexone, they should also be advised regarding 12-step meetings. Patients who have had negative experiences in 12-step meetings related to their being on methadone can now feel comfortable in these groups. If your clinic does not have a 12-step meeting on-site, explain what occurs at meetings. The need for additional support after methadone should be emphasized; the emotional, social, and spiritual benefits of 12-step meetings should be discussed. If possible, enlist a recovering staff person who is or has been involved with 12-step meetings to talk about self-help to patients who are tapering. Meeting directories should be available at the clinic, and patients should be encouraged to attend several meetings during the tapering periods.

Relapse prevention.

Counselors should emphasize the need to establish a plan for relapse prevention. Thoughts, emotions, or behaviors that signal a drift toward relapse need to be taken seriously and a preventive response needs to be made.

Treatment Termination and Fair Hearing

Voluntary termination.

Termination of methadone maintenance can occur in several ways. State regulations usually require that treatment be terminated after two years unless the program physician considers it likely that the patient would return to illicit opiate use. In practice, since in most cases cessation of methadone would likely result in a resumption of using, termination rarely occurs simply on the basis of two years of treatment. However, if the program considers termination reasonable, or if the patient requests it, you should modify the treatment plan and initiate tapering off.

Involuntary termination.

Regulations provide for involuntary termination under some circumstances. If the patient is considered to be a physical threat to either other patients or staff, for example, the patient may be immediately terminated from treatment. If you become aware of any threats on other patients or staff, you must alert the program director. A counselor bears responsibility for any harm in connection with threats that are then carried out if he/she did not pass information on to the program director or to the individuals who were at risk. (See the discussion of the Tarasoff decision in Chapter II.) Counselors should always seek immediate consultations in these matters.

In cases of program-rule violations, patients may be involuntarily terminated over a 15 day period. You should know which violations--polydrug use, diversion of methadone, violence or threats of violence to staff or patients, and multiple registration--trigger termination. When such a violation occurs, consult with the program director. The patient needs to be informed in writing of the violation and the termination. When a counselor is involved in the process of involuntary termination it can seem total inconsistent with his/her role. This disciplinary stance should be viewed as necessary at times for the overall functioning of the program and the safety of other patients and staff. It is important that counselors operate with a high level of integrity and not tolerate flagrant abuses of the program which can lead to a general feeling of low esteem for the treatment and diminishment of community acceptance of methadone treatment.

Fair hearings.

A patient who is involuntarily terminated may request a fair hearing except when the termination is because of threats to the safety of staff or patients. Fair hearing procedures are described in the regulations.

Illustrative Vignettes

Eligibility criteria. (Note: this is a portrayal of a telephone call between a counselor and a patient who is looking into the methadone maintenance program. In this dialogue, notice how the counselor helps alleviate some of the patient's misconceptions, provides information about requirements to facilitate the intake, and makes a plan for follow-up contact.)

Counselor: Hello, can I help you?

Patient: I want to find out about getting on the methadone program.

Counselor: Do you know which program? There is a 21-day detox program and there is also methadone maintenance

Patient: I've been on the detox, I guess it didn't work. I want to find out about maintenance but I've heard bad things about methadone so I'm not sure.

Counselor: What have you heard?

Patient: Well I've heard it's harder to kick than heroin and that it eats away your bone marrow.

Counselor: It is addicting, and the withdrawal takes longer than heroin but it's more gradual, too. If you want to get off methadone you can gradually taper off. The rumors about "eating away your bones" just aren't true. People who withdraw from any narcotic tend to have bone aches, but that has nothing to do with the drugs destroying the bones.

Patient: I don't know-- maybe it's just as good to keep using. I mean, what's the difference whether I'm strung out on stuff or on methadone?

Counselor: There's a big difference. First of all methadone is legal. You won't get arrested for taking methadone. Second, it means not having to use needles. That means much less chance of getting AIDS. Third, you can get medical attention and counseling as part of the program, so you can make changes in your life in addition to stopping using heroin. Fourth, methadone is cheap compared to heroin, no more stealing and dealing.

Patient: Maybe so. So how do I get on your program?

Counselor: You have to have a two-year history of heroin addiction and two treatment failures.

Patient: That's easy, I've been a junkie for 10 years.

Counselor: Well, we need to have written proof that you've been addicted at least two years.

Patient: How about if my old lady writes a letter, she's been with me six years?

Counselor: It needs to be from a program, parole officer, or some other place that can document your history. When were you on our detox?

Patient: About three years ago.

Counselor: O.K., I can find that record and that will give you the two-year history and one treatment failure. Were you ever in any other treatment?

Patient: No, that's it.

Counselor: Did you ever kick in jail?

Patient: Yeah, I was picked up for under the influence and I did 30 days. I'm on parole for some other stuff now.

Counselor: Can you ask your parole officer to give you a letter saying that you did time for "under the influence"? That would be your second treatment failure.

Patient: I think so. Is that it, do I just come in and get on then?

Counselor: Well, you'll need to get the parole letter -first, then we can set up a time for intake. We'll need to see a little withdrawal on the morning of the intake. You don't need to be sick, just starting to feel it. Our intakes start at 7 a.m., so don't use after midnight and you'll be o.k. Don't use anything else or drink, either, or the doctor might not be able to give you a dose, O.K.?

Patient: Alright, what do I do next?

Counselor: Call your parole officer and I'll call you tomorrow at noon to see how you're doing. If you have problems, don't give up, talk to me about it. I can help you.

Dealing with alcohol use (In this dialogue, notice the non-confrontational, caring, and informative way the counselor deals with the patient. The patient is willing to address the problem at a dosing-issue level and the counselor begins dealing with it at this level. If drinking continues, he will move into other possible reasons behind the drinking. If he presses for "bigger" issues too soon, he may drive the patient away and generate a negative feeling towards counseling. A treatment plan is revised with the patient and a subsequent contact is scheduled.)

Counselor: Hi, Tony, how's it going?

Patient: I'm, fine. That nurse has a problem.

Counselor: Well, she said she smelled alcohol on your breath again.

Patient: That's baloney, she's got it out for me.

Counselor: Let's try and clear this up. How about blowing in the breathalyzer for me. Take a deep breath and blow out through the tube. (Patient instead inhales, then blows a short puff on the next try.)

Counselor: Tony, watch me. A deep breath then blow it all out through the tube. (Patient complies after the evasive attempts. Note, the counselor does not confront him on this but rather persists in explaining the right way. In this way counselor avoids further complications which could result by questioning the patient's motives.)

Counselor: Let's see, it reads .13%. The machine's saying you've had a few drinks today, Tony. What's up?

Patient: I used some mouthwash before I came in, I think it has alcohol in it.

Counselor: This is pretty high, Tony. You'd have to drink the mouthwash for this reading.

Patient: So I had a couple beers, big deal. I came here for help with heroin, not alcohol anyway. This is starting to piss me off.

Counselor: Tony, let's sit down and talk. Can I get you some coffee? I'll explain why we care about this.

Patient: O.K., O.K.

Counselor: Drinking in the morning to show a .13 on the breath machine makes me concerned that you have a drinking problem. Drinking is even more of a problem for guys with a heroin history because there's usually some liver damage from the heroin use and alcohol can cause further damage.

Patient: Sometimes, I'm sick in the morning before I get my dose so I have a few beers to get over.

Counselor: I understand, but you know the alcohol might be the reason you're sick in the morning. Alcohol can sort of cut your dose. It makes your system burn off the methadone faster. If you stop drinking, you might find that your dose holds you through the morning and you won't feel a need to drink.

Patient: I didn't know that, I'll see if it works.

Counselor: The most important concerns I have are about your health and about other problems alcohol can cause you. If you're drinking, you're not giving yourself a chance to benefit from this program as much as you could. Drinking will get in the way of your work, cause problems in your marriage, and hold you back from learning new ways to deal with your problems. I don't see in your record any history of drinking problems. Let's deal with it for now with regard to your dose not holding.

Patient: It's the only time I drink. If what you say is true I'll stop, no problem.

Counselor: You know, if there is another positive breath test it will count just like a dirty-urine and will affect your take homes. I'm going to ask the nurse to breath test you every day to help you keep from drinking, O.K.?

Patient: I guess. What if I'm still sick though?

Counselor: Let's make an appointment to check in with the doctor this week to evaluate your dose. I want to help you as much as I can with this. I'm going to revise your treatment plan to include drinking as a problem. Short-term goal is one week of sobriety, intervention will be daily breath testing. Long term goal is 90 days of sobriety through periodic breath tests, evaluation for dose increase or Antabuse if need be, and one AA meeting per week. I'll see you tomorrow morning.

Patient: Thanks for the help.

Appendix

Chapter III

Table of Contents

HANDOUT **FORM**

Methadone Maintenance

HANDOUT	FORM

HANDOUT **FORM**

Form Guide

Criteria for Patient Acceptance

- Maintenance Criteria Checklist

Text: Criteria for Patient Acceptance

See Pages 32 - 36

Maintenance Criteria Checklist

Patient Name: _____ Counselor: _____

Date: _____

Patient's Age: _____ (If under 18 years STOP)

Two-Year History:

Detoxification:

Location: _____

Date: _____

Records Requested: (Date): _____

Records Received: (Date): _____

Comments: _____

Other Treatments:

Location: _____

Date: _____

Records Requested: (Date): _____

Records Received: (Date): _____

Comments: _____

Arrests:

Offense: _____

Date: _____

Records Requested:
(Date): _____

Records Received:
(Date): _____

Comments: _____

Two Detox Failures:

Detoxification 1:

Location: _____

Date: _____

Records Requested: _____

Records Received: _____

Comments: _____

Detoxification 2:

Location: _____

Date: _____

Records Requested: _____

Records Received: _____

Comments: _____

Exceptions to two-year history. Check all that apply:

_____ Referred for physician evaluation

Comments: _____

_____

____ Pregnant

Comments: _____

_____

____ HIV Positive, Critically Ill, Other

Comments: _____

_____

Outcome:

___ Eligible

___ Scheduled for physical exam on: (Date) _____

___ Scheduled for next counseling appointment with:

_____ on: (Date) _____
(Counselor's Name)

___ Not eligible for maintenance- Referred to other treatment:

_____

Counselor's Signature: _____ Date: _____

Form Guide

Needs Assessment

- Worksheet for Needs Assessment
- Needs Assessment
- Problem Severity Index - Cocaine
- Problem Severity Index - Amphetamine
- Addiction Severity Index
- M.A.S.T.
- Alcohol Intake Prescreening Instrument

Text: Needs Assessment

See Pages 38 - 40

Worksheet for Needs Assessment

This needs assessment is used together with the admission form which has an extensive, detailed assessment of heroin addiction history and current use pattern. Parts of this were adapted from a patient information form provided by George E. Woody, M.D., and his group at the Philadelphia Veterans Affairs Medical Center.

Name: _____ Date: _____

I.D.: _____ Counselor: _____

Instructions: (Counselor reads to patient). Methadone treatment is an opportunity to deal with a variety of problems and achieve a number of goals. The purpose of this questionnaire is to help me determine how I can best help you. Please answer these questions as best as you can. We will discuss a plan for your program here after you finish. (Ask the patient is he/she would like help reading the form. If so, read through the form item by item.)

I. Drug Use (Review medical evaluation prior to patient interviews. Include M.D. findings below.)

A. Types of drugs used:

	# Days used in past month	Amount used on typical recent day	# Years of regular use
1. Cannabis (marihuana, hashish)	_____	_____	_____
2. Cocaine: IV, smoke or snort? _____	_____	_____	_____
3. Amphetamines (Speed, Meth, Crank, Crystal)	_____	_____	_____
4. Benzos (Valium, Xanex, Librium, etc.)	_____	_____	_____
5. Barbs (Seconal, Tuinal, Quaalude, etc.)	_____	_____	_____
6. Other Opiates (Darvon, Percocet, etc.)	_____	_____	_____
7. Hallucinogens (LSD, inhalants, etc.)	_____	_____	_____
8. Other (Specify) _____	_____	_____	_____

B. Have you ever been treated for problems with any of the above drugs?
Yes _____ No _____
If yes, which one(s): _____
_____
_____

C. Have you ever experienced overdose symptoms? Yes _____ No _____
If yes, which drug(s): _____
_____

D. How many days since last drug use? _____ Drug: _____ Amount: _____
Drug: _____ Amount: _____

E. Do you feel you have an addiction to or a problem with any of the drugs above?
Yes _____ No _____
1. If yes, which?: _____
2. Do you think you will need help to stop? Yes _____ No _____

II. Alcohol Use (Review medical evaluation prior to patient interviews. Include M.D. findings below.)

A. Drinking History
1. Number of years drinking: _____
2. Number of years of heavy drinking (4 or more drinks per day): _____
3. Kind(s) of alcohol consumed: _____
4. Amount of alcohol consumed weekly (approximate): _____
Pattern: _____ Every day _____ Binge
_____ Weekends _____ Other (Specify) _____
5. Amount of money spent on alcohol per month: $_____
6. Does it take more ___ or less ___ alcohol to get the same effect?
7. Have you had lapses of memory due to drinking? Yes _____ No_____
8. Have you ever been arrested for an alcohol-related offense (e.g., drunk driving)?
Yes _____ No _____ If yes, why?: _____
_____
9. Longest period of sobriety: _____ yrs. _____ mos.
10. How many days since last drink: _____
11. Amount and type of alcohol last used: _____

B. Treatment Need
1. Do you feel you have an addiction to, or a problem with alcohol?
Yes _____ No _____ If yes, describe: _____
_____
2. Do you think you will need help in order to stop drinking?
Yes _____ No _____
3. Have you ever been treated for alcohol problems before?
Yes _____ No _____ If yes, describe:

When: _____ Where: _____

III. Medical History (Review medical evaluation prior to patient interviews. Include M.D. findings below.)

A. Hospitalizations in the past 5 years

1. Date: _____
   Location: _____
   Problem: _____
2. Date: _____
   Location: _____
   Problem: _____
3. Date: _____
   Location: _____
   Problem: _____
4. Date: _____
   Location: _____
   Problem: _____
5. Date: _____
   Location: _____
   Problem: _____

B. Are you aware of any current medical problems? Yes _____ No _____
If yes, describe: _____
_____

C. Are you currently taking any prescribed or over-the-counter medication?
Yes _____ No _____ If yes, describe: _____
_____

IV. Social/Social Services

A. Friends

1. How many close friends do you have? _____
2. How many of these are heroin users? _____
3. How many use alcohol or other drugs but not heroin? _____
4. How many friends use no drugs? _____
5. How many friends use no drugs or alcohol? _____

B. Family

1. What is your marital status?
   Single ___ Married ___ Common Law ___ Separated ___ Divorced ___
2. Do you have a spouse or partner? Yes ____ No ____
   If yes, does this person use drugs or alcohol? Yes ____ No ____
   Describe: _____
3. How many children do you have? _____

4. Do your children live with you? Yes _____ No _____
5. How many people live at your residence? _____
6. Do you feel you need relationship counseling? Yes _____ No _____
7. Do you feel you need help in dealing with your children? Yes _____ No ____

C. Social Service Need

1. Sources of Income - How much of your monthly income do you receive from:
   a. Job $_____ (indicate amount per week)
   b. Welfare $_____
   c. Unemployment $_____
   d. Friends/Family $_____
   e. Illegal Activities $_____
   Total $_____
2. How many people are dependent upon your income? _____
3. Do you think you are eligible for unemployment or public assistance (welfare)? Yes _____ No _____

V. Psychological History/Status

A. Have you had serious problems with any of the following during the past 30 days that were not related to drugs or alcohol?:

___ Depression	___ Paranoia
___ Anxiety (worrying excessively)	___ Aggressive/violent behavior
___ Suicidal thoughts	___ Mood swings
___ Imaginary voices or strange thoughts or experiences	___ Guilt or shame
	___ Other (specify): _____

B. Have you ever been treated for a psychological problem(s)?
Yes _____ No _____
If yes, for What condition(s)? _____
When? _____
What type(s) of treatment? _____
Total number of treatment experiences: _____

C. Do you feel you have any psychological or marital problems now?
Yes _____ No _____ If yes, describe: _____
_____

VI. Education

A. Highest Education Completed

___	6th Grade	___	Two Year College
___	9th Grade	___	College
___	High School or G.E.D.	___	Graduate School
___	Some College	___	Technical School (specify): _____

B. Do you wish to or plan to return to school? Yes _____ No _____
If yes, what is your goal?: _____
_____
_____

VII. Vocational

A. Employment History
1. Current Employment Status: (Check all that apply)
   - ___ Full-time: hours and days _____
   - ___ Part-time: hours and days _____
   - ___ Student: hours and days _____
   - ___ Retired: since _____
   - ___ Disabled: since _____
   - ___ Unemployed: since _____
2. Are you receiving financial assistance, disability, or compensation?
   Yes _____ No _____
3. Current or last occupation: _____
4. Longest period of work in past two years: _____ yrs. _____ mos.

B. Are you interested in job training? Yes _____ No _____
If yes, what job or skill are you interested in learning? _____
_____
Are there any other problems or goals not addressed here that you would like me (us) to help you with? Yes _____ No _____ If yes, describe: _____
_____
_____

STOP

Needs Assessment

Indicate your assessment of patient's need for assistance in each area (use additional pages if necessary). Consult with medical staff if medical or psychological problems are indicated. Review with clinical supervisor.

Target Problems/Goals

I. Drug Use Assessment

II. Alcohol Use Assessment

III. Medical Assessment

IV. Social/Social Services Assessment

V. Psychological Assessment

VI. Education Assessment

VII. Vocational Assessment

Counselor Signature: _____ Date: _____

Clinical Supervisor Signature: _____ Date: _____

Problem Severity Index
Cocaine

Patient Name: _____ **Date:** _____

This test is designed to help determine the extent of your involvement with cocaine. Circle the one most accurate item for each of the following. Your therapist will review the results with you.

A. **How long have you used cocaine?**
1) 0 - 6 months
2) 7 - 12 months
3) 1 - 5 years
4) More than 5 years

B. **One the average, how often have you recently been using cocaine?**
1) Once a week or less
2) 2 - 3 times per week
3) 4 - 6 times per week
4) Everyday

C. **Which best describes your type of cocaine use?**
1) Intranasal (snorting)
3) Intranasal with occasional freebase (crack) or occasional intravenous
6) Regular, primarily freebase
6) Regular, primarily intravenous

D. **How much cocaine are you using on the average?**
1) 1 gram per week or less
2) 2 - 4 grams per week
4) 5 - 6 grams per week
6) More than 6 grams per week

E. **During the past 12 months, what is the longest consecutive period that you have not used cocaine?**
1) More than 3 months
2) 1 - 2 months
3) 1 - 4 weeks
5) Less than one week
8) Have used daily

F. **Which of the following best describes your experience when you have stopped cocaine use?**
   0) No significant or obvious problems
   2) Mild depression, irritability, or infrequent cravings
   3) Moderate depression, difficulty concentrating or occasional cravings
   4) Deep depression or severe cravings

G. **Have you experience any of the following? (Circle all that apply.)**
   0) No significant physical problems
   2) Weight loss
   4) Headaches, nosebleeds, or chest pains
   6) Seizures, loss of consciousness, or automobile accident

H. **How would you describe your other drug use?**
   0) None
   2) Weekly or less
   3) Several times per week
   4) Daily

I. **How would you describe your alcohol use?**
   0) None
   2) Weekly or less
   3) Several times per week
   4) Daily

J. **How has your work been affected by cocaine?**
   0) Work has been unaffected.
   2) Have been late or missed work.
   3) Employer has become aware, job is in jeopardy, or I am unemployed.
   4) Have lost job or been unemployed for more than one year.

K. **How has your relationship been affected by cocaine use?**
   0) No significant problems.
   2) Problems developing; things getting strained.
   3) Situation bordering on break up; or, I have no significant relationship.
   4) Other person has left or filed for divorce.

L. **How has your family situation been affected by cocaine use?**
   0) No significant problem.
   2) Some family members are concerned about my cocaine use.
   3) My cocaine use has caused recent arguing and family disturbance.
   4) My family and I no longer communicate.

M. **How have your finances been affected by cocaine?**
- 0) No significant financial impact.
- 2) I'm spending more than I can afford, but I can pay my bills.
- 3) I'm spending far too much on cocaine, causing financial problems.
- 4) Experiencing severe financial drain, or bankruptcy.

N. **How important is cocaine to your sexual activities?**
- 0) Cocaine and sexual activities are unrelated.
- 2) Occasionally, cocaine and sexual activities are combined.
- 3) Usually, cocaine and sexual activities are combined.
- 4) Cocaine and sexual activities are strongly connected.

O. **Most of my friends:**
- 0) Use no cocaine.
- 2) Use very little cocaine.
- 3) Use cocaine moderately.
- 4) Are heavy cocaine users.

P. **Most of my friends:**
- 0) Use almost no drugs or alcohol.
- 2) Use very little drugs or alcohol.
- 3) Use drugs or alcohol occasionally.
- 4) Are heavy drug or alcohol users.

Q. **My cocaine is supplied in the following way:**
- 1) Other people give it to me, or I buy it in small quantities (less than 1 gram.)
- 2) I buy it in 1 - 3 gram quantities.
- 3) I buy it in ⅛th ounce or larger quantities.
- 4) I deal cocaine/I buy it at "rock houses."

R. **If any of the following apply, you need to seek assistance immediately: (Circle all that apply.)**

- 2) I feel as though I am someone else when I am using.
- 4) I don't even like cocaine anymore but I'm using more of it.
- 6) I've heard voices while on cocaine.
- 8) I've attempted suicide.

_____ **TOTAL SCORE**

ADDICTION SCALE

SCORE	PHASE OF ADDICTION
Less than 12	**Introductory Phase** - Although you may be using cocaine only socially you are in a position to increase your use if the stress in your life increases or if the drug becomes too accessible.
13 - 35	**Maintenance Phase** - The effects of cocaine on your life are substantial. It is recommended you obtain a professional evaluation to help you determine the most effective way to deal with your problem.
36 - 55	**Disenchantment Phase** - Cocaine abuse is a serious problem for you. You will need to seek assistance to learn what addiction is and how to deal with it.
56 - 100	**Disaster Phase** - It may be difficult for you to regain control of your life without hospitalization. You need help from professionals immediately.

Note: Frequent or heavy cocaine use, particularly intravenous or freebase use indicates a need for treatment despite overall score. Also, if psychological or medical problems have resulted, you should seek professional attention immediately.

Problem Severity Index
Amphetamine

Name: _____ Date: _____

This test is designed to help determine the extent of your involvement with amphetamines. Circle the most accurate item (s) for each of the following. Your therapist will review the results with you.

A. **How long have you used amphetamines?**
1) 0 - 6 months
2) 6 - 12 Months
3) 1 - 5 years
4) More than 5 years

B. **On the average, how often have you recently been using amphetamines?**
1) Once a week or less
2) 2 - 3 times per week
3) 4 - 5 times per week
4) everyday

C. **Which best describes your type of amphetamine use?**
1) oral
2) intranasal (snorting)
3) intranasal with occasional intravenous
6) regular, primarily intravenous

D. **How much amphetamine are you using on the average?**
1) 1 gram per week or less
2) 2 - 5 grams per week
4) 6 - 14 grams per week
6) more than 14 grams per week

E. **During the past 12 months what is the longest consecutive period that you have not used amphetamines?**
1) more than 3 months
2) 1 - 2 months
3) 1 week to 4 weeks
5) 2 or 3 days
8) have used everyday

F. **Which of the following have you experienced when you have stopped amphetamine use?**
   0) no significant obvious problem
   2) mild depression, irritability, or infrequent cravings
   3) moderate depression, difficulty concentrating or occasional craving
   4) deep depression or severe cravings

G. **Have you experienced any of the following? (Check all those that apply)**
   0) no significant physical problem
   2) Weight loss
   4) Headaches, nosebleeds, chest pains
   6) Seizure, loss of consciousness, automobile accident

H. **How would you describe your other drug use?**
   0) none
   2) weekly or less
   3) several times per week
   4) daily

I. **How would you describe your alcohol use?**
   0) none
   2) weekly or less
   3) several times per week
   4) daily

J. **How has your work been affected by amphetamine use?**
   0) work has been unaffected
   2) have been late or missed work
   3) employer has become aware, job is in jeopardy, or I am unemployed
   4) lost job or unemployed for more than one year

K. **Has your relationship been affected by amphetamine use?**
   0) no significant problems
   2) problems developing; things getting strained
   3) situation bordering on break up; or I have no significant relationship
   4) other person has left or filed for divorce

L. **How has your family situation been affected by your amphetamine use?**
   0) no significant problem
   2) some family members are concerned about my amphetamine use
   3) my amphetamine use has caused recent arguing and family disturbance
   4) my family has disowned me

M. **Have your finances been affected by amphetamine use?**
   0) no significant financial impact
   2) I'm spending more than I can afford, but can pay my bills
   3) I'm spending far too much on amphetamines, causing financial problems
   4) severe financial drain, bankruptcy

N. **Now important are amphetamines to your sexual activities?**
   0) amphetamines and sexual activities are unrelated
   2) occasionally amphetamines and sexual activities are combined
   3) usually amphetamines and sexual activities are combined
   4) amphetamines and sexual activities are strongly connected

O. **Most of my friends**
   0) use no amphetamines
   2) use very little amphetamine
   3) use amphetamines occasionally
   4) are heavy amphetamine users

P. **Most of my friends**
   0) use no drugs or alcohol
   2) use very little drugs or alcohol
   3) use drugs or alcohol often
   4) are heavy drug or alcohol users

Q. **My supply of amphetamines comes from**
   1) other people give it to me, or I buy it in small quantities
   2) buy it in ½ gram - 1 gram quantities
   3) I buy it in ⅛th ounce or larger quantities
   4) I deal amphetamines/I buy directly from a lab

R. **If any of the following apply, you need to seek assistance immediately. (circle all that apply.)**
   2) I feel as though I am someone else when I am using
   4) I don't even like amphetamine anymore but I'm using more of it
   6) I've heard voices when I've been high on amphetamines
   8) I have attempted suicide

ADDICTION SCALE

SCORE	PHASE OF ADDICTION
Less than 12	**Introductory Phase** - Although you may be using amphetamine only socially you are in a position to increase your use if the stress in your life increases or if the drug becomes too accessible.
13 - 35	**Maintenance Phase** - The effects of amphetamine on your life is substantial. It is recommended you obtain a professional evaluation to help you determine the most effective way to deal with your problems
36 - 55	**Disenchantment Phase** - Amphetamine abuse is a serious problem for you and you will need to seek assistance to learn what addiction is and how to deal with it.
56 - 100	**Disaster Phase** - It may be difficult for you to get control of your life back from amphetamine without hospitalization. You need help from professionals immediately.

Note: Frequent or heavy amphetamine use, particularly intravenous use indicates a need for treatment despite overall score. Also, if psychological or medical problems have resulted you should seek professional attention immediately.

THE ADDICTION SEVERITY INDEX

INSTRUCTIONS

1. Leave No Blanks – Where appropriate code items: X = question not answered
   N = question not applicable
   Use only one character per item.
2. Item numbers circled are to be asked at follow-up. Items with an asterisk are cumulative and should be rephrased at follow-up (see Manual).
3. Space is provided after sections for additional pertinent information.

ADDICTION SEVERITY INDEX

SEVERITY RATINGS

The severity ratings are interviewer estimates of the patient's need for additional treatment in each area. The scales range from 0 (no treatment necessary) to 9 (treatment needed to intervene in life-threatening situation). Each rating is based upon the patient's history of problem symptoms, present condition and subjective assessment of his treatment needs in a given area. For a detailed description of severity ratings' derivation procedures and conventions, see manual.

Third Edition

SUMMARY OF PATIENT'S RATING SCALE

0 - Not at all
1 - Slightly
2 - Moderately
3 - Considerably
4 - Extremely

I.D. NUMBER

LAST 4 DIGITS OF SSN

DATE OF ADMISSION

DATE OF INTERVIEW

TIME BEGUN :

TIME ENDED :

CLASS:
1 – Intake
2 – Follow-up

CONTACT CODE:
1 – In Person
2 – Phone
3 – Mail

GENDER
1-Male
2-Female

TREATMENT EPISODE NUMBER

INTERVIEWER CODE NUMBER

SPECIAL:
1 – Patient terminated
2 – Patient refused
3 – Patient unable to respond

GENERAL INFORMATION

NAME _____

CURRENT ADDRESS _____

GEOGRAPHIC CODE

1. How long have you lived at this address? (yrs. / mos.)
2. Is this residence owned by you or your family?
   0 – No 1 – Yes
3. DATE OF BIRTH
4. RACE
   1 – White (Not of Hispanic Origin)
   2 – Black (Not of Hispanic Origin)
   3 – American Indian
   4 – Alaskan Native
   5 – Asian or Pacific Islander
   6 – Hispanic – Mexican
   7 – Hispanic – Puerto Rican
   8 – Hispanic – Cuban
   9 – Other Hispanic
5. RELIGIOUS PREFERENCE
   1 – Protestant 4 – Islamic
   2 – Catholic 5 – Other
   3 – Jewish 6 – None
6. Have you been in a controlled environment in the past 30 days?
   1 – No
   2 – Jail
   3 – Alcohol or Drug Treatment
   4 – Medical Treatment
   5 – Psychiatric Treatment
   6 – Other _____
7. How many days?

TEST RESULTS

Shipley

C.Q.

I.Q.

Back

Total Score (62)

CARD 1 80

SEVERITY PROFILE

	PROBLEMS	MEDICAL	EMP/SUP	ALCOHOL	DRUG	LEGAL	FAM/SOC	PSYCH
9								
8								
7								
6								
5								
4								
3								
2								
1								
0								

V.A. FORM 10-4 (542) REVISED SEPT. 1980

I.D. [ ]

*1. How many times in your life have you been hospitalized for medical problems? *(Include o.d.'s, d.t.'s, exclude detox.)* [ ]

2. How long ago was your last hospitalization for a physical problem? [ ] yrs. [ ] mos.

3. Do you have any chronic medical problems which continue to interfere with your life? [ ]
0 – No 1 – Yes

4. Are you taking any prescribed medication on a regular basis for a physical problem? [ ]
0 – No 1 – Yes

MEDICAL STATUS

5. Do you receive a pension for a physical disability? *(Exclude psychiatric disability.)* [ ]
0 – No
1 – Yes _____ Specify

6. How many days have you experienced medical problems in the past 30? [ ]

FOR QUESTIONS 7 & 8 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE.

7. How troubled or bothered have you been by these medical problems in the past 30 days? [ ]

8. How important to you *now* is treatment for these medical problems? [ ]

INTERVIEWER SEVERITY RATING

9. How would you rate the patient's need for medical treatment? [ ]

CONFIDENCE RATINGS

Is the above information significantly distorted by:

10. Patient's misrepresentation? [ ]
0 – No 1 – Yes

11. Patient's inability to understand? [ ] 20
0 – No 1 – Yes

COMMENTS

---

*1. Education completed *(GED = 12 years)* 21 [ ] yrs. [ ] mos.

*2. Training or technical education completed [ ] mos.

3. Do you have a profession, trade or skill? [ ]
0 – No
1 – Yes _____ Specify

4. Do you have a valid driver's license? [ ]
0 – No 1 – Yes

5. Do you have an automobile available for your use? *(Answer No if no valid driver's license.)* [ ]
0 – No 1 – Yes

6. How long was your longest full-time job? [ ] yrs. [ ] mos.

*7. Usual (or last) occupation. [ ]
_____ *(Specify in detail)*

8. Does someone contribute to your support in any way? [ ]
0 – No 1 – Yes

9. (ONLY IF ITEM 8 IS YES)
Does this constitute the majority of your support? [ ]
0 – No 1 – Yes

EMPLOYMENT/SUPPORT STATUS

10. *Usual* employment pattern, past 3 years. [ ]
1 – full time (40 hrs/wk)
2 – part time (reg. hrs)
3 – part time (irreg., daywork)
4 – student
5 – service
6 – retired/disability
7 – unemployed
8 – in controlled environment

11. How many days were you paid for working in the past 30? *(Include "under the table" work.)* [ ]

How much money did *you* receive from the following sources in the past 30 days?

12. Employment *(net income)* [ ]

13. Unemployment compensation [ ]

14. DPA [ ]

15. Pension, benefits or social security [ ]

16. Mate, family or friends *(Money for personal expenses).* [ ]

17. Illegal [ ]

18. How many people depend on you for the majority of their food, shelter, etc.? [ ]

19. How many days have you experienced employment problems in the past 30? [ ]

FOR QUESTIONS 19 & 20 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

20. How troubled or bothered have you been by these employment problems in the past 30 days? [ ]

21. How important to you *now* is counseling for these employment problems? [ ]

INTERVIEWER SEVERITY RATING

22. How would you rate the patient's need for employment counseling? [ ]

CONFIDENCE RATINGS

Is the above information significantly distorted by:

23. Patient's misrepresentation? [ ]
0 – No 1 – Yes

24. Patient's inability to understand? [ ] 71
0 – No 1 – Yes

CARD 2 80

COMMENTS

I.D. ☐☐☐☐

CODE #

		PAST 30 DAYS	LIFETIME USE YRS.	LIFETIME USE MOS.
01	Alcohol - Any use at all	☐☐	☐☐	☐☐
02	Alcohol - To intoxication	☐☐	☐☐	☐☐
03	Heroin	☐☐	☐☐	☐☐
04	Methadone	☐☐	☐☐	☐☐
05	Other opiates/ analgesics	☐☐	☐☐	☐☐
06	Barbiturates	☐☐	☐☐	☐☐
07	Other sed/ hyp/tranq.	☐☐	☐☐	☐☐
08	Cocaine	☐☐	☐☐	☐☐
09	Amphetamines	☐☐	☐☐	☐☐
10	Cannabis	☐☐	☐☐	☐☐
11	Hallucinogens	☐☐	☐☐	☐☐
12	Inhalants	☐☐	☐☐	☐☐

CARD 3 80

Note: See manual for representative examples for each drug class.

13. More than one substance per day *(Incl. alcohol)*. $ ☐☐ DAYS ☐☐☐ YRS. ☐☐ MOS.

DRUG/ALCOHOL USE

14. Which substance is the major problem? *(Please code as above or 00-No problem; 15-Alcohol & Drug [Dual addiction]; 16-Polydrug; when not clear, ask patient).* ☐☐

15. How long was your last period of voluntary abstinence from this major substance? *(00 - never abstinent).* ☐☐ MOS.

16. How many months ago did this abstinence end? *(00 - still abstinent).* ☐☐

17. How many times have you:

Had alcohol d.t.'s ☐☐

Overdosed on drugs ☐☐

18. How many times in your life have you been treated for:

Alcohol Abuse ☐☐

Drug Abuse ☐☐

19. How many of these were detox only?

Alcohol ☐☐

Drug ☐☐

20. How much would you say you spent during the past 30 days on:

Alcohol ☐☐☐☐

Drugs ☐☐☐☐

21. How many days have you been treated in an outpatient setting for alcohol or drugs in the past 30 days? *(Include NA, AA).* ☐☐

22. How many days in the past 30 have you experienced:

Alcohol Problems ☐☐

Drug Problems ☐☐

FOR QUESTIONS 23 & 24 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

23. How troubled or bothered have you been in the past 30 days by these:

Alcohol Problems ☐

Drug Problems ☐

24. How important to you *now* is treatment for these:

Alcohol Problems ☐

Drug Problems ☐

INTERVIEWER SEVERITY RATING

25. How would you rate the patient's need for treatment for:

Alcohol Abuse ☐

Drug Abuse ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

26. Patient's misrepresentation? 0 – No 1 – Yes ☐

27. Patient's inability to understand? 0 – No 1 – Yes ☐ 80

CARD 4 80

COMMENTS

I.D. [ ][ ][ ][ ]

1. Was this admission promoted or suggested by the criminal justice system (judge, probation/parole officer, etc.)? [ ]
   0 – No 1 – Yes

2. Are you on probation or parole? [ ]
   0 – No 1 – Yes

How many times in your life have you been arrested and charged with the following criminal offenses:

CODE #

- *03 – shoplifting/vandalism [ ][ ]
- *04 – parole/probation violations [ ][ ]
- *05 – drug charges [ ][ ]
- *06 – forgery [ ][ ]
- *07 – weapons offense [ ][ ]
- *08 – burglary, larceny, B & E [ ][ ]
- *09 – robbery [ ][ ]
- *10 – assault [ ][ ]
- *11 – arson [ ][ ]
- *12 – rape [ ][ ]
- *13 – homicide, manslaughter [ ][ ]
- *14 – other [ ][ ]

LEGAL STATUS

*15. How many of these charges resulted in convictions? [ ][ ]

How many times in your life have you been charged with the following:

*16. Disorderly conduct, vagrancy, public intoxication [ ][ ]

*17. Driving while intoxicated [ ][ ]

*18. Major driving violations (reckless driving, speeding, no license, etc.). [ ][ ]

*19. How many months were you incarcerated in your life? [ ][ ]

20. How long was your last incarceration? [ ][ ] months

21. What was it for? *(Use code 3-14, 16-18. If multiple charges, code most severe.)* [ ][ ]

22. Are you presently awaiting charges, trial or sentence? [ ]
   0 – No 1 – Yes

23. What for? *(If multiple choice, use most severe).* [ ][ ]

24. How many days in the past 30 were you detained or incarcerated? [ ][ ]

25. How many days in the past 30 have you engaged in illegal activities for profit? [ ][ ]

FOR QUESTIONS 26 & 27 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

26. How serious do you feel your present legal problems are? *(Exclude civil problems)* [ ]

27. How important to you *now* is counseling or referral for these legal problems? [ ]

INTERVIEWER SEVERITY RATING

28. How would you rate the patient's need for legal services or counseling? [ ]

CONFIDENCE RATINGS

Is the above information significantly distorted by:

29. Patient's misrepresentation? [ ]
   0 – No 1 – Yes

30. Patient's inability to understand? [ ]
   0 – No 1 – Yes

84

CARD [5] 80

COMMENTS

I.D. 1

1. Marital Status 5
   1 – Married 4 – Separated
   2 – Remarried 5 – Divorced
   3 – Widowed 6 – Never Married

2. How long have you been in this marital status? (If never married, since age 18). yrs. mos.

3. Are you satisfied with this situation?
   0 – No
   1 – Indifferent
   2 – Yes

4. Usual living arrangements (past 3 yr.)
   1 – With sexual partner and children
   2 – With sexual partner alone
   3 – With parents
   4 – With family
   5 – With friends
   6 – Alone
   7 – Controlled environment
   8 – No stable arrangements

5. How long have you lived in these arrangements. (If with parents or family, since age 18). yrs. mos.

6. Are you satisfied with these living arrangements?
   0 – No
   1 – Indifferent
   2 – Yes

FAMILY/SOCIAL RELATIONSHIPS

7. With whom do you spend most of your free time:
   1 – Family 3 – Alone
   2 – Friends

8. Are you satisfied with spending your free time this way?
   0 – No 2 – Yes
   1 – Indifferent

9. How many *close* friends do you have?

10. How many days in the past 30 have you had serious conflicts:
    A. with your family?
    B. with other people? (excluding family).

Have you had significant periods in which you have experienced serious problems with:

0 – No 1 – Yes

	PAST 30 DAYS	IN YOUR LIFE
11. Mother		
12. Father		
13. Brothers/Sisters		
14. Sexual partner/spouse		
15. Children		
16. Other significant family _____		
17. Close friends		
18. Neighbors		
19. Co-workers		

Maintenance

FOR QUESTIONS 20-23 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

How troubled or bothered have you been in the past 30 days by these:

20. Family problems?
21. Social problems?

How important to you now is treatment or counseling for these:

22. Family problems?
23. Social problems?

INTERVIEWER SEVERITY RATING

24. How would you rate the patient's need for family and/or social counseling?

CONFIDENCE RATINGS

Is the above information significantly distorted by:

25. Patient's misrepresentation
26. Patient's inability to understand 49
    0 – No 1 – Yes

CARD 6 80

COMMENTS

---

*1. How many times have you been treated for any psychological or emotional problems?

In a hospital 5

As an Opt. or Priv. patient

2. Do you receive a pension for a psychiatric disability?
   0 – No 1 – Yes

Have you had a significant period, (that was not a direct result of drug/alcohol use), in which you have:

0 – No 1 – Yes

	PAST 30 DAYS	IN YOUR LIFE
3. Experienced serious depression		
4. Experienced serious anxiety or tension		
5. Experienced hallucinations		
6. Experienced trouble understanding, concentrating or remembering		
7. Experienced trouble controlling violent behavior		
8. Experienced serious thoughts of suicide		
9. Attempted suicide		
10. Have you taken prescribed medication for any psychological/emotional problem		

PSYCHIATRIC STATUS

11. How many days in the past 30 have you experienced these psychological or emotional problems?

FOR QUESTIONS 12 & 13 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

12. How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days?

13. How important to you *now* is treatment for these psychological problems?

THE FOLLOWING ITEMS ARE TO BE COMPLETED BY THE INTERVIEWER

At the time of this interview, is patient:

0 – No 1 – Yes

14. Obviously depressed/withdrawn
15. Obviously hostile
16. Obviously anxious/nervous
17. Having trouble with reality testing, thought disorders, paranoid thinking
18. Having trouble comprehending, concentrating, remembering
19. Have suicidal thoughts

INTERVIEWER SEVERITY RATING

20. How would you rate the patient's need for psychiatric/psychological treatment?

CONFIDENCE RATINGS

Is the above information significantly distorted by:

21. Patient's misrepresentation?
    0 – No 1 – Yes
22. Patient's inability to understand? 38
    0 – No 1 – Yes

CARD 7 80

COMMENTS

NAME: _____ DATE: _____

		CIRCLE ONE	
1.	Do you feel you are a normal drinker? (By normal we mean you drink less than or as much as most other people.)	YES	NO
2.	Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?	YES	NO
3.	Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking?	YES	NO
4.	Can you stop drinking without a struggle after one or two drinks?	YES	NO
5.	Do you ever feel guilty about your drinking?	YES	NO
6.	Do friends or relatives think you are a normal drinker?	YES	NO
7.	Are you able to stop drinking when you want to?	YES	NO
8.	Have you ever attended a meeting of Alcoholics Anonymous?	YES	NO
9.	Have you ever gotten into physical fights when drinking?	YES	NO
10.	Has drinking ever created problems between you and your wife, husband, a parent, or other near relative?	YES	NO
11.	Has your wife, husband, a parent, or other near relative ever gone to anyone for help about your drinking?	YES	NO
12.	Have you ever lost friends, girl friends or boy friends, because of your drinking?	YES	NO
13.	Have you ever gotten into trouble at work because of your drinking?	YES	NO
14.	Have you ever lost a job because of drinking?	YES	NO
15.	Have you ever neglected your obligations, your family, or your work for two or more days in a row because of your drinking?	YES	NO
16.	Do you drink before noon fairly often?	YES	NO
17.	Have you ever been told you have liver trouble? Cirrhosis?	YES	NO
18.	After heavy drinking have you ever had delirium tremens (DT's) or severe shaking, or heard voices or seen things that weren't really there?	YES	NO
19.	Have you ever gone to anyone for help about your drinking?	YES	NO
20.	Have you ever been in a hospital because of drinking?	YES	NO
21.	Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem that resulted in hospitalization?	YES	NO
22.	Have you ever been seen at a psychiatric or mental health clinic or gone to any doctor, social worker, or clergyman for help with any emotional problem, where drinking was part of the problem?	YES	NO
23.	Have you ever been arrested for drunken driving under the influence of alcoholic beverages?	YES	NO
24.	Have you ever been arrested, even for a few hours, because of other drunken behavior?	YES	NO

M.A.S.T. SCORING KEY

ITEM				
* 1.	YES	0	NO	2
2.	YES	2	NO	0
3.	YES	1	NO	0
* 4.	YES	0	NO	2
5.	YES	1	NO	0
* 6.	YES	0	NO	2
* 7.	YES	0	NO	2
8.	YES	5	NO	0
9.	YES	1	NO	0
10.	YES	2	NO	0
11.	YES	2	NO	0
12.	YES	2	NO	0
13.	YES	2	NO	0
14.	YES	2	NO	0
15.	YES	2	NO	0
16.	YES	1	NO	0
17.	YES	2	NO	0
18.	YES	2	NO	0
19.	YES	5	NO	0
20.	YES	5	NO	0
21.	YES	2	NO	0
22.	YES	2	NO	0
23.	YES	2	NO	0
24.	YES	2	NO	0

* Asteriks represent **"NO"** answers in which a point value is given.

YES or **NO** answers receive between 0 and 5 points, depending on the significance of the question. Total scores should be evaluated as follows:

0 - 5	Not diagnostic of Addiction
5 - 7	Possible Addiction
7 - 15	Early Addiction
15 - 25	Moderate Addiction
25 +	Severe Addiction

These scores represent generalizations and their accuracy depends upon the reliability of the answers given. Spouses or close friends of the alcoholic can take the test for the alcoholic with a 90 percent accuracy rating.

Alcohol Intake Prescreening Instrument

Part 1

Client Name: _____

Interviewer: The questions should be asked in an interview format. The attached CIWA should then be completed and the score entered in the space below.

Assessment Questions

Section A:

1. Have you ever had a seizure? Yes _____ No _____
2. Are you currently using any sleeping pills or tranquilizers on a regular basis? Yes _____ No _____

Section B: If you have had a drink within the past 72 hours please continue with this section. If you haven't had a drink within 72 hours, skip this section and go to Section C.

1. Do you typically drink alcohol soon after you arise and drink throughout the day? Yes _____ No _____
2. Have you needed medication in the past to stop drinking? Yes _____ No _____

If any answer above, sections A or B, are "YES", or if the CIWA score is 16 or greater, client will require medical evaluation and/or detoxification.

Section C:

1. * Do you currently have any medical conditions which need attention? Yes _____ No _____ If yes, describe: _____
2. * Are you currently under a physician's care? Yes _____ No _____ If yes, describe: _____

* If either of these questions are answered yes, a consultation from a supervisor is necessary prior to establishing a treatment plan.

C.I.W.A. Score: _____
If answers to all questions are no and if the CIWA score is 15 or less the client can be admitted to the standard admission procedure.

Screening Result: _____

_____

Counselor Signature: _____ Date: _____

Alcohol Intake Prescreening Instrument

Part 2

NAUSEA AND VOMITING - As "Do you feel sick to your stomach? Have you vomited? Observation.

0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

TREMOR - Arms extended and fingers spread apart. Observation.

0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient's arms extended
5
6
7 severe, even with arms not extended

PAROXYSMAL SWEATS - Observation.

0 no sweat visible
1 barely perceptible sweating, palms moist
2
3
4 beads of sweat obvious on forehead
5
6
7 drenching sweats

ANXIETY - Ask "Do you feel nervous?" Observation.

1 no anxiety, at ease
2 mildly anxious
3
4 moderately anxious, or guarded, so anxiety is inferred
5
6
7 equivalent to acute panic states, as seen in severe delirium or acute schizophrenic reactions

AGITATION - Observation.

0 normal activity
1 somewhat more than normal activity
2
3
4 moderately fidgety and restless
5
6
7 paces back and forth during most of the interview, or constantly thrashes about

Total CIWA - Score: _____
Rater's Initials: _____
Maximum Possible Score 67

TACTILE DISTURBANCES - Ask "Have you any itching, pins and needles sensations, any burning, any numbness or do you feel bugs crawling on or under your skin?" Observation.

0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning or numbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

AUDITORY DISTURBANCES - Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there? Observation?

0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

VISUAL DISTURBANCES - Ask "Does the light appear to be too bright? Is the color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there? Observation.

0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

HEADACHE, FULLNESS IN HEAD - Ask "Does your head feel different? Does it feel like there is a band around your head? Do not rate dizziness or lightheadedness. Otherwise rate severity.

0 not present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

ORIENTATION AND INCLUDING OF SENSORIUM - Ask "What day is this? Where are you? Who am I?"

0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place and/or person

Form Guide

Treatment Plan

- Treatment Plan
- 90-Day Treatment Plan Review

Text: Treatment Planning

See Pages 41 - 45

Treatment Plan

PROGRAM:_____

PROBLEM AREAS:

1. Drug Use
2. Alcohol Use
3. Medical
4. Social
5. Psychological
6. Vocational
7. Educational
8. Other

Patient: _____ Date: _____
Counselor: _____ Date: _____
Physician: _____ Date: _____

PA _____ STATEMENT OF PROBLEM _____

SHORT-TERM GOAL(S) AND OBJECTIVE(S) _____

LONG-TERM-GOAL(S) AND OBJECTIVE(S) _____

INTERVENTION (SHORT-TERM) _____
TARGET DATE: _____

INTERVENTION (LONG-TERM) _____
TARGET DATE: _____

PA _____ STATEMENT OF PROBLEM _____

SHORT-TERM GOAL(S) AND OBJECTIVE(S) _____

LONG-TERM-GOAL(S) AND OBJECTIVE(S) _____

INTERVENTION (SHORT-TERM) _____
TARGET DATE: _____

INTERVENTION (LONG-TERM) _____
TARGET DATE: _____

PA _____ STATEMENT OF PROBLEM _____

SHORT-TERM GOAL(S) AND OBJECTIVE(S) _____

LONG-TERM-GOAL(S) AND OBJECTIVE(S) ______________________________

INTERVENTION (SHORT-TERM) ______________________________
______________________________ TARGET DATE: __________
INTERVENTION (LONG-TERM) ______________________________
______________________________ TARGET DATE: __________

PA ________ STATEMENT OF PROBLEM ______________________________

SHORT-TERM GOAL(S) AND OBJECTIVE(S) ______________________________

LONG-TERM-GOAL(S) AND OBJECTIVE(S) ______________________________

INTERVENTION (SHORT-TERM) ______________________________
______________________________ TARGET DATE: __________
INTERVENTION (LONG-TERM) ______________________________
______________________________ TARGET DATE: __________

PA ________ STATEMENT OF PROBLEM ______________________________

SHORT-TERM GOAL(S) AND OBJECTIVE(S) ______________________________

LONG-TERM-GOAL(S) AND OBJECTIVE(S) ______________________________

INTERVENTION (SHORT-TERM) ______________________________
______________________________ TARGET DATE: __________
INTERVENTION (LONG-TERM) ______________________________
______________________________ TARGET DATE: __________

PA ________ STATEMENT OF PROBLEM ______________________________

SHORT-TERM GOAL(S) AND OBJECTIVE(S) ______________________________

LONG-TERM-GOAL(S) AND OBJECTIVE(S) ______________________________

INTERVENTION (SHORT-TERM) _____
_____ TARGET DATE: _____
INTERVENTION (LONG-TERM) _____
_____ TARGET DATE: _____

PA _____ STATEMENT OF PROBLEM _____
_____
_____
_____

SHORT-TERM GOAL(S) AND OBJECTIVE(S) _____
_____
_____

LONG-TERM-GOAL(S) AND OBJECTIVE(S) _____
_____
_____

INTERVENTION (SHORT-TERM) _____
_____ TARGET DATE: _____
INTERVENTION (LONG-TERM) _____
_____ TARGET DATE: _____

FREQUENCY OF COUNSELING AND TYPE: _____
_____

PATIENT SIGNATURE: _____
DATE: _____

COUNSELOR SIGNATURE: _____
DATE: _____

SUPERVISING COUNSELOR SIGNATURE: _____
DATE: _____

DOSE REVIEW: _____
_____
_____
_____

M.D. SIGNATURE: _____
DATE: _____

90-Day Treatment Plan Review

Patient: ______________________ Date: ______________
Counselor: ______________________ Date: ______________
Physician: ______________________ Date: ______________

PROBLEM AREA: ______________________
EVALUATION OF PROGRESS/LACK OR PROGRESS: ______________________

REVISION NEEDED? YES ____ NO ____
IF "YES" DESCRIBE: ______________________

PROBLEM AREA: ______________________
EVALUATION OF PROGRESS/LACK OR PROGRESS: ______________________

REVISION NEEDED? YES ____ NO ____
IF "YES" DESCRIBE: ______________________

PROBLEM AREA: ______________________
EVALUATION OF PROGRESS/LACK OR PROGRESS: ______________________

REVISION NEEDED? YES ____ NO ____
IF "YES" DESCRIBE: ______________________

PROBLEM AREA: ______________________
EVALUATION OF PROGRESS/LACK OR PROGRESS: ______________________

REVISION NEEDED? YES ____ NO ____
IF "YES" DESCRIBE: ______________________

PROBLEM AREA: ____________________
EVALUATION OF PROGRESS/LACK OR PROGRESS: ____________________

REVISION NEEDED? YES _____ NO _____
IF "YES" DESCRIBE: ____________________

PROBLEM AREA: ____________________
EVALUATION OF PROGRESS/LACK OR PROGRESS: ____________________

REVISION NEEDED? YES _____ NO _____
IF "YES" DESCRIBE: ____________________

PROBLEM AREA: ____________________
EVALUATION OF PROGRESS/LACK OR PROGRESS: ____________________

REVISION NEEDED? YES _____ NO _____
IF "YES" DESCRIBE: ____________________

PROBLEM AREA: ____________________
EVALUATION OF PROGRESS/LACK OR PROGRESS: ____________________

REVISION NEEDED? YES _____ NO _____
IF "YES" DESCRIBE: ____________________

COUNSELOR SIGNATURE: ____________________
DATE: ____________________

SUPERVISING COUNSELOR SIGNATURE: ____________________
DATE: ____________________

Form Guide

Contingency Contracting

- Take-Home Treatment Contract
- Treatment Contract
- Probation Treatment Contract

Text: Contingency Contracting

See Pages 47-48

Take Home Treatment Contract

Patient: _____ Counselor: _____

Date: _____

I understand that achievement of treatment goals and adherence to clinic rules and requirements is a requirement for take-home privileges. I understand that I must attain the following in order to earn or regain take-home privileges:

a) _____; by _____ (Date)

b) _____; by _____ (Date)

c) _____; by _____ (Date)

d) _____; by _____ (Date)

I understand that compliance with this contract will result in a recommendation to the physician for attainment or reinstatement of Step Level ____ on _____ (Date).

Patient's Signature: _____ Date: _____

Counselor's Signature: _____ Date: _____

Treatment Contract

Patient: _____ Counselor: _____

Date: _____

I understand that I must attain the following:

a) _____; by _____(Date)

b) _____; by _____(Date)

c) _____; by _____(Date)

d) _____; by _____(Date)

In order to earn the following privilege(s):

a) _____

b) _____

c) _____

Patient Signature: _____ Date: _____

Counselor Signature: _____ Date: _____

Probation Treatment Contract

Patient: _____ Counselor: _____

Date: _____

Mr. _____ you have been in treatment at this clinic for the past __ months. Within this time you have shown some progress but you are not presently meeting the required therapeutic efforts of the clinic.

Your lack of effort is reflected in the following (e.g., #dirty urines, failure to keep counseling and other clinic appointments, not employed or attending school, disruptive behavior, etc.):

a) _____
b) _____
c) _____
d) _____

Because of this (these) behavior(s) we are specifying a period of time during which you must attain the following:

a) _____; by _____ (Date)

b) _____; by _____ (Date)

c) _____; by _____ (Date)

d) _____; by _____ (Date)

Failure to comply with this treatment contract will result in the following (e.g., detox and suspension from the clinic; suspension and transfer to another program; suspension and referral to an inpatient program, etc.).

a) _____

b) _____

Patient Signature: _____ Date: _____

Counselor/Supervisor: _____ Date: _____

Form Guide

Suggested Counseling Topics

- Recognizing Stress
- Recreational Activities
- Staying Busy
- Nutrition
- Exercise
- Sources of Support

Text: Some Suggested Counseling Topics

See Pages 54 - 58

Counselor's Guide

Recognizing Stress

Recognizing Stress

This is an exercise to help patients become more aware of themselves and better able to recognize signs of stress for what they are. This information can be used in future groups when identified indicators of stress are evident. Patients may be showing obvious signs of stress but are not yet adept at recognizing the signs for themselves. The counselor may be able to help bring the signs to the patient's attention.

Recognizing Stress

Stress is what a person experiences as the result of difficult or upsetting events, particularly those which continue for a period of time.

Stress is the experience people have when the demands they make of themselves or those placed upon them are greater than what they feel they can handle. Sometimes we are unaware of this emotional state until the stress is producing physical symptoms. Check off any of the following problems you have experienced in the past 30 days:

_____ 1. Sleep problems
   a. Difficulty falling asleep
   b. Waking up off and on during the night
   c. Nightmares
   d. Waking up early and being unable to fall back to sleep

_____ 2. Headaches

_____ 3. Muscle Tension

_____ 4. Stomach problems

_____ 5. Chronic Illness

_____ 6. Fatigue

_____ 7. Moodiness

_____ 8. Irritability

_____ 9. Difficulty concentrating

_____ 10. General dissatisfaction with life

_____ 11. Feeling overwhelmed

If you have checked 2 or more of these items you need to think about reducing stress immediately. By becoming more aware of stress and learning ways to cope, you can further insure your continuing recovery.

Counselor's Guide

Recreational Activities

Recreational Activities

Patients must be reminded that it is important to put new activities in their lives as well as abstain from drugs and alcohol. Recovery involves making life interesting and enjoyable with new recreational activities. Caution patients that all new activities won't immediately be fun, nor will all old hobbies and recreations seem the same without alcohol and drugs. Regardless of how it "feels", however, it is necessary to proceed with trying new activities.

Recreational Activities

Read these suggested activities and circle ones you might try in the future:

Acting/Dramatics
Amateur radio
Archery
Attending auctions
Attending concerts
Attending swap meet
Auto racing
Auto repairing
Backpacking
Badminton
Baseball/Softball
Basketball
Bicycling
Billiards/Pool
Bird watching
Bowling
Boxing
Camping
Canoeing
Carpentry
Ceramics/Pottery
Checkers
Chess
Child-related activities:
Scouts, PTA, coaching, etc.
Civic organizations
Collecting coins, antiques, etc.
Cooking/Baking
Crossword puzzles
Dancing lessons
Dancing: Social
Darkroom work
Designing clothes
Dining out
Driving
Electronics
Encounter Groups
Fencing
Fishing
Flower arranging
Flying/Gliding
Folk dancing
Football
Fraternal Organizations
Gardening
Go to garage/yard sale
Go to movies
Go to park
Go to plays/lectures
Golf
Green Peace
Gymnastics
Hiking/Walking
Home decorating
Homeowner/Renters
organizations
Horseback riding
Horseshoes
Hunting
Iceskating
Jewelry making
Jigsaw puzzles
Jogging
Judo/Karate
Kite flying
Knitting/Crocheting
Leatherwork
Listening to Music
Marksmanship
Mechanics
Metalwork
Model building
Motorboating
Motorcycling
Mountain climbing
Needlework
Painting/Drawing
Playing cards
Playing a musical instrument
Political activities
Reading: newspaper/magazine
Religious activities
Roller skating
Rowing/Boating
Sailing
Sculpture
Sewing
Shuffleboard
Sierra Club
Sightseeing
Singing
Skiing
Skindiving
Squash/Handball
Sunbathing
Surfboarding
Swimming
Tabletennis/Ping Pong
Taking snapshots
Talking on the phone
Tennis
Traveling
Video games
Visiting friends
Visiting museum
Volleyball
Volunteer work
Walking
Watching sports
Watching TV
Water skiing
Weaving
Weight lifting
Woodworking
Wrestling
Writing poetry/songs
Writing letters

Counselor's Guide

Staying Busy

Staying Busy

Structure cannot exist in a schedule without activities. The counselor can be helpful in making suggestions for positive activities that can be used to fill idle time. The handout will help explain how idle time can be trigger.

Staying Busy

Learning to schedule and to provide a structure of activities to support your recovery is an important first step in outpatient treatment. Staying busy doing things is important for several reasons:

1. Often relapses begin in the head of a person who has nothing to do and nowhere to go. Casual thoughts about drinking or using can start the craving process.

   Describe a time when free time was a trigger for you?

   _____

   _____

   _____

   How could you respond to prevent relapse if the above happened to you?

   _____

   _____

   _____

2. When drug and/or alcohol use gets severe enough, the user will often begin to isolate. Being around people is uncomfortable and annoying. Being alone results in fewer hassles.

   Did you isolate when you drank or used?

   _____

   _____

   _____

   Does being alone now remind you of that experience?

   _____

   _____

   _____

3. Being involved with people and doing things keeps life more interesting. Living a drug and alcohol free life can sometimes feel pretty tame. You begin to think being sober is boring and using or drinking is exciting and desirable. People have to work at finding ways to make sobriety fun.

   What have you done lately to have fun?

   _____

   _____

   _____

4. When people are involved in an alcoholic and/or an addict lifestyle, many things they used to do and people they used to do them with get left behind. Beginning to reconnect or to build a life around drug and alcohol free activities and people is critical to a successful recovery.

   How have you reconnected or built new activities and people into your life?

   _____

   _____

   _____

Counselor's Guide

Nutrition

Nutrition

Just as exercise is important in helping brain chemistry return to normal, so is nutrition. We don't know enough at this point to recommend a specific diet, however, we do feel that common sense is important in selecting a diet that aids recovery. The handout can provide a vehicle for discussing the issue of eating frequency. Addicts often forget to eat. They need to plan their meals the same way they schedule other activities and begin to think about the value of certain foods.

Nutrition

Your body is like a machine. You need fuel to keep going and poor quality fuel can damage your body. When people are abusing drugs they often pay less attention to the fuel they put in their bodies. How many of these things have you done to your body?

_____ Not eat for long periods of time.
_____ Eat lots of food at one time.
_____ Eat lots of "junk food."
_____ Eat when you're exhausted.

When you drink alcohol with or without the use of drugs, your body is getting lots of calories and no nutrients. These are known as "empty calories" and are the reason many alcoholics and some addicts are overweight and undernourished at the same time.

To get the best fuel for the recovery trip, follow these simple rules:

1. **Eat regular meals.**
2. **Avoid being hungry (it can be a trigger).**
3. **Eat food that is nutritional.**
4. **Eat just enough to satisfy your hunger.**
5. **Avoid too much sugar or caffeine.**

Try to remember what and when you have eaten lately. Are you giving your body the highest quality fuel possible?

Sample Day

Breakfast: _____

_____

_____

Lunch: _____

_____

_____

Dinner: _____

_____

_____

Snack: _____

_____

_____

Counselor's Guide

Exercise

Exercise

The development of a regular regimen of exercise is extremely important to recovering drug users. This is an area that has been under-emphasized by traditional spiritually-based treatment approaches. Discuss endorphins and the body's ability to burn off the chemistry of unpleasant emotion. Exercise plays a central role in allowing clients to cope with stress and difficult emotions.

Exercise

Exercise is an important part of your program. People who engage in regular physical exercise generally do better in treatment than those who do not exercise. The physical demand that exercise places on the body brings on several physiological responses. Among these are increased heart, respiration, and metabolic rates. For your recovery, the most important reaction of all may be the body's increased production of endorphins. Endorphins are naturally occurring chemicals produced by the body to decrease pain and relieve depression.

Twenty to thirty minutes of aerobic exercise (such as dancing, walking, biking, Nautilus, jogging, tennis, swimming, or roller skating) stimulates endorphin production. It also provides other benefits that are extremely important to recovery from addiction. Below is a list of the benefits of exercise in this recovery process. Try building exercise into your schedule.

Regular exercise:

1. provides structure.
2. aids stabilization of sleep process.
3. improves spirit and moods.
4. builds self-esteem.
5. releases excess energy/invigorates when energy is low.
6. helps prevent weight gain during recovery.
7. offers a "downtime" escape from stress.

A. What type of exercise do you plan to do? _____

_____

B. What will be your exercise schedule? _____

_____

SECTION F. SOURCES OF SUPPORT

Next, I would like to ask some questions about how you have supported yourself.

F1. Have you ever worked at a legitimate full-time job? By legitimate jobs, I mean jobs that do not involve illegal activities. They do include working for yourself, as well as jobs paid off the books or under the table.

01 Yes

02 No → *(GO TO F7)*

F2. When were you last employed at any one legitimate full-time job?

☐☐ Month ☐☐ Day 19☐☐ Year

F3. What is the longest you ever worked in any one legitimate full-time job?

☐☐ Years ☐☐ Months ☐☐ Weeks ☐☐ Days

F4. Thinking about the job that you had the longest, what type of job was it? *(RECORD VERBATIM, THEN ENTER APPROPRIATE CODE FROM OCCUPATION CODES LIST)*

☐☐ _____

_____

_____

_____

OCCUPATION CODES

01 Professional and technical (accountant, architect, engineer, lawyer, or judge, scientist, doctor, registered nurse, teacher, social worker, writer, entertainer)

02 Manager and administrator (office manager, sales manager, school administrator, government official, small business owner)

03 Sales (sales representative, insurance agent, real estate broker, book salesperson, sales clerk, or other salesperson)

04 Clerical or office worker (bank teller, bookkeeper, secretary, typist, postal clerk or carrier, ticket agent)

05 Craft and kindred (baker, carpenter, electrician, bricklayer, mechanic, machinist, tool and die maker, telephone installer)

06 Operative (assembler, checker, gas station attendant, meat cutter, packer, laundry and drycleaning operative, miner operative, welder, garage worker)

07 Transportation equipment operative (bus driver, cabdriver or chauffeur, truck driver, delivery person)

08 Nonfarm laborer (construction worker, freight handler, sanitation worker)

09 Private household worker (maid, butler, cook)

10 Service worker (cook, waiter/waitress, barber, janitor, practical nurse, beautician, police officer, fireman)

11 Farmer and farm manager

12 Farm worker (foreman, picker)

13 Military service

F5. What was your wage, salary, or rate of pay before taxes at that job? *(RECORD ACTUAL AMOUNT—WEEKLY AND YEARLY SALARIES TO THE NEAREST DOLLAR, HOURLY WAGES TO THE NEAREST CENT. THEN CIRCLE THE CODE FOR RATE GIVEN)*

$☐☐☐☐☐☐.☐☐
Dollars Cents

01 Hour

02 Week

03 2 weeks

04 Month

05 Year

06 Other *(SPECIFY)* _____

Notes: _____

F6. When did you last work at that job?

☐☐ Month ☐☐ Day 19☐☐ Year

Now, please think about any legitimate jobs that you have now. These include both full- and part-time jobs.

IF CURRENTLY WORKING (F2 = TODAY'S DATE), GO TO F8. OTHERWISE, CONTINUE TO F7.

F7. Are you currently working at any legitimate paid job (either full- or part-time)?

01 Yes
02 No → *(GO TO F10)*

F8. How many hours do you work in all legitimate, paid jobs during a typical week?

☐☐ Hours worked

F8a. Do you have a regular work schedule?

01 Yes
02 No → *(GO TO F8c)*

F8b. What hours do you normally work?

☐☐:☐☐ am/pm to ☐☐:☐☐ am/pm

F8c. What types of jobs do you have now? *(RECORD VERBATIM, THEN ENTER APPROPRIATE CODES FROM OCCUPATION CODES LIST)*

_____

_____

☐☐ Main job ☐☐ 2nd job ☐☐ 3rd job ☐☐ 4th job

F9. What is your wage, salary, or rate of pay (at all jobs) before taxes? *(RECORD ACTUAL AMOUNT—WEEKLY AND YEARLY SALARIES TO THE NEAREST DOLLAR, HOURLY WAGES TO THE NEAREST CENT. THEN CIRCLE THE CODE FOR RATE GIVEN)*

$☐☐☐☐☐☐.☐☐
Dollars Cents

01 Hour
02 Week
03 2 weeks
04 Month
05 Year
06 Other *(SPECIFY)* _____

IF RESPONDENT IS WORKING (F7=01) OR (F2 = TODAY'S DATE), GO TO F11. OTHERWISE CONTINUE TO F10.

F10. What were you doing most of the last week? Were you looking for work, keeping house, going to school, or something else? *(CIRCLE ONE)*

01 With a job but not at work
02 Looking for work → *(GO TO F12)*
03 Keeping house
04 Going to school or training program
05 Unable to work, disabled
06 Retired
07 In jail, residential treatment program, or other institution
08 Illegal activity (hustling)
09 Drug activities
10 Other *(SPECIFY)* _____

_____

F11. Did you (look for work/look for another job) during the 4 weeks before trying to get treatment this time? *(CIRCLE ONE)*

01 Yes
02 No

Notes: _____

F12. During the past 12 months, how many paid legitimate jobs with different employers or businesses did you have?

☐☐ Jobs

(IF "NONE," ENTER 00 AND GO TO F14)

F13. During the past 12 months, about how many weeks were you employed 35 hours or more (at all jobs)?

☐☐ Weeks

F14. Did you ever support yourself mainly from illegal activity (hustling, dealing, crime) for at least 1 year?

01 Yes → *(GO TO F14a)*

02 No → *(GO TO F15)*

F14a. What is the longest time you supported yourself mainly with illegal activity?

☐☐ Years ☐☐ Months

F14b. What kinds of things did you usually do to support yourself? *(CIRCLE ALL MENTIONS)*

00 Variety, no specific type

01 Dealing drugs

02 Hustling illegal goods, other than drugs

03 Larceny, robbery, burglary

04 Forgery, fraud, embezzlement

05 Pimping, prostitution

06 Other *(SPECIFY)* _____

F14c. How long ago was this? *(IF STILL DOING THIS, ZERO-FILL)*

☐☐ Years ☐☐ Months

Next, I would like to ask about your sources and amount of income.

F15. During the past 12 months, did you receive any income from *(READ EACH INCOME SOURCE FROM INCOME CHART)*: *(IF "YES," CIRCLE 01 IN COLUMN F15 AND ASK F16; IF "NO," CIRCLE 02 AND ASK ABOUT NEXT INCOME SOURCE)*

F16. In the past 12 months, how much income before taxes did you personally receive from *(READ INCOME SOURCE)*: *(RECORD AMOUNT TO NEAREST DOLLAR IN COLUMN F16)*

INCOME CHART

Income source	F15. Source Yes	F15. Source No	F16. Amount past 12 mon.
a. Wages or salary from a legitimate job or business?	01	02	$ ☐☐☐☐☐☐
b. Spouse or family contribution?	01	02	$ ☐☐☐☐☐☐
c. Alimony or child support?	01	02	$ ☐☐☐☐☐☐
d. SSI—Supplemental Security Income?	01	02	$ ☐☐☐☐☐☐
e. Disability pay, such as SSDI, unemployment compensation for a work-related injury, or income from a private disability insurance plan?	01	02	$ ☐☐☐☐☐☐
f. Unemployment compensation for being laid off?	01	02	$ ☐☐☐☐☐☐
g. Retirement or a pension, other than Social Security, but including military retirement pay?	01	02	$ ☐☐☐☐☐☐
h. AFDC – Aid to Families with Dependent Children?	01	02	$ ☐☐☐☐☐☐
i. Veterans' Administration?	01	02	$ ☐☐☐☐☐☐
j. Criminal or possibly illegal sources such as hustling or dealing?	01	02	$ ☐☐☐☐☐☐
k. Any other sources not mentioned here? *(SPECIFY)* _____	01	02	$ ☐☐☐☐☐☐

F17. How troubled or bothered are you by employment problems?

00 Not at all
01 Slightly
02 Moderately
03 Considerably
04 Extremely

F18. How important to you now is counseling for employment problems?

00 Not at all
01 Slightly
02 Moderately
03 Considerably
04 Extremely

F19. How confident are you that you have the training, skills, and experience to get and hold a good job?

00 Not at all
01 Slightly
02 Moderately
03 Considerably
04 Extremely

Notes: _____

Form Guide

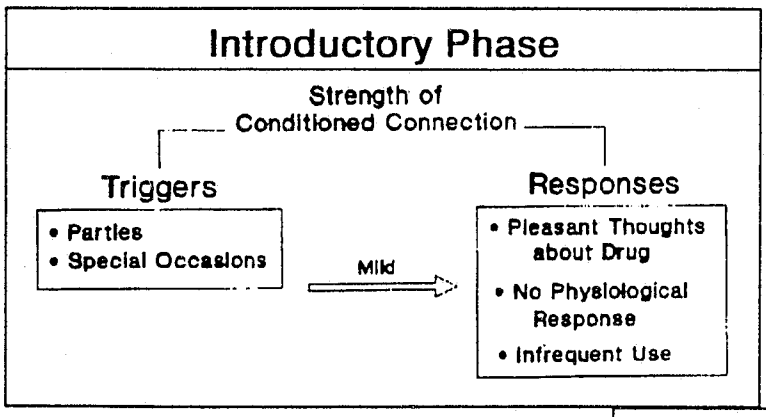
Dealing With Other Drug and Alcohol Use

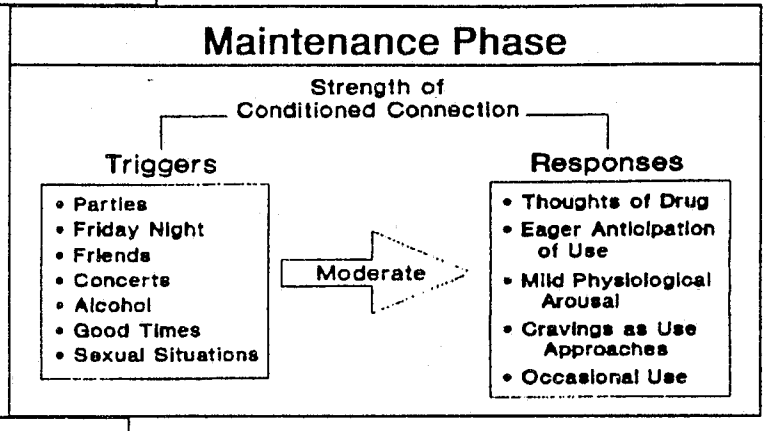
- Conditioning Process During Addiction
- Cognitive Process During Addiction
- Development of Craving Response

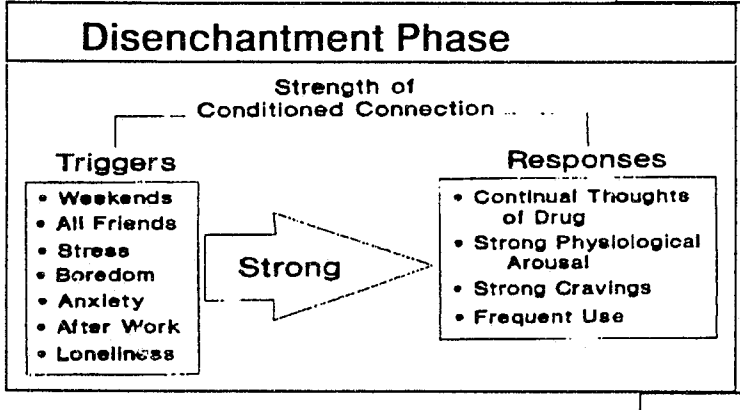
Text: Dealing With Other Drug And Alcohol Use, Episodic Chemical Dependencies.

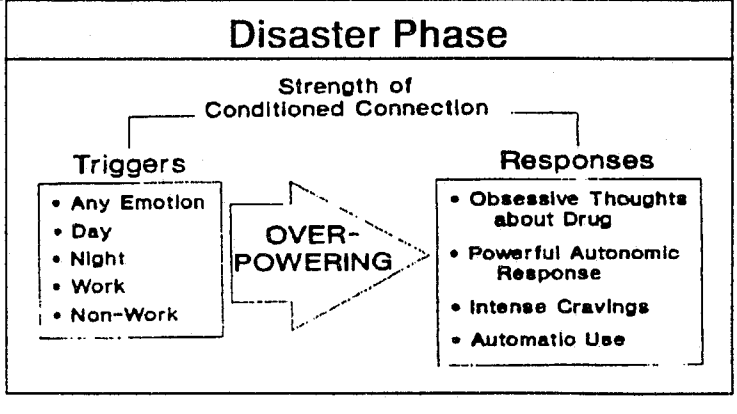
See Pages 72 - 78

Conditioning Process During Addiction









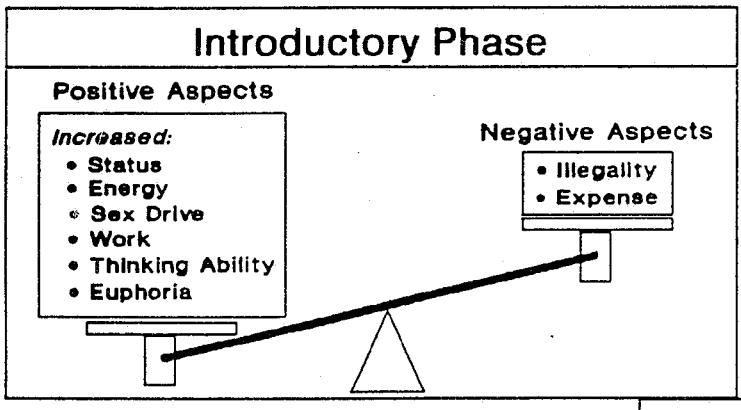
The neurobehavioral model involves an explanation of cognitive and conditioning processes during addiction. The cognitive process occurs in the higher, rational, intelligent part of the brain while the conditioning process occurs in the lower, emotional, irrational part of the brain.

Conditioning is the automatic result of taking cocaine in sufficient amounts over time. It is unaffected by rational processes such as an awareness of the detrimental effects of cocaine or an intention to stop cocaine. Understand-ing this is critical. Promises and intentions do not change the functioning of the lower brain. Intentions must translate into behavior change to control the lower, addicted brain.

The conditioning process occurs as people, places and situations become associated with cocaine. Over time these "triggers" develop the ability to cause cocaine thoughts, physiological arousal and cocaine cravings. In this way internal rational control of cocaine use is lost. The triggers in a person's environment take control through this powerful physiological process.

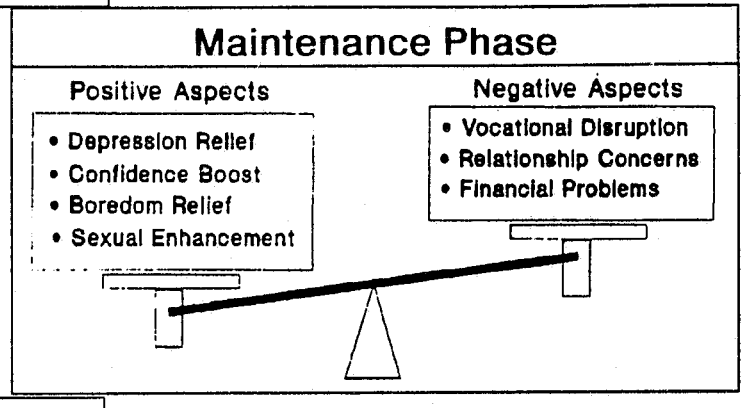
The diagrams show the progression of conditioning through the four phases of addiction. The number of triggers increases. The connection between these triggers and the responses (thoughts, physiological reactions, cravings) they elicit becomes stronger.

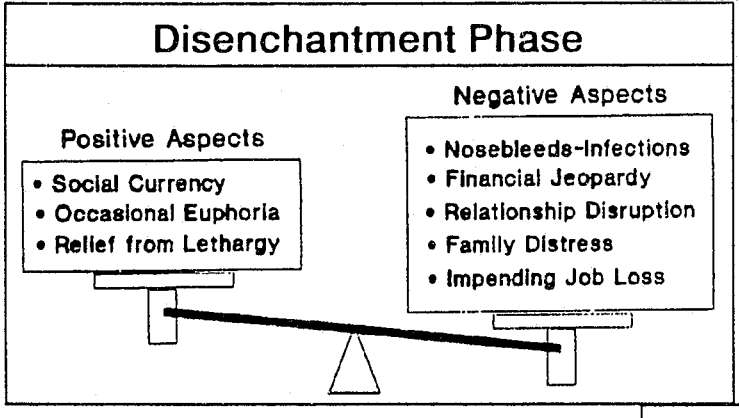
Cognitive Process During Addiction



The neurobehavioral model involves an explanation of cognitive and conditioning processes during addiction. The cognitive process occurs in the higher, rational, intelligent part of the brain while the conditioning process occurs in the lower, emotional, irrational part of the brain.

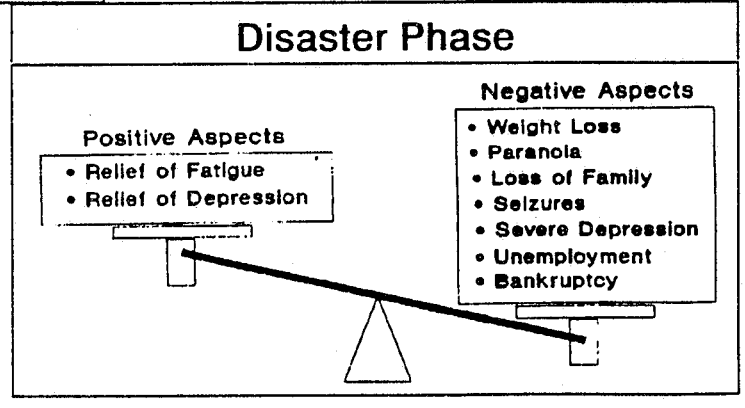
The cognitive process during the development of addiction is the increasing awareness of increasing negative aspects related to cocaine use and decreasing positive aspects. In the beginning stages of cocaine use, the decision scales are weighted more heavily on the positive side. As cocaine use increases, however, the scales tip toward the negative and it makes no sense to continue using.





Other types of behavior would cease when the scales tip to the negative. Addictive behavior, however, continues and actually increases in frequency despite mounting negative consequences. Without an understanding of addiction the person who has developed a cocaine problem is left with several inaccurate explanations for his or her behavior. These explanations usually involve ideas of being stupid, "bad", or mentally ill.

The cognitive process only makes sense with an understanding of the conditioning process which is occurring in another part of the brain. The conditioning process causes overwhelming urges to use drugs which are totally unaffected by the rational, cognitive process.



Development of Craving Response

The four diagrams below display the development of craving as cocaine use increases. *Craving* is the combined experiences of cocaine-related thoughts and an accompanying physiological reaction.

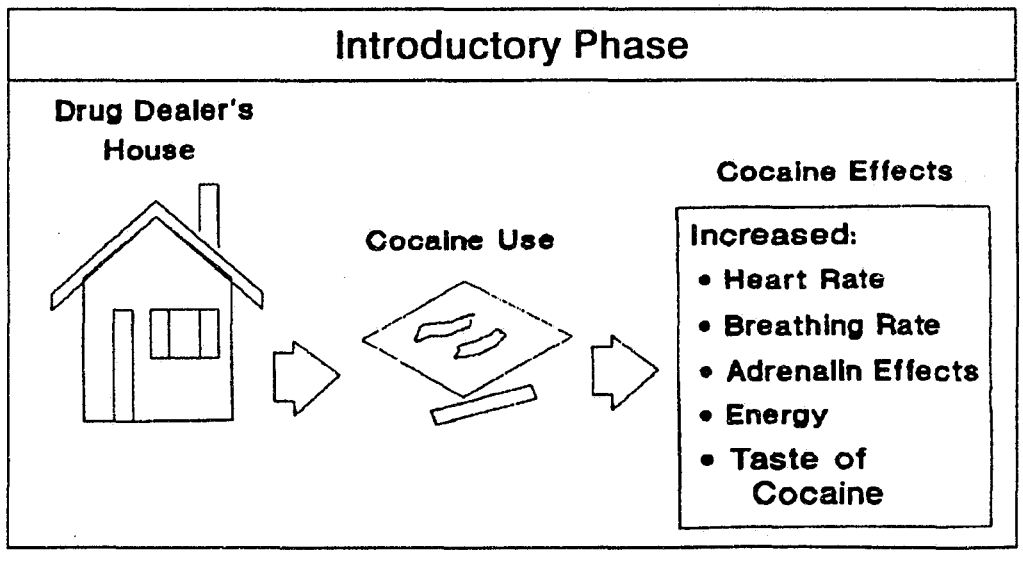
In the *introductory phase,* there is no craving. Craving is learned as a result of cocaine use over time. Prior to the development of craving there are no physical reactions before taking cocaine. After taking cocaine the person experiences increased heart rate, increased breathing rate, adrenalin effects, increased energy, and the taste of cocaine.

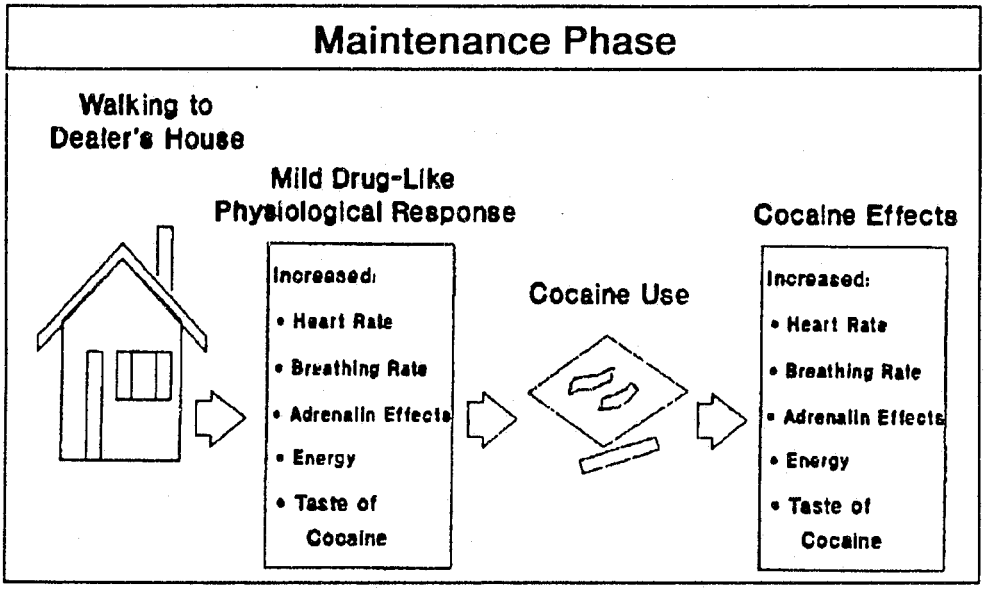
In the *maintenance phase* of more regular cocaine use, the person feels some physiological reaction to people, places and experiences which have been associated with cocaine. After using cocaine the same effects are amplified.

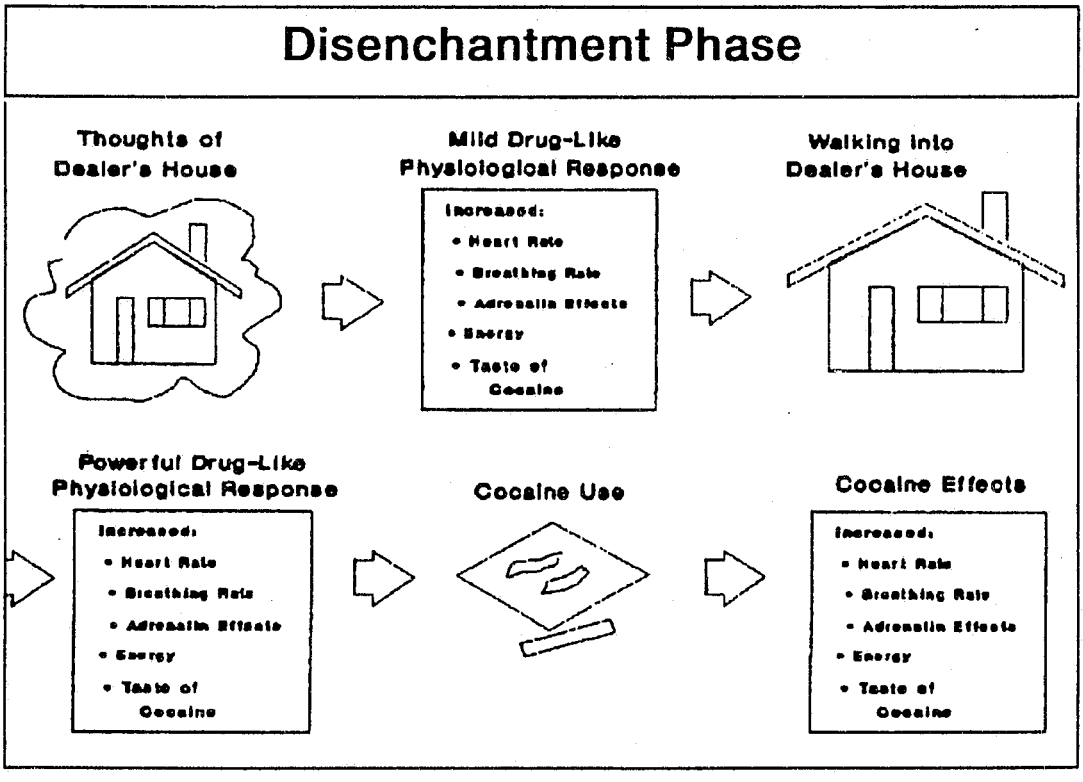
The craving response continues to develop as cocaine use becomes more frequent and greater amounts of cocaine are used. In the *disenchantment phase,* the mere thought of cocaine-related situations cause a mild physiological response. The craving which is caused by these thoughts grows in intensity as there is movement toward actually taking cocaine. The physiological reactions just prior to cocaine use are similar to the actual effects of cocaine.

In the *disaster phase,* when cocaine use is either constant or occurring in extended binges, thoughts of cocaine and cocaine-related situations elicit powerful physiological responses. These effects can resemble the experience of being on cocaine and they can be pleasurable in and of themselves. The thoughts cause a flooding of the brain's synapses with neurochemicals and the person is physiologically in a state similar to that of actually being on cocaine. Many cocaine users at this point describe the effects of cocaine itself to be aversive. It is as if the brain is already under the influence as a result of the craving response and the additional effects of cocaine produce an overload, toxic-like reaction.

Understanding the nature of craving and having a respect for the physical nature of cocaine craving is essential to overcoming cocaine addiction. Otherwise the cocaine addict continues to use psychological processes such as will power, determination, resolve, and attitude change against a physiological problem.

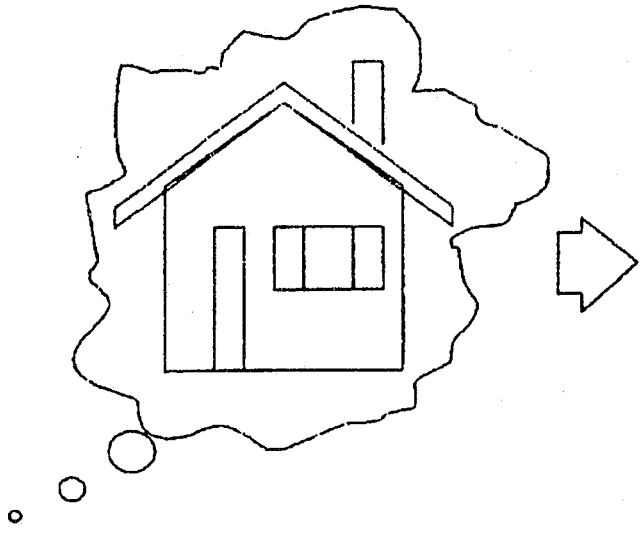



Maintenance Phase
Walking to Dealer's House
Mild Drug-Like Physiological Response
Increased:
• Heart Rate
• Breathing Rate
• Adrenalin Effects
• Energy
• Taste of Cocaine
Cocaine Use
Cocaine Effects
Increased:
• Heart Rate
• Breathing Rate
• Adrenalin Effects
• Energy
• Taste of Cocaine


Disenchantment Phase
Thoughts of Dealer's House
Mild Drug-Like Physiological Response
Increased:
• Heart Rate
• Breathing Rate
• Adrenalin Effects
• Energy
• Taste of Cocaine
Walking into Dealer's House
Powerful Drug-Like Physiological Response
Increased:
• Heart Rate
• Breathing Rate
• Adrenalin Effects
• Energy
• Taste of Cocaine
Cocaine Use
Cocaine Effects
Increased:
• Heart Rate
• Breathing Rate
• Adrenalin Effects
• Energy
• Taste of Cocaine

Disaster Phase

Thoughts of Dealer's House



Powerful Drug-Like Physiological Response

Increased:

- Heart Rate
- Breathing Rate
- Adrenalin Effects
- Energy
- Taste of Cocaine

Form Guide

Dealing With Non-Opiate Drug or Alcohol Use

- External Trigger Questionnaire
- Internal Trigger Questionnaire
- Trigger Chart

Text: Approaches for Dealing With Non-Opioid Drug Use or Alcohol Use

See Pages 77 - 78

External Trigger Questionnaire

1. Place a check mark next to activities or situations in which you frequently used cocaine. Place a zero (O) next to activities or situations in which you never have used drugs.

_____ Home alone	_____ Before a date	_____ After payday
_____ Home with friends	_____ During a date	_____ Before going out to dinner
_____ Friend's home	_____ Before sexual activities	_____ Before breakfast
_____ Parties	_____ During sexual activities	_____ At lunch break
_____ Sporting events	_____ After sexual activities	_____ While at dinner
_____ Movies	_____ Before work	_____ After work
_____ Bars/Clubs	_____ When carrying money	_____ After passing a particular freeway exit
_____ Beach	_____ After going past dealer's residence	
_____ Concerts		_____ School
_____ Driving	_____ With particular people	

2. List any other settings or activities where you frequently use drugs.

_____

3. List activities or situations in which you would not use drugs.

_____

4. List people you could be with and not use drugs.

_____

Internal Trigger Questionnaire

During the early and middle stages of cocaine addiction there are often certain feelings or emotions that trigger the brain to think about using cocaine. Read the following list of emotions and indicate which of them can trigger (or used to trigger) cocaine cravings for you:

_____ Afraid	_____ Frustrated	_____ Neglected
_____ Angry	_____ Guilty	_____ Nervous
_____ Confident	_____ Happy	_____ Passionate
_____ Criticized	_____ Inadequate	_____ Pressured
_____ Depressed	_____ Insecure	_____ Relaxed
_____ Embarrassed	_____ Irritated	_____ Sad
_____ Excited	_____ Jealous	
_____ Exhausted	_____ Lonely	

A. I thought about using cocaine when I felt:

_____

_____

B. Circle the above emotional states or feelings that have triggered your cocaine use recently.

C. Has your cocaine use in recent weeks/months been:

_____ 1. Primarily tied to emotional conditions
_____ 2. Routine and automatic without much emotional triggering.

D. Are there any times in the recent past in which you were attempting to stay drug free and a specific change in your mood clearly resulted in cocaine use? (e.g., You got in a fight with someone and went to use in response to getting angry.)

Yes _____ No _____
If yes, describe: _____

_____

TRIGGER CHART

Name:_____ Date:_____

Instructions: List people, places, objects, or situations below according to their degree of association with cocaine use.

0% Chance of Using — 100% Chance of Using

Never Use	Almost Never Use	Almost Always Use	Always Use

These are "safe" situations.

These are low risk, but caution is needed.

These situations are high risk. Staying in these is extremely dangerous.

Involvement in these situations is deciding to stay addicted. Avoid totally

Relapse Prevention

Form Guide

Relapse Prevention

- Counselor's Guide to Relapse Prevention
- Relapse Prevention
- Addict Behavior
- Relapse Justification I
- Dangerous Emotions
- Be Smart, Not Strong
- Alcohol - The Legal Drug
- Downtime
- Looking Forward
- Truthfulness
- Counselor's Guide to Relapse Analysis Chart
- Relapse Analysis Chart

Text: **Approaches for Dealing With Non-Opiate Drug Use, or Alcohol Use, Relapse Prevention**

See Pages 78 - 79

Counselor's Guide To

Relapse Prevention

Relapse Prevention

Relapses don't just happen. There are warning signs in behavior and thinking that patients can be taught to monitor. Also, there is frequently an emotional building prior to a relapse. This is a subtle and difficult concept. Addicts need to learn the indicators of stress and anxiety such as insomnia, nervousness, or headaches, and to view these as signals of possible relapse. Learning from previous relapses is critical.

Addict Behavior

Ask patients to identify which behaviors were characteristic of their addiction. Emphasize that the re-emergence of addict behaviors is an important relapse signal. This is a good opportunity to point out necessary behavior change and how changing behavior can lead the way to long term sobriety.

Relapse Justification I

The thinking which is characteristic of a person moving toward drug use is examined in this session. The point should be stressed that one may be less susceptible to these relapse justifications if they are identified and evaluated ahead of time. Ask patients to pick out particular relapse justifications to which they may have been susceptible in the past.

Dangerous Emotions

Several types of negative emotional states are very powerful triggers for recovering addicts. This handout explains a few of the most common. Discussion can assist patient in identifying their own most likely and most powerful emotional triggers.

Be Smart, Not Strong

The point of this exercise is that you cannot be stronger than addiction. Wanting to be abstinent is not enough, no matter how strong the desire. It is necessary to maintain maximum distance from drugs by avoiding risk and establishing positive, drug-incompatible activities. This is a basic principle in recovery. Keeping a distance from relapse does not, in itself, constitute recovery. However, it allows for the development of a comprehensive lifestyle change and a solid recovery.

Alcohol - The Legal Drug

Because alcohol is so much a part of people's everyday lives, it is often not thought of as a drug. This exercise is designed to help patients realize the situations they will probably encounter where drinking seems like the thing to do. Planning ahead for these events can help them cope more easily with remaining abstinent.

Downtime

Fatigue is an important contributor to relapse. Some stress and fatigue can be alleviated by scheduling downtime on a regular basis. Some patients have difficulty discriminating downtime from other types of leisure or recreational activities. This time away from the responsibilities of life will be a very personal escape. Each patient needs to identify downtime activities that are most refreshing to them personally and be encouraged to incorporate them into his/her normal life.

Looking Forward

Planning islands of rest and recreation in the future keeps the recovery process from seeming to be endless and gray. These oases provide something to work toward and they also break time into manageable chunks. Encourage patients to identify possible islands. Stress that island building should become an on-going activity throughout recovery.

Truthfulness

Truthfulness is one of the most important issues in recovery. This exercise presents the idea of truth versus lying as being the difference between reality and appearances. The adherence to truthfulness is essential to ground recovery in reality instead of the illusory realm of addiction. This topic should be addressed very seriously. The questions at the end of the handout provide patients with an opportunity to discuss areas where truthfulness is a problem. Patients who admit to lapses in truthfulness should be praised for their honesty.

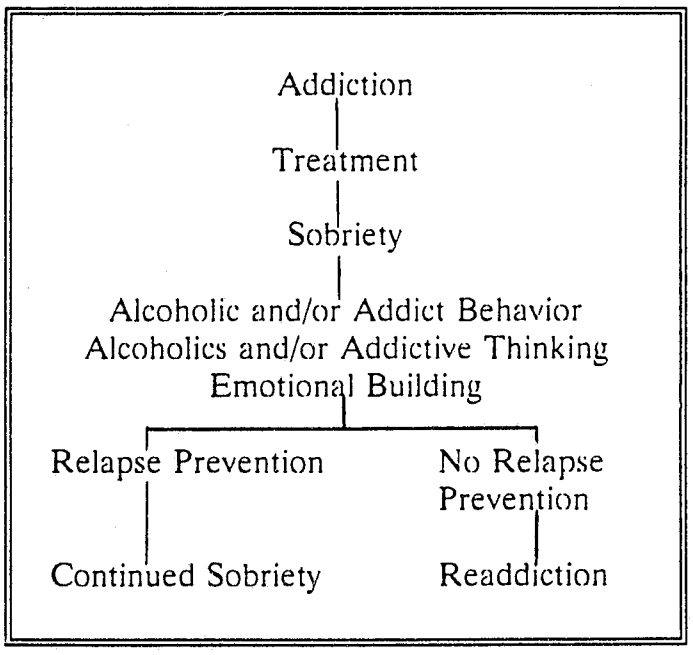
Relapse Prevention

Why is relapse prevention important?

Recovery is more than not using drugs or alcohol. The first step in treatment is stopping drug and alcohol use. The next step is not starting again. This is very important and the process for doing it is called RELAPSE PREVENTION.

What is relapse?

Relapse is going back to drug or alcohol use and to all the behaviors and patterns that go with that. Often the behaviors and patterns return before the actual drug or alcohol use. Learning to recognize the beginning of a relapse can help the recovering person stop the process before actual drug or alcohol use begins. The process looks like this:



What is Alcoholic/Addict Behavior?

The things people do as part of using drugs or alcohol are called alcoholic or addict behaviors. Often these are things the alcoholic or addict does to get drugs or alcohol, to cover-up drinking and using or as part of the use. Lying, stealing, being unreliable, and acting compulsively are types of alcoholic and addict behaviors. Describe yours:

_____

_____

_____

What is Emotional Building?

Feelings that don't seem to go away and just keep getting stronger cause emotional building. Sometimes the feelings seem unbearable. The kinds of feelings that can build are boredom, anxiety, sexual frustration, irritability and depression. Are any of these familiar to you now or in the past?

_____

_____

_____

What is Alcoholic or Addictive Thinking?

In AA these kinds of thoughts are called "stinking thinking." They are thoughts that make using or drinking seem O.K. Some examples are, "I can handle just one drink", "If they think I'm using, I might as well", or "I have worked hard. I need a break." What might your brain say to you?

_____

_____

_____

The important step is to TAKE ACTION as soon as you recognize the danger signs. Some possible actions might be:

Calling a therapist
Calling an AA friend
Going to an AA meeting
Beginning to exercise
Taking a vacation
Talking to your family
Talking to your spouse
Using time scheduling

Addict Behavior

As alcohol and/or drug use increases, the user tries to keep life under control. That gets harder and harder to do so. Finally the user does desperate things to try to continue to appear normal. These desperate behaviors are called alcoholic or addict behaviors. They are the things people do related to their alcohol and/or drug use. Sometimes the behaviors ONLY occur when people are using or moving toward drinking or using. Learning to recognize when one or more of these begin happening will help you know when to start fighting extra hard to move away from relapse.

Which of these behaviors do you think are related to your drug/alcohol use?

_____ Lying

_____ Stealing

_____ Being irresponsible (not meeting family/work commitments)

_____ Being unreliable (late for appointments, breaking promises, etc.)

_____ Being careless about health and grooming (wearing "using" clothes, stopping exercise, poor diet, messy appearance, etc.)

_____ Housekeeping gets sloppy

_____ Behaving impulsively (without thinking)

_____ Behaving compulsively (too much eating, working, sex, etc.)

_____ Changing work habits (working more, less, not at all, new job, change in hours, etc.)

_____ Losing interest in things (recreational activities, family life, etc.)

_____ Isolating (staying by yourself much of the time)

_____ Missing or being late for treatment

_____ Using other drugs, alcohol or prescription medicine

_____ Stopping prescribed medication (Antabuse, Naltrexone)

Relapse Justification - 1

Once a person decides not to use drugs/alcohol anymore, how do they end up doing it again? Does it happen completely by accident or is there some way of avoiding the relapse?

Relapse justification is a process that happens in people's minds. If a decision has been made to stop drinking and using but the addiction still has strength, the game gets tricky. The addicted part of the brain invents excuses that move the addict close enough to relapse situations that accidents can and do happen. The situation seems like it has nothing to do with drug/alcohol use but suddenly using seems logical and relapse occurs. Many of these situations are recognizable. You may remember times when you were planning to stay drug/alcohol free and such a situation happened before you used again. The sooner you can recognize the relapse justifications for what they are and interrupt the process, the better chance you have of remaining drug/alcohol free. Use the questions below to help you identify justifications your addicted brain might use:

Accidently or Other People

Does your brain ever try to convince you that you have no choice when unexpected situation caught you off-guard? Have you ever said to yourself:

1. **It was offered to me. What could I do?**
2. **An old friend called and we decided to get together.**
3. **I was cleaning my house and found cocaine I'd forgotten about.**
4. **I had friends come for dinner and they brought me some wine.**
5. **I was in a bar and someone offered me a beer.**

Catastrophic Events

Is there one unlikely, major event that is the only reason you would use? What might such an event be for you? How would using drugs/alcohol improve the situation?

1. **My spouse left me. There's no reason to stay sober.**
2. **I just got injured. It's ruined all of my plans. I might as well use.**
3. **I just lost my job. Why not?**

For a Specific Purpose
Has your addicted brain ever suggested that using a certain drug or alcohol is the only way to accomplish something?

1. **I'm gaining weight and need cocaine to control my weight.**
2. **I'm out of energy. I'll function better.**
3. **I need alcohol or drugs to meet people more easily.**
4. **I can't enjoy sex without drinking.**
5. **Relaxing after a stressful day is impossible without a drink.**

Depression, Anger, Loneliness, and Fear
Does feeling depressed, angry, lonely or afraid make using seem like the answer? Is it really? What might you do when your addicted brain asks these questions?

1. **I'm depressed. What difference does it make if I drink or not?**
2. **When I get mad enough I can't control what I do.**
3. **I'm scared. I know how to make the feeling go away.**
4. **If he or she thinks I've used, I might as well use.**

Dangerous Emotions

For many people there are certain emotional states that are "red flag" feelings. They are often viewed by people in recovery as "the reason I use or drink." It seems to the recovering person that if they could avoid feeling lonely, angry or deprived, they would never relapse. The emotional trigger leads to automatic use.

The most common negative emotional triggers are:

Loneliness - It is difficult to give up friends and activities that are part of an alcoholic or drug-using lifestyle. Being separated from friends and family leaves people feeling lonely. Often non-using friends and family members are not ready to get together with the addict/alcoholic. They are not ready to risk getting back into a relationship that didn't work earlier. The recovering person is stranded between groups of friends and the feeling of loneliness can become a driving force moving the person back toward drinking or using.

Anger - The intense irritability experienced in the early stages of recovery can result in floods of anger that are, for many people, instantly triggering. The rage comes directly from the limbic, addicted brain. Once a person is into that frame of mind it is a short trip to drug/alcohol use and can be a long trip back to the rational state of mind.

Deprived - Becoming drug/alcohol-free is a real accomplishment. Usually recovering people feel very good and proud about what they have been able to do. Recovery is a positive thing. Sometimes situations exist that make recovering people feel like they are having to give up "good times and good things." Recovery becomes a negative state. It becomes a sentence; something to be endured. Feeling that drinking/using behavior is positive and sobriety behavior is negative quickly leads to relapse.

It is important to be aware of these "red flag" emotions. Allowing yourself to be flooded with these powerful negative emotions is allowing yourself to be swept rapidly toward relapsing.

Have any of these emotional states been a trigger for you in the past?

_____

_____

Are there any other negative emotional states that are dangerous for you?

_____

_____

Be Smart; Not Strong

"I can be around drugs/alcohol. I am certain I don't want to use and once I make up my mind, I'm very strong."

"I have been doing well and I think it's time to test myself and see if I can be around friends who are using. It's just a matter of willpower."

"I think I can have a drink, I never had a problem with alcohol anyway."

Staying drug or alcohol free does not depend on strength. People who are able to maintain abstinence do it by being smart. They know that the key to not using is keeping far away from relapse situations. The closer you get, the more likely a relapse becomes. If drugs appear unexpectedly and you are close to them with friends, and drinking, your chances of using are much greater than if you weren't there in that situation. Smart people stay sober by avoiding triggers for as long as possible.

Don't Be Strong. BE SMART.

How smart are you being? Rate how well you are doing in avoiding relapse:

	Poor	Fair	Good	Excellent
1. Practicing Thought-Stopping	1	2	3	4
2. Scheduling	1	2	3	4
3. Keeping Appointments	1	2	3	4
4. Avoiding Triggers	1	2	3	4
5. Not Using Alcohol	1	2	3	4
6. Not Using Drugs	1	2	3	4
7. Avoiding Drug and Alcohol Users	1	2	3	4
8. Avoiding Drug and Alcohol Places	1	2	3	4
9. Exercising	1	2	3	4
10. Being Truthful	1	2	3	4

Total Recovery I.Q. _____

Alcohol

The Legal Drug

It is often difficult for clients to stop drinking when they enter treatment. Some of the reasons for this are:

1. Triggers for alcohol use are everywhere. It is sometimes hard to do anything social without facing people who are drinking.

   Do you have friends who get together without drinking?

   _____
   _____
   _____

2. Many people use alcohol in response to internal triggers. Depression and anxiety seem to go away when they have a drink. It's difficult for people to realize that sometimes the alcohol causes the depression.

   Does feeling a certain way make you want to have a drink?

   _____
   _____
   _____

3. If a person is addicted to an illicit drug and uses alcohol less often, alcohol may not be viewed as a problem. The problem doesn't exist until the person tries to stop drinking.

   Have you been able to stop drinking since you entered treatment?

   _____
   _____
   _____

4. Alcohol effects the rational, thinking part of the brain. It is difficult to think reasonably about a drug that is making thinking clearly more difficult.

   Have you ever been sober at a party and watched people drink and "get stupid"?

   _____
   _____
   _____

5. As alcohol dulls the rational brain, it promotes less controlled activity in the lower brain. This results in alcohol helping people become more sexual, less self-conscious and more social. When you are used to using alcohol to increase sexual pleasure and help you socialize, it feels uncomfortable without it.

   Do you depend on alcohol for sexual or social reasons?

   _____
   _____
   _____

6. Many of us grow up using alcohol to mark special occasions. It is hard to learn how to celebrate those times without drinking.

   What special occasions did your family celebrate with alcohol?

   _____
   _____
   _____

   How do you celebrate now?

   _____
   _____
   _____

7. In many families and social groups, drinking is a sign of strength, of being with it, or of being sophisticated. Our culture encourages drinking.

   Do you feel less "with it" when you are not drinking?

   _____
   _____
   _____

8. The habit of drinking gets to be part of certain activities. It seems difficult, at first, to do those things without a beer or a drink. (i.e., eating certain kinds of foods, going to sporting activities, relaxing. etc.)

   What activities seem to go with drinking for you?

   _____
   _____
   _____

It is important to remember that everyone who stops drinking has these problems at first. As you work through the difficult situations and get more time sober, it does get easier.

Downtime

THE PROBLEM

Being in recovery means living responsibly. Using the rational brain to decide what to do, to act intelligently and to constantly stay "with it" is exhausting. It is easy to run out of energy and become tired and negative. Life begins to become very narrow. It becomes a matter of going through the motions of getting up, going to work, coming home, lying on the couch, going to bed, getting up, etc. Addicts who allow themselves to get to this state of boredom and exhaustion are very vulnerable to relapse. It is difficult to resist anything or anyone when your energy level is so low.

THE OLD ANSWER

Drugs and alcohol provide quick relief from the above state. Using or drinking is an easy, fast way to get relief. All the reasons for not using chemicals are quickly forgotten when the body and mind desperately need refueling.

A NEW ANSWER

Each person needs to decide what can provide a refreshing, satisfying break from the daily grind. What works for you may not work for someone else. There are choices as to what you can do but there is no choice as to whether it is necessary to find downtime that works. The more tired and beaten down you become, the less energy there is to use in dealing with anything.

Notice how often you are feeling stressed, inpatient, angry, or shut down emotionally. These are signs of needing more downtime. Try some of the activities listed below:

_____	Walking	_____	Taking a class
_____	Going to the movies	_____	Reading
_____	Playing sports	_____	Learning meditation/yoga
_____	Writing	_____	Bicycling
_____	Watching T.V.	_____	Listening to music
_____	Playing with a pet	_____	Going to twelve-step meetings
_____	Painting-Drawing	_____	Fishing
_____	Exercising	_____	Playing a musical instrument
_____	Lying in the sun	_____	Shopping

Looking Forward

Structure is important. Scheduling is important. Balance is important. Downtime is important. So you're making it work. Recovery is working because you're working at it. Now what? Do you feel like something is missing? Do you feel like you need to take a break from the routine and get excited about something?

Some of the flat feeling in recovery may be a result of:

1. The recovery process the body is going through prevents you from feeling strong feelings of any kind.

   or

2. Normal life feels less exciting than life as an addict/alcoholic.

There is a trick people use to put a sense of anticipation and excitement into their lives. It is possible to plan certain things and to look forward to them. Some people think of this as building islands. Islands of rest, recreation, or fun. Islands to look forward to so that the future doesn't seem so endless and routine. The islands don't need to be big extravagant things. They can be things like:

- **Going out of town for a 3-day weekend**
- **Attending a baseball game**
- **Going out to eat**
- **Taking a day off work**
- **Visiting relatives**
- **Visiting an old friend**

They do need to be things you really look forward to doing. They also need to be spaced close enough together so that you don't get too stressed, tired, or bored; threatening your recovery.

List some past islands:

_____

_____

_____

_____

_____

What are some possible islands for you now?:

_____

_____

_____

_____

_____

Truthfulness

During Addiction
Not being truthful is part of addiction. It is very hard to meet the demands of daily living (in relationships, in families, in jobs, etc.) and also use drugs or alcohol regularly. As the addiction increases, so do the activities that are necessary to obtain, use and recover from the drug/alcohol use. It becomes more and more difficult to keep everything going smoothly and addicts find themselves doing and saying whatever is necessary to avoid problems. Truthfulness is not a consideration.

In what ways were you less than truthful during your addiction?

_____

_____

_____

During Recovery
Being honest with yourself and with others during the recovery process is critically important. Sometimes being truthful is very difficult because:

1. you may not seem to be a "nice" person.
2. your therapist or group members may be unhappy with your behavior.
3. you may be embarrassed.
4. other people's feelings may be hurt.

Trying to be in treatment without being truthful will make you feel crazy. It will make everything you are doing seem like a waste of time.

Has truthfulness been difficult for you in recovery? _____
Being partly honest is not being truthful. Do you ever:

1. decide to let someone believe a partial truth?
2. tell people what they want to hear?
3. tell people what you wish were true?
4. tell less than the whole truth?

ATTENDING GROUPS, ATTENDING MEETINGS, GOING TO A HOSPITAL OR GOING TO A THERAPIST ARE ALL A WASTE OF TIME AND MONEY WITHOUT TRUTHFULNESS. RECOVERY FROM ADDICTION IS IMPOSSIBLE WITHOUT TRUTHFULNESS.

Counselor's Guide

Relapse Analysis Chart

Relapse Analysis Chart

The categories itemized across the top of the sheet should be explored with the patient as to events that occurred within 1-4 week period preceding the relapse. Every change or stressor should be noted whether or not they seem pertinent. The categories include:

1. Career Events - Events or a change in status relative to a career or a job.
2. Personal Events - Events or a change in the status of relationships with family/friends as well as other events or situations unrelated to any other category.
3. Treatment Events - Events or a change in status of the regular treatment plans as well as transition from one phase of treatment to another.
4. Drug/Alcohol Related Behaviors - Behaviors directly related to drug and alcohol consumption. (e.g., drinking, going to bars, visiting a dealer, etc.)
5. Behavioral Patterns - New or resumed addict behaviors that are part of addiction. (e.g., lying, stealing behaving compulsively, isolating, etc.)
6. Relapse Cognitions - Thoughts that seem to condone or justify relapse, even if they were brief and seemed minor. Being aware, at any point, that a relapse might be in progress.
7. Health Habits Status - Events or a change in status or routine of normal eating, sleeping, exercise, or grooming behaviors. Illness or injuries are particularly pertinent.

It is not likely that there will be significant events in every singly category. It is important to get a picture of the client's overall vulnerability before the actual relapse occurred.

RELAPSE ANALYSIS CHART

Name:_____ Date of Relapse:_____

A relapse episode does not begin when alcohol or drug ingestion occurs. Frequently there are pre-use events that occur which are indicative of the beginning of a relapse episode. Identifying your individual pre-use patterns will allow you to interrupt the relapse episode before the actual alcohol or drug use and to make adjustments to avoid the full relapse. Using the chart below, note events occurring during the week immediately preceding the relapse being analyzed.

CAREER EVENTS	PERSONAL EVENTS	TREATMENT EVENTS	ALCOHOL/DRUG RELATED BEHAVIORS	BEHAVIORAL PATTERNS	RELAPSE COGNITIONS	HEALTH HABITS STATUS

FEELINGS RELATIVE TO ABOVE EVENTS						

Form Guide

Tapering:

Evaluating Readiness

- Tapering Readiness Inventory
- Tapering Readiness Inventory, An Explanation

Text: Evaluating Readiness

See Page 81

Tapering Readiness Inventory

The purpose of this inventory is to help you decide if you are ready to taper from methadone maintenance at this time. Each item represents an important part of the process of being ready to detoxify from methadone. The inventory can help to confirm whether or not you are ready.

The more questions you can honestly circle "yes," the greater the likelihood that you are ready to taper from methadone. Consider that each "no" response represents an area that you probably need to work on to increase the odds of a successful taper and recovery. Circle the appropriate response.

1. Have you been abstaining from illegal drugs, such as heroin, cocaine, and speed? Yes __No __

2. Do you think you are able to cope with difficult situations without using drugs? Yes __No __

3. Are you employed or in school? Yes __No __

4. Are you staying away from contact with users and illegal activities? Yes __No __

5. Have you gotten rid of your "works"? Yes __No __

6. Are you living in a neighborhood that doesn't have a lot of drug use, and are you comfortable there? Yes __No __

7. Are you living in a stable family relationship? Yes __No __

8. Do you have straight (nonuser) friends that you spend time with? Yes __No __

9. Do you have friends or family who would be helpful to you during a taper? Yes __No __

10. Have you been participating in counseling that has been helpful? Yes __No __

11. Does your counselor think you are ready to taper? Yes __No __

12. Do you think you would ask for help when you were feeling bad during a taper? Yes __No __

13. Have you stabilized on a relatively low dose of methadone? Yes __No __

14. Have you been on methadone for a long time? Yes __No __

15. Are you in good mental and physical health? Yes __No __

16. Do you want to get off methadone? Yes __No __

Tapering Readiness Inventory

An Explanation

If every person on methadone maintenance started to taper, only ten or twenty percent would make it to 0 milligrams "clean." Who can make it off methadone and who can't? The inventory highlights factors that indicate a readiness to get off methadone. Having many factors working in your favor means that you have a better chance of getting off methadone "clean", i.e., without abusing drugs. That doesn't mean that you are ready to get off methadone, but it shows that you have some of the readiness factors on your side. Having very few of the factors on your side, though, shows that you are not very likely to be able to get off methadone and stay "clean." If you have checked very few of the items, the odds are stacked against you. The inventory lists the factors that have been shown to predict success in tapering and later abstinence from drug abuse, for people who are already enrolled in methadone maintenance.

COMMENTS ABOUT READINESS FACTORS

NOT USING ILLEGAL DRUGS (Numbers I and 2). If you are using, the odds are stacked against you getting off methadone without continued or increased drug abuse.

EMPLOYED (Number 3). People with jobs have a better chance of making it. People with a long history of employment have an even better chance.

ASSIMILATED INTO NONDRUG WORLD (Numbers 4-7). People who cut ties with the drug world have a better chance of making it; people who also build meaningful ties with straight people have an even better chance.

FAMILY SITUATION STABLE (Numbers 8,9). People living with family members have a better chance. If the family is supportive of you and supportive of your detox attempt, then the odds improve. If family members living with you are "using", however, that decreases the odds that you will make it.

COUNSELORS AND COUNSELING (Numbers 10,11,12). Recommendation of counselor is one of the better predictors of success in tapering. We emphasize that counselors know a lot about how to help you to taper, and having their endorsement is an excellent sign.

ON A LOW DOSE OF METHADONE (Number 13). People who are stabilized at a low dose of methadone have a better chance of getting off it.

ON METHADONE FOR A LONG TIME (Number 14). People on methadone for a longer time have a better chance of making it off clean that people new to methadone. This is contrary to some people's expectations, but the research is clear. The only caution is that many of the research studies were done in the mid-1970's, before people had been on methadone for over a decade. If you have been on methadone for over 7-9 years, this principle might not fit very well for you.

SOME FACTORS ARE QUESTIONABLE. AGE, for example. Nineteen research studies have looked at this factor: One found that younger people were better able to get off of methadone, nine found that older people were better able, and nine didn't find any difference. Basically, your age doesn't seem to matter, as long as you are physically fit enough to take the stress that goes with detoxification.

MOTIVATION is another tricky factor. It's hard to be sure about deep motivations that people have. Some motivations to taper can be really strong, but really destructive, too - for example, being forced to taper because of financial pressures might be a strong motivation, but it loads the dice against you making it off methadone "clean."
On the other hand, we know that motivation is the reason that clients most frequently cite as most important in getting off methadone without abusing drugs.

SOME FACTORS CLEARLY DON'T MATTER. The research is clear that your **RACE, SEX,** or **EDUCATIONAL LEVEL** do not predict whether or not you can get off methadone "clean."

Form Guide

Tapering:

Monitoring Progress

- Withdrawal Rating Sheet

Text: Monitor Progress

See Pages 84 - 85

Withdrawal Rating Sheet

KEY:
I.D.
0 = NONE
1 = MILD
2 = MODERATE
3 = SEVERE

INSTRUCTIONS: Ask the patient to provide a rating on each item on the basis of the previous twenty-four hours.

Today's Date:	_____	_____	_____
- Sweating	_____	_____	_____
- Problems with sleep	_____	_____	_____
- Nervousness/Restlessness	_____	_____	_____
- Low Energy	_____	_____	_____
- Irritability	_____	_____	_____
- Chills/Hot flashes	_____	_____	_____
- Nausea/Vomiting	_____	_____	_____
- Diarrhea	_____	_____	_____
- Runny Nose	_____	_____	_____
- Cravings	_____	_____	_____
- Tearing	_____	_____	_____
- Muscle/Joint Aches (Myalgia)	_____	_____	_____
- Gooseflesh	_____	_____	_____
- Other: _____	_____	_____	_____
DAILY TOTAL:	_____	_____	_____

Form Guide

Aftercare Issues

- Naltrexone Information Sheet

Text: Aftercare Issues, Naltrexone

See Pages 86 - 87

Naltrexone Information Sheet

What is Naltrexone?

It is an opiate (heroin) blocker. It prevents you from feeling the effects of opiates and thereby getting re-addicted.

Is it safe?

Yes. It has been approved by the FDA and is manufactured by DuPont under the brand name "Trexan."

How is it taken?

In a pill form, usually one pill per day.

Can anyone take it?

No. You need to be completely free of all opiates including methadone, for about 7 days in order to begin taking naltrexone.

What do feel when you take it?

In the beginning it may cause minor stomach upset. After a couple of days, this goes away and you don't really feel anything when you take it.

What happens if you fix?

Nothing. Naltrexone blocks the effects of heroin.

Are there any risks?

If you take naltrexone after there is opiate in your system you will become very sick. This is why people need to wait a week or so after their last methadone dose before beginning naltrexone.

Also, if you are injured and have a need for pain relievers, they will be ineffective until the naltrexone is not in your system (usually about a day).

Is Naltrexone Addictive?

No. You feel no discomfort when you stop taking it.

Does it have any other benefits?

People who take it usually report feeling better faster. The continued discomfort during the first months off methadone seem to be significantly reduced.

Also, most people on naltrexone report having no cravings.

Who should take it?

Only 10% to 20% of people who get off methadone are able to successfully stay clean. Given these odds, it is advisable for everyone getting off methadone to seriously consider naltrexone.

Does it always work?

Yes, if you take it. Many people prematurely stop taking it and relapse. A plan for discontinuation should be discussed with your counselor.

Is taking naltrexone enough?

Naltrexone can allow the recovering opiate addict to make changes and continue progressing in life without a risk of readdiction. The changes in lifestyle and work on problems are necessary for a successful recovery.

CHAPTER IV

THE 21-DAY DETOXIFICATION PROGRAM

Opiate Detoxification

Methadone detoxification is a process that often provides an entry point into the system of opiate treatment. As opposed to methadone maintenance, detoxification is available to virtually any addict. Programs who assign a counselor to work specifically with patients on the detoxification program should select an experienced person for this role. It is unlikely that a new, inexperienced counselor could successfully meet the challenges of the detoxification program and maximize therapeutic benefits for these patients.

Because the abrupt cessation of opiates by an addict results in an uncomfortable withdrawal syndrome, most addicts fear stopping drug use. Those who do attempt to quit "cold turkey" are likely to return to opiate use during the periods of acute withdrawal (approximately 2-4 days after the last ingestion of an opiate). Opiate detoxification techniques attempt to minimize or alleviate the severity of withdrawal, to reduce the patient's need to "self-medicate" with illicit opiates. (The term "detoxification" is actually inappropriate. According to Lipton and Maranda, (1983), "The term is a misnomer stemming from a discredited theory that the withdrawal syndrome was caused by toxins and that treatment consisted of purging the body of these toxins. A more accurate term would be "supervised withdrawal," since the procedure consists of ameliorating the withdrawal syndrome.")

Use of methadone

Any cross-tolerant opiate can suppress the withdrawal associated with the cessation of another opiate. Methadone, the most commonly used agent for detoxification, like other agents is able to suppress the withdrawal that would otherwise occur when an addict stops heroin use. The advantages of methadone are that it is oral, each dose lasts 24 hours, and the amount taken can be regulated precisely and gradually reduced over time.

Use of other pharmacotherapies

Although methadone is the most commonly used agent for detoxification, others have been and are still used. These include clonidine and buprenorphine.

Clonidine is a non-opiate medication that can help in alleviating some withdrawal symptoms. It is not well received by all patients. Some report no significant benefits from it; others complain of side effects (particularly the feeling of having no energy, and dry mouth). Clonidine also has the effect of lowering blood pressure, which necessitates close monitoring of patients who are taking it. The major advantage of clonidine over other medications is that it can alleviate withdrawal symptoms without transferring the addiction over to itself. Because clonidine is not an opiate, it is useful for helping patients get on to naltrexone (see Chapter III, Aftercare). Patients become tolerant to clonidine's withdrawal-relieving effects after about two weeks.

Buprenorphine is being investigated under special research approval. It is called an agonist-antagonist, which means it produces the euphoric effects associated with opiates and also blocks the action of other opiates (as naltrexone does). It is being studied for use in detoxification or maintenance. Until it is approved by the FDA for opiate addiction treatment, its use will be restricted to specially approved sites and practitioners. Occasionally, patients report receiving treatment from private physicians who use buprenorphine. Unless there is approval by the California Research Advisory Panel and the FDA, such "freelancing" is inappropriate. Patients should be advised against receiving buprenorphine and encouraged to seek help within authorized, licensed settings such as the methadone program or research facilities in the area.

Other detoxification approaches have included propoxyphene(Darvon) and acupuncture. While these may be useful in some cases, their widespread use for detoxification is unlikely to be effective.

Goals of Methadone Detoxification

Title 9, section 10005 states that "the specific goal of methadone detoxification programs shall be to provide a medically safe and supervised means by which a patient may be withdrawn from an addiction/dependence to opiates."

As a counselor, you should be mindful of this goal but also aware of the limitations of the 21-day detoxification period in withdrawing patients successfully from opiate addiction. Because many–probably most–patients will not proceed through 21-day detoxification and into abstinence, it is important that you orient patients to other goals of the program. Otherwise, most patients will feel as though they have "failed" the program, and you may become frustrated at patients' inability to become drug-free.

The 21-day detoxification program may be the first step in bringing addicts into the treatment system. It can allow you to evaluate and advise addicts during a period of time when they are feeling physically comfortable and not using heroin. You should consider the program to be successful if it helps in bringing patients into the treatment process. If a patient drops out, you can still feel that something was accomplished (apart from the brief period of heroin abstinence) if you have made the patient more aware of treatment opportunities. The patient may re-enter treatment at some other time on the basis of the information he/she received during detox. Lipton and Maranda (1983) have said "Detoxification seems most appropriate...as a preliminary step in the treatment process and should be viewed as a means of channeling heroin-dependent individuals into long-term treatment."

Robert Newman (1979) makes the point that each day of treatment is "a safe legal alternative to the self-administration of illicit drugs. By definition, this aim is achieved on the very first day of treatment, and on each subsequent day that the patient returns. The benefit to the individual addict is obvious, since each and every illicit dose of narcotics carries with it a risk of morbidity and mortality, and the criminal activity generally needed to procure each dose is associated with the possibility of arrest and incarceration. From the perspective of the community as well, there is a clear-cut benefit to reducing, even for a single day, the need of the addict to procure money with which to buy narcotics." You should hope that patients attain goals beyond the brief cessation of heroin use, but the perspective of each day as a goal can help to provide some basis for a feeling of treatment usefulness even when other goals are not met.

Initial Contact with the Prospective Patient

As a counselor, you are often the person who makes the first contact with addicts seeking information about the program. This initial contact gives you an opportunity to establish a connection with the person and to provide information regarding eligibility requirements (see criteria for patient selection, below).

Counselors who handle telephone inquires about treatment give the initial impression of the program. They must be courteous and sympathetic, even if the caller is hostile and demanding. The addict may be sick, desperate, or angry at the lack of immediate help. It is not uncommon for addicts to make comments such as, "I thought you people were suppose to help us; you don't care", or "You're telling me I should just keep using." It is important that you maintain your professionalism, express sympathy for the plight of the caller, and offer the encouragement of help at the earliest opportunity. Counselors who respond with irritation or an unsympathetic attitude may cause the addict to form a negative opinion of the program.

You can help callers by explaining program eligibility issues such as the need for evidence of early stages of withdrawal (see Chapter III). You should also try to make some contact with the patient at intake, introducing yourself as the person who spoke on the phone, to establish a positive connection to the program.

Intake

Criteria for patient selection

The eligibility for detoxification treatment is partly determined by the physician, but, as with methadone maintenance, the counselor can help in the initial screening and refer ineligible persons to more appropriate treatment. Counselors should refer to state and federal regulations and consult with supervisors or appropriate regulatory agencies to determine eligibility. Some considerations are:

1. Current dependence (see Chapter III).

2. Minimum age of 18 unless the person has written consent of parent(s) or guardian.

3. Seven days since end of last detoxification. (Medi-Cal requirements specify 28 days.)

Pregnant women in the last trimester (months 7, 8, or 9) of pregnancy are not eligible. Counselors should discuss methadone maintenance in these cases. It may be that these women are not aware of their eligibility to maintenance under the pregnancy option. Counselors should also advise these women of the advantages of being on methadone versus other options (detox, cold turkey, heroin use.)

Orientation to program

Counselors should refer to state and federal regulations which delineate information that must be provided to patients entering treatment.

Expectations. It is important that you orient patients to the detoxification program with regard to their expectations and plans for aftercare. You should explain that, although the goal of the detoxification program is to withdraw addicts from opiate dependency, this is usually not achieved. You should stress that:

- Patients will be given every opportunity to withdraw successfully.

- Most patients begin to experience withdrawal symptoms in the last week of the program.

- Many patients drop out and/or resume heroin use in the last week of the detox.

- Patients should take advantage of the period of relative stability during the first two weeks of the program to make plans for aftercare.

- Patients who are eligible for methadone maintenance might consider this program to extend the period of detoxification. For example, a patient could enter methadone maintenance with a plan of gradual tapering off over 90 days.

- Counseling sessions during the detoxification program will focus on aftercare planning.

If patients respond negatively to this information, (e.g., "It sounds like this program doesn't work"), emphasize that the methadone detoxification for many people can be a first significant step towards a new life. It "works" if it helps a person withdraw from opiates, or if it is the first in a sequence of treatments resulting in the discontinuation of illicit opiates. Too narrow a definition of "success" leaves too much room for failure. Any treatment that begins or continues to engage addicts in the process of recovery is achieving a level of success.

The orientation to the program should be brief, because patients are usually uncomfortable and impatient during the intake and possibly the first one or two days of treatment. The orientation can be reviewed more thoroughly after program induction.

Special problems/circumstances

Many patients who enter the detoxification program are entering treatment for the first time. They may be suspicious, anxious, angry, fearful, sick, or under the influence. You may encounter some difficult situations that call for tact, patience, or occasional outside help. Other issues necessitate that you provide information to direct the person to other types of assistance (e.g., in the case of an ineligible applicant).

1. The under-the-influence person. The counselor or intake worker who handles the telephone inquiry about treatment can significantly reduce the number of times this is a problem. It should be made clear in the phone call that the caller must show initial signs of withdrawal and that persons under the influence cannot be admitted.

   You should usher an under-the-influence person into a private office to explain calmly that the intake may need to be postponed due to the person's condition. If there is an odor of alcohol, a breath test can be administered to help eliminate or abbreviate a discussion about the fact of alcohol in the person's system. If the intoxication is a result of alcohol or sedatives, the patient should be informed that he/she cannot be under the influence of these at intake time. If the patient describes a physical dependency on these drugs, you should consult with the medical staff to

see if inpatient treatment is necessary, or if detoxification procedures for these non-opiates need to be instituted, along with the methadone detox procedures.

If the person appears to be under the influence of opiates, explain the need to postpone the intake. Ask the person how long it has been since the last opiate use, and what opiate was taken. In some cases it might be possible to reschedule intake later in the same day. For example, if the person reports injecting heroin two hours prior to a 6:00 a.m. intake appointment, an appointment in the early afternoon should provide time for the metabolism of this heroin and the onset of withdrawal. You may need to involve medical staff for consultation in these cases.

2. The belligerent person. If a person is turned away for being under the influence or any other reason, he/she can become angry or belligerent. Your goal should be to calm the person and get him/her out of the clinic. A calm, apologetic, sympathetic approach will often soothe things. Do not return threats in kind. An intimidating, threatening response by you will more likely exacerbate the situation.

   Explain the reason(s) for not admitting or dosing the person and offer sympathy for the circumstance (e.g., "We can't start a person on the program who is under the influence. I know how much you want to get started with the program and I'm really sorry we have to delay things a bit. We can start over tomorrow. Let's make an appointment. I'll help you get the appointment and be here to help tomorrow"). It may be necessary to repeat expressions of sympathy and offers of help to calm the person.

   If the person does not become calm, it may be necessary to seek a family member or friend to take the patient home. If this is not possible, you should ask the person to leave and to call back for an appointment after he/she has calmed down. As a last resort, it may become necessary to call for clinic security, to threaten to call the police, or to call the police. If circumstances reach this point, the program director should be called first. The police should not be called to handle problems that do not involve threats of violence or situations of extreme volatility. The presence of police in the clinic can be very disturbing and may disrupt operations. By informing applicants of intake requirements, and using calm, professional action, you can prevent many problems of this type.

3. Ineligible for program. If a person does not meet eligibility requirements, explain the basis of ineligibility, describe what conditions will allow program entry (e.g., when the necessary time since the previous detoxification will have elapsed), or refer to other treatments such as residential, drug-free, naltrexone, or self-help meetings.

   Pregnant women in the third trimester should be strongly encouraged to enter methadone maintenance. Counselors should explain:

- Methadone maintenance is preferable to continued use of street drugs.

- The cycle of heroin effects and heroin withdrawal is experienced by the fetus. Withdrawal stimulates uterine contractions and can cause fetal stress.

- Prenatal care and advice in issues related to pregnancy and parenting are offered in maintenance treatment.

4. HIV positive, AIDS, terminal illness. Patients who would otherwise not meet eligibility criteria for methadone maintenance may be eligible under exceptions described in Chapter III.

Week One Activities

Bonding

Counselors have a great opportunity to establish a strong bond with patients during the first week of the program. The patient tends to "imprint" to who is in contact with him/her during the initial period of treatment. The counselor who helps orchestrate the entry and induction in treatment, provides support and encouragement during periods of discomfort, and checks on the patient daily becomes a trusted and influential figure.

Counselors should seize this opportunity to engage new patients by scheduling at least two sessions during the first week of the program. Brief check-in visits between full counseling sessions are advisable to sustain continuity, monitor progress and strengthen the patient-counselor bond.

Needs assessment

A needs assessment is not required by the regulations. However, it is recommended that a needs assessment be done towards the end of the first week, to give the counselor a clearer picture of the patient's problems and facilitate aftercare planning. (A Needs Assessment form is provided in the appendix to Chapter III.)

Treatment plan

The treatment plan form provided in the appendix to Chapter III can be used. Some areas may not be applicable to the detoxification patient and longterm goals will not be relevant to the 21-day program. Problems that require interventions beyond the scope of those possible during the detox program should be handled by referral to aftercare. For example, under short-term "Intervention Strategies" you could indicate "referred to methadone maintenance," or "vocational rehabilitation," if appropriate.

The type and frequency of counseling services can be indicated under intervention strategies, short-term, in the category "Drug Use." It is recommended that all counseling during the detoxification be on an individual basis, and that at least two sessions be conducted in the first week, and one per week in weeks two and three. Counseling sessions should be at least 15 minutes in duration.

Counseling Issues -- Weeks One and Two

Accommodation of patient's immediate needs

Particularly during the beginning of the detoxification, the patient may be uncomfortable, irritable, and disinterested in everything except his/her dose. You needs to be sensitive to this and not push the patient beyond his/her ability or interest. "Being there," asking how it's going, engaging in general chit-chat may be the extent of initial interaction. After a few days it is usually possible for the counselor to spend some extended time with the patient.

The patient who has extensive needs in many areas may be focused solely on issues surrounding drugs and drug use. If so, you should stay focused on these issues.

In scheduling time with patients it is important to be flexible. It is not realistic to expect that patients will reliably make scheduled appointment times. Attempt to be available throughout all dosing hours.

Finally, it is usually better to see a patient after he/she has been dosed. If the counseling session precedes the dose, the patient may be edgy, uncomfortable, and distracted. The impression of counseling as an obstacle to dosing will not enhance the patient's view of counseling. On the other hand, some patients tend to avoid counseling after they have received their dose. Although holding the patient's dose is a way of ensuring the patient's physical attendance in a counseling session, it does not necessarily increase his/her interest, involvement, or positive feelings about counseling. Holding a dose as leverage should only be used as a last resort. A better approach is for you to work harder at establishing a connection so that you become a positive aspect of the program.

Discussion of goals of detoxification

The primary goal of ceasing illicit drug use and becoming drug-free should be discussed. Patients who do not stop using heroin by the end of week one will pretty clearly need another type of treatment such as methadone maintenance or residential treatment. Patients who stop using should be encouraged to take advantage of this time to stop associating with drug-using friends, attend to their health, and plan for the period following the program. It is important to impress upon patients the brevity of the period in which methadone will effectively suppress withdrawal. Those who do not plan to enter methadone maintenance should be advised of:

- The need for support such as NA to help in efforts to stay clean during the third week of the detox and afterward.

- The expected course of the withdrawal syndrome following methadone treatment. Explain that withdrawal generally will return as the dose moves below approximately 15 mg., and that it will continue throughout the remainder of the program. Advise that there will be continued discomfort and sleep problems for about 30 days following the last methadone dose.

- The infrequency of success in sustaining abstinence following a 21-day detoxification.

Transition to other treatment

You should discuss the need to plan for the next step in treatment during the first week. Patients should not be pressured into a decision, but the issues should be brought up during week one. Patients are sometimes upset that this means the program doesn't "work." Counselors can explain that the program "works" if it helps people to stop using illicit drugs and begins a course of recovery that extends beyond 21 days.

Patients who balk at entering other treatment should at least be made aware of options. Self-help directories should be provided, maintenance eligibility requirements discussed, naltrexone information given, and locations and descriptions of residential programs reviewed. The goal of week one is to begin to orient the patient to the limits of the program and introduce aftercare possibilities.

AIDS information

It is essential that counselors provide information regarding AIDS to new patients. Written information regarding HIV-antibody testing, high-risk behaviors, and prevention of HIV transmission should be provided at intake. This information should be reviewed and discussed at the first reasonable opportunity (i.e., after treatment has begun, and the patient is sufficiently comfortable to listen). Counselors who delay the discussion beyond the first week may miss some patients who drop out prematurely.

Intravenous drug users (IVDU's) become infected with HIV primarily by sharing needles used by an HIV-infected person. If the virus is present in blood in a previously used needle, the person injecting with that needle may transmit the virus to himself or herself. A secondary mode of HIV transmission is via sexual activity. Counselors need to educate addicts entering methadone detoxification about risks and ways of changing high-risk behaviors. For some addicts the detox will be a brief encounter with the treatment system.

Counselors must make the most of this opportunity by imparting potentially life-saving information.

The following is from an article by Sorensen and Batki (in press), that discusses AIDS prevention with I.V. drug users:

"Salient Points to Communicate

Drug use and unsafe sexual practices are the two major practices that need to be modified to prevent HIV transmission among IVDU's. In both areas, abstinence is the most sure defense against HIV infection. However, a "just say no" approach to drugs and sex is not realistic for most adults. Instead, it may be helpful for drug educators to employ a "levels of defense" model of AIDS prevention, which should communicate the following points:

Drug Use

1. **Abstinence** provides the best line of defense against HIV infection. If one does not use intravenous drugs, there will be no need to worry about HIV transmission through shared needles. Abstinence from alcohol and other drugs may also reduce the likelihood of risky sexual activities, which are more likely to occur under the disinhibiting effect of drugs. However, abstinence is not realistic for most.

2. **Don't use needles** is the next best defense. Drugs can be taken without the risk of blood-to-blood transmission posed by needles. However, for IVDU's, this advice may be too late or seem naive.

3. **Don't share needles** is the next step in the hierarchy of risk reduction. IVDU's should be advised to use their own needles and syringes every time. This also applies to the "cooker" (the container in which drugs are mixed), "cotton" (a small piece of cotton wool used to strain out impurities while the drug is being drawn into the syringe), and rinse water. Similarly, apparatuses should not be rented or borrowed.

4. **Clean needles before each use** is the last line of defense. Because needles are in short supply and drug use is frequently a social activity, advising IVDU's not to share is not always realistic, and the drug user may need to consider this final level of defense. Basic research has identified materials that kill HIV under laboratory conditions. An unpublished report has also confirmed the efficacy of bleach, disinfectant, and dishwashing liquid in trials that approximate real-life condition."

Sexual Behavior

1. **Abstinence** is the best defense against acquiring HIV infection through sexual activity. This is not realistic for many IVDU's, particularly young adults or those who make their living in the sex industry.

2. **Monogamy** is generally a less safe defense, but it is reasonably effective for low-risk populations. IVDU's should understand, however, that even in a monogamous sexual relationship, they may acquire HIV infection through needle-sharing and then pass it on to their sexual partner.

3. **Safer sex** is the final level of defense. Important aspects to emphasize with IVDU's are that they present risks to their sexual partners and vice versa. Some evidence indicates that female prostitutes use condoms regularly with their paid partners but are less likely to do so with their primary partners, who are often drug users.

4. **Information** does not necessarily lead to behavior change. Although a certain threshold of knowledge may be necessary for change, other attitudes, skills, and support systems may be final determinants of whether people adopt and maintain the safe behaviors described here.

5. **Skills training** - Drug users may be particularly in need of learning and becoming comfortable with the new skills needed for safe needle use and safer sex. It can be helpful to divide each process into discrete, measurable steps. The following steps and methods are used in teaching drug users to clean needles and use condoms correctly at the Substance Abuse Services of San Francisco General Hospital.

   a. **Cleaning needles** - Materials for the demonstration include three small glasses, bleach, water, and a syringe.
      1. Fill a container with bleach.
      2. Fill the syringe **completely** with bleach.
      3. Empty bleach from the syringe.
      4. Fill the syringe **completely** again with bleach.
      5. Empty the bleach again from the syringe.
      6. Fill a container with water.
      7. Fill the syringe **completely** with water.
      8. Empty water from the syringe.
      9. Fill the syringe **completely** again with water.
      10. Empty water from the syringe again.

b. **Using condoms** - Materials for the demonstration include a condom, a tube of spermicidal lubricant, and a large candle or other phallic object.

1. Open the condom package without tearing the condom.
2. Apply lubricant to the inside tip of the condom.
3. Pinch the tip and roll the condom all the way down the penis.
4. Apply lubricant to the outside of the condom.
5. Afterward, hold the base of the penis and remove the condom without spilling its contents.
6. Dispose of the condom without spilling fluids."

Counselors should also discuss HIV-antibody testing. It is beyond the scope of this manual to discuss all of the issues surrounding testing. Programs should provide training to counselors in matters surrounding HIV-testing and make use of available community resources for training and counseling. It may also be useful to designate some staff person as a specialist in issues regarding HIV testing, and AIDS prevention. (A protocol for pre- and post- test counseling developed by George Woody, M.D., is provided in the appendix to this chapter.)

Identify/assess other problems

You may begin to help the patient address other drug or alcohol problems if he/she is not doing so. Patients with other drug or alcohol problems may need to be referred to additional chemical dependency treatment if they do not plan to remain in methadone treatment beyond 21 days.

If needs assessment did not reveal the presence of other drug or alcohol problems, counselors should still be aware of behavioral indications of problems and respond accordingly. (See Chapter III.) Given the brevity of the program, you will not be able to provide substantial assistance in dealing with these problems. The focus should be on helping the patient admit the existence of a problem and planning for continuing care.

Psychiatric evaluation is often part of the intake procedure and performed by medical staff or staff psychologist. If this is not the case, however, counselors may provide assistance to medical staff in bringing unusual patient behavior to their attention. Counselors are not expected to make psychiatric diagnoses but should be aware of some behaviors that should prompt referral to medical staff. These include:

- Suicidal references;
- Hallucinations–hearing voices, seeing things;
- Delusions–unusual beliefs about one's own importance or plots by imagined enemies;

- Thought disorder–the patients words don't make sense;
- Non-responsiveness–the patient does not answer questions, won't make eye contact, appears to be in his/her own world.

Aftercare Counseling - Weeks Two and Three

The primary focus of counseling for most patients in weeks two and three involves aftercare. Because most patients do not successfully proceed through the 21-day detoxification to abstinence, it is critical that patients plan for the next step in treatment at this time. (An Aftercare Plan form is included in the appendix.)

Methadone maintenance

The maintenance program should be seriously considered, particularly if the patient has resumed heroin use or if he/she has had previous detoxification failures. You should determine whether the patient meets eligibility criteria and discuss this option with those who do. If a patient appears to meet requirements for an exception to eligibility criteria, you should refer him or her to medical staff or the program director for a ruling. If the patient is fearful of methadone maintenance, you should be prepared to answer the patient's questions and allay his/her concerns. Patients sometimes believe that methadone addiction is worse then heroin addiction. Counselors should point out the contrasts between oral vs. IV use; medically supervised vs. street drug use; expensive vs. inexpensive daily costs; and the increased risks of AIDS with heroin use.

For patients who have previously attempted detoxification, counselors should stress the unrealistic expectations of achieving abstinence and encourage a different approach to dealing with the addiction problem.

Counselors should direct the patient through this intake process as quickly as possible. Long delays in the waiting room, unnecessary red tape, or a feeling of being lost in the system can cause a potential maintenance patient to slip through the cracks and most likely return to heroin addiction. You can help avoid this by facilitating the treatment transition.

Naltrexone

Patients who are remaining abstinent from other opiates should be advised to go on naltrexone as a follow-up to the detoxification program. These patients should be referred to the medical staff for continued post-methadone detoxification and naltrexone induction. Counselors should contact these patients daily during the third week and if possible during the week prior to their starting naltrexone (the week following the last methadone dose). (See Chapter III for more information on naltrexone.)

Residential treatment

Some patients may prefer live-in treatment as an alternative to pharmacologic-supported outpatient treatment. The residential setting can provide a safe environment that eliminates the need for methadone maintenance or naltrexone. Patients who opt for residential treatment may need to be advised of the cost, the waiting lists, and the counseling approaches, which can sometimes be intense and confrontational. Counselors should discuss these issues as well as the impact of residential treatment on the patient's personal life and employment.

You should set up the referral to the residential program and follow up to ensure patient compliance.

12-step groups

Regardless of the patient's aftercare plan, you should encourage participation in 12-step meetings as a part of aftercare support. If there is a meeting on-site patients should be urged to attend. (See Chapter III for a discussion of 12-step meetings.)

Treatment Termination

There are provisions in the regulations for terminating patients for absences. Counselors should familiarize themselves with these regulations. (The patient may be readmitted by the program physician.) It is generally advisable for counselors to call patients who have "disappeared," to encourage them to enter the program. In most cases, there is little benefit in preventing the readmission of such patients into treatment. It is sometimes presumed that patients who do not make all of their scheduled appointment are "not taking the program seriously," but, counselors should not forget that these patients are fresh off long periods of out-of-control drug use, and in some cases expectations of perfect attendance may not initially be realistic. You should explore the reasons behind failure to make appointments.

Counselors can sometimes help turn around what appears to be a treatment failure by working harder with the patient.

Illustrative Vignettes

Intake

Counselor: Hi, I'm Alan I talked with you on the phone yesterday. How are you doing?

Patient: Not too good, man. Thanks for talking to me yesterday. I'm sorry I copped an attitude with you. I wasn't feeling too good.

Counselor: Don't worry about it, I'm just glad you got in. Have you filled out your papers?

Patient: Yeah, it's taking a long time. I'm ready to go take care of myself outside.

Counselor: Hang on. I'll go see what's going on. Don't go anywhere.

Patient: O.K. Thanks.

Counselor: The doctor's finishing up. You'll get in next, about 5 minutes. I know you're not up to it today but I'd like to sit down with you when you're feeling better.

Patient: Sure. Is that doctor ready yet?

Counselor: Pretty soon. Don't worry I won't hold you up here. I'll check in and see how you're doing tomorrow. Maybe we can meet for a few minutes, or if you're not up to it, we'll put it off until the next day.

Patient: Thanks for sticking with me on the phone yesterday. I'll see you tomorrow.

[Notice how the counselor began making a connection with the patient on the phone and continued to sustain contact. He is sensitive to the patient's concern with getting dosed and recognizes the inadvisability of pursuing any other matters. However, he does make a plan for subsequent contacts and establishes himself as a positive and facilitating factor.]

Discussion Of Aftercare (Week 2)

Counselor: You're looking much better this week.

Patient: Yeah, I feel better. The dose is holding me now. I'm eating and sleeping right for the first time in a while.

Counselor: That's great. Let's talk about your plans for after the detox program, O.K.?

Patient: Sure, why not.

Counselor: I'm looking at your history and I see that you've been here on the detox a few other times over the past few years.

Patient: That's right.

Counselor: What were you expecting from the program those other times?

Patient: I was mainly just looking to clean up. I figured I could get off the street and maybe even stop using for good. To tell you the truth, I didn't give much thought at first to anything long-term.

Counselor: How long did you keep coming to the program those other times?

Patient: I'd usually start using again before the end. The dose would stop holding me in the last week sometime and I'd get sick, so I'd use. Pretty soon, I'd be back to my old habit.

Counselor: What about this time?

Patient: I really haven't thought about it. I'm just happy to be where I'm at now.

Counselor: I understand, but maybe you can do better than before by making plans this week that could change the usual course of your detoxes.

Patient: What kind of plans?

Counselor: Well, have you ever thought about methadone maintenance?

Patient: I don't want to get strung out on methadone. I've heard too many bad stories.

Counselor: Like what?

Patient: Like it's harder to kick than heroin and it gets in your bones.

Counselor: It's true that there are lots of stories but not everything you hear is true. For instance, methadone withdrawal is longer than heroin withdrawal, but it's not as intense. It might be longer to kick but not necessarily harder to kick. And it doesn't "get in your bones." There are bone aches during methadone withdrawal just as there are with heroin withdrawal but the aches aren't because the drugs are inside the bones.

Patient: I don't know. I see some of these people coming here for years and years.

Counselor: Some people stay on methadone for a long time. But let's talk about you, not other people. I think it's safe to say that any choice you make about what to do next can be weighed against the likelihood or re-addiction to heroin.

Patient: So, say I stay on for two months. I'm still going to have to kick if I want to get off.

Counselor: If you decide to get off you can gradually taper off over a long period of time. You can also use the time you're on to get your life together a little bit. You can also stay on longer if you decide.

Patient: O.K., maybe there's some advantages, but I'm still addicted, right?

Counselor: Yes, absolutely, but there are some big differences between the program and the street. First of all, methadone is legal; you're not going to get busted being on methadone. Second, you'll receive medical attention and counseling here. Third, it's affordable, particularly compared to heroin. And finally, no needles, no getting AIDS.

Patient: Maybe you're right. Let me think about it. I'll let you know next week.

Counselor: Do you think that's a good idea? I mean in the past you've left the program in the last week. I don't want to be pushy but there isn't much time. How about if we touch base tomorrow, and you tell me what you've decided.

Patient: All right. Thanks for your help. See you tomorrow.

[Notice how the counselor uses the patient's treatment history to present a realistic expectation of treatment outcome. The counselor deals with the patient's misconceptions regarding methadone treatment, points out some advantages of methadone maintenance, and urges a decision before the patient is lost to heroin addiction again.]

Appendix

Chapter IV

Table of Contents

HANDOUT **FORM**

21-Day Detoxification Program

Aftercare Plan

Patient: _____ Date: _____

Program: _____ Counselor: _____

I. **Previous Treatments(s):**

Detoxification(s): Dates_____

_____

_____

_____

Maintenance: Dates_____

_____

_____

_____

Other: Dates_____

_____

_____

_____

II. **Heroin Status:**

Week One: Clean___Using_____

Week Two: Clean___Using_____*

Week Three: Clean___Using_____**

Has dropped out before completing previous detoxifications.***

* If using, maintenance or residential suggested.
** If clean, naltrexone suggested.
*** Maintenance or residential suggested.

III. **Living Arrangement:**

___Family
___Clean Friends
___Using Friends*
___Street*
___Other_____

*Maintenance or residential indicated.

IV. **Pregnant?**

Yes___ No___
If "yes", suggest methadone maintenance or residential.

V. HIV-Positive?

Yes___ No___
If "yes", suggest methadone maintenance or residential.

Counselor Summary

Eligible for maintenance? Yes___ No___

Aftercare recommended to patient: (Check all that apply)

___Methadone/Maintenance
___Residential
___Naltrexone
___Self-Help
___Other (Describe):

_____

_____

Patient's reactions to recommendation:

_____

_____

_____

Next contact with patient: Date_____
None Scheduled_____

Counselor's Signature:_____

Date:_____

Patient's Signature:_____

Date:_____

PROTOTYPE FORMAT
FOR
COUNSELING PEOPLE WITH SERONEGATIVE HIV
ANTIBODY TEST RESULTS

I. **INTRODUCTION**

A. INTRODUCE (OR REINFORCE YOURSELF IF YOU PRETEST COUNSELED).

B. DEFINE THE PURPOSE OF THE SESSION.

C. BRIEFLY REVIEW CONFIDENTIALITY.

D. ASK THE PATIENT TO RESTATE EXPECTATIONS ABOUT THE TEST.

II. **THE TEST RESULT**

A. GIVE RESULTS. LET THE PATIENT ABSORB THE INFORMATION, AND SIT QUIETLY, ALLOWING THE PATIENT TO REACT FIRST.

B. PROMPT THE PATIENT WHO DOES NOT REACT AFTER A TIME BY ASKING: "HOW DO YOU FEEL ABOUT HAVING A NEGATIVE TEST?"

C. DEAL WITH ANY PATIENT RESPONSES (AVOID ABSORBING THE PATIENT'S EMOTIONAL BURDEN).

-**GUILT**--THE PATIENT MAY FEEL GUILTY IF A SEX PARTNER IS SEROPOSITIVE, ESPECIALLY IF THAT PARTNER IS CLOSE OR IN A MONOGAMOUS RELATIONSHIP WITH THE PATIENT.
-**ANGER**--THE PATIENT MAY FEEL ANGRY FOR THE SAME REASONS AS ABOVE.
-**DISBELIEF**--THE PATIENT MAY NOT BELIEVE A NEGATIVE RESULT; MAY NOT UNDERSTAND BEING NEGATIVE AFTER ENGAGING IN THE SAME TYPES OF UNSAFE SEX PRACTICES AS FRIENDS WHO ARE POSITIVE OR HAVE AIDS.
-**RELIEF**--THE PATIENT MAY FEEL AND EXPRESS RELIEF THAT THE TEST IS NEGATIVE. **SUCH PATIENTS WHO ARE HIGH RISK MUST BE BROUGHT BACK TO REALITY.** THEY NEED TO KNOW THAT A NEGATIVE TEST DOES NOT MEAN THEY ARE FREE OF THE VIRUS AND CAN HAVE UNSAFE SEX OR SHARE NEEDLES. ALSO, THE RELIEF MAY NOT BE JUSTIFIED IF THEY HAD UNSAFE SEX OR SHARED NEEDLES WITHIN THE PAST 6-12 WEEKS.

III. **INFORMATION ABOUT THE TEST**

A. INFORMATION FOR EACH HIGH RISK PATIENT:

-**TEST PURPOSE**--THIS IS A TEST FOR ANTIBODIES TO THE VIRUS WHICH CAUSES AIDS.

-**FALSE NEGATIVE**--A SMALL PERCENTAGE OF PEOPLE WHO HAVE A NEGATIVE ANTIBODY TEST WILL BE INFECTED AND ABLE TO TRANSMIT THE VIRUS.
-**RISKS REMAIN**--A NEGATIVE TEST DOES NOT NECESSARILY MEAN FREEDOM FROM THE VIRUS NOW OR IMMUNITY TO IT IN THE FUTURE.
-**RECENT RISK**--THE PATIENT WHO HAS ENGAGED IN **ANY** HIGH RISK PRACTICE IN THE LAST 6 MONTHS MAY HAVE THE VIRUS BUT NOT YET HAVE THE ANTIBODIES TO MARK ITS PRESENCE.
-**RETESTING**--RETESTING IS NOT RECOMMENDED UNLESS THERE HAS BEEN "UNSAFE SEX" OR NEEDLE SHARING IN THE PAST 6 MONTHS.
-**REGULAR PARTNER**--IF THE PATIENT IS A REGULAR SEX PARTNER OF A SEROPOSITIVE INDIVIDUAL, SUGGEST THEY SEEK TESTING EVERY 3-6 MONTHS TO MAINTAIN A CHECK.
-**PLAN**--ASK ABOUT THE PATIENT'S PLANS TO REMAIN NEGATIVE AND FOR REDUCING THE CHANCES OF ACQUIRING THE VIRUS.
-**RISK REDUCTION**--INFORM THE PATIENT ABOUT THINGS THAT THEY CAN DO TO DECREASE CHANCES OF ACQUIRING THE VIRUS.

B. INFORMATION FOR EACH LOW RISK PATIENT:

-**TEST PURPOSE**--THIS IS A TEST FOR ANTIBODIES TO THE VIRUS WHICH CAUSES AIDS.
-**TEST MEANING**--A NEGATIVE TEST ALMOST ALWAYS MEANS THAT THE PERSON IS NOT INFECTED WITH THE VIRUS.

IV. RISK REDUCTION

A. WHEN HAVING SEX, DO NOT PASS OR RECEIVE BODY FLUIDS, PARTICULARLY BLOOD, SEMEN, SALIVA, FECES, OR URINE. USE CONDOMS. SEXUAL ACTIVITY IN WHICH BODY FLUIDS ARE SHARED PLACE A PERSON AT GREATER RISK FOR INFECTION.

B. DO NOT HAVE SEX WITH PEOPLE WHO HAVE AIDS OR MAY BE INFECTED WITH THE VIRUS.

C. REDUCE YOUR NUMBER OF SEX PARTNERS. SERONEGATIVE PERSONS CAN REDUCE RISKS BY LIMITING SEX TO A PARTNER WHO IS ALSO SERONEGATIVE.

D. DO NOT SHARE NEEDLES.

E. HIGH RISK PATIENTS SHOULD AVOID DONATING BLOOD, PLASMA, BODY ORGANS, OTHER TISSUE, AND SPERM.

F. DO NOT USE POPPERS.

V. **TUBERCULOSIS TESTING REFERRAL** FOR CERTAIN HIGH RISK PATIENTS.

1. SERONEGATIVE PATIENTS AT HIGH RISK FOR HIV INFECTIONS WHO ARE FROM POPULATIONS AT INCREASED RISK FOR TB INFECTION (E.G., IV

DRUG ABUSERS) OR WHO WERE BORN IN COUNTRIES KNOWN TO HAVE A HIGH PREVALENCE OF TB (E.G., HAITI AND OTHER THIRD WORLD NATIONS) SHOULD BE REFERRED FOR A MANTOUX TUBERCULIN SKIN TEST. EXPLAIN THAT IF BY CHANCE THE PATIENT IS INFECTED WITH HIV, DESPITE HAVING A NEGATIVE ANTIBODY TEST TODAY, AND IS ONE OF 10 MILLION PEOPLE IN THE U.S. UNKNOWINGLY INFECTED WITH THE TB BACILLUS, BEING EVALUATED FOR PREVENTIVE TREATMENT TO AVOID POSSIBLE SERIOUS HEALTH PROBLEMS DUE TO TB IS VERY IMPORTANT. IF NEEDED, ELABORATE USING THE FOLLOWING POINTS:

-PEOPLE INFECTED WITH THE TB BACILLUS USUALLY DO NOT DEVELOP CLINICALLY ACTIVE TUBERCULOSIS BECAUSE THE BODY'S DEFENSE SYSTEM IS ABLE TO KEEP IN CHECK.

-PEOPLE "BREAK DOWN" WITH CLINICALLY ACTIVE TUBERCULOSIS WHEN THEIR DEFENSE IS NO LONGER ABLE TO CONTROL MULTIPLICATION OF THE TUBERCLE BACILLI.

-EFFECTIVE DRUGS ARE AVAILABLE TO TREAT INFECTED PEOPLE AND PREVENT CLINICALLY ACTIVE TUBERCULOSIS.

2. MAKE A REFERRAL TO THE HEALTH DEPARTMENT TB CLINIC, INCLUDING:

-ADDRESS OF THE CLINIC.

-HOURS OF OPERATION AND NEED TO SCHEDULE AN APPOINTMENT.

-A RECOMMENDATION THAT THE PATIENT NOT IDENTIFY TO THE TB CLINIC THAT HE/SHE WANTS TO BE TESTED BECAUSE OF POSSIBLE RISK OF HIV INFECTION.

-A RECOMMENDATION THAT IF THE TUBERCULIN SKIN TEST IS POSITIVE, THE PATIENT THEN INFORM THE TB CLINIC PHYSICIAN ABOUT HIS/HER RISK FOR HIV INFECTION AND RECENTLY NEGATIVE ANTIBODY TEST.

VI. CONCLUSION

A. ADDRESS ANY QUESTIONS WHICH THE PERSON HAS.

B. PROVIDE A HANDOUT TO HIGH RISK PEOPLE WHICH REINFORCES THE PREVENTION RECOMMENDATIONS.

C. PROVIDE INFORMATION ABOUT TELEPHONE HOTLINES-LOCAL AND NATIONAL, TAPED AND STAFFED.

PROTOTYPE FORMAT
-FOR-
PROVIDING PRETESTING INFORMATION ABOUT
HIV-ANTIBODY TESTING

I. **INTRODUCTION**

A. INTRODUCE YOURSELF AND YOUR PROFESSIONAL ROLE.

B. DEFINE THE PURPOSE OF THE SESSION.

C. EXPLAIN CONFIDENTIALITY AND ADDRESS ANY CONCERNS. EXPECT CONCERNS TO INCLUDE:

-JOB.

-MEDIA.

-INSURANCE.

-GOVERNMENT USE OR MISUSE OF INFORMATION.

-CURRENT AND FUTURE HEALTH STATUS.

D. EXPLAIN THAT PEOPLE TESTED HAVE 5-10cc OF BLOOD TAKEN FROM THE ARM USING STERILE EQUIPMENT.

II. **ASSESSMENT**

A. ASSESS WHY THE PERSON WANTS THE TEST. QUESTIONS THAT CAN HELP THIS ASSESSMENT INCLUDE:

1. WHEN WERE YOU LAST TESTED, WHY, WHERE, AND WHAT WAS THE RESULT?

-IF NOT PREVIOUSLY TESTED, PROCEED.

-IF PREVIOUSLY TESTED, ASSESS THE NEED TO CONTINUE-INCLUDING RECENT HIGH RISK EXPOSURE-AND PROCEED ACCORDINGLY.

2. WHY DO YOU WANT THE TEST DONE TODAY? (MAY PRODUCE AN EVASIVE RESPONSE)

3. WHY ARE YOU CONCERNED ABOUT AIDS?

4. WHAT MAKES YOU BELIEVE YOU HAVE BEEN EXPOSED TO THE VIRUS?

5. WHAT ROLE DID A FRIEND OR SEX PARTNER PLAY IN YOUR DECISION TO COME IN FOR A TEST?

NOTE: BASED ON THE PERSON'S RESPONSE TO THE ABOVE QUESTION. DETERMINE IF THE PATIENT IS HIGH RISK OR LOW RISK/CONCERNED. POSSIBLE INDICATIONS TO IDENTIFY LOW RISK/CONCERNED INCLUDE:

-USUALLY MORE TENSE THAN HIGH RISK PERSONS.

-COMMONLY POSSESS CONSIDERABLE MISINFORMATION ABOUT AIDS.

-OFTEN WILL GO INTO A DETAILED DESCRIPTION OF HEALTH PROBLEMS.

-WILL MAINTAIN THAT THEY ARE NOT IN A HIGH RISK GROUP.

-USUALLY HAVE FEW SEX PARTNERS.

IF YOU DETERMINE THEY ARE LOW RISK/CONCERNED, TELL THE PATIENT THAT YOU ASSESS THEM TO BE AT LOW RISK OF ACQUIRING HIV INFECTION; PROVIDE BASIC INFORMATION ABOUT HIV AND AIDS, THE ANTIBODY TEST, AND RISK REDUCTION; AND ASK IF THEY STILL WANT TO BE TESTED. IF YES, GIVE THE TEST AND MOVE DIRECTLY TO SECTION IV (CONCLUSION).

IF YOU DETERMINE THEY ARE AT HIGH RISK, PROCEED TO THE NEXT ITEM IN THE FORMAT.

B. ASSESS THE PERSON'S KNOWLEDGE ABOUT AIDS AND THE HIV ANTIBODY TEST (EVEN THE PERSON WHO CLAIMS TO BE KNOWLEDGEABLE AND ANXIOUS TO MOVE ON). THE FOLLOWING QUESTIONS CAN HELP THIS ASSESSMENT:

1. WHAT DO YOU KNOW ABOUT AIDS?

2. WHAT DO YOU KNOW ABOUT THIS TEST?

3. WHAT ARE YOU CURRENTLY DOING TO REDUCE YOUR CHANCES OF EXPOSURE TO THE VIRUS?

4. WHAT DO YOU CONSIDER TO BE "SAFER SEX"?

NOTE: SUPPLEMENT OR CLARIFY ANY INCOMPLETE OR INCORRECT INFORMATION BY STRESSING THE FOLLOWING:

-**TEST PURPOSE**--THIS TEST IS FOR ANTIBODIES TO THE VIRUS WHICH CAUSES AIDS-IT DOES NOT DIAGNOSE AIDS OR TELL WHETHER THE PERSON WILL GET AIDS.

-**AIDS PROGNOSIS**--AS FAR AS WE KNOW ALL PEOPLE WITH A POSITIVE TEST GO ON TO DEVELOP AIDS.

-**INFECTIOUS**--A STRONGLY POSITIVE TEST USUALLY INDICATES INFECTION WITH THE VIRUS AND THE ABILITY TO TRANSMIT THE VIRUS TO OTHERS.

-**TEST ACCURACY**--SOME PEOPLE WILL HAVE FALSE REACTIVE TESTS, BUT THE TEST IS VERY ACCURATE IN PEOPLE WITH RISK FACTORS FOR INFECTION.

-**NEGATIVE TEST MEANING**--A NEGATIVE TEST DOES NOT MEAN THAT A PERSON IS FREE OF THE VIRUS. ANYONE WHO RECENTLY HAD "UNSAFE SEX" OR SHARED NEEDLES WITH THE INFECTED PERSONS MAY LATER DEVELOP A POSITIVE TEST. ANYONE AT INCREASED RISK OF ACQUIRING THE VIRUS WHO IS NEGATIVE NOW SHOULD TAKE CONTROL AND REDUCE THOSE RISKS.

-**FALSE NEGATIVES**--A VERY SMALL PERCENTAGE OF PEOPLE WHO HAVE A NEGATIVE ANTIBODY TEST ACTUALLY WILL BE INFECTED AND ABLE TO TRANSMIT THE VIRUS.

-**TEST IMPACT**--A POSITIVE OR NEGATIVE ANTIBODY THAT CAN HAVE A SIGNIFICANT PSYCHOLOGICAL IMPACT ON BOTH THE PERSON TESTED AND THOSE WHO ARE CLOSE TO HIM OR HER.

-**"SAFER SEX"**--"SAFER SEX" IS AVOIDING ANY EXCHANGE OF BODY FLUIDS AND EVEN THE POSSIBILITY THAT IT MIGHT OCCUR.

C. ASSESS THE IMPACT OF TEST RESULTS ON THE PERSON'S LIFESTYLE. THE FOLLOWING OR SIMILAR QUESTIONS CAN HELP THIS ASSESSMENT:

-"WHAT ARE YOUR EXPECTATIONS ABOUT THE TEST RESULTS?"

-"WHAT WOULD A POSITIVE TEST MEAN FOR YOU?"

-"WHAT CHANGES WILL YOU MAKE IN YOUR LIFE IF YOU ARE POSITIVE?"

-"WHAT WOULD A NEGATIVE TEST MEAN FOR YOU?"

-"WHAT CHANGES WILL YOU MAKE IN YOUR LIFE IF YOU ARE NEGATIVE?"

III. PREVENTION RECOMMENDATIONS

A. REINFORCE ALL THE FOLLOWING PREVENTION RECOMMENDATIONS

THAT THE PERSON BRINGS UP IN RESPONSE TO QUESTIONS 3 AND/OR 5 ABOVE AND COVER ANY WHICH DO NOT SURFACE:

-AVOID DONATING BLOOD, PLASMA, BODY ORGANS, OTHER TISSUE, AND SPERM.

-WHEN HAVING SEX, AVOID PASSING OR RECEIVING BODY FLUIDS, PARTICULARLY BLOOD, SEMEN, SALIVA, FECES, OR URINE. USE CONDOMS.

-AVOID SEX WITH PEOPLE WHO HAVE AIDS OR MAY BE INFECTED WITH THE VIRUS.

-REDUCE THE NUMBER OF SEX PARTNERS.

-AVOID SHARING NEEDLES.

-DECREASE OR STOP USING "POPPERS" (INHALANT NITRITES).

IV. SEX PARTNER REFERRAL

A. ASSESS THE PERSON'S WILLINGNESS TO REFER SEX PARTNERS IF TEST IS POSITIVE. THE FOLLOWING CAN HELP THIS ASSESSMENT:

-HOW MUCH DO YOUR SEX PARTNERS KNOW ABOUT YOUR POSSIBLE EXPOSURE TO THE VIRUS?

-WHAT WOULD THEIR RESPONSE BE IF YOU TOLD THEM YOU WERE POSITIVE?

B. INFORM THE PERSON THAT IF THE TEST IS POSITIVE WE WILL STRONGLY ENCOURAGE THAT SEX PARTNERS BE INFORMED AND BE GIVEN THE OPPORTUNITY TO BE COUNSELED AND TESTED. WE WILL HELP THE PERSON TO DO THIS BY OFFERING VARIOUS TECHNIQUES AND SUGGESTIONS TO SENSITIVELY DISCUSS THIS AND WILL BE AVAILABLE TO ASSIST IF THEY PREFER.

V. CONCLUSION

A. ASSESS HOW THE PATIENT PLANS TO HANDLE THE WAITING UNTIL THE TEST RESULTS ARE RECEIVED. THE FOLLOWING QUESTIONS CAN HELP WITH THIS ASSESSMENT:

-HOW DO YOU PLAN TO COPE WHILE YOU ARE WAITING FOR TEST RESULTS?

-WHAT PLANS HAVE YOU MADE TO TELL ANYONE THAT YOU HAD THE TEST DONE?

B. ADDRESS ANY QUESTIONS THE PERSON HAS.

C. PROVIDE A HANDOUT REINFORCING THE PREVENTION RECOMMENDATIONS.

D. TELL THEM RESULTS ARE NOT GIVEN BY PHONE OR LETTER, ONLY IN PERSON.

E. MAKE SURE THE PERSON KNOWS WHEN TO RETURN FOR TEST RESULTS AND THAT THEY WILL BE DISCUSSED AT THAT TIME.

F. ADVISE THE PERSON IF THERE WILL BE A DIFFERENT POST-TEST COUNSELOR.

G. ADVISE THE PERSON THAT ANYBODY WITH A POSITIVE TEST IS REFERRED TO MEDICAL SPECIALIST FOR FOLLOW-UP MEDICAL EVALUATION.

CHAPTER V

SPECIAL POPULATIONS

Counselors in methadone programs need to be able to provide specialized information and counseling approaches to patients who have special problems, such as terminal illness, and patients who fall into some general categories, such as minorities or women. Regulations that are pertinent to this chapter (e.g., eligibility exceptions for pregnant patients, take-home exceptions for the terminally ill) have been discussed previously in the methadone maintenance and detoxification chapters. The treatment plan requirements for pregnant patients are discussed in this chapter.

Patients who are HIV-Positive

Because intravenous drug users are at high risk for contracting and transmitting HIV, counselors should strongly urge patients to be HIV tested. Counselors should receive training in pre- and post- test counseling as well as in dealing with ongoing issues with the person who tests positive. (Some information regarding this is provided in Chapter IV.)

The primary goal of counseling with patients who are HIV-positive is to establish behavior that reduces the risk of transmissions to others. Factors that can affect behavior change are the patient's understanding of HIV transmission and his/her current behavior patterns.

A questionnaire to evaluate "AIDS preparedness" with regard to knowledge and beliefs, recent behavior, plans for behavior in the next month, attitudes about intravenous drug use and needle sharing, and social relations is provided in the appendix to this chapter. This instrument was developed by Felipe Castro, Ph.D. Counselors should review the questionnaire with the patient to point out high-risk behaviors, assess faulty beliefs, educate the patient on virus transmission issues, and change attitudes regarding safe sex and intravenous drug use. To accomplish these goals, counselors must be well-trained, have access to consultation from medical staff and/or staff specialist in HIV issues, and be knowledgeable of community resources.

Although it is beyond the scope of this manual to provide all of the information necessary for counseling persons who are HIV-positive, these are some general approaches that can be helpful (see Batki, 1988, 1990):

- Persuade the patient to discontinue sharing needles, to reduce the risk of infecting others:

- Persuade discontinuation of needle use, for the patient to maintain his/her health;

- Encourage continued treatment. Addicts who are on methadone have better functioning immune systems than heroin addicts. Most patients who discontinue methadone return to heroin use.

- Be flexible with regard to program rules and willing to accept less than ideal performance in treatment rather than terminating treatment. It may be necessary to weigh the public health consequences as well as the consequences to the individual patient in considering treatment termination. Patients who are not doing as well as one might hope may sometimes need to be tolerated simply because they have reduced intravenous drug use while they are on methadone. As Batki (1988) states:

  > "Terminating services to a patient who continues to use drugs has traditionally been the final form of so-called limit setting that is applied by methadone programs. However, the potential consequences of such measures are serious: patient discomfort, deterioration of health, and public health risks from unbridled needle use and needle sharing. Programs may thus be required to adopt a more flexible or lenient approach to the treatment of patients with AIDS. Having to compromise traditional drug abuse treatment values may be necessary, but for many clinicians it is a better pill to swallow."

- Institute groups of HIV-positive patients for emotional support and mutual encouragement of safe and healthy lifestyles.

Critically Ill

With the increasing spread of AIDS among intravenous drug users, methadone programs are faced with the problems of providing medication to people who have difficulty getting to the clinic. In addition, counselors are now dealing with issues of death and dying as well as addiction. Counselors need to be aware of regulatory issues in light of illness and of some special counseling issues.

Regulatory issues

Most of these issues were discussed in the Methadone Maintenance chapter. They are reviewed here.

- Take-homes. Counselors should refer to state and federal regulations regarding take homes as they relate to critical illness. Examples of these issues are that it is not necessary that the patient's clinic attendance be incompatible with employment, education, and responsible homemaking; the physician may allow an exception to the normal take-home schedule and allow up to the Step IV level. Counselors would most likely consult with a supervisor or appropriate regulatory agency when dealing with these or other take home issues relevant to this area.

- Patient responsibility. Federal regulations require that patients handling methadone be "responsible in handling narcotic drugs." Programs need to make a judgment as to whether this is the case.

Counseling issues

(Much of the following has been adapted or excerpted from "Management of Psychosocial Sequelae of HIV Infection among Drug Abusers," by James L. Sorensen and Steven L. Batki, in J. H. Lowinson, P. Ruiz, and R.R. Millman (Eds.), *Comprehensive textbook of Substance Abuse*. Baltimore: Williams and Wilkins, 1990.)

The presence of AIDS may exacerbate some of the psychiatric disorders (depression, anxiety, and cognitive impairment) that often occur in opiate addicts. Four disorders that commonly affect opiate addicts with AIDS or ARC who are enrolled in methadone maintenance are denial, anger (with antisocial behavior), depression, and isolation.

Denial is well-recognized in substance abuse and is often exacerbated with the problems that accompany HIV. Patients can deny having AIDS and hide it from their family members and

friends. Moreover, denial can also cause patients to refuse to accept medical treatment for HIV disease. Anger also appears, and patients can direct anger about having AIDS at their counselors, at their drug treatment, or at their AIDS treatment. They can express this anger by refusing to comply with the prescribed treatment or missing appointments at the clinic. They may also exhibit antisocial aspects of anger--continued drug abuse, the selling of medications, or threats of violence. Depression, already common among substance abusers, may be nearly universal among injection-drug users with AIDS. And drug abusers with AIDS can feel doubly isolated, as both drug users and people with AIDS.

Treatment of patients with AIDS or ARC requires much more flexibility than is customary in traditional substance-abuse programs. These patients generally have more psychological problems than other drug users and may need more time than others to discontinue their drug use.

Counseling about AIDS issues is a necessary part of the treatment plan. Such counseling is different from the typical drug-abuse treatment in several ways. It may involve assisting patients' families in coping with the impact of HIV, or intervention when patients' friends or family members die.

Psychosocial problems influencing risk behavior

The problems that accompany HIV infections are social, not just psychological. Intravenous drug users with AIDS have few economic or educational resources, which makes it difficult to help them build the self-confidence and skills needed to make good use of drug-abuse treatment.

It is a mistake to think that all drug users are alike. There are considerable differences among these patients: variations in culture, ethnicity, and sexual orientation are integral to understanding AIDS among drug users. African-Americans and Hispanics are dramatically over-represented among AIDS cases, and 7% of AIDS victims are men who report both intravenous drug use and homosexual/bisexual contact. Treatment programs must be culturally sensitive.

In addition, HIV-infected intravenous drug users have far greater service needs than "healthy" addicts. Minimal social services are not enough when drug abusers have AIDS. These patients have difficulties making and keeping the numerous appointments with health care and social service providers. Consequently, the burden of care often will fall on the drug treatment program.

Psychosocial management approaches to slowing the spread of HIV

Drug-treatment programs also face a growing responsibility to assist disabled patients with social services. These include making referrals for food, shelter, and general assistance. In

some geographic areas, stand alone clinics for AIDS patients may be available to those in methadone treatment. However, drug-abuse treatment staff may at times need to be the case managers and advocates for their patients, to help them gain access to these services. In some communities, drug-treatment programs may need to become the primary health care providers for their patients because of the shortage of social services in the community.

Staff problems

AIDS has created a psychological crisis for staff in drug-treatment programs. They are being asked to attend to the physical, psychological, and social stressors of HIV infection among their patients, while their program policies and practices may be counterproductive for coping with AIDS. In addition, they need to cope with their own fears of infection and feelings about death. This combination of professional stressors and personal helplessness creates a situation that is ripe for professional burnout.

Fear of infection

When a drug-abuse treatment program begins to treat patients with AIDS, a concern is likely to arise among staff about becoming infected with HIV by drawing blood (which is clearly risky), and they may have other concerns at different levels of certitude about the safety of collecting samples for urinalysis, dispensing medications, and simply being near so many HIV-infected patients.

Programs can manage these concerns by developing guidelines and providing training. It is important to apply clear infection-control guidelines derived from hospital universal precautions for handling potentially infectious body fluids. Staff group support sessions and in-service training sessions are helpful.

Confidentiality dilemmas

Staff can be perplexed by the ethical binds that are posed by unclear and changing confidentiality regulations. For example, should they inform a patient's needle-sharing partner about a patient's HIV infection if the patient refuses to do so and continues to share needles? Similarly, lack of clarity may exist about how much information staff should share with other drug-abuse or AIDS-treatment providers. Different localities have different requirements about reporting HIV infection.

There are no perfect solutions to these dilemmas. Drug-abuse treatment programs must keep up to date with confidentiality laws and guidelines and make use of outside experts. Until the judicial and legislative systems promulgate a consistent set of local, state, and federal regulations, confidentiality will remain a confusing problem for drug-treatment staff who have patients with AIDS or ARC. Counselors should always consult with the program manager in any case of uncertainty regarding confidentiality.

Psychiatric Problems

Counselors are not expected to treat patients' psychiatric disorders. However, it is not uncommon for counselors to work with patients who have some psychiatric problems. Counselors who feel that a patient needs a psychiatric assessment should refer him/her to the medical staff or staff psychologist. Counselors who observe any of the following should seek consultation:

- Suicidal thoughts or plans
- Extreme changes in mood
- Extreme change in sleep/activity patterns
- Hyperactivity
- Paranoid thinking
- Hallucinations
- Unresponsiveness
- Confusion

In working with these patients, counselors should focus on chemical dependency and "daily living" issues. Because patients with psychiatric problems generally do more poorly in treatment, counselors should be ready to spend more time and effort with them. An ongoing communication with psychiatric, medical, or psychological staff is essential for good patient care.

There is some evidence that opiates such as methadone have some anti-psychotic properties. Patients whose psychoses are not evident may begin to show symptoms as they taper off methadone. Counselors should be aware of this possibility and provide feedback to medical staff.

Women's Issues

Pregnancy

State regulations describe methadone maintenance treatment requirements for pregnant patients. Counselors should review this section, which includes the following:

1. The pregnant woman should be under the care of an obstetrician or gynecologist (see State regulations).

2. The program physician must ensure that arrangements have been made for the addiction-related medical care of the patient and baby following birth.

3. Treatment plans must include these additional services:

   - physician consultation at least once monthly;
   - nutritional counseling;
   - parenting training including newborn care, handling, health, and safety;
   - family planning; and
   - weekly full-screen urinalysis.

[Note: The treatment-plans requirement is in addition to the normal treatment plan requirements described in the State regulations.]

Counselors should be trained in nutritional, parenting, and family-planning issues or should make use of program specialists or community resources. (A suggested pregnant-addict program curriculum is provided in the chapter appendix. This program was developed by Barbara Casucci of Cornerstone Rehabilitation Services, Inc., Pico Rivera, California.)

There are some misconceptions that surround the issue of methadone and pregnancy. Patients, the community, other treatment providers, and sometimes even medical practitioners express strong negative feelings about the use of methadone by pregnant addicts. Joan Zweben (1988) states,

> "A tacit assumption of many protesters is that if the pregnant woman were refused methadone, then she might be motivated to become abstinent, which is of course preferable. The realities of the opiate-addicted pregnant woman are in fact quite different, and the choice is usually between use of street drugs and participation in a program."

Some pregnant addicts are pressured to withdraw from opiates. Unfortunately, withdrawal from opiates can cause fetal distress which can lead to miscarriage or premature labor. On the other hand, methadone maintenance coupled with good prenatal care is generally associated with non-problem delivery. Although these newborns tend to have a lower birth weight and smaller head circumference than drug-free newborns, there are no apparent developmental differences at six months of age (from Zweben and Payte, 1990).

Finally with regard to the severity of methadone withdrawal Zweben and Payte (1990) state:

> "Contrary to the impression given by television and other media coverage of the newborn abstinence syndrome, the withdrawal associated with maternal methadone maintenance is fairly straight forward and uncomplicated. It is a popular myth that methadone withdrawal is more severe than any other. In reality, because of the long plasma half-life, the abstinence syndrome develops slowly, is of moderate intensity, and lasts a long time. Heroin or morphine addiction, on the other hand, results in a rapid onset of a more intense withdrawal that is fairly brief in duration."

The option of methadone treatment is sensible and usually best for mother and baby. Counselors should be supportive of this choice and help alleviate guilt or misgivings related to misconceptions.

Sexuality

The following is excerpted from Zweben (1991).

> "Sexuality is a source of special concern. Those women who have engaged in prostitution often find themselves with troubling feelings in their sexual relationships with significant others. Clinicians have noted that is not uncommon for them to become involved in lesbian relationships, temporarily or permanently, in search for a more neutral arena of expression.
>
> "Within heterosexual relationships, safety from the AIDS virus can be difficult to secure. A study of heterosexual partners of intravenous drug-abusers by Murphy, Brown and Primm (1988) indicated that women's partners were more likely to be another intravenous drug user. The counselor wishing to address these issues may meet with difficult obstacles. Talking about feelings and preferences with respect to sex may be difficult despite the range of a woman's previous activities and

experiences. Many women express fears, ranging from rejection to beatings, if they press their partner to use condoms. Often the fear of loss is so great that women are not willing to risk raising the issue.

"Smith and colleagues (1982) noted a significant degree of concern and sexual dysfunction in both male and female heroin addicts, and recommended screening for all addicts and additional evaluation if a primary or secondary sexual dysfunction is discovered. Women who chronically use high doses of heroin may not only see a reduction of sexual desire but irregular menstrual cycles or amenorrhea, and they may misinterpret this physiological effect (depression of pituitary hormones by the opiate) to mean that they are temporarily sterile and hence conclude there is no need to use contraceptives. Ralph and Spigner (1986) reported that only 25.8% of heroin-addicted women used any type of contraceptive, as compared to 48.5% of a national sample. The most commonly cited reason for this low rate of contraceptive use was the confusion between amenorrhea and infertility. Also, women need to be alerted that methadone normalizes endocrine function and menstrual periods are likely to resume. These issues are best addressed in MMT clinics through a coordinated effort between the medical component and counselor follow-up to reduce obstacles to the implementation of effective contraceptive practices."

Minority Issues

Counselors can be more effective if they are aware of and sensitive to the differences among the minority groups with whom they are working. It is important for counselors to deal with patients as individuals, but it is also important that they are aware of issues or attitudes that may be sensitive for minority-group members. Some general guidelines are:

- Be open and honest; be yourself. Don't pretend you are of the patient's group if you are not; don't try to mimic the language or behavior style of the patient in order to impress a familiarity with the patient's ethnic group.

- Be patient. Many minority groups have suffered from discrimination, and minority-group patients may initially be suspicious or wary of the counselor and his/her intentions. Counselors should be sensitive to these legitimate feelings and allow time for the patient to "size up" the situation.

- Address the differences. Ask the patient how he/she feels about having a counselor who is not of the same minority group, if you feel there may be a problem. Patients should, if possible, be given the option of having a counselor with whom they feel more comfortable. This is particularly important if there are language problems.

- Be sensitive to cultural and ethnic differences that affect counseling. It may be necessary to alter the general style of counseling in light of these differences. Some general characteristics of some groups follow.

Mexican-Americans

Mexican-Americans tend to be more family-oriented than other groups. Counselors may be able to involve family members in counseling, which may facilitate progress towards treatment goals. There is a preference for personal informal approach versus a staid, detached approach. The informal "chit chat" at the beginning of a session can be very important in establishing a productive relationship. It is important that counselors be professional as well as personal and informal. A friendly style within the professional role of "counselor" is very different from acting as the patient's friend. Counselors should always keep the boundaries between patient and counselor clear. (An article by Reyes Ramos that describes the languages and subculture of the Chicano intravenous drug user is provided in the appendix.)

African-Americans

Some of the characteristics of this group include nonverbal communication, sometimes a lack of eye contact when listening, a de-emphasis of the relevance of childhood experiences in explaining current problems, and a preference for a directive pragmatic approach.

Asian-Americans

Although there are cultural difference among the various nationalities of Asian-Americans, there are some general commonalities. These include patriarchal families, a tendency to deal with problems within the family, a difficulty in expressing feelings, and a preference for clear and structured counseling approaches.

These brief descriptions of some differences among minorities in treatment are meant to raise awareness of this as an issue in counseling, not as a definitive description of the qualities of all minorities. Counselors should seek training and supervision in these matters and be aware of possible culturally based factors that can either impede or facilitate the course of treatment. A counselors who is fixed to a single point of view that may be associated with his or her own cultural or ethnic background may be unable to connect with certain patients. Consideration of the patient's perspective and a flexible approach in light of this can help in the treatment process.

Appendix

Chapter V

Table of Contents

HANDOUT **FORM**

Special Populations

METHADONE MAINTENANCE PROGRAM

#1.2

ID #_____.

Today's Date_____
Interviewer_____

I. AIDS PREPAREDNESS

A. Knowledge and Beliefs

Please circle the answer which you think is correct for each of these items.

	False	Perhaps	True
1. AIDS is a disease that weakens the body's capacity to fight off infections.	1	2	3
2. The spread of AIDS can be reduced by using condoms.	1	2	3
3. Women who are infected with the HIV (AIDS) virus can pass it along to their babies during pregnancy.	1	2	3
4. Carrying the HIV (AIDS virus) and having AIDS are the same thing.	1	2	3
5. There is a test that tells if you have been exposed to the HIV (AIDS virus).	1	2	3
6. You can carry HIV (AIDS virus) without being sick with AIDS.	1	2	3
7. A positive test for HIV antibody (AIDS virus antibody) means you could transmit the HIV by sharing a needle.	1	2	3
8. There is treatment for people with AIDS.	1	2	3
9. Putting needles in a flame will prevent infection with the HIV (AIDS virus).	1	2	3
10. If needles for sale are sealed, you always know they are clean.	1	2	3
11. You cannot get AIDS by having oral sex.	1	2	3
12. Cleaning needles and works with soap and water will kill the HIV (AIDS virus).	1	2	3
13. Cleaning needles and works in bleach will kill the HIV (AIDS virus).	1	2	3
14. Once you are diagnosed as HIV +, you need not worry about reinfection with HIV.	1	2	3
15. There is no treatment available for people who are HIV positive.	1	2	3
16. Cleaning needles and works in rubbing alcohol will kill the HIV (AIDS virus).	1	2	3
17. If you have AIDS, you are at greater risk of getting other diseases.	1	2	3
18. Cleaning needles and works in hydrogen peroxide will kill the AIDS virus.	1	2	3

B. Events and Situations

Please answer these statements about what you have done during the past month.

	NONE (0)	1 TO 5	6 TO 10	11 TO 15	16 TO 20	21 TO 25	26 TO 30
1. In the past month, I have had sex (without a condom) with this many different sexual partners.	A	B	C	D	E	F	G
2. In the past month, the number of times I have injected (shot up) drugs is:	A	B	C	D	E	F	G
3. In the past month the number of times I have shared a needle while doing drugs:	A	B	C	D	E	F	G
4. On a typical day, the number of times that something about AIDS comes to my mind is:	A	B	C	D	E	F	G
5. I used someone else's needle because it was convenient (I did not have to buy a new one or bring my rig with me).	A	B	C	D	E	F	G

C. Plans

Please answer these statements about your plans for the NEXT MONTH.

	ABSOLUTELY NOT	PROBABLY NOT	MAYBE	PROBABLY YES	ABSOLUTELY YES
1. I plan to use a condom every time I have intercourse with a partner.	1	2	3	4	5
2. I plan to use a condom every time when having sex with my spouse or partner.	1	2	3	4	5
3. I plan to avoid contact with female prostitutes and male hustlers, and others who may be infected with the HIV (AIDS) virus.	1	2	3	4	5
4. I plan to attend a clinic program in my community where information on AIDS is being given.	1	2	3	4	5
5. I plan to have a blood test which can detect the presence of the AIDS virus.	1	2	3	4	5
6. I plan to avoid sexual contact with strangers.	1	2	3	4	5
7. I plan to have a baby.	1	2	3	4	5
8. If I got a positive AIDS antibody test, I would tell my test result to anyone I shoot up with and/or have sex with.	1	2	3	4	5
9. I plan to shoot drugs (heroin, cocaine, etc.)	1	2	3	4	5
10. I plan to use someone else's needles	1	2	3	4	5
11. I plan to share my needles and works with other users	1	2	3	4	5
12. I plan to actually observe that needles I use are cleaned properly before I use them.	1	2	3	4	5
13. I plan to clean my needles and works before I let someone else use them.	1	2	3	4	5

D. Behaviors

Please indicate how often you have engaged in the following activities in the PAST MONTH.

	NOT AT ALL (0)	SOMETIMES/ ABOUT MONTHLY (1 to 3x/mo)	MUCH OF THE TIME/ABOUT WEEKLY (1 to 6x/wk)	EXTREMELY OFTEN/ABOUT DAILY (7+ times/wk)
1. Have engaged in male-to-female sexual contact without the use of a condom.	1	2	3	4
2. Have engaged in sexual intercourse with a female prostitute without using a condom.	1	2	3	4
3. Have engaged in sexual intercourse with a male prostitute without using a condom.	1	2	3	4
4. Have used alcohol or drugs hoping to make my sexual experiences more exciting.	1	2	3	4
5. Have shared a needle when doing intravenous drugs.	1	2	3	4
6. Have had sex (without a condom) with a partner of the same sex as myself.	1	2	3	4
7. I have shot drugs (heroin, cocaine, etc.) without sharing my needles.	1	2	3	4

II. IV DRUG USE AND NEEDLE SHARING

Please indicate how much you agree or disagree with these statements. Answer the way you feel **RIGHT NOW.**

A. Attitudes	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. It's okay to share needles and works with anyone.	1	2	3	4	5
2. It's okay to share needles and works with people you know very well (close friends, relatives, etc.)	1	2	3	4	5
3. It's not okay to have unprotected sex (sex without a condom) with someone who shares needles.	1	2	3	4	5
4. I am willing to share my used needle with someone else.	1	2	3	4	5
5. It's important to always clean my needles and works before I use them.	1	2	3	4	5
6. Using bleach and water to clean needles and works is a hassle.	1	2	3	4	5
7. It's better to feel sick (withdrawal symptoms) than to use dirty needles and works.	1	2	3	4	5
8. There is no point in starting to clean needles if you've used dirty needles and works in the past.	1	2	3	4	5
9. I only shoot up once in awhile, so I don't have to own my own needles/works.	1	2	3	4	5
10. I shoot drugs because I want to.	1	2	3	4	5
11. I shoot drugs because I have to.	1	2	3	4	5
12. I take methadone because I have to in order to feel normal (no withdrawal symptoms).	1	2	3	4	5

SOCIAL RELATIONS

Please indicate how you feel abouth these statements right now.

	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE
A. Reference Groups					
1. My buddies would consider it an insult if I refused to share my needles/works with them.	1	2	3	4	5
2. My buddies would consider it an insult if I refused to use needles/works after them.	1	2	3	4	5
3. My sex partner would be insulted if I said that we should use a condom (rubber).	1	2	3	4	5
4. My sex partner would refuse to have sex with me unless we used a condom.	1	2	3	4	5
5. My sex partner wants me to shoot I.V. drugs.	1	2	3	4	5
6. I share my needles/works with my buddies because they want me to.	1	2	3	4	5
7. I use my buddies' needles/works after they use them, because I don't want them to be insulted.	1	2	3	4	5
8. I don't use a condom (rubber) with my sex partner to avoid insulting my partner.	1	2	3	4	5
9. We use a condom (rubber) when we have sex because my partner insists upon it.	1	2	3	4	5
0. I shoot I.V. drugs because my partner wants me to.	1	2	3	4	5

Cornerstone Health Services

Pregnant Addict Program Cirriculum

Patient Name_____ Starting Date_____

PARENTING CLASS ATTENDANCE SHEET

PRENATAL CLASSES:	**DATE ATTENDED**
1 VIDEO - Conception to Birth (20 min.) & Fetal Development	_____
2 VIDEO - What Mother Takes (25 min.) & Effects of Drugs on Fetus	_____
3 Danger Signs During Pregnancy & Premature Births	_____
4 VIDEO - Knowing the Unborn (30 min.) & Bonding	_____
5 AIDS and STDS - Transmission and Risk Reduction	_____
6 Nutrition During Pregnancy & Prenatal Vitamins	_____
7 VIDEO - The Miracle of Life (60 min.)	_____
8 Labor, Delivery, and C-Sections - Breathing and Exercises	_____
9 VIDEO - CPR (50 min.) & Safety and Accident Prevention	_____
10 Sibling Rivalry - Preparing the Home for the Newborn	_____
11 VIDEO - Breastfeeding (13 min.) & Nursing or Bottle Feeding	_____
12 VIDEO - Baby Basics (48 min.) & Car Safety	_____
13 Premenstrual Syndrome and Post-Partum Depression	_____
14 VIDEO - Innocent Addicts (45 min.) & Discussion	_____
15 VIDEO - Caretakers of Drug Babies (17 min.) & Infant Withdrawal	_____

POSTPARTUM CLASSES:	
1 Jaundice, Colic, and Dehydration - Sudden Infant Death Syndrome	_____
2 VIDEO - Parenting and Child Safety (35 min.)	_____
3 Immunizations, Well Baby Care, Nutrition and Eating Behaviors	_____
4 VIDEO - Stress Reduction (20 min.) & Preventing Parent Burnout	_____
5 Contraception and Planning for Growth of Family	_____
6 Teething, Weaning, and Toilet Training & Packing Diaper Bags	_____
7 VIDEO - The First year of Life (30 min.) & Child Development	_____
8 Child Development and Tests:APGAR, Neonatal, Development	_____
9 Child Abuse and Neglect & Discipline and Setting Limits	_____
10 Battered Women and Children & Crisis Shelters	_____
11 Common Childhood Illnesses and Head Lice	_____
12 Bedtime and Wake-up Routines & Childhood Fears	_____
13 VIDEO - The Discovery Years (60 min.) Discussion	_____
14 Parent/Child Communication and Development of Self-Esteem	_____
15 Play Therapy, Toy Selection & Rotation, & Skill Development	_____

A TOTAL OF 30 HOURS OF CLASS IS REQUIRED TO OBTAIN A CERTIFICATE OF GRADUATION

Chicano Intravenous Drug Users

Reyes Ramos

INTRODUCTION

Not long ago, I went to a shooting gallery. An outreach worker, an ex-addict, had permission to take me and my research assistant there to give a presentation on acquired immunodeficiency syndrome (AIDS) and intravenous (IV) drug abusers to the clientele of the gallery.

We spoke with 12 Chicano men, mostly in their twenties. The owner and two others appeared to be in their late forties or early fifties.

During a question-and-answer period after our talk, an addict said:

> This stuff is interesting. If you are going around doing this, I'll be your consultant. For a fee, of course. We can get the wire out [i.e., the word out]. But, you understand, we need to look into it.

The day after the meeting, the "consultant" and another individual from the gallery came to our office. During the interview, the consultant told my assistant that they had come to check us out. The consultant said that they wanted to check out the relationship between the AIDS project and the host agency, a drug treatment agency. As the consultant put it, "We want to see if you people are independent from this place. We don't trust some of the people here." He was referring to the host agency and staff.

The consultant, like other IV drug users, was trying to make sense of the world in which he lives. Sometimes professionals forget this basic fact of human nature and treat IV drug users as unidimensional people. Researchers, like social service people, may think of IV drug users as if they live in a vacuum. They do not. IV drug users lead busy and complicated lives, and they constantly assess who is doing what with whom and for what reason. Thus, any effort to reduce the IV drug user's chances of acquiring AIDS must address the complex features of the addict's life and how the addict goes about making sense of his practical circumstances.

The purpose of this chapter is to describe the complex and dynamic world of Chicano IV drug users and to describe one method we use to discover

this world. Ethnographic data are presented to illustrate various aspects of the Chicano IV drug user's world. Some of these data come from cities on the U.S. and Mexican border where ethnographic work is now underway. In addition, we show how the methodological aspects of the "Indigenous Leader Outreach to IV Drug Abusers" model enriches the quality of ethnographic data that we obtain, data that we then use to influence behavioral change among IV drug users at risk for acquiring the AIDS virus.

DRUG CULTURE

Much is said about IV drug users in general, but little is known about the drug culture of the Chicano IV drug user (Aumann et. al. 1972; Bullington 1977; Jorquez 1984; Moore 1978; Moore and Mata 1982; Morales 1984). What Chicano IV drug users themselves say about their culture and the people who make up that culture is informative.

Chicano IV users claim that there are at least three aspects to their drug culture. One aspect is the way Chicano IV users classify themselves. Another aspect is linguistic, the language that Chicano IV users create and use. The third aspect deals with the ways "helpers" hinder drug addicts.

Chicano IV Users' Self-Classifications

Chicano IV drug users refer to themselves as "tecatos." It is said that the term tecato was applied to heroin users in Mexico in the 1940s. Then, it was used to distinguish heroin users from other drug users. The other major drug of preference at that time was opium. Even though some tecatos use cocaine today, the term is still used to refer to heroin users.

Tecatos stratify themselves into three groups: high class, medium class, and cucarachos.

High Class. Individuals in this group are known as tecatos buenos, good tecatos; they provide for themselves. They have money, and they do not ask for credit. They go to the connection or drug source and buy what they need. If they do not have the money for the drug, they do without. If they are arrested and they have to "kick" (withdraw from the drug habit), they kick quietly and do not complain about the pain.

The older and good tecatos see the young tecatos as crybabies. As some of the good tecatos put it:

> The guys today are spoiled. Or, rather, they have made themselves spoiled because, when they get arrested, they know that they are going to get medicine in the county jail, and they start to cry. They can't take it like in the past. Then, you were arrested and you knew that you were going to suffer and you

> prepared yourself. It is bad to break [kick], but when you break, like I tell you, you learn to take it and not to fear breaking.

There is truth in what the older good tecatos say about some of today's Chicano addicts. Older good tecatos can talk a supposedly good young tecato out of being sick for a while or into waiting for his fix. There is a lesson to be learned here for AIDS prevention. For example, good tecatos can train younger tecatos into waiting for their fix until they clean their needle with bleach.

This account may serve to illustrate the point Mata and Jorquez make when they write, "We found that controlled IV drug users tended to be older and more experienced" (Mata and Jorquez 1987, p. 49). Mata and Jorquez go on to say that these individuals "use various precautions, e.g., less frequent drug use and less drugs used, and they are more careful about who they share their drugs and IV injection works with" (Mata and Jorquez 1987, p. 49). This may be the case, but another explanation for controlled use may be that older tecatos operate under the old drug culture norms of a good tecato.

Other characteristics of good tecatos are that they dress well and act and talk responsibly. It is also said that they are reliable. Moreover, they may be employed at a "regular" job, or they may have a hustle (i.e., an illegal activity that makes money for them). Finally, these individuals may be married and appear to live ordinary lives.

Medium Class. (In Spanish, these individuals are called "medianos," so the label "middle class" does not translate into mediano.) These individuals are also seen as good tecatos. They do not ask for credit or a handout. But, they are different from tecatos buenos. While the good tecato is a leader or inner-directed type of person, the tecato mediano is not motivated to go out either to "connect" or to find a way to get money (i.e., steal). The tecato mediano waits around for someone to invite him to do a job or to connect. This person is a follower.

Cucarachos (Cockroaches). The cucaracho is an individual who hangs around the connection. Usually, there are one or two cucarachos around a connection. This individual always asks for a handout. The cucaracho does not pay his own way. He depends on real tecatos. He just waits around to see who will give him a "taste" or provide him with the drug.

Although the cucaracho behaves and talks as if he were a real tecato, this individual is not seen as a real tecato by other tecatos. It is said that these individuals rarely get hooked. If they get any drug, it is what is left in the cotton, or the cooker, or the syringe.

Cucarachos get a taste of heroin by doing favors or little jobs for the users and the seller. The cucaracho may also get a taste for lending his works (drug equipment) to a user who may not have his at the time of purchase. Or, he may run an errand either for the buyer/user or seller. For example, the cucaracho may go get cigarettes or syringes at the drug store, or do little odd jobs, like clean the car or yard for the seller or user.

There are some exceptions to the above description of the cucaracho. There are cases where a cucaracho lends or turns his home into a shooting gallery. In these cases, the cucaracho gets more than a taste. The cucaracho may get a large quantity of drugs because of the service he is rendering and may therefore become addicted. In a recent case in El Paso, TX, a cucaracho overdosed and died in this way.

A cucaracho plays a critical role in the life of IV users who shoot up when they buy in the home of the connection. More often than not, the cucaracho provides the works. While waiting for a tecato to buy and use, the cucaracho may spend time rinsing his works with water. Cucarachos could be trained to use bleach for cleaning works. An outreach worker on our project is helping cucarachos to develop a routine of rinsing injection equipment with bleach to prevent the spread of AIDS.

Cucarachos have a negative side to them. They may "burn" some people. It is said that cucarachos do not burn real tecatos, but that they may burn a newcomer, a "narc" (a police informer) or an informer for a narc. An informer for a narc is said to wear a chaqueta de relaje, or jacket of shame. Often, in a group of people, an individual may stare at another who is not in his group and say, "He has a jacket" (trae chaqueta).

Informers will use a cucaracho to buy drugs from a connection, so that the narc may locate the connection with the drug. In these cases, the cucaracho will take the money and not come back with the drug. These people, narc or narc informer, usually will not harm the cucaracho. An informer or individual with the jacket of shame will not go after the cucaracho who burned him. The informer cannot ask for the whereabouts of the cucaracho because nobody will cooperate with him. People in the community tend to know who is a narc informer.

A newcomer, either to the neighborhood or town or to drug use, who gets burned by a cucaracho often does nothing, perhaps because the newcomer does not know where to find the cucaracho or because he thinks he got burned by a real tecato. As pointed out, cucarachos present themselves as real tecatos.

Finally, the cucaracho depends on others for his support. He may be married, but he rarely has a steady job. Often, his wife is on welfare, and

he lives off her check. Or, as pointed out above, he may go work for a tecato for a day. He may fix a car, clean a yard, or take trash to the dump.

Implications of Self-Classifications. Needle sharing is common in these three groups of people. The high-class tecato bueno mostly shares with his partner, who may be his wife, girlfriend, or male buddy. Prior to the AIDS epidemic, these people only rinsed their works with water before passing it on to the partner. Now, these people tend to use new needles or needles rinsed with bleach if they are going to share with someone other than their wife.

As noted, the tecato bueno tends to be more controlled in his drug use. He or she will not share needles with anyone who is not in his group of tecatos buenos. This norm is similar to the one dealing with money. The tecato bueno will not buy drugs if he or she does not have the money. Instead, they will wait until they have the money.

The tecato mediano, like the high-class tecato, shares with his drug-using buddies. The cucaracho shares his needle with whoever gives him a taste of the drug. As pointed out earlier, the cucaracho can play a significant role in cleaning needles with bleach.

The status of a tecato may also be influenced by other factors. For example, the tecato may be a connection, a pusher, or a consumer. Connections are seen as being higher in status than the pusher and consumer. The pusher is higher in status than the consumer.

There is a behavior that may transcend these three classifications of tecatos. In the southwest, some recent arrivals from prison are using drag queens. If, in the past, an individual had one or several female prostitutes to provide sex, drugs, and income, he now may have a drag queen in his stable of prostitutes.

In some border cities, drag queens and gay prostitutes appear to make more money than female prostitutes. An interesting aspect of this situation is that these tecatos do not think of themselves as homosexual, and they are not seen by others as homosexual. They are seen as tecatos with a good hustle.

Tecatos and Language Use

In the emerging literature on AIDS prevention, AIDS researchers and social services delivery people call for "culturally and linguistically" appropriate prevention programs (Amaro 1987; Worth and Rodriguez 1986). These suggestions look great, but most writers do not specify what they mean by "cultural" and "linguistic" (Amaro 1987). They assume that the reader knows what these terms mean. This section addresses the linguistic aspects

of these recommendations; another section of this chapter will address the problems created when researchers do not define "culturally appropriate."

The few writers who define "linguistically appropriate" do so in a limited way (Amaro 1987). For example, the claim to have linguistically appropriate prevention programs only means that written materials and verbal interactions will be in Spanish and/or "spanglish." The assumption made is that the Spanish used is standard and that the spanglish is a mixture of Spanish and English.

This basic notion of presenting materials either in the subject's standard native language or in some dialect is fine, as far as it goes. But it is limited because it does not address how individuals use language, create and use language codes, and do code switching. Moreover, it does not address the contextual aspects of the social and physical environment that IV users and sex partners use to make sense out of what they and others do (e.g., buy drugs, steal, fence stolen goods, and get and hold jobs).

Tecatos, like any other people, create words and word usage that make up a language unique to them. The words that follow are used by tecatos as codes in specific situations.

Algoda. Algoda comes from the word algodon, which means cotton in standard Spanish. But, in the drug culture, cotton can mean any item that the tecato uses to filter the drug after it is cooked. The "cotton" often is the filter from a cigarette. Usage: Preste las algodas. (Lend me the cottons.) Móchate con las algodas. (Share with me the cottons.) Mochate is not often used in this way. The root word in standard Spanish is mochar, which means to cut. With the use of the phrase, mochate con las algodas, the individual reveals his status. It is said that only beginners and cucarachos ask for the algodas/cottons.

Aliviane. Aliviane comes from the standard Spanish word alivianar, which means to heal or cure. In slang, aliviane means to lighten up or get better. Usage: Pasame un aliviane. (Pass me a cure or help me out for the moment by giving me a fix or at the very least a few drops, or a cotton.) Andaba malillia, pero ya me aliviané. (I was sick, but now I have gotten healed or cured.) In other words, the individual is saying, "I was sick, but I have just fixed."

Apáre. Apáre comes from the Spanish word aparar, which means to stop. Here it means armed robbery. Usage: Hacer un apáre (to do an armed robbery).

Carga. Carga means load in Spanish. In the tecato world, it means heroin. Usage: Traes carga? (Do you have heroin?)

Chafa. Chafa means cheap. Usage: Es tecato chafa. (He is a cheap or not a serious/real tecato).

Chiva. Chiva means goat in Spanish and heroin in the tecato world. Usage: La chiva esta buena. (The heroin is good.)

Cincho. Cincho comes from the Spanish word cincha and the English word cinch. In the tecato world it means the same. Usage: De cincho la puedo agarrar. (For sure, I can get it, in a cinch [easily].)

Clávate. Clávate comes from the Spanish word clavo, which means nail. Clávate in the tecato world means to wait or hide. Usage: Clávate porque hay ropa tendida. Literally translated, this means: Nail yourself because clothes are on the clothesline. For the tecato, the sentence means "Wait, don't talk, because there are people listening."

Cotorrear. Cotorrear comes from the Spanish word cotorra, which means parrot. For the tecato, cotorrear is the back and forth head movement that an addict engages in when he is fixed (i.e., following recent injection of the drug). Usage: Estas cotorriando? (Are you fixed?) Being able to recognize this behavior is very useful to outreach workers and researchers. Saying, "Estás cotorreando?" gives the workers credibility with addicts and helps to establish rapport. As we have learned, the tecato opens up more when he perceives that we are knowledgeable. We assume that this perception leads him to believe that we are members of his culture.

Cura. Cura comes from the word curar, which means to cure or heal. In the tecato world, it has several meanings. Usages are given with the definitions. It can mean "to fix" as in the expressions: Para la cura, o me voy ir a curar. (For the cure, or I am going to cure myself.) Cura can also mean to laugh at something or someone, as in: Es bien cura. (He is funny.) It can also mean fun activities, like curadas, or indicate the nodding behavior that addicts engage in after a fix.

Enjable. For the tecato, enjable means to break into a house or a business to steal. Usage: Vamos enjablamos a esa casa or negocio. (Let's go rob a house or a business.)

Esquinear. Esquinear comes from the Spanish word meaning corner. In the tecato world, the word means support. Usage: Esquinéame. (Give me support, or give me a corner so that I may help myself.)

Fardear. For the tecato, fardear means to shoplift. Usage: Vamos a fardear, o anda fardeando. (Let's go shoplift, or he is shoplifting.)

Filerear. Filerear comes from the Spanish word filo, which means cutting edge. For the tecato, it means to inject with a needle or syringe. Usage: Se filereáron? (Did they inject themselves?)

Jále. Jále comes from the Spanish word jalar, which means to pull or haul. For the tecato, jále means a job or employment. Usage: Vamos hacer éste jále. This sentence can have two meanings. It can mean let's go do this job. Or, it can mean let's go steal. Tecatos always talk about jáles or jalesitos.

Jugar el Número. Jugar el número (play the number) means to play a game or to develop a strategy/movida. Usage: The person assesses a situation and determines whether it requires that he play a fool or appear innocent or smart. He then plays el número or the part of a fool or an innocent or smart person. A good interviewer who knows tecato life can say to a tecato, "no me jueges el número." In saying this, the interviewer lets the respondent know that he or she knows the situation and that the respondent needs to be "straight" with him or her.

La Muleta. Muleta means crutch. This is one of the important words in the tecatos' vocabulary. For the tecato, la muleta refers to something that can become a problem. Usage: Me voy a quitarme esta muleta. This means that I am going to take away something that is or can become a problem. For example, I am going to a job that I don't really want to do, but I'm going to do it. Or, if I have a gun on me, I will go hide it because if I don't it can be a problem. The same thing applies to having drugs on you. You need to hide them. Usage: Para no traér la muleta. (So that I will not be carrying the problem.) An addict may say, "Mi quiciera morir para quitarme esta muleta." (I would like to die to be rid of my problem of being an addict.)

Malilla. Malilla comes from the Spanish word mal, which means bad or ill. The tecato may use the word to mean that he is sick in the "straight" sense or that he needs a fix. Usage: Ando buti malilla. (I am very sick.) (The word buti may be a word indigenous to El Paso, TX.)

Movida. Movida means strategy. Usage: Andar en una movida (having a motive or being in a strategy).

Parchar. Parchar means to patch. For the tecato, the word means to have sexual intercourse. Usage: Esta madre no se pega nomás parchando. Con erres. (You can get this mother [the AIDS virus] in other ways besides sexual intercourse. With works or rigs.) Some tecatos call condoms bandaids, and they request them because they are going to parchar.

Piña. Piña means pineapple in Spanish. For the tecato, piña means story or lie. Usage: Es piña? (Is it a story/lie?)

Ponle por la puerta. Literally, put it at the door, this phrase is used to mean to confront the person. Usage: Sálele por la puerta, no me descuentes. (Come out the door, don't discount me.) The confrontation may result in a physical fight. But, whatever may occur, the point is that, at the start, the activity is face to face, not catching the other off guard or coming at him from behind. If someone has pulled a movida (literally, strategy) on you, and you meet him on the street, he knows that he pulled a movida on you, so he may say, "Sálele por la puerta, no me descuentes."

Rayarse. Rayarse means to get something. This word is an important word in the tecato's vocabulary. Usage: Te rayas con algo. (You came out with something.) The something is usually money or an item that can be exchanged for money or drugs.

Rollo. Rollo means roll in Spanish. Rollo means talk/conversation or "rap" for the tecato. Usage: Tirar rollo. (Give them a talk.) Our outreach workers often say, "Les tiré el rollo de AIDS." (I gave them the AIDS talk.)

Soda. Soda means cocaine. Usage: Traen soda. (They have cocaine.)

Talonear. Talonear means to hustle. Usage: Vamos a talonear. (Let's go hustle.) Anda taloneando. (He is hustling.) Ese bato es muy talón. (This guy is always looking for something to do, like a job, or something that he can steal.)

Traer Cola. Literally, having a tail, traer cola means being on probation or parole. It can also mean being followed or being searched for. Usage: Traer cola de tres años. (I have a probation period of 3 years.)

To explain this term with a brief digression, there are some interesting treatment aspects to the idea of having a tail or traer cola. A tecato on parole or probation is not supposed to be on drugs during this period, but many tecatos do use drugs. If they want to enroll in a treatment program that requires payment, the tecato can't go to his parole or probation officer (PO) for help, even though the PO might be able to obtain financial help to pay for the treatment program. The situation is a catch 22.

If the tecato admits to his PO that he is using again, he runs the risk of having his parole or probation revoked. Thus, a tecato can only go to a counselor in a treatment program whom he trusts.

A tecato may go to a counselor/friend and say, "Ando malilla, y también ando buscando puerta para quitarme ésta muleta. Pero, traigo cola." As translated: "I'm strung out, and I am also looking for a way out to get this thing off of me. But, I have a tail."

If the counselor knows the PO and knows that he can work with him, the counselor may approach the PO to tell him the actual situation. And, thus, he may help the tecato.

In this situation, the tecato must have someone who can understand his plight and language and can "front" for him. The advocate needs to know the tecato's language, to be able to esquinear/support the tecato.

Transa. Transa means transaction or deal. The concept of transa implies that the deal should be "under the table" and that the items being exchanged for the money are probably stolen. Usage: Vamos hacer esta transa. (We are going to go make a deal.)

Toriquear. Toriquear means to lie. Usage: Me estas toriquiando? (Are you lying to me?) As pointed out before, an outreach worker and researcher may use this word like the other words listed here. In so doing, he can communicate and establish or reveal that he has membership in the tecato community.

Vaquita. Vaquita means little cow in Spanish. In the tecato world, it means that two people share the price of a fix. Each person gets half of the drug in the cooker, and these two people share the syringe. Usage: Busco una vaquita. (I am looking for a little cow.) Tecatos with little money practice the vaquita process. Many tecatos in the border cities of Mexico do this.

The words given are codes. Tecatos use them to communicate with one another and to make sense of what they are doing in specific situations. These words convey meaning to the tecato in terms of the context in which they are used by particular individuals.

For example, an individual can say to a friend, "Let's go do a job." (Vamos hacer este jále.) A third person or listener to the verbal exchange may want to know what job they are talking about. He may ask, "Qué jále?" Often the response is something like the following: "Un jále." (A job). In the drug culture, this response tells the person asking the question that he is not going to be told. The response also lets the questioner know that he should not probe. In the drug culture, people who probe engage in unacceptable behavior. Membership in the culture is maintained by knowing the norms of appropriate behavior.

Helpers and Hinderers

Tecatos play out their lives in particular contexts, which are populated by significant others who help them and hinder them at times. People in helping agencies like drug treatment centers and in private business are

often tempted by the inexpensive items that tecatos can provide for them. Here I will point out how some helpers hinder the tecato.

Pharmacists, drug treatment center employees, policemen, and ordinary community people, for example, are part of the drug culture. They help perpetuate tecatos' deviance by buying stolen goods from them. Worse, these people give tecatos "shopping lists" of items that they need.

For instance, a methadone employee may "help" a tecato pay for his methadone by buying from him or her stolen items that she, the employee, ordered. Of course, a $70 dress will cost only $18. If the tecato complains, he or she has trouble getting methadone. As an employee put it to the tecatos, "I am the goddess, and you are to bring me gifts."

Some policemen, the very people who arrest tecatos for their drug use, buy goods from tecatos for their own use and to sell at a profit. As in the above example, if the tecato doesn't produce, he can get burned.

Housewives also may seek out tecatos to put in their orders. Some tecatos do a thriving business selling clothing and meat to housewives.

There are two interesting aspects to the buying of stolen goods from tecatos. One aspect is that tecatos develop a list of customers that he or she supplies. The other aspect is that these "helpers" and "good" community people reinforce the tecato's idea that everyone is a crook.

OUTREACH AND RESEARCH: A CASE STUDY

In AIDS prevention among IV drug users, much is said about the role of research and outreach intervention practices. Often, the roles of research and outreach are not clearly spelled out in prevention projects. Here, I present a descriptive account of how researchers and outreach workers of the El Paso, TX, project of the University of Illinois at Chicago work together to learn about the tecato's actual situations, and to show how pushers who run galleries can further the aims of the project by becoming prevention advocates. They can become "informal staff" because they do outreach in their galleries. They continue our work by using bleach to rinse their needles and by telling other tecatos who come to connect and/or shoot up to use bleach and condoms to prevent getting the AIDS virus. It can be said that these pushers in galleries represent an indigenous leadership outreach. The ex-tecato or nontecato indigenous outreach workers and researchers represent another important aspect of effective outreach intervention.

The following material consists of our observations and taped recorded interviews with tecatos. Some of the material is presented in Spanish. An English translation follows the Spanish account. The material is presented

in both languages for two reasons. First, to show how some of the vocabulary presented above occurs in real life. Second, to remind the researcher and the reader that being bilingual and sharing the tecato's experiences by sharing the language are important for ethnography and for effective outreach.

Here we describe some of the ways we do our work. The cast of characters are the following people whose names have been changed, except for the research assistant and the outreach worker:

Lorenza, research assistant
Pete, outreach worker, ex-tecato and old friend of Berta, Mono, and Norberto
Berta and Mono, two 55-year-old tecatos/pushers and sex partners
Gloria, 36-year-old tecata lesbian
Dolores, 26-year-old tecata lesbian/bisexual and sex partner of Gloria
Norberto, 50-year-old tecato and shooting gallery proprietor
Bruno, 30-year-old tecato and shooting gallery proprietor

The context of the account will reveal the relationships we have established with tecatos. An objective of our project is to work with IV drug users who can influence others to change their behavior to reduce the risk of getting and passing the AIDS virus. These gatekeepers or leaders often are the pushers and proprietors of galleries.

We established rapport through Pete, our outreach worker, and by helping tecatos get housing and other basic necessities. We met Gloria through one of her lesbian friends who asked if I could help get Gloria out of jail. We met Dolores through Gloria. When Gloria got out of jail, she returned to Dolores, her lover and shooting partner. Both women went back to using and selling drugs to support their habit. Norberto and Bruno were acquaintances of Pete.

Lorenza:

> I met Mono today, finally. I had heard so much about Mono for the past 2 months that I wanted to meet him. I first heard about him from Gloria. She said that she had talked with Mono and Berta, his girlfriend, about coming for an interview. She thought that I would like to interview them because they are interesting people. But they refused.

Gloria:

> It's good for you to hear what they have to tell because they are sharing needles. Berta and Mono are sharing needles, and they should know more about AIDS and tecatos.

Lorenza:

Later, when I was inside the building, Pete asked me what Gloria wanted. He thought that I had given her money. I told him I'd only given her food stamps. Then, I asked him if he thought that they would go buy groceries because of the little boy.

Pete:

No, andan con la Berta, y el Mono. Yo los conozco. Ahorita van ir a conectar. Van a vender las estampías. (No, they are with Berta and Mono. I know them. Right now they are going to connect. They are going to go sell the stamps.)

Lorenza:

The third time I heard about Mono was when Gloria came to visit. Apparently, she and Dolores had been staying off and on at Berta's house. She told me that Berta had some kind of income, either social security or a widow's pension, something like that. And that income gave Berta a way to live. Gloria also said that Berta has a nice home and that Mono lives with her. Gloria went on to tell me that Berta never really needed to go out (to get drugs), because she always had money and a good home. But, in the last year, Berta has had to go out in the streets. Gloria reported that she had again encouraged them to come for an interview with me and you [i.e., Ramos]. They said, "No, we already heard about what they are doing there at the agency. El Pete nos invitó. Pero le dijimos que no." (Pete has invited us. But, we told him no.)

Today, el Mono came. Pete came and said, "There is this guy outside. And, he came in for an interview. I didn't expect him. No lo esperaba, pero si no lo quieres entrevistár yo le digo que venga otro día." (I didn't expect him, but if you do not want to interview him, I'll tell him to come some other day.)

As usual, my question was, "Es tecato?" I wanted to know if he was a current user.

Pete:

Oooh, de los buenos. (Oooh, of the best.)

Lorenza:

Then, I asked him, "Who is it? Do you know him?"

Pete:

Yes, es el Mono. (Yes, it is Mono.)

Lorenza:

El Mono! Finally! I told him that I would be ready in 5 minutes. Then I went to the lobby to meet him and to tell him that I would interview him in 5 minutes.

During the interview, Mono was very open and cooperative. He was very honest. I believed the influence was Pete's, because Pete had already talked with him about the program.

After the interview, he went to Pete's cubicle, and Pete did a risk assessment. That is, they explored ways of changing behavior that could reduce the risk of getting the AIDS virus. I joined them and listened.

As I said, he was very cooperative. But, this may be an exception. During the interview, I asked him, rather than ask Pete later, where he connected. He told me that he connected downtown. I said, "Mono, I know where some of the connections are. And, you are not divulging anything. I just want to know where it is that you find your drugs best."

Of course, I knew from Gloria that he sold drugs. So, perhaps Mono didn't need to go to the different areas that users go to. But I still asked, "Do you buy it at Florencia, or Pugas, or the church, or San Jose?"

Mono:

No, I buy it downtown.

Lorenza:

During the time he visited with Pete, he mentioned two places, Bruno's and Norberto's. From the conversation, I learned that his actual connection is Norberto's and not downtown.

Norberto's and Bruno's names came up because Mono mentioned that last night or early this morning Bruno, at San Jose, had gotten busted. The police had not found anything except a marijuana cigarette. As he said, "no más les encontraron un cachito de grifa." He added, "Ahorita estaba muy caliente la situacion ahí, y que por un rato

nadien se fba acercar. El San Jose esta seco ahorita." (Presently, the situation there is very hot, and for a while nobody is going to get near it. El San Jose is dry right now.)

I noticed how quickly drug users know the situation with connections. Of course, if he knew, it was likely that many more knew by now. They wouldn't hang around San Jose because they would run the risk of arrest.

Mono also mentioned that the cathedral (Norberto's gallery) was going to be next. "Porque ya la han estado cuidando desde la ventana de la iglesia o San Pedro." (Because they are already observing the cathedral from San Pedro church.) I realized that although Mono didn't want to tell me where he connected, he knew Norberto, or the cathedral, and he frequented the place. As the conversation developed, Pete told him, "You can speak with her, because she has been to Norberto's. We have been there twice, and they have accepted us. Also, we have shown them two videos."

Mono:

Si ahoríta ya me estoy acordando que sí, porque Norberto carga una botellita con cloro y ahí la tiene cerca de él. Y, también le he visto unos papelitos que tiene por ahí del AIDS, y me lo ha enseñado. Y, aparte que cuando entran y cuando se presentan—que porque no todos se presentan para oír, él, Norberto, les platica del AIDS, y les platica del cloro. (Yes, right now, I am remembering that, yes, you've been there. Because, Norberto carries a small bottle of clorox, and he has it near him. And, also I have seen several little papers on AIDS. And, he has shown them to me. And, besides when people come and present themselves—not everyone is open to listening—he talks to them about AIDS, and he talks to them about clorox.)

Lorenza:

Then I asked him, "De verda, no piña. Verdad? (Really, it is not a pineapple, i.e., you are not lying? The truth?)

Mono:

Porque le voy a decir piña? Y se reía. (Why am I going to say pineapple, i.e., lie to you?)

Lorenza:

But what is going to happen? I asked Pete what is going to happen to Norberto if they arrest them?

Pete:

No, they won't arrest them. They won't arrest him. In the past, they have arrested him only twice, and they have only given him a ticket.

Lorenza:

Pete changed the subject of the conversation from Norberto to Berta. He asked Mono, "Y la Berta?" (And, Berta?)

Mono:

Malilla, como lo debes de saber. (Sick, as you must know.)

Lorenza:

Then, Mono told us why he had come for the interview. Mono came for the $10. Because he and Berta have hit hard times, they needed the $10. Berta was sick; they needed the money to buy Berta a fix.

While in Pete's cubicle, Mono called Berta and told her that he was on his way. Pete took the telephone and talked with Berta.

Pete:

Aguante como una soldada, que llegarán en un rato. De hoy en adelante piensa venir nada más para platicar—a tirar un rollo. Para ver si te podemos quitar esa muleta de encima. (Endure like a soldier woman, they will arrive in a short while. From here on, think about coming to do nothing else but talk—to rap. And to see if we can help take away the problem that is upon you.)

Lorenza:

Mono waited for another person being interviewed. As he waited, he continued talking with Pete, and he gave me and Pete information on the drug scene in El Paso.

The information Mono gave Lorenza and Pete is typical of information that we often turn into lines of inquiry to follow in the future. For example, before he left, he told Pete that a tecato whom they knew had been cut off by several connections (i.e., was no longer able to obtain drugs from usual sources). They didn't know, and Lorenza thought it would be interesting for us to know, why a tecato gets cut off, the length of time a person is cut off, how the tecato manages while cut off, and how the tecato eventually reestablishes himself with the connections.

CONCLUSION

Descriptive material on tecato culture and a list of vocabulary words are evidence of the ways that tecatos, in relationship with others, create the tecato culture. It is not simply the case that the culture determines how the tecato copes with his practical circumstances. Yes, cultural norms do influence behavior, but they do not explain totally how tecatos interpret the norms and take into account other information that may not be part of the tecato culture (Ramos 1979).

To prevent the spread of AIDS among Chicano IV drug users, we need to discover what the tecato takes into account as he defines the many situations that he creates to manage his life as a tecato. To this end, I have some recommendations:

(1) AIDS researchers and service delivery people need to discover the practical circumstances of the specific IV drug user and sex partner under study.

(2) AIDS researchers and service delivery people need to discover what the specific IV drug user and sex partner under study take into account when they define, construct, and manage the situations they create with others. Specifically, researchers should study:

- how high-risk people define reality for themselves;
- how high-risk people create and cope with the events in their lives;
- how high-risk people create and use language codes;
- how high-risk individuals define help; and
- how and where researchers and social services delivery may enter into the lives of high-risk people.

REFERENCES

Amaro, H. Hispanic women and AIDS: Considerations for prevention and research. Presented at the NIMH/NIDA Research Workshop on Women and AIDS: Promoting Healthy Behaviors. September 28-29, 1987.

Aumann, B.; Hernandez, M.; Medina, M.; Stewart, C.; and Wherley, N. *The Chicano Addict: An Analysis of Factors Influencing Rehabilitation in a Treatment and Prevention Program.* Phoenix, AZ: Valle del Sol, 1972.

Bullington, B. Heroin Use in the Barrio. Lexington, MA: Lexington Books, 1977.

Jorquez, J. Heroin use in the barrio: Solving the problem of relapse or keeping the tecato gusano asleep. *Am J Drug Alcohol Abuse* 10(1):63-75, 1984.

Mata, A., and Jorquez, J. Mexican-American intravenous drug user's needle-sharing practices: Implications for AIDS prevention. In: Battjes, R., and Pickens, R. eds. *Needle Sharing Among Intravenous Drug Abusers: National and International Perspectives.* National Institute on Drug Abuse Monograph 80. DHHS Pub. No. (ADM)88-1567. Washington, D.C.: Supt. of Docs., U.S. Govt. Print. Off., 1988. 189 pp.

Moore, J., and Mata, A. *Women and Heroin in a Chicano Community. A Final Report.* Los Angeles: Chicano Pinto Research Project, 1982.

Morales, A. Substance abuse and Mexican American youth: An overview. *J Drug Issues* 14(2):297-311, 1984.

Ramos, R. Movidas: The methodological and theoretical relevance of interactional strategies. In: Denzin, N., ed. Studies in Symbolic Interaction, Vol. 2. Greenwich: JAI Press, 1979. pp. 141-165.

Worth, D., and Rodriguez, R. *Latina Women and AIDS.* New York: SIECUS, 1987.

ACKNOWLEDGEMENTS

Pete Estrada and Lorenza Mena, of the University of Illinois at Chicago AIDS Demonstration Project in El Paso, TX, helped in data collection and shared their knowledge of the tecato culture.

AUTHOR

Reyes Ramos, Ph.D.
PAHO
Suite 600
6006 N. Mesa
El Paso, TX 79912

CHAPTER VI

ADMINISTRATION

Working as a Team

There is more to good treatment than individual skill and commitment. To function effectively methadone program staff need to operate as a team. It is important that counselors see themselves as part of a coordinated effort. Counselors who view administrative and medical components of treatment as separate, irrelevant, or antagonistic may be limiting their effectiveness as well as the program's overall. Good methadone treatment requires an open communication among all treatment staff and the counselor plays a pivotal role in this regard. Throughout this manual there have been references to the counselor's need to consult with medical staff or direct the patient to the program director as the need arises. Counselors can facilitate the addiction treatment and medical care of patients by communicating observations and patient complaint to the appropriate staff.

Counselors should recognize that sometimes they may have a different perspective on patient issues than that of medical or administrative staff. It is important to work together even when there are disagreements.

Some ways to build an effective, harmonious team include:

Mutual Respect. Negative, insulting or disrespectful references to other staff will drive wedges between staff and patient as well. Differing opinions do not require that someone is right or wrong, or good or bad. A commitment to uphold respect for other staff will help keep the focus of differences upon issues instead of people. The frustrations and stress of addiction treatment can sometimes lead to staff splitting. In worst cases staff can seek to enlist the allegiance of patients versus other staff. Some patients sense this type of discord and try to manipulate by "taking sides." For example, a patient may comment "that nurse is really terrible. I don't think she knows what she's doing. I told her I talked to you about that take home and she said you don't know what you're talking about. "In this case the counselor who is in the "team" mode will not take the bait. He/she may have differences regarding an issue but mutual respect dictates a response such as "I'm sure there's just a communication problem we can work out." A response that would contribute to staff splitting would be "she said that? Well she doesn't know what she's talking about. I'll give her a piece of my mind." If in the future this nurse were to tell the counselor that his patient had been intoxicated at the dosing window, the counselor would have a difficult time discussing this with the patient. The counselor would have already characterized the nurse

in terms which would diminish her credibility. Consequently their ability to work as a team to deal with this patient's problems would have been lost.

Communication. Ongoing communication in regular staff meetings helps maintain cohesion and morale. A sense of common purpose as well as an awareness of various points of view and priorities can arise out of open communication in staff meetings. Counselors should take the opportunity of such meetings to express issues and concerns and to listen to those of other staff.

Conflict Resolution. When problems develop between staff it is important to take constructive action to resolve differences. Open and honest communication is essential. Sometimes the help of a mediating supervisor may be necessary. The indirect communication of anger through passive aggressiveness or personal remarks is a destructive pattern which can often be stopped through a direct expression of differences and feelings.

Team Building Exercises. Periodic staff activities for the explicit purpose of team building may be helpful. Consultants who specialize in these exercises could be brought in or staff might choose to simply work on air clearing or morale building.

Case Conferencing. A weekly meeting of clinical staff for the purpose of discussing patient issues can significantly enhance treatment quality. Counselors should not work in isolation, but rather seek out help and input from other staff. The insights of other counselors or medical staff can shed new light on patient problems or offer novel approaches to deal with them. It is recommended that a clinical supervisor be identified within the staff. This person would moderate these meetings, provide clinical direction to counselors, and generally oversee the counseling component of the program. Some of the duties of the clinical supervisor would be to:

- Supervise counselors in their clinical and administrative responsibilities.
- Facilitate weekly supervision group for counselors.
- Meet weekly with each counselor.
- Do periodic evaluations of counselors.

In the weekly meeting with the clinical supervisor counselors should present cases of new patients and patients with whom they are having difficulty. In addition other patients on the counselor's caseload should be included so that each patient is presented at least once every 90 days. (A case conference presentation outline is included in the chapter appendix).

Patient Management

Rationale.

The general atmosphere of a clinic can contribute to or detract from the treatment services. The general activities in and around a clinic can suggest either professionalism or non-professionalism; respect or disregard for patients; expectations of courteous behavior by patient or any "anything goes" environment; tolerance or intolerance of activities such as drug use, drug dealing, methadone diversion, and intoxication. Delivering good treatment is helped by running an orderly, well-managed clinic. Program rules can help in this regard but enforcing of rules can vary. Counselors should be aware of program rules and when necessary enforce rules. In a broad sense this is therapeutic activity that helps establish a good context in which treatment can occur.

Physical Settings.

The cleanliness, neatness, and general appearance of the clinic convey an attitude about the program and about the patients. The physical setting of the clinic should reflect an atmosphere of professionalism that is typical of a physician's or therapist's office. Too often methadone programs are in messy, cluttered, depressing environments which implicity communicate a disconcern for patients. A professional-looking, clean clinic says to the patient "we care about you" and "we want you to feel good about being here." In like manner, the personal appearance of the counselor should reflect professionalism and self-respect. This in turn translates into an expression of respect for patients.

Loitering.

Patients who are on the clinic premises or parking lot should have a specific reason to be there. Patients who loiter risk becoming involved in activities which are not in their interests or the interests of the program. Because a methadone program is a daily meeting place for opiate addicts drug dealers sometimes view the program as a convenient market place. In addition, it is possible that some patients on the program could be involved in dealing. Other activities which generally depend upon loitering are the buying and selling of urine specimens and take-homes. It is impossible to monitor all of the activities occurring in and around a clinic, and it is not the responsibility of counselors to conduct surveillance in order to catch dealers. It should be the responsibility of all staff however to encourage patients who are done with clinic business to go home. At best patients who hang around the clinic are not making good use of their time. Staff who see non-patients in and around the clinic should ask them to leave or inform clinic security. All of the progress derived from

counseling can be undone as a result of a program's tolerance of loitering. Counseling patients to leave the clinic immediately following dosing, counseling, or medical visits maybe as important a piece of advice as any offered.

Drug Dealing And Diversion.

Drug dealing or methadone diversion simply can not be tolerated. Counselors who become aware of such activities should alert supervisors and consider involuntary termination. Patients who regularly loiter, seek out other patients for secret conversations, disappear to the parking lot and reappear in the waiting room, "lose" or "misplace" take-home bottles, attempt to leave the clinic with their dose (either by not swallowing or spitting the dose back into another container), or are seen exchanging unknown objects for money should be closely watched, confronted, or terminated depending upon the infraction.

Sometimes patients who are caught dealing or diverting will attempt to persuade the counselor to keep it a secret. An appeal can be made on the basis of "friendship" or a code of street conduct which condemns "snitching." Both of these notions are irrelevant. The relationship between the counselor and the patient is not friendship, it is a professional relationship. It is the counselor's professional responsibility to take appropriate action if he/she becomes aware of drug dealing. The notion of "snitching" belongs on the street or in jail, not in the clinic. Advising a supervisor about dealing or diversion is taking a necessary action for the benefit of the patients and the maintenance of program integrity.

Application Of Clinic Rules.

Patients should be made aware of clinic rules when they are oriented to the program. In enforcing clinic rules counselors should be clear that they are not arbitrarily making life difficult for patients but are merely ensuring that the program operates according the same rules for everyone. Counselors should remain professional and be non-authoritarian when enforcing rules. They should avoid statements which can inflame or personalize the issue (e.g., "if you don't like it, too bad," or "because I said so"). Rather, reference should be made to the rules and if appropriate an explanation given. If rule enforcement risks violence or physical danger to staff, give in. No rule is worth getting injured over. The consequences to the patient of a situation which involves danger can be invoked at a later time. Generally, a consistent and fair application of clinic rules results in fewer incidents. Poor limit setting and lax or uneven rule enforcement invite ongoing problems with patient management and too-frequent acting out episodes. The result is a setting in which patients feel out of control and unsafe. These attributes are not conducive to the goals of counseling.

Illustrative Vignette

Enforcing Rules - Loitering

Counselor: (Walking through the waiting room.) How are you guys doing today?

Patient: Just fine, how about you?

Counselor: Real good, thanks. You guys waiting for your dose?

Patient: No, were just hanging out for minute.

Counselor: Well, you probably ought to move along if you're done here today.

Patient: What's the big deal - We're not doing anything.

Counselor: I know, it's just that there's a rule against loitering.

Patient: It's a free country, man.

Counselor: You're right but remember you freely chose to follow the rules here. Let's not make a big deal out of this, O.K.. It's really better for everyone if we keep things moving. The more crowded it gets the longer you have to wait for your dose, you can't find a place to park. People get frustrated and into all kinds of hassles.

Patient: Yeah, I guess.

Counselor: Thanks. I'll be around tomorrow, why don't you stop by for a minute to bring me up to date?

Patient: You're on. See you tomorrow.

[Notice how the counselor keeps cool, stays focused on the rules instead of becoming personally involved, provides a rationale for the rule, and ends on a positive note.]

Appendix

Chapter VI

Table of Contents

HANDOUT **FORM**

Administration

Case Conference Presentation Outline

I. Client Data
   A. Name
   B. Age
   C. Marital status
   D. Residence where and with whom
   E. Occupation
   F. Payment - arrangement and status

II. Background Information
   A. Raised by whom and where
   B. Siblings
   C. Family history of chemical dependency
   D. Educational status

III. Drug Use on Admission
   A. Drug(s) of choice
   B. Length of use
   C. Amount and frequency

IV. Current Status
   A. Length of time in treatment
   B. Relapses
   C. Present attitude toward treatment
   D. Family members involved in program

V. Treatment
   A. Long term goals
   B. Immediate goals
   C. Concerns and difficulties

REFERENCES

Anglin. M.D., Almog, I.J., Fisher. D..G., and Peters, K.R. (1989). Alcohol use by heroin addicts: evidence for an inverse relationship. A study of methadone maintenance and drug-free treatment samples. American Journal of Alcohol Abuse, 15, 191- 207.

Batki, S.L. (1988). Treatment of intravenous drug users with AIDS: the role of methadone maintenance. Journal of Psychoactive Drugs, 20, 213-216.

Batki, S.L. (1990). Drug abuse, psychiatric disorders, and AIDS: dual and triple diagnosis. Addiction Medicine, 152, 547-552.

Brummett, S., Dumontet, R., Wermuth, L. Gold, M., Sorensen. J.L., Batki, S., Dennis R., and Heaphy, R. (1986). Methadone maintenance to abstinence, unpublished manuscript.

Castro, F.G. (1991). Evaluation of Project PARA: an AIDS education/prevention program. San Diego State University, unpublished manuscript.

Casucci, B. Cornerstone services pregnant addict program curriculum (1991). Pico Rivera: Cornerstone Rehabilitation Services.

Childress, A.R., McLellan, A.T., and O'Brien, C.P. (1985). Behavioral therapies for substance abuse. The International Journal of the Addictions, 20, 947-969.

Corey, G. (1982). Theory and practice of counseling and psychotherapy. Monterey: Brooks/Cole.

D'Zurilla, T.J. (1986). Problem-solving therapy: A social competence approach to clinical intervention.. New York: Springer.

Fairbank, J., Bonito, A.J., Dennis, M.L., and Rachal, J.V. (1991). Enhanced Counselor's Manual, Research Triangle Institute.

Gambrill, E.D. (1977). Behavior modification: Handbook of assessment, intervention, and evaluation. San Francisco: Jossey-Bass.

Lipton, D.S., and Maranda M.J. (1983). Detoxification from heroin dependency: an overview of method and effectiveness. Advances in Alcohol and Substance Abuse, 2, 31-55.

Miller, W.R., and Rollnick, S. (Eds.). (1991). Motivational interviewing, New York: Guilford Press.

Murphy, D., Brown, L. and Primm, B.(1988). Heterosexual partners of IV drug abusers: Implications for the next spread of the AIDS epidemic. In:Harris, L.S. (Ed.) Problems of Drug Dependence, (1987). National Institute on Drug Abuse Research Monograph 81. Rockville, Maryland: National Institute on Drug Abuse.

Newman, R.G., (1987). Detoxification treatment of narcotic addicts. In R.I. Dupont, A. Goldstein, and J.O'Donnell (Eds.), Handbook on drug abuse. Rockville Md: National Institute on Drug Abuse.

Nezu, A.M., Nezu, C.M., & Perri, M.G. (1989). Problem-solving therapy for depression: Theory, research, and clinical guidelines. New York: Wiley.

O'Farrell, T.J., and Langenbucher, J.W. (1985). Alcohol abuse. In M. Hersen (Ed.), Practice of inpatient behavior therapy: A clinical guide. Orlando: Grune and Stratton.

Platt, J.J., and Metzger, D.S. (1987). Cognitive interpersonal problem-solving skills and the maintenance of treatment success in heroin addicts. Psychology of Addictive Behaviors, 1, 5-13.

Ralph, N. and Spigner, C. (1986). Contraceptive practices among female heroin addicts. American Journal of Public Health, 76, 1016-1017.

Ramos, R. (1990). Chicano intravenous drug users. In The collection and interpretation of data from hidden populations. National Institute on Drug Abuse Research Monograph 98. Washington, D.C.:U.S. Govt. Print. Off. 128-145.

Resick, P.A., and Jordan, C.G. (1988). Group stress inoculation training for victims of sexual assault: A therapist manual. In P.A. Keller and Heyman, S. (Eds.), Innovations in clinical practice: A source book(Vol.7). Sarasota, FL: Professional Resource Exchange.

Rawson, R.A., Obert, J.L., McCann, M.J., Smith, D.P. & Scheffey, E.H. (1989). The Neurobehavioral Treatment Manual: A Therapist Manual for Outpatient Cocaine Addiction Treatment. Beverly Hills, California: Matrix Center.

Selzer, M.L. (1971). The Michigan alcoholism screening test: The quest for a new diagnostic instrument. American Journal of Psychiatry, 127, 1653-1658.

Smith, D.E.; Moser. C., Wesson, D.R., Apter, M., Buxton, M.E., Davison, J.V., Orgel, M. and Buffum, J. (1982). A clinical guide to the diagnosis and treatment of heroin-related sexual dysfunction. Journal of Psychoactive Drugs, 14, 91-99.

Sobell, L.C., Sobell, M.C, and Nirenberg, T.D. (1989). Behavioral assessment and treatment planning with alcohol and drug abusers: A review with an emphasis on clinical application. Clinical Psychology Review, 8, 19-54.

Sorensen, J.L., and Batki, S.L. (in press) Education and intravenous drug use. In P.T. Cohen, M. Sande, and P. Volberding (Eds.), San Francisco General Hospital AIDS Knowledgebase. Wattham, MA: Massachusetts Medical Society.

Sorensen, J.L. and Batki, S.L (1990). Management of psychosocial sequelae of HIV infection among drug abusers. In J.H. Lowinson, P. Ruiz, and R.R. Mullman (Eds.), Comprehensive Textbook of Substance Abuse. Baltimore: Williams and Wilkins.

Truax, C., and Carkuff, R. (1967). Toward effective counseling and psychotherapy. Chicago: Aldine.

Zweben, J.E.(1991). Counseling issues in methadone maintenance treatment. Journal of Psychoactive Drugs, 23, 177-190.

Zweben. J.E. and Payte, J.T. (1990). Methadone maintenance in the treatment of opiate dependence: A current perspective. Western Journal of Medicine, 152, 588-599.

Zweben, J.E. and Sorensen, J.L. (1988). Misunderstandings about methadone. Journal of Psychoactive Drugs, 20, 275-282.

INTRODUCTION

This guide is designed to help the program manager or other clinical supervisor facilitate the implementation of "The Treatment of Opiate Addiction Using Methadone: A Counselor Manual." Each chapter of this guide parallels a chapter of the manual. A brief summary of the chapter is followed by some suggested guidelines for evaluating counselor performance and some instruments (Counselor Review Forms) which may help in assessment. There are also some suggested topics for discussion with counselors to promote the use of the manual and to increase familiarity with its contents. These are presented in the format of questions and answers and can be used to facilitate comprehension through a guided discussion or in a formal testing manner.

The goal of the counselor manual is to improve methadone treatment. The program manager plays a pivotal role in effecting the conversion of manual information into real-life counseling practice by encouraging counselors to apply manual materials and providing them with constructive feedback.The materials in this guide can be used to facilitate the process of giving counselors feedback. They should be used in a constructive and helpful way. As much as possible the program manager should try to reinforce any applications of manual materials. The Counselor Review Forms may point out deficiencies but "comment" sections should always provide suggestions or references to manual sections which can help in areas where improvement is needed. This should be an exercise in shaping counselors towards enhanced services versus sanctioning for deficiencies. The guide and manual can form the basis for ongoing staff training. Sections of the manual can be discussed in regularly scheduled training sessions or staff meetings. Managers might also work individually with counselors to provide more in depth or selective feedback. Both managers and counselors are encouraged to use the manual as a tool and a resource but not as a substitute for regulations. Managers should continue to advise staff to refer directly to appropriate state and federal regulations or agencies on regulatory issues.

TABLE OF CONTENTS

CHAPTER I

INTRODUCTION AND OVERVIEW

Summary:

This chapter describes some of the controversy surrounding methadone treatment. It introduces the purpose of the manual as providing counselors with a description of their role in treatment and of improving treatment quality. A history of heroin treatments and methadone treatment is provided. Some common misconceptions about methadone are discussed. There are few direct applications of the content of this chapter to counselor's activities. An understanding of the general context and history of methadone treatment should most likely promote more intelligent and effective treatment. However it would be difficult to trace specific counselor activities to this information. A questionnaire on Chapter I information is included for counselors who wish to assess their understanding of the chapter contents. The program manager may wish to offer this instrument to counseling staff to facilitate discussion and provide a basis for offering specific information.

CHAPTER I
INTRODUCTION AND OVERVIEW

DISCUSSION SUGGESTIONS FOR CHAPTER I

INSTRUCTIONS: This is not a test. It is to help you determine your understanding of the chapter. You can use it to direct a re-reading of parts of the chapter or to indicate areas where you may want to ask questions of your supervisors.

1. What is the "Medication Only" point of view regarding methadone treatment?

2. What effects did the Harrison Act have upon heroin addicts?

3. What are the characteristics of treatment approaches like Synanon?

4. Who was responsible for the development of methadone treatment?

5. What were some of the problems and controversies surrounding methadone treatment in the 1960's and early 1970's?

6. What caused a turn around in acceptance of methadone treatment in the 1980's?

7. What are some ways in which methadone is preferable to heroin?

8. Are methadone patients "high" for 24 hours?

9. Are low doses of methadone "better" than high doses?

10. Should pregnant addicts stay off methadone?

ANSWERS:

1. Counseling is not necessary. Opiate addiction and treatment are in the medical domain exclusively. This view is not shared by the federal or state drug offices which regulate methadone treatment.

2. The Harrison Act made heroin illegal. Addicts were subjected to legal penalties for use. The need for treatment ultimately arose out of the restrictions on access to opiates.

3. Synanon-like approaches usually employ ex-addicts, in drug free settings, using harsh confrontational techniques. Treatment settings are usually "Therapeutic Communities."

4. Drs. Vincent Dole and Marie Nyswander saw methadone as analogous to insulin treatment for diabetes.

5. Methadone was controversial because it conflicted with the drug-free philosophy of the therapeutic communities; methadone was sometimes diverted resulting in street use of methadone; early proliferation of methadone treatment resulted in sometimes chaotic, nonprofessional, poorly run clinics.

6. The spread of HIV/AIDS in the 1980's resulted in a new acceptance of the need for and benefits of methadone treatment.

7. Methadone is preferable to heroin in that it is oral, legal, long acting, and is provided in a therapeutic context.

8. No, methadone patients on a properly adjusted dose simply feel "normal."

9. Some studies suggest that patients on a 60mg dose do better than patients on lower doses. The best dose is the one which allows patients to eliminate heroin use and stay in treatment.

10. Pregnant addicts who are on methadone have access to prenatal care, nutrition information, parenting classes and do not need to use heroin. Heroin-using women and their babies are at a greater risk and do more poorly than those on methadone.

CHAPTER II

COUNSELING IN METHADONE TREATMENT

SUMMARY:

This chapter describes some of the important basic elements of counseling in general and in methadone treatment in particular. Discussion suggestions are offered for managers to encourage understanding and application of the contents of this chapter. General discussions of counseling or professionalism should be non-critical and non-threatening. The purpose of such discussions is to promote the use of the manual, raise awareness of issues, and promote better counseling.

It is hoped that counselors in methadone treatment will view themselves as part of the professional community of chemical dependency treatment counselors. Counselors in methadone treatment too often exclude themselves from the rest of the treatment field because of limited knowledge of general counseling issues and variable standards of professionalism. Program managers can greatly facilitate the integration of methadone counselors into the larger community of professional counselors.

CHAPTER II
COUNSELING IN METHADONE TREATMENT

DISCUSSION SUGGESTIONS FOR CHAPTER II

1. Why is it sometimes felt that only ex-addicts can counsel addicts?

2. What factors are important in establishing a bond with patients?

3. What is a way in which a counselor can explore and assess a patient's motivation for treatment?

4. What are some particular advantages and disadvantages of individual and group counseling sessions?

5. What are some factors which are related to counterproductive groups with drug addicts?

6. Why do some methadone patients have difficulty in 12-step groups? How can these difficulties be minimized?

7. What information regarding patients is confidential? Is confidentiality ever outweighed by other considerations?

ANSWERS:

1. It is thought by some people that ex-addicts are better able to be nonjudgmental about the use of illicit drugs; that they can provide a role model for a straight lifestyle; and that they fully understand the nature of the addiction in with the addict struggles.

2. Important factors are therapists' degree of caring, their interest and ability in helping the patient, and their genuineness.

3. Counselors can assess a patient's motivation by asking questions about the good versus bad things surrounding heroin and other drug use; asking about the patient's current satisfaction with his/her lifestyle; and by comparing and contrasting the benefits and costs of continuing drug use.

4. Individual sessions allow the patient to discuss issues which are personal, embarrassing, intimate, or are simply the patient's choice not to divulge to other patients. Groups can be useful forums for patients to discuss issues of common concern. Groups can also provide a basis for peer support and reinforcement for making positive changes.

5. Factors which are related to counterproductive groups include lack of purpose or theme, a confrontational approach, and extensive discussion of previous drug use (war stories).

6. Sometimes patients on methadone are viewed as not being in true recovery because they are using a medication and therefore not drug free. This problem can be minimized by methadone programs holding 12-step meetings on site, or by advising patients to not discuss their methadone use at outside meetings.

7. Patient information and treatment records for patients in methadone treatment are closely governed by state and federal laws. Both written and verbal information is confidential and cannot be provided to social agencies, law enforcement, family members, or friends of patients. Violation of confidentiality is both an ethical and a legal transgression.

   Confidentiality can be outweighed in some circumstances: when a patient has stated an intention to harm another person, counselors are obligated to warn that person ("Tarasoff Decision"); if the counselor is made aware of physical abuse or neglect to a child or to the elderly appropriate agencies must be notified; representatives of authorized governmental agencies who perform program inspections may have access to patient records; some court orders can cause the program to relinquish patient information. In all cases where confidentiality of patients is breached for mandatory reporting the counselor should consult supervisors prior to filing such reports.

CHAPTER III

METHADONE MAINTENANCE

SUMMARY:

This chapter covers the counselor's activities as they relate to methadone maintenance. Many sections in this chapter are directly related to regulatory requirements (e.g., take-home requirements, criteria for patient selection, urine testing), while others involve topics and counselor activities which are not specified in regulations (e.g., tapering, relapse prevention, aftercare). The "Counselor Review Forms" are provided to help in evaluating the counselor's performance with regard to specific areas covered in the chapter. These instruments may help in providing feedback to counselors and may direct counselors to sections of the manual where they can find useful information which can improve counseling. "Discussion Suggestions" are questions which the program manager can offer to counselors in order to provide an understanding of the counselor's manual and to increase awareness of the manual's usefulness. These questions are not tests. Rather they are offered to help generate discussion on counselor's issues.

GUIDE TO CRF

CRITERIA FOR MAINTENANCE TREATMENT AND PROGRAM SELECTION

This CRF allows for an evaluation of the quality of documentation of two year history and two detoxification failures prior to treatment. It also allows the program manager to evaluate exceptions and note the use of the eligibility checklist.

This instrument is not meant to point out deficiencies but rather to facilitate training in this area. Efforts should be made to reinforce positive aspects of the counselor's performance. There should also be an emphasis upon inappropriate exclusion from maintenance. Counselors should be aware of areas where there is flexibility in documentation and where exceptions are possible.

COUNSELOR REVIEW FORM

Criteria for Maintenance Treatment and Program Selection

Counselor: _____

Supervisor: _____ Date of review: _____

1. Use of eligibility checklist (See counselor manual):

   ____A. Used regularly

   ____B. Used sometimes

   ____C. Used with unusual cases

   ____D. Not used

Comments:_____

_____

_____

2. Documentation of two-year history and two detoxification failures:

   ____A. Complete and appropriate

   ____B. Sometimes lacking in completeness or thoroughness

   ____C. Generally insufficient

Comments:_____

_____

_____

_____

3. Exceptions to two year history two detoxification failures, and one year of addiction:

____A. Appropriate and with explanation

____B. Sometimes inappropriate or unclear

____C. Generally inappropriate or unclear

Under-use of exceptions? Yes____ No____

Over-use of exceptions? Yes____ No____

Comments:_____

_____

_____

CHAPTER III
METHADONE MAINTENANCE

DISCUSSION SUGGESTIONS FOR CHAPTER III
CRITERIA FOR MAINTENANCE SELECTION

1. What are some examples of documentation?

2. Can you acquire treatment histories by telephone? What is the procedure for this?

3. What are some signs of opiate withdrawal? When would you expect withdrawal? When would you expect to see initial signs of withdrawal?

4. Do fresh needle marks always indicate current addiction?

5. What are some conditions that you would bring to the attention of medical staff?

6. Why do we have restrictions on admission to methadone maintenance?

ANSWERS:

1. Documentation implies written records as opposed to telephoned information or personal testimony. Examples include copies of treatment records, letters from previous treatment programs indicating dates and type of treatment, arrest records or letters from acceptable sources which indicate dates and conditions of arrest.

2. History can be obtained by telephone as long as the patient first signs a release of information allowing the counselor to make a telephone inquiry regarding this information. The counselor can record information obtained by telephone and follow up by mailing a request with the signed waiver of confidentiality in order to obtain the written documentation.

3. Signs of opiate withdrawal include runny nose, eyes tearing, chills, yawning, goose flesh, large pupils, sweating, diarrhea, and nausea. Withdrawal only occurs when a person is addicted. For heroin, withdrawal begins about 6 to 8 hours after the last drug use.

4. Fresh needle marks may indicate current addiction but not always. It may be that the person is injecting nonopiate substances such as cocaine, or these may be heroin injection sites but the person may not yet be addicted.

5. Counselors should alert medical staff if the patient is under the influence, if there are no fresh needle marks, if there no apparent signs of withdrawal, or if there is extreme withdrawal which precludes the normal processing of the patient.

6. Restrictions are in place in order to prevent addicting individuals to methadone who are not already addicted illicit opiates, and to ensure that other treatment approaches are attempted prior to entering methadone maintenance.

GUIDE TO CRF

NEEDS ASSESSMENT

This CRF allows the program manager to note and reinforce use of the needs assessment forms. Attention to each area of needs assessment is evaluated. If the needs assessment form is not used the CRF may be completed by reading patient record. It may be helpful if the program manager fills out a sample needs assessment form on the basis of information in the patient record in order to demonstrate the usefulness of the form. This exercise might also demonstrate the limitations of relying solely upon the patient record in performing the assessment. As always, the purpose is to point out ways of improving counselor performance rather then focusing on deficiencies.

COUNSELOR REVIEW FOR

NEEDS ASSESSMENT

Counselor: _____

Supervisor: _____ Date of review: _____

1. Use of needs assessment forms

   ____A. Used regularly

   ____B. Used sometimes

   ____C. Used rarely

   ____D. Never used

Comments:_____

_____

_____

2. Needs assessment: Drug Use

   ____A. Usually complete and accurate

   ____B. Sometimes complete and accurate

   ____C. Rarely complete and accurate

   ____D. Insufficient, not done.

Comments:_____

_____

_____

_____

3. Needs assessment: Alcohol

____A. Usually complete and accurate

____B. Sometimes complete and accurate

____C. Rarely complete and accurate

____D. Insufficient, not done.

Comments:_____

_____

_____

4. Needs assessment: Medical History

____A. Usually complete and accurate

____B. Sometimes complete and accurate

____C. Rarely complete and accurate

____D. Insufficient, not done.

Comments:_____

_____

_____

5. Needs assessment: Social/Social Services

____A. Usually complete and accurate

____B. Sometimes complete and accurate

____C. Rarely complete and accurate

____D. Insufficient, not done.

Comments:_____

_____

_____

6. Needs assessment: Psychological Status

____A. Usually complete and accurate

____B. Sometimes complete and accurate

____C. Rarely complete and accurate

____D. Insufficient, not done.

Comments:_____

_____

_____

7. Needs assessment: Educational

____A. Usually complete and accurate

____B. Sometimes complete and accurate

____C. Rarely complete and accurate

____D. Insufficient, not done.

Comments:_____

_____

_____

8. Needs assessment: Vocational

____A. Usually complete and accurate

____B. Sometimes complete and accurate

____C. Rarely complete and accurate

____D. Insufficient, not done.

Comments:_____

_____

_____

9. Overall rating of needs assessment

____A. Excellent

____B. Very good

____C. Good

____D. Fair

____E.Unsatisfactory (needs improvement)

Comments:_____

_____

_____

CHAPTER III
METHADONE MAINTENANCE

DISCUSSION SUGGESTIONS FOR CHAPTER III
NEEDS ASSESSMENT

1. When should needs assessment be performed?

2. Where should counselors look first to assess drug, alcohol, and medical needs?

3. Do patients always accurately assess their needs for help with drinking or other drug use? What are some indications of problems?

4. How can a counselor increase his/her awareness of medical problems?

5. What might indicate a need for referral to social service agencies?

6. What might indicate vocational needs?

ANSWERS:

1. The needs assessment should be performed in order to construct the treatment plan which must to be done within the first four weeks of treatment. Needs assessment should be completed after the patient has become physically comfortable, after a time which allows for the establishment of a trusting relationship with the counselor, and soon enough so that problems can begin to be addressed.

2. Counselors should review the medical evaluation in order to help in the assessment of these needs.

3. Opiate addicts sometimes minimize drug or alcohol use which is less than regular, daily, chronic use in the manner of heroin addiction. Indications of drug problems are any current regular drug use particularly long term or heavy. Indications of alcohol problems include daily drinking, binge drinking, or drinking related arrests.

4. Counselors can increase awareness of medical problems by communicating closely with program medical staff and with outside practitioners who are providing care for their patients.

5. Some indications of a need for a referral include unemployment, eligibility for public assistance, and dependence upon illegal sources of income.

6. Vocational needs may be indicated by unemployment, disability, or interest in job training.

GUIDE TO CRF

TREATMENT PLANNING

The treatment plan should be derived out of the needs assessment. Short-term goals, long-term goals, interventions, type and frequency of counseling, and target dates should be identified. Goals should be realistic, specific, and objective. Patients should participate in treatment planning and plans should be reviewed every 90 days. The program manager should reinforce individualized treatment plans which follow from the needs assessment. Counselors should be encouraged to formulate treatment plans which chart a course for the patient and counselor in a variety of areas which have specific problems and goals. Managers should particularly try to help counselors who are writing similar plans for all of their patients and not identifying areas of need outside of drug use problems.

COUNSELOR REVIEW FORM

TREATMENT PLANNING

Counselor: _____

Supervisor: _____ **Date of review:** _____

1. Treatment plans reflect needs assessment:

   ____A. Always

   ____B. Usually

   ____C. Sometimes

   ____D. Never

Comments:_____

_____

_____

2. Treatment plan identifies short-term goals and long-term goals:

   ____A. Always

   ____B. Usually

   ____C. Sometimes

   ____D. Never

Comments:_____

_____

_____

_____

3. Treatment plans specify steps to be taken:

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

4. Treatment plans specify time frames:

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

5. Treatment planning done after stabilization or within 4 weeks:

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

6. Treatment plan is realistic?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

7. Patients participate in treatment planning?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

8. Treatment plans reviewed at least every 90 days?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

9. Treatment plans could be more individualized:

____Yes ____No

Comments:_____

_____

_____

CHAPTER III
METHADONE MAINTENANCE

DISCUSSION SUGGESTIONS FOR CHAPTER III
TREATMENT PLANNING

1. Where can you get information to help in formulating the treatment plan?

2. What are some benefits of involving the patient in treatment planning?

3. What are some examples of short-term goals which can be linked to long-term goals of employment and cocaine abstinence?

4. What are some of the issues to consider in deciding on a specific treatment plan?

5. How often do treatment plans need to be reviewed? What should you consider in reviewing a treatment plan?

ANSWERS:

1. Information for formulating the treatment plan can be obtained from the needs assessment and from discussions with the patient.

2. Patient involvement provides the counselor with more and better information; it increases patient motivation; it insures that goals are mutually determined; and it increases patient morale.

3. Short term goals related to employment might include bringing in the classified ads from the newspaper or setting up appointments for job interviews. Short term goals for cocaine abstinence might include finding a Cocaine Anonymous meeting in the area or scheduling new recreational activities for the weekend.

4. Counselors should consider whether the treatment plan is realistic with regard to likelihood of success, structural barriers that might impede the patient, and personal liabilities and weaknesses of the patient, the treatment team, and the range of community resources that effect the ability to deliver services.

5. Treatment plans need to be reviewed at least every 90 days. In reviewing treatment plans counselor should consider patient progress or lack of progress towards short term and long term goals, the development of new problems which need to be addressed in the treatment plan, and the appropriateness of the patients dose level.

GUIDE TO CRF

COUNSELING ISSUES

In this section program managers may be helpful in suggesting the use of specific counseling techniques (e.g., contingency contracting) in particular cases. Counselors may have difficulty in implementing techniques described in the manual. They may not recognize situations where particular techniques are appropriate or they may not see the usefulness of these methods. Managers can also suggest inclusion of specific topics (e.g., nutrition, exercise) and increased or decreased frequency of counseling. The focus of feedback should be on increasing counseling effectiveness through an expansion of the scope of counseling or the inclusion of additional techniques.

COUNSELING REVIEW FORM

COUNSELING ISSUES

Counselor: _____

Supervisor: _____ **Date of review:** _____

1. Frequency of counseling?

____A. Appropriate

____B. Too frequent in some cases

____C. Too infrequent in some cases

Comments:_____

_____

_____

2. Use of contingency contracting?

____A. Appropriate in all cases

____B. Usually appropriate

____C. Sometimes inappropriate

____D. Not used

Comments:_____

_____

_____

_____

3. Problem solving techniques used?

____A. Appropriate in all cases

____B. Usually appropriate

____C. Sometimes inappropriate

____D. Not used

Comments:_____

_____

_____

4. Use of other techniques?

____A. Appropriate in all cases

____B. Usually appropriate

____C. Sometimes inappropriate

____D. Not used

Comments:_____

_____

_____

5. Inclusion of counseling on stress management, leisure, exercise, diet and nutrition, vocation and education.

____A. Appropriate in all cases

____B. Usually appropriate

____C. Sometimes inappropriate

____D. Not used

Comments:_____

_____

_____

CHAPTER III
METHADONE MAINTENANCE

DISCUSSION SUGGESTIONS FOR CHAPTER III
COUNSELING ISSUES

1. When is a counseling session too long? When is it too short?

2. How could contingency contracting help in dealing with possible treatment termination?

3. What are the basic components of problem solving?

4. How could problem solving be applied to a conflict with someone at work?

5. What is shaping? How does the idea relate to treatment planning?

6. What are some creative ways to promote exercise in resistant patients?

ANSWERS:

1. A counseling session may be too long if it causes the patient to view counseling as burdensome or aversive. The session may be too short if it does not allow sufficient time for input or for the monitoring of progress.

2. A contingency contract (Probation Treatment Contract) can specify conditions necessary to avoid treatment termination. This type of contract can also indicate the time period in which changes must be made and can be signed off by both the patient and the counselor.

3. Basic components of problem solving are: a. problem orientation, b. problem definition, c. generation of alternative solutions, d. decision making, e. implementation and monitoring.

4. With regard to work problems the counselor can help the patient define the problem (e.g., my supervisor is being overly critical of me), generate possible solutions (e.g., discuss feelings with the supervisor or reevaluate sensitivity to supervisor's input), implement a solution, and evaluate the outcome.

5. Shaping refers to a learning process wherein small improvements, or changes in behavior, which are headed in the direction of a treatment goal are rewarded. With regard to treatment planning this translates into praising the person for achievement of short term goals which are in the direction of long term goals.

6. Shaping can be used to promote exercise in resistant patients. For example, a patient might agree to a short walk by parking a block away from the clinic before the next counseling appointment. The counselor could then shape exercise by praising this small step in the right direction.

GUIDE TO CRF

TAKE HOMES

This section is primarily dealing with the appropriate application of regulations. However, there may be cases where counselors could make better use of the incentive value of take homes to facilitate attainment of treatment goals.

COUNSELOR REVIEW FORM
TAKE HOMES

Counselor: _____

Supervisor: _____ **Date of review:** _____

1. Take homes earned on schedule:

   ____A. Always

   ____B. Usually

   ____C. Sometimes

   ____D. Never

Comments:_____

_____

_____

2. Documentation or notes explaining that daily attendance is incompatible with employment, education, or homemaking?

   ____A. Always

   ____B. Usually

   ____C. Sometimes

   ____D. Never

Comments:_____

_____

_____

_____

3. Treatment goals tied to take homes?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

4. Are exceptions to take-home requirements appropriate?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

5. Are restrictions and revocations to take homes appropriate?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:

CHAPTER III
METHADONE MAINTENANCE

DISCUSSION SUGGESTIONS FOR CHAPTER III
TAKE HOMES

1. Why aren't take homes routinely given to all patients?

2. Is being drug-free for the required length of time sufficient to earn take homes?

3. What are some detrimental effects of a counselor overlooking violations of take-home regulations?

ANSWERS:

1. There is a concern that methadone intended for a patient might be diverted to another person. Take homes also function as an incentive to patients to make progress in treatment.

2. No, in addition to being drug free for the specified lengths of time patients must be employed, involved in education or responsible home making which is incompatible with daily program attendance. In addition, program protocols may establish more stringent requirements for take homes than those specified in state regulations.

3. Inappropriate special treatment can cause a diminished respect for the counselor; future requests for "rule bending"; negative role-modeling with regard to honesty; a message that behavior does not carry consequences; and an undermining of the rehabilitative process.

CHAPTER III
METHADONE MAINTENANCE

DISCUSSION SUGGESTIONS FOR CHAPTER III
URINE TESTING

1. What are three reasons for urine testing patients?

2. What does methadone only (the absence of methadone metabolite) in a urine result indicate?

3. What does a "methadone metabolite only" result suggest?

4. What drugs might be detected in a urine screen several weeks after they had been taken?

5. What is the difference between a qualitative and a quantitative urine test?

6. What are some indications of a falsified specimen? How should a counselor deal with these?

ANSWERS:

1. Urine testing allows the program to determine that a patient has methadone in his/her system; testing sometimes uncovers the use of illicit drugs; testing provides the patient with an additional tool to prevent drug use.

2. Absence of methadone metabolite indicates that the methadone has not passed through the person's system. In other words, methadone was put directly into the urine specimen of a person who had not been taking methadone.

3. This result indicates a very small amount of methadone in the person's system. This may mean that the person had not ingested his/her dose the previous day or that the person is on a very low dose.

4. Drugs which are stored in the body's fat such as marijuana or PCP can be detected weeks after their last use.

5. "Qualitative" tests indicate the present or absence of a drug or its metabolite in the body. "Quantitative" tests indicate the amount of a substance or its metabolite in the body.

6. Indications of a falsified specimen are appearance (clear, lacking in yellow coloration), temperature (too cold or too warm), or "methadone only" or "negative for methadone and methadone metabolite" results. A counselor should deal with falsified specimens by assuming that there has been drug use, discussing the situation with the patient, and by possibly observing the patient while he/she is providing the specimen.

GUIDE TO CRF

DEALING WITH DRUG AND ALCOHOL USE

This CRF focuses on the counselor's response to drug and alcohol use. Some of the issues considered are whether there has been a response by the counselor to drug or alcohol use and whether treatment interventions have been attempted. If an intervention was not successful was another approach tried? This review may help counselors identify instances where they may be inappropriately tolerant of drug or alcohol use. It also may help to promote the use of a variety of techniques or interventions to deal with drug or alcohol use. As always, program managers should use this CRF to encourage better treatment by increasing counselor's awareness of patient problems and possible solutions to these problems.

COUNSELOR REVIEW FORM

DEALING WITH DRUG AND ALCOHOL USE

Counselor: _____

Supervisor: _____ **Date of review:** _____

1. Counselor responds to opiate use:

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

2. Arm checks performed or referred to in determining opiate use:

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

_____

3. Prescription opiates:

____A. Frequency used

____B. Sometimes used

____C. Rarely used

Comments:_____

_____

_____

4. Explanation of purpose of prescriptions in chart:

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

5. Prescription drug use possibly excessive?

____Yes ____No

Comments:_____

_____

_____

_____

6. Counselor responds to non-opiate drug use?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

7. Counselor responds to alcohol use?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

8. Specific counseling for drug or alcohol use provided?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

9. Breath alcohol testing done with patients who present with alcohol odor or intoxication?

____Yes ____No

Comments:_____

_____

_____

10. Patients referred for evaluations for Antabuse?

____A. After other interventions fail

____B. On the basis of some number of positive breath test.

____C. Without attempting other interventions

____D. Antabuse rarely or never used

Comments:_____

_____

_____

11. Relapse prevention materials used?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

12. Take-home status appropriate in light of drug or alcohol use?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

13. Do patients participate in 12-step meetings?

____Yes ____No

Comments:_____

_____

_____

14. Are 12-step meetings held on site?

____Yes ____No

Comments:_____

_____

_____

_____

CHAPTER III
METHADONE MAINTENANCE

DISCUSSION SUGGESTIONS FOR CHAPTER III
DEALING WITH OTHER DRUGS OR ALCOHOL

1. What are some indications of current opiate use?

2. How can you differentiate fresh versus old needle marks?

3. What are stimulants? What are some indications of stimulant use?

4. What are some common sedative/hypnotics or tranquilizers? What are some indications of their use?

5. Why is it especially dangerous to use sedatives, tranquilizers, or alcohol along with methadone?

6. When is it dangerous to abruptly discontinue drug or alcohol use?

7. Can a person be dependent upon or addicted to a substance that is used only on the weekend?

8. What are some examples of triggers? How can this concept be used in helping a patient who is addicted to crack?

9. How does Antabuse work?

ANSWERS:

1. Indications of use are urine results, needle marks, or prescriptions from physicians for opiates.

2. Injections within 24 hours will appear as tiny pink dots; between 24 and 72 hours these dots will scab over.

3. The most common stimulant are: cocaine, crack, rock, free-base, methamphetamines, crystal, crank, and in some areas ice. Stimulants produce an increased arousal accompanied by a sense of confidence and euphoria. Indication of use are urine tests which are positive for cocaine or amphetamines; weight loss; numerous needle-marks; exhausted appearance; missed clinic appointments; hyperactivity or talkativeness; agitated, or paranoid behavior; increased financial, vocational, relationship problems.

4. Common drugs in this class include the benzodiazepines (Valium, Xanax, Ativan, Halcion, Dalmane, Restoril, and others); barbiturates (phenobarbital, Seconal, Nembutal, Fiornal, Tuinal); and sleeping pills such as Placidyl, Doriden, quaaludes, and chloral hydrate. Indications of use are urine tests positive for benzodiazepines or barbiturates; intoxicated appearance without the odor of alcohol; anxiety or insomnia complaints coupled with prescriptions from outside physicians.

5. Because both these drugs and methadone are depressants there is an increased risk of overdose when they are used in combination with methadone.

6. In the case of a physical addition to sedative/hypnotics or to alcohol, abrupt discontinuation can be lifethreatening.

7. Although this pattern of use may not reflect a tissue dependence the person still may be out of control or addicted. This type of episodic dependency is fairly common with cocaine and alcohol.

8. Triggers are people, places, circumstances, and emotions which have been associated with drug or alcohol use. Some examples are money, Friday night, certain people, or anger. A first step in helping a patient who is addicted to crack would be identifying his/her triggers and strategizing for the avoidance of these.

9. Antabuse interrupts the metabolism of alcohol and thereby causes a buildup of a toxic substance in the person who drinks. As a result a person who is on Antabuse and drinks will become very sick. Understanding the consequences of drinking usually motivates the person who is on Antabuse to not drink.

GUIDE TO CRF

TAPERING

This CRF can help counselors deal with patients who are interested in tapering or those who are attempting to taper off of methadone. Program managers should try to determine if patients are evaluated for readiness to taper, if special assistance is provided for tapering patients, and if counselors advise patients to stop tapering when it appears to be failing. Aftercare planning is also considered in this section.

COUNSELOR REVIEW FORM

TAPERING

Counselor: _____

Supervisors: _____ **Date of review:** _____

1. Is tapering readiness inventory used?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

2. Do counselors use the results of the inventory to advise patients on readiness?

____Yes ____No

Comments:_____

_____

_____

3. Does the counselor interact with medical staff regarding tapering progress?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

4. Are patients counseled to prepare them for problems related to tapering?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

5. Are families counseled on problems associated with tapering?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

6. Are counseling strategies and topics presented to facilitate tapering?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

7. Are withdrawal rating sheets used to monitor progress?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

8. Are tapering efforts aborted when heroin use or other problems indicate?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

9. Do counselors specify aftercare plans for tapering patients?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

10. Are patients advised on naltrexone?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

11. Are patients referred to 12-step groups or other support groups?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

CHAPTER III
METHADONE MAINTENANCE

DISCUSSION SUGGESTIONS FOR CHAPTER III
TAPERING

1. What are some of the issues to consider on evaluating readiness to taper off of methadone?

2. What are some problems normally encountered by patients who are tapering? What are some ways of dealing with these problems?

3. How can a counselor monitor progress during tapering?

4. What are indications that the taper is failing?

5. What should be discussed if the taper needs to be aborted?

6. What is the "Abstinence Syndrome"?

7. How does naltrexone work?

8. When can a patient start taking naltrexone?

9. What are the advantages of 12-step meetings?

ANSWERS:

1. Some issues to consider in evaluating readiness include: abstinence from drugs and alcohol, coping skills, employment status, disassociation with drug users and illegal activities, family support, involvement in counseling, and dose level.

2. Problems typically encountered are craving, anxiety, emotional unsteadiness,impatience, withdrawal symptoms, pain, and isolation. These problems should be discussed with the patient before and during the tapering. Specific strategies for dealing with some of these problems can be offered (e.g., relaxation techniques, exercise, increased counseling frequency, and sometimes medical or psychiatric evaluation).

3. The use of the Withdrawal Rating Sheet can help to monitor progress and sometimes indicate either reductions or increases in severity of withdrawal throughout the tapering process.

4. If the patient resumes the use of heroin or other opiates during the course of the taper it is a clear indication that the tapering is failing.

5. The counselor should point out that the patient now knows more about what is involved in tapering off methadone and that the taper has resulted in a lower maintenance dose (if this is the case). The counselor and the patient should also discuss what may have caused the taper to fail and they should discuss a plan for dealing with tapering differently in the future.

6. The abstinence syndrome is a period following the cessation of opiates which is characterized by irritability, insomnia, tiredness, anxiety, and craving which lasts from 30 to 90 days.

7. Naltrexone is an opiate blocker which prevents the person who is taking it from experiencing an opiate high or becoming readdicted.

8. In order to begin taking naltrexone the patient must be completely free of all opiates for a period of about 5 to 7 days.

9. 12-step meetings can provide the patient with emotional, social, and spiritual benefits. Meetings are available at all hours throughout the day and night and in all parts of the country.

CHAPTER IV

THE 21-DAY DETOXIFICATION PROGRAM

SUMMARY:

This chapter covers the counselor's activities as they relate to the 21-day detoxification program. Because there are few regulations which deal specifically with the counselor's activities with patients on this program, most of the material in the counselor's manual suggests ways of enhancing counseling versus implementing regulatory requirements. Program managers may find that most of the applications of CRF's in this section are to promote versus assess application of the counselor's manual.

COUNSELOR REVIEW FORM

INTAKE

Counselor: _____

Supervisor: _____ **Date of review:** _____

1. Do counselors facilitate induction into treatment?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

____E. Unable to determine

Comments:_____

_____

_____

2. Eligibility requirements met?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

_____

3. Patient oriented to program?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

4. Ineligible applicants referred to other treatment?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

COUNSELOR REVIEW FORM

WEEKS ONE AND TWO

Counselor: _____

Supervisor: _____ **Date of review:** _____

1. Is contact sufficiently frequent and of appropriate length to promote bonding?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

2. Is needs assessment performed?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

_____

3. Treatment planning reflects needs assessment?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

4. Treatment plans realistic?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

5. Program limitations discussed and aftercare possibilities introduced?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

6. HIV/AIDS information provided?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

7. Other drug or alcohol problems assessed?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

COUNSELOR REVIEW FORM

WEEKS TWO AND THREE

Counselor: _____

Supervisor: _____ **Date of review:** _____

1. Aftercare plan form used?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

2. Do aftercare plans relate to patient's previous detoxification attempts or to current detoxification?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

_____

3. Are plans for methadone maintenance appropriate?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

4. Are plan for naltrexone appropriate?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

5. Are plans for residential treatment appropriate?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

6. Are 12-step groups or other support groups planned or encouraged?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

CHAPTER IV
21-DAY DETOXIFICATION PROGRAM

DISCUSSION SUGGESTIONS FOR CHAPTER IV
METHADONE DETOXIFICATION

1. Why is the term detoxification not technically accurate?

2. What is the major advantage of clonidine versus other detoxification agents?

3. What are some of the goals of the 21-day detoxification program?

4. What can most patients expect to occur over the course of the program?

5. Is it a good idea to hold the patient's dose in order to ensure counseling attendance? What is a alternative approach?

6. When should AIDS information be provided to patients?

7. Summarize the critical information regarding sexual behavior and drug use as it relates to preventing HIV infection.

8. What are some reasons to discuss methadone maintenance with patients on the detoxification program?

9. Review possible aftercare options for detoxification patients and describe examples of patients who would be most appropriate for each.

ANSWERS:

1. The term detoxification is not accurate because it suggest that the withdrawal syndrome is caused by toxins. Detoxification treatment suggests that the body is being cleansed of these toxins. A more accurate term would supervised withdrawal.

2. The major advantage of clonidine is that it is a nonopiate medication and because of this it can alleviate withdrawal without sustaining the addiction. It is particularly useful in helping patients get on to naltrexone.

3. The goals of the twenty-one day detoxification program are: it provides a medically safe and supervised means by which a patient may be withdrawn from an addiction to opiates; it facilitates bringing patients into long term treatment; it allows for the brief cessation of illicit opiate use.

4. Patients can expect to be relatively comfortable and stable over the first two weeks of treatment and can expect to experience withdrawal symptoms during the last week of the program. During the last week of the program most patients drop out and resume heroin use.

5. Holding the patient's dose to ensure counseling may ensure the patient's attendance but does not necessarily increase the patient's interest, involvement, or positive feelings about counseling. A better approach is for the counselor to work harder at establishing a connection with the patient so that the counselor as well as the dose becomes a positive aspect of the program.

6. Written information regarding AIDS should be provided to patients at intake. This information should be reviewed and discussed after the patient is sufficiently comfortable to listen. This discussion should not be delayed beyond of the first week of treatment.

7. Critical information regarding sexual behavior includes: when having sex do not pass or receive body fluids (semen, blood, saliva, feces, or urine); use condoms; do not have sex with people who have AIDS or may be infected with the virus; reduce your number of sex partners. Regarding drug use: do not share needles; and clean needles and syringes with bleach.

8. Methadone maintenance should be discussed with patients who have had previous detoxification failures and who almost certainly will resume chronic heroin use unless they enter methadone maintenance treatment.

9. Methadone maintenance would be most appropriate for patients who have had previous detoxification failures, who have resumed heroin use during the course of the 21 day program, who are living with heroin-using friends or on the street, who are HIV positive, or who are pregnant. Naltrexone should be discussed with patients who are remaining abstinent from heroin during the third week of the program and are not eligible for methadone maintenance. Residential treatment should be discussed with patients who are using heroin during the second or third week of detox, or living with using friends or on the street, and who desire a non-pharmacologic approach.

CHAPTER V

SPECIAL POPULATIONS

SUMMARY:

This chapter discusses some important subgroups of patients and some pertinent counseling approaches and regulations. Program managers can encourage enhanced services to groups such as HIV-positive, critically ill, pregnant women, and those with psychiatric problems. In addition counselors can be encouraged to develop a sensitivity to the special problems and concerns of women, ethnic groups, and other minorities.

COUNSELOR REVIEW FORM

SPECIAL POPULATIONS

Counselor: _____

Supervisor: _____ **Date of review:** _____

1. "AIDS Preparedness" questionnaire used?

   ____A. Always

   ____B. Usually

   ____C. Sometimes

   ____D. Never

Comments:_____

_____

_____

2. Does counseling address misinformation, knowledge gaps, or high risk behaviors indicated on questionnaire?

   ____A. Yes

   ____B. No

   ____C. Form not used

Comments:_____

_____

_____

3. Does counseling address special issues related to those HIV-positive?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

4. Are patients who are critically ill provided appropriate exceptions or waivers of regulations?

____A. In most cases

____B. In some cases

____C. In too few cases

____D. Too often when not appropriate

Comments:_____

_____

_____

5. Counselor's understanding of issues related to HIV/AIDS:

____A. Excellent

____B. Very good

____C. Fair

____D. Poor, misinformed

____E. Unable to assess

Comments:_____

_____

_____

6. Counselor appropriately refers possible psychiatric cases to medical staff?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

7. Treatment plan requirement for pregnant women followed?

____A. Always

____B. Usually

____C. Sometimes

____D. Never

Comments:_____

_____

_____

CHAPTER V
SPECIAL POPULATIONS

DISCUSSION SUGGESTIONS FOR CHAPTER V
SPECIAL POPULATIONS

1. Why is it important for programs to adopt a more flexible or lenient approach to the treatment or HIV/AIDS patients?

2. What are four common psychological problems of methadone patients who have AIDS?

3. How can counselors deal with their fear of HIV infection?

4. What are some conditions which might warrant referring a patient to the staff psychologist or psychiatrist?

5. What are additional treatment plan requirements for pregnant women?

6. Why is it usually preferable for a pregnant woman to stay on methadone?

7. What are the effects of methadone on a newborn?

8. Why do very few heroin-addicted women use birth control?

9. What are some general guidelines in working with patients who are of different ethnic cultural, or racial groups from the counselor?

ANSWERS:

1. It may be necessary to weigh the public health consequences as well as the consequences to the individual patient in considering treatment termination.

2. Four common problems of patients who have AIDS are denial, anger (with antisocial behavior), depression, and isolation.

3. Staff should receive in service training and possible support sessions. Programs should develop guidelines related to safety and infection, and provide training.

4. Some conditions that warrant a psychiatric referral include: suicidal thoughts and plans, extreme changes in mood, extreme changes in sleep/activity patterns, hyperactivity; paranoid thinking, hallucinations, unresponsiveness, or confusion.

5. Treatment plan requirements for pregnant women are: obstetric or gynecologic care as a condition of admission or continued treatment; program physician must ensure addiction-related medical care for the patient and baby following the birth; and program provision of monthly physician consultation, nutritional counseling, parent training, family planning, and weekly full urine screens.

6. Methadone is preferable for pregnant addicts because it prevents the resumption of heroin use, it prevents opiate withdrawal which can cause fetal distress and miscarriage, and it ensures good prenatal care.

7. Methadone-addicted newborns tend to have a lower birth weight and a smaller head circumference than drug-free newborns. However, there are no apparent developmental differences at six months of age.

8. Many women confuse heroin-caused amenorrhea with infertility.

9. Some general guidelines are: be open and honest, be yourself; be patient, understand initial suspiciousness; address the differences, give patients the option of a counselor with whom they might be more comfortable; be sensitive to cultural and ethnic differences which may require a different style of counseling.

CHAPTER VI

ADMINISTRATION

SUMMARY:

This chapter stresses the importance of a team approach. Some ways to promote a harmonious approach and to resolve conflicts are discussed. In addition the importance of establishing and enforcing clinic rules is stressed. Program rules are described as creating a context within which treatment can occur. There are no CRF's for this chapter. There is usually not a clear "paper trail" differentiating well versus poorly managed programs. Programs can look good on paper and be infested with drug dealers in the parking lot or waiting room. Program managers should attempt to raise staff consciousness regarding the importance of patient and clinic management while stressing a respectful and humane application of rules.

CHAPTER VI
ADMINISTRATION

DISCUSSION SUGGESTIONS FOR CHAPTER VI

1. How would you respond (or not respond) to a patient "bad-mouthing" another staff member?

2. What are some examples of patient issues which would be important to bring up at a case conference?

3. Why is loitering not tolerated? How would you deal with someone who is loitering?

4. What are some indications that a person is dealing drugs or diverting methadone?

5. Should staff ever "back off" rule enforcement?

ANSWERS:

1. Staff should not engage in negative or critical discussions of other staff members with patients but should work towards a positive and professional resolution of problems between patients and other staff.

2. Counselors should discuss new and difficult cases at a case conference with particular emphasis on drug and alcohol use or issues which immediately bear upon drug and alcohol use.

3. Loitering creates a condition conducive to buying and selling drugs, urine specimens, or take homes. Counselors should encourage patient who are loitering to move along and remind them if necessary about clinic rules against loitering. Counselors should view advice regarding loitering as important as any advice they may be giving their patients.

4. Indications of dealing drugs or diverting methadone are loitering, seeking out patients for secret conversation, repeated "loss of take homes", and exchanging unknown objects for money.

5. Staff should always back off rule enforcement if there is a risk of violence or physical danger.