



The Academy for  
Addiction Professionals

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# Client, Family and Community Education

## Introduction

### Definition

The process of providing clients, families, significant others, and community groups with information on risks related to psychoactive substance use, as well as available prevention, treatment, and recovery resources.

*Instructor Note: For you, the student and future professional addiction counselor you will need all of this information to educate your clients and their families as it is those same families that form communities. One of the most important things we can do to serve others is educate, as we know education is one of the single most effective ways to prevent substance abuse. Remember...as always...keep an open mind, prevention and intervention work.*

### Overview

**Drug addiction is a complex illness** characterized by intense and, at times, uncontrollable drug craving, along with compulsive drug seeking and use that persist even in the face of devastating consequences. While the path to drug addiction begins with the voluntary act of taking drugs, over time a person's ability to choose not to do so becomes compromised, and seeking and consuming the drug becomes compulsive. This behavior results largely from the effects of prolonged drug exposure on brain functioning. Addiction is a brain disease that affects multiple brain circuits, including those involved in reward and motivation, learning and memory, and inhibitory control over behavior.

Because drug abuse and addiction have so many dimensions and disrupt so many aspects of an individual's life, treatment is not simple. Effective treatment programs typically incorporate many components, each directed to a particular aspect of the illness and its consequences. Addiction treatment must help the individual stop using drugs, maintain a drug-free lifestyle, and achieve productive functioning in the family, at work, and in society. Because addiction is typically a chronic disease, people cannot simply stop using drugs for a few days and be cured. Most patients require long-term or repeated episodes of care to achieve the ultimate goal of sustained abstinence and recovery of their lives.



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**Too often, addiction goes untreated:** According to SAMHSA's National Survey on Drug Use and Health (NSDUH), 23.2 million persons (9.4 percent of the U.S. population) aged 12 or older needed treatment for an illicit drug or alcohol use problem in 2007. Of these individuals, 2.4 million (10.4 percent of those who needed treatment) received treatment at a specialty facility (i.e., hospital, drug or alcohol rehabilitation or mental health center). Thus, 20.8 million persons (8.4 percent of the population aged 12 or older) needed treatment for an illicit drug or alcohol use problem but did not receive it. These estimates are similar to those in previous years.

### **Why Is Substance Abuse Important?**

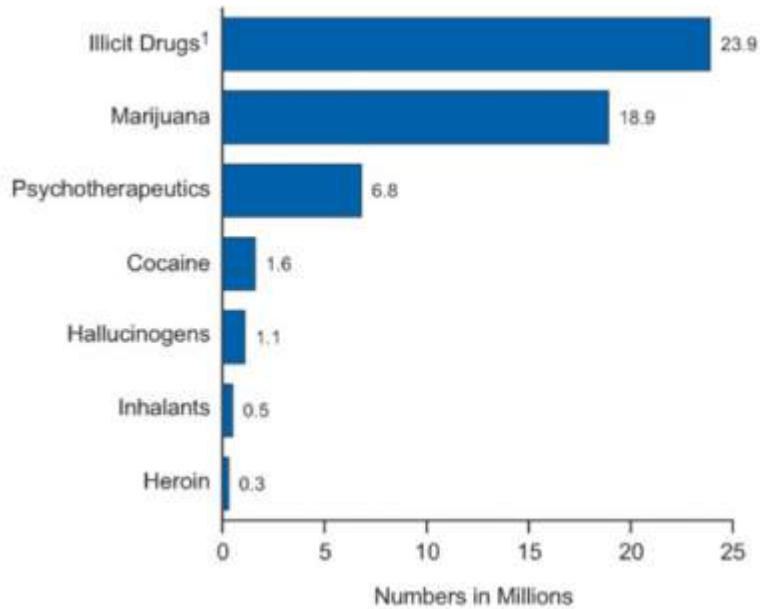
Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include:

- + Teenage pregnancy
- + Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- + Other sexually transmitted diseases (STDs)
- + Domestic violence
- + Child abuse
- + Motor vehicle crashes
- + Physical fights
- + Crime
- + Homicide
- + Suicide

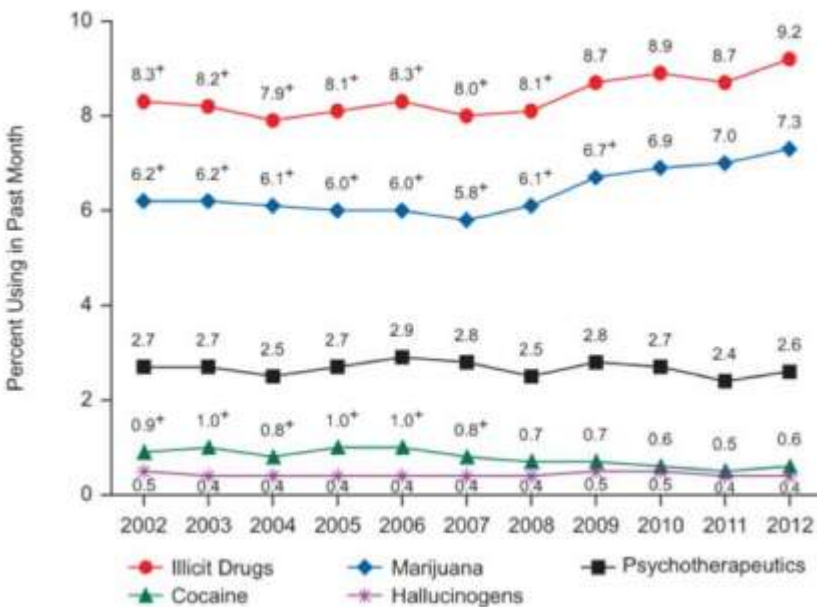
### **Illicit Drug Use – Recent Research**

**Illicit drug use in America has been increasing.** In 2012, an estimated 23.9 million Americans aged 12 or older—or 9.2 percent of the population—had used an illicit drug or abused a psychotherapeutic medication (such as a pain reliever, stimulant, or tranquilizer) in the past month. This is up from 8.3 percent in 2002. The increase mostly reflects a recent rise in the use of marijuana, the most commonly used illicit drug.

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**Marijuana use has increased since 2007.** In 2012, there were 18.9 million current (past-month) users—about 7.3 percent of people aged 12 or older—up from 14.4 million (5.8 percent) in 2007.

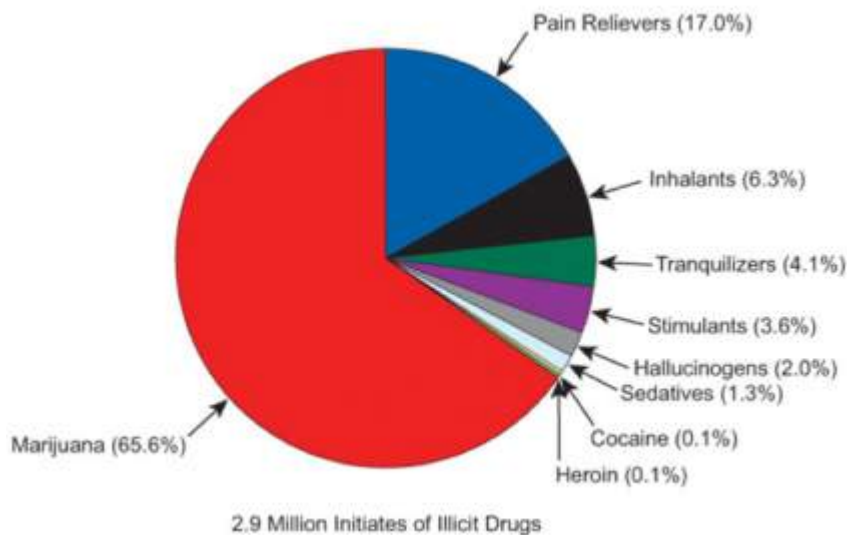


**Use of most drugs other than marijuana has not changed appreciably over the past decade or has declined.** In 2012, 6.8 million Americans aged 12 or older (or 2.6 percent) had used psychotherapeutic prescription drugs non-medically (without a prescription or in a manner or for a purpose not prescribed) in the past month. And 1.1 million Americans (0.4 percent) had used hallucinogens (a category that includes Ecstasy and LSD) in the past month.

Cocaine use has gone down in the last few years; from 2007 to 2012, the number of current users aged 12 or older dropped from 2.1 million to 1.7 million. Methamphetamine use has remained steady, from 530,000 current users in 2007 to 440,000 in 2012.

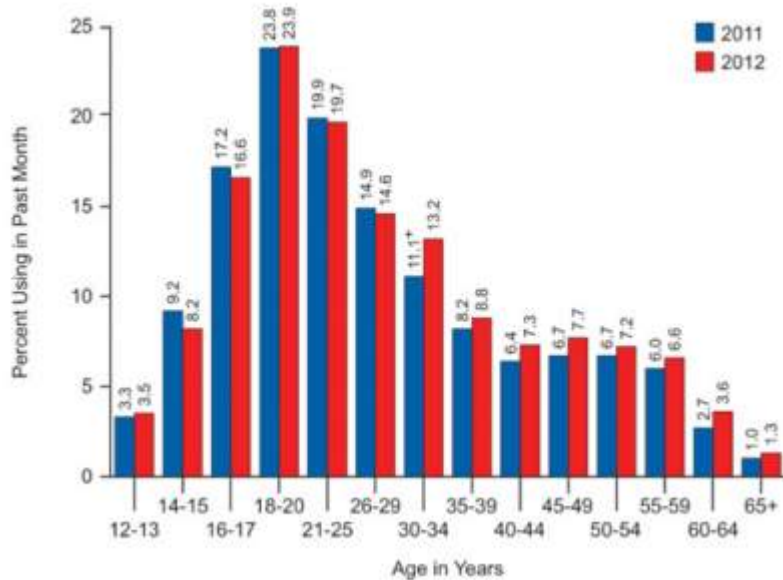
**Most people use drugs for the first time when they are teenagers.** There were just over 2.8 million new users (initiates) of illicit drugs in 2012, or about 7,898 new users per day. Half (52 per-cent) were under 18.

**More than half of new illicit drug users begin with marijuana.** Next most common are prescription pain relievers, followed by inhalants (which is most common among younger teens).

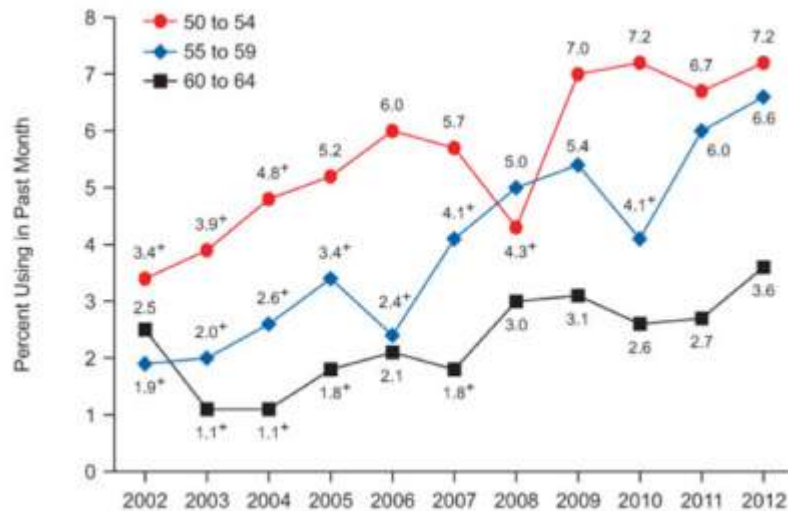


**Drug use is highest among people in their late teens and twenties.** In 2012, 23.9 percent of 18- to 20-year-olds reported using an illicit drug in the past month.

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**Drug use is increasing among people in their fifties.** This is, at least in part, due to the aging of the baby boomers, whose rates of illicit drug use have historically been higher than those of previous cohorts.



## Alcohol



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**Drinking by underage persons (ages 12–20) has declined.** Current alcohol use by this age group declined from 28.8 to 24.3 percent between 2002 and 2012, while binge drinking declined from 19.3 to 15.3 percent and the rate of heavy drinking went from 6.2 to 4.3 percent.

**Binge and heavy drinking are more prevalent among men than among women.** In 2012, 30.4 percent of men 12 and older and 16.0 percent of women reported binge drinking (five or more drinks on the same occasion) in the past month; and 9.9 percent of men and 3.4 percent of women reported heavy alcohol use (binge drinking on at least five separate days in the past month).

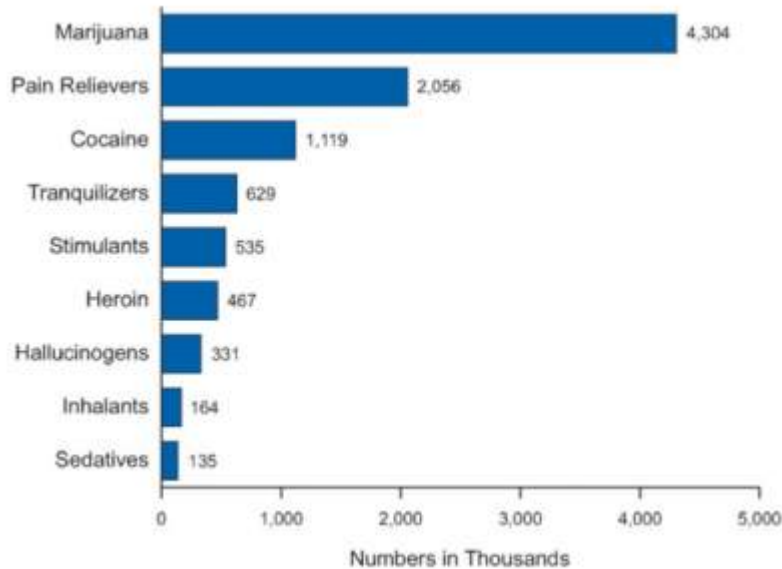
**Driving under the influence of alcohol has also declined slightly.** In 2012, an estimated 29.1 million people, or 11.2 percent of persons aged 12 or older, had driven under the influence of alcohol at least once in the past year, down from 14.2 percent in 2002. Although this decline is encouraging, any driving under the influence remains a cause for concern.

### **Substance Dependence/Abuse and Treatment**

**Rates of alcohol dependence/abuse declined from 2002 to 2012** In 2012, 17.7 million Americans (6.8 percent of the population) were dependent on alcohol or had problems related to their use of alcohol (abuse). This is a decline from 18.1 million (or 7.7 percent) in 2002.

**After alcohol, marijuana has the highest rate of dependence or abuse among all drugs.** In 2012, 4.3 million Americans met clinical criteria for dependence or abuse of marijuana in the past year—more than twice the number for dependence/abuse of prescription pain relievers (2.1 million) and four times the number for dependence/abuse of cocaine.

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**There continues to be a large “treatment gap” in this country.** In 2012, an estimated 23.1 million Americans (8.9 percent) needed treatment for a problem related to drugs or alcohol, but only about 2.5 million people (1 percent) received treatment at a specialty facility.

***\*\*Note that the terms dependence and abuse as used in the NSDUH are based on diagnostic categories used in the Fourth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV); in the newly published Fifth Edition (DSM-V), those categories have been replaced by a single Substance Use Disorder spectrum.***

# Signs and Symptoms of Addiction

## Chapter 1

*TAP 21 Competency: Describe warning signs, symptoms, and the course of substance use disorders.*

*Instructor Note: Before going headlong into this chapter let's review what we are looking for when attempting to determine whether an individual is indulging in risky substance use or has progressed to substance abuse. This chapter will provide the basics in identifying the signs & symptoms of drug abuse as well as defining prevention and intervention philosophies and proven benefits.*

### **Warning Signs and Symptoms of Substance Abuse**

Some people are able to use recreational or prescription drugs without ever experiencing negative consequences or addiction. For many others, substance use can cause problems at work, home, school, and in relationships.

Learning about the nature of drug abuse and addiction—how it develops, what it looks like, and why it can have such a powerful hold gives us a better understanding of the problem. If we are going to act as educators to our clients, their families and the community we need to understand the core process of addiction and the varied and multiple levels of care and support available.

#### **Physical warning signs of drug abuse**

- ✚ Bloodshot eyes, pupils larger or smaller than usual
- ✚ Changes in appetite or sleep patterns. Sudden weight loss or weight gain
- ✚ Deterioration of physical appearance, personal grooming habits
- ✚ Unusual smells on breath, body, or clothing
- ✚ Tremors, slurred speech, or impaired coordination

#### **Behavioral signs of drug abuse**

- ✚ Drop in attendance and performance at work or school
- ✚ Unexplained need for money or financial problems. May borrow or steal to get it.
- ✚ Engaging in secretive or suspicious behaviors
- ✚ Sudden change in friends, favorite hangouts, and hobbies
- ✚ Frequently getting into trouble (fights, accidents, illegal activities)



### Psychological warning signs of drug abuse

- + Unexplained change in personality or attitude
- + Sudden mood swings, irritability, or angry outbursts
- + Periods of unusual hyperactivity, agitation, or giddiness
- + Lack of motivation; appears lethargic or “spaced out”
- + Appears fearful, anxious, or paranoid, with no reason

### Warning signs of teen drug abuse

While experimenting with drugs doesn’t automatically lead to drug abuse, early use is a risk factor for developing more serious drug abuse and addiction. Risk of drug abuse also increases greatly during times of transition, such as changing schools, moving, or divorce. The challenge for parents is to distinguish between the normal, often volatile, ups and downs of the teen years and the red flags of substance abuse. These include:

- + Having bloodshot eyes or dilated pupils; using eye drops to try to mask these signs
- + Skipping class; declining grades; suddenly getting into trouble at school
- + Missing money, valuables, or prescriptions
- + Acting uncharacteristically isolated, withdrawn, angry, or depressed
- + Dropping one group of friends for another; being secretive about the new peer group
- + Loss of interest in old hobbies; lying about new interests and activities
- + Demanding more privacy; locking doors; avoiding eye contact; sneaking around

### Signs and symptoms of Drug Dependence:

Drug dependence involves all the symptoms of drug abuse, but also involves another element: physical dependence.

- 1. Tolerance:** Tolerance means that, over time, you need more drugs to feel the same effects. Do they use more drugs now than they used before? Do they use more drugs than other people without showing obvious signs of intoxication?
- 2. Withdrawal:** As the effect of the drugs wear off, the person may experience withdrawal symptoms: anxiety or jumpiness; shakiness or trembling; sweating, nausea and vomiting; insomnia; depression; irritability; fatigue or loss of appetite and headaches. Do they use drugs to steady the nerves, stop the shakes in the morning? Drug use to relieve or avoid withdrawal symptoms is a sign of addiction.

In severe cases, withdrawal from drugs can be life-threatening and involve hallucinations, confusion, seizures, fever, and agitation. These symptoms can be dangerous and should be managed by a physician specifically trained and experienced in dealing with addiction.

**3. Loss of Control:** Using more drugs than they wanted to, for longer than they intended, or despite telling themselves that they wouldn't do it this time.

**4. Desire to Stop, But Can't:** They have a persistent desire to cut down or stop their drug use, but all efforts to stop and stay stopped, have been unsuccessful.

**5. Neglecting Other Activities:** They are spending less time on activities that used to be important to them (hanging out with family and friends, exercising or going to the gym, pursuing hobbies or other interests) because of the use of drugs.

**6. Drugs Take Up Greater Time, Energy and Focus:** They spend a lot of time using drugs, thinking about it, or recovering from its effects. They have few, if any, interests, social or community involvements that don't revolve around the use of drugs.

**7. Continued Use despite Negative Consequences:** They continue to use drugs even though they know it's causing problems. As an example, person may realize that their drug use is interfering with ability to do their job, is damaging their marriage, making problems worse, or causing health problems, but they continue to use.

## Diagnostic and Statistical Manual of Mental Disorders (DSM)

### What is the DSM?

- DSM stands for Diagnostic and Statistical Manual for Mental Disorders. It is the manual published by the American Psychiatric Association which lists all classifications of mental disorders.
- The organizing concept of the DSM is to assign symptoms to the classification for which they are most relevant. For example, even if obsessive symptoms are frequently found with the manic/depressive symptoms of bipolar disorder, they would nevertheless be categorized with obsessive-compulsive disorder as they are more relevant to that category.
- Each classification contains threshold criteria for the symptoms it includes; that is, the length and/or severity which are needed for that symptom to qualify for the diagnosis.

In October of 2013 the DSM was updated and re-published as DSM – 5 from the previous DSM – IV. There are several changes in the DSM – 5 in several areas of mental disorders. One of the significant changes made is in the area of substance diagnoses.

The following is the highlights of the changes from the DSM-IV TR to the DSM – 5 as it relates to substance and addiction disorders.

### **Substance-Related and Addictive Disorders**

#### **Gambling Disorder**

An important departure from past diagnostic manuals is that the substance-related disorders chapter has been expanded to include gambling disorder. This change reflects the increasing and consistent evidence that some behaviors, such as gambling, activate the brain reward system with effects similar to those of drugs of abuse and that gambling disorder symptoms resemble substance use disorders to a certain extent.

#### **Criteria and Terminology**

##### **DSM-5 does not separate the diagnoses of substance abuse and dependence as in DSM-IV.**

Rather, **criteria are provided for substance use disorder**, accompanied by criteria for intoxication, withdrawal, substance/medication-induced disorders, and unspecified substance-induced disorders, where relevant.

The DSM-5 substance use disorder criteria are nearly identical to the DSM-IV substance abuse and dependence criteria combined into a single list, with two exceptions. The DSM-IV recurrent legal problems criterion for substance abuse has been deleted from DSM-5, and a new criterion, craving or a strong desire or urge to use a substance, has been added. In addition, the threshold for substance use disorder diagnosis in DSM-5 is set at two or more criteria, in contrast to a threshold of one or more criteria for a diagnosis of DSM-IV substance abuse and three or more for DSM-IV substance dependence. Cannabis withdrawal is new for DSM-5, as is caffeine withdrawal (which was in DSM-IV Appendix B, “Criteria Sets and Axes Provided for Further Study”). Of note, the criteria for DSM-5 tobacco use disorder are the same as those for other substance use disorders. By contrast, DSM-IV did not have a category for tobacco abuse, so the criteria in DSM-5 that are from DSM-IV abuse are new for tobacco in DSM-5.

Severity of the DSM-5 substance use disorders is based on the number of criteria endorsed: 2–3 criteria indicate a mild disorder; 4–5 criteria, a moderate disorder; and 6 or more, a severe

disorder. The DSMIV specifier for a physiological subtype has been eliminated in DSM-5, as has the DSM-IV diagnosis of polysubstance dependence.

Early remission from a DSM-5 substance use disorder is defined as at least 3 but less than 12 months without substance use disorder criteria (except craving), and sustained remission is defined as at least 12 months without criteria (except craving). Additional new DSM-5 specifiers include “in a controlled environment” and “on maintenance therapy” as the situation warrants.

### Changes Simplified and an Example

#### Alcohol Use Disorder: A Comparison between DSM–IV and DSM–5

In May 2013, the American Psychiatric Association issued the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM–5). Although there is considerable overlap between DSM–5 and DSM–IV, the prior edition, there are several important differences:

#### Changes Disorder Terminology

- ✚ DSM–IV described two distinct disorders, alcohol abuse and alcohol dependence, with specific criteria for each.
- ✚ DSM–5 integrates the two DSM–IV disorders, alcohol abuse and alcohol dependence, into a single disorder called **alcohol use disorder (AUD) with mild, moderate, and severe** sub-classifications.

#### Changes Diagnostic Thresholds

- ✚ Under DSM–IV, the diagnostic criteria for abuse and dependence were distinct: anyone meeting one or more of the “abuse” criteria (see items 1 through 4) within a 12-month period would receive the “abuse” diagnosis. Anyone with three or more of the “dependence” criteria (see items 5 through 11) during the same 12-month period would receive a “dependence” diagnosis.
- ✚ Under DSM–5, anyone meeting any two of the 11 criteria during the same 12-month period would receive a diagnosis of AUD. The severity of an AUD—mild, moderate, or severe—is based on the number of criteria met.

#### Removes Criterion

- ✚ DSM–5 eliminates legal problems as a criterion.

### Adds Criterion

- ✚ DSM–5 adds craving as a criterion for an AUD diagnosis. It was not included in DSM–IV.

### Revises Some Descriptions

- ✚ DSM–5 modifies some of the criteria descriptions with updated language.

*Instructor Note: So by now you are asking “why do I, the addiction professional counselor need to know about this book? Isn’t it for psychologists or psychiatrists only?” The short answer is NO, it is not. While the addiction counselor will not use this manual with the frequency of a professional working in mental health settings but you will need to use it with every client.*

*The addiction clinician will use this book to determine if a client meets the criteria for a substance diagnosis- which means treatment yes or treatment no. This is necessary to admit clients to treatment, to obtain approval from insurance companies and to help determine what level of care the client needs.*

*For almost of every drug you can think of there will be matching DSM 5 diagnostic criteria and correlating code.*

*For example:*

*Alcohol Use Disorder*

*Cocaine Use Disorder*

*Opiate Use Disorder*

*Stimulant Use Disorder*

*Cannabis Use Disorder*

*All require a specifier to go with the diagnosis – Mild, Moderate or Severe.*

**DSM – IV**

**DSM - 5**

Any 1 of #'s 1 -3 = Alcohol Abuse	Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to alcohol use; alcohol-related absences, suspensions, or expulsions from school; neglect of children or household.	1	Alcohol is often taken in larger amounts or over a longer period than was intended. (See DSM- IV, criterion 7.)
	Recurrent alcohol use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by alcohol abuse).	2	There is a persistent desire or unsuccessful efforts to cut down or control alcohol use. (See DSM-IV, criterion 8.)
	Recurrent alcohol-related legal problems (e.g., arrests for alcohol-related disorderly conduct).  **This is not included in DSM-5**	3	A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects. (See DSM-IV, criterion 9.)
	Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the alcohol (e.g., arguments with spouse about the consequences of intoxication, physical fights)	4	Craving, or a strong desire or urge to use alcohol.  **This is new to DSM-5**
Plus Any 3 of #'s 5 - 11 = Alcohol Dependence	Tolerance, as defined by either of the following:  a) A need for markedly increased amounts of alcohol to achieve intoxication or desired effect  b) Markedly diminished effect with continued use of the same amount of alcohol	5	Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home. (See DSM-IV, criterion 1.)
	Withdrawal, as manifested by either of the following:  a) The characteristic withdrawal syndrome for alcohol  b) Alcohol is taken to relieve or avoid withdrawal symptoms	6	Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol. (See DSM-IV, criterion 4.)

	Alcohol is often taken in larger amounts or over a longer period than was intended.	7	Important social, occupational, or recreational activities are given up or reduced because of alcohol use. (See DSM–IV, criterion 10.)
	There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.	8	Recurrent alcohol use in situations in which it is physically hazardous. (See DSM–IV, criterion 2.)
	A great deal of time is spent in activities necessary to obtain alcohol (e.g., driving long distances), use alcohol, or recover from its effects.	9	Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol. (See DSM–IV, criterion 11.)
	Important social, occupational, or recreational activities are given up or reduced because of alcohol use.	10	Tolerance, as defined by either of the following: a) A need for markedly increased amounts of alcohol to achieve intoxication or desired effect b) A markedly diminished effect with continued use of the same amount of alcohol (See DSM–IV, criterion 5.)
	Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., continued drinking despite recognition that an ulcer was made worse by alcohol consumption).	11	Withdrawal, as manifested by either of the following: a) The characteristic withdrawal syndrome for alcohol (refer to criteria A and B of the criteria set for alcohol withdrawal) b) Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms. (See DSM–IV, criterion 6.)

DSM 5 - The presence of at least 2 of these symptoms indicates an Alcohol Use Disorder (AUD).

The severity of the AUD is defined as:

Mild: The presence of 2 to 3 symptoms

Moderate: The presence of 4 to 5 symptoms

Severe: The presence of 6 or more symptoms

## Prevention Model -

# The Role of Risk and Protective Factors

## Chapter 2

*TAP 21 Competency: Describe factors that increase the likelihood for an individual, community, or group to be at risk for, or resilient to, psychoactive substance use disorders.*

*Instructor Note: The information here is really important in helping new addiction counselors look beyond the individual that is sitting in front of them. By that I mean no one exists in a bubble and all too often counselors develop tunnel vision, neglecting/refusing to see that the family, community and environment of our clients all play an important role in determining substance use and other high risk behaviors. We need to open our minds, especially during clinical assessments, to see and incorporate the big picture that is the client's life.*

### Risk and Protective Factors Exist in Multiple Contexts

Individuals come to the table with **biological and psychological characteristics** that make them vulnerable to, or resilient in the face of, potential behavioral health problems. Individual-level risk factors include genetic predisposition to addiction or exposure to alcohol prenatally; protective factors might include positive self-image, self-control, or social competence.

But individuals don't exist in isolation. They are part of families, part of communities, and part of society. A variety of risk and protective factors exist within each of these contexts.

For example:

- ✚ In **families**, risk factors include parents who use drugs and alcohol or who suffer from mental illness, child abuse and maltreatment, and inadequate supervision; a protective factor would be parental involvement
- ✚ In **communities**, risk factors include neighborhood poverty and violence; protective factors might include the availability of faith-based resources and after-school activities
- ✚ In **society**, risk factors can include norms and laws favorable to substance use, as well as racism and a lack of economic opportunity; protective factors include policies limiting availability of substances or anti-hate laws defending marginalized populations, such as lesbian, gay, bisexual, or transgender youth



Practitioners must look across these contexts to address the array of factors that influence both individuals and populations: targeting just one context is unlikely to do the trick. For example, a strong school policy forbidding alcohol use on school grounds will likely have little impact on underage drinking in a community where parents accept underage drinking as a rite of passage or where alcohol vendors are willing to sell to young adults. A more effective—and comprehensive—approach might include school policy plus education for parents on the dangers of underage drinking, or a city ordinance that requires alcohol sellers to participate in responsible server training.

### **Epidemiology and Prevention**

Epidemiology is the study of the distribution and determinants of the health and wellness of populations. In the substance abuse prevention field, epidemiologists study the patterns of use and abuse and the factors associated with an increased or decreased risk of developing substance abuse problems. In substance abuse prevention, epidemiologists are concerned with two big questions:

1. What are the nature, extent, and pattern of substance use behaviors and their associated consequences?
2. What risk and protective factors influence the substance abuse behaviors?

### **Prevention Approaches**

Some substance abuse prevention interventions are designed to help individuals develop the intentions and skills to act in a healthy manner. Others focus on creating an environment that supports healthy behavior. Research tells us that the most effective prevention interventions are those that incorporate both these approaches.

### **Individual-level Strategies**

Many prevention approaches focus on helping people develop the knowledge, attitudes, and skills they need to change their behavior. Most of these strategies are classroom-based. A comprehensive review of classroom-based programs yielded these conclusions about effective programs:

- ✚ Programs that focus on life and social skills are most effective.
- ✚ Programs that involve interactions among participants and encourage them to learn drug refusal skills are more effective than non-interactive programs.





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- ✚ Interventions that focus on direct and indirect (e.g., media) influences on substance use appear to be more effective than interventions that do not focus on social influences.
- ✚ Programs that emphasize norms for and a social commitment to not using drugs are superior to those without this emphasis.
- ✚ Adding community components to school-based programs appears to add to their effectiveness.
- ✚ Programs delivered primarily by peer leaders have increased effectiveness.
- ✚ Adding training in life skills to trainings that focus on social resistance skills may increase program effectiveness.

### **Communication and Education**

The media plays a large role in shaping how many youth think and behave. Many of the messages kids receive from television, music, magazines, billboards, and the Internet glamorize drug, alcohol, and tobacco use. Yet, the media can be used to encourage positive behaviors as well. Four communications strategies—public education, social marketing, media advocacy, and media literacy—can be used to influence community norms, increase public awareness, and attract community support for a variety of prevention issues. These strategies are most effective when coupled with more potent prevention approaches, like policy, enforcement, education, and skill building.

RISK FACTORS	PROTECTIVE FACTORS
<ul style="list-style-type: none"> <li>Chaotic home environment</li> <li>Ineffective parenting</li> <li>Little mutual attachment and nurturing</li> <li>Inappropriate, shy, or aggressive classroom behavior</li> <li>Academic failure</li> <li>Low academic aspirations</li> <li>Poor social coping skills</li> <li>Affiliations with deviant peers</li> <li>Perceived external approval of drug use (peer, family, community)</li> <li>Parental substance abuse or mental illness</li> </ul> 	<ul style="list-style-type: none"> <li>Strong family bonds</li> <li>Parental engagement in child's life</li> <li>Clear parental expectations and consequences</li> <li>Academic success</li> <li>Strong bonds with pro-social institutions (school, community, church)</li> <li>Conventional norms about drugs and alcohol</li> </ul> 

SOURCE: US Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse, (1997) Preventing drug use among children and adolescents: A research-based guide. NIH Publication No. 97 - 4212.

## **Risk Factors and Protective Factors - Prevention Principles**

**PRINCIPLE 1** - Prevention programs should enhance protective factors and reverse or reduce risk factors.

- ✚ The risk of becoming a drug abuser involves the relationship among the number and type of risk factors (e.g., deviant attitudes and behaviors) and protective factors (e.g., parental support).
- ✚ The potential impact of specific risk and protective factors changes with age. For example, risk factors within the family have greater impact on a younger child, while association with drug-abusing peers may be a more significant risk factor for an adolescent.

- ✚ Early intervention with risk factors (e.g., aggressive behavior and poor self-control) often has a greater impact than later intervention by changing a child's life path (trajectory) away from problems and toward positive behaviors.
- ✚ While risk and protective factors can affect people of all groups, these factors can have a different effect depending on a person's age, gender, ethnicity, culture, and environment.

**PRINCIPLE 2** - Prevention programs should address all forms of drug abuse, alone or in combination, including the underage use of legal drugs (e.g., tobacco or alcohol); the use of illegal drugs (e.g., marijuana or heroin); and the inappropriate use of legally obtained substances (e.g., inhalants), prescription medications, or over-the-counter drugs.

**PRINCIPLE 3** - Prevention programs should address the type of drug abuse problem in the local community, target modifiable risk factors, and strengthen identified protective factors.

**PRINCIPLE 4** - Prevention programs should be tailored to address risks specific to population or audience characteristics, such as age, gender, and ethnicity, to improve program effectiveness.

## **Prevention Planning**

### **Family Programs**

**PRINCIPLE 5** - Family-based prevention programs should enhance family bonding and relationships and include parenting skills; practice in developing, discussing, and enforcing family policies on substance abuse; and training in drug education and information.<sup>2</sup> Family bonding is the bedrock of the relationship between parents and children. Bonding can be strengthened through skills training on parent supportiveness of children, parent-child communication, and parental involvement.

- ✚ Parental monitoring and supervision are critical for drug abuse prevention. These skills can be enhanced with training on rule-setting; techniques for monitoring activities; praise for appropriate behavior; and moderate, consistent discipline that enforces defined family rules.

- ✚ Drug education and information for parents or caregivers reinforces what children are learning about the harmful effects of drugs and opens opportunities for family discussions about the abuse of legal and illegal substances.
- ✚ Brief, family-focused interventions for the general population can positively change specific parenting behavior that can reduce later risks of drug abuse.

### School Programs

**PRINCIPLE 6** - Prevention programs can be designed to intervene as early as preschool to address risk factors for drug abuse, such as aggressive behavior, poor social skills, and academic difficulties.

**PRINCIPLE 7** - Prevention programs for elementary school children should target improving academic and social-emotional learning to address risk factors for drug abuse, such as early aggression, academic failure, and school dropout. Education should focus on the following skills:

- ✚ self-control;
- ✚ emotional awareness;
- ✚ communication;
- ✚ social problem-solving; and
- ✚ academic support, especially in reading

**PRINCIPLE 8** - Prevention programs for middle or junior high and high school students should increase academic and social competence with the following skills:

- ✚ study habits and academic support;
- ✚ communication;
- ✚ peer relationships;
- ✚ self-efficacy and assertiveness;
- ✚ drug resistance skills;
- ✚ reinforcement of anti-drug attitudes; and
- ✚ strengthening of personal commitments against drug abuse.



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## **Community Programs**

**PRINCIPLE 9** - Prevention programs aimed at general populations at key transition points, such as the transition to middle school, can produce beneficial effects even among high-risk families and children. Such interventions do not single out risk populations and, therefore, reduce labeling and promote bonding to school and community.

**PRINCIPLE 10** - Community prevention programs that combine two or more effective programs, such as family-based and school-based programs, can be more effective than a single program alone.

**PRINCIPLE 11** - Community prevention programs reaching populations in multiple settings—for example, schools, clubs, faith-based organizations, and the media—are most effective when they present consistent, community-wide messages in each setting.

## **Prevention Program Delivery**

**PRINCIPLE 12** - When communities adapt programs to match their needs, community norms, or differing cultural requirements, they should retain core elements of the original research-based intervention<sup>27</sup> which include:

- ✚ Structure (how the program is organized and constructed);
- ✚ Content (the information, skills, and strategies of the program); and
- ✚ Delivery (how the program is adapted, implemented, and evaluated).

**PRINCIPLE 13** - Prevention programs should be long-term with repeated interventions (i.e., booster programs) to reinforce the original prevention goals. Research shows that the benefits from middle school prevention programs diminish without follow-up programs in high school.

**PRINCIPLE 14** - Prevention programs should include teacher training on good classroom management practices, such as rewarding appropriate student behavior. Such techniques help to foster students' positive behavior, achievement, academic motivation, and school bonding.



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**PRINCIPLE 15** - Prevention programs are most effective when they employ interactive techniques, such as peer discussion groups and parent role-playing, that allow for active involvement in learning about drug abuse and reinforcing skills.

**PRINCIPLE 16** - Research-based prevention programs can be cost-effective. Similar to earlier research, recent research shows that for each dollar invested in prevention, a savings of up to \$10 in treatment for alcohol or other substance abuse can be seen.

*Instructor Note: So, as you can see the best chance a society, a community, a family or an individual has in nipping addiction in the bud is prevention, just like in any other disease. The take-away is that in order for prevention services to work optimally looking at risk factors in schools, families, mental health issues, developmental issues, as they relate to the individual at risk ensures that interventions meet the needs of that individual. In a way discharge planning, after a person has completed substance abuse treatment, requires the same planning efforts. After all we, addiction counselors are trying to assist our clients in maintaining the sobriety they have just achieved. To do that we must look at risk & protective factors and look at the areas of that person's life where they need help, education and support. Keep looking at the WHOLE person, not just the addiction piece, if you do that you will help that person on their road to wellness and recovery.*

## Continuum of Care

### Chapter 3

*TAP 21 Competency: Describe the continuum of care and resources available to the family and concerned others.*

#### **Overview of Continuum of Care**

“Continuum of care” refers to a treatment system in which clients enter treatment at a level appropriate to their needs and then step up to more intense treatment or down to less intense treatment as needed. As outlined by [Mee-Lee and Shulman \(2003\)](#), an effective continuum of care features successful transfer of the client between levels of care, similar treatment philosophy across levels of care, and efficient transfer of client records. The American Society of Addiction Medicine (ASAM) has established five main levels in a continuum of care for substance abuse treatment:

- Level 0.5: Early intervention services
- Level I: Outpatient services
- Level II: Intensive outpatient/Partial hospitalization services (Level II is subdivided into levels II.1 and II.5)
- Level III: Residential/Inpatient services (Level III is subdivided into levels III.1, III.3, III.5, and III.7)
- Level IV: Medically managed intensive inpatient services

These levels should be thought of not as discrete levels of care but rather as points in a continuum of treatment services ([Mee-Lee and Shulman 2003](#)).

#### **Conceiving a Continuum of Care**

To reinforce the idea of a continuum of care, [Mee-Lee and Shulman \(2003\)](#) suggest that clinicians and administrators “envision admitting the client into the continuum *through* their program rather than admitting the client *to* their program” (p. 456). This early focus on moving the client along the continuum also prompts clinicians to look ahead to the next step in a





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client's treatment. This, in turn, helps clinicians engage in the treatment planning that is integral not only to the client's ongoing care but also to the transition from one level of treatment to the next.

### **Transfer to Continuing Community Care**

Having completed their last phase of outpatient type treatment, clients are discharged from formal treatment to continuing community care. Clients who remain within a system of ongoing care relevant to their needs are more likely to maintain their gains in abstinence and overall lifestyle changes. Participation in continuing community care is related to an increase in positive outcomes ([Miller et al. 1997](#); [Ritsher et al. 2002](#)). Continuing care planning is therefore a central task for IOP/OP program staff whose clients remain in stepdown care within the program. IOP programs that refer clients to separate programs for a stepdown level of care must ensure, through their referral agreements and procedures, that the outpatient treatment program agrees to engage in continuing care planning.

Continuing community care in the form of 12-Step support groups, faith fellowship, or other community-based organizations is sometimes neglected by treatment providers because of the difficulties of remaining engaged with clients after formal treatment is completed. Still, the benefits of carefully planning for transferring clients into community support groups are such that added attention should be given to these tasks. To ensure client access to a full continuum of care, treatment programs need to be aware of support groups and other community resources and introduce this information to clients early in the treatment process. Other key responsibilities for providers include ensuring transition of case management responsibilities, supporting clients' early engagement in continuing community care, contributing to the expansion of community services, and encouraging clients who drop out to reengage with treatment.

### **Continuing Community Care**

Continuing community care following IOP and step down care is essential for all substance abuse clients, especially for those who may have other long-term psychiatric, social, or medical issues. The process of rebuilding a healthy, productive, and stable life takes years, and maintaining gains made over time may require continuous support for some individuals.

Once the client maintains abstinence and has begun to address other serious problems that could threaten recovery, the client can be discharged into continuing community care. Community

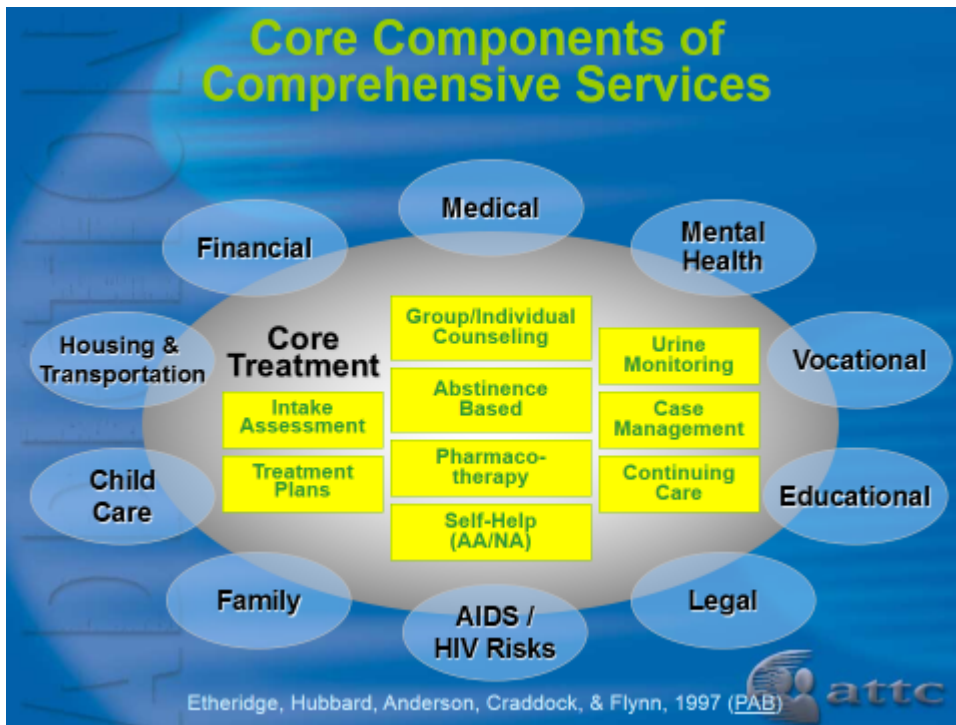
support consists of the client's participating in 12-Step or other mutual-help groups and meeting with psychologists, case managers, or staff from community-based agencies, with limited support and involvement from the treatment program.

### Services in Continuing Community Care

As part of continuing care services, programs can sponsor alumni meetings and provide booster or checkup counseling sessions at the IOP or outpatient treatment facility. Periodic telephone contact also may be valuable (McKay et al. 2005). Other aspects of continuing care include involvement with selected community resources as needed, such as vocational training, recreational therapy, family therapy, or medical care.

**Community Support - Goals and duration** - This stage is based on a detailed and individualized discharge plan for continuing recovery in the community using available resources.

The chart below reflects the comprehensive services needed to help individuals, families and significant others to obtain and maintain recovery.





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*Instructor Note: This is a “no-brainer” – a person’s need for continued help and support does not end just because they have successfully completed rehab, residential, IOP and/or OP. Being back out in the community can be terrifying to some, anxiety provoking and confusing. The continuum of care helps address the confusion, anxiety, fear, doubt and all the other emotions that can contribute to relapse.*

# Community Education, Awareness & Impact

## Chapter 4

### **Overview**

A significant portion of this course relates to learning about and understanding the impact of substance abuse on communities. The information provided in this chapter will look at some statistics to give you an actual idea of how many people and it what ways substance abuse impacts communities. Also included is information on prevention and intervention and their proven positive impact on individuals, families and communities as whole.

The goal of both prevention and intervention is to reduce substance abuse to protect the health, safety, and quality of life for all, especially children.

### **Impact of Substance Abuse on Communities**

Drug abuse is a major public health problem that impacts society on multiple levels. Directly or indirectly, every community is affected by drug abuse and addiction, as is every family. Drugs take a tremendous toll on our society at many levels.

This includes health care expenditures, lost earnings, and costs associated with crime and accidents. This is an enormous burden that affects all of society - those who abuse these substances, and those who don't.

### **Drug Abuse is a Major Public Health Problem**

Americans Perceive Drug Abuse as a Major Public Health Problem

Many of America's top medical problems can be directly linked to drug abuse:

- **Cancer:** Tobacco contributes to 11-30% of cancer deaths.
- **Heart Disease:** Researchers have found a connection between the abuse of tobacco, cocaine, MDMA (ecstasy), amphetamines, and steroids and the development of cardiovascular diseases. Tobacco is responsible for approximately 30% of all heart disease deaths each year.



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- **HIV/AIDS:** Approximately one-third of AIDS cases reported in 2000 (11,635) and most cases of hepatitis C (approximately 25,000 in 2001) in the United States are associated with injection drug use.
- Approximately half of pediatric AIDS cases (4,700 reported through 2002) result from injection drug use or sex with injection drug users by the child's mother.

**Many of America's top community problems relate to or impact drug abuse:**

- **Drugged Driving:** The National Highway Traffic Safety Administration estimates that drugs are used by approximately 10 to 22 percent of drivers involved in crashes, often in combination with alcohol.
- **Violence:** At least half of the individuals arrested for major crimes including homicide, theft, and assault were under the influence of illicit drugs around the time of their arrest.
- **Stress:** Exposure to stress is one of the most powerful triggers of substance abuse in vulnerable individuals and of relapse in former addicts.
- **Child Abuse:** At least two-thirds of patients in drug abuse treatment centers say they were physically or sexually abused as children.

**Drug abuse impacts the individual, family, and community**

**Individual:**

- **Adolescence:** This is a time period of high vulnerability to drug abuse and other risk taking behaviors.
- **Mental Illness:** People with mental illness are particularly at risk for problems related to substance abuse.
- **Consequences of Substance Abuse:** These can include illness, injuries, and death. Each year approximately 40 million debilitating illnesses or injuries occur among Americans as the result of their use of tobacco, alcohol, or another addictive drug.
- **Deaths:** In 2000, approximately 460,000 deaths were attributable to illicit drug abuse and smoking.

**Families**

- **Prenatal:**
  - **Smoking:** Infants born to women who smoke during pregnancy have a lower average birth weight and may be at increased risk for attention deficit hyperactivity disorder, conduct disorders, and childhood obesity.



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- **Cocaine:** Babies born to mothers who abuse cocaine during pregnancy can be born prematurely and have low birth weights. There may be as many as 45,000 cocaine-exposed babies per year.
- **Child Abuse:** Approximately 50% to 80% of all child abuse and neglect cases substantiated by child protective services involve some degree of substance abuse by the child's parents.

### **Community:**

- **Homelessness:** 31% of America's homeless suffer from drug abuse or alcoholism.
- **Crime:** As many as 60% of adults in Federal prisons are there for drug-related crimes.
- **Education:** Children with prenatal cocaine exposure are more likely (1.5 times) to need special education services in school. Special education costs for this population are estimated at \$23 million per year.
- **The Workplace:** In 1997, illicit drug users were more likely than others to have missed 2 or more days of work in the past month and to have worked for three or more employers in the past year.

### **Prevention (more information)**

The primary goal of prevention is to delay the first use of alcohol or other drugs. Research indicates that adolescents who begin drinking before age 14 are significantly more likely to experience alcohol dependence at some point in their lives compared to individuals who begin drinking after 21 years of age. In addition, youth who drink alcohol are more likely to experience a number of negative consequences, such as physical or sexual assault, unintentional injuries, memory problems, legal problems, and impaired school performance. That's why delaying the age of first use of alcohol and drugs is a critical goal of prevention. However, other protective factors, especially proactive parenting and strong family bonds, can help delay adolescents' experimentation with drugs and alcohol and thus help reduce long-term problems.

Prevention works best when attention is given to multiple risk and protective factors. Such factors exist in many areas of an adolescent's life and common risk factors can predict many problems. Reducing one risk factor may result in reduction of multiple problems in the family, school, peer group, and/or community. Increasing protective factors supports healthy development in all life areas, which helps them to resist influences to use.

Research has identified seven key strategies shown to be effective in preventing and reducing substance abuse and related risky behaviors:

- ✚ Changes in public policies (laws and regulations)
- ✚ Rigorous enforcement of laws and regulations
- ✚ Collaboration among groups of citizens
- ✚ Communications to impact public perceptions about alcohol, tobacco, and drugs
- ✚ Education for both children and adults;
- ✚ Alternatives: activities, such as recreational programs, after-school, and weekend programs, community service activities, and tutoring and mentoring
- ✚ Early intervention—with pre-adolescents showing signs of antisocial behavior.

### Prevention Prepared Communities

A prevention prepared community is one where individuals, families, schools, faith-based organizations, workplaces, and communities take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide.

### Community Process: Strategic Prevention Framework (SPF)

- ✚ The recommended approach to support effective prevention in communities is the Strategic Prevention Framework (SPF), which identifies **five phases: assessment, capacity building, planning, implementation, and evaluation**. In addition, cultural competence and sustainability are identified as key aspects that cut across the five phases.
- ✚ Prevention programs should take into consideration the target audience, which may be described in three levels: universal (all populations), selective (populations at risk) and indicated (populations that have demonstrated early involvement with substance use). The type of prevention strategies used should vary across these audience types.
- ✚ Prevention programs need to understand their target audience in terms of risk factors and protective factors, which may be categorized in multiple domains: individual, family, school, and community.

### Risk Factors

- ✚ Risk factors are conditions that increase the likelihood that youth will get into trouble or expose themselves to danger.
- ✚ The greater the intensity or number of risk factors, the greater the likelihood that youth will engage in delinquent or other risky behaviors.

- ✚ Examples of risk factors are: inadequate life skills, low self-esteem, emotional or psychological problems, family conflict, a lack of bonding with the school environment, and association with delinquent peers.

### **Protective Factors**

- ✚ Protective factors are safeguards that promote resiliency and enhance a young person's ability to resist risks or hazards and make good decisions. Like risk factors, protective factors can exist in—and be addressed by—individuals, families, communities, and institutions.
- ✚ Examples of protective factors are: problem-solving skills, communication skills, a sense of self, positive parenting, bonding with a positive school environment, and association with peers who have a constructive influence.
- ✚ Exposure to protective factors helps young people make better decisions, confront obstacles, and find the supports they need. They may prevent, diminish, or counteract the effects of risk factors.
- ✚ Families and communities are keys to enhancing positive youth development when they provide strong parenting, good adult role models, and dependable sources of adult supervision, a strong sense of community, safe neighborhoods, and effective community-based and government services.

### **Perception of Risk (Consequences) and Its Relationship to Substance Use**

- ✚ Perception of risk of substance use is associated with use rates. Youth who perceived greater risk from substance use were less likely to engage in substance use.
- ✚ The most effective approach in getting youth to perceive risk in substance use is to engage in meaningful conversation that encourages the young person to reflect on the negative consequences of substance use.
- ✚ Research indicates that use of “scare tactics” or purely didactic delivery of information about substance use is minimally effective. However, focusing information dissemination on the consequences of substance use can increase perception of risk and have positive results.

### **Early Intervention: Bridging the Gap between Prevention and Treatment**





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This study examined a SAMHSA model program— ‘keepin it REAL’—that has been demonstrated to be effective in delaying initiation of substance use among middle school students. The focus here, however, was whether this universal prevention program is also effective in leading to reductions or cessation in substance use among middle school students who were already using substances prior to the delivery of the prevention program. Results indicated that participation in the program increased the odds of substance use cessation by 65 percent and of reduction in use by 73 percent.

Except for alcohol, the time windows for targeted intervention to prevent progression to malignant patterns in adolescence are critically small, leaving little time for targeted intervention to prevent transition. The fast transitions to abuse and dependence in adolescence may be indicative for the increased vulnerability to substance effects in this time period.

### **Intervention Services**

Activities that are sub-clinical or pre-treatment (ASAM .05) and designed to explore and address problems or risk factors that appear to be related to substance use, and/or to assist individuals in recognizing the harmful consequences or inappropriate substance use. ***Early Intervention services are for individual(s) whose problems and risk factors appear to be related to substance abuse but do not meet any diagnostic criteria for substance abuse related disorders.*** Such individuals are defined "at risk" and early intervention may be delivered in a wide variety of settings to at-risk adolescents or adults with the length of such service varying according to the type of activity. The ultimate goal is the reduction of the effects of substance abuse within the targeted community by identifying and engaging those in need of services.

Early intervention services are delivered in a variety of settings, including clinical offices, schools, work sites, community centers, or an individual's home.

Substance abuse treatment services and this early intervention component are delivered by community-based agencies who are under contract to DHS/Office of Alcoholism and Substance Abuse. Generally, these services are available locally in communities throughout states. This system enables clients to be assessed and treated as close to their home communities as possible, allows communities to take ownership of their programs, and facilitates public information. Treatment services are delivered through a ***continuum approach***, with individual clients moving from one level of care to another based on their assessed needs.

## **What's New in Prevention, Intervention and Treatment**




### **Evidence-Based Prevention Practice**

Evidence-based prevention refers to a set of prevention activities that evaluation research has shown to be effective. Some of these prevention activities help individuals develop the intentions and skills to act in a healthy manner. Others focus on creating an environment that supports healthy behavior.

### **Screening, Brief Intervention, and Referral to Treatment (SBIRT)**

SBIRT is a public health approach to the delivery of early intervention and treatment services for people with substance use disorders and those at risk of developing these disorders. Many different types of community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

#### About SBIRT

-  Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment.
-  Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
-  Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

SBIRT includes an early intervention approach that targets individuals with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive services.

### **SBIRT Consists of Three Major Components:**

Screening – a healthcare professional assess a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any healthcare setting.

Brief Intervention – a healthcare professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice.



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Referral to Treatment – a healthcare professional provides a referral to brief therapy or additional treatments to patients who screen in need of additional services.

***Instructor Note: There are many more types of intervention services available in communities everywhere. Intervention is a response to the devastation substance abuse has on individuals, families and entire communities. Remember that the premise for prevention and intervention services is to stop substance abuse by addressing situations and circumstances that have been proven to promote substance experimentation (prevention) and intervening on risky substance use by addressing situations and circumstances that promote risky behaviors and practices (intervention).***

## Treatment and Recovery

### Chapter 5

*TAP 21 Competency: Describe principles and philosophy of prevention, treatment, and recovery.*

#### **Principles of Effective Treatment**

Scientific research since the mid–1970s shows that treatment can help patients addicted to drugs stop using, avoid relapse, and successfully recover their lives. Based on this research, key principles have emerged that should form the basis of any effective treatment programs:

- + Addiction is a complex but treatable disease that affects brain function and behavior.
- + No single treatment is appropriate for everyone.
- + Treatment needs to be readily available.
- + Effective treatment attends to multiple needs of the individual, not just his or her drug abuse.
- + Remaining in treatment for an adequate period of time is critical.
- + Counseling—individual and/or group—and other behavioral therapies are the most commonly used forms of drug abuse treatment.
- + Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
- + An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs.
- + Many drug–addicted individuals also have other mental disorders.
- + Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long–term drug abuse.
- + Treatment does not need to be voluntary to be effective.
- + Drug use during treatment must be monitored continuously, as lapses during treatment do occur.
- + Treatment programs should assess patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases as well as provide targeted risk–



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reduction counseling to help patients modify or change behaviors that place them at risk of contracting or spreading infectious diseases.

## **Effective Treatment Approaches**

Medication and behavioral therapy, especially when combined, are important elements of an overall therapeutic process that often begins with detoxification, followed by treatment and relapse prevention. Easing withdrawal symptoms can be important in the initiation of treatment; preventing relapse is necessary for maintaining its effects. And sometimes, as with other chronic conditions, episodes of relapse may require a return to prior treatment components. A continuum of care that includes a customized treatment regimen—addressing all aspects of an individual's life, including medical and mental health services—and follow-up options (e.g., community – or family-based recovery support systems) can be crucial to a person's success in achieving and maintaining a drug-free lifestyle.

## **Behavioral Treatments**

Behavioral treatments help patients engage in the treatment process, modify their attitudes and behaviors related to drug abuse, and increase healthy life skills. These treatments can also enhance the effectiveness of medications and help people stay in treatment longer. Treatment for drug abuse and addiction can be delivered in many different settings using a variety of behavioral approaches.

## **Evidence-Based Practices (EBP) in Addiction Treatment**

EBP's are growing in number, particularly in the world of substance abuse treatment. It is difficult to find an explicit clear definition of what an EBP is, however, I can tell you what is required for a practice/intervention/approach/method to become accepted as an EBP.

The practices in the EBP have met the following minimum criteria:

- ✚ Research: The practice has been subjected to scientific study that included randomized controlled trials, quasi-experimental studies, or in some cases a less rigorously

controlled research design. For the most part the research has been published in a peer-reviewed journal.

- + Meaningful Outcomes: The practice has resulted in benefits to the individuals receiving the service. It has helped consumers achieve desired outcomes related to treatment goals and objectives.
- + Standardization: The practice or intervention has been standardized so that it can be replicated. Standardization typically involves a published description that clearly defines the nature of the practice, the audience for whom it is intended and the desired impact of the practice on the individuals receiving it. Thorough instructions are available, as well as copies of printed materials and other tools needed to implement the practice.
- + Replication: The interventions and practices included in the database have been studied in more than one setting and findings have yielded consistent results.
- + Fidelity Measure: A fidelity measure either exists or could be developed from available information. Such measures allow practitioners to verify that an intervention is being implemented in a manner consistent with the protocol evaluated in the research.

The following is the website for a database for many of the EBP's in substance abuse treatment.  
<http://www.nrepp.samhsa.gov/>

### **EBP for Alcohol Treatment**

- + Brief Intervention
- + Social Skills Training
- + Motivational Enhancement
- + Community Reinforcement
- + Behavioral Contracting

### **EBP for Addiction Treatment**



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- ✚ Cognitive Behavioral Interventions
- ✚ Community Reinforcement
- ✚ Motivational Enhancement Therapy
- ✚ 12-Step Facilitation
- ✚ Contingency Management
- ✚ Pharmacological Therapies
- ✚ Systems Treatment

### **Levels of Substance Abuse Care/ Treatment**

As professional counselors we understand that entering treatment for substance abuse is difficult whether it's by personal choice, or if it's being recommended or required by an outside source such as the court system, family, or employer. The first step in establishing a treatment plan for a substance abuse issue disorder is a full evaluation. The evaluation typically includes:

- Complete assessment of the person's current use
- Previous substance abuse and treatment history
- Physical history
- Social situation
- Identification of treatment goals

The results of the evaluation provide information that allows the professional addiction counselor to recommend a type of treatment, for the individual seeking help, based off of safety concerns and medical necessity. The recommended treatment will occur on either an inpatient or outpatient basis, referred to as a level of care (LOC).

## **Outpatient Care**

**Outpatient behavioral treatment encompasses** a wide variety of programs for patients who visit a clinic at regular intervals. Most of the programs involve individual or group drug counseling. Some programs also offer other forms of behavioral treatment such as—

- *Cognitive-behavioral therapy*, which seeks to help patients recognize, avoid, and cope with the situations in which they are most likely to abuse drugs.
- *Multidimensional family therapy*, which was developed for adolescents with drug abuse problems—as well as their families—addresses a range of influences on their drug abuse patterns and is designed to improve overall family functioning.
- *Motivational interviewing*, which capitalizes on the readiness of individuals to change their behavior and enter treatment.
- *Motivational incentives* (contingency management), which uses positive reinforcement to encourage abstinence from drugs.

### **12-Step Programs (Community-based and free):**

- Includes programs such as Alcoholics Anonymous, Narcotics Anonymous, Al-Anon, or Ala-Teen.
- Typically very useful for patients trying to achieve recovery, and for family members affected by substance abuse.
- Allows opportunity for contact with individuals with many years of recovery
- Offers support and strategies for a successful recovery
- Research suggests that commitment to these types of programs is what makes the difference in long-term sobriety

### **Traditional Outpatient Care**

- Includes individual counseling with a therapist who has training/experience with substance abuse
- May also include a Psychiatrist to determine if medication would be helpful to achieve and maintain sobriety
- Does not include the medical treatment of complicated withdrawal symptoms

### **Substance Abuse Intensive Outpatient Program (IOP)**

- Structured treatment that teaches about the concepts of addiction and recovery
- Usually encourages participation with 12-step programs



- Typically consists of 3-5 days per week and an average of 3-4 hours of treatment per day for a set number of sessions or period of time
- Many programs are structured so individuals may continue to live and work in their community

#### **Substance Abuse Partial Hospitalization**

- Structured treatment sometimes recommended for those who have been unsuccessful in maintaining sobriety despite active treatment at a lower level of care
- Typically consists of 5-7 days per week for 6-8 hours each day
- May offer an arrangement for sober housing while attending the program

#### **Ambulatory Detox**

- Provided on an outpatient basis for those that are highly motivated for recovery but need medical treatment for complicated withdrawal symptoms
- Appropriate when the individual can be seen by medical professionals often enough to be safely monitored and detoxified

### **Inpatient Care**

#### **Inpatient Detox**

- Recommended for individuals that require 24-hour intensive medical care to ensure their safety
- Sometimes recommended when the individual is dependent on alcohol, sedatives, and some opiate-based drugs such as narcotic painkillers or heroin
- Typically intended for people whose situations are medically-complicated (because withdrawal symptoms are common when stopping the regular use of most substances, this type of treatment may not be recommended for most people)

#### **Inpatient Acute Care**

- May be recommended following inpatient detox after withdrawal symptoms have decreased, but medical or psychiatric symptoms that require 24-hour care and daily doctor visits are needed for continued stabilization
- Treatment is typically short-term




#### **Inpatient Residential**

- Usually considered after multiple attempts at other levels of care have failed
- Intended for people who do not need medical supervision
- May last 28 days or more
- This type of treatment has not been found to be any more effective in predicting long-term sobriety than any other level of care
- Should include weekly family therapy

### **When to Consider a Higher Level of Care**

A higher level of care should be considered in the following situations.


When the person:

-  has been attending treatment consistently and following recommendations of the treatment team, but still drinks/uses,
-  is struggling with medical complications, and/or
-  shows a decrease in level of functioning.

### **Expectations of Treatment**

Clients, their families and communities often ask, “What is the success rate of each level of care?” “What is the success of treatment?” There is no simple answer to this question.

Addiction is a chronic and progressive disease, much like diabetes. If a diabetic takes his medication but does not watch his diet or exercise, the medication will not be very effective.

-  Substance abusers are most likely to have a successful recovery if they:
  - learn about their addiction,
  - manage conflict in a healthy way,
  - take care of their physical and emotional health,
  - follow the direction of their behavioral health care professionals,
  - develop a sober support group, and
  - make changes to the parts of their life that support drinking/using.

Recovery takes heroic effort every day. Most people that achieve quality recovery feel that it is worth it. Experiencing relapse is common during the recovery process. Relapse doesn’t mean



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that the person or treatment program has failed. It's often a sign that the treatment program may need to be re-examined or changed.

Extra support is needed during this time. If the person is put down for having a relapse, they may be less likely to return to recovery or treatment.

***Instructor Note: Not all levels of care of available in all communities. When working with clients and their families in making a referral for treatment remember you MUST follow ASAM guidelines. The ASAM is covered in detail in the Clinical Evaluation course. The ASAM provides counselors with detailed descriptions of presenting signs and symptoms and what level of care they match.***

## Family Education

### Chapter 6

*TAP 21 Competency: Describe how substance use disorders affect families and concerned others.*

#### **Treating the Family**

Traditionally, the focus in treatment for those with substance abuse problems has been on the substance abuser, not on the family members surrounding him. Treatment professionals did not realize that the substance abuser had a profound effect on family members and others who often developed problems and unhealthy behavior patterns of their own as a reaction to the substance abuser. Not until alcoholism became recognized as a disease did treatment begin to address the problems of the whole family and its individual members, not just those of the substance abuser.

In dysfunctional families it is natural for family members to care for and be affected by the member who has a substance abuse or serious behavior problem. As this member's problems become more serious and unresolved, the family members become more affected and react intensely. This is a reactionary process in which the family members/involved people see the substance abuser or unhealthy member destroying himself. As a result, they become compulsively "dependent" on similar destructive behavior patterns of their own, such as work addiction, eating disorders, or unhealthy relationships with one person or many people.

#### **Family Dynamics**

It's common for family and loved ones of people with a substance abuse addiction to try to cope with the situation in unhealthy ways. These behaviors may have developed over years and sometimes are a result of childhood experiences. In most cases, these patterns of behavior are accompanied by the best of intentions, as loved ones want to help the person.

The loved one is usually concerned for the person's safety and wants them to be in protective environment where they know they are safe.

It's a common myth that certain types of treatment will guarantee that the person will be "fixed". Often loved ones hope there is a "cause" for the behavior and that as soon as this can be identified, the addictive behavior will stop.

Loved ones may also resent the amount of time and energy the person must dedicate to recovery, and urge them to turn their focus away from recovery and more on the needs of the family. As the person recovers, they may resent the lifestyle changes necessary for long-term change, as well as their loss of the role of the "healthy one" in the family. For the healthiest recovery, all family members must work on their own "recovery" and learn new ways of operating within the new family.

### **Codependent Relationships & Family Dynamics**

Understanding codependent relationships and family dynamics (how the family interacts with each other) is complicated.

It's a bit easier to begin by seeing what positive family dynamics are:

- + Open communication is present, and it is honest, clear and direct
- + Each person has goals and plans to reach those goals
- + Each family member supports the others in reaching their goals
- + Family rules are present, but open to change and flexibility
- + The family sees itself as naturally connected to society
- + Home is viewed as a place of safety and comfort
- + When conflicts arise, the family discusses, listens, keeps an open mind, and looks for a positive solution

In reality, we all know that conflicts come up, temperaments clash, and feelings get hurt. But healthy family dynamics lead to a positive outcome that helps a family grow.

What affects one family member generally affects other family members. This can be good or bad, depending on the circumstances.

In dysfunctional families, like those based on codependent relationships, open communication and resolution of problems is extremely difficult. Stress affects each member of the family in specific ways, and therefore affects the entire family unit. Families with addiction as the hub of daily life are surrounded by severe and ever present stress.

Here are some behaviors that may be repeated over and over:

- + Family members aren't sure what they feel, so have difficulty sharing their emotions
- + Family interactions or decisions are often focused around the addict or alcoholic



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- ✚ Open communication is difficult, since a pattern of avoidance or denial has been set in place
- ✚ Blame and anger are often present, making it difficult for common solutions to be found
- ✚ Codependent family roles keep the addict from “hitting rock bottom”
- ✚ Family members do whatever it takes to avoid confrontation, chaos or pain

## More about Addiction and the Family

### Healthy Family System:

- Self-worth is high.
- Communication is direct, clear, specific and honest and feelings are expressed.
- Rules are human, flexible and appropriate to change.
- It is natural to link and be open to society.
- Each person has goals and plans to get there, and should be supported by the family.

### Rules in a dependent or addicted family:

- Dependents use of drug is the most important thing in a family life.
- Drug use is not the cause of family problems, it is denial which is the root.
- Blaming others, don't make mention of it, covering up, alibis, and loyalty of family enables.
- Nobody may discuss problem outside the family.
- Nobody says what they feel or think.

## ROLES IN ADDICTION

### Family Role 1, The Addict

The person with the addiction is the center, and though the key to alcohol and drug addiction recovery, not necessarily the most important in family recovery. The "world" revolves around this person, causing the addict to become the center of attention. As the roles are defined, the others unconsciously take on the rest of the roles to complete the balance after the problem has been introduced.

### Family Role 2, The Hero

The Hero is the one who needs to make the family, and role players, look good. They ignore the problem and present things in a positive manner as if the roles within the family did not exist.



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The Hero is the perfectionist. If they overcome this role they can play an important part in the addiction recovery process.

The underlying feelings are fear, guilt, and shame.

### **Family Role 3, The Mascot**

The Mascot's role is that of the jester. They will often make inappropriate jokes about the those involved. Though they do bring humor to the family roles, it is often harmful humor, and they sometimes hinder addiction recovery.

The underlying feelings are embarrassment, shame, and anger.

### **Family Role 4, The Lost Child?**

The Lost Child is the silent, "out of the way" family member, and will never mention alcohol or recovery. They are quiet and reserved, careful not to make problems. The Lost Child gives up self needs and makes efforts to avoid any conversation regarding the underlying roles.

The underlying feelings are guilt, loneliness, neglect, and anger.

### **Family Role 5, The Scapegoat**

The Scapegoat often acts out in front of others. They will rebel, make noise, and divert attention from the person who is addicted and their need for help in addiction recovery. The Scapegoat covers or draws attention away from the real problem.

The underlying feelings are shame, guilt, and empty.

### **Family Role 6, The Caretaker (Enabler)**

The Caretaker (Enabler) makes all the other roles possible. They try to keep everyone happy and the family in balance, void of the issue. They make excuses for all behaviors and actions, and never mention addiction recovery or getting help. The Caretaker (Enabler) presents a situation without problems to the public.

The underlying feelings are inadequacy, fear, and helplessness.

### **Addiction and the Family Roles How the They lead to Codependency**

The parts played by family members lead to codependency. Members make decisions concerning what the other person needs. Codependency leads to aversion and lack of self-



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orientation in a situation where an addiction is present. Ultimately people "become" the part they are playing.

The goal in alcohol and drug addiction recovery is to bring each member as a whole into a situation where the problems can be dealt with. Individual talents and abilities should be integrated into the situation allowing emotional honesty about the situation without guilt or punishment.

***\* The overall goal in overcoming codependency is to make each person whole.***

People become familiar with and dependent on the role they play in families. In overcoming the family roles you will begin to overcome issues and what could be classified as the addiction to the role. While the conquering of the substance is important to the person with the addiction, a point to remember is the substance(s) is not the key to family recovery; removing the underlying roles are.

In beginning recovery each family member must become proactive against the addiction to the role and learn to become their true self. The goal is for each person to become independent and then approach the substance addiction recovery as a group of individuals, rather than as people playing a part. Whole, independent people can freely contribute to the recovery of the person overcoming the addiction. A person playing a part can only perform the role.

### **Help for Families in Addiction**

As addiction professionals we owe it to the family members and significant others of the active addict to provide resources for on-going support and treatment. Education in these areas is of great importance. It is necessary to remember that even if the "addict" does not achieve recovery their family and/or significant absolutely can!!

Families and significant others can opt to attend family therapy and/or couples counseling or individual counseling (if the addict continues to use).

### **Family Systems & Recovery**

Systems theory proposes that all systems like the maintain balance and harmony. The common expression, "Don't rock the boat" aptly describes a system's need to maintain balance.

Therefore, every individual within any given system participates in the maintenance of that balance. However, if the natural balance (status quo) of a system is dysfunctional, then the



system serves to maintain that dysfunction. In other words, it would "rock the boat" if we tried to improve the systems functioning. This is how some dysfunctional systems can promote and foster addictive behavior for some individuals in that system. With respect to addiction, the principal system of interest is the family system.

Like all systems, families operate to maintain a balance. Usually this entails activities and pressures to avoid conflict, hostility, aggression, or other things that leads to disharmony. The cost of maintaining this balance can be quite high. When someone in a family attempts to discontinue their addiction, it affects all the family members. In other words, recovery "rocks the boat."

Recovery involves family therapy that evaluates the family system. This evaluation serves to uncover hidden forces that serve to continue dysfunction. These forces have allowed addiction to flourish. Once these forces are identified, family members work together to foster a more functional family system that does not promote addiction.

Bowen (creator of Family Systems Theory) proposed that the problems of one family member cannot be understood apart from those of all other members. And so it is also true with recovery.

In addition to treatment are support services/groups. The following are a list of a few.

### Helpful Links for Family and Friends of Addicts

- [Al-Anon.org](http://al-anon.org) (al-anon.org) For family members of alcoholics.
- [Nar-anon](http://nar-anon.org) (nar-anon.org) For family members of addicts.
- [Gam-anon](http://gam-anon.org) (gam-anon.org) For family members of gamblers.
- [Coda.org](http://coda.org) (coda.org) For co-dependent individuals.
- [Adultchildren.org](http://adultchildren.org) (adultchildren.org) For adult children of alcoholics and addicts.

***Instructor Note: The role of the family and significant others in the client's treatment and aftercare is huge; just as the impact of addiction on families and significant other's is huge, pervasive and all-encompassing when left untreated. Families operate in a system, as system that tries to function no matter how disrupted the system is by addiction. In order for an individual to heal and recover so must the individual's family and/or significant others. As long the client/individual plans to return to that family system then that system needs to be educated and treated as well. Never underestimate the power of the family system both positively and negatively.***

# Cultural Competence in Addiction Prevention and the Recovery Process

## Chapter 7

### Defining Cultural Competency

*TAP 21 Competency: Provide culturally relevant formal and informal education programs that raise awareness and support substance abuse prevention and the recovery process.*

*TAP 21 Competency: Sensitize others to issues of cultural identity, ethnic background, age, and gender in prevention, treatment, and recovery.*

#### **Administrative Level:**

Defines cultural competency as the melding of philosophical and operational practices among three major program administrative levels:

- 1) attitudes, beliefs, values, and skills at the provider level
- 2) policies and procedures that clearly state and outline the requirements for the quality and consistency of care
- 3) readiness and availability of administrative structures and procedures to support such commitments.

The idea is that each person's cognitive style, personal and social history, and family culture contain both the origins and understanding of their problems and are keys to their recovery. Understanding the whole person is necessary in the process of evaluation, assessment, and clinical intervention in determining an appropriate treatment course.

The understanding that clinical interventions and a person's recovery are more successful when the services offered are compatible with cultural values and views of the individual, family, and community.



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According to The Pennsylvania Office of Medical Assistance Programs (OMAP) in Appendix CC of “Indicators of the Application of Cultural Competence” (Second Edition, 2003) “Cultural competency entails knowledge of consumers’ literacy level, native languages, levels of acculturation and assimilation, and cultural health care beliefs, customs and practices. Making this knowledge a service requirement of the provider encourages the services system to increase consumer access to services and to better design, implement and evaluate services to particular cultural groups.”

As addiction professionals we need to develop goals and strategies that meet the behavioral health care needs of the full range of different populations including “differences between urban and rural cultures, the deaf, hard of hearing, late deafened and deaf-blind populations, lesbian, gay, bi-sexual and transgender communities, and other ethnically or culturally defined groups.” The goal is to address cultural competence in the delivery of behavioral health services and have it implemented by all behavioral health care providers.

### **Culturally Competent Recovery Models**

The current movement of behavioral health providers to develop and utilize client-centered, strength-based, recovery-oriented, patient-directed models of behavioral health care that include awareness of and sensitivity to cultural competence factors in the delivery of services.

There is growing consensus that patient-centered, strength-based approaches to health care produce better clinical outcomes. The findings of Clarke and DeGannes suggest that developing culturally competent approaches to providing health care services inherently includes a patient-centered and directed approach to service plan design and implementation that will affect the clinical outcomes of any group or specific community, including those defined by gender, sexual orientation, disability, or other cultural variables including age and social class.

OMAP’s “Indicators of the Application of Cultural Competence” (Second Edition, 2003) Appendix CC states that services that are culturally competent must be provided by individuals who are trained and skilled to “recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies and practices characteristic of a particular group of people.”

Considering that communication is an essential and often key cultural variable in the therapeutic process, a number of models regarding cross-cultural communication are available



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to improve providers' ability to elicit patients' understanding of their illnesses and preferences in treatment during the clinical encounter.

One model is LEARN, an acronym for Listen, Explain, Acknowledge, Recommend, Negotiate.

- ✚ Listen with sympathy and understanding to the patient's perception of the problem.
- ✚ Explain your perceptions of the problem.
- ✚ Acknowledge and discuss the differences and similarities in perceptions.
- ✚ Recommend treatment.
- ✚ Negotiate treatment.

### **The Impact of Traditional Treatment interventions on Diverse Populations**

Those who have been in the drug and alcohol field for some time will recognize the mantra of D&A therapist training 101 - "A drug is a drug is a drug," and "An addict is an addict, is an addict." These old saws formed core concepts of how many D&A counselors and therapists were taught to think about and understand substance abuse and addiction. They helped shape attitudes about treatment models including interventions and treatment approaches. Given today's science, these old saws are no longer valid in their universality and application of treatment to all clients and patients.

It is estimated that up to 60% or more of persons entering into drug and alcohol treatment programs present with both mental and substance abuse disorders. It is noted that these individuals frequently relapse to D&A use or psychiatric symptoms within one year of detox and inpatient treatment. Persons who present with concurrent disorders complicate diagnosis and treatment planning, suggesting more than a universal approach to treatment for all.

Of interest is that despite the proven success of long-used therapeutic methodologies such as twelve step programs, pharmacological interventions, and new personal and group techniques such as motivational interviewing, DBT, and cognitive behavioral methodologies, outcome studies show poorer outcomes in general for ethnic and racial populations.

These differences have generally been explained as being due to inherent tendencies for African Americans, especially males, such as lack of motivation, non-compliance, and resistance in treatment. Similar reasons in addition to language barriers have been given for the poor outcomes of recovering Hispanics and Latinos.



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Sadly, the majority of the treatment providing community have been unwilling to attribute some of these poor outcomes to cultural differences. Discomfort in discussing race, ethnicity, prejudice, racism, homophobia, and sexism as a possible explanation can result in anger, resentment and defensive denials on the part of organization and staff.

While substance abuse and chemical dependence are equal opportunity disease, all do not necessarily encounter them in the same way, do not enter treatment in the same fashion, and do not use substances for the same reason. Persons may actually select their substance(s) of choice for different purposes. Some may be more or less affected by treatment due to individual and cultural variables.

Sensitivity and susceptibility differences between men and women to drugs and medications suggest differential approaches to education and prevention efforts, assessment, evaluation, and treatment procedures. The implications regarding treatment compliance related to possible medication side effects, medication effectiveness, and negative previous treatment experiences related to medications suggest more consideration and discussion.

Studies continue to indicate that assessment and diagnosis of ethnic and racial minorities versus those of whites continue to show a higher rate of diagnosis error, uncertainty, and inconsistency among therapists when evaluating African Americans as opposed to whites.

Social class, education, family, legal, and social environmental factors are interdependently linked and are seen as cultural variables that play a significant role in contributing to a person's personality and behavior. They often define a cultural group's cultural difference and uniqueness. These variables influence the understanding of chemical dependence and offer some insight as to possible approaches to treatment engagement and therapeutic options. Sexual orientation and the lifestyles of those belonging to other particular groups suggest service plans focused on social-environmental concerns as well as substance use issues in cultural context.

### **Know Thyself**

For those of us who are counselors, we are ethically bound to follow the advice we dispense each day to clients—know yourself. We must also explore the biases and prejudices which exist in our profession.



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Cultural competency cannot occur without people confronting their own biases and prejudices. Historically, education and training in this area has remained in the cognitive and objective domain, preventing self-exploration (Sue, D., & Sue, S., 2008).

Reports from authors/researchers Derald Wing Sue, PhD and David Sue, PhD who indicate that mental health professionals must realize that “good counseling” in the United States uses white Euro-American norms that exclude 75 percent of the world’s population. While the extrapolation for the United States was not stated, this fact alone is enough to give pause, they say. Sue and Sue state, “Without awareness and knowledge of race, culture, and ethnicity, helping professionals and other support staff could unwittingly engage in cultural oppression.”

***Instructor Note: Thankfully the research in the area of cultural competence and addiction treatment is growing into more and more differing populations. Just as there are and have been continual changes (for the better – mostly ☺ ) in understanding and treating substance misuse there are now new fresh intervention, prevention and treatment techniques that take into account cultural issues, viewpoints and backgrounds. All of this we do is in the effort to meet the needs of our clients and improve their road to recovery and healing.***

## **Substance Abuse and Health Risks**

### **Chapter 8**

***TAP 21 Competency: Understand and describe the health and behavior problems related to substance use, including transmission and prevention of HIV/AIDS, tuberculosis, sexually transmitted diseases, Hepatitis C, and other infectious disease.***

People who abuse drugs and/or alcohol are at greater risk of contracting or transmitting HIV and viral hepatitis; lack of treatment can lead to mental health issues.

#### **Medical Consequences of Drug and Alcohol Abuse**

Although initial drug use might be voluntary, drugs of abuse have been shown to alter gene expression and brain circuitry, which in turn affect human behavior. Once addiction develops, these brain changes interfere with an individual's ability to make voluntary decisions, leading to compulsive drug craving, seeking and use.

The impact of addiction can be far reaching. Cardiovascular disease, stroke, cancer, HIV/AIDS, hepatitis, and lung disease can all be affected by drug abuse. Some of these effects occur when drugs are used at high doses or after prolonged use, however, some may occur after just one use.

#### **HIV, AIDS, and Viral Hepatitis**

Drug abuse not only weakens the immune system but is also linked to risky behaviors like needle sharing and unsafe sex. The combination greatly increases the likelihood of acquiring HIV-AIDS, hepatitis and many other infectious diseases.

Drug abuse and addiction have been inextricably linked with HIV/AIDS since the beginning of the epidemic. The link has to do with heightened risk—both of contracting and transmitting HIV and of worsening its consequences.

According to the Centers for Disease Control and Prevention (CDC), people with substance use disorders are at greater risk of contracting or transmitting an HIV infection because the misuse of drugs and/or alcohol can impair judgment and contribute to poor decision making (for

example, sex without condoms or unprotected sex with multiple partners). According to The National Survey on Drug Use and Health (NSDUH) Report on HIV/AIDS and Substance Use – 2010 (PDF | 336 KB), one-fourth of people ages 12 and older who had been told by a doctor they had HIV/AIDS engaged in binge drinking in the past month, and nearly one-third used illegal drugs in the past month. Injection drug use and needle sharing are responsible for about 10% of HIV cases annually, and one in six people with HIV/AIDS have used an illegal drug intravenously in their lifetime. In particular, studies have shown a strong link between methamphetamine use and the transmission of HIV among men who have sex with men, a population group disproportionately affected by HIV and AIDS.

## **How Do Drugs Affect HIV?**

Most people know that intravenous drug use and needle-sharing can transmit HIV; less known is the role that drug abuse in general plays. A person under the influence of certain drugs is more likely to engage in risky behaviors such as having unsafe sex with an infected partner. Indeed, the most common (but not only) way of contracting HIV is through unsafe sex. This includes “transactional” sex—trading sex for drugs or money. Drug abuse and addiction can also worsen HIV symptoms, causing greater neuronal injury and cognitive impairment, for example.

Because of the strong link between drug abuse and the spread of HIV, drug abuse treatment can be an effective way to prevent the latter. People in drug abuse treatment, which often includes HIV risk reduction counseling, stop or reduce their drug use and related risk behaviors, including risky injection practices and unsafe sex.

## **Viral Hepatitis – A Consequence of Substance Abuse**

### **What is hepatitis?**

Hepatitis is an inflammation of the liver. It can be caused by a variety of toxins (such as drugs or alcohol), autoimmune conditions, or pathogens (including viruses, bacteria, or parasites). Viral hepatitis is caused by a family of viruses labeled A, B, C, D, and E; each has its own unique route of transmission and prognosis. Hepatitis B (HBV) and hepatitis C (HCV) are the most common viral hepatitis infections transmitted through the risky behaviors that drug users often





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engage in. Approximately 800,000–1.4 million people are living with HBV and 2.7–3.9 million people are living with HCV in the United States.

Left untreated, hepatitis can lead to cirrhosis (progressive deterioration and malfunction) of the liver and a type of liver cancer called hepatocellular carcinoma (HCC). In fact, HBV and HCV infections are the major risk factors for liver cancer worldwide—an estimated 22,000 people are expected to die from this disease in 2013 in the United States alone, a number that has been steadily increasing over the past several years and now exceeds deaths linked to human immunodeficiency virus. During the next 40–50 years, 1 million people with untreated chronic HCV infection will likely die from complications related to their HCV.

### **What is the relationship between drug use and viral hepatitis?**

Drug and alcohol use places individuals at particular risk for contracting viral hepatitis. Engaging in risky sexual behavior that often accompanies drug use places individuals at risk for contracting HBV, and less frequently HCV. Injection drug users (IDUs) are at high risk for contracting HBV and HCV from shared needles and other drug preparation equipment, which exposes them to bodily fluids from other infected people. Because of the compulsive nature of addiction, IDUs repeatedly engage in these unsafe behaviors, which can make them “super-spreaders” of the virus. A recent study reported that each IDU infected with HCV is likely to infect about 20 others and that this rapid transmission of the disease occurs within the first three years of initial infection. Drug and alcohol use can also directly damage the liver, increasing risk for chronic liver disease and cancer among those infected with hepatitis. This underscores that early detection and treatment of hepatitis infections in IDUs and other drug users is paramount to protecting both the health of the individual and that of the community.

### **What other health challenges do IDUs with hepatitis have?**

Injection drug users (IDUs) with hepatitis often suffer from several other health conditions at the same time, including mental illness and HIV/AIDS thus requiring care from multiple healthcare providers. Drug abuse treatment is critical for IDUs, as it can reduce risky behaviors that increase the chance of transmitting hepatitis. Research has shown that patients with hepatitis receiving medication-assisted therapy for their opioid addiction can be safely treated with antiviral medications. To enhance HCV care, NIDA (National Institute of Drug Abuse) is examining coordinated care models that utilize case managers to integrate HCV specialty care

with primary care, substance abuse treatment, and mental health services so that these patients get treatment regimens that address all of their health care needs.

Drugs that can lead to HIV, Hepatitis and other infectious diseases:

- [Heroin](#)
- [Cocaine](#)
- [Steroids](#)
- [Methamphetamine](#)

### **Tuberculosis & Substance Abuse**

Illicit drug users continue to be a group at high risk for tuberculosis (TB) infection and disease. Drug users, and injection drug users in particular, have driven TB epidemics in a number of countries. The successful identification and treatment of TB among drug users remains an important component of a comprehensive TB strategy, but drug users present a unique set of challenges for TB diagnosis and control.

Tuberculosis (TB) control efforts are often ineffective in controlling TB among patients who use illicit drugs or abuse alcohol (substance abuse). Studies between the years of 1996 – 2007 have shown the prevalence of substance abuse among TB cases reported in the United States and assessed the relation between substance abuse and indicators of TB transmission.

Substance abuse is the most commonly reported behavioral risk factor among patients with TB in the United States. Patients who abuse substances are more contagious ( i.e, smear positive) and remain contagious longer because treatment failure presumably extends periods of infectiousness.

### **Sexually Transmitted Diseases and Substance Abuse**

If people engage in alcohol or drug abuse they are taking a risk with their health. It is not necessary for the individual to become addicted before they begin to cause harm to their body and mind. Substance abuse can damage almost every organ, and even a short period of using these chemicals can have a lasting impact. As well as the problems caused by alcohol or drugs, there are also additional risks associated with the lifestyle of substance abuser. One of these additional dangers is sexually transmitted disease.

### **Types of Sexually Transmitted Disease**

The most common types of STD that addicts are likely to encounter include:

- \* Chlamydia is most likely to affect the genitals and eyes. This is the most common form of STD in the US, and it is caused by a bacterial infection.
- \* Gonorrhea is another bacterial infection. It can cause damage to many body organs if it is not treated.
- \* Genital herpes is a viral infection that can lead to sores appearing on the genitals. Some people can have repeated attacks for many years after the initial infection.
- \* Genital warts are soft growths of skin that appear on the mucous membranes of the genitals. They are caused by the human papilloma virus (HPV).
- \* Viral hepatitis includes hepatitis A, B, and C – all of these can be caught by having sex with an infected person. Hepatitis can cause inflammation to the liver, and it is potentially life threatening.
- \* Syphilis is a bacterial infection that is most usually found in those parts of the world that would be considered undeveloped – it has mostly been eradicated in the west through the use of antibiotics.
- \* Human immunodeficiency virus (HIV) is the STD that has received the most attention by the media in recent years. This is a virus that interferes with the normal functioning of the immune system.

### **Addicts are More Susceptible to Sexually Transmitted Disease**

There are a number of reasons for why substance abusers are more susceptible to STDs including:

- \* When people are intoxicated they are more likely to make bad decisions such as having unprotected sex.
- \* The lifestyle of people who abuse mind altering substances tends to encourage unsafe sex.
- \* Alcohol and drugs lowers inhibitions and this can make people more promiscuous. This can often mean that promiscuous people are having sex with other promiscuous people.
- \* The addictive personality describes a number of characteristics that substance abusers tend to share and one of these traits is risk taking. This type of individual is likely to be less cautious when it comes to protection so more likely to catch STDs.
- \* Not only are addicts more likely to catch sexually transmitted disease but they are also more likely to ignore the symptoms. This means that treatable diseases can progress for longer and cause more damage.
- \* If a substance abuser is being treated for an STD their alcohol and drug use may interfere with their treatment. Their lifestyle might also interfere with their ability to follow any prescribed treatment.
- \* Most addicts tend to have low self-esteem. This may mean that they are more willing to engage in promiscuous sex with strangers, and that they may not believe they have the power to safeguard their future by using protection.



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## **Educating Clients & Communities**

With the idea of protecting communities and keeping communities safe and thriving the common goal is to reduce substance abuse to protect the health, safety, and quality of life for all, especially children.

In 2005, an estimated 22 million Americans struggled with a drug or alcohol problem. Almost 95 percent of people with substance use problems are considered unaware of their problem.\* Of those who recognize their problem, 273,000 have made an unsuccessful effort to obtain treatment. These estimates highlight the importance of increasing prevention efforts and improving access to treatment for substance abuse and co-occurring disorders.

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include:

- Teenage pregnancy
- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Other sexually transmitted diseases (STDs)
- Domestic violence
- Child abuse
- Motor vehicle crashes
- Physical fights
- Crime
- Homicide
- Suicide

As we discussed in earlier chapters' prevention and intervention methods are employed through school and community education services and programs. The goal is to cut the percentages of children, adolescents and young adults who involve themselves in substance use and other risky behaviors.

***Instructor Note: I think the research speaks for itself, addiction has far reaching effects. The risky behaviors involved when a person's judgment and reality testing are out of whack because of drugs***



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*and alcohol do NOT just endanger the user, nope, it endangers families, children, wives, husbands, partners, lovers, significant others and strangers. This is evidenced by the proven direct relationship between those risky behaviors whole under the influence and diseases – the contracting and spreading of diseases. The percentages mentioned in this chapter show how disproportionate the number of infected people within the addicted community are compared to non-using people/communities. Prevention models are needed the most here, we need to educate children and adolescents about these dangers and their relationship to using drugs and alcohol. Sadly, adolescents have shown some of the greatest increases in HIV/AIDS and other sexually transmitted disease. Remember, children and adolescents represent future communities but they have to live to make that happen.*

## Don't Forget Life Skills

### Chapter 9

*TAP 21 Competency: Teach life skills, including but not limited to stress management, relaxation, communication, assertiveness, and refusal skills.*

#### **Psycho-education for Clients and Families – Individual and Group**

Psycho educational groups are designed to educate clients and their families about substance abuse, and related behaviors and consequences. This type of group presents structured, group-specific content, often taught using videotapes, audiocassette, or lectures.

Psycho-educational groups provide information that aims to have a direct application to clients' lives, such as instilling self-awareness, suggesting options for growth and change, and prompting people using substances to take action on their own behalf.

Some of the contexts in which psycho-educational groups may be useful are:

- Helping clients in the pre-contemplative or contemplative stage of change to reframe the impact of substance use on their lives, develop an internal need to seek help, and discover avenues for change.
- Helping clients in early recovery learn more about their disorders, recognize roadblocks to recovery, and deepen understanding of the path they will follow toward recovery.
- Helping families understand the behavior of a person with a substance use disorder in a way that allows them to support the individual in recovery and learn about their own needs for change.
- Helping clients learn about other resources that can be helpful in recovery, such as meditation, relaxation training, anger management, spiritual development, and nutrition.

Principal characteristics:



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Psycho-educational groups generally teach clients that they need to learn to identify, avoid, and eventually master the specific internal states and external circumstances associated with substance abuse.

Leadership skills and styles - Leaders in psycho-educational groups primarily assume the roles of educator and facilitator.

Techniques - Techniques for conducting psycho-educational groups are concerned with (1) how information is presented and (2) how to assist clients to incorporate learning so that it leads to productive behavior, improved thinking, and emotional change.

### **Life Skills**

Many chemically dependent people have hidden deficits in basic life skills (e.g., knowing how to balance a checkbook, prepare a meal, and accept feedback from an employer). While these deficits are as individual as the client, it is of momentous importance that treatment programs address a range of instrumental skills (e.g., meal preparation, money management, laundry, resume writing), as well as some basic social skills, particularly those needed in employment and other interpersonal situations. In addition to the findings of the assessment or bio-psychosocial counselors should also observe clients to identify problem areas.

Among the skills most underdeveloped in substance abuse clients are basic problem-solving skills. Because of their impulsiveness and difficulty delaying gratification, many clients are particularly poor at breaking down moderately complex problems into the few basic steps required to get from problem to solution. Practice is needed to learn clear problem identification, generation of options, thinking through likely outcomes, option selection, trying out options, and reviewing outcomes.

### **Life Skills and Recovery**

Many addicts, alcoholics and those with co-occurring disorders lack basic life skills. The stress of leaving treatment and reintegrating into the larger community can be intense and challenging for some including those with co-occurring disorders. Those who haven't received the information and experiences needed to avoid relapse or haven't incorporated the tools from treatment are at greater risk of relapse.

For most substance abusers, the basics of living day to day were never learned. Addictive behavior and thinking has destroyed the recovering substance abusers' ability to function

calmly on a daily basis. Many treatment programs have incorporated aspects of daily living requirements to help ease the shock of moving from treatment back to everyday life.

#### Some Life Skills that Strengthen Recovery:

- ✚ Educating clients about the benefits and impact of healthy nutrition is an important component of recovery and in rebuilding the body and mind. Since most alcoholics and addicts are in poor health it is always beneficial to implement a psycho-education group where clients can learn healthy eating habits, shopping for food, and cooking their food. Discussions about money and budgeting are also significant as these conversations prepare clients for aftercare and for living in a halfway house or independently.
- ✚ Clients often need to learn responsibility for cleaning their rooms and organizing their belongings. They are responsible for their own laundry. Clients also need education on how to follow dress codes that must be adhered to in various life/work situations and settings.
- ✚ When working with clients with co-occurring disorders, medication management as a life skill is crucial, as well as identifying healthy self-productive behaviors that stop a relapse from occurring.
- ✚ Learning social etiquette is extremely important to function in the daily world. No longer living in a world of drug and alcohol use, clients must learn how to engage in conversation, participate in healthy interactions, modulate emotions (not suppressing emotions), and more. This process provides clients with self-awareness and understanding of the interactions required for clear communications.
- ✚ Personal responsible such as getting up on time, arriving promptly to group, individual counseling or house meetings or being accountable are important skills for anyone hoping to function in daily life.
- ✚ Finally, life skills include learning how to enjoy one's self without drugs and alcohol. Most treatment programs take clients go to the movies, bowling, play laser tag, go to the beach and go boating etc. to establish fun, laughter and good times not associated with the use of drugs and alcohol.





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*Final Instructor Note: Never underestimate the importance of teaching daily living skills to your clients. Just because your client is an adult do NOT assume they have practice completing simple daily tasks like waking up on time to go to work, brushing their teeth, eating breakfast, prepping lunch, washing clothes etc. Most of our clients have been using for a very long time, and for that time drugs/getting high/getting the drugs/getting the money for the drugs was the center of their daily life; not taking care of themselves, their hygiene, their nutrition, their careers etc. But that is what will be expected of them by their families, significant others, future employees, friends etc. This could be more daunting than anything else we ask clients to do in their newly obtained sobriety. Don't set your client up to fail, make some of their treatment plan goals and objectives around practicing these daily living skills and when your client is able to wake up the same time for a week, make breakfast and follow a written daily plan give them big high fives, compliments, be their cheer leader, stress the importance of taking care of themselves, their presentation and their health. This will give them a boost of ego strength and confidence and empowerment. This is your job, our goal and hopefully your passion.*



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