

Drug Counsellor's Handbook

A Practical Guide
for Everyday Use



DRUG COUNSELLOR'S HANDBOOK

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On behalf of the United Nations International Drug Control Programme, (UNDCP) I am pleased to introduce this counselling guide to you. My colleagues and I in the UNDCP Regional Office in Eastern Africa trust that you will find it useful. The Handbook has been produced under the UNDCP assistance project, "Mobilisation of NGOs in Demand Reduction in Eastern and Southern Africa" (AD/RAF/95/967), which has been funded by generous contributions from the Governments of Denmark, Finland and Sweden.

While implementing this project with organisations throughout eastern and southern Africa, my colleagues found a real need for a hands-on guide to counselling techniques. As drug-related problems increase at an alarming rate and the counselling facilities throughout the region are limited, the Handbook aims to fill a practical need. It is intended as a user-friendly tool to be used by drug counsellors, nurses and others who meet drug abusers in performing their duties.

This English version is the first step. Plans are underway to produce the Handbook in French and Swahili, thereby making it accessible to larger numbers of potential users throughout this region and perhaps elsewhere in Africa.

I would like to thank our collaborators in the Dr. Idrice Goomany Centre in Mauritius, the Muhimbili Medical Centre in Tanzania and Christopher Lowry from Canada for their inputs to this Handbook. Their efforts reflect the UNDCP's commitment to work closely with communities and to help them find practical solutions to problems that fall within the mandate of our organisation.

Frank Albert
Representative
UNDCP Eastern Africa

A Practical Guide for Everyday Use

If you work with drug abusers or their families, you know that drug counsellors learn by doing. The more clients you see, the more you learn about what makes drug abusers 'tick'. And you have to learn fast, because drug abusers can be challenging, often difficult, people.

While some of us are trained health workers, many of us have not chosen to be drug abuse counsellors. We are responding to a need in the community, in the clinic, in the school or in the institution where we live and work.

Even if you are good at this work, even if you are able to reach and help many of the people you work with, there are probably times when you feel the need for some good counselling for yourself – advice on how to approach a hard case, or some new ideas.

Perhaps you are just learning your counselling skills or maybe you are a seasoned counsellor who sometimes feels the need for a second opinion. Whether you work with young people



or with adult populations, with alcoholics or people who abuse legal or illegal drugs, this book may be of use to you in your work.

You will be happy to know that this handbook is not just another summary of research data or a reference book for doctors (although doctors may make use of it). Rather it is a guide that will help with some of the confusing issues which you confront in your efforts to help people, such as:

- Why is it so difficult to understand a drug abuser?
- What is the difference between counselling, advising and moralising?
- Why is the relapse rate so high worldwide?
- What is relapse prevention and aftercare service?
- Why should the family be involved?

This practical tool is intended for everyday use. It contains guidelines that you can follow to achieve positive results and includes answers to specific questions that may, from time to time, come up in your work.

This handbook can help you achieve the sweetest success of drug counselling – to learn from your clients and to help them discover in themselves the strength to choose a healthier way of life.

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- What is the difference between counselling, advising and moralising?
- Why is the relapse rate so high worldwide?
- What is relapse prevention and aftercare service?
- Why should the family be involved?

Substance abuse is a variety of persons, having a variety of problems, living in a variety of social conditions, using a variety of psycho-active substances, for a variety of motives, to achieve a variety of effects.

– A.O. Pela and J. Ebie

CHAPTER ONE

Overview of Drug Abuse in Africa

Who abuses drugs? What kinds of drugs?

In Africa, youth and adults, rich and poor, rural and urban people abuse drugs. From a drug counselling point of view, we are most concerned with the problem of abuse, that is, use which causes harm to personal health, others and society.

It is important for you to know that in Africa and the rest of the world, alcohol is by far the most widely-abused drug, causing the most harm to families and communities. Traditional brew can be particularly toxic due to a common practice of adding battery acid to speed the fermentation process and increase the 'kick' of the drink.

Abuse of the most dangerous illegal drugs, such as cocaine and heroin is increasing among young people, particularly among urban youth

who have money to pay for these costly substances. Cannabis (bhang, marijuana) is the most common illegal drug traditionally produced and abused in Africa.

An emerging concern is the growing trafficking and abuse of heroin and cocaine. These drugs have become available in major cities of the region because African ports are now used as transit points in the global traffic of heroin from the Far East and cocaine from Latin America.

In South Africa there are drug abuse patterns quite different from other countries in the region. For example, the depressant methaqualone ('mandrax') – often combined with cannabis in a highly potent mixture known as 'white pipe' – is abused in South Africa. While the use of an amphetamine stimulant called 'ecstasy' among young people at 'rave' parties is reported to be on the rise in Namibia and South Africa.

Khat production and use is traditional to the highlands of East Africa, especially in the Horn of Africa, and its abuse is common in that region. The rest of the world first learned about khat as a common drug abused among fighters in the Somali civil war.

Common solvents, glue, and fuels are cheap, legal substances abused as drugs by the very poor, particularly homeless youths in cities and towns. These substances, known as 'inhalants', are sniffed to get high. Since inhalants are available to young people in the home, school children may also abuse these mind-numbing substances.

We have limited information about the extent of illegal drug abuse in Africa. In your work it is likely that you will encounter a variety of drugs being used by your clients. You can expect alcohol and cannabis to be the most common, but you may also meet clients who abuse cocaine, opiates, inhalants or various kinds of pills (hypnotics). Some of these pills have medical purposes while others are only manufactured illegally for non-medical use. For detailed descriptions of these drugs, see Appendix One.

In some African cities the situation is changing so rapidly that local decision-makers may be unaware of the increased availability of illegal drugs in their marketplace. As a drug abuse counsellor close to the street, you may be better informed than the authorities are.



Why?

In Africa as in the rest of the world, people use drugs to alter or enhance their mood based on a variety of needs that fall broadly into two categories:

- The need to self-medicate, to feel better, to alleviate real or imagined pain; and
- appetite and desire for pleasure or entertainment.

The rich may turn to drugs for entertainment or relief from boredom, while the poor are more likely to use drugs to escape from their unfortunate situation.

As a counsellor you will find that a large number of your addicted clients have experienced difficult childhoods including abuse, neglect, and family breakdown. For these clients, drugs provide a way to deal with their troubles, to feel better. We know that poverty can destroy families; and circumstances may force young people to drop out of school, leaving them very limited choices in life. In turn, this may lead them to choose drugs as a way of giving themselves medicine,

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Many children and youth working on city streets abuse substances on a daily basis to help themselves feel better, to be close to their friends, to separate themselves from the hard, cold pavement. If you work with these young people, you know that they have many reasons why they want to get high.

‘self-medicating’ to escape their dreary lives or in an effort to improve their mental health.

Many children and youth working on city streets abuse substances on a daily basis to help themselves feel better, to be close to their friends, to separate themselves from the hard, cold pavement. Few of these so-called street children are homeless, but home may be a very hostile, unhealthy place from which they may want to escape through drugs. If you work with these young people, you know that they have many reasons why they want to get high and they will generally use any drugs that are available to them. Some may be involved in petty drug trading, but the bulk of this business is controlled by adults.

There are many reasons for the increase in drug abuse throughout the region. Certainly the main factor is the stress of economic hardship coupled with the breakdown of traditional systems of community and family support which, in the past, might have helped individuals to meet their needs in healthier ways. In some countries this breakdown is much greater because of armed conflict. War goes hand-in-hand with drug abuse because the

terrible stresses increase the need for self-medication – among both the fighters and the civilian population.

Many of your clients may have turned to drugs as a reaction to the experience of broken dreams when they moved to the city. Drawn to the promises and allure of urban life, they confront the stark reality of poverty. Drugs offer temporary relief and, for some, ‘easy’ money.

One study in Tanzania (1993) suggested that experimentation and abuse of drugs – such as cannabis, opiates and cocaine – among school-going youth was limited to the cities and was not evident in small towns. This could be due to the lack of availability of non-traditional drugs outside the cities and also to the survival of traditions controlling the behaviour of young people in rural areas.

The small country of Mauritius has a relatively large number of heroin addicts. The Mauritian experience shows how quickly drug abuse can get out of hand in the age of globalized trade. Between 1985 and 1986, the country experienced a sharp increase of heroin addicts. This happened because Mauritius became established as a transit point for the international heroin trade from Asia to Africa

and the West – making heroin more easily and cheaply available.

What is the Drug Culture?

In Africa, as elsewhere, drug abusers may be part of a powerful ‘culture’ where drug use is considered ‘normal’. They may come from a tradition of social drug use, such as a community of adults who drink home brew, smoke cannabis or chew khat as a social activity – despite the negative effects that this habit has on their health and the well being of their families.

Drug use, particularly drinking, may be part of their family culture. Drunkenness, good natured or violent, may be tolerated within their family. Parental drug use is an especially powerful influence on children’s behavior.

Finally, there is what we call the ‘drug culture’ of pop music and movies. It may be useful for you to be aware of how powerful this drug culture is for young people. For example, the Rastafarian Reggae star Bob Marley, one of the most popular recording artists of all time, was an advocate of social, recreational, and religiously justified cannabis use. Young people may have deep affection, even reverence, for



Young people may feel that drugs help them to have fun, to be accepted, or to be grown up. With TV and the Internet young people in the cities of Africa feel that they are part of a global culture that includes the values of ‘sex, drugs and rock and roll’.

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artists who openly admit to drug use – giving some young people expectations and misconceptions about the effects of drug use, which influence experimentation and continued abuse. With TV, video and the Internet young people in the cities and suburbs of Africa feel that they are part of a global pop culture that includes the values of ‘sex, drugs and rock and roll.’

The Value of Our Traditions in Counselling

One of the strongest assets in your efforts to help drug abusers is tradition. While it is true that drug and alcohol use has a long history of cultural acceptance throughout the region, there are also strong traditions of disapproval of drug abuse, especially when it weakens responsibility, honour and reputation. This traditional disapproval of drug abuse in African communities can be promoted without limiting public education and assistance to addicts.

With many of your clients, it is possible to help them recover the sources of personal strength in their own traditions – to find the path to

recovery in responsibility to family, community, elders and ancestors.

On the other hand, many addicts come to counselling when they are beyond the reach of their families. Part of your role as a counsellor, whether you are a health worker or a social worker, is to provide some support that may make it possible for your client to re-connect with family and community.

Women and Drugs in Africa

While it is true that in Africa drug and alcohol abuse is much more common among men than women, this situation is changing rapidly. Substance abuse among women is less visible, more private than among men, but girls and women are fast catching up with males. Because drug abuse is viewed mainly as a man’s problem, female substance abusers in Africa suffer from a lack of access to counselling and treatment.

Women are often the victims of domestic violence because of their partners’ drug abuse, but this is commonly denied or ignored.

In many places, women are involved in the drug trade, and in some communities they are the

main sellers of drugs and drink (e.g., Botswana, Mozambique and Djibouti). We can learn from UNAIDS, where it is now well understood that (primarily female) sex workers are the key to effective AIDS prevention work. Likewise, we need to recognize that the people who sell drugs and alcohol are in the best position to reach our target group. They know them well. You can gain a great deal by establishing trusting relationships of mutual learning with people involved in petty trade of drugs and alcohol, in your local community.

Your Cultural and Economic Context

Each country and community is different and each of us must work in our own local context. There are a number of factors that will effect the drug abuse situation where you live. These include the question of available resources for counselling and treatment services, local laws regarding drug use and treatment, local drug and alcohol production and the degree of public acknowledgment of the drug problem.

The more you understand your local situation, the more effective you will be in your work.



Use and Abuse, Legal and Illegal, Hard and Soft, Mood Altering Drugs and Mild Stimulants

First, there is the question of ‘use’ and ‘abuse’. Remember that drug ‘abuse’ is drug use that causes harm to personal health, to others and to society. This is important because we are not concerned with the moderate use of legal drugs like alcohol. Similarly, it is important to understand that if a young person tries an illegal drug, it may not lead to addiction or health problems. Young people know this and they will not believe you if you tell them that ‘all drugs are deadly all the time’. From a counselling perspective, you may need to know that moderate use of some illegal drugs like cannabis is defined as ‘abuse’ because it is illegal – although it may not cause immediate health problems.

In your work you will often encounter clients who use several different drugs. How can you tell what to focus on? It is useful to identify differences among the substances called ‘drugs’ – making it easier to reach drug abusers with appropriate counselling and health care.



Remember that drug 'abuse' is drug use that causes harm to personal health, to others and to society. It is important to understand that if a young person tries an illegal drug, it may not lead to addiction or health problems. Young people know this and they will not believe you if you tell them that 'all drugs are deadly all the time'.

While the nicotine in tobacco and the caffeine in coffee are addictive, they are legal stimulants rather than illegal mood-altering drugs. They affect the emotions and cause mood changes in subtle ways. The health dangers of tobacco are great but need to be set apart as a separate issue in drug abuse counselling. Habits are very hard to change, so pick your 'battles' carefully.

The law defines drugs as either legal or illegal, but drug users believe that there is a difference between 'soft' and 'hard' drugs. As a counsellor, you need to take the beliefs and experiences of drug users very seriously.

The difference between hard and soft drugs is in the mind of the user and is based on: the intensity of the high, the dangers of addiction, the method of use and accessibility. In the drug culture alcohol, cannabis and the 'Ecstasy' distributed at 'rave' parties are soft drugs, while cocaine and heroin are hard drugs. Any drug that is injected by users is believed to be a hard drug.

Powerful drugs that provoke hallucinations and dreams such as LSD may be considered as hard.

It is commonly believed that soft drugs tend to be easily obtained from petty traders, found in nature or home-grown. Whereas hard drugs are generally more expensive than soft drugs and the user must buy them from criminal dealers. Soft drugs tend to be easily consumed by smoking, drinking or swallowing. Hard drugs tend to be more difficult and uncomfortable to use, involving needles and syringes, etc. Cocaine burns the nose if it is snorted – or must be prepared with tools and flame to be smoked or injected in its stronger 'crack' form (common in the USA).

It is important to understand that what is considered as a soft drug may be as harmful as a so-called hard drug.

Effects of Drug Abuse

As a person moves into a regular pattern of drug abuse, the drug takes centre stage of the person's life. Drugs become the emotional and social focus at the expense of other interests and activities. There is decline in initiative, drive and interest in drug-free activities. This gradually leads to social, emotional and physical problems. Loss of control and the breakdown of close relationships may lead to feelings of self-doubt, poor self-esteem, guilt, anxiety and sadness, all leading to further drug abuse as an escape. Tolerance and dependence accompany this process. These terms are described below.

Tolerance: The repeated use of a drug leads to changes in the brain and nervous system so that the user needs more of the drug in order to get the expected effect. This is the basis of drug tolerance.

Dependence: Drug dependence is an emotional and sometimes a physical need experienced by the drug abuser. The drug abuser or alcohol-dependent person feels a compulsion to take the drug on a regular basis, to feel its effects and to avoid the discomfort of its absence



(see Withdrawal, below). Physical dependence on any drug can be treated in a detoxification program ('detox'). However, psychological dependence is much harder to treat – this is the principal challenge for you as a counsellor.

Addiction: Addiction is the physical and psychological habit or feeling of need, which comes from repeated use of a drug. Drug abusers often continue to feel the need and desire for drugs after they have been treated for drug-dependence ('detoxification').

Withdrawal

In a drug dependent person, it is necessary to take the drug in order to maintain normal body functions. When the drug is not taken, the person suffers from physical and mental discomforts as a result. The fear of suffering from withdrawal is like an emotional prison which makes the addict feel trapped and controlled by the drug. If, initially, drugs are taken to experience particular sensations, in the later stages they are used to avoid suffering the unpleasant effects of withdrawal.

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Many of us think that our job is to inform young people and drug abusers of the dangers of drugs in order to make them change their ways. Unfortunately, this is not enough.

Consequences of Drug Abuse

As a drug counsellor, it is important for you to consider both the unintended and the intended consequences of drug use. Many of us think that our job is to inform young people and drug abusers of the dangers of drugs in order to make them change their ways. Unfortunately, this is not enough as people have all kinds of ideas and feelings about the desirable effects of drugs.

The drug user may feel that drugs help him or her to have fun, to have courage, to be accepted, to be grown up or to feel better. He may feel that the drug is a trusted friend, especially if people or society's promises have betrayed him.

The negative health consequences of drug abuse are many and varied, involving the body, mind and emotions.

A major and growing consideration is the contribution of drug abuse to the spread of HIV/AIDS. Intoxication with drugs leads to risky sexual behavior that could be a major contributing factor to the rapid spread of this dreaded condition. Injecting drug abusers who share needles can also infect each other with HIV/AIDS (blood-to-blood).

Infections common to drug addicts include: viral hepatitis, chest, heart, kidney infections and abscesses. Other physical effects on women may include hormonal changes leading to menstrual irregularity, infertility, negative effects on fetal growth and development for the growing child.

Effects on the brain lead to emotional instability, poor impulse control and mental difficulties. For example, regular use of cannabis impairs fine memory functions. Habitual drug abuse saps both physical and mental vitality, causing the user to be less productive in all areas of life. It affects the senses in such a way that social and emotional cues are blunted. Drug addiction may lead to stunting of social and emotional development in young people.

Drug abuse is a major cause of fatalities from accidents, suicide, accidental poisoning and infections. Mental disorders are often associated with drug abuse. Behavior associated with drug abuse also leads to family conflicts and abuse of women and children. Drug abuse among poor people leads to criminal activities to support this expensive habit.

If we want to help drug abusers to avoid all these real dangers, we need to understand what they are trying to get from drugs and help them to fulfill these needs in healthier ways.

Identification of Drug-Dependent Individuals

Early in the course of drug dependence, clients come to the attention of counsellors as a result of poor school or work performance, family conflicts associated with expenses of drug abuse or other irresponsible actions. People close to the drug abuser may notice a change in the person's emotional control and normal activities. More severely dependent people reveal their problem by compulsive drug-seeking.



Quitting: Management of Withdrawal

Addicts who abuse opiates and depressants, including alcohol, are very likely to experience severe and sometimes life-threatening withdrawal symptoms. You need to involve experienced health workers to carefully assess the severity of withdrawal symptoms before helping an addict to quit. The assessment is based on the person's physical condition as well as the quantity, method and frequency of drug abuse. The intensity of physical symptoms and psychological craving can be managed by gradually reducing the quantity and frequency of the drug or by the temporary use of a replacement drug, provided in a treatment program, such as methadone in the case of opiates and benzodiazepines in the case of alcohol. Fluids with some salt and sugar are given if the client is dehydrated. Most clients need to take vitamins and minerals to restore their health.

EMPATHY is the ability to understand and share the feelings of another person. It is the act of imagining what it would be like to be 'in the other person's shoes'. Empathy requires kindness and compassion. It increases with practice and is the essence of the counsellor's art.



CHAPTER TWO

Assessment

What is Assessment?

Assessment is the first major step in treatment and recovery. It is the process we use in the first few meetings with the client ('intake') to identify and evaluate the client's general situation, including his/her strengths, weaknesses, problems and needs in order to develop the client's treatment plan and recovery goals. Assessment is a process of learning the personal history of the client by listening to the client and his family. We cannot pretend to succeed in helping until we have knowledge of a client's background, including personal and work history in relation to his or her substance abuse. Assessment is critical for you to determine what specific treatment will help to set the client's recovery goals and make the necessary lifestyle changes to reach those goals.

Your Objectives in the Assessment Interview

- To gather information about the client's social, physical, mental and work history.
- To learn about the factors that led to the use and abuse of drugs by the client.
- To identify the client's existing emotional, personal or economic needs that may require immediate attention and care.
- To make the necessary arrangements that will address these needs.
- To collect information required by the centre/service for administrative purposes (e.g. home contact information or the person/institution that referred the client to your service).
- To provide information to the client about how you will work with her, the centre/service treatment philosophy and programme structure.

The Assessment Process

Assessing a client at intake is a very delicate step in treatment and rehabilitation because clients are very often depressed and confused. Even those who appear calm and positive are normally hiding their feelings; they will need a lot of encouragement and

support to talk about delicate personal problems. Persons who abuse drugs may resort to several defense mechanisms, including denial, to protect their drug habit from criticism.

After breaking the ice by showing that you care about the client's feelings, you can start filling the client's file (p. 19/101).

Please do not attempt to fill in the whole file during the first meeting – this will be too tiresome for the client and for you. The various parts of the client's file can be filled in during successive counselling sessions after you have established feelings of trust and confidence between you and the client. The file (p. 19/101) allows for continuous record-keeping even during the rehabilitation phase. Feel free to use additional information sheets to record major events (lapses and relapses as well as important achievements) for as long as you stay in touch with the client.

While some clients may arrive with the expectation that you can help them, others will simply resist and test your understanding of the drug problem. Some may see you as a negative authority figure, part of a system that has never helped them before. Your job as a counsellor is to approach all new clients with



compassion, no matter how hostile or difficult they may be. Negative clients or addicts who have been forced to join treatment by a spouse, their parents, a doctor or a legal institution may resist by refusing to answer any of your questions.

You can respond to this attitude with empathy by saying, for example: "I can understand your feelings about having to come here today, but these things can and do happen to anybody, in any family. Problems are there to be solved and we shall do it together. But first, I would really like to learn more about you."

A common tactic used by clients is rationalization. They may try to justify their drug abuse by blaming it on friends, other members of the family or on society at large.

A questionnaire with a good set of questions is an important tool for you to gather a complete history from each of your clients. However, the client may be scared of questionnaires. Therefore it is better to start the interview informally without the questionnaire rather than putting it between you and the client.

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Your job is to hold a mirror up to the client by helping him to tell you his life story. Then, as you talk about the story with the client, you can help him to accept the challenge of counselling and treatment.

During the first intake interview, limit your questions to the following issues alone:

Whether the client is appropriate for admission to your service; and, if not, what alternative services might be more appropriate.

Emphasize that full confidentiality is ensured.

Personal, Emotional and Social Life Story ('Psycho-Social History')

Apart from basic information such as name, address, age, sex, etc., you will need to know whom the client is living with; their roles and attitudes toward the client; and whether any other member of the family has a drug use/abuse problem. It is also important to know about any close friends, relatives and other significant people who may have an influence on your client. You need to assess to what degree the client's family and other relationships have been harmed by your client's drug use. It is important for you to know what triggered your client to join a treatment programme. Is it because the spouse has left? Has he recently been arrested by the police? Is he scared about

the probability of losing his job? Is he being driven out of home by the parents? Or is it because of the death of a close friend by overdose? All these are common reasons evoked by addicts to join a treatment programme.

Many addicts, particularly those who are being forced into treatment, may tend to deny or dismiss the harm caused by their addiction. The client may claim that everything is alright. Maintaining your compassionate attitude, you can probe into the following areas:

- Are you maintaining a job? Tell me about how you make a living.
- Do you have debts? Please tell me about them.
- Have you had to sell your own valuables or those belonging to other members of the family to purchase drugs?
- Have you had any trouble with the police? Tell me about that.

Confronted with his own replies, it becomes quite difficult for him to keep denying having serious problems with drugs. It also becomes difficult for them to look for scapegoats who would be responsible for the above problems because all these consequences are client-centred as a result of serious addiction.

- How motivated is he to recover from the addiction?
- What are her expectations of your services?

Here, you may seize this opportunity to ask your client about priorities. Some addicts may say they want their spouse to return home to help them follow the treatment correctly, but their spouse refuses to come back until the client has gone through 'detox'. Other addicts could tell you they are stressed because of their debts or because they have been suspended from work. Their priority is that somebody else must pay back their debts or they must get their jobs back.

It is important for you to help your clients talk through these issues so that they will be able to start taking responsibility for their problems.

Your challenge in the assessment stage is to learn about your client's life and help him to recognize the value of counselling. There may be many pressures in the client's life that have led to his drug problem. You need to learn as much as you can about this background before you can presume to judge. It is not helpful to make the client feel guilty. The first meeting will be successful if you can help the client to:



Drug abusers may be part of a powerful tradition of social drug use, such as the community of adults who drink home brew or chew khat together, despite the negative effects that this habit may have on their health and the well being of their families.



For the best results, female counsellors should assess female clients.

- Recognize and admit that he has a problem with drug abuse.
- Agree to voluntarily accept counselling and treatment.
- Understand that while drugs may appear to help him to feel better and cope with problems, drug abuse is a negative destructive force in his or her life.
- Understand that he will need to work very hard and cooperate with you if he really wants to solve his problems. Assure the client that through counselling, healthier, safer ways to meet and overcome many of his problem can be learned.

During the assessment, your job is to hold a mirror up to the client by helping him to tell you his life story. Then, as you talk about the story with the client, you can help him to accept the challenge of counselling and treatment. The client needs to know that it will be hard work, but it will be worth the struggle and you will be there to help.

Substance Abuse History

The main reason why the addict knocked at the doors of your service or centre may not really have been to lead a drug-free life but, perhaps, to be relieved of the withdrawal syndrome associated with the addiction. You will need a lot of information on her past and present use and abuse of legal and illegal substances in order to gauge her real situation. It is important to ask:

- How, and under what circumstance was drug use initiated and what types of drugs are used?
- How long has she been using each of them?
- The amount used as dosage in the past, recently, as well as the present daily dose?
- Which substance is perceived by your client as her main problem?
- How does she take the drug? Is she inhaling, smoking or injecting the drug or drugs?
- If injecting, is it done alone or in the company of friends with sharing of needles?
- Is he cleaning or sterilizing the syringe before and after use? (Hepatitis and HIV infection are real threats to addicts who use syringes to inject drugs into their veins. The client may not care about this health risk at first, but in the process of counselling and rehabilitation he may recover a desire to care for his health.)

Your client may have followed other treatment programmes in the past. It is interesting to learn about the frequency and duration of his/her abstinence episodes for each drug of abuse. You may even enquire about previous treatments the client has tried and how he perceives these approaches to treatment. But most important, your client will probably need your assistance to discover the exact causes of his past relapses.

Different addicts relapse for different reasons – one person can relapse for various reasons in different circumstances. Generally speaking, each addict has got his weak points or ‘personal triggers’ that lead to relapse. This information will be very important during the rehabilitation and relapse prevention phase.

Work History

Holding and maintaining a job is a major contributing factor in rehabilitation and relapse prevention. Encourage the client to talk about his work history.

- Does the client have a work history, current occupation or job?
- If he is unemployed, why and when did he leave the last job? How long has he been able



- to maintain past jobs (average length of time)?
- How many past jobs did he leave voluntarily and for what reasons?
- In how many cases had he been dismissed and for what reasons?
- What are her employable skills, educational qualifications?
- If the client still has a job, what is her performance level, regularity, punctuality, productivity, and use of sick leave?
- How are her relationships with co-workers, supervisors?
- What are the promotion prospects?

When you feel you have gathered enough information on the client’s situation you will be able to make a first diagnosis of the client’s needs in terms of detoxification, crisis intervention, rehabilitation, group counselling, self-esteem group or other complementary and supportive services.

The client may be referred to another service or admitted to the centre providing rehabilitation counselling. This information needs to be recorded by the counsellor on the Recommendations Form (Sample Form B on page 25/105).

With many of your clients, it is possible to help them recover the sources of personal strength in their own traditions - to find the path to recovery in responsibility to family, community, elders and ancestors.



To facilitate the counselling process you will need to propose precise rehabilitation goals and define specific tasks to be undertaken by the client and his family in order to attain the decided and agreed goals (see Client's Recovery Goals in the Client's File, Sample Form A, p. 24/104).

Additional sheets will need to be attached to the client's file as he progresses along the road to recovery. At the same time, brief notes will be entered at the time of each slip or full-blown relapse.

Special Considerations for Female Clients (Gender Issues)

For many reasons, most addicts find it difficult to talk about their addiction. Women who have drug problems find it particularly difficult to reveal their health and personal problems at intake. They are likely to feel shame and many other mixed emotions; and they may expect to be treated badly. On the other hand, clinicians, administrative officers and counsellors must be knowledgeable about, supportive of, and sensitive to the specific needs of women under treatment.

For the best results, female counsellors should assess female clients. If this is not possible, male counsellors should not discuss sexual health matters with the female client. These questions can be discussed at another meeting with a female counsellor, health worker or a doctor (through a referral). Group counselling sessions can also effectively bring out these issues.

A major problem area is the reluctance of women to talk about health factors such as gynecological and obstetrical problems and especially Sexually Transmitted Diseases (STD's) including HIV/AIDS and hepatitis. These infectious diseases need to be identified in both men and women as they are critical issues particularly for residential programmes. Confidentiality is extremely important. Women fear that personal problems may become known outside the treatment centre. In small community-based treatment programmes, divorced or separated female addicts fear that they could lose custody of their children if they reveal their problems. This additional and female-specific information must be recorded in an attached sheet or in a modified assessment questionnaire making room for gender-specific questions. To protect confidentiality, record only the information that is absolutely necessary.



S A M P L E F O R M A

copy and use this form if you need it

Client's File

Name _____ Date _____

Present address _____

Home phone number _____

Identity card nº _____

Date of birth _____ Sex: Male _____ Female _____

Marital status: Single _____ Married _____ Separated _____ Divorced _____ Other _____

Currently living with _____

Family address (if different)

Person to contact, and how to contact for follow-up

History of Drug and/or Alcohol Use

Drugs used _____



ASSESSMENT

Drug	Year first used	Duration	Using now? (yes or no)	Abstinence episodes? (when, how long)
Tobacco _____				
Alcohol _____				
Cannabis _____				
Heroin _____				
Cocaine _____				
Psychotropics (e.g., LSD) _____				
Methaqualone _____				
Other drugs (specify) _____				

Treatment and rehabilitation services or programmes attended _____

Client's feeling about services attended _____

Factors that led to substance abuse

Alcohol _____

Cannabis _____

Heroin _____

Cocaine _____

Psychotropics (e.g., LSD) _____

Methaqualone _____

Other drugs (specify) _____



Client's personal triggers which provoked previous relapses (see Common Causes of Relapse, p. 63)

Incidents of relapse

Triggers

Work History

Does the client hold a job?

Yes _____

No _____

If yes, what is the job? _____

How does the client feel about the job?

Good _____

Satisfactory _____

Bad _____

Very bad _____

Does the client always fulfill his or her work responsibilities?

Does the client always arrive at work on time?

Ask the client to describe his or her relationships with co-workers.

Ask the client to describe his or her relationship with the job supervisor.

Does the client have daily responsibility for children, other family members, household or property which requires work?

Yes _____

No _____

If yes, how does the client feel about this work?

Good _____

Satisfactory _____

Bad _____

Very bad _____



Brief Employment History

Employer	Job description	Year
<hr/>		

What job skills does the client have?

Levels of Education

Primary _____ Secondary _____ College, University _____

Additional training

What is the probability that the client will keep his current job?

Very Good ____ Good ____ Don't know ____ At risk ____ Unlikely ____

Employability, if unemployed.

Very Good ____ Good ____ Satisfactory ____ Bad ____ Very bad ____

Employment goals (note any new skills needed to achieve these goals)

1.

2.

3.

Family and Social History (as reported by the client)

Family members	Roles in the household	Attitude toward the client
<hr/>		
<hr/>		
<hr/>		
<hr/>		



Close friends/relatives

Their attitudes/influence toward the client

Neighbourhood/community attitude towards client:

Good _____

O.K. _____

Bad _____

Very bad _____

Client's interests and hobbies prior to addiction

What are the client's interests and hobbies now?

What are the client's expectations about counselling and treatment?

Acknowledged criminal activities, if any (to be filled in preferably at third or fourth meeting, after establishment of required trust) _____

Client's priority issues or needs _____



Client's Recovery Goals

Clients Motivation to Follow Treatment/Rehabilitation:

Very Good ____ Good ____ Satisfactory ____ Bad ____ Very bad ____

Individual goals

- 1. _____
- 2. _____

Family goals

- 1. _____
- 2. _____

Employment/social goals

Any special programme conditions recommended

Date _____

Client name _____ Signature _____

Staff name _____ Signature _____



S A M P L E F O R M B

copy and use this form if you need it

Assessment-based recommendations

Client name _____ Date _____

Overall case description and comments

Recommendations

Admit to Centre/Service _____ Referred to alternative service _____

Programme components Service Contact person Phone n°

Detoxification _____

Individual counselling _____

Group counselling _____

Family counselling _____

Self help group _____

Additional support services recommended _____

Special programme conditions recommended _____

Date _____

Staff signature _____ Case manager _____



Love for sale: On city streets, sex and drugs go hand-in-hand. Sex workers may use drugs in order to cope with the pain of their work, or they may sell sex in order to pay for their expensive drug habit.

Physical Health Assessment

A good physical assessment can be effectively done by a counsellor who has some basic training. This does not have to be done by a doctor or nurse, if they are not available in your daily work.

Drug Use History

This assessment relies on a good drug-specific history-taking and a number of other other procedures. The history-taking of the drug use is the first step. Here is a series of questions that you can use.

- What drug(s) are you taking?
- What is the main drug that you take?
- Are you using it daily/x times per week/ weekly?
- How much are you using daily?
- How many times are you using daily?
How much each time?
- Mode of use: How are you taking the drug(s)?
- Do you take the drug(s) alone or with friends or both?
- If with friends, how many are they?
- If the client injects drugs) Do you share the same needle with others?
- If not, a) do you use a new needle each time

b) do you clean your needle before injecting the drug? How do you do it?

- If you share needles, who uses the needle first? (your client is at greater risk of disease she is not the first one who gets the needle)
- Do you inject with male or female friends, or both?
- Are there sex workers in this group?

General Physical Examination (Male and Female Clients)

- Body hygiene and clothes: Is he clean?
- Face: How does the client look? In reasonably good shape? Poor shape?
- Arms and legs: Are there needle marks and/or sores on the forearms in the front of the elbow joint, in the armpit, on the legs, in the groin, or in the neck?
- Dehydration: Does the client have dry skin, dry lips and tongue, and/or sunken eyes?
- Pallor: Is she pale?
- Jaundice: Do the whites of his eyes look yellow?
- Mouth/lips: are there whitish patches? Are there bad teeth? (Potential source of infection)
- Body weight: Ask the client to use the weight scales, if available.
- Ask the client if he or she has lost any weight in recent months or years, during the time of his or her drug use.



Assessment of Risk of Sexually Transmitted Diseases (STD) and HIV/AIDS (Male and Female Clients)

If your client uses needles to take drugs, he is at risk for HIV infection and should have the opportunity to be tested. Other key risk behaviours for STD or HIV/AIDS infection include:

- Sex without a condom, especially with promiscuous partners such as sex workers or long-distance truck drivers.
- Engaging in anal sex without a condom

If you are not an experienced counsellor dealing with HIV/AIDS issues, you should refer the client to people who have this experience. The AIDS test is a difficult experience and an HIV positive result may strike the client as a death sentence. The counsellor must offer compassion, sensitivity, and accurate information to the client. The details of HIV/AIDS counselling are beyond the scope of this book. A wide variety of excellent learning materials on this subject are available in Eastern and Southern Africa from your local health authorities and non-government health organizations.

The AIDS test is a difficult experience and an HIV positive result may strike the client as a death sentence. The counsellor must offer compassion, sensitivity, and accurate information to the client.



Substance abuse is not an isolated activity. It is part of a wider behaviour pattern and life experience.

Clients with a serious illness such as HIV/AIDS or Hepatitis will benefit from family counselling sessions. Both the family and the addict need psychological support to foster coping skills, particularly in cases of HIV/AIDS (see Chapter Four: Group Counselling and Family Counselling, p. 43).

Additional Physical Health Assessment Question for Male Clients

Ask the client if he had noticed any yellowish discharge coming from the penis in recent weeks. Explain that if this has occurred, it may mean that he has a Sexually Transmitted Disease (STD) and he should be referred to a doctor for a complete check up.

Additional Physical Health Assessment Questions for Female Clients

Is the client pregnant or has she recently given birth? (observe and ask) If the client is pregnant, it is advisable to refer her to pre-natal health services immediately.

Ask the client if she had noticed any yellowish discharge coming from the vagina, or any white patches around the vagina in recent weeks. Explain that if this has occurred, it may mean that she has a Sexually Transmitted Disease (STD) and she should be referred to a doctor for a complete check up.

Special Considerations in Assessing the Female Client

The female substance abuser has special needs that have to be recognized in order to develop a good treatment plan with her. To do this work, it is important for you to deal with any prejudices you may have against the female drug abuser. She probably experiences some disrespect out there in the world. You, the counsellor, need to approach her with respect and compassion. This will help her to overcome any apprehension, embarrassment or shame she may have. While addressing her drug problems, you need to look at the whole person, including all the factors in her life that may interfere with an appropriate treatment plan. Substance abuse is not an isolated activity. It is part of a wider behaviour pattern and life experience.

It is useful to explore the following areas:

- Her marital status: Is she single, married, separated, divorced or living with a partner?
- Does she have children?
- Does she have a stable partner or different partners?
- Does she have any special vocational skills or hold a stable job?
- Is she engaged in sex work?
- Is her husband or partner himself a substance abuser?
- Is her husband or partner away from home for long periods (e.g. truck driver, sailor) or in jail?
- Is her husband or partner involved in drug trafficking, and is she involved in it?
- Does her social network consist of mainly female or male drug users or both or some other network?

You should consider the possibility that the client may have experienced or be experiencing sexual abuse or incest. You need to be sensitive and careful in history-taking, especially if you are a male counsellor. Female counsellors, if available, may be more appropriate to assess women and girls, although this is not absolutely necessary.



Special Considerations in Assessing the Adolescent Client

Sexual health counselling for young people is very important. In order to get through to them, this information needs to be shared with them in a way that is appropriate and acceptable to them. Through the use of open-ended questions you can find out how much the adolescent client knows about sex. You can build on this knowledge base by sharing information about the risks of unprotected sex, Sexually Transmitted Diseases, pregnancy, when and how to use condoms and clinical services that may be available to young people in your community.

In order to improve her ability to take care of herself, the adolescent female substance abuser needs special care and counselling in life skills, particularly if she is pregnant or already a mother.

Always remember that you may not be in a position to cater to *all* the needs of your client and that you may need to refer her to the appropriate specialized service. For example, you may refer the pregnant substance abuser to an obstetrician.

Drug counselling is an art in which knowledge of human relations and skills in relationship are used to help the individual substance abuser find the personal strength and resources in the community so that he or she can adjust, cope and lead a productive life free from drug abuse.

C H A P T E R T H R E E

Individual Counselling

The Drug Counsellor's Art

Counselling is a helping process. The helping process consists of three major phases. Each of these phases has distinct objectives. While you may use some of the same skills and processes in all phases, each phase has distinct objectives. The three major phases are:

Phase I: Exploration, Assessment and Planning

Your main objectives in the first phase are to understand the client as a whole person, not merely as a complex of problems; to plan your intervention; and to work out an agreement with the client.

Phase II: Rehabilitation Counselling and Goal Attainment

Your objectives in this phase are to initiate and implement your treatment plan in cooperation with the client.

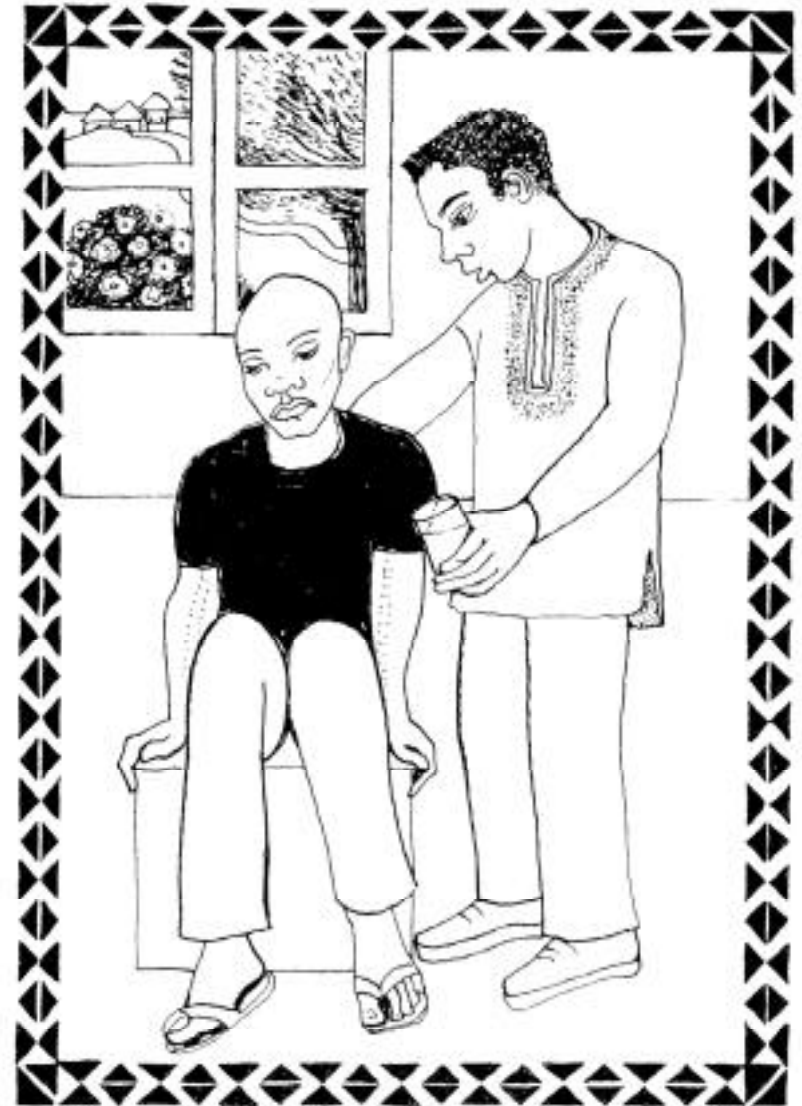
Phase III: Termination and Evaluation

The objectives in the final phase are to conclude treatment and discuss its outcome with the client, and to work out agreement on future action with the client.

As a counsellor, you need to be committed to a set of principles that can guide the way that you treat your clients.

Principles of Counselling

- 1 Individualization:** it is your recognition and understanding of each client's unique qualities. Individualization is based upon the right of human beings to be individuals.
- 2 Purposeful expression of feelings:** your recognition of the client's need to express his feelings freely without being discouraged or condemned.
- 3 Controlled Emotional Involvement:** the counsellor's sensitivity to the client's feelings, an understanding of their meaning and a response to the client's feelings.
- 4 Acceptance:** the counsellor perceives and deals with the client as he really is.
- 5 Non-Judgmental Attitude:** excludes assigning guilt or innocence or degree of client's responsibility for causation of the problems; includes evaluative judgments about the client's attitudes or actions.
- 6 Client self determination:** your practical recognition of the client's right and need to freedom in making his own choices and decisions in the counselling process. This promotes responsibility.
- 7 Confidentiality:** the preservation of private, personal information concerning the client which is disclosed in the professional relationship. Confidentiality is a client's basic right. However, in some countries the counsellor is legally required to report any evidence of physical abuse or the intention to commit suicide to the appropriate authorities, such as health authorities, Children's Aid agencies or the Police.



Empathy requires kindness and compassion, and it increases with practice. It is the essence of the counsellor's art.

Maintain eye contact, if this is culturally acceptable. In many African and Islamic cultural contexts, the client may avoid eye contact with you, particularly if you and the client are of the opposite sex.

Guidelines for First Face-to-Face Meeting

- Before beginning the face-to-face session you need to anticipate what the client may be thinking and feeling. Be prepared to respond in an understanding way to a client's fears, ambivalence and confusion.
- Make the seating arrangement comfortable for a conversation between two people.
- Use language that matches the client's capacity to understand and level of education.
- Start with introductory remarks and a friendly attitude. Make some general conversation, then move to specific issues.
- Explain the rules of confidentiality that will apply to your meeting.
- Explain how much time you have to spend with the client so that she can anticipate how long the session will last.
- Give serious attention to what the client describes as her concerns.
- Do not jump to conclusions about the nature of the client's presenting problem. Keep an open mind.

- Do not rush the client. Respect his need to be silent and to pause after speaking.
- Use open-ended questions unless you need specific data. "Tell me more about that." "How did you feel about that?"

Some note-taking during the intake phase is usually necessary and appropriate. Writing down pertinent information can demonstrate concern for the client. Maintain eye contact with the client as much as possible during note-taking to convey respect and concern, if this is culturally acceptable. In many African and Islamic cultural contexts, the client may avoid eye contact with you, particularly if you and the client are of the opposite sex.

Plan the next meeting with the client, if one is necessary. Before the interview ends, be sure the client has your name and phone number and you have his or her full name, address, phone number.

These are a set of skills that help the counsellor to engage the attention of the client on a moment by moment basis and to convey accurate understanding of his or her messages.

Verbal Following Skills

Verbal following skills include furthering, minimal prompt, open-ended questions, paraphrasing, seeking concreteness, close-ended questions, providing and maintaining focus, and summarizing.

1. Furthering indicates that you are listening attentively and encouraging the client to talk. There are many ways to do this:
2. Minimal prompt indicates your attentiveness. Use short but encouraging responses such as “Yes”, “I see”, “Mmm-hmm”. Non-verbal component of minimal prompt includes head nodding and facial expressiveness.
3. Open-ended questions invite expanded expression and allow the client to express freely. “How did you feel about that?”
4. Paraphrasing involves using fresh words to restate the client’s message concisely. For example, “So, he makes you feel angry and depressed?”
5. Seeking concreteness means that you look for concrete and specific information, using close-ended questions.



6. Close-ended questions are used to elicit specific information, such as “How many times did that happen?”
7. Providing and maintaining focus is vital, as you and the client will spend limited time together it is important to use the time fruitfully. Your client has a limited perspective of his problems and seeks your guidance.

Types of probes that help clients to give clear, complete answers:

Clarify the meaning of vague or unfamiliar terms.

Ask the client to explain her point of view.
“Why do you think that is so? Please tell me more about why you feel that way.”

Assist clients to personalize their statements.

8. Summarizing: from time to time during the interview, it is useful to tell the client what has told you – to ensure that you understand each other. This also helps the client to reflect and be responsible for his story.

The reason why we have two ears and only one mouth is so that we may listen more and talk less.

– Ancient Greek proverb

Listening Skills

Listening is the central skill and act of counselling.

As a general rule, a good counsellor should try to listen to the client ninety percent of the time and talk only ten percent of the time. The client begins to take responsibility for his problems because you help him to describe his life and look at himself with fresh eyes. Half of counselling involves the naming and accepting of one's problems. Part of your job is to be a mirror; and another part is to be a wise friend, to accompany your client on the path toward self-knowledge and recovery.

Hearing is the capacity to hear sound; while listening is the capacity to hear sound and to understand.

'Reward' Listening

Reward listening is active listening with empathy, were you reward the speaker by showing your interest and encouragement. Empathy is the ability to understand how the client feels about herself and her environment.

Reward listening is important in order to:

- Establish and maintain rapport.
- Help clients to disclose.
- Help clients to express feelings.
- Create a mutual knowledge base for both client and counsellor.

For example, small rewards are brief verbal expressions of interest designed to encourage the client. Examples of verbal small rewards:

- “Um-hmm, please continue.”
- “I see.”
- “So...”
- ‘I hear you...’ (American expression)

Respect and acceptance are essential to practice reward listening. You need to communicate your sincerity in your manner, your body language and your face without saying it in words. It is not sufficient to simply say things like ‘I really care.’ or “You can trust me.”

You may have to overcome personal barriers that limit your ability to respect and accept your client. Factors that create obstacles to acceptance are:

- Strong feelings about an issue, e.g. you cannot accept people who are racist or people who hurt their children.
- Anxiety-provoking people, e.g. highly politicized persons.
- Anxiety-evoking situations, e.g. the client uses strong words, or the client inflicts injuries on himself.
- Personal prejudices – these may be gender, race, cultural, or social prejudices.

You may be physically uncomfortable with a client, e.g. if the client has a criminal record, if the client's sexuality makes you nervous, if the client is dirty or otherwise unpleasant to you.

You always need to be aware of your emotions and feelings at a personal level and learn to have objective attitudes towards your clients. This is a basic characteristic of 'professional' behaviour.

The following Inventory of counsellor's non-verbal communication may be useful to you to enhance your reward listening skills.



A good counsellor should listen to the client 90 percent of the time and talk only 10 percent of the time. Part of your job is to be a mirror and a wise friend.



Inventory of Counsellor's Non-verbal Communication

Desirable

Facial expression

Direct eye contact (except where culturally unacceptable).

Warmth and concern reflected in your face.

Eyes at same level as client's.

Appropriately varied and animated facial expression.

Mouth relaxed, occasional smiles.

Posture

Arms and hands moderately appropriate gestures.

Body leaning slightly forward, attentive but relaxed.

Physical proximity

Three to five feet between your chairs.

Voice

Clearly audible but not loud;

Warmth in tone of voice; voice modulated to reflect feelings of concern, approval, etc.

Moderate speech tempo.

Undesirable

Avoidance of eye contact (unless it is a sign of respect in your culture).

Eye level higher or lower than client's.

Staring or fixating on person or object.

Nodding head excessively.

Frozen or rigid facial expressions.

Pursing or biting lips.

Rigid body positions, arms tightly expressive, folded.

Body turned at acute angle.

Fidgeting with hands.

Clipping nails or doing other private tasks.

Rocking in chair.

Standing or placing feet on desk.

Hand or fingers over mouth.

Pointing finger for emphasis.

Excessive closeness or distance.

Mumbling; speaking inaudibly

Monotone voice; frequent grammatical errors

Prolonged silences, nervous laughter, speaking loudly

The Counselling Process

You will really begin the counselling process after the client's problems have been explored and agreement reached as to the nature of the problem and the issues involved. The counsellor is thus in a position to formulate a contract with the client. A contract specifies goals to be accomplished and the means of accomplishing them. It clarifies the roles of the participants and it establishes the conditions under which assistance is provided. Goals specify what the client wishes to accomplish or change, based on the wants and needs which you have helped to identify.

Goals serve the following functions in the helping process:

- To make sure that you and the client are in agreement about objectives to be achieved.
- To provide direction and continuity in the helping process.
- To facilitate the development and selection of appropriate strategies and interventions.
- To assist you and your client to monitor their progress.
- To help you and the client to evaluate the effectiveness of specific interventions and of the helping process.



Goals may be categorized in a broad sense as 'discrete' or 'ongoing'. Discrete goals are one time actions or changes that address problems. An example may be obtaining a needed resource (e.g., medical treatment). Ongoing goals, by contrast, involve actions that are continuous and repetitive. Progress towards such goals is step-by-step. Examples of ongoing goals include managing conflict effectively, for example avoiding the use of force or violence (anger management).

Guidelines for Selecting and Defining Goals

Goals should be selected and defined with care. Below are some guidelines for goal selection that you can use with your clients:

- Goals should relate to the desired end sought by clients.
- Goals should be defined in explicit and measurable terms.
- Goals should be feasible.
- Goals should be within the range of your knowledge and skills as a counsellor.
- Goals should be stated in positive terms that emphasize growth.
- Goals should be consistent with the functions and mission of your group or agency.

You always need to be aware of your emotions and feelings at a personal level and learn to have objective attitudes towards your clients. This is a basic characteristic of 'professional' behaviour.

The easiest goals should be addressed first. This allows the client to feel success, which builds confidence and motivation.

Process of Mutually Selecting and Defining Goals with the Client

- Determine your client's readiness to negotiate goals.
- Explain to your client the purpose of selecting and defining goals.
- Select appropriate goals mutually.
- Define the goals explicitly.
- Determine the feasibility of goals and discuss their potential benefits and risks.
- Assist your client to make a choice about committing himself to specific goals.
- Rank goals according to your client's priorities and according to the nature of the goals. The easiest goals should be addressed first. This allows the client to feel success, which builds confidence and motivation.

Breaking Down Large Goals into Smaller Steps

The first task in developing strategies to attain goals is to reduce them to manageable parts. These parts consist of discrete actions to be undertaken by the client. Behaviour change is very difficult for all of us and particularly for addicts.

It is important to bear in mind that when a client agrees to carry out a task, it does not necessarily mean that the client has the knowledge, courage, interpersonal skill or emotional readiness to implement the task successfully. You need to help your client to set small, realistic goals that are achievable, so that neither of you will be disappointed by large failures at the beginning of the relationship.

Example of breaking down large goals into smaller steps

If the ultimate goal of a couple is to reduce the frequency and severity of marital conflict, then the goal can be broken down into the following steps.

- To reduce criticism and put downs that provoke defensiveness and recriminations.

- To identify physical outlets or calming techniques for either or both partners so that they can resist the impulse to use physical violence. This should be an immediate urgent priority for you as a counsellor.
- To identify sources of anger and to learn and apply effective conflict resolution skills.
- To work together in identifying problems and employing problem solving strategies.

Formulating Tasks

After having begun work on sub-goals, the next step is to help your client develop the means for reaching them. This involves mutually planning the tasks or actions that the client needs to accomplish to attain each sub-goal. Tasks may consist of changes in thought or actions that require effort on the client's part. An example of an active task : "To talk about feelings of hurt to a significant person in your life." An example of a thinking task could be "to meditate for thirty minutes daily or to recognize your angry feelings before they get out of control."

After agreeing on one or more tasks, your next step is to assist your client in preparing to do each task. To do this, it is useful to:




- Enhance the clients' commitment to carry out a specific task by asking her to repeat the task out loud and promise to do it.
- Plan the details of carrying out the task.
- Analyze and resolve obstacles that the client expects to face.
- Ask the client to rehearse or practice the behaviours involved in carrying out the task.
- Summarize the plan of task implementation. Offer encouragement and express your expectation that the client will carry out the task.
- Determine a time-frame to perform the task.

How to Develop the Client's Confidence and Ability to Change

One of the counsellor's major tasks is the attempt to create an incentive for change. Although many clients know what their problems are and have a real desire to change, they may lack the confidence to try. The capacity to hope is essential for the recovering addict; it is part of your job to revive and foster this precious feeling in your client.

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Addicts typically convince themselves that they are victims of forces beyond their control. By helping the client to tell his stories, you can help him recall how he may have shown personal strength in the past.

Small victories are very important. Identify small changes that the client can make in her life that will have a positive impact, increase their comfort, security and sense of self-worth. Look for the smallest signs of hidden strength, latent goodness or buried desire for approval and acceptance in your clients. These are the addict's hidden inner resources, out of which new self-esteem can grow.

To inspire the client to seek change, you need to communicate your own hope, respect and confidence in the client's basic potential and dignity. You need to have faith that you can help her deal effectively with her problems.

You can also help the client to see and understand how his own habits of thought may be preventing him from changing. Addicts typically convince themselves that they are victims of forces beyond their control. The drugs are too powerful, everything happens to them, they have no control to change their situation. By helping the client to tell his stories, you can help him recall how he may have shown personal strength in the past. You can help him to regain confidence in his ability to change.

Acknowledge that his drug-taking may have been an attempt to take care of himself in very difficult circumstances, while pointing out that this has had negative consequences for him. Self-knowledge is liberating. For the recovering addict, it is half the battle.

Referral

The recovery of the whole person is complex and can benefit from a large variety of services. No single centre will be able to offer all the most appropriate facilities and cater for all the rehabilitation needs of the addict. You have to work with the resources that are available to you. If you have access to other helping units or services, you will often refer clients to these other services and opportunities.

Over time, you will need to establish links with other organizations, detoxification centres, self-help groups, hospital wards, social welfare centres, religious and spiritual organizations, the probation service, trade schools or vocational training institutions, Alcoholics Anonymous (AA) etc. It is important for you to know where these services are located, who to contact within each and their telephone numbers.

When making a referral, it is a good idea to meet with the service provider in the other centre to discuss the contents of your client's file (with the client's consent). The client must not feel rejected. You need to be sure he understands that it is in his best interests to be transferred to a specialized service and that appropriate follow-up will be ensured by the Case Manager.

Referring clients to other resources requires careful handling, otherwise clients often do not follow through to reach resources that could be very beneficial to them. The following are guidelines that can help you in making referrals:

- Be clear about the reason why you are considering referral. A referral is an action intended to assist a client solve a specific problem. Therefore, it is important to help the client identify and clarify the problem as she sees it. Only then can the counsellor hope to make an appropriate and effective referral.
- Determine which resource best matches the client's needs. To accomplish this, you must be knowledgeable about various helping



people and organizations in your community, the quality of their services and any rules or conditions that your client should know about. It is useful for you to develop your own list of resources and to have personal contact with the responsible officers or helpful individuals in each place.

- You can recommend positive referral options but, but you need to respect the client's right to self-determination. He may not be ready or willing to seek additional help.
- Avoid making unrealistic promises about what another agency can do in assisting the client.
- Although you should clarify the function and methods of the agency selected, avoid specifying which services will be provided to your client. You probably have very little influence on the approaches and services provided by your colleagues.



Consider these seven 'connection techniques' which can enhance your rate of achieving successful connections between clients and resources in the community:

1. Write out the necessary facts about contacting the resource, including such information as name and address of the resource, how to obtain an appointment, how to reach the resource and what the client may expect upon arrival.
2. Provide the client with the name of a specific contact person. To avoid disappointment and discouragement if the contact person is not available, provide alternate names. Ideally, help make the contact by phoning to introduce the client.
3. If the client's problem is complex, provide the client with a brief written statement, addressed to the resource, detailing the problem, actions initiated and the services desired or needed by the client.
4. If your client is reluctant to go to the resource alone, it may be advisable to arrange for the accompaniment of a family member or friend.
5. Have the client call the resource from your organization/office to make an appointment. You may choose to place the call to assure that the client reaches the contact person and then turn the conversation over to the client.
6. Make a follow-up call to ensure contact has effectively been made.
7. If a client has been referred to your service, it is a good practice to send an acknowledgment note to the person who sent the client.

Group Counselling and Family Counselling

Principles and Methods of Group Counselling

How to approach group counselling

The emphasis so far has been upon a helper working with an individual. Not all counselling and helping takes place in this way. Counselling activity can take place in groups of individual clients or when two or more people are seeking help together.

To be successful, group counselling needs to involve two interdependent ways of communicating among group members:

- Task behaviours, that is, those related to goal achievement; and
- socio-emotional behaviours, ways of acting and feeling to maintain harmony among group members while they are working to achieve goals.



The following are task behaviours that you, as the facilitator, can encourage:

- Giving suggestion or direction.
- Giving opinion, evaluation, expressing feelings or wishes.
- Giving orientation or information or repeating, clarifying or confirming.
- Asking for opinion, evaluation or analysis or expressing feeling.
- Asking for suggestion, direction or possible ways to act.

Here are some positive socio-emotional behaviours to encourage and model by your example in the group:

- Showing solidarity, raising the status of others, giving help, rewarding.
- Showing tension release, joking, laughing, showing satisfaction.
- Agreeing, showing passive acceptance or understanding.

Disagreement is not always a bad thing. It can be positive because new learning often requires the free expression of different points of view.

Creative Disagreement

Disagreement is not always a bad thing. It can be positive because new learning often requires the free expression of different points of view. Part of your job as the group facilitator is to foster feelings of safety so that group members can express strong feelings and points of view without fear of rejection.

Negative socio-emotional behaviours to discourage in the group include:

- Aggressive disagreement including personal attacks, showing passive rejection, formality and withholding help.
- Withdrawal, showing antagonism, negative put-downs.

The maintenance and task functions within the group correspond to the Yin/feminine and Yang/masculine principles of ancient Chinese philosophy. These two qualities, when they are in proper balance, assure fruitfulness and fulfillment.

Some Key Factors for Success

Stay connected whatever happens. Discussions around personal faults and shortcoming may be very tough at times.

Remind group members that confrontations with peers can be healthy.

Encourage group members to learn from each other's failures and successes in their common struggle to overcome addiction.

Each member must commit himself to perform specific tasks in relation to his rehabilitation goals and those of the group.

Draw the issues chosen for discussions from real-life situations that the members are likely to encounter in their everyday life, such as peer influence, coping with negative feelings, social pressure etc. (see *Common Causes of Relapse*, p. 63).

To fully participate, each member must be ready to provide support and encouragement to other members in difficult times.

Participation in the group sessions is voluntary and should not be imposed on recovering addicts.

Techniques of Group Counselling

- **Attending:** letting others in a group know that you are paying close attention to what they say and do. Attending comes first because it is basic to all other techniques.
- **Information management:** asking questions and giving information in a group.
- **Contract negotiation:** working out an agreement on objectives for the group and for the individuals in it. Ask each member to make a pledge to respect and adhere to the group's rules and responsibilities.
- **Rewarding:** providing payoffs, for example, praise, for effort and achievement in a group.
- **Responding to feeling:** letting others in a group know that you understand accurately how they feel about a situation.
- **Focusing:** keeping a group discussion on track.
- **Summarizing:** gathering together what has been said by group participants for review and consideration of next steps.
- **Gate-keeping:** achieving a balance of participation in a group.
- **Confrontation:** informing a participant, sub-group or the entire group about any contradictions between words and actions. Confrontation is placed here rather than earlier because it is more likely to be useful and creative once a group has established mutual trust and worked through its contract.
- **Modelling:** teaching by demonstration and learning by imitation.
- **Mediating:** resolving conflicts among group participants.



All members must promise to observe strict confidentiality if they want their peers to express their inner feelings and personal problems freely and voluntarily. The details of others' personal stories should not be shared outside the group.

Group members need to develop their capacity to listen to the views of their peers and other wise friends, and discover that there are new ways of seeing things once the veil of addiction is lifted from their eyes.

The group provides opportunities to constructively criticize and be criticized for attitudes and behaviours that are contrary to the rehabilitation goals of the individual and the group. This attitude differs greatly from the blaming and accusing approach of parents and relatives who do not understand the complexity of addiction. On the contrary, the group criticisms come from people who have gone through similar or even worse problems but who, through their participation in the programme, have developed new insights and coping skills on their road to recovery. They are no longer in denial or looking for scapegoats to justify their addictive behaviour.

The details of others' personal stories should not be shared outside the group.

The peer group provides a more intimate and understanding atmosphere, less stigma and shame; more support and unity; less rejection and exclusion.

The group helps its members to identify their personal triggers that may result in a slip or a relapse. Many will relapse and abandon the recovery vehicle, but the counsellor and the group must be prepared to intervene spontaneously; first to avoid the slip as far as possible; and second, to help the member cope with the situation and resume the recovery journey after a slip or lapse. Each successful intervention adds to the credibility of the group and reinforces its importance as a vehicle on the road to recovery.

Recovering Addicts as Co-counsellors

It is extremely valuable to train a few senior recovering addicts to gradually play a more prominent role than others during the group counselling sessions. These alumni or graduates of your programme represent credible role models for newcomers who may accept their points of view more easily because they speak

from experience. When new clients find the tasks they have been asked to perform by the professional counsellor too difficult or unrealistic, these 'mentors' can boost morale and help new clients see these challenges as important milestones on the road to recovery. Furthermore, since these people were once part of the same sub-culture, they have deep insights into the addicts' problems and can communicate with and understand them better than many health professionals. They are living proof that rehabilitation is possible. Their testimony can motivate effected families and mobilize the community to support the social re-integration of detoxified addicts.

The senior recovering addicts not only act as mentors and key resource people in the group counselling sessions, they also gain from the experience. By participating actively in the group sessions, they pursue their own recovery goals and their self-confidence is enhanced. Whereas they may have caused great suffering due to their drug habit, they now become part of the solution instead of part of the problem. By staying abstinent and helping others out of drugs and alcohol, the senior recovering addicts prove that drug addiction or alcoholism are treatable diseases. And after rehabilitation, by

becoming productive members of the community, they help a great deal in removing the stigma that excludes former drug abusers from the mainstream of society.

Group Counselling Process

Although there are variations in the way that rehabilitation counsellors conduct group sessions, these meetings can be divided into three main stages:

1. Sharing personal problems, slips, frustrations, as well as success and growth events.
2. The whole group discusses an agreed topic of the day.
3. Defining next steps and specific tasks to achieve rehabilitation tasks

Sharing of Personal Failures and Successes

As new members keep joining the group it is good to start each session by a brief presentation of each member of the group. This is immediately followed by a series of individual statements on issues relating to personal problems, constraints, negative



encounters and pressures to use alcohol or drugs since the last group meeting. Other members are given the opportunity to share their experience and how they coped in such situations.

After a first round of negative issues, the members are invited to share positive growth events and small successes registered since the last group session. The counsellor underlines the coping and resistance skills used in overcoming difficulties to achieve rehabilitation goals.

Group Discussions

During the second part of the group meeting, the counsellor, after consultation with the group, suggests a rehabilitation topic for open discussion. A list of such topics could include:

- forms and sources of alternative recreational activities
- the value of productive work and other activities that can diminish the urge to use drugs or alcohol
- resisting drug offers
- coping with social/family pressures

It is extremely valuable to train a few senior recovering addicts to gradually play a more prominent role than others during the group counselling sessions.

In almost all families where there is a drug abuser, the family suffers from severe stress and conflict.

- coping with negative feelings
- managing highly positive or happy events without using drugs
- what is ambivalence (mixed, contradictory feelings) and how to cope with it
- coping with injuries and pain without using drugs
- understanding psychological dependence
- identifying personal triggers
- how to prevent a slip or lapse
- what to do immediately after a slip or lapse
- other helping resources in the community

This part of the session can at times be replaced by a video, slide show or a brief talk by a knowledgeable person or a graduate who has successfully gone through all the stages of recovery. A role-play on a particular aspect of rehabilitation is another constructive alternative.

After the sharing and discussion of personal problems, sharing of ideas and coping skills, you may assign specific tasks to individual members according to the challenges with which each is dealing. Their efforts to complete tasks or overcome challenges serve as a basis for discussion in successive meetings.

Principles and Methods of Family Counselling

Why should we involve the family?

People who misuse drugs often live with their family. Even when they live on their own, there is nearly always a family member or close friend in their life. The effects of the drug-user's habit may have a profound consequences on family members and significant others. Often it is somebody other than the user who first seeks help.

In almost all families where there is a drug abuser, the family suffers from severe stress and conflict. All the members who interact with the drug abuser suffer directly or indirectly from his behaviour. Family members suffer because they do not understand the dynamics of drug dependence and therefore lack the necessary skills to cope with the manipulative behaviour of the drug-dependent person. There may also be co-dependency which needs to be addressed in counselling (see Co-Dependency: The Family Disease, p. 53). Family counselling aims to help the members understand and cope with the situation and to enlist their support in achieving the recovery goals of the drug-dependent person.

A major challenge for the family counsellor is to convince family members (who may or may not be using drugs or alcohol themselves) to attend counselling sessions. Even if all the members of a family do not turn up for counselling sessions, you can start working with those who do – in order to assess the family situation.

Substance abuse is a coping strategy. People do it in order to ‘feel better’, so relapse often occurs when the recovering addict is confronted with conflict, rejection or a sense of failure.

Very often a relapse is provoked by a family member’s negative attitude or behaviour towards the addict. This occurs because he or she does not understand how fragile the addict may be during the early stages of detoxification and rehabilitation. In numerous cases, bad family conditions in themselves might have contributed to the addiction of one member. Family counselling aims to reduce these tensions and to enlist the whole family in the rehabilitation process.



Counselling for young people on substance abuse and sexual health matters often leads to family counselling. Your aim is to help family members understand the situation, and to enlist their compassion for your client.

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The Challenge of Engaging the Family in Counselling

Family members usually experience the following anxieties when confronted with their relative's drug problems:

Denial: Parents deny that a member of their family has a drug problem even when faced with strong facts. As a counsellor, you need to be careful not to reinforce this denial by your disapproving, judgmental words or attitude. Pride tends to increase when it is opposed.

Shame: Whether the substance is socially acceptable like alcohol or is illicitly obtained, people in the family often feel ashamed. Their first response to the problem may be an effort to hide it.

Self-blame: Some families often feel they are to blame for the situation and reproach themselves. Parents may feel they have failed. "This is the child on whom so many hopes have been pinned but perhaps I got it wrong. Did I over-indulge him or did I sometimes neglect his real needs?"

Anger: Throwing blame around is another common family response. The school, friends, society as a whole, the pub, or pushers are all blamed. Alternatively, the user or drinker may be blamed. "How could he have betrayed me like this?" For instance, a wife who is taking tranquilizers daily may blame her husband, who drinks too much, for all the difficulties in the family.

Confusion: Family members often feel at the mercy of conflicting emotions. While they strive to protect the user from harm or censure, they feel furious that he or she has been "so stupid." Some people deny these unpleasant feelings by saying, "There must be some mistake." "Even if it is true, I am not going to let it upset me."

Ways of Offering Help to Family Members

A variety of strategies are available for helping the relatives of drug abusers. These are:

- To provide individual support, counselling or casework to the relatives.
- To work with the family which may include the use of family therapy techniques.
- To teach them what they must do and what the must not do in their relationships with the recovering addict.

To provide clear information to the family about drugs, the stages leading to the Drug Dependence Syndrome, tolerance, physical and psychological dependence.

It is important to talk to the family about things that they should stop doing, or not do, if they want to help the drug abuser. They should not:

- Remain isolated.
- Maintain a judgmental attitude.
- Give money to the addict.
- Pay off the addict's debts.
- Move out from where they live presently.
- Habitually compare the addict to others who are healthy or successful.

Encourage family members to:

- Maintain contact and care for the drug abuser.
- Be understanding and compassionate toward the drug user. Recognize her habit as an illness to be healed with love and hard work.
- Confront the problem and not the person.
- Remain confident and hopeful.




The 'Enabler' in the Family

One of your first jobs as a family counsellor is to identify the enabler(s) in the family. These are people who sympathize with the addict to the extent that they might cover-up the addict's destructive behaviour. Enablers protect and shield the addict from the consequences of his heavy drinking or drug abuse. Enablers will go as far as lying, making excuses, hiding his mistakes and even give Monday morning alibis when the employed drinker or addict does not want to or cannot attend work. Worst of all, they may secretly provide the alcoholic or drug abuser with money to buy alcohol or drugs.

Once a degree of trust and open communication has been established (see Techniques of Group Counselling, p. 45) you can begin to work with the enabler. Your task is to help the enabler in the family to take responsibility for the consequences of her condoning attitude. You can help her see that the addict will not seek help or recovery outside the family as long as his needs are met within

Enablers protect and shield the addict from the consequences of his heavy drinking or drug abuse. Enablers will go as far as lying, making excuses, hiding his mistakes and even give Monday morning alibis.



the family. He will not attempt to solve his own problems in a responsible way if the anxiety or sense of honour of the family prevents the addict from facing the nature of the addiction.

Indifferent Members of the Family

In contrast, other members in the family, after having suffered for years, may become completely indifferent to the fate of the addict. They have reached that stage because they did not think it fit to seek help outside the family. Furthermore, they discovered that moralizing and making long sermons or pleading and begging the addict to stop, did not work. These attitudes tend to increase the sense of guilt in the addict. Such members pretend they no longer care, but they are deeply effected. They will continue to suffer as the family breaks down under the burden of conflict, lies, betrayal and the financial costs of the drug habit.

Supportive Members of the Family

Apart from the enablers and those who appear indifferent there may be members of the family who continue to show a genuine concern for the condition of the addict. They want to understand and to help.

In the family counselling process, start by working with these supportive family members. Arrange to meet with them (in the absence of your client) for a session to explain physical and psychological dependence, so that they understand the compulsive behaviour of the addict. They need to know how and why neither the sympathetic attitudes of the enablers nor the tough, indifferent, or violent attitudes of others will help the addict and the family out of their problems. The more disturbed the emotions of the family, the less adequate their help and support will be.

Most family counselling sessions are conducted in the presence of the client who is in rehabilitation. During such sessions, members of the family are informed about progress achieved and problems encountered by the addict during the recovery journey. Eventually the supportive members will realize the importance of adopting and practicing new

ways of relating to both the addict and one another. In the long run this bridges the gap between them and the enablers and/or indifferent members of the family. Equipped with the necessary coping skills, they thus become active partners of the rehabilitation team, helping the whole family adopt and practice a healthier lifestyle. Your aim is to help these people attain the emotional maturity necessary for their own recovery and that of the addict.

By having the family members and the substance abuser in the same counselling sessions you can also find out whether your client is sticking to his rehabilitation goals by respecting his commitments to recovery. Here you must avoid taking sides, rather you need to maintain and nurture the respect and confidence of both the client and the family, to help them progress and grow together.

Co-dependency: The 'Family Disease'

Co-dependency is a term used to describe certain types of family relationships that may reinforce or help to maintain various types of addictions, including addiction to alcohol. For example, the spouse of an alcoholic may find gratification in managing and controlling the



alcoholic, which affirms the addict's sense of powerlessness and reinforces the desire to drink.

The following scenario illustrates how a family may progressively come to tolerate and support the unhealthy habits of a drug abusing adult parent:

The drug dependent person denies the drug problem, blames others, forgets and tells stories to defend and protests against humiliation, attack and criticism from others in the family – while wasting money on drugs. He becomes unpredictable and impulsive in behaviour, resorts to verbal and physical abuse and lies; gradually losing the trust of family, relatives and friends. He may experience diminishing sexual drive.

As his health deteriorates, he has feelings of despair and hopelessness; and loses interest in his physical looks and environment.

The spouse tries to hide and deny the existing problem of the dependent person. She takes on the responsibility of the other person,

The children may be torn between both parents. In being loyal to one, they arouse and feel the anger of the other. One or more of the children may become responsible for the addicted parent, and may become emotionally invested in caring for and protecting the dependent adult.

managing all family affairs. She takes a job to care for the family which, in turn, takes her away from home. She finds it difficult to be open and honest because of resentment, anger and hurt feelings, and shows gradual social withdrawal and isolation. She may lose self-respect and self-worth despite the empowerment of being head of the household – leading to her possible use of alcohol or prescription drugs to cope with the stress.

The children may be torn between both parents. In being loyal to one, they arouse and feel the anger of the other. One or more of the children may become responsible for the addicted parent, and may become emotionally invested in caring for and protecting the dependent adult. The children may be deprived of emotional and financial support, and lose their ability to trust adults. They may lose sight of values, standards and goals because of the absence of consistent and strong parenting. They may lose confidence and self-worth; avoid contact with friends; and may perform less well at school or sometimes may drop out of school.

This describes a typical family affected by drug or alcohol addiction, in which the parents and sometimes the children are co-dependent.

Learning New (and old) Ways to Feel Good Without Drugs

As soon as the family relationship starts to stabilize, we need to help the addict and the family discover new pleasures and rediscover old ones. The drug and its rituals represented a reward that removed the pain and relieved the client from the terrible symptoms of withdrawal. She may have lost touch with positive, rewarding activities as her life became more centered around getting drunk or getting high.

After detoxification, it is imperative that the recovering addict gets into situations where she can unlearn the destructive drug abuse lifestyle *before* starting to re-learn and re-acquire positive ideas, beliefs, values, attitudes and behaviours which will facilitate his rehabilitation in society. Group counselling is an ideal platform for such growth and learning.


Rehabilitation and Relapse Prevention

Rehabilitation

Whole Person Recovery

Rehabilitation is the process of recovering those capacities that have been diminished due to illness or injury. This recovery can only be sustained if the addict does not relapse or return to substance abuse. Thus, the proof of successful rehabilitation is in relapse prevention. However, rehabilitation is more than simply avoiding drugs. Our goal is to help our clients to re-integrate into their community as productive and valued people.

The Whole Person Recovery concept is a way of understanding the process of rehabilitation as a long journey. The various methods and contexts for rehabilitation – such as individual, group and family counselling, self-help groups and vocational rehabilitation – are vehicles for the journey. But the client is not a passive passenger in these vehicles. With the help of the



counsellor, he is now back in the driving seat on the new journey along his life path. The counsellor acts as a guide and shows the route, takes on board travelling companions and can even act as mechanic to ensure that the vehicles are properly maintained. The vehicles of therapy and the support of the counsellor/mechanic are essential, but the recovering person can only progress on the journey through his own participation and energies.

As the client comes out of the detoxification phase of treatment you can start to lay the foundations of the rehabilitation process. Abstinence in itself is not enough. If the addict does not see the benefits of remaining abstinent she will relapse sooner or later. As described in Chapter Three, the recovering person needs your active guidance to clarify the paths to a major change in lifestyle.

Rehabilitation comes from the Latin word rehabitare, to return home to your self (to be yourself again).

Your Role as a Rehabilitation Counsellor:

Effective rehabilitation counsellors are like skilled and experienced tutors. "They know when the learner should work harder, when to speed up, slow down, or repeat an exercise, and when a skill has finally been mastered and it's time to move on to the next step. They can communicate so that the client hears, and can listen so that they understand what the client feels. In short they know how to teach and not merely preach." – Fred Zackon

The Counsellor as a Positive Role Model

The client perceives us as positive role models. We need to live up to the standards we urge upon our client in terms of frankness, honesty, reliability, interpersonal skills, responsibility, perseverance, genuine concern for others and commitment to self-improvement. We must maintain a professional relationship with the client. We must show care and respect for the client if we want the client to demonstrate care and respect in his own life.

What We Cannot Do for the Client

In spite of all the experience, wisdom and goodwill of the individual counsellor, there are certain decisions we cannot take and things we cannot do for the client. If a drug-dependent person really wants to achieve complete recovery the individual will have to:

- Develop the ability to honestly criticize her self, her attitudes and behaviour.

- Acknowledge the fact that he has lost control over his drinking and/or drug using habit. Learn or relearn the basic, undisputed facts about drug abuse, physical and psychological dependence.
- Acknowledge the economic, health and psycho-social consequences of abusing drugs.
- Realize that the road to recovery is very difficult and that he can do it, but not alone.
- Obey the rules and norms of the treatment facility, the recovery self-help group or other services that she participate in.
- Participate actively in skills development exercises organized by the recovery centre.

Case Management

As each case needs to be closely monitored, it is advisable for each client to have what we call a Case Manager. Case management aims at a continuous supervision and documentation of the client's needs. The Case Manager is preferably, but not necessarily, the person who welcomed and assessed the needs of the client on his first visit to the treatment facility. The Case Manager may also discuss the case with a staff team, which could include the vocational counsellor, the family counsellor, the group counsellor and the psychotherapist, if any of these are available to you.

Duties of the Case Manager

The Case Manager is the client's personal link to the treatment facility. He or she is expected to be in command of all the important facts about the client; and has a variety of duties as shown below:

- Ensuring the appropriate assessment of the client's problems.
- Co-ordinating with relevant services as required.
- Taking special and urgent action if needed.
- Encouraging the client to participate actively in the recovering peer group.
- Preparing the client for vocational rehabilitation (job skills training).
- Helping the client to secure and maintain a job.
- Ensuring follow-up action on measures recommended by the multidisciplinary team.

As mentioned in Chapter Three, all the information shared during these staff meetings should be treated with the strictest discretion.



Street vendors know our target group very well. You can learn a great deal by establishing relationships with people involved in the petty trade of alcohol and drugs in your community.

Rehabilitation is more than simply avoiding drugs. Our goal is to help our clients to re-integrate into their community as productive and valued people.

During the individual counselling session, the recovering addict may reveal very delicate and personal problems, such as having been involved in burglary; female and even male prostitution; homosexuality or being HIV positive. Addicts have many such 'secrets' which they do not want or have not had the opportunity to share with others. This information should only be shared with other staff as needed to help the client. All clients should be informed of this important principle.

Record Keeping

Regular entries in the client's file are extremely important for various reasons. As the client may be 'coached' by several counsellors during the rehabilitation process, these entries help the recovery team to take appropriate and timely decisions. Notes should be simple, clear and brief – recording the progress of the client in relation to his recovery goals. Unexpected problems as well as proposed measures, services offered, or other major decisions relevant to the client

should also appear in the file. The Case Manager then ensures appropriate follow-up action based on the team's recommendations. Precise records also provide useful information for assessment and evaluation of staff performance.

Peer Counsellors: Engaging the Support of Recovering Addicts

Ex-addicts, particularly those who have achieved their full rehabilitation, can be very effective resource people in rehabilitation programmes, as described in the Group Counselling in Chapter Four. In some excellent programmes, the programme alumni (rehabilitated addicts) are employed to provide ongoing follow-up support to clients. Here are some ways that ex-addicts can help you:

- Counselling addict-clients (peer counsellors).
- Co-leading Self-Help support groups.
- Serving as 'mentors' and 'big-brothers' for other ex-addicts who are struggling to find their place in the community.
- Helping to counsel the families of addicts and ex-addicts.
- Encouraging the staff to improve their programme.
- Helping staff planners and policy makers to improve their rehabilitation programme.

- Educating the public about the problems of addiction and recovery through presentations to community groups and the media.

Volunteer service performed by ex-addicts supports their own recoveries. It increases their self-knowledge, yields the satisfaction of helping, brings them esteem and gives them experience that might lead to paying careers. However, one of the biggest challenges of programme managers is to find and recruit appropriate ex-addicts. Since addiction is a chronic relapsing disorder, any ex-addict may relapse. It is important to recruit the right people in order to minimize these problems. Three strategies can be used to recruit ex-addicts:

1. Solicit ex-addict volunteers as one does with other citizens.
2. Form a Self-Help organization for fully drug-free addicts.
3. The third strategy is the simplest and most practical. Use the graduates and senior clients of one's own rehabilitation programme. For some clients, volunteer activities can be a fulfilling part of after-care and social reintegration activities.



Vocational Rehabilitation

For most of us, it is very important to have productive work in order to feel good about ourselves. This is also true for recovering addicts. Work is an essential path toward rehabilitation. Unemployment may lead to drug abuse, but it is equally true that drug abuse may lead to sacking and unemployment. Apart from the legitimate income that paid employment can provide to men and women, job responsibilities fulfill many other rehabilitation goals. This can be a paid or volunteer job, or the work of maintaining a home and vegetable garden.

During the individual counselling session, the recovering addict may reveal very delicate and personal problems, such as having been involved in burglary; female and even male prostitution; homosexuality or being HIV positive. Addicts have many such 'secrets'. This information should only be shared with other staff as needed to help the client.

In some excellent programmes, the programme alumni (rehabilitated addicts) are employed to provide ongoing follow-up support to clients.

Work can provide:

- A structured activity that provides focus for time and energy.
- Opportunities to make new abstinent friends.
- A positive social environment that requires harmonious interaction with co-workers, supervisors or members of the public.
- Sense of accomplishment and contribution to the family and society at large.
- A structure for responsibility and respectability.
- A productive solution to idleness and boredom which in themselves can trigger a slip or a relapse.
- Occasions to develop self-discipline and to follow rules and regulations.

A structure to develop patience, as the employee may be required to operate within a limited space for long hours. This is of great therapeutic value because the recovering addict may be accustomed to seeking immediate gratification or relief from pain through drugs.

A structure to become more trustworthy and reliable.

Community Service

The involvement of recovering addicts in volunteer work is a good transition towards social reintegration. Such work may include small environment protection projects: cleaning a yard or public place; helping at community/health centres, orphanages or old people's homes; painting social welfare centres or other public buildings, or attending to handicapped persons.

If properly planned and adequately explained, community service can fulfill the following rehabilitation goals:

- Boosting the client's self-esteem.
- Promoting feeling of being helpful to the community.
- Providing good and regular occasions to meet social workers and other positive role models
- Opportunities to practice good time management and work habits.

Important Points to Consider

Help the recovering addict to consider all the above-mentioned aspects of productive work, whether it is paid or unpaid.

Although employment is an important recovery vehicle, simply getting a job is not in itself a long-term rehabilitation goal. Your client needs careful preparation and training to increase his or her chances of becoming and remaining employable.

If possible, the client needs to have opportunities to engage in productive, useful work at the recovery centre. Small chores like cleaning, gardening, washing, cooking, preparing a room for a group meeting, and maintenance are ideal. These tasks provide a context for the client to develop good work habits, attitudes, values, comfort with routine, punctuality and the general discipline necessary to maintain a job. Later on, in the group meetings, you can discuss how the client has responded to supervision; the way she interacted with others; the degree of patience he or she demonstrated and the rewards of responsibility. Help her express any dissatisfactions or frustrations as well as joy and feelings of accomplishment.

You can talk to your clients about the basic skills required to search for a job, and how to behave in an interview. Help them to practice self-presentation in brief role-plays.

To introduce your clients to work that may be appropriate and accessible to them, you can invite relevant guest speakers – such as ex-addicts who are now employed – to give talks.

When your clients find jobs, encourage them to perform well and to set an example for others to follow. The more the employers are satisfied with the quality of your referrals, the more willing they will be to offer jobs to other recovering addicts and the more credible the rehabilitation centre will become.

Organize adult education classes and promote the idea of life-long learning among your clients. It is difficult for many illiterate people in cities and towns to find and maintain a decent job. The uneducated person with a drug problem is doubly disadvantaged.

Provide your clients with current information on local job opportunities, where to look for work, and who to contact.

Note: For follow-up with employers and supervisors see Chapter Six: Termination and Follow-Up.

Apart from the legitimate income that paid employment can provide to men and women, job responsibilities fulfill many other rehabilitation goals. This can be a paid or volunteer job, or the work of maintaining a home and vegetable garden.

Often, clients will quit attending counselling and relapse prevention sessions once they are drug-free and no longer experience withdrawal symptoms. They wrongly believe they are now 'cured'.

Community Awareness

For social reintegration to become a reality, you need to generate support and acceptance for your clients in the community at large.

Talks in schools, socio-cultural and religious organizations and parents' groups can be organized to give an opportunity to recovering and recovered addicts to talk about their experiences and their struggle to re-join the mainstream of society. All the social partners in the community need to be sensitized to have compassion for drug abusers, and to understand more about the dangers of substance abuse. Public speaking is a good opportunity to put a human face on the drug problem; to increase understanding and recognition of drug problems as a public health issue; and to reduce fear in your community. It is in the interest of each and every member of society to fight against substance abuse, each according to his or her means. Our efforts to understand and help the substance abuser must go hand-in-hand with the abuser's efforts to re-join the community and stay healthy.

Relapse Prevention

Understanding Psychological Dependence

As a rehabilitation counsellor your most challenging task is to prevent your client from relapsing into addiction after weeks or months of patient counselling. The relapse rate is very high worldwide, because most addicts think that if they have conquered the withdrawal syndrome associated with physical dependence, they are free of the addiction. They fail to recognize the power of psychological dependence, which is the root-cause of most, if not all, relapses. Often, clients will quit attending counselling and relapse prevention sessions once they are drug-free and no longer experience withdrawal symptoms. They wrongly believe they are now 'cured'.

Viewed from the public health perspective, drug addiction is now largely recognized as a disease. But as a counsellor you know that drug addiction is not just a physical disease.

As far as other diseases are concerned, patients tend to be happy about their recovery and want to forget the past. When it comes to addiction, the situation is quite different. The addict wants to avoid the withdrawal pains and the economic

and social consequences of the disease; but he does not shun the bottle itself or the needle. This is because he associates the drugs and the rituals of substance use with pleasure and euphoria. Psychological dependence is that constant longing for the substance in order to re-experience the euphoria.

It is amazing how, after several months or years of total abstinence, the recovered addict recalls the euphoria associated with early use but forgets about the cycle of painful withdrawals and compulsive drug-searching behaviour.

The Addict as an Immigrant

The recovering addict may be compared to an immigrant. The first thing that an immigrant needs, after leaving his homeland, is to seek new relationships and new friends. He needs moral support and understanding, particularly during the first few weeks when he will experience a strong nostalgia for his homeland. Similarly, if the recovering addict does not find understanding and support, he will feel very isolated and will want to return to his 'friends', his substance abuse rituals and his old lifestyle.



Common Causes of Relapse and Some Ways to Respond

The recovering addict, although completely drug-free after detoxification, remains a highly vulnerable person. Our role as counsellors is to help her remain constantly on the look-out for dangers at any cross-roads. Research studies and surveys have shown that there are many causes of relapse.

All the social partners in the community need to be sensitized to have compassion for drug abusers, and to understand more about the dangers of substance abuse.

It is amazing how, after several months or years of total abstinence, the recovered addict recalls the euphoria associated with early use but forgets about the cycle of painful withdrawals and compulsive drug-searching behaviour.

The most common causes of relapse

- a) Being in the presence of the drug/s of abuse.
- b) Being in the company of drug users.
- c) Spending time on a drug using site.
- d) Negative feelings such as anger, sadness, solitude, monotony, anxiety, stress, blame, fear.
- e) Highly positive feelings such as a long awaited promotion, success at an examination, a marriage.

Preventive measures & approaches you can use


- a) Keeping in mind the public health approach, if addiction has reached the stage of an epidemic, drugs of abuse can be considered as communicable viruses. The recovering addict has to keep away from them to avoid re-infection.
- b) The drug abuser's 'friends' are the front line vectors of the virus. You can help the recovering addict demystify the word 'friend' when it comes to substance abusers. A friend by definition is one who cares, protects and looks after the welfare of his mate. Therefore how can a person who willingly and purposely provokes the relapse of a recovering addict be a real friend to the addict? By his action he will be doing exactly the opposite of what a friend is expected to do i.e. harming the recovering addict and his family.
- c) Keeping in mind the disease spread point of view, you can draw the attention of your client to the need to avoid a drug-using site which serves as a breeding ground for the spread of the disease.
- d) It is easier to manage negative feelings by staying sober, i.e. being in full possession of one's physical and mental faculties.
- e) Help your client realize that it is not worth celebrating one positive event for a few hours in the company of close relatives to suffer alone for months or years following a relapse.

The most common causes of relapse

- f) The fear of having to explain the reason for a refusal to 'highly positive' people or relatives.
- g) Experiencing euphoria following the use of strong pain killers, depressants or other psycho-active substances.
- h) Strong physical pains following injuries in the past medical and addiction history.
- i) Listening to stories/events linked with euphoria.
- j) Sudden availability of a large sum of money, such as winning a lottery or inheritance.
- k) The negative or indifferent attitude of some drug-free people.
- l) Strong social pressures.
- m) The belief that one is completely cured and that one can use alcohol or drugs occasionally.

Preventive measures & approaches you can use

- f) If they are really positive they must genuinely care for the welfare of the recovering person and there is no shame in letting them know that the 'dear one' is undergoing treatment.
- g) Put your client on guard against all forms of self-medication.
- h) Doctors need to be informed of an accident.
- i) Help your client shift his thoughts from euphoria to the dreadful pains of withdrawal that will follow a full-blown relapse.
- j) With re-addiction rich people can go broke. Whole families are ruined by the addiction of a single member.
- k) Try not to take it personally. It takes time to overcome the stigma of drug abuse and previous relapses.
- l) Social pressures including negative peer pressure are real threats but in the end who does the action of bringing the glass or the joint to the lips? Who extends his arm to welcome a needle? The last decision rests with the recovering addict.
- m) No way. A recovering addict always remains vulnerable.



In spite of all precautions taken, the recovering addict will generally slip a couple of times. It is important to understand that use of the drug itself does not necessarily mean that the person has become addicted again.

These are common causes of relapse. However each recovering addict has his own personal causes of relapse. You can help your client to review his past relapse episodes, and reflect on the events and feelings leading up to each relapse. This way you can help your client identify his own personal triggers.

Distinguishing Between a Slip (lapse) and a Relapse

Just as among pedestrians who miss a step, some slip but do not really fall while others slip and fall heavily to the ground, a slip in the recovery journey is like a minor accident. They may simply need to recover their footing and sense of direction.

In spite of all precautions taken, the recovering addict will generally slip a couple of times. This is a delicate moment when he or she needs understanding and solid moral support more than ever, particularly from family members. The consequences can be catastrophic if the family has not been prepared to face such a situation. In the case of hard-core addicts, the

longer the period of abstinence the greater the hope of the family. They may even be convinced that the client is completely cured and they no longer expect him to relapse. When a slip or lapse occurs their degree of despair and discouragement is proportionate to their hopes and expectations. It is in such circumstances that the recovering addict and family may lose faith in counselling, thinking that recovery is impossible.


During family counselling sessions, you can help the members to understand what goes on in the head of the addict immediately after a slip or lapse. When a slip occurs after months or years of hard work to remain drug-free, the addict feels very disappointed. Family members may think that he is happy because of the euphoria, but that is simply not true. He even curses himself for not being strong enough to resist the 'temptation'. This is the time when he really needs understanding and support from both the family and the counsellor. It is at this point that negative attitudes like anger, blame, condemnation or rejection can and do provoke a relapse. It is important to understand that use of the drug itself does not necessarily mean that the person has become addicted again.

Therefore a mere slip or lapse is not a relapse as many families believe. Although nobody wishes the addict to relapse, all those concerned must bear in mind that she may slip and fall at any moment during the recovery journey.

What Else Can You Do?

If the slip is reported immediately, you can restore hope in the client and family fairly quickly. Your client can recover from a lapse or even a full-blown relapse by reflecting on the episode and understanding what provoked the lapse. Help your client to analyse what went on in her mind just before it happened; who was with her, and where. This is what we call 'identifying triggers'.

The counsellor and the self-help group can be very helpful in assisting the client to identify the pre-lapse triggers and the personal pattern that broke down his resistance. Drawing the necessary lesson from what happened can be a 'growth event' instead of a catastrophic backsliding. The client and his family need support to define and adopt healthy behaviours and practices that can replace the urge to use drugs. What the person had gained during rehabilitation – in terms of improved family



relationship, new positive friends, new skills, values, beliefs, behaviour and new forms of pleasure – must be preserved.

Brief relevant notes have to be entered in the client's file after each lapse or relapse with emphasis on causes, solutions and coping skills.

Crisis Intervention

Apart from the normal slip or lapse, there are cases where unexpected problems crop up provoking a full-blown relapse and serious re-addiction. Among these unexpected problems are:

- the sudden death of a parent or close relative
- a serious accident
- the diagnosis of a serious illness
- a robbery
- loss of employment
- a violent domestic or workplace dispute
- any form of serious grief

Rapid intervention may take the following forms: getting the addict admitted to hospital, holding an emergency family meeting, finding a new job or another home, calling peer counsellors for support, or intervening with the employer.

The centre or service may not be appropriately staffed to deal with such crisis situations. After a rapid assessment, you may feel the need to appeal to other specialized services. Crisis intervention means emergency service. According to the nature of the crisis based on your rapid assessment, you need to find appropriate help for the stressed client. Rapid intervention may take the following forms: getting the addict admitted to hospital, holding an emergency family meeting, finding a new job or another home, calling peer counsellors for support, or intervening with the employer for a modification in the work schedule.

The Self-Help Group

Those recovering addicts who have graduated from the programme can constitute a self-help group. The only marked difference between a rehabilitation counselling group and a self-help group is that the former is conducted or co-ordinated by a professional counsellor while the latter is composed of recovering addicts who have graduated from the programme. These graduates have a more flexible schedule than the

rehabilitation counselling group and usually have a long period of abstinence behind them. At the same time, and although they may be functioning as normal productive members of society, they are aware that they must remain cautious. They meet at regular intervals for mutual support.

Gender Considerations in Rehabilitation and Relapse Prevention

Special Needs of Female Clients

As abuse of alcohol and other drugs by women is becoming more prevalent in all parts of the world including African countries, it is becoming important for directors and board members as well as staff to re-adjust their services to provide gender-sensitive treatment and rehabilitation for women. As counsellors, we need to commit ourselves to update our knowledge, skills and attitudes to meet the specific needs of women clients.

A major problem in designing a rehabilitation programme for women is that at intake they may not provide information about medical, psychological, behavioural or familial circumstances of which they are ashamed or about which they feel guilty. Because of the

stigma attached to such behaviours or circumstances they are unwilling to talk about them. The importance of confidentiality in such situations cannot be over-emphasized. It is preferable to have a few female counsellors on the staff because of the high prevalence of sexual health problems among female drug abusers (see Chapter Two, Physical Assessment.).

Counsellors dealing with female clients need to remember how women in many of our African cultures are brought up to be submissive or passive with respect to their own needs and health. Women may be conditioned to accept abuse, discrimination, and sexual infidelity from men. They may feel powerless to influence the behaviour of their male partners or male children with respect to such issues as drug abuse, violence, sexual promiscuity and condom use.

Attention to the physical environment, the furniture and interior decorations can also make the centre more comfortable for women.




Dealing with Denial in Female Substance Abusers

One of the most difficult tasks of counsellors who work with female substance abusers is helping them to face their denial of existing drinking or drug using behaviours.

The most frequent reasons given by women for seeking treatment are: depression, medical problems related to alcohol use, problems with partner or children and, especially among middle-age women, 'empty nest' feelings related to children leaving home. Because of the greater social stigma associated with alcohol and drug abuse for women than men, women are less likely than men to seek help from a drug or alcohol treatment facility. They prefer to consult doctors or mental health clinics where their primary problem is less likely to be diagnosed.

Women, like men, do not want to be labeled as alcoholics or drug addicts and often delay entering alcoholism or drug abuse treatment because of feelings of guilt and shame.



As counsellors, we need to commit ourselves to update our knowledge, skills and attitudes to meet the specific needs of women clients.

Women, like men, do not want to be labeled as alcoholics or drug addicts and often delay entering alcoholism or drug abuse treatment because of feelings of guilt and shame. They may consider admission to a treatment programme as an indication of their failure to fulfil adequately their roles of mother, wife and/or sexual partner.

Helping the Abused Client

Research indicates that many drug-addicted women may have been emotionally damaged by sexual abuse at some time in their lives. To help these women, rehabilitation centres may use staff members with advanced training in treatment of sexual problems or may collaborate with sex therapists or other health-care professionals. Female counsellors working with these clients must be comfortable with discussing sexuality and intimacy issues with women during individual counselling and women-only group sessions. If counsellors are embarrassed in dealing with such issues, the client's fears and sense of shame or guilt may

increase and her chance of recovery is considerably reduced. Counsellors must also feel comfortable in discussing rape or sexual abuse as these are core sources of deep suffering that may emerge in the counselling process. It is very important that you identify and assess the type and severity of problems experienced and provide specialized treatment if necessary.

Many women who have been victims of personal violence, use alcohol and other drugs as a coping mechanism, whereby they may self-medicate to alleviate feelings of anxiety, fear and anger that result from violence. Women who are victims of a partner's violence do not generally seek support services. To find them and encourage them to seek help, you need to do outreach work in the community, promoting your counselling service.


The women are then given individual counselling and are put in women-only counselling groups to talk about their experience and to realize that their cases are not unique. They can share experience and coping skills. The partner-abuser should also be asked to join treatment and rehabilitation. At a later stage the woman and her partner can participate in mixed groups with couples in the same situations.

Counsellors must see to it that the sessions do not become a context for male-female conflict. You can direct their discussions toward self-analysis, self-criticism and understanding.

As many rehabilitated addicts want to cut off from anything that would remind them of their difficult years of addiction, they are at times reluctant to attend self-help group meetings held in treatment or rehabilitation centres or hospital wards. They respond more positively when meetings are held in a more 'neutral' place such as a social welfare centre, youth club, or community centre. It is also useful to arrange joint meeting between the two self-help groups. This provides new clients with the opportunity to interact with a large pool of rehabilitated people who represent positive role models for them.

Other Health Care Activities to Prevent Relapse

The Case Manager should ensure that the female client has continued access to the following health care services before she is discharged from treatment:

- 
- The existing network of primary health care services for women and children.
 - A directory of local physicians, dentists, and other health care providers with names of contact persons and telephone numbers where available.
 - Specialized and sustained medical care for clients with STDs, HIV/AIDS and hepatitis
 - Obstetric care for pregnant clients including prenatal, delivery and post-natal care. It is a good idea for you to develop agreements with hospital administrators to ensure this health care access for your clients.
 - Pediatric care for children.

A child-friendly facility has an indoor or outdoor play area with toys and books for young children, as well as access to kitchen and washroom facilities for parents and children.

Other Assistance for Women with Children

As the main and often only caretaker in the home, a female client may need assistance to improve her nurturing and parenting skills.

Special attention should be given to the single mother's situation as the lack of reliable child care can prevent her from seeking or continuing treatment. Mothers without access to child care may have to forego treatment early, or face the frustrations of bringing young children with them – if children are even allowed on the premises. Work with your clients to help them arrange child care.

Work with your colleagues to ensure that your treatment centre is child-friendly. A child-friendly facility has an indoor or outdoor play area with toys and books for young children, as well as access to kitchen and washroom facilities for parents and children.

We need to ensure that in all phases of recovery the woman's positive motivation and nurturing instincts are encouraged and that she is given access to the social support systems that promote and sustain her role as mother.

1. Women clients who are having serious difficulties coping with their children should be referred to appropriate family counselling and support services, if available.
2. Liaise with women's organizations, ministries, local curriculum development officers to develop a parenting curriculum to equip mothers in difficult situations with appropriate coping skills.
3. Develop a resource directory of parenting assistance, child-care agencies, nurseries, foster homes. Visit them and invite such social partners to your centre to familiarize them with your services. These resource people can even come and deliver talks to women-only or mixed groups who are undergoing rehabilitation.

Termination and Follow-Up

Termination of the Different Stages of the Helping Process

The termination (ending) of the helping process at all stages of recovery needs to be handled with care. The processes of detoxification, individual counselling, group therapy, family counselling, self-help group, and vocational counselling all have a beginning, middle and an end.

For example, we have seen how important it is for your client to understand that relief from the withdrawal symptoms is only a minor part of recovery, before leaving the detoxification stage of the programme. She needs to be reminded that people relapse because of psychological dependence, so that the client will be understand how important it is to stay in touch for long-term follow-up with you.

The client has now spent several weeks or months with you as her rehabilitation



Our goal is to help our clients re-integrate into their community as productive and valued people. Positive relationships are the key to recovery.

You have worked hard to develop a solid and positive human relationship with the client. The end of this solid, helping relationship needs to be planned carefully.

counsellor. During this period you have worked hard to develop a solid and positive human relationship with the client based upon hope, trust, understanding, warmth and a sense of humour. The end of this solid, helping relationship with your client – at the end of counselling and treatment – needs to be planned carefully. If it is too abrupt, without proper closure and expression of goodwill, the client may feel a great sense of loss and even betrayal. Rejection and abandonment are common triggers for relapse.

The end of counselling and treatment is called the 'discharge'.

While ending one phase of recovery and referring the client to another service it is important that we evaluate the client's progress up to that point.

Termination and Individual Evaluation

With continuous record keeping all along the recovery journey from one service to another, the case manager will be in a position to make an overall evaluation of the client's progress at any stage of the recovery journey.

Questions We Must Ask Ourselves Before Discharging a Client

- Does the client feel ready for discharge?
- Have all the client's goals been met?
- To what extent have specific goals been met?
- What have been the successes in each phase?
- What problems were encountered in each phase?
- What were the key factors that facilitated the client's recovery?
- What were the main obstacles for the achievement of the client's recovery goals?
- Who proved really helpful in crisis situations?

Keeping in mind the answers to the above questions, assess the present state of affairs with respect to the following:

- The client's attitude to substance use
- General physiological health
- His mental health
- His motivation
- Vocational and educational needs
- Family functioning
- Financial situation/support

The most important part of ending a client's treatment is the timing for discharge. After treatment, the client may feel a strong temptation to rely on the counsellor for emotional and psychological support. At this time, your job is to help send the client out into the world with the capacity to look after his own needs, with the support of friends and relationships outside your service. You need to avoid a situation where the client becomes dependent on you or your service.

A client could feel dependent on you if he does not have another caring individual available for the active listening, empathy, understanding and patience that you provided during treatment. That is why we have stressed that the counsellor cannot solve the client's problems, but you have helped the client identify and take responsibility for his own life. In this context, you have offered support and guidance. Now, you must be careful not to end the contract or helping process prematurely or too abruptly, because the client will feel rejected and hurt.

A key factor to ensure a positive and healthy ending of the counselling relationship is to make sure that your clients have established long-term relationships with other seniors and



graduates of the programme. They will support each other and help to maintain links to the self-help group which can be a long-term support group for the client. This emphasis on long-term mutual support among former addicts is a key factor for success of programmes with low relapse rates in many countries.

Follow-Up

After achieving the goals of rehabilitation and aftercare, clients normally graduate from the service/centre. The risk of relapse declines over the years but it never ceases entirely.

Psychological drug dependence is a force that can be controlled or 'put to sleep' but it never disappears entirely. Thus, recovery can be understood as a life-long process of personal growth.

A key factor to ensure a positive and healthy ending of the counselling relationship is to make sure that your clients have established long-term relationships with other seniors and graduates of the programme. They will support each other.



What is Follow-Up?

Follow-up differs from after-care. After-care refers to services that are available to clients in the later stages of recovery; while follow-up means monitoring clients and collecting information about them long after they graduate from a programme. Most clients disconnect with the treatment centre for various reasons. Many begin to lead normal lives and do not recall the painful years of addiction. Some will relapse and not come back. Others will keep contact with the centre or the self-help group. Ensuring follow-up of a maximum number of clients is a good idea for everyone concerned – the recovering addict, his family, the centre and you. As a counsellor, you will want to know what becomes of your clients, and whether they have managed to stay healthy after graduating from the programme.

It's good to know when they have done well, and we have to accept the fact that many clients will not be able to stay free from substance abuse.

Follow-up also gives us information in order to show objective conclusions both in successful and relapse cases.

Maintaining contact with clients over a reasonable period of time helps the centre to maintain relations with a group of successfully rehabilitated clients who can support the programme in various ways particularly in self-help groups, vocational support groups, and community education efforts.

Assessing the progress of your clients enables the centre to determine the effectiveness and outcome, thus allowing continuous adjustments and improvements.

Preparing the Client and Family for Follow-Up

You need to prepare you client and her family to expects follow-up contacts.

Both the client and her family can be told in advance that the service providers will contact them regularly. Follow-up, like other elements of the programme, is voluntary, so you need to ask the client for consent to follow-up. She will co-operate if convinced of the value of the process. So that they do not oppose or fear a

visit, clients and their families should be notified that these visits will continue even long after graduation. Any change of address should be forwarded to the treatment facility. The client should be told about the type of information that will be sought and why. You need to promise that confidential facts will be kept confidential.

It is a good idea to ask the rehabilitated client to call at the centre periodically to provide feedback to his case manager. Usually those who are still abstinent are more likely to stay in touch, although as mentioned earlier, a sizable number of them will wish to stay away from the centre or anything else that may remind them of their addiction. Another means of follow-up is to organize home visits by field workers to meet the client or family members.

It is up to you to ensure that everyone understands the possibility of a relapse, and that they are willing to seek your help again if they need you. If the client or family members experience a relapse as an embarrassing crisis, this suggests that they were not sufficiently prepared for this possibility during the counselling process.



Before graduation you must make it clear to the client and family that although he has attained rehabilitation goals, a slip may happen at any time. It is far better for the addict to call at the centre just after the slip – if not earlier, when he started feeling vulnerable – rather than waiting for a full-blown relapse. Crisis intervention immediately after a slip can ensure that the client will not backslide too much before getting back on the recovery path. If a former client does not feel comfortable to reach out for help due to a slip, he may fall completely into relapse, requiring that he starts the whole process of detoxification and rehabilitation over again.

It is up to you to ensure that everyone understands the possibility of a relapse, and that they are willing to seek your help again if they need you.



Cannabis amplifies the feelings of the user. Thus, it can make a happy person feel happier, but it can make a depressed person more depressed, anxious, fearful and paranoid. Like alcohol, cannabis is a disinhibitor – it ‘loosens up’ or reduces the inhibitions of the individual user.

A P P E N D I X O N E

Common Drugs of Abuse

Cannabis

The cannabis plant (*Cannabis sativa*) grows wild and thrives in a wide variety of locations in the world. It is known by many names: bhang, mbanje, marijuana, grass, weed, pot, dope, ganja, reefer, jive, hemp; rolled in a cigarette paper it is called a joint, an ace, or a stick. The active chemical in cannabis is called delta-9-tetra-hydrocannabinol (THC), which is concentrated in the resin. The abused drug is often obtained from the flowering tops and leaves of dried plant and frequently contains seeds and stems. In this form it is greyish green to greenish brown. It can be prepared as a fine powder or coarse material like tea. The more potent form called hashish is the dried caked resin that is produced from flowers and leaves of female plants.

Cannabis is smoked alone or combined with tobacco. Cannabis is sometimes also taken with drinks or baked into sweetmeats.

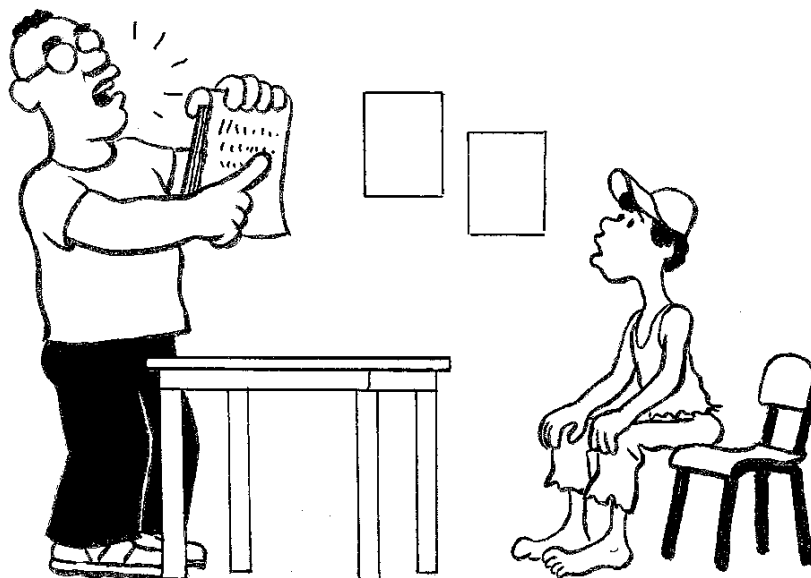
Use of cannabis is associated with a variety of effects depending on the amount of cannabis used and the personality and expectations of the person using it. When cannabis is used in small to moderate doses it brings hilarity and euphoria, including pleasurable physical sensations. Recent research in Europe and America indicates that it may be useful as a painkiller, to prevent vomiting and to improve appetite in cancer and AIDS patients. Further research is recommended.

Cannabis causes a change in perception of time and space. Reports of its impact are mixed. Users claim experiences of increased perceptions, loss of inhibitions, temporary enhancement of creative sensitivity and ability in playing music, telling stories, singing, or dancing. This is why it is a popular drug among artists, as noted in Chapter One. Cannabis is popularly believed to have aphrodisiac effects in the early stages of being ‘stoned’, increasing sexual appetite and enjoyment but not necessarily performance, before the more narcotic, sleep-inducing effects set in.

Cannabis amplifies the feelings of the user. Thus, it can make a happy person feel happier, but it can make a depressed person more depressed, anxious, fearful and paranoid.

Like alcohol, cannabis is a disinhibitor – it ‘loosens up’ or reduces the inhibitions of the individual user. This is why it may be favoured by artists as a creative stimulant. However, it also causes impairment in coordination, reflexes, judgment and memory, particularly if it is used habitually. Typically it causes itching and redness of the eyes, and dilation of the pupils. When the user is stoned, lethargy and sleepiness eventually set in.

Negative health effects of continuous use may include conjunctivitis and bronchitis. On higher dose, such as heavy smoking of concentrated hashish, more serious perceptual and affective disturbances are observed. Confusion and psychotic behaviour may manifest and in some cases may lead to ‘acute cannabis psychosis’. Prolonged, habitual use of cannabis is associated with loss of libido, impairment in cognition, reduced immunity and decrease resistance to infections. It sometimes causes loss of energy and drive, slow and confused thinking and impairment of memory.



In Southern Africa cannabis is sometimes smoked with mandrax in a potent mixture called ‘white powder’. Heroin users may mix heroin with marijuana in order to smoke it. Taken in this form, heroin has a narcotic dream-inducing effect similar to smoking opium.

“All drugs are deadly, all the time. Look– it says so right here!”



Khat

The khat plant (*Catha edulis*) is indigenous to East Africa. The main active part of the plant is alpha-aminopropiophenone, cathinone. The effects of the cathinone are related to those of amphetamine, which is also a stimulant drug.

Khat grows naturally in the relatively humid mountainous regions in Ethiopia, Kenya and to a lesser extent northeastern highlands of Tanzania and the northern part of Madagascar. The wide range of names like 'mirungi' in Kiswahili, 'miraa' or 'miurungi' by the Kikuyu; 'muraa' by the Meru; 'ol-meraa' by the Maasai and 'chat' attest to the wide geographical distribution and old knowledge by people in the region. In the past, use of this drug was occasional and largely restricted to the areas where it grows naturally. The recent past has seen the expansion of cultivation and export of this drug to various countries to be consumed by mostly immigrants from the region. It is a major export earner for Ethiopia and Kenya. Cultivation, trade and use of khat were prohibited in Kenya until 1977 when a presidential decree repealed the prohibition.

Since then abuse of khat has accelerated, especially in the urban areas of highlands of central Kenya. Khat is extensively used in Somalia and Djibouti. Since the mid-1980s, this predominantly male activity has been increasingly emulated by females.

Khat is consumed by chewing of the tender, juicy leaves and stems. This explains why khat has to reach the market in a fresh state. Its use is evident in all levels of the society. The users usually allot a special time for this purpose. It plays an important role in the social life amongst its users. Khat chewing is accompanied by the drinking of large amounts of sweet tea or soda.

When used in small amounts, the user experiences a sense of well being, as if he or she owns the world and acts in the same manner. The user has mental alertness, excitement and sometimes anxiety or increased sexual libido. The climax of these effects should be after khat chewing for a period of four to six hours.

Once the euphoric effects of the drug cease, the user may become morose, irritable and slack. The habitual user may develop insomnia, numbness, decrease in concentration and anorexia. Chronic users of khat develop some

degree of psychological dependence, depression, anxiety and irritability. Excessive use sometimes leads to toxic psychosis and aggressive behavior.

Other effects resulting from the long-term abuse of khat are gum disease, as well as illnesses of the stomach and intestines due to the tannin in khat that causes tissue damage. Cardiovascular effects may include palpitation, migraine headaches, extrasystoles, hypertension, cardiac insufficiency, and cerebral hemorrhage. Other effects may include hypothermia, sweating, mydriasis, and impairment of sex drive among men, pulmonary edema, and toxic effects to the liver. Some of this direct tissue damage is due to effect of nnin, a constituent of khat.

Heroin and other Opiates

Opium is coagulated juice from the unripe capsule of the poppy plant (*Papaver somniferum*). The opium poppy grows in temperate and sub-tropical climates and it appears to have originated in the Eastern Mediterranean region about 5,000 years ago. Opium has been widely used since ancient times, eaten as a pain killer or smoked, causing



what is known as the 'opium dream'. Opium is a depressant, inducing lethargy and deep sleep.

The main medicinal drugs derived from the poppy are morphine and codeine. Presently opium is used as a raw material for the legal production of these drugs but unfortunately also for the illicit production of heroin.

Heroin (smack, horse, junk), which is obtained from morphine by a simple process, is considered by abusers to be the most powerful drug of all. It also produces strong dependency. In the west the heroin addict is known as a junkie.

As mentioned in Chapter One, heroin comes through African ports on its way to the rich markets of the West where it fetches the highest prices. Initially, supply to African markets was from drugs destined for the West, but now traffickers are targeting the local drug scene. There are reports that drug syndicates are working on cultivation of the opium poppy in Africa.

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There is evidence that abuse of heroin is now spreading to include mainstream youth in Africa. In Tanzania there is clinical evidence of intravenous drug use among youth.

Consumption of heroin is through smoking of the drug mixed either with tobacco or cannabis; by sniffing of the powder, and by injections either in a vein, a muscle or just under the skin. Other opiates such as codeine and opium (liquid tincture or solid in a paste like hashish) can be consumed orally.

Following the administration of heroin the initial effect of the drug is that of a 'buzz' or a 'rush'. Intravenous (needle injection) heroin users report that this rush is a feeling of intense pleasure that cannot be described in words. They say that it is like a hundred orgasms, and that it makes you feel like a god. If you stop doing it, the withdrawal is so painful that it makes you wish you were dead. The intensity of the first heroin rush is unique, and this state of bliss is known in Asia as 'the dragon'.

The initial rush may be followed by intense itching and redness of the eyes, then by

drowsiness, after which the heroin user has a feeling of relaxation and euphoria. During this period there is loss of appetite and loss of libido. In the early stages of heroin use the user may also experience nausea.

Repeated use of heroin is associated with tolerance and development of partial or full withdrawal symptoms when there is a rapid reduction of use or abstinence from the drug. The withdrawal symptoms begin several hours after the last dose of heroin, peaking after two to three days and disappearing within a week.

Early effects of withdrawal (8-12 hours since last dose of heroin was taken) include watering of eyes, runny nose, yawning and sweating. This progresses to agitated sleep for several hours, a state called the 'yen'. When the addict awakes agitation continues and depression and poor appetite set in. The person experiences goose bumps, dilated pupils and tremor within this period.

Within 36 to 72 hours the patient experiences chills and shivering alternating with flushing and sweating. There is gooseing of flesh, irritability, insomnia, appetite suppression, violent yawning, sneezing, watering eyes, runny nose, nausea, vomiting, intestinal cramps,

diarrhea, increased pulse rate, elevation of blood pressure, pain in bones and joints and uncontrolled kicking movements. This progresses to severe weakness and emotional depression. Because of poor appetite, nausea and vomiting the patient loses body weight, gets dehydrated and has disturbed electrolyte and acid base balance in the body. After 7 days since last dose of heroin, these withdrawal symptoms disappear. Symptoms can also easily be treated with a medical substitute for heroin such as methadone, along with supportive therapy including correction of electrolyte fluid imbalance and vitamin supplements.

Psychological dependence usually persists as does poor appetite, agitation and craving, accounting for high frequency of relapse. If life does not get better after the addict quits heroin, if the user remains jobless or estranged from family and friends, he may imagine that heroin is the only friend he can return to, and he may seek that phantom of desire again.

If there is strong support for the reformed addict, there is less danger of relapse. 90% of Vietnam veterans who were addicted to heroin completely remitted after return to their homes and loved ones in USA.



Cocaine

The coca bush (*Erythroxylon coca*) is an evergreen shrub predominantly found in the Andes Mountain region of South America. Its active ingredient is the alkaloid cocaine, a white powder which is extracted from its leaves by a simple chemical process. Cocaine is a drug with stimulant effects.

Coca use was a tradition in some regional Indian cultures in the Andes Mountains. It acts as a stimulant, increasing physical and mental stamina while tending to suppress appetite for food and drink. The chewing of coca leaves is also known to play an integral part in ritual and celebratory activities of some native tribes of South America, stimulating the repetition of collective myths and the revival of historical memory through storytelling.

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The illegal production of cocaine doubled in the world between the years 1985 and 1994. The trend has resulted in increased trafficking and thus spreading of the drug to new geographical areas including parts of Africa.

The mode of consumption of cocaine powder is by sniffing. The powder can also be heated, melted and converted to a more concentrated, hardened substance called 'crack' cocaine, which can then be smoked in a pipe, or dissolved in liquid and injected. Coca leaves can also be chewed alone, but this is rarely practiced outside of local native cultures in South America.

The drug has a high potential for causing both psychological and physical dependence. Physical dependence, when present, is associated with cocaine use in high doses over a long period of time. Initial use of cocaine is associated with a 'rush' that is followed by euphoria, which may last from 30 minutes to a few hours, depending on the quantity inhaled. Users report a sense of heightened mental and physical stamina, intensified perceptions, feelings of well being, power and sometimes anxiety or paranoia. After these feelings diminish, the cocaine user may

develop restlessness, anxiety, depression, irritability, insomnia and craving of more cocaine. Cases of aggressiveness have been reported. Hallucinatory experiences have been observed among frequent abusers of the drug. Chronic abuse of cocaine tends to make the user self-centered, and it is known in the drug culture as a 'selfish' drug.

Inhalants

There are great varieties of chemicals that can be inhaled to get 'high' such as: shoe glue, varnish, gasoline, cleaning fluids, aerosols, thinners, spray paint, nail polish remover, correction fluids and coloured markers. These substances, known as 'inhalants', have varying degrees of abuse potential and adverse effects on the abuser. These materials are freely available at home, work, the petrol station, the hardware store, the grocery store, the shoe repair stand and other places.

These substances are abused through breathing and sniffing. Regular users may inhale the substance from a plastic bag or container in order to concentrate the effect. This practice is dangerous and may lead to suffocation, particularly if the user puts his head inside a plastic bag.

Inhalants are 'stupeficients' (stupefy: to stun, make dull or lethargic). They tend to have a numbing, stoning, mildly euphoric, desensitizing effect. Users report that inhalants help them forget their troubles, suppress their appetites, numb their physical pain, give them courage to steal or take other risks, and help them sleep. Inhalant users may be bold and aggressive in the first stages of use, but dull and slow as they inhale more of the chemical fumes.

The main risk group is children, including school children, particularly boys and young male adolescents who can easily get and experiment with these household substances at little or no cost. Children who live and/or work on the streets in many cities use inhalants as a cheap and easy alternative to other drugs. Adults who do not have money for other drugs or alcohol may also use inhalants to get 'high'. The effects of these substances are well known to both adults and children in the slums and shantytowns of African cities.

With chronic use psychological dependence develops. The chronic abuser may also experience depression, confusion and disorientation. Chronic abusers may experience weight loss, nausea and vomiting. They suffer



from damage to the kidney, eyesight, and brain, nerve fibers, lungs, heart, liver and blood that may be manifested by anemia or bone marrow suppression. Chronic inhalant abuse and/or overdose may lead to coma and death.

Despite the negative health effects of inhaling these toxic chemicals, young people who are motivated can recover remarkably well from inhalant abuse, even after some years of exposure.

Alcohol and other Depressant Drugs

'Depressants' are drugs which slow and lower the functions of the brain, especially the higher centres of mental functioning such as attention, mental concentration, thinking, recognition, making decisions and initiating reasoned actions. Drugs falling under this broad class include alcohol, sedatives, anti-anxiety drugs, sleeping medications and antihistamines as well as inhalants (see Inhalants).

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This class of drugs is complex. While they act to slow the mental functions they are also disinhibitors. Thus, they may be experienced by the user as stimulants depending on the social context, for example if the user is at a party among friends.

Important depressants include alcohol, benzodiazepines (diazepam commonly known as valium, oxazepam, lorazepam, triazolam, diazepam or librium, temazepam, nitrazepam and flurazepam), barbiturates (amylbarbitone, butobarbitone, phenobarbitone, secobarbitone, pentobarbitone and quinalbarbitone), and methaqualone or mandrax.

This class of drugs is complex. While they act to slow the mental functions they are also disinhibitors. Thus, they may be experienced by the user as stimulants depending on the social context, for example if the user is at a party among friends. The depressant effects are experienced more immediately if the user is alone or in a quiet context.

These drugs are taken primarily because of their effects on the brain, mind and behavior. Social drinkers, for example, report that alcohol consistently helps them to relax, to 'get happy', to get 'high', to loosen up, to 'party'. These drugs do, however, have other unintended or undesirable physical and mental effects as well.

Depending on the amount taken, any one of these drugs may progressively produce relaxation, disinhibition, mild sedation, drowsiness, intoxication and sleep. The stages of sedation and drowsiness may be accompanied by feelings of euphoria (a feeling of elation or buoyant well being) and disinhibition, accounting for the popularity of this group of drugs, particularly alcohol.

With moderate to high dosage, there is increased depression of the user's central nervous system. Physical co-ordination may be impaired, leading to slurred speech, shaky hands or unsteady walking. In the case of alcohol abuse, this is the familiar figure of the staggering drunk. The user has difficulties in carrying out complex tasks such as operating machinery or driving a motor vehicle. Perception is distorted, thinking is slowed and memory is blunted. The intoxicated person experiences a loss of impulse control and a lower tolerance for frustration. After falling asleep or passing out, the individual wakes up with a 'hangover' including fatigue, headache and nausea. Most depressants also lead to poor quality sleep with daytime restlessness.

In general, women have a lower tolerance for alcohol than men – due to physical and internal differences – and experience the effects of drunkenness more quickly than men. Alcohol use during pregnancy retards fetal growth and may cause lifelong mental, nervous, and emotional problems in the newborn (Fetal Alcohol Syndrome).

Heavy overdoses can cause anesthesia (deep level of unconsciousness to the extent that pain cannot wake an individual) leading to coma and death. The danger of unconsciousness, coma and even death from high doses is more likely with some types of depressants, such as the barbiturates.

With repeated long-term use, there is a tendency for the individual to adjust to the drug so that the same dose no longer brings about the desired effect. The individual, therefore, has to keep increasing the dose in order to obtain the desired sedation, euphoria or intoxication. This may be partly due to body's adjustment and increased tolerance for the drug, and partly because of the user's mental adaptation and increased comfort with the drug and the drug-using social context,



such as the group of young people who develop a social drinking habit together.

This tolerance to a depressant drug may also be shared with other drugs in the same group (cross-tolerance). The individual who uses these drugs continuously for weeks or months tends to develop a psychological need or craving for the drugs. People who feel addicted to depressants such as alcohol often experience physical symptoms if they try to quit using the drugs (withdrawal syndrome).

Withdrawal symptoms may include anxiety, panic attacks, disturbed sleep, nightmares, psychotic symptoms, flu-like symptoms, trembling and convulsions.

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Ecstasy is distributed at little or no cost to attract youth participants to so-called 'rave' parties in some cities.

Tobacco

While tobacco smoking is very hazardous to the user's health, it does not have emotional effects or cause behavior changes in any way comparable to the other common drugs of abuse. Therefore, it is not a drug of primary concern from a drug counsellor's point of view. From time to time you may have opportunities to inform clients or students about the dangers of tobacco.

Tobacco smoking is highly addictive. It is the number one cause of death in industrial countries and it is increasingly threatening human health throughout the world. It is the only legally available consumer product worldwide that is harmful to one's health when used as intended. It is also known to cause more death than all other psychoactive drugs. It is the single most important, preventable public health problem in developed countries. If current trends continue, deaths from tobacco worldwide are projected to reach 10 million

every year or more than 10% of total deaths worldwide by the second quarter of the next century.

Tobacco use by pregnant women can cause complications of pregnancy, fetal growth retardation, low birth weight, premature births, spontaneous abortions, still births, neonatal death and infant mortality. Long term effects to the newborn child include impaired physical and intellectual development. Recent evidence also indicates that smoking undermines immunity and hence further compromises immunity of HIV positive individuals who smoke.

At present smoking accounts for 90% of lung cancers, which is 30% of all cancers put together. Over 80% of chronic bronchitis cases are caused by smoking as well as 20-25% of all coronary heart diseases and strokes. Passive smoking, when non-smokers such as children breathe cigarette smoke in a poorly ventilated room with a smoker, can cause respiratory ailments, especially in children.

Amphetamines (Ecstasy, etc.)

Amphetamines are psychostimulants which affect the functions of the body and mind, and cause extreme excitement. Chronic use commonly causes personality and behaviour changes such as aggression, irritability and hyperactivity. Heavy use may lead to paranoid psychosis, which often includes hallucinations. The chance of a user becoming dependent is high. Withdrawal symptoms seem to be limited to temporary feelings of fatigue and depression. Some amphetamine-like stimulants are Ecstasy, methamphetamine, MDA, and 'ice'. Ecstasy is distributed at little or no cost to attract youth participants to so-called 'rave' parties in some cities. While high on amphetamines such as Ecstasy, the user may be very active, for example dancing all night, unaware of the need for fluids, becoming severely dehydrated leading to illness or even death.



Hallucinogens (LSD, etc.)

Hallucinogens are usually taken orally. They alter the user's mood, the way things around him are perceived, and the way the user experiences his or her own body. A user may also hallucinate which means to see, smell, taste, hear or feel something that does not exist. Perceptions are radically different and new for a period of 3 to 6 hours, which is why hallucinogens are known in the drug culture as mind-expanding or psychedelic drugs. Sometimes the experiences are bizarre or frightening; this is known as a 'bad trip'. Also, the user may have hallucinations for a while after the initial effects have subsided. These are known as 'flashbacks'. Users usually do not become dependent on hallucinogens. Some examples of hallucinogens are LSD, psilocybin mushrooms, PCP, peyote, and mescaline.

Hallucinogens are known in the drug culture as mind-expanding or psychedelic drugs. Sometimes the experiences are bizarre or frightening; this is known as a 'bad trip'.



APPENDIX TWO

Useful Words and Ideas

Abstinence: The condition of not taking or using a substance. A person who does not drink is practicing abstinence from alcohol. When a drug abuser, usually after treatment, stops taking drugs and remains drug-free, that person is abstinent.

Addiction: Addiction is the physical and psychological habit or feeling of need, which comes from repeated use of a drug. Drug abusers often continue to feel the need and desire for drugs after they have been treated for drug-dependence ('detoxification').

Co-dependency: A relationship between two or more people who rely on each other to meet and provide for their needs, particularly unhealthy emotional ones.

Confidentiality: The preservation of private, personal information concerning the client

which is disclosed in the professional relationship. Confidentiality is a client's basic right. However, in some countries the counsellor is legally required to report any evidence of physical abuse or the intention to commit suicide to the appropriate authorities, such as health authorities, Children's Aid agencies or the Police.

Dependence: Drug dependence is an emotional and sometimes a physical need experienced by the drug abuser. The drug abuser or alcohol-dependent person feels a compulsion to take the drug on a regular basis, to feel its effects and to avoid the discomfort of its absence (see Withdrawal, p. 9). Physical dependence on any drug can be treated in a detoxification program ('detox'). However, psychological dependence is much harder to treat – this is the principal challenge for you as a counsellor.

Depressant: A drug or medication (such as a sedative) that lowers the nervous and physical activity of the user. Depressants can cause feelings of weariness, sadness and sleepiness.

Detoxification ("detox"): The treatment of physical drug dependence. The drug user submits to be cared for with nourishing food, medication and vitamins until his physical

withdrawal symptoms end. Treatment may involve gradual reduction of the quantity and frequency of the drug or the temporary use of a replacement drug, provided in a treatment program. Fluids with some salt and sugar are given if the client is dehydrated. Most clients need to take vitamins and minerals to restore their health.

Drug addict (or drug-dependent person): Someone who has used a drug repeatedly and has developed a strong attachment to it.

Euphoria: The feeling of emotional uplift, exhilaration, being turned on, being high; intense happiness; may be accompanied by physical sensations of pleasure. A person can experience euphoria without using drugs, such as the euphoria that can be experienced by the runner, the dancer, the singer and the lover.

Psychotropic: Having an altering effect on the mind. Strong psychotropics are drugs such as LSD (“acid”) that cause the user to have hallucinations or imagined experiences (the “acid trip”).



Recovering Addict: A person who has been strongly dependent on a drug, who is building a new drug-free lifestyle and not currently using drugs (“staying clean”).

Relapse: When a recovering drug or alcohol abuser starts to use drugs or alcohol again after a period of abstinence.

Syndrome: A set of characteristics or symptoms that a client may have that reveals a certain condition or disease.

Tolerance: The repeated use of a drug leads to changes in the brain and nervous system so that the user needs more of the drug in order to get the expected effect. This is the basis of drug tolerance.

Withdrawal: In a drug dependent person, it is necessary to take the drug in order cope with life and perform normal activities. When the drug is not taken, the person suffers from physical and mental discomforts called withdrawal symptoms. Physical symptoms of heroin withdrawal, for example, may last three to seven days.



APPENDIX THREE

Four Case Studies

1. The young man of the street

A twenty-six year-old single man is brought to your clinic by a court probation officer. He has a long-standing history of abuse of alcohol, tobacco, cannabis and more recently heroin. Over the years he lost his capacity to hold on to employment as a motor mechanic. He then supported himself by pick-pocketing, shop lifting and illicit drug dealing on the streets. As time went on he got into trouble with the law and spent some months in prison. A year ago he was evicted from the two rooms he rented in the centre of a major African metropolis because of irregular payment of rent and frequent quarrels with other tenants. Currently he has no work and no fixed abode. He lives with people he meets on the streets, sometimes in abandoned buildings or under bridges. He says he has no friends other than the ones he meets on the streets. He had been evading his parents all this time.

The day before being brought to your clinic, he woke up in a ditch with bruises, with no memory of how he got there. Dazed and confused, he was picked by the police for loitering. He spent a day in police cell and due to his court record he was assigned to a probation officer that was instructed to obtain counselling for him. He presents in a pathetic, disheveled manner with minor bruises on his head and limbs. He is sweating profusely even though the ambient temperature is cool. He is yawning, his nose is dripping, and his eyes are watering.

Some Questions to Consider

At this point, what are the main reasons why you are considering assessment and treatment at a residential detoxification centre? What arguments would support a residential treatment centre following detoxification? Under what circumstances would you consider community-based counselling and care?

Guidelines for Treatment and Counselling

This young man has exhausted his personal and human resources. His social environment is shattered. He is outside all structured social systems. The one obvious resource he has is his parents, but he avoids them. He is currently experiencing severe heroin withdrawal symp-

toms. Treatment and counselling could include:

Crisis Management and Intense Short-Term Residential Care. Admit the client for detoxification to deal with heroin withdrawal as well as any health problems such as poor nutrition and infections. Obtain his permission to invite his parents for family assessment and family counselling. The primary goal of family assessment and counselling would be to promote reconciliation, provide a support system for him and involve the family in the counselling and rehabilitation. Ideally, other significant professional helpers should be involved such as the probation officer, social workers and vocational workers, to help him prepare for a productive life in the community and to help him improve his social and vocational skills.

Long-Term Residential Treatment/Community Rehabilitation. This young man may also need residential treatment following detoxification for the purpose of taking stock of the destructive effects of drug abuse and to motivate change. He will need to find a healthy social environment including new and old relationships as well as to regain lost skills to prepare for continued community-based counselling and resumption of normal community life.



2. The adolescent female sex worker

A sixteen year-old girl left her family and school to join her girlfriends in a luxurious city apartment paid for by a pimp. The pimp caters for all their upkeep expenses but in return he pimps them to tourists who visit the city. He also introduced the girl to heroin. Initially when your client smoked the drug, she associated it with the glamour of smoking cigarettes. She then increased the amount she smoked and became more dependent on the pimp. She soon started shooting heroin though she has not been sharing needles. Then one of the friends who invited her to the apartment recently died of what is suspected to be AIDS. She has heard of your counselling facility and comes to you because she fears she has AIDS.

Some Questions to Consider

What counselling would you offer her regarding her sex and drug habits and the risk of HIV infection? Would you try to persuade her to take an AIDS test? What drug addiction treatment programme would you offer to her?



Guidelines for Treatment and Counselling

This young girl is in a high-risk situation at a tender age. Her anxiety is a mobilizing opportunity. The following treatment options need to be considered:

Admission for detoxification followed by HIV counselling (pre-test and post-test). Immediate short-term goals in counselling are to increase her understanding of HIV, how it is transmitted, and to correct any misconceptions. Discussions should address the relationship between drug abuse and HIV as well as her current state of dependency on heroin. Your aim will be to develop a risk reduction plan with her. She needs social and emotional support to be able to handle the possibility of a positive HIV test result. With her permission, it will be beneficial to involve parents and family in the counselling process to build up this important source of social support. This adolescent may, in addition, benefit from long-term counselling and vocational training opportunities. Should she decline admission or family involvement, at least make sure that she is linked to an appropriate support group while you continue to offer her access to your counselling services. If possible, ensure that she has access to clean syringes, needles and condoms.

3. *The man who loses everything before he asks for help*

John is a fifty-five year-old man who started life with all the promises of a good future. First born son of a schoolmaster, he was brilliant in school, popular with peers and admired as role model by youngsters. He went to university as expected and qualified as an electrical engineer. He married in his late twenties and fathered three children whom he adored. He drank alcohol and smoked cigarettes as many colleagues did, as a way of dealing with high pressure of corporate responsibilities. In his mid thirties he was appointed provincial supervisor of a large engineering company. Partly to deal with boredom of provincial life and partly join in the recreational habits of some of his friends, he started smoking cannabis. He liked cannabis for its calming effect after a day's hard work and as an escape from the pressures and responsibilities of supervising many workers and expansion of services in the province.

Over the years he spent more and more time with the friends who enjoyed spending long hours drinking and smoking cannabis. He gradually lost interest in sports, church, or socializing with people outside his drinking circle. He started keeping late hours either drinking or smoking cannabis, sometimes

spiked by other drugs such as 'brown sugar'. His work performance suffered leading to frequent conflict at work with colleagues whom he accused of having designs for his position. Eventually he was laid off. The situation at home also became desperate and his wife was forced to take over the responsibility of providing for the family. Whenever the issue of his drinking and smoking drugs came up, he would insist that these are exaggerations of people who do not like him.

Ultimately the couple separated with John moving to the capital city in search of a job. Within a few months he exhausted his meagre savings and begged for money from acquaintances and distant relatives. With dwindling resources he resorted to drinking illicit alcoholic spirits and was frequently brought to the city hospital for detoxification. During counselling he was acutely aware of his devastated condition and he recognized that it was his own fault. He wanted reconciliation with his family, but he felt like a miserable failure. This made him feel the need for further escape from this reality and the only escape way he knew was resort to drinking and smoking drugs. One morning he woke up on the side of a street with his clothing soiled with mud and vomit. He cried and prayed. He then resolved to seek help.



Some Questions to Consider

Now that you have reviewed John's file, what would you like to focus on in your first assessment interview? What are the important issues to remember that will help him continue with his new resolve to recover from his drug dependence? What possible motivation does he have for recovery?

Guidelines for Treatment and Counselling

This man had developed resources and life skills that made it possible for him to attain a high station in life. Yet despite his apparent strengths, he is a troubled soul who has allowed heavy substance abuse to ruin his life. He appears to be actively aware of his predicament and consumed by guilt and low self-esteem. It is important during assessment and counselling to emphasize his assets and positive attributes, to help him recover a sense that he can regain control of his life. The involvement of the family is a good starting point for self-examination and a key resource for social reintegration.

Family counselling may be the treatment of choice for a number of reasons. John wants to be reconciled. He needs to be reintegrated into a support system. His family may be his only



option. There are a number of additional reasons for involving the family members. First they may need help in their own right, and second, the pattern of their reaction to John over the years may have hindered his recovery in the past.

John has a long history of multiple substance abuse, and while he may be highly motivated to stop he may not have the strength to do it alone. A simple relapse prevention behaviour programme involving the support of the family may be beneficial.

4. Rebellious youth and worried parents

A husband and wife in their late forties visit your counselling office. You recognize that they are in a sombre mood. The woman is a housewife with responsibility for five children aged 5, 8, 11, 14 and 17. The man is a general manager of the local branch of an international commercial company. After appropriate courtesies and introductions you ask what assistance you can provide to them. They both respond by shedding tears. You allow a minute or so as permission for them to cry.

You then say: "You are obviously distressed. Is there anything I can do to help you?" The woman replies, sobbing: "It is about our son."

Their first born son, Peter, had been a pride of the family, well-liked by relatives, friends and colleagues. He has been doing well in school but for the past several months his school performance has been falling down. 3rd year of secondary school is crucial if he is to do well in ordinary level examination during the fourth year. The parents had already arranged for private tuition for Peter, but this did not seem to help. He appeared to have lost interest in his studies. He did not complete his homework and sometimes had difficult waking up in the morning. On some days he would leave for school but failed to go to his classes.

During this period he had lost valuable gifts that his parents had given him including his radio cassette and fine clothes. The family also experienced losses of valuables such as money, a video camera and the like, which they attributed to unfaithfulness of domestic workers. They changed both house girls and garden hands but these objects kept disappearing. The day before when valuables of young siblings disappeared under circumstances that ruled out domestic workers, the parents had to confront the children about the possibility that one of them was the culprit. This is when Peter admitted that he had been the thief all along.

Peter told them his story. A friend had introduced him to drugs after school. He experi-

mented with cannabis and later with heroin, and he liked the heroin so much that he began smoking it often. He quickly became dependent on the drugs and had to raise money to be able to meet the cost. He says he never used needles, and he shows no evidence of needle 'tracks' on his arms. His craving for the drugs was so overpowering that he had to sell all he had and then steal valuables from his family to meet the cost of his drug habit. The parents feel confident that he has not stolen from anybody else outside the family. They feel that John has been quite honest with them about this.

You offer to arrange for an appointment to see John, but the parents say that he came with them and he is outside waiting.

Some Questions to Consider

What is your response? Do you know enough about the case now to propose a treatment and counselling plan to John? What do you think is the significance of John stealing from family members only? Will you ask him? Before you talk to John, what do you think are the main tasks for John during counselling? What appear to be the positive strengths in this case?

Guidelines for Treatment and Counselling

This young man has very supportive parents who are already willing to forgive.



The main problem appears to be drug-abuse behavior, but the challenge is to find out what motivates him to betray the trust of his family. The fact that he has not stolen outside the family suggests that his antisocial urges are still within limits.

Peter was forced to admit his theft and he was brought to the counsellor by his parents. The main approach while assessing him would be to determine how he sees the problem and clarify with him the factors that led to drug abuse and his motivation for change. Assess the extent of peer pressure. Does he have the skills to refuse peers? What are the implications of involving the school?

When you gain his confidence, you will be better able to identify any other factors that may have led to his drug abuse.

Counselling may include a simple relapse prevention programme. Family counselling will involve reconciliation with his siblings whose valuables he has sold off. It may also require adjustments in the family to define the young man's responsibilities and rights more clearly as he grows toward adulthood and independence.



APPENDIX FOUR

Evaluation

Regular collection of follow-up information provides programme planners and counsellors with essential information to evaluate the counsellors' performance; the effectiveness of the processes put in place by the service; as well as the impact of the programme on the client, his family and the community. It is unfortunate that many services do not carry out evaluation exercises. Consequently, they keep repeating the same mistakes and do not improve further on what seem to work well.

An evaluation exercise can only be possible if regular data is collected throughout the helping process: from intake to months or years beyond graduation. Provisions for compiling information for evaluation must be made in the various forms of the client's file relating to the different services offered to the client. The information required is generally of the following types: process, outcome and impact.

Evaluation helps you in a number of ways:

- Provision of factual findings which allow the formulation of more realistic goals and solutions.
- Better identification of the needs of the addicts and their family.
- Concrete data add to the credibility of a programme and justify further funding and programme expansion.
- Better understanding of the complexities of the tasks undertaken by counsellors and other service providers.
- Maximum use is made of existing resources and services, particularly when funding is scarce.

Process Evaluation

Process data covers the whole array of procedures established and measures taken to help the client in recovery. Careful scrutiny of client's files and other staff records will help the programme planners determine the following issues:

- Which approach or strategy was more appropriate and efficient for individual client profiles?

- Number of clients admitted in each service or phase of recovery.
- Number of clients who dropped out of programme.
- Frequency and duration of sessions spent in:
- Individual counselling
- Medical detoxification
- Group counselling
- Family counselling
- Vocational counselling
- Self-Help groups
- Paper work/entries in clients files
- Staff team consultation
- Follow-up period after graduation

Outcome Evaluation

Outcome evaluation refers to the effectiveness of the processes put in place and determines how far the client has achieved treatment and rehabilitation goals. With appropriate outcome information the programme planners and service providers will be able to determine the following:

- How many clients achieved which treatment and rehabilitation goals?



- How many have developed and are participating in new alternative recreational activities?
- How long did it take to achieve specific goals?
- How many clients are now drug-free?
- How many have managed to find a work (paid or unpaid, e.g. household occupations)?
- How many are maintaining their chosen work?
- How many have lost their jobs and why?
- How many have progressed in a job and have attained promotions?
- How are they getting along with the family?
- How many new (abstinent or non-addicted) friends do they have?
- What recovery practice or vehicle do they find most helpful? Least helpful?
- How many clients slipped but recovered after early crisis intervention?
- How many full-blown relapses were reported?
- How many have become regular members of the Self-Help group?



Impact Evaluation

Impact evaluation aims at learning about the unexpected or unintended effects of the programme on individuals and groups in the community. Depending on the efficiency of the programme and the performance of the counsellors and other service providers, the programme may have a far-reaching impact on the community. This kind of information can be obtained through structured interviews of a representative sample of citizens. Talking and interacting with individuals and groups in the same community may obtain a similar result. An effective counselling and rehabilitation programme may impact the community in the many ways, such as:

- A decrease in drug abuse
- A decrease in drug-related crimes
- Less stigmatization of the addict
- More individuals and services inquire about and make use of the programme
- Better public awareness of the complexities of treatment and rehabilitation

The results of these exercises will have greater credibility if they are done by people who are not part of the programme ('external evaluators'). Staff need to be informed about the purpose of the exercise. It is also a good idea for staff to be involved in its design in order to be able to respond honestly and objectively to its findings. The evaluation should not be perceived as a judgment on the individual performance of the counsellors. Rather, the purpose of the exercise is to help staff and management to improve the quality of the service.

If all partners in the recovery programme see the evaluations as opportunities for new understanding and improvement, then successive periodic evaluation exercises will show marked improvements in the various services. This will give counsellors higher motivation, which in turn, will positively impact their performance. The credibility of the centre will have a big boost and consequently more substance abusers may come to seek treatment and rehabilitation.

S A M P L E F O R M A

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Client's File

Name _____ Date _____

Present address _____

Home phone number _____

Identity card n° _____

Date of birth _____ Sex: Male _____ Female _____

Marital status: Single _____ Married _____ Separated _____ Divorced _____ Other _____

Currently living with _____

Family address (if different) _____

Person to contact, and how to contact for follow-up _____

History of Drug and/or Alcohol Use

Drugs used _____

Drug	Year first used	Duration	Using now? (yes or no)	Abstinence episodes? (when, how long)
------	-----------------	----------	---------------------------	--

Tobacco _____

Alcohol _____

Cannabis _____

Heroin _____

Cocaine _____

Psychotropics (e.g., LSD) _____

Methaqualone _____

Other drugs (specify) _____

Treatment and rehabilitation services or programmes attended _____

Client's feeling about services attended _____

Factors that led to substance abuse

Alcohol _____

Cannabis _____

Heroin _____

Cocaine _____

Psychotropics (e.g., LSD) _____

Methaqualone _____

Other drugs (specify) _____

Client's personal triggers which provoked previous relapses (see Common Causes of Relapse, p. 63)

Incidents of relapse

Triggers

Work History

Does the client hold a job? Yes _____ No _____

If yes, what is the job? _____

How does the client feel about the job?

Good _____ Satisfactory _____ Bad _____ Very bad _____

Does the client always fulfill his or her work responsibilities?

Does the client always arrive at work on time?

Ask the client to describe his or her relationships with co-workers.

Ask the client to describe his or her relationship with the job supervisor.

Does the client have daily responsibility for children, other family members,
household or property which requires work? Yes _____ No _____

If yes, how does the client feel about this work?

Good _____ Satisfactory _____ Bad _____ Very bad _____

Brief Employment History

Employer _____

Job Description _____

Year _____

What job skills does the client have? _____

Levels of Education

Primary _____

Secondary _____

College, University _____

Additional training _____

What is the probability that the client will keep his current job?

Very Good ____

Good ____

Don't know ____

At risk ____

Unlikely ____

Employability, if unemployed.

Very Good ____

Good ____

Satisfactory ____

Bad ____

Very bad ____

Employment goals (note any new skills needed to achieve these goals)

1. _____

2. _____

3. _____

Family and Social History (as reported by the client)

Family members _____

Roles in the household _____

Attitude toward the client _____

Close friends/relatives _____

Their attitudes/influence toward the client _____

Neighbourhood/community attitude towards client:

Good ____

O.K. ____

Bad ____

Very bad ____

Client's interests and hobbies prior to addiction

What are the client's interests and hobbies now?

What are the client's expectations about counselling and treatment?

Acknowledged criminal activities, if any (to be filled in preferably at third or fourth meeting, after establishment of required trust) _____

Client's priority issues or needs _____

Client's Recovery Goals

Clients Motivation to Follow Treatment/Rehabilitation:

Very Good ____ Good ____ Satisfactory ____ Bad ____ Very bad ____

Individual goals

- 1. _____
- 2. _____

Family goals

- 1. _____
- 2. _____

Employment/social goals

Any special programme conditions recommended

Date _____

Client name _____ Signature _____

Staff name _____ Signature _____

S A M P L E F O R M B

copy and use this form if you need it

Assessment-based recommendations

Client name _____ Date _____

Overall case description and comments

Recommendations

Admit to Centre/Service _____ Referred to alternative service _____

Programme components Service Contact person Phone n°

Detoxification _____

Individual counselling _____

Group counselling _____

Family counselling _____

Self help group _____

Additional support services recommended _____

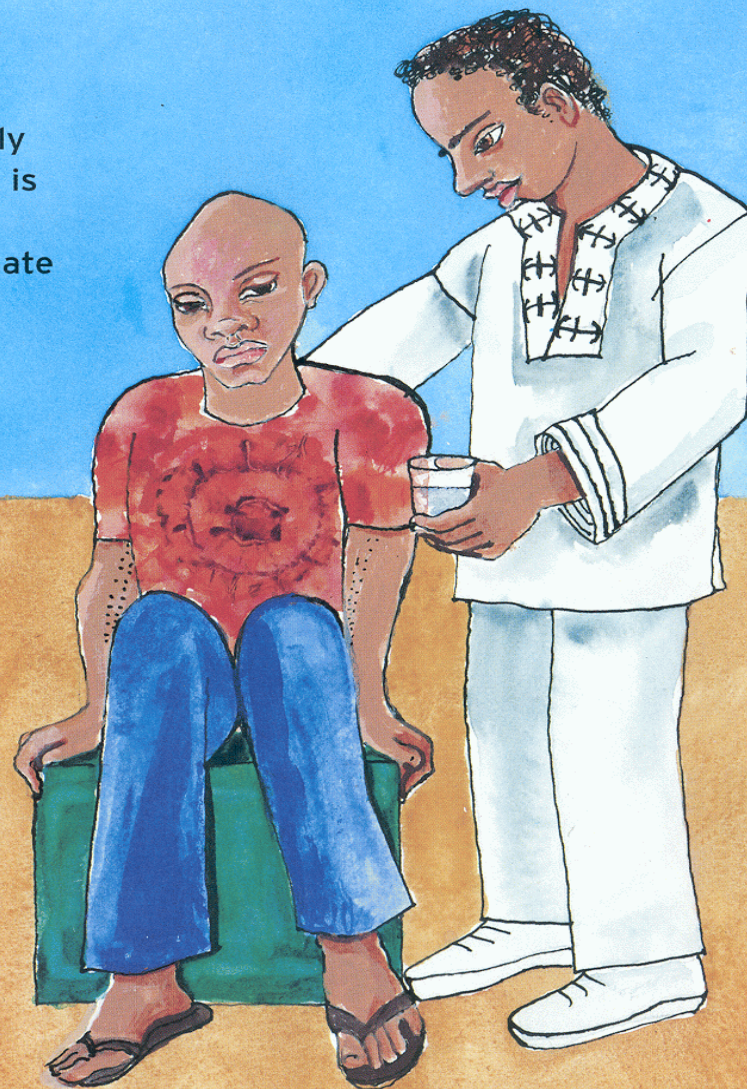
Special programme conditions recommended _____

Date _____

Staff signature _____ Case manager _____



This handbook will help you to work effectively as a drug counsellor in the African context. It is written by an international team of African health workers and doctors who specialize in compassionate drug counselling, treatment and rehabilitation. As a practical guide for everyday use, it combines internationally accepted standard practices with a distinctly African perspective.



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