UNITED NATIONS
Office on Drugs and Crime

Advanced Level Training Curriculum For Drug Counsellor

5 Training Modules in complete set of 5 handbooks

- **Handbook 1:** Introduction to Professional Drugwork
- **Handbook 2:** Clinical and Client Management for Drug Services
- **Handbook 3:** Counselling Skills and Techniques
- **Handbook 4:** Pharmacology, Mental Health and Harm Reduction
- **Handbook 5:** Short Practice Guides on Drug Counselling Therapies

United Nations Office on Drugs and Crime
AD/VIE/H68 Project
Technical Assistance to Treatment and Rehabilitation at Institutional and Community Level
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PRINCIPAL AUTHOR:

Wendy Dodd

PROJECT COORDINATOR:

Vi Cuong Tran

PROJECT PARTNERS:

Ministry of Labour, Invalids and Social Affairs, Department of Social Evils Prevention, Hai Duong, Hai Phong, Phu Tho, Lao Cai, Da Nang, Tay Ninh and An Giang Provinces in Viet Nam, UNODC Laos, Shanghai Drug Abuse Treatment Center

DONORS:

Luxembourg, Australia, Sweden

CONTRIBUTION:

David Bagott, Dinh Thi Thanh Hoa, Ngo Thi Khanh, Patrick Burke, Min Zhao, Pham Huu Vuong, Pham Tuan, Do Thi Bich Thu, Jamie Uhrig

TRANSLATION:

Nguyen Thi Thanh Huyen, Le Thi Thanh Huyen, Nguyen Thi Huong Giang, Do Thi Thu Nga

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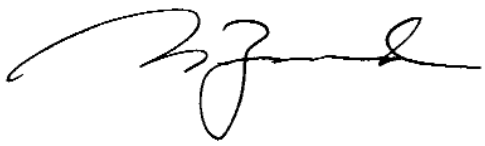
foreword

"Technical Assistance to Treatment and Rehabilitation at Institutional and Community Level" project (AD/VIE/H68) has been developed as a response to the urgent need for assistance in drug treatment and rehabilitation and HIV prevention for drug users in Viet Nam. Supported by the governments of Sweden, Luxembourg and Australia, UNODC and the Ministry of Labour, Invalids and Social Affairs (MOLISA) launched the project in August 2006. Its immediate objective is to assist local partner institutions in selected localities in Viet Nam to improve the effectiveness of community-based and residential treatment and rehabilitation. The emphasis is on developing diversified treatment models and training of service providers taking into account relevant best practices and treatment services derived from evidence-based approaches.

Following a training needs assessment in December 2006, the project began a 2-year effort to design and materialize a training curriculum aimed to best serve the drug rehabilitation sector in Vietnam to take into account on-site experiences and feedback. The process involved field testing workshops, Training of Trainer (TOT) workshops, review meetings with drug work professionals and trial counselling practices. The final outcome is a comprehensive, detailed and plain language training curriculum targeting the training of career drug workers to deliver professional drug treatment and rehabilitation services. This carefully-designed training curriculum does not only impart the range of skills and knowledge in advanced drug work but also educate the drug treatment and rehabilitation service providers in Viet Nam about the important role and meaningfulness of their profession.

I strongly hope that this curriculum will be widely used, especially for training in drug counselling, equipping service providers and drug counsellors with technical knowledge and best practice, leading to the provision of more effective drug treatment and rehabilitation services in Viet Nam

NARUMI YAMADA



UNODC Representative, Vietnam

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- Dr Mark E. Barrett, Consultant, United Nations Office on Drugs and Crime (UNODC)
- Mr Vi Tran, United Nations Office on Drugs and Crime (UNODC) Vietnam
- Clinical treatment guidelines for alcohol and drug workers. No 1: Key principles and practices prepared by Turning Point (Addy, et al., 2000)
- Making values and ethics explicit: A new Code of Ethics for the Australian alcohol and other drugs field prepared by Alcohol and other Drugs Council of Australia (ADCA) (Fry, 2007a)
- Making values and ethics explicit: The development and application of a revised Code of Ethics for the Australian Alcohol and Other Drug Field. ADCA Discussion paper prepared by ADCA (Fry, 2007b)

Understanding Drug Addiction

APA definition of addiction

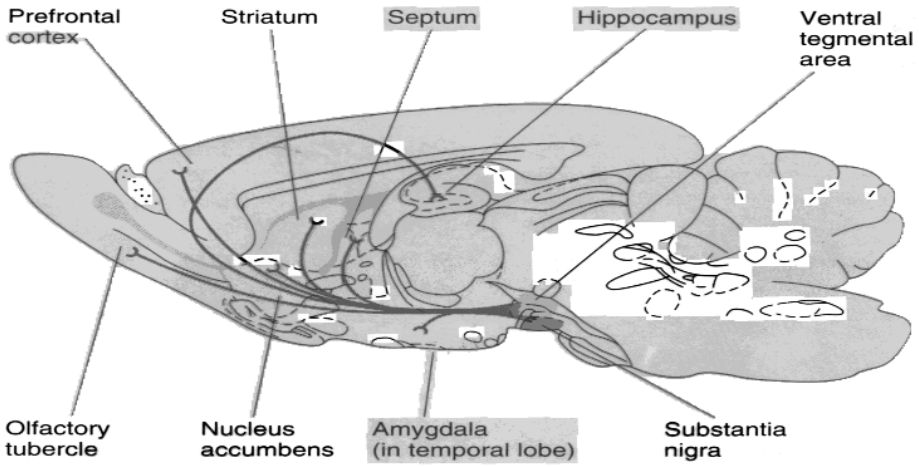
The American Psychiatric Association's (APA) diagnostic manual defines addiction as follows: "The symptoms include tolerance (a need to increase the dose to achieve the desired effect), using the drug to relieve withdrawal symptoms, unsuccessful efforts or a persistent unfulfilled desire to cut down on the drug or stop using it, and continued use of the drug despite knowing of its harm to yourself or others."

ABOUT ADDICTION

- Research has shown that in addition to behavioral, social and psy chological aspects, addiction is an illness that involves physical alter ations to nerve cells in the brain as a result of repeated exposure to the drug.
- This has important implications for treatment and rehabilitation.

PHYSIOLOGICAL BASIS OF ADDICTION

- Neurological studies have identified a common basis in the brain for all drugs that cause addiction (e.g., nicotine, heroin, cocaine, alcohol, etc.).
- This site of action in the brain is the mesolimbic dopamine system, also referred to as the **Brain Reward System.**



Brain Reward System

BRAIN REWARD SYSTEM

- The Brain Reward System reinforces behaviors that generally are good for survival–e.g., eating of sweet, pleasant tasting foods provides nutrition, drinking water, sexual activity leads to procreation, exercise improves ones fitness, and so on.
- The brain reinforces these behaviors to ensure that we continue to do them.
- Addictive drugs, like heroin, cause long lasting, possibly permanent, changes to the nerves in the area of the Brain Reward System.
- This is why addiction is difficult to overcome and, why relapse occurs so often, and why it sometimes takes many years before addicts are successful in permanently stopping drug use.

ADDICTIVE DRUGS "FOOL THE BRAIN"

- Addictive drugs such as heroin fool the brain by artificially creating pleasurable feelings (euphoria) and reinforcement (reward) for drug taking behavior.
- In effect, drugs tell the brain to "take more drugs!"

PHENOMENON OF "DRUG CRAVING"

- Craving is an impulsion to reinstate drug-taking during abstinence and is associated with an activation of the Brain Reward System. Craving can be triggered by drug cues (needles, mirrors, pipes, etc)
  - Unpleasant feelings of abstinence
  - Pleasant recall of positive drug state

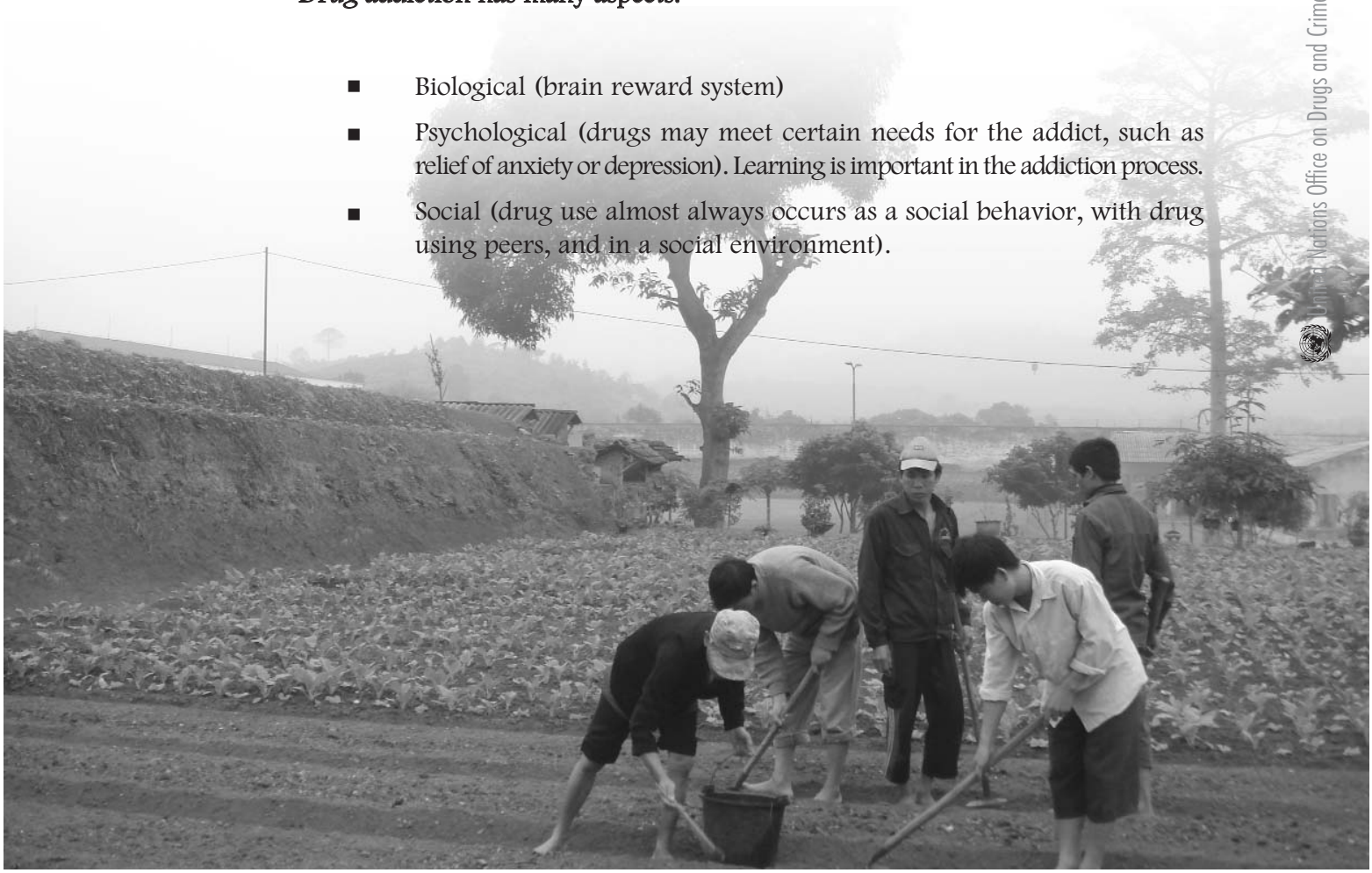
WHAT ARE THE IMPLICATIONS OF THIS VIEW OF ADDICTION?

- The fact that there are several addictive drugs that act at this site in the brain (Brain Reward System) also means that addicts may substitute one drug for another.
- One example is to switch from heroin to amphetamine type substances or alcohol in order to reduce craving and withdrawal symptoms.

BIO-PSYCHO-SOCIAL MODEL

Drug addiction has many aspects.

- Biological (brain reward system)
- Psychological (drugs may meet certain needs for the addict, such as relief of anxiety or depression). Learning is important in the addiction process.
- Social (drug use almost always occurs as a social behavior, with drug using peers, and in a social environment).



Policies and programs

- The way addiction is viewed will strongly influence the type of policies and programs that governments will adopt to address the use of addictive drugs.
- If it is viewed as primarily a moral or criminal matter, then the focus will be on punishment to deter use.
- On the other hand, if addiction is viewed as primarily a health issue (such as heart disease and diabetes), then policies will favor providing health care, including:
- The most effective drug treatment and rehabilitation approaches, and, most importantly,
- Measures to reduce health and other problems associated with drug use (such as spread of HIV and other illnesses, crime, disruption of families and communities).

Source: Dr Mark E. Barrett, UNODC Consultant

Models of dependence

There are many models of dependence and they help put in perspective the development of problematic behaviours and provide the theoretical basis for interventions.

Different models stress different causative influences such as

- Psychopathology,
- Social deviance,
- Maladaptive functioning,
- Moral deficits,
- Inherited predispositions and
- Social learning.

Some of the more popular and influential models address disease, social learning and public health:

In the case of models of dependence, of which there are many, there are several which have proven useful in helping to understand why people develop problematic drug use.

Different models have been dominant at different times and most were devised in response to alcohol dependence.

These models also form the theoretical basis upon which various interventions have been developed.

Many descriptions and models of drug problems are circular and therefore not very useful. For example, any use of illicit substances is sometimes labelled abuse or addiction, irrespective of the level of harm experienced or the amount of use.

A WORD ABOUT ADDICTION OR DEPENDENCE

The terms addiction and dependence are often used interchangeably. However, many people question the validity of this as they believe that the term addiction labels a person as an addict, whereas the term dependence is more precise in referring to an aspect of a person. Another distinction people make is that the term dependence is more transient, whereas the terms addict or alcoholic are used to describe a person long after the dependency has ceased. We will use the term dependence.

What is dependence?

The fact that people can become dependent on or addicted to drugs is part of what gives drugs great social power and is, for many, a source of their mystique and fascination. Its also the source of much prejudice towards people who find themselves in this situation.

It is important to remember that most people who use drugs (any drugs) do not develop significant problems.

- So why do some people develop problems in relation to their drug use, and not others?
- What are some of the possible causes of drug dependence?

There are many theories about the causes of dependence. These have changed and developed over time, as more is understood about the phenomenon and as the focus of social and scientific concerns and attention change.

THE MORAL VIEW

The moral view of addiction developed around the middle of the 19th century. In this view some people were considered unable to drink moderately because of a moral weakness. Extreme versions held that drinking excessively was a sin or vice. The acceptance of this view generally led to punitive responses and labelling and provided little in the way of treatment.

THE PHARMACOLOGICAL VIEW

According to this view addiction resides in the substance itself, rather than within the individual. The shift in focus from a weakness within the individual to the overwhelming power of the substance was highlighted by the worldwide rise of temperance societies. Alcohol was vested with a power that humans had no control over and which society had an obligation to defend itself from. Legislative responses to this include both the Defence of the Realm Act in Britain and the Prohibition era in the United States.

THE DISEASE VIEW

Strictly speaking there is more than one disease view. In the context of health generally there are many different ideas about what disease is, and this lack of agreement is reflected in different versions of the disease model of dependence.

Generally, this disease model holds that dependence is a diseased condition beyond the control of the person. Once again the source of the condition is located in the person. It is not seen as a symptom of another disease, but a discreet and well-defined entity in itself. Inherent physiological and genetic factors are seen to predispose someone to developing alcoholism. Within this view there is the belief that after years of heavy consumption there are irreversible changes that prevent that person from returning to normal drinking. In this model the only treatment is that of abstinence.

SOCIAL LEARNING MODEL

The social learning model emphasises the user and their social context and can apply equally to drug use, eating or any other behaviour. The two central notions are that drug use is learnt and is functional. It can be learnt from peers, parents, partners or the media. It can be learnt from the observation of other people, or from personal experience. Based on this model, drug use is seen as neither good nor bad; there are simply costs and benefits. Social learning interventions focus on altering the clients relationship with their environment. A key concept is self-efficacy, which refers to a persons beliefs about their ability to perform tasks and achieve goals. A persons beliefs about their ability to change problematic drug use can strongly influence the outcome of the attempt to cease.

Coping skills and cognitive restructuring methods are used to assist people to change and control their drug use. Prevention strategies address individual environmental conditions that foster problematic behaviour *(Miller & Hester, 1995)*.

THE PUBLIC HEALTH VIEW

The public health model takes into consideration the drug, the individual and the environment. However, unlike social learning and disease models that emphasise one or two components, the public health model proposes that a comprehensive effort must acknowledge and address all three. An approach that focuses on only one component is likely to be limited in its ability to eradicate the problem, according to the public health theory.

The public health approach acknowledges that drugs can be hazardous and place people at risk when consumed unwisely or beyond moderation. It recognises that there are significant individual differences in susceptibility to drug problems.

It stresses the relevance of social and environmental factors in determining rates of drug use and related problems. It also highlights the importance of influences such as the availability and promotion of drugs *(Miller & Hester, 1995).*

The public health approach focuses on the overall patterns of drug use in the community, which is seen as a continuum, with those who abstain at one end and those who use very heavily at the other -most of the population lie somewhere in the middle of that continuum.

The public health approach moves the emphasis away from alcoholics and addicts towards the discourse of alcohol and drug related problems.

Factors that have been found to influence the occurrence of drug problems are adopted from each perspective, and integrated into a complex and interactive model.

No single factor is considered sufficient for understanding drug use or the problems that may arise. A range of interventions is offered to suit the many different types of people affected. From a public health perspective, these would include harm reduction strategies and structural changes to the environment, as well as treatment interventions. Figure 2 illustrates the intersecting factors involved in the public health view of drug use.

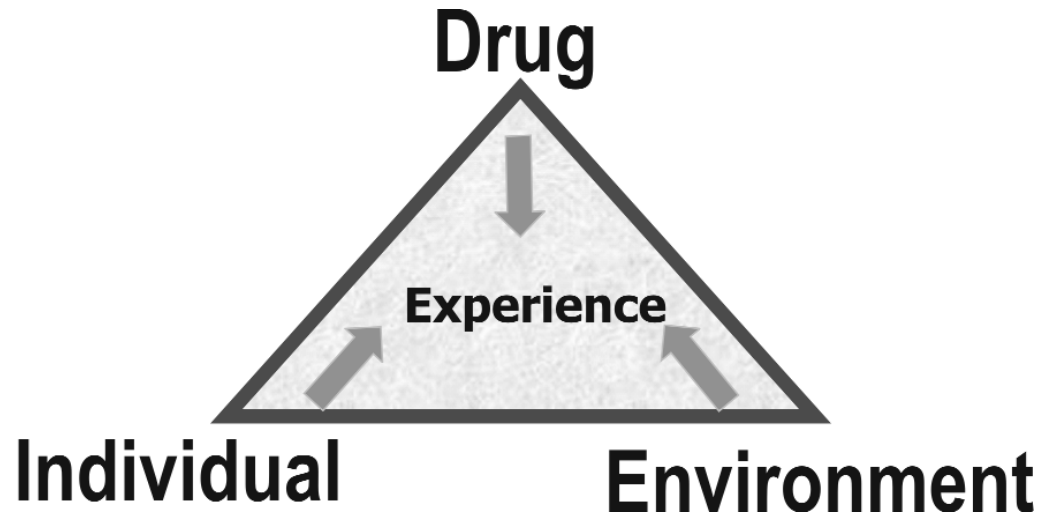


Figure 2. The public health model

Source: Turning Point Alcohol and Drug Centre *Clinical treatment guidelines for alcohol and drug workers. No 1: Key principles and practices prepared by Turning Point (Addy, et al., 2000)*

Evidence -Based Drug Treatment Approaches

Source: Dr Mark E. Barrett, UNODC Consultant

Supplementary reading provided for this module: UNODC drug abuse treatment kit, Contemporary Drug Abuse Treatment, A Review of Evidence base. Contains a summary of researches on the effectiveness of drug treatment methods in the detox-stabilization phase and relapse-prevention phase.

EVIDENCE - BASED PRACTICES MEAN INTERVENTIONS THAT SHOW CONSISTENT SCIENTIFIC EVIDENCE OF BEING RELATED TO PREFERRED CLIENT OUTCOME.

- **Medical detoxification is recommended but is only the first stage of addiction** treatment and by itself does little to change long-term drug use. Medical detoxification manages the acute physical symptoms of withdrawal. For some individuals it is a precursor to effective drug addiction treatment.
- **Recovery from drug addiction can be a long-term process** and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Participation in self-help support programs during and following treatment often helps maintain abstinence.
- Addicts in recovery move through **progressive stages of change**
- Regarding change process at the individual level there is movement through stages as suggested by the Trans-theoretical Model:
  Pre- contemplation → Contemplation → Preparation →Action → Maintenance.
- Regarding **treatment process** addicts progress through the following stages 1) induction stage, followed by 2) engagement, 3) compliance, and then 4) commitment stage
- An effective treatment/rehabilitation program will recognize these processes and use appropriate interventions to facilitate the movement of the addict toward commitment and maintenance of long term recovery. TCs pay particular attention to and reward positive changes with increased status and privileges.
- The major treatment variables or components associated with better outcome following rehabilitation- oriented treatments include:
- **Remaining in treatment for an adequate period of time is critical for treatment** effectiveness. For most patients, the threshold of significant improvement is reached at about 3 months in treatment. Additional treatment can produce further progress. Programs should include strategies to prevent patients from leaving treatment prematurely.
- **Reinforcement/rewards** (such as financial incentives or vouchers for attendance and abstinence)
- **Individual and/or group counselling and other behavioral therapies are critical components of effective treatment for addiction**. In therapy, patients address motivation, build skills to resist drug use, replace drug- using activities with constructive and rewarding non-drug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships.

- **Specialized** services for psychiatric, employment and family problems. Treatment must address the individual's drug use and associated medical, psychological, social, vocational, and legal problems.
- Medications:
  - To block drug craving and the effects of drugs
  - To reduce psychiatric symptoms
- Participating in **self-help groups** (Alcoholics Anonymous, Narcotics Anonymous) following rehabilitation.
- A therapeutic **climate** conducive to recovery.
- **Treatment** does **not need to be voluntary to be effective**. Sanctions or enticements in the family, employment setting, or criminal justice system can significantly increase treatment entry, retention, and success.
- Possible **drug use during treatment must be monitored continuously**. Monitoring a patient's drug and alcohol use during treatment, such as through urinalysis, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that treatment can be adjusted.
- **Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and** other **infectious diseases**, and counselling to help patients modify or change behaviors that place them or others at risk of infection. Counselling can help patients avoid high-risk behavior and help people who are already infected manage their illness. Other components, all of which have been shown to be important for minimizing health consequences of drug use, are:
- Needle and exchange programs: If implemented properly, so that clean syringes are available on demand to drug injectors, along with education, this is probably the fastest way to stop the spread of HIV infection among IDUs.
- Primary Health Care: is desperately needed by many addicts, and which may provide opportunities for HIV prevention and to engage the addict to enter drug treatment.
- Removing barriers to safer injecting: this could include legal, social and cultural barriers that make it difficult for addicts to find the means to inject safely.
- Peer Education Programs: education and behavior change around safe injecting and HIV prevention among IDUs is most effective and sustainable when it is delivered by peers-persons who have used Drugs themselves-in a supportive environment.

Treatment Interventions in Practice

Source: Turning Point Alcohol and Drug Centre Clinical treatment guidelines for alcohol and drug workers.
No 1: Key principles and practices prepared by Turning Point (Addy, et al., 2000)

Treatment services range from early brief intervention to long-term residential treatment.

General practitioners, hospital nurses and community workers are ideally placed to provide interventions for a range of clients. Services can facilitate complete abstinence and/or reduced or controlled use, and/or focus on other health benefits through drug substitution and reducing harmful drug use and associated risk behaviour. Ideally, service providers should collaborate to resolve other health and social problems which often confront individuals and families affected by harmful drug use.

Treatment works

- The goals of drug treatment include;
- Reducing or stopping drug use, 1
- Reducing criminal activity,
- Improving physical
- Emotional health,
- Improving social functioning and relationships,
- Making meaningful contributions, such as employment, to the community.

A number of international studies have found that treatment does work (Simpson & Sells,1982; Hubbard et al, 1989; Hubbard et al, 1997 and Gossop et al, 1997).

Points to consider

Treatment for drug dependence should be considered within the context of the following **key points:**

- Drug dependence can be a chronic relapsing condition, like asthma and diabetes, and may require life-long care (OBrien & McLellan, 1996).
- Treatment can be successful in reducing drug use, crime and psychosocial dysfunction (Gossop et al, 1997; Hubbard, Craddock, Flynn, Anderson & Etheridge, 1997).
- The costs of providing treatment are significantly offset by the savings associated with its outcomes (Gerstein & Harwood, 1994).
- Providing treatment achieves a significant reduction in drug-related costs for significantly less investment than law enforcement (Rydell & Everingham, 1994).

No single treatment type will suit all individuals. The greater the treatment choice, the more likely clients will be to access and complete treatment. Ritter et al (1999) note that treatment for a drug problem involves many domains:

- The physical (withdrawal services,and diagnosis and treatment of other physical problems);
- The psychological (counselling and psychotherapy as well as assessment of co-occurring psychiatric illness where present);
- The social (rebuilding areas such as relationships and employment).

Source: Turning Point Alcohol and Drug Centre Clinical treatment guidelines for alcohol and drug workers. No 1: Key principles and practices prepared by Turning Point (Addy, et al., 2000)

A Comprehensive Model

Source: Dr Mark E. Barrett, UNODC Consultant

United Nations Office on Drugs and Crime

A comprehensive model needed

The best practices that were reviewed above suggest a comprehensive model of drug addiction treatment. Such a model would incorporate the understanding of addiction as a chronic illness requiring many treatment components, such as the following:

- Intake Processing/Assessment and Treatment Planning
- Pharmacotherapy
- Continuing (After) Care
- Clinical and Case Management
- Behavioral Therapy and Counselling
- Multiple modalities, suited to different needs of addicts (Group Therapy,Abstinence-based Therapeutic Communities, Methadone Maintenance Treatment, In/Outpatient programs, Structured day programmes, Relaxation and anti-stress techniques, Self-Help Groups, 12 Step facilitation etc.)
- Substance Use Monitoring
- HIV Prevention
- Self-Help/Peer Support Groups
- Drug Substitution Programs, such as methadone maintenance.

Having such components would help to develop a more therapeutic climate at the centers. However, many of these components require trained professionals, such as social workers, psychologists and drugs counsellors/workers.

These resources are not available to rehabilitation centers in Vietnam at present. Therefore, the project envisages the birth of professional career drugs counsellors and drugs counselling clinics in Vietnam. This vision is the most practical tool to translate drugswork training into action being the most practical human resource allocation to effectively implement the above treatment model.

An Overview of Counselling Approaches

Source: Dr Mark E. Barrett, UNODC Consultant

Implementing counselling therapies in drug rehabilitation

Many important studies have provided evidence that access to drugs abuse counselling can make an important contribution to the engagement and participation of the patient in a treatment programme and to its outcome. The positive impact of counselling therapies has been observed where greater frequency of attendance at counselling and self-help groups were associated with lower risk of relapse over the subsequent six months.

1. General outpatient drug-free/abstinence oriented counselling
2. Specific cognitive psychotherapies / motivational interviewing / solution focused therapy
3. Cognitive-behavorial approaches
4. 12-step approach
5. Self-help group
6. Living Values
7. Crisis intervention/ Coping skills/Relapse Prevention training
8. Community reinforcement approach model integrating contingency managed counselling, community-based incentive and family therapy.

The Therapist Effect (Therapist=Therapist/Clinician/Drugs Counsellor)

Several studies suggest that programme counsellors who possess strong interpersonal skills, are organized in their work, see their clients more frequently, refer clients to ancillary services as needed and generally establish a practical and "therapeutic alliance" with their patients achieve better outcomes.

Identifying resourceful and committed drugs counsellors and providing intensive and supervised training amounting to several weeks are key factors in starting up effective drugs counselling programmes.

What Works with Clients who Have AOD Issues?

INTRODUCTION

The available information on the utility of the various counselling styles within the AOD sector varies considerably. In a small number of cases there is moderate evidence from some well documented studies, whereas in other areas, the reality is that there has been minimal or no research undertaken. In addition to this, much of the research has been undertaken overseas and may not be easily applicable to Australia. In total, this poses some difficulty in making direct comparisons but nonetheless, the content within this section should provide you with additional information of relevance to your work with clients who have alcohol and other drug issues.

Cognitive behavioural therapy

Cognitive behavioural therapy, particularly relapse prevention, is one of the most studied interventions for drug use treatment. (Carroll, 1996), in a general review, noted that relapse prevention appeared to be more effective than no treatment and as effective as other active psychotherapy treatments. Project MATCH 1997, also found that all three interventions they tested (cognitive behavioural, motivational enhancement and 12-step facilitation) were equally as effective. However, a meta-analytic review of 26 published and unpublished studies conducted by Irvin et al. in 1999 found differential effectiveness of CBT for different types of drugs, noting there was evidence to suggest that relapse prevention may not be as effective in treating cocaine dependence as other interventions. They found overall that relapse prevention was most effective for alcohol and polydrug users and in combination with adjunct medication, and was equally effective as a group or individual therapy.

There have been several systematic and meta-analytic reviews in the past few years examining the effectiveness of a range of treatments. The most recent and probably most comprehensive is the Prime Ministers Australian National Council on Drugs (ANCD) 2001 publication, Evidence supporting treatment: The effectiveness of interventions for illicit drug use The following table is adapted from this report and indicates the strength of evidence around the utility of CBT with three major psychoactive drugs.

Drug	Approach	Effectiveness
Opiates	CBT	Moderate and durable
Psychostimulants	CBT	Moderate to high and durable
Cannabis	CBT	Moderate to high

The report categorised the studies that contributed to the analysis as moderate evidence from some well conducted studies. It is also noted that the data with respect to psychostimulants are mostly from the US with cocaine users. Caution is therefore required in translating these results to Australia as the treatment context and philosophy is quite different.

Cognitive therapy has gained widespread application in the AOD sector due to its flexibility in meeting clients specific needs. It is readily accepted by clients due to high level of client involvement in treatment planning and goal selection. It is attractive to many because it is derived from scientific knowledge and applied to treatment practice and has, structured within it, guidelines for assessing treatment progress. It also empowers clients to make their own behaviour change. (Rotgers, 1996) CBT is the most researched and the most evidence based treatment to date.

Solution focused therapy

Although there are many texts describing the mechanics and process of SFT, there is very little controlled research on the effectiveness of the approach and almost none in the alcohol and drug field. Several studies give an indication that SFT may be an effective intervention technique for a variety of emotional and behavioural difficulties. (de Shazer, 1991).

However, much of the research is in the form of evaluation of services offering SFT or case studies, rather than controlled clinical trials. However, a serious omission from this body of research is well-designed quantitative, experimental, outcome research. Given the growing popularity of this approach, such studies would promote stronger confidence in the effectiveness of SFT within the AOD sector.

Narrative therapy

The literature reveals little research into Narrative Therapy in the AOD field. Most of the research that has been conducted into its effectiveness with alcohol and drug populations has been limited to case reports. In 1994 at the National Australian Professional Society on Alcohol and Other Drugs conference, Raven reported that few if any attempts have been made to apply narrative therapy to the AOD field. (Raven, 1994). At this time this was partly because narrative therapy was relatively new and seen as philosophically differing from traditional models such as the medical or disease models.

The Dulwich Centre in South Australia devoted a 1997 issue of their newsletter (DulwichCentre, 1997) to AOD issues and narrative approaches. In this newsletter they report on the success of utilising Narrative Therapy in this area. In a more recent publication on the Announcements section of their web site they acknowledge limitations in the area of research with respect to the efficacy of narrative therapy. They express concern that isolating the active ingredient of the effectiveness of Narrative Therapy is complicated and not measurable and could be minimised by scientific measures. In 2003 the centre announced its intention to develop a research publication describing the importance of narrative/post modern approaches to counselling or psychotherapy and has been seeking ways of doing research which is compatible with narrative post modern ways of doing therapy,(DulwichCentre, 2003) Further rigorous research is required to determine the efficacy of this approach.

Reality therapy

Wubbolding describes reality therapy as being a widely used therapeutic modality and educational medium. He goes on to say that according to an unpublished document in 1981 from the United States Department of Defence over 90 percent of the more than 200 armed forces clinics which treated drug and alcohol abuse were using reality therapy as their preferred therapeutic approach. More recently, survey results showed that in the state of Arkansas, 90 percent of drug abuse programs using group therapy followed a reality therapy model. Individual alcohol and drug counsellors ranked the 12 step model higher than reality therapy, (Wubbolding, 2000).

Although it does have prominence in some countries, there is very little recent controlled research into the effectiveness of Reality Therapy, including with clients in drug treatment. Further research is required to establish an evidence base for this therapy.

Transactional analysis

Whilst there has been some evidence of Transactional Analysis within the broader sector, very little recent study has been done into its effectiveness within the alcohol and drug sector. Further research would be required to establish an evidence base within the alcohol and drug sector.

Family inclusive practice

Family involvement in treatment of drug abuse has been a major focus of international research; however there has been little research into the capacity of AOD services to involve families in treatment programs, (NH&MRC, 2001). Much of the research has focused on the context of family or a family member presenting with concerns about anothers drug abuse. Australian research is not extensive in comparison to research from the USA around drug use and families (SuccessWorks 2000 & NH&MRC, 2001) and requires adaptation to the Australian setting. There is some support in the literature for the involvement of family members in that it has a positive effects on drinking behaviour, (McCrady, 1989).There is also evidence that it is better than no treatment (National Drug Strategy Monograph Series, No.20. 1993) and assists motivation into treatment, (Edwards, & Steinglass, 1995).

Family inclusive practice, a relatively new initiative within AOD services, has seen the sector responding to the needs of families/friends/carers of AOD users (adults and young people) in relation to drug use and treatment options. It is only recently, with the latest National Drug Strategic Framework 1998-99 to 2002-03 (Commonwealth Government of Australia, 1998) that the family has received significant recognition as important for intervention.

The National Health and Medical Research Council in 2001 commissioned a report on The Role of Families in the Development, Facilitation, Prevention and Treatment of Illicit Drug Problems (Mitchell, et al., 2001) to assist in the understanding of the role that families take in illicit drug problems. This report goes on to provide an overview of research involving families and illicit drugs. This report identifies the difficulties in identifying causal factors of drug use and reports that no one single factor or risk factor is definitive of later drug use. The report includes a chapter on research considering the roles of families in the treatment of drug use, most of which has been overseas research. What this research clearly identifies is that family inclusive treatments produce more sustainable and effective outcomes for clients.

Group counselling interventions

The effectiveness of group counselling within the alcohol and drug sector has not been extensively researched. Much of the research has focussed on the efficacy of specific counselling styles within group or individual programmes rather than the efficacy of group counselling over individual counselling. It is difficult to generalise the findings of Gottheil et al (Gotteil, E., et al., 1998) or Weinstein et al (Weinstein, A., et al., 1997) who found no significant distinction between individual and group programmes utilising CBT, with group programs that might utilise other counselling styles. Whilst some studies indicate improved outcomes in group programmes, (Mc Kay, J., et al., 1997) the more widely held view is that group counselling is as effective, but not more so, than individual counselling, (Knight, 1980) (O; Brien, C., et al., 1992)

Case management

Little research has been conducted into case management effectiveness for clients in alcohol and drug treatment. One major longitudinal study from the USA (Siegal, A., et al., 1997) has found that case management can increase retention in drug treatment.

In a related area, authors of a Cochrane review of case management for people with severe mental disorders have suggested that it should not be considered the cornerstone of treatment. Although results clearly showed that case management increases the numbers of people who maintain contact with a treatment service and that case management in this context can improve medication compliance, there was no evidence that case management alone improves clinical or social outcomes, (Marshall, M., et al., 2003). Assertive community treatment, similar to case management, has also shown good outcomes in mental health compared to standard care, (Marshall, & Lockwood, 2000).

A meta-analysis of mental health case management, (Ziguras, S. 2000) found an improvement in mental health symptoms, increased contacts with services, fewer dropouts and greater satisfaction with treatment compared to usual treatment.

In relation to AOD treatment, there is evidence that case management may be a valuable tool in retaining clients in treatment, (Ziguras, S. 2000) but is not and should not be considered as a treatment in its own right. Further Australian research is required to assess the role that case management can play in the management of AOD issues.

Care Plans in Drugs Work

Source: Dr Mark E. Barrett, UNODC Consultant

A care plan is a document containing an individualized plan of care for the drug user. It is a flexible and evolving document that can vary depending on the complexity of needs.

It details information from the assessment process which covers the following domains: drug use, alcohol use, physical problems, psychological problem, housing, education and employment, issues relating to social exclusion, legal problems.

It is an action plan setting the goals of treatment that is SMART (specific, measurable, achievable and realistic, time limited) and indicate the set of interventions planned and which agency and professional is responsible for carrying out the interventions. Planning interventions should be in the context of a harm reduction approach that aims to reduce relative risk.

It should have a contingency plan should milestones fail to realised. It should have regular review dates and follows a timescale for review. A review should involved recoding revised needs, goals and interventions onto a new form.

Agencies should have standard paper forms for its care plan records. The format should be simple and understandable enough to share with other agencies.

The process of care planning is an important part of primary care based drug treatment. Devising a care plan is the key part of the assessment process and delivering the care plan needs to be in the framework of the clients treatment journey divided into 4 overlapping segments starting from treatment engagement to treatment delivery to community integration to treatment completion. It aids quality improvement, performance monitoring and risk management for the service provider and provides a focus for care and interventions for the drug user in the drug treatment journey.

Care plan- contents checklist

- Name
- Date of Birth
- Date of care plan
- Keyworker and agency responsible for care plan
- Indication of the main phase(or phases) of the treatment journey
- Needs and risks identified, with reference to the main domains
- Goals
- Interventions(and who is responsible for it, including client if appropriate)
- Review date
- Signature of client

A drugs worker can use mapping to work with the client during care planning. The maps should be recorded as part of the care plan record

Supplementary reading material:- Confidentiality and Information Sharing chapter from UK NHS issued Developing drug services polices practice guide.

Professional Practice Issues in Drugs Work

United Nations Office on Drugs and Crime

Organisational context

Within an organisation, an alcohol and other drug (AOD) worker should be aware of the following depending on the context of the work setting:

- Professional conduct guidelines developed by the various professions, for example nursing, psychology, medicine, social work
- Job description and job role
- Organisational policy and protocols
- Protocols with other services
- Best practice guidelines

In addition there may be legal issues that apply to all members of the community in a particular jurisdiction. These include all the laws of the land such as criminal and civil law, parliamentary regulations and rules, and local government laws provinces.

It is also important that you understand the difference between ethics, policy and law.

- **Ethics** - are concerned with the correctness or morality of action and the attitudes or motives for such an action. They are a matter of conscience.
- **Policy** - includes attitudes or requirements of a government authority, a health institution or a professional body on a particular subject (Edginton, 1995; Zweben & Smith, 1989). Policy is not law but employees may be required to agree to work within organisational policy as part of their contractual obligations. The employee may be subject to disciplinary action for non-adherence to policy.
- **Law** - is concerned with conduct rather than motives. It defines the limits of social and moral behaviour and involves a minimum standard of conduct with external sanctions.

Values and attitudes

Drug use in our society is a highly emotive subject and one in which people tend to have strong and varied opinions. Our opinions, values and attitudes, particularly towards drug use, are built up over a lifetime of experiences.

In some situations we may be comfortable with drug use; after all, most of us are drug users (eg alcohol, tobacco and caffeine use). However, in some cases, an individuals drug use and the circumstances surrounding that use can be both personally and professionally challenging. Developing an awareness of your own values and attitudes and the influences that have moulded them will help you to ensure that they do not negatively impact on your interaction with a client.

WHAT ARE VALUES AND ATTITUDES?

There are many definitions for the terms values and attitudes, some of which are listed below.

VALUES ARE:

General beliefs about desirable behaviour and goals that transcend attitudes and influence the form attitudes take.

Standards for evaluating actions, justifying opinions and conduct, planning behaviour, deciding between different alternatives, engaging in social influence and presenting ourselves to others.

(Feather, et al., 1991)

ATTITUDES ARE:

A relatively enduring organisation of beliefs.

A general feeling or evaluation, positive or negative, about some person object or issue.

(Robbins, et al., 1994)

HOW PERSONAL VALUES AND ATTITUDES AFFECT OUR WORK IN THE ALCOHOL AND OTHER DRUGS SECTOR

Many of you will be aware that, while the drugs involved may vary, drug taking is an activity that crosses both social and cultural boundaries.

For many people, the use of certain drugs or the behaviours associated with drug taking can at times be challenging or confronting.

For example, as an AOD worker you may find that:

- The drug your client is taking is an illicit drug and this may conflict with your own beliefs about drug use and the law
- The client engages in illegal practices (eg burglary, prostitution) to finance their drug use and this may conflict with your own values
- The client engages in risky behaviour (injecting drugs intravenously, poly drug use, for example) and you may be extremely anxious and concerned about the clients health and the risk of overdose
- The client engages in risky behaviour (eg injecting drugs intranously and carelessly disposing of the used syringe) and you may be extremely anxious and concerned about the risk of needle stick injuries to the community
- The client gets intoxicated on a regular basis and you may be concerned about the potential consequences of this behaviour (eg driving while intoxicated, acts of aggression or poor parenting).

How the above situations impact on you will largely depend on your values and attitudes.

CORE VALUES

A wide range of values exists which are potentially relevant to the AOD field. These typically reflect the ideas of respect for persons, engagement and acceptance of others, and the need for trust and confidence in human relationships. The following list of core values is not exhaustive or intended as mutually exclusive. However, the purpose of making these values explicit is to orientate AOD workers to some of the core issues that may be relevant in the applied ethical dilemmas encountered in AOD practice (Fry, 2007a).

Autonomy — enhance freedom of personal destiny (individual and relational)

Beneficence — help others

Compassion - embracing the common humanity

Competence - be knowledgeable and skilled

Community - encompassing collaboration, democratic participation, equity of access, diversity

Conscientious refusal - disobey illegal or unethical directives

Diligence - work hard

Discretion - respect confidentiality and privacy

Equity - equal treatment for equal needs

Fidelity - dont break promises

Gratitude - pass good along to others

Health - all people have a right to resources necessary for health

Honesty - tell the truth

Loyalty - dont abandon

Justice - be fair, distribute by merit

Non-maleficence - actively avoid harm to others (individual and social)

Obedience - obey legal and ethically permissible directives

Reciprocity - in-kind positive response towards the actions of others

Respect - prejudice free consideration of the rights, values and beliefs of all people

Restitution - make amends to persons injured

Self-improvement - be the best you can be

Self-interest - protect yourself

Stewardship - use resources judiciously

Transparency - openness in relation to the decisions affecting others and any limitations on such decisions.

Guiding principles

Many of the values outlined above are implicit in the following thirteen guiding principles of ethical practice for the AOD field (Fry, 2007a).

Equity and access is important in service provision. Clients should have ready access to the services they need and receive equal treatment for equal need (non-discriminatory). This is particularly important for people who have dual or multiple problems as they are often referred from one service to another without receiving appropriate treatment. Access and equity can be promoted through a non-discriminatory approach to all service users, significant others and community stakeholders, and by consideration of cultural, physical, religious, economic and social needs.

Services should be relevant and responsive to the individuals needs. They should be appropriate for the clients gender, social circumstances, ethnic and cultural background and take into account any other problems or disabilities the person may have (for example: mental illness, intellectual, physical or sensory disability, brain injury, or chronic illness). The clients values, expectations and belief systems should be respected. Providing opportunities for clients and ex-clients to participate in the planning, development, management and evaluation of services will help ensure that services are relevant and responsive to clients.

Services should be responsive to community needs. In recognising that individual health and wellbeing is a relational concept dependent upon the place and practices of individuals as members of communities, AOD services have a responsibility to consider the broader community needs that may exist in relation to service operation.

Services should be effective. Services should strive to deliver positive outcomes for the client. The overall effectiveness of services should be measured from the perspective of the clients, and include consideration of ethics and values alongside other traditional outcome measures. Services should hold regular planning and evaluation sessions. Programs that are not effective should be revised and amended so they do provide a positive outcome.

A commitment to actioned community consultation and consumer involvement. Purposive consumer consultation and involvement can enhance health service design, quality, outcomes and community acceptance. Community consultation should be built into the formative processes that guide what we actually do. Implicit in this is the notion of community/ consumer/client expertise on their own values and interests as a positive territory of authority in relation to planning and implementing new AOD innovations. It also entails the duty of AOD workers to inform clients of their rights and responsibilities as service users or participants.

AOD research should proceed on the basis of ethics committee approval. Consistent with peak ethics guidelines (eg NHMRC, Australasian Evaluation Society), research projects (including quality assurance and evaluation) involving human participants should be submitted to appropriate level of ethics committee review prior to conduct.

Services should be cost efficient. They should use the available resources to achieve the best possible effect.

Privacy and confidentiality should be maintained. Privacy and confidentiality to the extent permissible by law is vital in any area of human service: However, it is even more important in the AOD field. The illegal nature of some drug use and the stigma associated with drug dependency mean that confidentiality is a key issue for clients.

Training and professional development should reinforce ethical standards. Ongoing training and professional development is crucial to maintain high ethical standards. Increased funding needs to be devoted to this area to ensure that all staff have opportunities to develop their skills and awareness of ethical issues.

Stress and workload issues contribute to poor ethical standards. Breaches of ethics often occur when workers are under a high level of stress or have an impossible workload. Under these conditions it is difficult for staff to maintain appropriate ethical and professional standards. Such breaches are unacceptable. It is incumbent upon management to ensure that staff have a reasonable workload and suitable working conditions and that appropriate procedures, including support and training for the worker, are followed when such breaches do occur.

The client/worker relationship is of critical importance. A good relationship between the client and the worker is extremely important in achieving positive outcomes for the client. Services are most effective when the relationship is collaborative and focuses on working together to solve problems. Like any human relationship, the relationship between a client and a worker is complex. It is not appropriate for workers and clients to engage in any kind of sexual or financial relationship, as this will breach the therapeutic relationship they have developed. The welfare of clients and the general public, and integrity of profession, take precedence over self-interest and the interests of a members employer and colleagues.

Advocacy in relation to public policy and public health outcomes is important. AOD workers, in adopting the stance of equality and social justice in relation to AOD use and consequences, have a responsibility to engage at some level in ongoing debate and advocacy around drug policy reform issues and the social goals of other reforms to improve health and wellbeing of clients. In performing an advocacy role, AOD workers should strive to draw from a wide range of resources in relation to knowledge access and protection, science, ethics, practice and communication.

Ethics engagement. All AOD workers should be able to engage with the moral and ethical basis of drug use and its outcomes (both positive and negative). Ethical issues and value questions are as important in drug policy, practice and research as other clinical, empirical and political concerns. The AOD workforce has an obligation to consider the ethical, social and political dimensions of proposed programs and interventions, and in doing so seek the value perspectives and participation of all groups whose interests are affected.

It also warrants a willingness to consider guides to decision-making processes around ethical challenges, and the consideration of ethics in evaluation of self-practice and innovations in the AOD field (eg research, policy, and treatment).

The responsibility of ethics engagement exists for all sectors of the AOD workforce, including treatment, outreach, education and training, policy, research, administration, law enforcement, health promotion, prevention, primary care etc.

IMPORTANT ETHICAL ISSUES

Important ethical issues you need to be aware of when working within the AOD sector include:

- Confidentiality
- Professional boundaries
- Prejudice
- Limitations
- Financial considerations

It is vital to note that this section is designed as an overview only and in no way replaces any existing ethical guidelines for professionals working in the AOD field.

Confidentiality

The principle of confidentiality exists to ensure that clients confidently and freely disclose information necessary to the therapeutic relationship.

You should explain the limits of confidentiality at the beginning of each therapeutic relationship. The rights and privacy of clients must be respected and safeguarded at all times. Your relationship with any client should be private and confidential.

Client information should not be communicated to any person other than those qualified to help within the case management/managed care program designed specifically for that person and to which that person has consented. Information obtained in clinical or consulting/counselling relationships, or evaluative data concerning children, students, employees or other clients may be communicated only for professional purposes and only to persons legitimately concerned with the case. **You must receive consent from the client or guardian *before* you do this.**

You must maintain the principle of confidentiality at all times except in those exceptional circumstances whereby to do so would result in clear danger to the client or others. In these circumstances a decision to breach confidentiality should only be taken after discussion with senior staff as to the most appropriate course of action.

In addition, you may also be required by law to disclose client information. All decisions relating to the disclosure of personal information must be taken with the law and the best interests of the person (or the person to whom the information relates) as central considerations.

Client confidentiality must be upheld unless the following exceptional circumstances apply:

- With the consent of the client, for example, where the client may request the health worker discuss issues with family or friends
- For the clients benefit - disclosure of information to other professionals involved in the clients treatment. this must be only for the purpose of treatment
- There is clear risk of harm to the client or others (including children)
- You are a professional who is mandated to report child abuse (refer to the next section)
- Your client reports involvement in serious criminal activity such as homicide or rape. the obligation of confidentiality is overridden if in a particular situation it is regarded as being contrary to public policy and would impede the investigation of a serious crime
- Client records are subpoenaed by the courts or access is requested through government requests.
- You are a professional that needs to notify to authorities regarding infectious disease diagnosis
- Public interest - for example, intervention to prevent the release of a psychiatrically unstable person who may harm the community

The term breaching confidentiality is where a health care worker negligently discloses information about a client and this results in the client suffering damage.

Professional boundaries

Establishing and maintaining professional boundaries can be a challenging aspect of working in the AOD field.

Some workers come with their own experience of AOD issues and can effectively use this background to inform their practice. In general, it is very important for the worker to consider the appropriateness of self-disclosure.

The worker should ask:

> *"Will the client benefit?... Do I have any other motives for self-disclosing?...Whose needs are being met by the disclosure? Am I placing myself at risk, personally or professionally, by self-disclosing?"*

AOD workers should receive ongoing regular supervision and support.

The most common trap in counselling for ex-users, and potentially for all workers, is to become over involved or to over-identify with their client. This could lead to the blurring of boundaries between worker and client or even to the development of personal relationships. This is not appropriate and is invariably unhelpful to the client. Other ethical principles concerned with maintaining appropriate boundaries include:

- Personal relationships with **ex-clients** should be approached with caution. Serious consideration must be given to factors such as the type of relationship, potential harm to the client, and the amount of time between the end of the professional relationship and the start of any non-professional liaison. Many professional codes of conduct specify an appropriate time frame after which a worker could possibly commence a different type of relationship with a client.
- AOD workers should avoid dual relationships that could impair their professional judgement, increase the risk of exploitation or harm the client. Examples include: treatment of employees, students, supervisees, close friends and relatives.
- Therapeutic treatment involving physical contact should be approached with caution. Such treatment would require the clients consent in writing regarding the purposes of the procedure and the expected risks and benefits.
- Sexual relationships between the worker and clients are highly unethical.

PREJUDICE

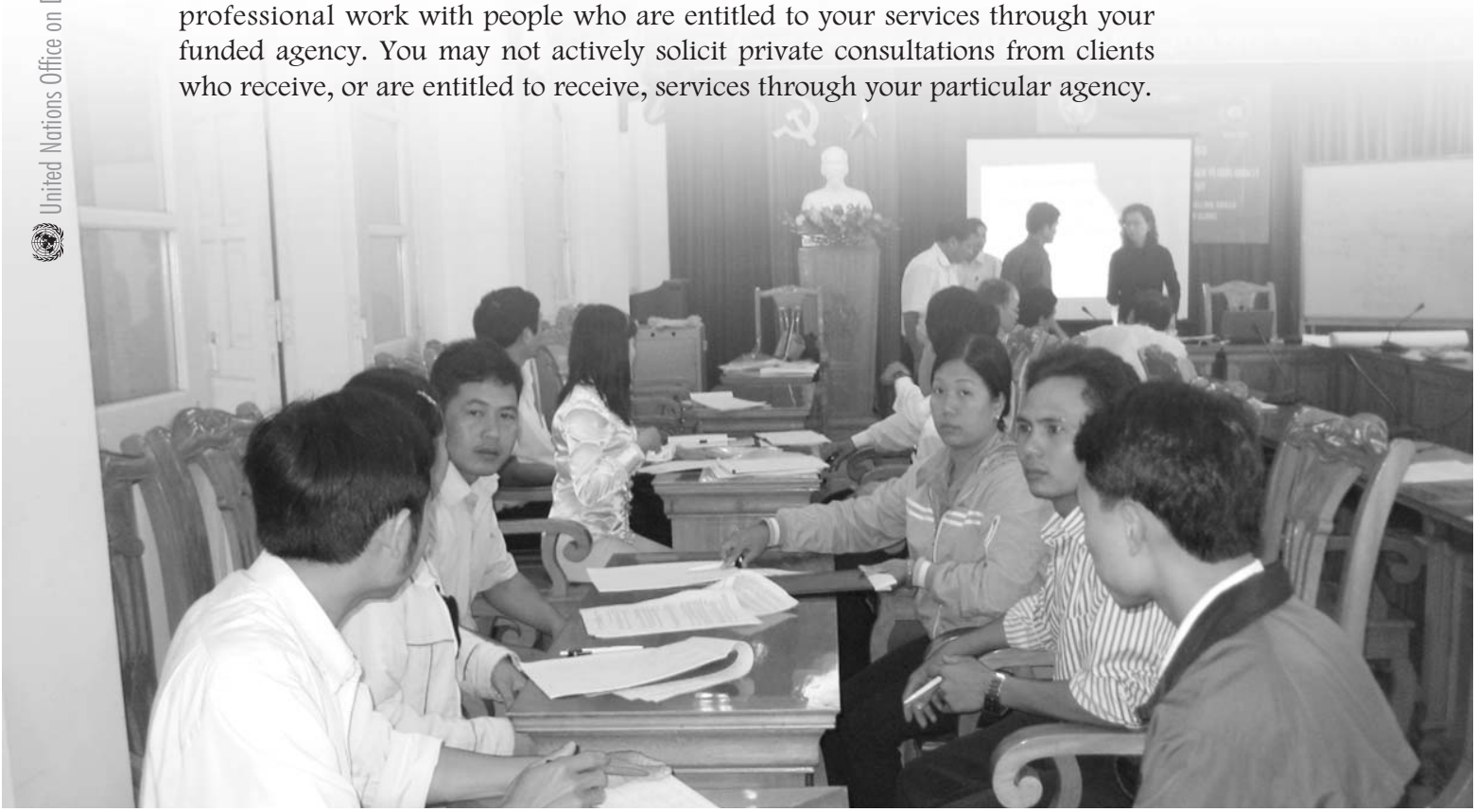
As AOD workers, you must be aware of your responsibilities to your clients. You must ensure, to the best of your ability, that any prejudices you might have do not lead to discrimination against any individual. Such prejudices can occur due to the activities in which a client has been involved, something about a client that reminds you of another person, or personality differences between you and the client. In such cases you should be aware of your potential prejudice or blind spot and your response. Supervision, consulting with another AOD worker or referring the client to a colleague may be an appropriate course of action. Refer to previous section on Values and attitudes for more information.

LIMITATIONS

You should accept the limits of your particular training and not operate outside the boundaries of your professional competence. You should have regular access to clinical supervision from senior professionals. You should also refer clients to other services when appropriate. This function is in fact crucial to the provision of holistic client care.

FINANCIAL CONSIDERATIONS

You should not receive private fees, gratuities or other remuneration for professional work with people who are entitled to your services through your funded agency. You may not actively solicit private consultations from clients who receive, or are entitled to receive, services through your particular agency.



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HỖ TRỢ KỸ THUẬT CAI NGHIỆN VÀ PHỤC HỒI TẠI TRUNG TÂM VÀ CỘNG ĐỒNG
TECHNICAL ASSISTANCE TO TREATMENT AND REHABILITATION AT INSTITUTIONAL AND COMMUNITY LEVEL

Becoming a drug counsellor

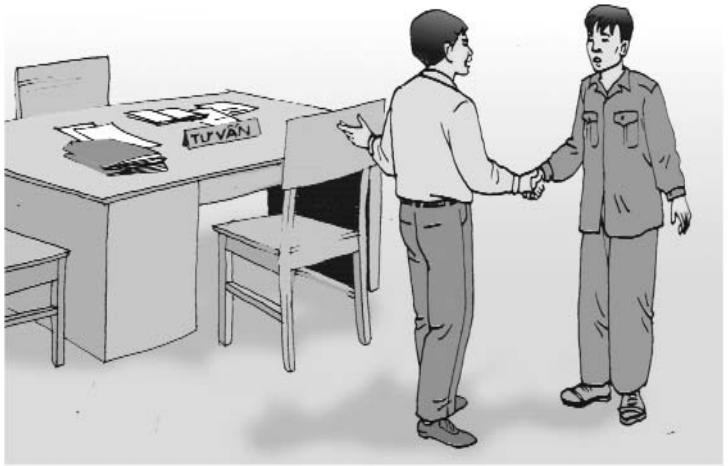
Written by Vi Tran

TRAINING MATERIALS FOR H68 PROJECT
UNITED NATIONS OFFICE ON DRUGS AND CRIME, VIET NAM COUNTRY OFFICE
DECEMBER 2006

1

DRUGS COUNSELING IS A PROFESSION

- A drugs counsellor establishes a professional counsellor-client relationship with his/her drug-using client that is based on good practices, evidence-based counselling and giving objective information



2

WHAT CONSTITUTE A COUNSELLOR- CLIENT RELATIONSHIP?

- Respect client's confidentiality,
- Non-bias, non-discrimination, non-judgment,
- Pursues evidence-based treatment and counselling
- Keep client aware and informed

3

WHAT MAKES A GOOD PROFESSIONAL COUNSELLOR?

- Interested in working with drugs users,
- Respect client's privacy,
- Non-judgmental attitude,
- Objective viewpoint,
- Able to see things from different viewpoints,
- Work in a team and learn from each other
- Implements evidence based treatment.
- Knowledge in different drugs treatment approaches.
- Knowledge in HIV counselling
- Trained in referral work
- Trained to understand basic safety and security issues.
- Trained to handle and deal with situations that arise.

4

DOCUMENTATION AND CLINICAL MANAGEMENT OF CLIENTS- KEEPING CASE FILES

- Maintain log of contacts with clients.
- Record background information/drug use history/assessment,
- Record what is said by both parties during meetings,
- List down information/ counselling/ advice/referrals given to client.

5

WORKING IN A DRUG COUNSELING TEAM

- Work in a team and share information
- Assign areas of responsibility
- Hold regular consultation meetings with team members
- Examine difficult cases together

6

PURSUIT OF JOB-SPECIFIC TRAINING AND KNOWLEDGE

A)Knowledge on drug treatment and drugs counseling therapies
-detoxification-stabilization phase, rehabilitation-relapse prevention phase
-principles of effective treatment
-scientifically based approaches to addiction treatment such as
12 steps facilitation, behavioral therapy and group therapy, pharmacological therapy
B)Important counseling topics
-HIV/Hep B/Hep C counseling
-harm reduction, safe injection, overdose
-Drugs facts information
-Referral counselling

C)Understanding key findings in drugs research
- Addiction is an illness that involves physical alterations to nerve cells in the brain as a result of repeated exposure to the drug.
- Medical detox is only the first stage of treatment.
- There is no evidence that psychosocial treatment alone is adequate Cochrane Review
- Counselling and other behavioral therapies are critical components of effective treatment.
- Remaining in counseling treatment for an adequate period of time is critical in treatment effectiveness.
- No single treatment is appropriate for all.

References

Addy, D.R., A, Clinical treatment guidelines for alcohol and drug clinicians. No.4: Reducing harm for clients who continue to use drugs. 2000, Turning Point Alcohol and Drug Centre: Fitzroy, Victoria.

Addy,D.R., Ritter, A., Lang, E., Swan, A., & Engelander, M. (2000). Clinical treatment guidelines for alcohol and drug clinicians. No. 1: Key principles and practices. Fitzroy, Victoria: Turning Point Alcohol and Drug Centre Inc.

Carroll, K., Integrating psychotherapy and pharmacotherapy in substance abuse treatment, in Treating substance abuse, F. Rotgers, D.S. Keller, and Morgenstern, Editors. 1996, Guilford Press: New York USA.

Commonwealth, National Drug Strategic Framework 1998-99 to 2002-03. 1998, Commonwealth Governement of Australia: Canberra.

de Shazer, S., Putting difference to work. 1991, New York: Norton.

DulwichCentre, Dulwich Centre Newsletter: New perspectives on Addiction. 1997, Dulwich Centre: Adelaide.

DulwichCentre, Announcements. 2003, Dulwich Centre.

McCrady, B.S., Outcomes of families involved in alcoholism treatment. Recent Developments in Alcoholism, 1989. 7: p. 165-182.

Edwards, M.E. and P. Steinglass, Family therapy treatment outcomes for alcoholism. Journal of Marital and Family Therapy, 1995. 21(4): p. 475-509.

Gotteil, E., et al., A randomised controlled study of the effectiveness of intensive outpatient treatment for cocaine dependence. Psychiatric Services, 1998. 49: p. 782-787.

Feather, N.T., Volkmer, R.E., & McKee, I.R. (1991). Attitudes towards high achievers in public life: Attributions, deservingness, personality, and affect. . Australian Journal of Psychology, 43(2), 85-91.

Gossop, M. (1996). Living with Drugs (4th edition). Vermont: Ashgate Publishing Company.

Gossop, M., Johns, A., & Green, L. (1986). Opiate withdrawal: Inpatient versus outpatient programmes

and preferred versus random assignment to treatment. British Medical Journal, 293, 103-104.

Gossop, M., Marden, J., Stewart, D., Edwards, C., Lehmann, P., Wilson, A., & Segar, G. (1997). The

national treatment outcome research study in the United Kingdom: Six month follow-up outcomes. Psychology of Addictive Behaviours. 11(4), 324-337.

Gowing, L., et al., Evidence supporting treatment: The effectiveness of interventions for illicit drug use. 2001, Australian national Council on Drugs: Canberra.

Hubbard, R., Craddock, S., Flynn, P., Anderson, J., & Etheridge, R. (1997). Overview of 1-year follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). Psychology of Addictive Behaviours, 11(4), 261-278.

Hubbard, R., Marden, M., Rachal, J., Harwood, H., Cavanaugh, E., & Ginzburg, H. (1989). Drug Abuse Treatment: A national study of effectiveness. North Carolina: University of North Carolina Press.

Irvin, J.E., et al., Efficacy of relapse prevention: A metanalytic review. Journal of Consulting and Clinical Psychology, 1999. 67: p. 563-570.

Knight, J., The family in the crisis of alcoholism, in Alcoholism; a practical treatment guide, S. Gittow and H. Peyser, Editors. 1980, Grune & Stratton: New York.

Marshall, M., et al., Case management for people with severe mental disorders (Cochrane Review). in The Cochrane Library,. 2003, Update Software: Oxford.

Marshall, M. and A. Lockwood, Assertive community treatment for people with severe mental disorders, in Cochrane Library. Issue 2., C. Collaboration, Editor. 2000, Oxford.

Miller, W., & Hester, R. (1995). Treatment for alcohol problems: Toward an informed eclecticism. In R. K.

Hester and W. R. Miller (Eds), Handbook of alcoholism treatment approaches: Effective alternatives (2nd ed). Boston: Allyn & Bacon.

Mc Kay, J., et al., Group counselling versus individualised relapse prevention aftercare folllowing intensive outpatient treatment for cocaine dependence: Initial results. Journal of Consulting and Clinical Psychology, 1997. 65: p. 778 - 788.

Mitchell, P., et al., The role of families in the development, identification, prevention and treatment of illicit drug problems. 2001, NH&MRC.

NH&MRC, The Role of Families in the Development, Identification, Prevention and Treatment of Illicit Drug Problems. 2001, Commonwealth of Australia.

National Drug Strategy Monograph Series, ed. R.P.J. Mattich, T. Vol. No.20. An outline for the managements of alcohol problems: quality assurance project. 1993, Canberra.

O; Brien, C., et al., Developing and evaluating new treatments for alcoholism and cocaine dependence. Recent Developments in Alcoholism, 1992. 10: p. 303 - 325.

O'Brien, C., & McLellan, A. (1996). Myths about the treatment of addiction. Lancet, 347 (January 27), 237-240.

Project MATCH Research Group, Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. Journal of Studies on Alcohol, 1997. 58: p. 7-29.

Raven. A narrative approach to alcohol and other drug problems. in Alcohol, Drugs and the Family: APSAD National Conferences. 1994. Melbourne: Australian Drug Foundation.

Robbins, S.P., Waters-Marsh, T., Cacioppe, R., & Millett, B. (1994). Organisational behaviour: Concepts, controversies and applications. Sydney: Prentice Hall.

Rotgers, F., Behavioural theory of of substance abuse treatment: Bringing science to bear on practice, in Treating substance abuse: Theory and technique, F. Rotgers, D.S. Keller, and J. Morgenstern, Editors. 1996: New York, USA.

Rydell, C., & Everingham, S. (1994). Controlling cocaine-supply versus demand programs.

Siegal, A., et al., The role of case management in retaining clients in substance abuse treatment: An exploratory analysis. Journal of Drug Issues, 1997. 27(4): p. 821-831.

Simpson, D., & Sells, S. (1982). Effectiveness of treatment for drug abuse: An overview of the D.A.R.P.research program. Advances in Alcohol and Substance Abuse, 2(1), 7-29.

Skinner, H. (1988). A model for the assessment of alcohol use and related problems. Drugs and Society, 2(2),19-30.

Sobell, L.C., Cunningham, J.A., & Sobell, M.B. (1996). Recovery from alcohol problems with and without treatment: Prevalence in two population surveys. American Journal of Public Health, 86(7), 966-972.

SuccessWorks, Involving families in alcohol and drug treatment. 2000, Department of Human Services: Drug and Health Protection Services, Public Health Division: Victoria.

Weinstein, A., et al., Imagery craving in opiate addicts undergoing detoxification. Drug and Alcohol Dependence, 1997. 48: p. 25-31.

Wubbolding, R.E., Reality Therapy for the 21st Century. 2000, USA: Brunner Routledge.

Ziguras, S. and S. G.M., Meta -Analysis of the Effectiveness of Mental Health Case Management over 10 years. Psychiatric Services, 2000. 51: p. 1410-21.