National Drug Law Enforcement Agency

STANDARD POLICY AND PRACTICE GUIDELINES FOR NDLEA COUNSELLING CENTRES

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Response to Drugs and Related Organized Crime in Nigeria

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Foreword

Illicit drug trafficking and abuse remain a global phenomenon which countries are making concerted efforts to address, Nigeria inclusive. The government of Nigeria being deeply concerned about the rising trend in the demand for and traffic in narcotic drugs and psychotropic substances and related organized crime, established the National Drug Law Enforcement Agency (NDLEA), in 1989 by decree 48 now known as CAP N30 L F N 2004. The Agency by the Act is charged with the responsibility of controlling the illicit drug cultivation, abuse, possession, manufacturing, production, trafficking in narcotic drugs, psychotropic substances and precursor chemicals.

By the provisions of the Act, the Agency has dual responsibility of reducing the demand for and the supply of narcotic drugs and psychotropic substances. One of the key Drug Demand Reduction functions of the NDLEA as the first responder is the counselling of people with drug dependence problems. To carry out this function the agency established counselling centres in States of the Federation including the Federal Capital Territory, Abuja.
Thus, the "Standard Policy and Practice Guidelines" seeks to provide best practice guidelines for the counsellors/staff working in NDLEA Counselling Centres.

I am confident that the Guidelines will not only provide a uniform framework for the NDLEA counsellors and counselling centres but will also enable the Agency provide evidence-based counselling/psychosocial interventions that are at par with International Standards and Best Practices.
The management of the National Drug Law Enforcement Agency will ensure that this policy and practice guideline document strictly informs the services delivered in our Counselling Centres Nationwide.

I, on behalf of the Agency, acknowledge the support of the European Union (EU), through UNODC to Nigeria in producing these Guidelines in particular and in the area of drug control in general. I also extend my appreciation to the United Nations Office on Drugs and Crime UNODC, for its efforts in developing the "Standard Policy and Practice Guidelines" for the National Drug Law Enforcement Agency.

I enjoin all Counselling Centres of the National Drug Law Enforcement Agency to adhere strictly to the strategies provided in the guidelines in their day-to-day activities to provide evidence based care to individuals in need of such and for the overall benefit of Nigerian citizens.

Brigadier General Mohamed Buba Marwa (Rtd) OFR
Chairman/Chief Executive
National Drug Law Enforcement Agency

Contributors

In partnership with the Government of Nigeria, UNODC is implementing the large-scale, EU-funded project "Response to Drugs and Related Organized Crime in Nigeria". The project aims to support Nigeria's efforts in fighting drug production, trafficking and use, and curbing related organized crime. The project adopts a balanced approach to drug control, with equal attention paid to drug interdiction and drug demand reduction, including drug prevention, treatment and care (DPTC).

This Standard Policy and Practice Guidelines for NDLEA Counselling Centres document was developed as part of this project.

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Executive Summary

The Standard Policy and Practice Guidelines document, SPPG, seeks to provide instructions and establish protocols for staff working in NDLEA counselling centres, as well as for those in senior management positions. The mandate of the National Drug Law Enforcement Agency (NDLEA) is to curtail illicit trafficking, cultivation and distribution of psychoactive substances, and to reduce demand for these substances. Over the years, NDLEA has been fulfilling its role in the areas of drug supply and demand reduction. One of the key aspects of NDLEA's Drug Demand Reduction (DDR) function is counselling, which is provided at counselling centres in every state command.

The SPPG was developed with an aim to address the identified gaps in the area of DDR interventions being provided by the NDLEA. The Guidelines are meant to provide a uniform framework within which all NDLEA counselling interventions should be provided. Within this framework, there is enough scope and flexibility for the individual centres/staff members to provide care according to the demands of the context, situation or individual client. A number of counselling interventions are described in this document. Every client that counsellors work with may not need all of the counselling interventions described here. The counsellor is expected to choose the most effective types of counselling interventions and the intensity of those interventions based on the unique requirements of the individual client. These Guidelines are expected to facilitate that decision-making processes.

The document also describes some operational aspects of running and managing counselling centres. While a detailed description of all the operational procedures involved in managing NDLEA counselling centres is outside the scope of this document, certain aspects related to the core areas of counselling and care interventions are addressed here. Thus, this document serves the dual purpose of aiding the *clinical* as well as *managerial* DDR functions of NDLEA.

This document consists of six chapters. Chapter 1 provides ***an overview of substance use disorders***. This chapter describes basic issues related to various substances/drugs, substance use disorders, principles of treatment, the intervention process, and some basic aspects of psychosocial interventions and counselling. The second chapter provides the clinical as well as operational aspects of conducting an initial ***assessment*** of clients upon arrival at NDLEA counselling centres. The guidance provided in this chapter will aid counsellors in formulating intervention plans for clients. Chapter 3, ***Delivery of Specific Types of Counselling Interventions,*** describes various *types of counselling interventions* as well as modes through which these can be delivered. Each type of counselling intervention is described, and step-by-step guides are provided, making it easier for counsellors to operationalize interventions. Chapter 4, ***Life as a Counsellor***, describes the professional aspects of counselling and should be useful for people who work as counsellors, particularly in the context of substance use disorders. The fifth chapter describes the ethical and legal issues of counselling. Many of the

issues described in Chapter 5 are not unique to substance use disorders and are therefore applicable to counsellors working in any type of setting. Finally, Chapter 6, ***Standard Operating Procedures (SOP),*** describes operational aspects of managing NDLEA counselling centres. Forms for record keeping are included in the Annex.

Adhering to these standard procedures and maintaining up-to-date records will result in a standardization of interventions at all NDLEA centres. This will raise the quality of care and standards of services across the country.

This document should be regarded as dynamic and evolving. Implementation of these Guidelines will no doubt generate new and different challenges and experiences. It will be necessary to refine and improve upon this document in light of the experiences of those using and reviewing it.

1. Substance Use Disorders: An Overview

1.1 Substance use disorders: Classification and definitions

The most common terms associated with drug use are "Drug Addiction" and "Drug Addict". However, these terms have fallen out of favour because of their pejorative and derogatory implications, and new terms like "Substance Use Disorder(s)" and "People Who Use Drugs (PWUD)" have taken their place. It is also increasingly recognized that substance use is not an all or none phenomenon (that is "Every user is an addict, and a non-user is a good Samaritan"), but instead is a complex spectrum ranging from occasional or recreational use to dependent use. Further confusion arises from the fact that there is no single, precise definition of the word "Drug", and its meaning changes from time to time (cocaine, now a drug, was once a constituent of a popular beverage – Coca Cola) and from place to place (is coffee a drug?). In this section we will look into these important concepts and try to understand the current terminologies that are used to describe the "Drug Addict" (Substance User) and his/her "Drug".

1.1.1 Types of drugs

A drug, broadly speaking, is any chemical substance that, when absorbed into the body of a living organism, alters normal bodily function.[1] There is no single definition, as there are different meanings in medicine, government regulations and colloquial usage.

In the area of Substance Use Disorders (SUD), a drug or a substance is any chemical that, upon consumption, leads to changes in the functioning of the human mind and, more specifically, leads to a state of intoxication. These drugs/substances are also referred to as narcotics and psychotropics. As per international conventions, certain substances have been listed under the category "Narcotic Drugs" and certain others have been placed under "Psychotropic Substances".

The term **narcotic** is of Greek origin and refers to agents that "benumb or deaden, causing loss of feeling or paralysis." International conventions list coca leaf, cannabis (hemp), opium and poppy straw, including all manufactured goods from them, as narcotics. A **psychotropic substance** is a chemical that acts primarily upon the central nervous system, altering brain function, which results in temporary changes in perception, mood, consciousness and behaviour.

1 Throughout this document, terms 'drug' and 'substance' have been used interchangeably.

Some of these substances, like alcoholic beverages and nicotine (tobacco), are legally allowed for trade and consumption in most countries, including Nigeria (albeit in a strictly regulated fashion). These may be called **licit** (or legal) substances. The trade and consumption of many other substances are strictly prohibited and are therefore called **illicit** (or illegal) substances.

Popular literature often talks about substances like **recreational drugs/party drugs/designer drugs** (drugs used to enhance an experience) and **entheogen** (spiritual and religious use). They are all subtypes of psychotropic substances and do not have any particular medical significance. The World Health Organization (WHO) lists substance use disorders for the following classes of substances.

Substances listed by WHO

- **Alcohol**
- **Opioids**
- **Cannabis**
- **Sedative hypnotics**
- **Cocaine**
- Other **stimulants**, including caffeine
- **Hallucinogens**
- **Tobacco**
- **Volatile solvents**

Brief descriptions of common substances of use/abuse follow.

Alcohol

Alcohol is one of the oldest and most popular psychotropic substances/drugs known to humankind. Ethyl alcohol (ethanol) is the active ingredient. Distilled spirits such as whisky, brandy, rum, vodka and gin contain 35 to 50 per cent alcohol (usually about 42 per cent in most countries), whereas beers ordinarily contain 4 to 8 per cent. Wines usually contain approximately 12 per cent alcohol. Due to these variations, alcoholic drinks are measured in "Standard Units", where one standard unit of alcohol is 10 ml of absolute alcohol. The rule of thumb, for comparison, is one standard drink = one can of beer (33 cl) = one small bottle of stout (33 cl) = a small glass of wine = a shot of liquor (brandy, whiskey or gin) = a medium size calabash of pito or burukutu. Note that one bottle of beer (60 cl) is two standard drinks. This will help readers identify the magnitude of the drinking problem of a particular person.

The effects of alcohol on the user depend on the level of alcohol in the blood (this is called blood alcohol concentration or BAC) and are as follows:

BAC in mg/dl	Effects
Around 40 to 80	Feelings of happiness and relaxation, talking freely, some clumsy movements of hands and legs, reduced alertness but user believes him/herself to be alert.
More than 80	Noisy, moody, impaired judgment, impaired driving ability.
At 100-200	Blurred vision, unsteady gait, talking loudly, slurred speech, quarrelsome, aggressive, lack of coordination.
At 200-300	Inability to remember the experience – blackout.
More than 300	Coma and, in higher levels, even death.

Opioids

Opium is the prototype opioid derived from the poppy plant (Papaver somniferum). An opioid is any drug that acts like opium in the human body (as described below). There are three broad classes of opioids: (1) Naturally occurring substances, such as morphine and codeine; (2) Semi-synthetics such as heroin and oxycodone, which are produced by modifying natural substances; and (3) Pure synthetics, such as fentanyl and methadone, which are not produced from opium but act just like opium on the human brain.

When given to a person who has not previously experienced the effects of the drug, opioids produce an unpleasant feeling. However, with continued use, injecting heroin or taking morphine orally produces a short-lived (less than a minute) intense experience, known as a rush. It is described as a state of profound happiness. Opioids reduce the user's ability to feel any pain (and are therefore used as medications for pain relief) and cause a dreamlike state characterized by decreased responsiveness to the user's surroundings. At very high doses, severe intoxication leads to decreased breathing and even death (this is called an overdose).

Heroin, available as 'smack', 'brown sugar' or 'gbana', is commonly smoked, chased (inhaled) or injected (intramuscular or intravenous). Several other opioids that are supposed to be used as medications (for pain relief) are also liable to be used for pleasure. Common among these are cough syrups containing codeine, morphine, pentazocine injections, dextropropoxyphene capsules and buprenorphine tablets/injections. Oral ingestion of opium and smoking the substance through a special wooden pipe have been the traditional methods of use in many parts of the world.

Cannabis

Cannabis is derived from the plant cannabis sativa, which grows in the wild in many parts of the world. In low doses, cannabis causes a state of well-being (a high) and a dreamy state of enjoyment, which is generally followed by a period of drowsiness. Even relatively modest amounts of cannabis can impair coordination and make the operation of heavy machinery hazardous. Dexterity and hand steadiness are both adversely affected. At medium doses, perceptual and sensory distortions occur. Capacity for depth perception declines and scenes appear to have greater depth. Sounds and colours may become more intense along with derealization (when what is seen or heard has an air of unreality) and depersonalization (when one's own body feels unreal). Users' sense of passage of time seems to be much slower than it actually is. Sometimes restlessness, fear and even panic may spoil the experience (this is known as a bad trip). At higher doses, delirium (confusion), psychosis and paranoid ideations (unwarranted suspicion) occur but are generally self-limited.

Cannabis is also available in various forms: either as a paste of leaves of the plant or dried leaves, *ganja, igbo, weed* – the dried flowering stem of the plant – or as hashish oil, extracted from the resin covering the plant. It can be smoked in cigarettes, clay pipes or in water pipes, where the smoke passes through water before being inhaled.

Nicotine

Nicotine is the main active chemical in tobacco, yet another legal and popular substance the world over. Nicotine generally causes heightened alertness and improved functioning in continuous repetitive tasks. Users also report relaxation and decreases in fatigue with smoking. When trying to quit, people often experience irritability, restlessness, anger, frustration, and difficulty concentrating and sleeping.

Tobacco is a very common substance of use. It is legally and socially sanctioned in many parts of the world and used in a wide variety of ways. While smoking is the most common way of using tobacco in Nigeria, it is also chewed, applied to gums, sniffed, sucked and gargled, as in many other parts of the world.

Sedatives/hypnotics

These are medications that are prescribed by doctors to reduce anxiety and induce sleep. They are also liable to be abused because of their easy availability and cheap price. Though detailed discussion is outside the scope of this chapter, certain medications like diazepam, nitrazepam and pheniramine are widely used. These may be used in tablet form, as injections or as cough syrups.

Cocaine

A common substance in developed countries, cocaine is extracted from the leaves of Erythroxylon coca, a plant that grows wildly in Latin American countries. It is generally snorted but can also be chewed and smoked. Its use causes a short-lived sensation (lasting between seven to 10 minutes) of "rush", which is intensely pleasurable to the user. Therefore, it is not generally taken continuously but in "binges" or "runs", when it is taken every 30 minutes to a few hours for consecutive three to seven days.

Stimulants

These are a group of substances that cause activation of the brain, thereby increasing alertness, producing euphoria, improving performance and decreasing fatigue. The prototype drug of this group is amphetamine.

Hallucinogens

Also called **psychedelics**, these are a group of various drugs that have the common property of altering how a person sees or hears (hallucinations). The classic example is LSD (lysergic acid diethylamide), which has been described as making one see music and hear light. Other substances in this group include PCP (phencyclidine) and ecstasy.

Inhalants

These are substances that emit vapours without heating. They are mostly petroleum products and are ubiquitous, present in glue, thinners, cleaners and solvents, to name just a few. The

vapours are "huffed", sniffed or "bagged" (re-breathed from a bag). Their use also produces a rush, a sense of well-being and an urge to reuse again after only five to six minutes. However, with regular use, inhalants are associated with brain damage, and multiple liver and lung problems.

Injecting Drug Use (IDU): A special mention needs to be made about this pattern of drug use whereby users inject themselves with drugs. Apart from the risks inherent to the substance used, injecting drug use poses additional risks such as injection-site infection, thrombosis (vessel gets clotted), skin necrosis (skin dies and falls off), and the spread of various infections, most notably HIV (human immunodeficiency virus).

1.1.2 Important concepts/definitions

Various terms have been used to describe the phenomenon of substance use. These include 'use', 'abuse', 'misuse' and 'dependence'. The following section describes the meaning of each of these terms.

✍ Use

Use is simply the ingestion of alcohol or other drugs **without experiencing any negative consequences**. It may be **social use** (at parties or weddings), **recreational use, experimentation,** a group activity among youth, a **dietary practice** or a **religious ritual**. However, use is not to be taken lightly because once initiated, susceptible individuals may graduate to more problematic categories of abuse and even dependence.

Example: If a student at a party takes a sip of beer, it can be said that he experimented or used alcohol.

✍ Misuse

Broadly speaking, misuse is when a person is taking a drug for purposes that are not legal or as medically prescribed or recommended by the manufacturer. Using a drug in large quantities that have adverse health and social consequences and may take the form of drug dependence is an example of drug misuse.

✍ Abuse

Abuse is a maladaptive pattern of use resulting in physical, social or legal harm, or continued use in spite of such negative consequences. In the most recent systems of diagnosis and classification, the term 'abuse' has been removed. However, in the literature on substance use disorders, the term continues to be employed.

Example: The same student described above continues drinking alcohol even after the party and experiences negative consequences.

✍ Harmful use

Harmful use is understood as a pattern of substance use that causes damage to health, whether physical or mental. To classify use as harmful, actual damage should have been caused to the mental or physical health of the user. The mere possibility of harm is not sufficient to label harmful use. The terms abuse and harmful use are quite similar in implication except that abuse includes legal and social dimensions in addition to health, which is the sole consideration of the term harmful use.

✍ Dependence

First and foremost, it is necessary to understand that drug dependence is a "syndrome" (see box, below). This implies that there is no single test, sign or symptom that can tell us definitively if a person drug dependent. Rather, when a substance user exhibits a number of signs and symptoms, and a pattern of use becomes evident, then the diagnosis of dependence is reached.

> When something goes wrong in the body it generally manifests in signs (observable to others, like a fever or rash) and symptoms (felt by self, like physical pain or a headache). If the root cause of the problem is found and diagnosis made, it can be promptly treated. When the root cause is not found or a diagnosis cannot be made, it is prudent to recognize clusters of signs and symptoms, because, once a treatment is found to help the individual in dealing with the group of symptoms, it can be utilized every time the same cluster of signs/symptoms appear. When such a cluster of signs/symptoms occurs more frequently than by chance, this constitutes a 'syndrome'.

The World Health Organization (WHO) defines Substance Dependence Syndrome as: "A cluster of physiological, behavioural and cognitive phenomena in which use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value." The complete WHO diagnostic guideline is given in the box below.

✍ Addiction

Addiction is an older term that has similar meaning to dependence. It is not favoured in current diagnostic systems because of its derogatory connotation. However, it is ingrained in literature and, hence, continues to be used.

1.1.3 Diagnostic guidelines

The following box presents the guidelines provided by the WHO for a diagnosis of substance dependence.

> **WHO diagnostic guidelines for substance dependence**
>
> A definite diagnosis of dependence should usually be made only if three or more of the following have been present together at some time during the previous year:
>
> a. A strong desire or sense of compulsion to take the substance;
> b. Difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use;

c. A physiological withdrawal state when substance use has ceased or has been reduced, as evidenced by the characteristic withdrawal syndrome for the substance, or use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms;
d. Evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses (clear examples of this are found in alcohol- and opiate-dependent individuals who may take daily doses sufficient to incapacitate or kill nontolerant users);
e. Progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects;
f. Persisting with substance use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking, depressive mood states consequent to periods of heavy substance use, or drug-related impairment of cognitive functioning; efforts should be made to determine that the user was actually or could be expected to be aware of the nature and extent of the harm.

1.2 Causes of substance abuse and dependence

There is no simple explanation for why people take drugs. Many hypotheses exist to explain the occurrence of drug dependence. Some of these are the *moral model* (use seen as a sin or crime), *characterological* (use seen as a defect in personality), *conditioning model* (use as a result of learning new behavior) and *biomedical model* (genetic and physiological/biological cause of SUD). However, it is not possible to explain the phenomenon of SUD based on one model exclusively. Currently SUDs are best conceptualized as biopsychosocial in origin, which is to say, a variety of factors interact with each other to result in substance use and dependence. Let us take a brief look at the current understanding of SUD.

1.2.1 Substance use: Biological causes

Genetic

Many studies have tried to determine if drug use is a heritable condition, that is, if a person is predisposed from birth to become drug dependent. Researchers have found that sons of alcoholic fathers took to drinking more frequently, twins separated at birth showed similar drinking patterns later in life and children of non-alcoholic parents adopted by liberal alcoholic families were less susceptible to alcohol use. Indeed, for alcoholism, between 40 to 60 per cent of the predisposition is heritable (runs in families). For other drugs, too, genetic predisposition has also been found, albeit to a lesser extent. Recent genome-wide scans are trying to pinpoint if humans have a drug dependence gene.

Neurobiological mechanisms

Brain researchers have pinpointed a **pleasure centre** in the brain, which becomes activated when we are exposed to 'good' (likable) things like food, sex and music. It has been shown that drug use stimulates the same pleasure centre and therefore is felt by the user as a highly satisfying and rewarding experience, resulting in repeated use. Indeed, so rewarding is this experience that even in laboratory conditions, animals like rats who could stimulate their own pleasure centre by pushing a lever (after undergoing a surgery that placed an electrode in their brain) continued doing it thousands of times, until they died of exhaustion.

1.2.2 Substance use: Environmental causes

Drug-related factors

Easy availability of drugs and widespread social acceptance of drug use are the chief factors that promote initiation and continuation of drug use. The very fact that socially sanctioned drugs, like alcohol and tobacco, are the drugs most commonly used first indicates that availability plays major role in initiation. Studies have shown that, for alcohol and tobacco, consumption dropped to a certain extent when prices increased. Availability also determines the pattern of drug use.

Additionally, smoking a drug or injecting it into a vein increases its addictive potential, as compared to drinking it. Both smoked and injected drugs enter the brain within seconds, producing a powerful rush of pleasure. However, this intense high can fade within a few minutes, taking the user down to lower, more normal levels. It is a starkly felt contrast, and scientists believe that this low feeling drives individuals to repeated drug abuse in an attempt to replicate the high pleasurable state.

> Across the world, studies have found that a sizable population of drug users reported onset of drug use when they were young. Users generally started with 'softer' drugs like alcohol and cannabis, then gradually graduated to 'harder' drugs like opioids. These observations have given rise to the **gateway hypothesis**, which says that drug use is a developmental sequence in which earlier drug use results in greater risk of use of later drugs. Nicotine and alcohol have been labeled **gateway drugs** because they are socially sanctioned and provide the gateway of entry for a novice user to the world of drugs. However, evidence does not support this hypothesis as many people do not progress from one drug to others.

Social/cultural/legal factors

Environmental risk factors are characteristics in a person's surroundings that increase their likelihood of becoming addicted to drugs. A person may have many environments, or domains, of influence such as the community, family, school and friends. An individual's connection with the community in which they live plays a significant factor in their likelihood of using drugs. Statistics show that if a person's community has a favourable attitude towards drug

use, the risk of substance use is increased. Even religious proscriptions influence drug use, as evidenced by the low use of alcohol in Islamic societies. The single biggest contributing risk factor is having friends (peer group) who use drugs. Family conflict and home management problems are contributory factors in drug use. If parents have favourable attitudes towards drug use or use drugs themselves, often their children will be more likely to use drugs. Conversely, if a substance user is often in conflict with family and authority, the individual is pushed towards accepting their drug-using peer group.

1.2.3 Substance use: Psychological causes

Concept of 'self-medication'

A model of 'self-medication' as an etiological factor in substance use has been proffered. It is believed that many drug users are trying to counteract feelings of pain or depression by taking drugs. In this light, the drug acts as medication, helping the user alleviate emotional problems. Under this principle, chronic cannabis users may be seen as self-medicating for anxiety problems, alcohol may be used to alleviate panic and anxiety, opioids to control anger, amphetamines to alleviate depression, and cocaine to help overcome fatigue and alleviate depression. While such use may provide immediate relief of some symptoms, in the long term it may itself lead to psychiatric complications.

Psychologists also see substance use as a *learned behaviour*, picked up from parents and peers, and describe continued use as forms of classical and/or operant conditioning.

Conditioned behaviors

We often learn to associate one behaviour with another, for instance a cigarette after dinner, or a cup of coffee after work. Over time, such behavioural associations become fixed and difficult to alter. Such 'classically conditioned' behaviours significantly contribute to the continuation of drug use, even when the client is trying to quit.

We also learn to do many things to get a reward or avoid punishment, such as studying to avoid failing, dressing well to be complimented by others, and so on. Use of substances also similarly rewards the user with a high, while non-use punishes the user with withdrawal symptoms. Over time, these rewards and punishments becomes subconsciously ingrained, and the client may be averse to changing their behaviour for fear of punishment or losing the reward. Such behaviours are then said to be 'conditioned'.

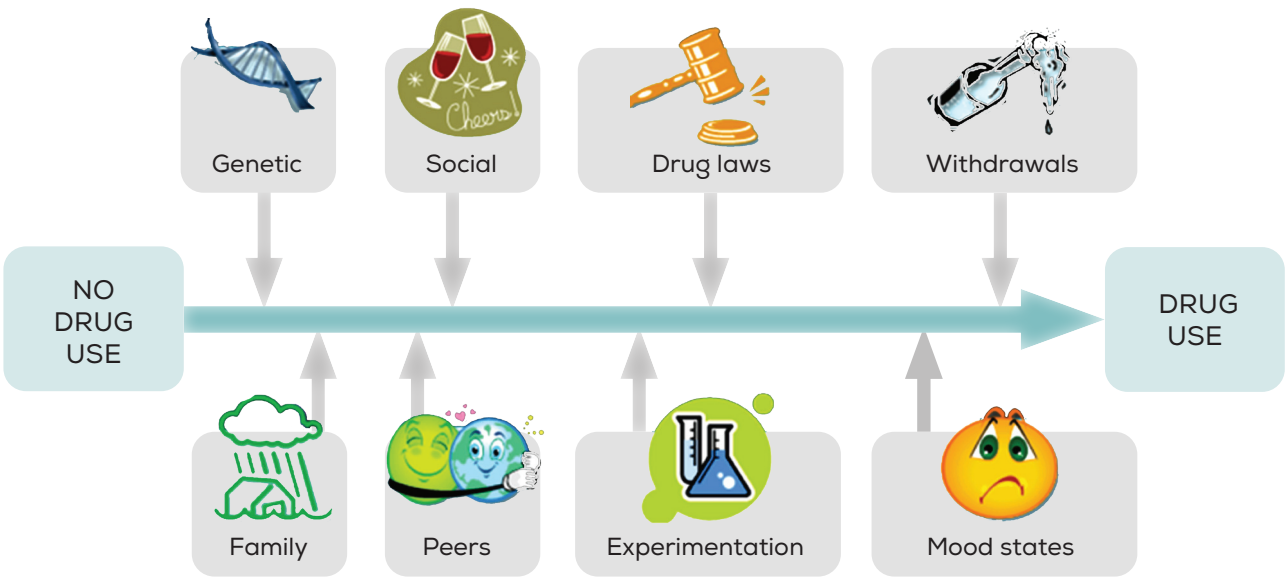
Personality-related variables

Several common personality traits (that is, patterns of feeling and behaving in particular situations) have been observed in people who take up and continue using drugs. Low frustration tolerance and sensation seeking are by far the most studied of them. People with low frustration tolerance seek to avoid immediate pain at the cost of long-term stress and defeatism. They take to drugs to escape the simple and inevitable problems of daily life. Sensation seeking,

on other hand, focuses on the need for new and varied experiences through risky behaviour. Doing things at the spur of the moment without consideration of outcome (impulsivity) and nonconformity to social rules and norms are integral parts of their lives. Many substance users also suffer from inability to experience pleasure from normal activities (anhedonia) or to understand their own emotions (alexithymia), and therefore require a stronger high to feel pleasure. It has been postulated that such personality traits maintain substance use in affected persons.

These models of causation of SUD are not mutually exclusive and generally many factors overlap in every substance user to result in his/her dependence on substances. Someone may have a genetic vulnerability, which predisposes him/her to SUDs. This individual finds him/herself in an environment where a substance (say alcohol) is easily available, and he/she may also have many alcohol-using friends. He/she may initiate drinking alcohol due to pressure from friends, and, after finding it pleasurable and anxiety reducing, may continue to drink. Then, after long periods of continuous use, his/her body may become physically dependent on alcohol (such that absence of alcohol would evoke distressing withdrawal symptoms). In order to relieve these symptoms, as well as to continue experiencing pleasure, that person continues to drink and ultimately suffers from alcohol dependence. The following illustration (figure 1) explains the interplay of various factors leading to drug use.

Figure 1: Factors leading to substance use



1.3 Consequences of substance use

It is necessary to understand the widespread consequences of substance use on the user, family and society at large. Such knowledge not only helps to better understand the disorder but also can be used during counselling sessions to highlight harms of the client's behaviour that are not imminently visible, thus leading to a shift in the decisional balance. Also, outcomes of treatment are measured not only by the direct decrease in substance use but also by indirect decrease in such harmful consequences.

1.3.1 Physical consequences

Physical complications of drug use are varied, numerous and differ from substance to substance. In general, any drug harms the body in acute use by intoxication and by overdose toxicity. Acute alcohol overdose can cause a person to fall, go unconscious, vomit and bleed internally. Progressed conditions include sedation, coma and ultimately death. Adulterants of alcohol can go blind, and even die. Opioids, cannabis and other drugs can cause various mental illnesses including psychosis during overdose. Chronic (long-term) use causes harm to almost all organ systems of the human body. Jaundice and liver disease (alcohol), dementia (alcohol), cardiac problems (alcohol), cancer (tobacco and alcohol), asthma (tobacco), viral hepatitis (IDU), HIV (IDU) and psychiatric illness (most drugs) represent only a tiny fraction of the list. Even sudden stoppage of drugs by a dependent user can cause severe physical symptoms in the withdrawal state, which sometimes may be fatal. Rather than listing all possible physical harms in each case, it is important to find out what physical harm has actually occurred to the user and explain the benefits ceasing use.

1.3.2 Social/familial/economic consequences

It must be remembered that young adult males are most commonly affected by substance use problems. In other words, people who are among the most productive members of any society are ironically the most vulnerable to substance use disorders. Apart from the direct economic loss of money spent on substances, people who use drugs face various indirect monetary losses due to loss in productivity, absenteeism from work and being fired, to name a few. Adolescent users drop out of school, jeopardizing future earning capabilities. Multiple physical complications and recurrent hospitalizations drain money. Stigma of substance use prevents people from getting jobs even when they are trying to quit substances.

Family members of substance users bear the major burden. Apart from money being diverted from family funds for sustaining substance use, the whole family suffers from the stigma of drug use and discrimination. On a more personal level, substance users are often in conflict with family members. In societies where most substance users are males and dominant members of the family, women suffer silently from physical abuse, sex without consent and

risk of infections transmitted to them by their partners. Children of such families often suffer from psychiatric illness and have increased chances of substance use.

Society at large suffers loss of productivity and an increased burden to support and treat these potentially productive members. Crime rates also rise, as do as accidents (workplace, road traffic and domestic) and properties are vandalized.

1.3.3 Psychological consequences

Psychological complications range from lack of well-being to depression. Substances like alcohol can cause depression with long-term use and attempts to quit are often accompanied by severe anxiety. Cannabis has been long associated with precipitation of illnesses like schizophrenia. Cannabis can also cause 'amotivational syndrome', where the user loses all interest and goals in life. Opioids and amphetamines are known to cause psychosis. Any underlying mental illness is generally aggravated by substance use.

1.3.4 Legal consequences

Substance users are often in conflict with law. They are often arrested and incarcerated when caught with illicit substances, and a life in and out of correctional facilities follows, thereby severely hampering gainful employment. In order to sustain substance use behaviour, many users are forced to indulge in illegal activities like theft, robbery, commercial sex work and drug peddling. This makes them more of a criminal in the eyes of the law than an individual with a medical condition. Often, when young persons who use drugs are put in restrictive settings with hardened criminals, they progress to more dangerous activities and drug use patterns rather than getting reformed. Thus, even when applied with the best of intentions, the law may not result in optimal outcomes for substance users.

Such dire consequences of substance use make it imperative to develop strategies that will help in early identification and effective treatment of substance users to minimize harmful consequences.

1.4 Assessment of substance use disorders

> Assessment is the cornerstone of diagnosis and management of substance use disorders. A proper assessment is necessary for making a diagnosis, developing a treatment plan and referring clients to a specialist when required. It also helps establish rapport and motivate the client to quit. Assessment, however, is not a one-time phenomenon. Generally, it is done at the beginning of treatment, to define the problem and formulate a treatment plan. It also needs to be repeated during treatment to monitor progress, and after treatment to assess maintenance of abstinence status. In this section we look into various methods of assessment. More details are provided in the next chapter.

1.4.1 Clinical interview and history

A clinical interview and history taking is a process through which the objective is to gather relevant and correct information quickly about various aspects of the problem. Therefore, the interview should neither be a social chitchat nor a rigid checklist tally. Rather, the counsellor should begin by asking open-ended questions. This should be followed by guiding questions to steer the conversation in a meaningful direction. The questions are meant to gain insights into important aspects of a client's drug use, which are necessary for management.

Examples of open-ended and close-ended questions

Open-ended questions	Close-ended questions
What brings you here?	Do you want to stop smoking weed?
Could you tell me a little bit about your marriage?	Do you have a good marriage?
How did you feel as a child?	Did you feel left out as a child?
Tell me about your drinking pattern?	Do you drink excessively?

Guidelines for taking history of PWUD as clients

1. Allow the client to **settle down** and ask about their **sociodemographic profile,** including name, age, marital status, qualification, occupation, type of family, name of parents/spouse, maiden name for women, accommodation/living arrangement, place of birth, place of residence and nationality.

2. **Details of drug use** are then inquired into. These include:
   a. Age of **initiation?**
   b. Various **drugs** used?
   c. **Frequency** of use of those drugs?
   d. Quantity of drug taken usually (**usual dose**)?
   e. Time since the dose **last used?**
   f. If the client has needed to increase the quantity of drug consumed in order to produce the same effect (**tolerance**)?
   g. If the client has experienced any symptoms of **intoxication?**
   h. Symptoms and signs when the particular drug is not taken or taken in reduced amounts (**withdrawals**)?
   i. If the client feels a compelling need/urge to take the substance (**craving**)?

3. **Complications** associated with drug use should be asked about. These are areas to be focused on during rehabilitation. The areas probed are:
   a. **Physical**: long-term health hazards associated with drug use
   b. **Psychological**: chronic mental effects of continuous use of drug
   c. **Financial**: losses suffered/debts incurred
   d. **Occupational**: frequent absenteeism from work, constant change of job, memos issued, periods of unemployment

e. **Familial/social**: frequent fights with spouse or other family members, neglect of responsibility at home, social outcast
f. **Legal**: involvement in illegal activities to sustain drug use, arrests, charges on account of drug use, caught driving under intoxicated state, drinking brawl
g. **High-risk behaviours**: presence of injection use with needle sharing and unsafe sexual practices

4. **Past abstinence attempts** – herein inquiry should be made regarding:
   a. **Number of attempts** made
   b. **Duration** of each attempt
   c. **Reason** for abstinence (why the client wanted to quit)
   d. Whether **treatment** was sought (what treatment worked or did not work before)
   e. **Nature of treatment sought**: pharmacological, psychological or combined
   f. **Reason for relapse**

The information collected will be helpful in formulating a treatment plan and determining measures to be taken to prevent relapses.

5. **Reason for seeking treatment** and **motivation level** of individual: whether the client is self-motivated in seeking treatment or brought forcibly by a family member. Assessing level of motivation will help the counsellor decide the type of intervention needed.
6. **Co-morbid psychiatric illnesses** such as a mood disorder, psychotic disorder and personality disorders that need specialist care.
7. **Other health issues**: Ever been tested for HIV and HCV? Ever been diagnosed of certain ailments/diseases?
8. **Family history** of SUD, psychiatric illness and current living arrangements. Extent of social support should be assessed.

It is often thought that self-reporting, especially in the area of substance use, may not be reliable because of a perceived notion that the substance user does not accurately report the true extent of substance use. However, research suggests that the possible distortion in self-reporting is less problematic than it is feared to be. Self-reports can be made more reliable by enhancing motivation and developing an empathic and non-judgmental attitude towards the drug user. An intimidating interview setting, a moralistic and authoritarian style of interview and lack of confidentiality are barriers to accurate information collection. The counsellor should therefore never exhibit these general qualities when interacting with a person who uses drugs and should instead seek to make the client as comfortable as possible.

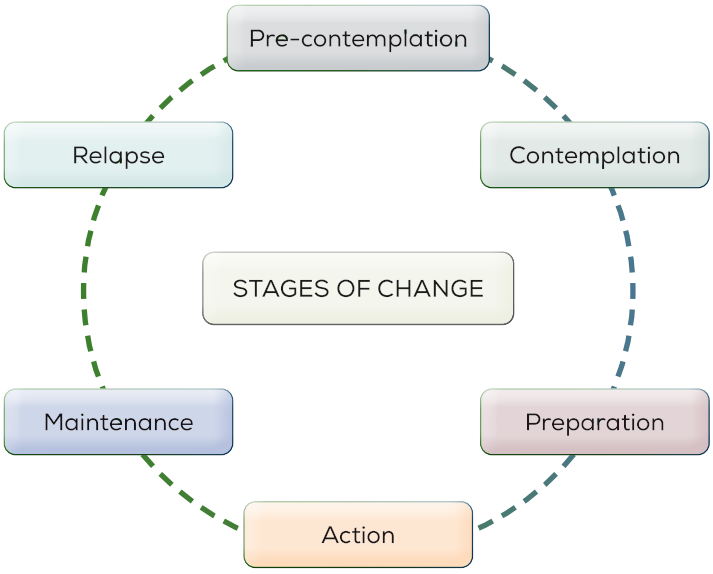
1.4.2 Examination

A detailed clinical examination is best left to the clinician (medical doctor). However, cursory examination for routes of drug use (as evidenced by burn marks/nicotine stains on fingers

in cases of both cigarette and (inhaled) heroin use; injection marks in case of injecting drug use (IDU)) may help to corroborate the client's history. Similarly, a detailed mental status examination is best conducted by a trained professional, but the counsellor should enquire about the mood state of a client (whether feeling low, depressed, anxious, angry or suicidal) and any abnormality should be reported.

It is more important to assess the **motivational stage of the client** (described in detail in 1.6.1). Motivation is simply the will to change (or maintain the changed behavior). For the purpose of substance use, the most influential model of change has been the **transtheoretical model** put forward by Prochaska and DiClemente in 1984. This model states that motivation is dynamic, fluctuating and cyclical as the client progresses from one stage to the next. The stages proposed are **pre-contemplation, contemplation, preparation, action and maintenance**, along with the issue of **relapse or recurrence**. Essentially, during pre-contemplation, individuals do not feel impelled to do anything about their behaviour, perhaps as a result of denial or selective exposure to information. As they become aware that a problem exists, they enter the contemplation stage, which is characterized by conflict and dissonance. Preparation is defined as a time when the individual drug user formulates action plans and is serious about his or her intention to alter behaviour. Action is a period when overt changes are made, after which successful individuals enter the maintenance stage, when new behaviours are strengthened and consolidated. The individual who does not relapse during this stage eventually exits the change system to termination, or, in other words, a favourable long-term outcome. Most people do not immediately sustain the new changes they are attempting to make and may return to substance use. When this occurs, it is known as relapse. These stages follow a cyclical pattern in that people may move back from action to contemplation and pre-contemplation before eventually achieving long-term resolution of the problem. One of the essential purposes of counselling is to enhance the motivation of the client to move further along the continuum of pre-contemplation to maintenance.

Figure 2: States of change



Additionally, a laboratory assessment to confirm and corroborate drug use and to identify physical complications may be conducted in specialized treatment centers.

1.4.3 Use of structured tools for assessment

Questionnaires and **scales** are structured tools that have been specifically developed to measure some aspects of substance use. They offer the advantage of being brief, easy and rapid to administer, and their results can be objectified and compared. However, they are limited in scope, and can augment but not replace the clinical interview.

Screening

Screening is usually applied to a large group of individuals and is very brief by nature. It is usually applicable in settings where individuals encounter problems that may not appear to be related to substance use, yet the association of the problem with substance use may be strong. Such settings may include a general medical facility or community clinic, a prenatal checkup or in a legal setting (for example, in prisons among individuals arrested for reckless driving).

Efforts have been made to develop brief questionnaires and interviews so that individuals with substance use disorder may be identified in a relatively short period. Consequently, a number of instruments have been developed towards this end. Some frequently used instruments are

1. **CAGE**: An acronym for four questions used to assess those with alcohol problems
2. **MAST**: Michigan Alcohol Screening Test
3. **DAST**: Drug Abuse Screening Test
4. **AUDIT**: Alcohol Use Disorder Identification Test
5. **ASSIST**: Alcohol, Smoking and Substance Involvement Screening Test

The usefulness of these instruments depends on the setting and the type of population for whom these instruments are used.

Severity

The most commonly used tool for measuring severity is the **Addiction Severity Index (ASI)** (McLellan et al., 1980, 1992). The ASI assesses history, frequency and consequences of alcohol and drug use, as well as five additional domains that are commonly associated with drug use: medical, legal, employment, social/family and psychological functioning. The ASI can be administered in 30 minutes and has a 10-point problem severity rating in the above seven areas.

Another tool in wide use is the **Maudsley Addiction Profile (MAP)**. MAP is a brief instrument for assessing treatment outcomes with 60 items across substance use, health risk, physical/psychological health, personal/social functioning domains. The MAP assessment takes an average 12 minutes to complete.

1.4.4 Motivation

The most common questionnaire used to judge motivation is the **Readiness to Change Questionnaire (RTCQ)** (Heather, 1999). The RTCQ is a 12-item questionnaire, based on Prochaska and DiClemente's stages-of-change model, for assignment of excessive drinkers (that is, harmful and hazardous drinkers) in the pre-contemplation, contemplation and action stages. It is a self-administered test with three subscales. Generally, it takes two to three minutes to administer and one minute to check. No prior training is required for administration. The **Readiness to Change Questionnaire Treatment Version (RTCQ-TV)** is a modification of the RTCQ, with three additional items, used to assess motivation in persons undergoing treatment.

1.5 Treatment of substance use disorders: Principles and overview

> More than medicines and techniques of psychotherapies, the successful treatment of SUDs requires understanding of the illness, empathy for the user and patience from the counsellor. SUDs require long-term treatment and users generally go through a period of being on and off drugs (which may span years) before finally quitting. Establishing good rapport with the user helps them stay in treatment, which research has shown to be the single most important predictor for a successful outcome.

1.5.1 General principles

The World Health Organization (WHO) outlines nine key principles for the development of services for treatment of drug use disorders, not only for individuals but also at the community level and for government policymaking. They are briefly as follows:

Principle 1: Treatment should be available at places accessible to substance users. The operating hours should be flexible and those seeking treatment should not face any legal consequences. Importantly, services should be available at a cost the drug user can bear.

Principle 2: Screening, assessment, diagnosis and treatment planning should go hand-in-hand and comprehensive treatment targeting all the needs of the individual drug user (for example, medical complications and social problems) should be offered.

Principle 3: Any treatment for drug dependence should be evidence based (shown by research to be effective).

Principle 4: Human rights and client dignity should be maintained, and discrimination should be avoided.

Principle 5: Needs of special subgroups like adolescents, pregnant women, sex workers, and patients with conditions like medical and psychiatric co-morbidity should be addressed.

Principle 6: Addiction treatment and the criminal justice system should not come in conflict with each other. Drug use should be seen as a health condition and drug users should be treated in the health care system rather than in the criminal justice system.

Principle 7: Community involvement, participation and patient orientation should be promoted.

Principle 8: Clinical governance of drug dependence treatment services should be the rule. Accountability should be specified, and service policy and protocols clarified.

Principle 9: Policy development, strategic planning and coordination of services should be done at the government level to have a comprehensive service package.

1.5.2 Goals of treatment

Treatment goals differ from client to client and may need to be reframed over time as treatment progresses. Traditionally, the **primary goal** of treatment is to achieve permanent abstinence. However, this goal may remain elusive and alternate goals may need to be pursued for some. In this subgroup, intervention is directed towards decreasing the harmful consequences of continued drug use. Such an effort is practical and attainable and is called **'harm reduction'**. Strategies for harm reduction are discussed in Chapter 3. The other goals are improved physical, psychosocial and occupational functioning.

Goals may also be classified as immediate, short term and long term. **Immediate goals** may be completion of detoxification (treatment of withdrawal symptoms) and intervention targeting psychosocial and medical crisis (crisis management). **Short-term goals** may include management of medical and psychiatric problems and re-integration with family. **Long-term goals** consist of prevention of relapse, reintegration into society, occupational rehabilitation and improvement in overall quality of life.

Treatment goals

- Abstinence
- Harm reduction
- Improved health, social and occupational functioning
- Improved quality of life

1.5.3 Phases of treatment

Comprehensive treatment of SUDs comprises initial, middle and late phases. In the **pre-treatment period**, acceptance of the problem by the client occurs and the client prepares for treatment. The peer group and family members play a significant role. The **initial phase** is detoxification, which usually lasts between two and four weeks. Here, efforts are made to free the person of all intoxicants, treat the symptoms of withdrawal (caused by stopping drug use) and attend to the immediate medical consequences of drug abuse. The **middle phase**

is aimed at maintaining a drug-free status (relapse prevention) and initiates the process of reintegration into society. It may last three to six months. During the **late phase**, adoption of a healthy lifestyle and alternate coping strategies are promoted. Usually, treatment is multimodal and includes pharmacological and non-pharmacological treatment approaches.

1.5.4 Treatment modalities

Certain basic principles of management are common, irrespective of the substance being used. Broadly speaking, there are two modalities: **pharmacotherapy** and **psychosocial interventions**.

The goals of pharmacotherapy are:

- Reversal of acute effects (intoxication and overdose)
- Amelioration of withdrawal symptoms
- Reduction of cravings
- Prevention of relapse
- Restoration of normal physiological functions

Currently, various pharmacological agents are available for the above purposes.

Detoxification is the initial step in substance abuse intervention. Medications are used for this purpose but need to be supplemented with various forms of psychological and social interventions. These include single session counselling and brief therapies like **motivational interviewing** and **motivational enhancement**. In tertiary care settings, more complex therapies like **family and marital therapy** and **network therapy** may be carried out to promote sobriety and a healthy drug-free lifestyle. Other common tasks include building an improved client-counsellor relationship, therapeutic alliance and improved communication with the client and his/her relatives. Such treatment to enhance motivation is very effective in improving treatment compliance.

Achieving permanent abstinence is a slow process. Clients go through short periods of abstinence and a reduction in drug consumption before becoming totally drug free. In the process, considerable patience is required on part of the client, family members and the treatment team.

Once the client becomes drug free, the goal shifts to maintaining the drug-free status. **Relapse prevention,** a psychological technique, involves strategies that help the client maintain the necessary changes in their drug-free life over time (described in detail in 1.6.3). The client is made to understand that relapse is a process and lapsing to occasional drug use does not mean treatment failure. Family support is encouraged. The client is also taught to identify high-risk relapse factors and the social pressures of drug use and trained on strategies to address them.

Other treatment modalities include the **self-help approach** where people with similar problems unite to form self-help groups for mutual support. These groups are voluntary

and self-sufficient and provide mutual assistance to all members. Self-help groups like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are active in many countries. Additionally, self-help groups for family members, friends and children of drug and alcohol users have been developed. In the **social correctional approach**, drug and alcohol abuse is seen as a social deviance and residential programmes are offered as correctional methods. **Therapeutic community** (TC) is the most well-known of the approaches offered under this concept. **Workplace-based interventions** like the Employee's Assistance Programme (EAP) offer assessment, referral and follow-up services for mental health, alcohol and other drug-related problems for workers with the aim of promoting productivity at the workplace.

1.5.5 Assessment of outcome and effectiveness of treatment

Traditionally, treatment success was measured by abstinence. Today, most service providers understand that drug use/abstinence should not be the sole criteria to assess outcomes. Rather, improvement should be seen in the total functioning of the person. Most studies show satisfying improvement in various dimensions of the client's life (familial, financial and legal) whenever treatments have been implemented. The more comprehensive the treatment package and longer the therapeutic contact, the bigger and better the change. Detoxification in isolation has been found not to change the outcome and continuation of treatment is necessary to achieve any benefit. The application of psychosocial therapies usually results in better outcomes than medicines alone.

Various outcomes of substance use treatment are as follows:

1. Abstinence
2. Employment
3. Decrease in crime
4. Stability in housing
5. Service capacity
6. Retention to treatment
7. Social support
8. Perception of care
9. Cost effectiveness
10. Evidence-based practice

1.6 Psychosocial approaches to treatment

1.6.1 Motivational enhancement

As described earlier, motivation to reduce or stop taking drugs (or, for that matter, motivation for changing any behaviour) is a dynamic, ever-changing process. Consequently, a person with substance use problems encountered by a counsellor may not be fully motivated to quit. Thus, the first step in the treatment of a poorly motivated substance user is 'motivational enhancement'. The variable nature of motivation is highlighted by three critical elements: that a person is *ready to change*, *willing to change* and *able to change*. One may be able to change, but not be willing to due to lack of motivation. Thus, the purpose of motivational enhancement is to help the client become *ready*, *willing* and *able*. The motivational style of

counselling is useful not only to instill motivation initially, but throughout the preparation, action and maintenance stages as well. Motivational enhancement counselling varies according to the stage of change (described earlier). The principles of motivational enhancement are discussed below.

General principles of motivational enhancement:

- Give factual information
- Provide personalized feedback about assessment findings
- Explore the pros and cons of substance use
- Examine the discrepancies between the client's and others' perceptions of the problematic behaviour
- Express concern
- Keep the door open, in other words, do not end a session on a negative and/or pessimistic note

✍ Give factual information. *"Let me tell you about all the possible harms that continued alcohol use over a long period of time can cause a person. This can result in…"*

✍ Provide personalized feedback about assessment findings. "*I have talked to you in detail. I also have your lab reports and doctor's notes with me. It is very clear that your pattern of drinking is excessive and harmful. There is already much evidence that drinking has affected your health, your work performance, your family life, your finances and your reputation…"*

✍ Explore the pros and cons of substance use. *"OK, let's do an exercise. I want you to imagine your life five years from now in both these situations: if you continue to drink or if you manage to stop drinking completely. Can you describe and compare both situations?"*

✍ Examine the discrepancies between the client's and others' perceptions of the problematic behaviour. *"I understand that you think that you do not drink excessively. However, by all the other accounts – your wife's, your mother's – it appears that you have been drinking a fully bottle of whiskey almost every day."*

✍ Express concern. *"It is indeed worrying that if you continue to drink this way, you may lose your job as well as the respect of your own family."*

✍ Keep the door open, that is, do not end a session on a negative and/or pessimistic note. *"Well, today you do not appear to be willing to take this conversation further. But I am sure we will have another opportunity to discuss your drinking issues very soon. Should you feel like discussing them, you are always welcome."*

The specific approaches in motivational enhancement may differ depending on which phase of change the client is in. These phases are described below.

Contemplation phase: In this phase, the counsellor's primary goal is to help the client with decision-making. Therefore, normalize ambivalence; help the client tip the decisional

balance towards change by eliciting and weighing pros and cons of substance use *("Can you imagine your life five years from now if you continue to drink? How different would it look if you stop drinking?").* Examine the client's personal values in relation to change. Emphasize responsibility *("Only you can change yourself, no one else can")* and self-efficacy *("Yes, with our help, you can certainly change yourself. You have it in you.")*. Elicit self-motivational statements of intent and commitment. Elicit ideas regarding perceived self-efficacy and expectations for treatment. Summarize self-motivational statements.

Preparation phase: Clarify the client's own goals and strategies for change. Offer a menu of options. With permission, offer advice. Negotiate a change or treatment plan and behaviour contract. Help the client enlist social support. Explore treatment expectancies and the client's role. Ask about what has worked in the past for the client or for people he or she knows. Help the client to negotiate finances, childcare, work and other barriers. Have the client publicly announce plans to change.

Action phase: Engage the client in treatment and reinforce the importance of remaining in recovery. Support a realistic view of change based on small steps. Acknowledge difficulties for people in early stages of change. Help identify high-risk situations and develop appropriate coping strategies to overcome them. Assist in finding new advocates of change. Assess whether the person has strong family and social support and encourage such support.

Maintenance phase: Help the client identify and try out drug-free sources of pleasure. Support lifestyle change. Affirm their resolve and self-efficacy. Assist the person in employing new coping strategies to avoid returning to drug use. Maintain supportive contact. Develop a 'fire-escape' plan if the client resumes substance use.

In summary, motivational enhancement is a client-centered directive therapeutic style to resolve ambivalence and promote greater commitment to change.

1.6.2 Brief intervention

As described above, not all substance users become *dependent*. Indeed, most users do not fall in the category of *dependence* but in the categories of *use* or *harmful use*. There is evidence that many people who use drugs may not require intensive treatment but can be helped by less intense psychosocial interventions. One such category of interventions is brief intervention (BI).

BI has been mostly employed in primary care settings and for counselling people who use drugs but are not willing to enter into treatment. These counselling sessions are short (between five and 20 minutes), focused, and aim to identify a real or potential problem – and motivate an individual to do something about it.

Motivational interviewing (or motivational enhancement, as described above) is the cornerstone of BI. Motivational interviewing is a non-judgmental and non-confrontational technique that attempts to address the specific issues that people are facing at any particular stage. The technique attempts to gauge a person's awareness of the potential problems caused,

consequences experienced and risks faced. When the BI process is complete, people receive personalized feedback about their substance use behaviours. As feedback is presented, the clinician or programme provider may foster the development of discrepancies between the perception of self and the reality of the person's situation. In short, the strategy seeks to prompt individuals to think differently about their use of substances and, ultimately, to consider what might be gained through change.

The key features in BI can be summarized using the acronym **FRAMES**

Feedback: Provide personally relevant feedback on issues such as the individual's drug use

Responsibility: Emphasize that it is the responsibility of the user to change

Advice: Offer non-judgmental advice on strategies for change

Menu of options: Provide alternate strategies and solutions available for each problem faced

Empathy: Express that you can relate to the client and understand their reasons for drug use

Self-efficacy (confidence for change): Encourage the client's confidence that change is possible

One of the limitations of such information-only programmes is that they may raise awareness and knowledge about the effects of a substance but leave the individual to make behavioural change on their own. Another important aspect of BI is problem solving and skills training. As motivational interviewing helps the individual become aware of their behaviour, skills training programmes help equip the individual with the skills they need to make changes in their behaviour.

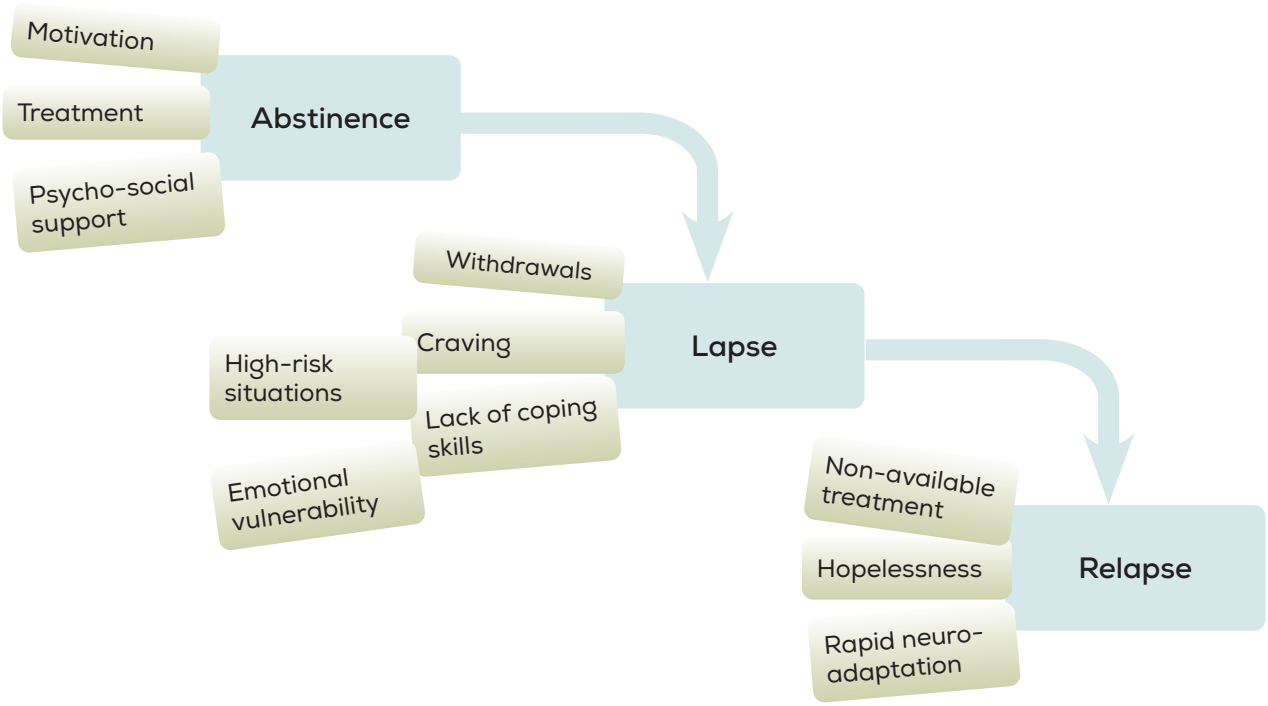
1.6.3 Relapse prevention

A college student was trying to abstain from cannabis use. He expected that everybody would support him once they knew how hard he had worked to quit the substance. However, at college, friends would avoid him saying: "Once a sinner, always a sinner." At home, his parents refused to give him the money he needed for his books (which he actually intended to buy this time) because they did not believe that's what he would spend the money on. A fight with his parents left him feeling lonely and irritable and, in the evening, he left his house in a fit of anger. On the street, he ran into the friends who he regularly smoked with – they welcomed him heartily and offered him a puff. Though he declined at first, he finally relented to their urging and took a puff of the cannabis-laced cigarette, which felt even better than before. The next morning, however, he was remorseful. He thought that what people said about him was right: "Once a drug user, always a drug user." He decided to continue cannabis use.

Substance use is best seen as a chronic, *relapsing* condition. After treatment, between 60 and 80 per cent of clients relapse, or start using substances again, within one year. Thus, prevention of relapse is an important issue in the treatment of addictive behaviours. Relapse prevention is a generic term for a variety of approaches to the treatment of drug and alcohol

use, primarily aimed at those in the maintenance stage of change. However, it must be remembered that a single instance of using a substance after achieving abstinence does not mean relapse. Most experts would term an occasional slip as 'lapse' while 'relapse' is a return to the original pattern of use. Researchers have found that relapse is more likely in individuals with few coping resources and who have encountered a relatively large number of risk situations. The following illustration (figure 3) clearly explains the factors affecting abstinence, lapse and relapse.

Figure 3: Factors affecting abstinence, lapse and relapse



Relapse prevention is a set of techniques broadly derived from social learning theory. In this program, individuals are first taught to recognize that the possibility of relapse is real and therefore to plan for it, rather than to suppress it as feared failure. Essentially, the client receives training in specific coping strategies. These can include broad-based skills trainings like **behavioural rehearsal** (for instance *what to do at a party*), **assertiveness** (*how to say 'no' to pressure*), **changing ways of thinking** (*though he may relapse, this only means he needs to come back to treatment and not to despair*) and **lifestyle interventions** (relaxation and physical exercises). Clients are taught to recognize early warning signals and seemingly irrelevant decisions that can increase the possibility of relapse. Emphasis is placed on the modification of faulty beliefs or dysfunctional assumptions. Throughout, the client is encouraged to practice these strategies using rehearsal, role play and homework tasks.

Notes

Coping skills are behavioural tools that are often used by individuals to overcome adversity or disability without correcting or eliminating the underlying conditions. There are two primary styles of coping with stress:

- **Emotion-based** coping skills reduce the symptoms of stress without addressing the sources of stress. There are both positive and negative coping strategies that can be defined as emotionally based. Emotion-based coping can be useful to reduce stress to a manageable level, enable action-based coping or when the source of stress cannot be addressed directly:
  - Relaxation strategies (breathing, meditation)
  - Reappraisal (what went well and what could have been worse)
  - Humour (making jokes, taking things lightly)
  - Distraction (watching a movie, playing, sleeping)
  - Discussing the source of stress with a friend
  - Denial, repression, wishful thinking (these are negative emotional coping techniques, but can be temporarily helpful in managing the problem)
- **Action-based** coping involves actually dealing with a problem that is causing stress and is generally seen as superior to emotion-based coping. Examples of action-based coping include:
  - Planning (how to face and do the task)
  - Time management
  - Prioritizing
  - Suppression of competing activities
  - Self-control
  - Restraint

Learning coping strategies is the cornerstone of relapse prevention and survival. Relying only on 'avoidance strategies' (such as avoiding parties where alcohol is being served) is less effective in preventing relapse than employing active strategies, such as carrying out alternative activities, seeking support from others, positive self-talk and cognitive problem-solving.

1.6.4 Specific issues regarding psychosocial approaches

Therapeutic relationship

A therapeutic relationship is a constructive alliance between the counsellor and the client that fosters the development of a meaningful outcome. Trust and empathy are the cornerstones of establishing a relationship, and a good rapport is the outcome. There can be various models of interaction between the counsellor and client: *the paternalistic model*, in which the counsellor decides what is best for the client; *the informative model*, where the role of the counsellor is simply to provide information on the available choices; and *the interpretive model*, when the counsellor suggests the best of the available choices based on their understanding of the client's past and present situation. The paternalistic model tends not to work well for substance users. As rapport is established, one may shift to the interpretive model. It is possible

that good rapport between the client and counsellor may lead the two to grow close. The therapeutic relationship is a defined relation with boundaries that should not be violated. The role of the counsellor is to remain a part of the therapeutic process and not to become a family member or a friend. Such proximity weighs upon clinical decision-making and puts an undue burden of responsibility on the counsellor.

Qualities of a good counsellor

Throughout the chapter we have often given clues as to what skills a counsellor needs in order to work in the field of substance use disorder. Here we briefly discuss those qualities.

First and foremost a good counsellor should be **non-judgmental** and have a **medical** rather than a moralistic view of SUD. This involves identifying the client's problems and trying to find solutions, rather than pinpointing causes that might have resulted in the problems. Behaviours should be judged as harmful or non-harmful rather than as good or bad, or right or wrong. Substance use/dependence should be discussed freely and treated like other chronic lifestyle illnesses like hypertension and diabetes. Indeed, if clients diagnosed as hypertensive are not stigmatized for leading unhealthy lifestyles, people who use drugs should likewise not be stigmatized for their drug use.

Another important quality is possession of good **communication skills**. It must be remembered that communication entails not just talking but also active listening. Communication occurs at both verbal and non-verbal levels and certain non-verbal gestures can go a long way in establishing rapport. Greet the client in a culturally appropriate manner, offer a chair and begin the interview. Leaning forward and establishing eye contact to an appropriate degree helps establish rapport. Nodding and gesturing when the client is speaking shows the counsellor is paying attention without breaking the client's train of thought. Finally, summarizing what the client said demonstrates that the counsellor understands the client's perspective.

Sometimes clients ask: "How can you understand what I am going through without being in my position?" Modern mental health approaches are based on the belief that it is not necessary to have had other people's literal experiences to understand them. The shared experience of being human is often sufficient. Such ability of the counsellor to understand the mental state of the client without being affected by it is called **empathy**.

The attitude of the counsellor should be logical and informative. A paternalistic and dominating attitude becomes a hindrance to developing rapport as it leads drug users to associate the counsellor with other authority figures they have encountered. Similarly, counsellors should constantly be on guard to prevent their own personal life experiences from clouding their **objectivity**. The counsellor should be **pragmatic** and **compassionate** and demonstrate **knowledge** and **authority** on the subject to gain the client's confidence. Indeed, clients often take comfort in the fact that the counsellor is not shocked by their condition.

The counsellor should always **instill hope** and reinforce that quitting is possible. This apparently easy point becomes difficult as time progresses, and the counsellor suffers from burn out.

When this occurs, it is very easy to give up on the client. A counsellor who cannot instill hope undermines the client's confidence and motivation to quit. It is helpful to remember at such times that change always occurs slowly and in small steps. High expectations for radical change are generally counterproductive. Lastly, the counsellor should be able to exercise the golden virtue of **patience**, as substance use disorders often require long-term treatment. To summarize, the skills a counsellor should possess and avoid are listed below.

Qualities a counsellor...	
...should have	**...should avoid**
Objectivity	Bias (religious, moral)
Trustworthiness	Ambiguity
Non-intrusiveness	Authoritative attitude
Sensitivity	Insensitivity
Respect for confidentiality	Boundary violation
Empathy	Impatience
Knowledge	Judgment

Combination of pharmacological and psychosocial approaches

Medical treatment of substance use disorders involves both pharmacological and psychosocial approaches. Most studies agree that a combination of pharmacological and psychological treatment yields better outcomes than either alone. Studies have also shown that the more intensive and comprehensive the treatment package, the better the outcome. When the clients are also receiving pharmacotherapy, it is very important to ensure that the psychosocial interventions are synergistic to the pharmacological treatment. Specifically, counselling should seek to enhance compliance with pharmacological treatment. In other words, clients undergoing pharmacological treatment should be reminded by their counsellors to take medicines regularly and follow the advice of their doctor. A counsellor should never tell them that they don't need to take prescribed medicine and should be able to stay sober on their own.

Ethical and legal issues

During counselling, ethical problems often present a dilemma to the counsellor regarding the best course of action. The counsellor should remember that any information given by the client is privileged communication and therefore cannot be divulged to any agency except with explicit (and often written) permission from the client. For example, a client's substance use behaviour cannot be divulged to their employer even if the programme is being sponsored by the employer. Similarly, family members cannot be told about client's substance use pattern or risk behaviours that the client has not communicated himself. Moral dilemma occurs when a client suffering from infectious diseases like HIV/hepatitis (and is thereby capable of harming others) asks for confidentiality. In such situations, the counsellor may encourage the client to inform others, but the counsellor cannot inform people for the client, as it is tantamount to

breach in confidentiality. However, in cases of psychiatric illness, paranoid ideations, suicidal or homicidal ideas, the counsellor has the right to inform proper persons to keep the client safe. Professional boundaries of the client-counsellor relationship should be respected.

Taking any favour from the client severely hampers the therapeutic relationship as the client then becomes "entitled" to special favours from the counsellor in return. These favours may be as simple as asking for extra counselling time or as large as asking for falsified legal records. Another severe form of boundary violation is having an emotional or physical relationship with the client. Literature is replete with court cases of this, and most decisions find the counsellor guilty, as the counsellor is seen by the law as taking advantage of the dependency a client. To address this issue, the counsellor may wish to request that a family member or a chaperone stay in the room and/or keep the doors open while interviewing a client of the opposite sex. The counsellor also needs to be aware of current policies and laws regarding drugs in Nigeria and be able to advise the client on behaviours that could be illegal in the eyes of the law.

Special populations: Minors, women, clients in criminal justice system, etc.

Substance abuse among **women** is a growing concern. Most surveys have found a small minority of female substance users. While it is true that fewer women use substances than men, it is also the case that very few women substance users seek help and hence substance use among women remains a hidden phenomenon. This is because substance use by women is highly stigmatized in Nigerian society as compared to substance use by men. Studies have found some common themes among women substance users: an early age of onset, use in the context of a heterosexual relationship, marital conflict, physical and sexual abuse, greater emotional problems and poor social support. Women are more vulnerable to the adverse physical consequences of substance use than men. Studies suggest that women experience greater medical, physiological and psychological impairment earlier in their substance use. In addition, women seem to progress between landmarks associated with the developmental course of alcoholism (for example, when women initiate drug use, they tend to increase their rate of consumption more rapidly than men. They tend to develop much faster problem use and dependency – a phenomenon referred to as 'telescoping').

Important issues to consider in dealing with women substance users are those related to reproductive health. Substance use makes women vulnerable to various reproductive health problems, including reduction in fertility. Consumption of alcohol and other drugs by pregnant women also results in abnormalities in the unborn child. Fetal alcohol syndrome (FAS) has been identified as one of the leading causes of mental retardation. While dealing with women substance users, counsellors need to be aware of these issues.

Another group of substance users who are a cause of concern are **minors and adolescents**. Though adolescents constitute a very small proportion among the clients seeking help for substance use in counselling centres, various studies have found that adolescence is the period when most substance users initiate their drug use. Thus, adolescence is typically a period of

experimentation with substances and initiation of substance use, and not usually the period when treatment is sought for substance use problems. Increasingly though substance use by minors and adolescents is being noticed. Among adolescent substance users, preferred substances are tobacco and alcohol; some report using cannabis and heroin. However, a sharp increase in the use of inhalants (solvents like eraser fluid, paint thinners and petroleum products) has been found in the recent years. This rise in the use of inhalants has been noticed among school students as well as street children. Drug abuse among minors is a cause of concern because drug use in this age group is associated with increased risk of accidents, violence and high-risk sexual behaviour. Behaviours like impulsivity, aggression, sensation seeking, low harm avoidance, inability to delay gratification, low achievement striving and lack of religiosity have been postulated as causes of drug use. Familial factors like stressful life events, deficient parental support or supervision, poor discipline, ambiguous parental attitudes towards substance use, and parental and sibling substance use also contribute. Co-morbid psychiatric disorders have been found to be more common in adolescents who have SUD. Intervention for substance-using adolescents remains a challenge, as it requires involvement of parents as well as teachers. The family needs to be counselled about the nature of treatment and the process of recovery. Another challenging issue for this population is related to confidentiality. Adolescent substance users may request the counsellor keep information about their substance use confidential from their families, while the counsellor may be keen to involve families in the treatment.

Role of the family in substance use and treatment

The family plays a significant role in the development, continuation and relapse of substance use. The genetic predisposition of substance use means that a person born to such a family is more vulnerable from birth. Permissiveness and social learning from drug-using parents lead to early experimentation and initiation. Children growing up unsupervised and in violent families are at greater risk of substance use to counteract their anxiety and emotional stress. This is how family-related factors play a role in the development of SUDs.

Sometimes family members may not see a client's drug use as a problem, but as a minor deviation thereby leading to continuation of the drug use, a phenomenon called 'enabling'. Even after quitting substance use, recovering substance users often suffer from distrust and denouncement from family members. The family members often use phrases like "You can never get better," "You will always be an addict," or "We do not trust you," even when the person is on a path to recovery. During the vulnerable period of early abstinence, this often becomes the reason for relapse.

Thus, family involvement is crucial in every step of dealing with substance use problems. From the first contact, the family can be an invaluable source of additional information about the genetic predisposition, attitudes towards substance use, and the family dynamics that promote or hinder recovery. The family may be a source for corroborating the client's history regarding the duration and severity of substance use. Also, a family interview will give the counsellor an idea about the resources the client can count on during the recovery phase.

During the motivation/contemplation phase, family members can give support and help tilt the decisional balance towards quitting. The counselor should involve the family when they are found to be an external locus of control for the client's motivation. Family members need to be educated about the medical nature of SUD to orient them to the process of treatment. Any distorted views about substance use should be corrected at this stage.

During the maintenance and relapse prevention phase, families need to be aware of the vulnerable emotional state of clients and warned that harsh and critical comments should be avoided. Any confrontation is to be postponed for later resolution and crisis intervention strategies are to be taught to the family members. The family can achieve a lot by providing emotional support during withdrawal and by providing alternate sources of pleasurable activities that help the client cope with cravings. The family can reduce the environmental risks for relapse by keeping the client away from the drug milieu through simple strategies like supervision, sending the client to a relative's place for some time, or providing a gainful daytime job (even if without monetary benefit). Support of family members often helps the client face social stigma better. In case of occasional lapse, the family can initiate early treatment, which the client may not be able to do for the shame of failing treatment.

From the classical family therapy perspective, the whole family is taken as a unit suffering from the ill effects of substance use disorder in one of its members. Here, illness of one member is seen to decrease family stability, create pairing and power disequilibrium within family members (a mother may support her son while her other children may not, thereby creating conflict between parents and non-drug-using children), and ultimately causing suffering to the whole unit. In family therapy, the whole family is assisted. One generally starts by working with the most motivated family member or members, convening other family members as needed. The problem is defined, and a contract is negotiated. The crisis faced by family members when they go through the change is managed and help is given to members in need. Roles of family members are defined, and they are counselled about their own behavior patterns. Thus, the family unit is helped to achieve closeness, intimacy and a substance-free life that they otherwise lacked.

A similar form of family therapy is marital or couples' therapy. In this form of therapy, spouses are treated as a unit to address the drug use of one spouse.

It must also be pointed out that problematic drug use by one or more family members has a substantial negative impact on the entire family unit. Despite the widespread negative impact of drug use on the family in general, the primary and traditional focus of service delivery is upon the drug user. Family members may need help to meet their own pressing needs and to provide effective support to their drug-using relative and to other family members. Current treatment modalities tend to focus on the person dependent on drugs, without providing sufficient attention and care to the overall family's problems and suffering. This requires specific focus, and counsellors who are the first point of contact to suffering family members must keep this in mind and use available options to offer support to such family members.

2. Assessment

People who use drugs (PWUD) experience a wide variety of consequences of substance use. Because of these consequences, PWUD often need help to quit or reduce their substance use, or to reduce the harmful consequences of substance use. It is also quite common for PWUD to not realize the gravity of their situation and hence be reluctant to seek help. In such cases, it's often family members and others close to them who encourage, motivate, pressure or force them to seek help.

Thus, counsellors should be able to:

1. **Assess the degree/severity of a client's substance use patterns**
2. **Decide the best course of action for the client**
3. **Assess the level of motivation of the client**
4. **Enhance the motivation of the client to engage with the intervention**

In this chapter, we discuss the assessment processes to be followed at NDLEA counselling centres.

2.1 Purpose and process of assessment

While the primary purpose of assessment is to diagnose and provide treatment to a client, the utility of assessment goes much beyond that. Assessment also serves the following purposes:

- Building a rapport with the client: The time spent in assessment provides an opportunity for the counsellor to build a relationship of trust and harmony with the client and helps build the client's confidence in the counsellor.
- Measuring the extent of problems faced by the client: Through a proper assessment, the types and severities of problems faced by the client can be understood.
- Planning appropriate interventions for the client.
- Providing motivation enhancement to the client for seeking help.

A PWUD presenting to a counselling centre (either voluntarily or under family pressure) should be first **REGISTERED** as a client. The form for the intake registration can be found in Appendix 8.

After registration, the client should undergo an **INTAKE ASSESSMENT**. For this purpose, the counsellor's attitude and demeanor need to be welcoming and non-judgmental. During an intake assessment, the following processes should be observed:

- Conduct the interview in a setting that provides comfortable seating and privacy for the counsellor, client and accompanying family members.

- When possible, begin the conversation with the client, not the family. If the client is reluctant to speak, the family may be asked to quickly summarize the problems that brought them to the centre. However, the client must receive adequate opportunity to express him or herself (if required, in private, after asking the family to wait outside).
- The style adopted by the counsellor should be conversational and not interrogatory. While it is important to document the information in the INTAKE ASSESSMENT FORM (Annex 8), the sole focus of the conversation should not appear to be for filling out of a form.
- Sometimes, the clients may find it difficult to provide all the information at once. Small breaks may be allowed in such cases. Additionally, not all information is necessary in the first meeting. Some information can be collected in subsequent sessions. The necessary information (indicated in the form) must be collected.

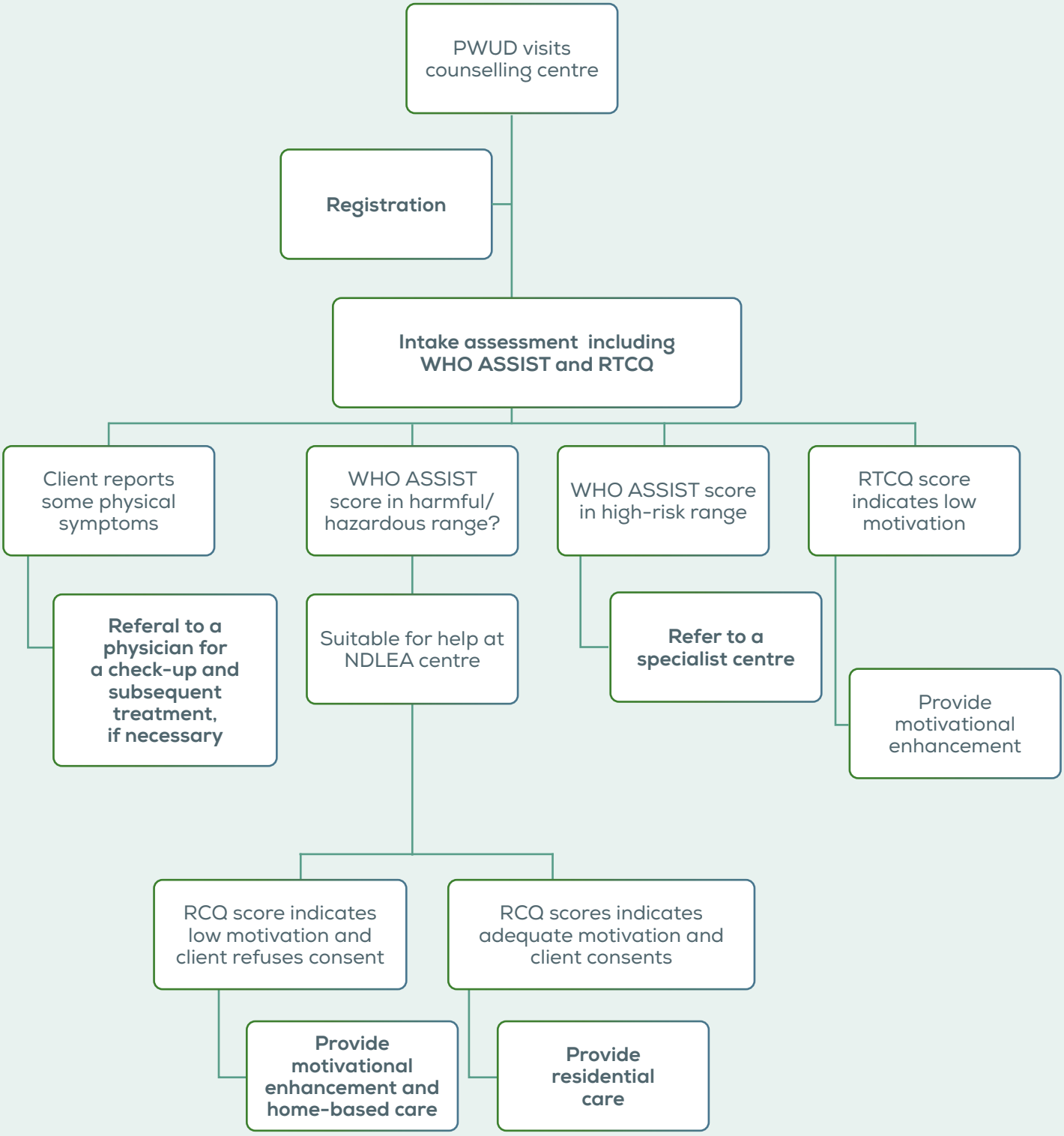
The decision regarding further courses of action will depend upon the findings of the assessment process. The following flow chart (figure 4) will help the counsellor understand this process. Depending on the outcomes of this initial assessment a pathway for management of this clients is services that could be offered is shown in the flowchart.

2.2 Areas of assessment

All the following areas need to be explored by the counsellor in detail to understand the extent of problems faced by the drug-using client. However, it is not necessary that all the following areas be asked in the exact order listed below; depending upon the flow of the conversation, the counsellor may adapt the order, based on the demands of the situation.

- **Basic sociodemographic profile:** The client's age, sex, marital status, educational status, place of residence.
- **Details of drug use:** While it is important to get the details of the lifetime drug use pattern, during the first session the counsellor may prioritise and focus on the current (last three months) drug use pattern. The important issues are:
  - **Type of drug**: In cases where the counsellor does not know the exact chemical name, he/she should write the local name that is used in the community and find out the chemical name later.
  - **Frequency and amount of drug**: It is important to know how often the client uses a particular drug, and how much. This is especially helpful in determining whether the PWUD is dependent on the particular drug or not.
  - **Mode of use of drugs**: The manner in which the particular drug is consumed should be assessed. While certain drugs such as alcohol are consumed only orally, other drugs, such as opioids, can be consumed either orally (as opium), through inhalation (smoking/chasing heroin), or by injection (injecting heroin or pharmaceuticals).
  - **Last dose of drug used**: It is important to know whether the client is currently intoxicated or in withdrawal.

Figure 4: Client assessment and decision-making



- **Complications/consequences with drug use:** Complications resulting from drug use can occur in multiple spheres of life. All of the following areas should be actively asked about:
  - **Physical**: Health damage caused by drugs. In cases of physical damage or harm, the client should be referred to a doctor for further assessment and examination.
  - **Legal**: Involvement in illegal activities to obtain drugs (like thefts, pickpocketing), arrests/detentions by the local police that could lead to prosecution under drug laws.
  - **Occupational/financial**: Inability to work productively, accidents at the workplace due to intoxication, frequent absenteeism at work, loss of job (unemployment), frequent change of jobs, loss of income and/or accumulation of debts.
  - **Marital/familial/social**: Fights with family/spouse due to drug use, neglect of household responsibility, physical violence towards family members, outcast from family, separation/divorce, homelessness, societal stigmatization due to drug use.
  - **Psychological**: Guilt and shame due to drug use, anxiety, depression.
- **Help sought by the client in the past**: Details of all the types of help for drug use problems that the client sought prior to coming in contact with the current service provider should be noted. This may include a previous attempt at seeking help from this or other NDLEA centres. This also includes any history of trying to quit drugs without seeking help.
- **History of medical and mental illness**: The client should be asked about co-occurring medical or mental illnesses and treatment sought for them.
- **Current living status**: Details should be sought regarding where the client is currently living, with whom and the nature of the relationship. This provides an understanding of the social support available to the client.

All the information collected as a part of the history should be recorded in the appropriate formats on the 'Client Intake Form'.

2.3 Making a diagnosis

After a complete assessment, it is the mandate of qualified medical/paramedical professionals and trained counsellors to make a diagnosis. When making a diagnosis, the counsellor needs to take into account the following (for each drug used by the client):

- Scores WHO ASSIST tool
- Diagnostic guidelines/criteria being fulfilled

The details of the tool WHO ASSIST and diagnostic guidelines can be found in Annex 9.

2.4 Deciding the intervention plan

Very often, it is the diagnosis that determines the next course of action. As noted in the flow chart above, clients that are clearly dependent on a drug are best treated at health facilities that have the capacity to provide medical treatment. Clients who can be provided services at the NDLEA counselling centres are:

- Those who use drugs but do not meet the diagnosis for drug dependence.
- Those who have a diagnosis of drug dependence but who have recently received medical treatment for their drug dependence (for instance, a client recently discharged from a hospital after receiving the complete treatment for drug withdrawals).

For clients who are not drug dependent and do not have urgent medical concerns, key factors indicating the choice of treatment setting (residential versus home-based) are:

- Availability of social support.
- Association with drug-using peer group.
- Family environment.
- Willingness to provide informed consent for residential care.

Those clients who have reached NDLEA counselling centre as a result of law enforcement (such as a raid operations) may be willing to provide consent for residential care.

Guidelines for deciding between residential and home-based care

Clients with

- Poor social support
- Significant peer group association with other PWUD
- Stressful family environment
- Willingness to provide consent

➠ Suitable for residential care

Clients with

- Good social support
- No peer group association with other PWUD
- Peaceful family environment
- Unwillingness to provide consent

➠ Suitable for home-based care

2.5 Obtaining consent

It is necessary to obtain written informed consent from all clients receiving RESIDENTIAL services from NDLEA counselling centres. The signed consent form serves as evidence that the client is receiving services voluntarily. The consent document acts as a contract between the client and service provider and provides an overview of duties, responsibilities and rights of both parties.

Sometimes clients are not willing to provide consent for residential care. In such cases, an attempt to enhance their motivation must be made. If, after undergoing motivational enhancement counselling, the client still refuses then RESIDENTIAL care is not an option. Instead, such clients should be provided HOME-BASED care and counselling sessions should be scheduled as often as possible.

In all cases where consent has been provided by the client for residential care, that consent should be reviewed periodically. If the clients change their mind during the course of their stay, they should be allowed to LEAVE AGAINST PROFESSIONAL ADVICE (LAPA). These issues are discussed in more detail in Chapter 6.

Tips for conducting a comprehensive assessment

Some counsellors are better able to perform assessments than others. A successful assessment is defined not only by the completeness of information acquired (which can be achieved even by a police interrogation), but also by the degree to which a rapport has been established between the client and counsellor.

There are a number of factors that contribute to a successful assessment:

- **Establishment of rapport**: If the assessor is able to form a good rapport with the client, the chances of client cooperation in answering truthfully increases manifold.
- **Non-judgemental attitude**: The counsellor should not judge the client on the basis of drug use behaviour, lifestyle, or other factors such as religion, tribe and gender.
- **Effective communication**: The counsellor should be able to articulate his/her thoughts clearly and be able to answer the client's queries as truthfully as possible.
- **Patient listening**: The counsellor should listen to the client patiently about his/her problems.
- **Confidentiality of the responses**: The counsellor should ensure that confidentiality of the information provided by the client is maintained. When information has to be shared with other staff members, the counsellor should get permission from the client before doing so.
- **Drug-using status of the client**: If the client is intoxicated or is suffering from severe withdrawal, then the counsellor will not be able to assess the client effectively. In such cases, the client should be asked to return for assessment when he/she is feeling better.
- **Outcome of assessment**: The client should be informed about the benefits of undergoing the assessment (for instance, in planning the next course of action). Otherwise, the client may feel that the assessment was conducted just to fulfil obligations of the counsellor (like maintaining records).

Carrying out a good assessment requires much patience and practice on the part of the counsellor. With time and effort, a motivated counsellor is able to assess a client effectively in a short period of time.

3. Delivery of Specific Types of Counselling Interventions

3.1 Introduction

Substance use disorders are understood as biopsychosocial disorders and therefore need to be addressed at all levels for a better outcome. Treatment of substance dependence primarily involves pharmacological management (medications). People with less severe substance use disorders, however, can be helped by using techniques like motivation, lifestyle changes, risk behaviour management, coping skills, and prevention of lapses and relapses. Depending on the setting, drug-use patterns, client's choice of treatment and availability of trained staff, a wide variety of psychosocial interventions (grouped under the broad term 'counselling') can be delivered. Even if the client is receiving pharmacological management, psychosocial interventions can be helpful; the combination of pharmacological and psychosocial interventions is more effective than either of the treatments alone.

Over the years, various psychosocial interventions have been developed to effectively manage substance use disorders. These interventions, if provided in a timely fashion, can help the client to reconsider his/her substance use habit, make positive lifestyle changes, and learn alternative ways of pleasure seeking and coping. While there are certain types of interventions (broadly termed as 'psychotherapies') that can only be delivered by specially trained and qualified experts, many other psychosocial interventions ('counselling') can be learned with some training and supervision. These counselling interventions can be delivered in individual or group sessions and may also involve family members or peers.

This chapter provides an overview of the various types of psychosocial interventions along with an understanding of how each intervention needs to be delivered. Included in this chapter are the following specific interventions:

1. **Motivational enhancement**
2. **Psychoeducation**
3. **Relapse prevention**
4. **Dealing with craving**
5. **Lifestyle modifications**
6. **Stress management**
7. **Managing interpersonal relationships including peer pressure**
8. **Managing finances**
9. **Crisis intervention**
10. **Minimizing the negative consequences of substance use**
11. **Dealing with drug-use affected individuals in the family**

It must be noted that this is not an exhaustive list of counselling interventions to be delivered to clients who seek treatment. In the typical settings in which NDLEA delivers Drug Demand Reduction interventions, counsellors must possess the capacity to deliver these listed counselling interventions.

Each of these types of interventions will be described in detail. The delivery setting, method, step-by-step guide as well as the dos and don'ts of each intervention will be highlighted.

3.2 Motivational enhancement

Motivation or willingness to change a behaviour, be it to lose weight, or to reduce or stop taking drugs, is a dynamic and ever-changing process. The variable nature of motivation is highlighted by three critical elements: *readiness, willingness* and *ability to change*. A client with poor motivation to change:

- May not enter treatment.
- Shows resistance to the treatment process.
- Is difficult to engage in treatment.
- Tends to drop out of treatment at an early stage.

The purpose of motivation enhancement counselling is to help the client become ready, willing and able to change.

Motivational enhancement can be understood as a "collaborative, goal-oriented method of communication with particular attention to the language of change. It is designed to strengthen an individual's motivation for and movement toward a specific goal by eliciting and exploring the person's own arguments for change."

Motivational enhancement is useful not only for interventions for substance use. It can also be used to achieve other health care goals, for instance to increase adherence to treatment while referring clients for testing or treatment of TB, for risk-behaviour reduction and for bringing about lifestyle changes.

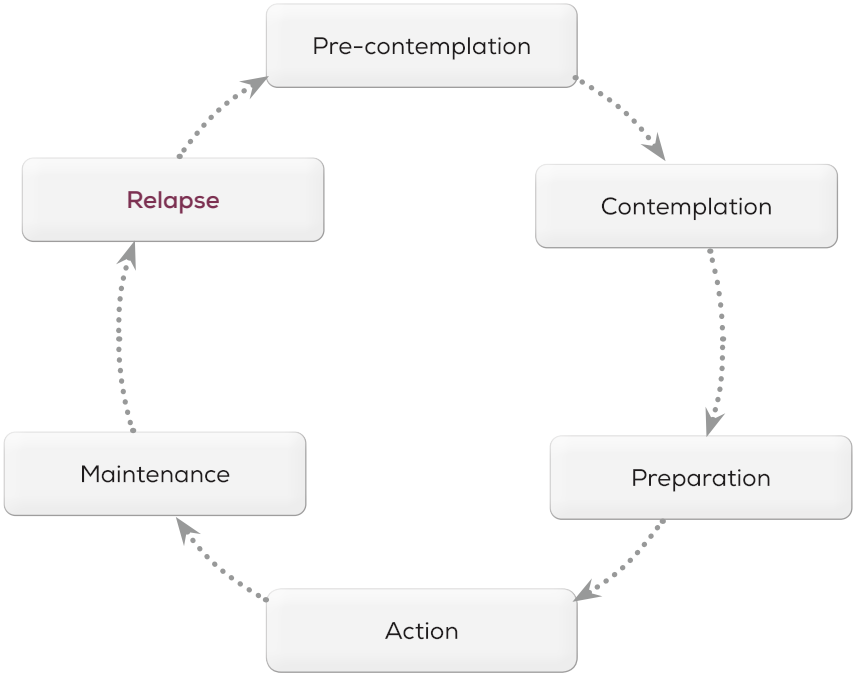
The spirit of motivational enhancement is based on the following three elements:

- **Collaboration** between the counsellor and client helps build rapport and facilitate trust in the relationship. It is in contradiction to a true hierarchical model wherein the "Counsellor is always right," and is based on mutual understanding and development of goals.
- **Evocation or drawing out**, which involves the counsellor drawing out the clients' ideas and thoughts rather than imposing their own. This is based on the premise that motivation and commitment to change is powerful and durable when it comes from within the client rather than being enforced by an external agency. Thus, the counsellor, through motivational enhancement, draws out positive statements from the client rather than telling them what to do.

- **Autonomy** is given to the client with the belief that the ultimate power to change rests with the client. This approach not only empowers the client but also gives him or her the responsibility for his or her actions.

Motivational enhancement is guided by the Stages of Change Model (below) as described by Prochaska and DiClamente (1984).

Figure 5: Stages of Change



Pre-contemplation is the stage wherein individuals do not feel impelled to do anything about their behaviour and deny the need for change ("*I don't have a problem*"). When people gradually become aware that their behaviour is problematic, they enter the stage of **contemplation**, which is characterized by conflict and dissonance ("*I may have a problem, but I am not sure*"). This may lead to the **preparation** stage in which individuals formulate action plans or enquire about alternatives available. **Action** is a time when changes are actually and actively made. This can lead to **maintenance** of positive behaviour change. Individuals who do not relapse during this stage eventually exit the change system to termination. Many times, individuals are not able to sustain change and move back to earlier patterns of using drugs. This is known as **relapse** and they enter the change cycle again.

These stages follow a cyclical pattern in that people may move back from action to contemplation and pre-contemplation before eventually achieving long-term resolution of the problem. Thus, the goal of motivational enhancement is to help the client move further along the continuum of pre-contemplation to maintenance.

3.2.1. Delivery setting

Mode of delivery

Motivation enhancement is usually conducted one-to-one through individual counselling.

Setting

An ideal setting for delivering motivational enhancement should have a comfortable sitting space for both client and counsellor. The room should have adequate ventilation and lighting and provide audio-visual privacy. However, if required, motivational enhancement sessions can also be delivered in an informal setting or community.

Number of sessions

There is no standard number of sessions for motivational enhancement; this depends on the client's readiness to change. Since motivation is a dynamic concept, more than one session may be required. Usually four to five sessions, including the assessment, are found to be effective. However, the counsellor should periodically assess motivation and reinforce the confidence to change.

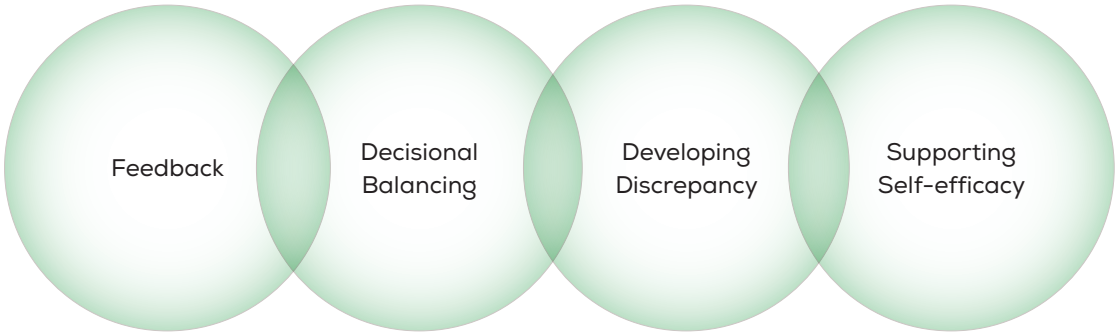
Required training

Counsellors must undergo basic training to be able to deliver this intervention since this is not just a casual conversation. However, intensive training for delivering motivational enhancement is not usually required. Outreach workers and counsellors can be trained on the principles of motivational enhancement.

3.2.2 Methods

The methods of motivational enhancement are summarized in figure 6 below. Motivational enhancement counselling typically involves four overlapping strategies. It is not necessary to employ all four strategies in each and every individual case.

Figure 6: Motivational enhancement methods



Feedback: Involves giving feedback to the client regarding the ACTUAL negative consequences facing them. During the assessment phase, the negative consequences experienced by the client due to their drug use are elicited and the information is consolidated and presented back to the client. It is important to remember that the counsellor should not preach to the client about the negative consequences of drug use but should instead focus on how it has affected the client's life. An example of personalized feedback is given below:

"As you told me, your body has become weak, and you get tired easily because of your cannabis use. Moreover, you have become forgetful and irritable. You also told me that you and your wife fight regularly, and she has threatened to leave you if you do not stop smoking cannabis. At the workplace, you often miss work, which has led to a pay cut."

Decisional balancing: The counsellor helps the client weigh the benefits of changing with those of not changing, and then compare the costs of changing against those of not changing. This approach is based on the premise that change requires effort and acknowledges that staying the same may have advantages in the short run, but the costs are much higher in the long run. The counsellor should remember that usually the client will not accept the benefits of staying the same and will give socially appropriate answers. However, with gentle probing, the counsellor can elicit the costs as well as the benefits specifically for the client. An example of decisional balancing is given below.

Decisional balancing

	BENEFITS	COSTS
Continuing drugs (not changing)		
Quitting drugs (changing)		

Developing discrepancy

- The counsellor helps the client to compare his/her life with those of peers and relatives who are not using drugs or with those who have successfully changed their behaviours.
- Another way of doing this is to make the client evaluate his/her current life situation, and how it relates to his/her values and future goals. For example, the counsellor may ask, "*You told me that you would like to earn enough to be able to buy your own house in the next five years. If your drug use continues, where do you see yourself five years down the line?*"

  Yet another way would be to help a client compare his/her present situation with the past, examining where the client is now versus when he/she started using drugs. This method is meant to help the client understand how drug use has contributed to his/her present status.

Supporting self-efficacy: Self-efficacy is a client's belief in his/her ability to change. A majority of PWUD have low self-efficacy. They also tend to be pessimistic and do not believe in their ability to change (*"It is impossible to quit taking drugs. I cannot do it."*). The task of the counsellor engaged in motivational enhancement is to instill hope in the client that change is possible and confidence that they can attain it. This can be done by telling a client about other's success stories or highlighting examples from the client's own life of when they succeeded in any kind of change (*"It is possible to quit taking drugs. You can do it."*).

Eliciting change talk: Individuals tend to believe and value what they say, therefore, subtly suggesting change to a client and eliciting self-motivational statements are more effective than forcing or coercing change. Direct confrontational statements like, *"You must change because you are causing lots of problems for your family,"* or *"You are an addict, and you need to change"* will only lead to counter-reactions and resistance to change. Self-motivational statements, or change talk, is based on the following: **D**esire to change, **A**bility to change, **R**easons for change, **N**eed to change and **C**ommitment to change (DARN-C). Open-ended questions can be used to elicit change talk as shown below:

- What brings you here; how can I help you?
- How has your drug use changed over time? Tell me what you have noticed, has it been bothering you in any way?
- What do people around you say about your drinking? What do you think are their concerns?
- How important it is for you to change? (Rate on a scale of 0-10 with 0 being not important and 10 being extremely important). Why not less or more?
- *How confident are you about your ability to change? (Rate on a scale of 0-10 with 0 being not important and 10 being extremely important). Why not less or more?*

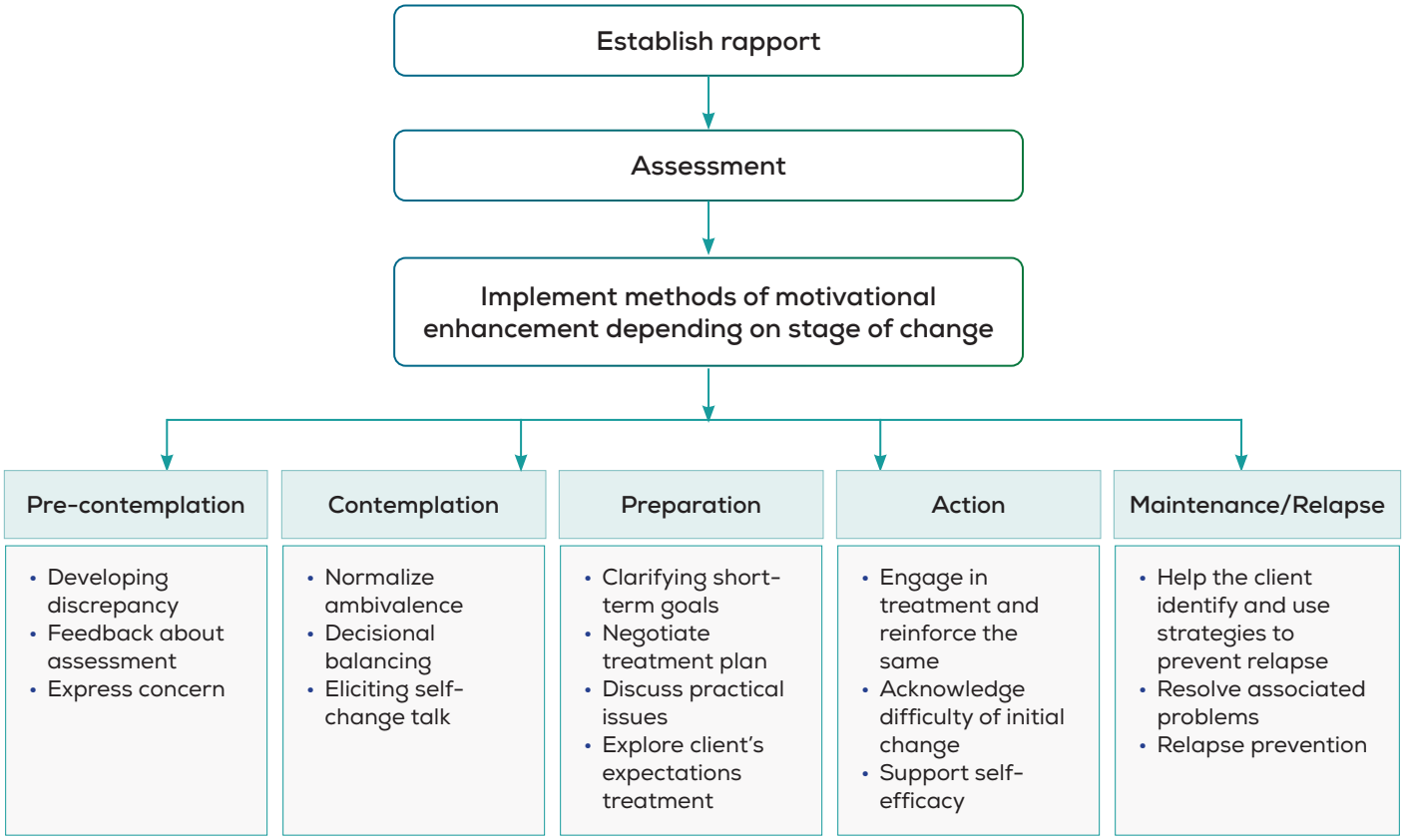
3.2.3 Step-by-step guide

As mentioned above, motivation is a dynamic concept, and an individual may move back and forth from one stage to another. The process for motivational enhancement is shown in figure 7 below.

Establishing rapport: Rapport can be established with clients by making them comfortable, listening carefully to what they say and by repeating it back to them in your own words. The counsellor should encourage clients to talk and express themselves and seek to understand what they really mean. At this stage, it is important to affirm to clients that are accepted unconditionally.

Assessment: The basis for enhancing the motivation of each individual client relies on thorough feedback, which should cover the substance used, the extent and pattern of use, positive as well as negative consequences of using, reasons for quitting (if any) and their importance, previous attempts at abstinence and readiness to change.

Figure 7: Step-by-step guide (MET)



Implementing methods of motivational enhancement: Although there are different strategies to be employed at different stages of change, there is no hierarchy or rigid order of implementation. It is important to maintain the flow of conversation and elicit change talk from clients rather than trying to cover all strategies in a theoretical manner.

Dos and Don'ts

- Be non-judgmental and accepting
- Empathize with the difficulty to change
- Roll with resistance rather than arguing
- Avoid arguments
- Ask open-ended questions
- Enhance self-efficacy
- Make short-term plans and discuss obstacles to change
- Involve significant others in change process
- Accept if a client does not want to change; offer hope and reinforce that the client can come back again
- Avoid moralistic stances
- Do not preach or lecture

3.3 Psychoeducation

It is often the case that clients have limited knowledge about the nature and consequences of drug use, its relationship with other co-morbid conditions, help available and their role in the recovery process. Psychoeducation is an educational process involving both clients and significant others that aims to provide necessary information and training to work with this chronic, relapsing condition. It has been defined as: "*Systematic, structured, didactic information on the illness and its treatment, and includes integrating emotional aspects in order to enable clients, as well as family members, to cope with the illness.*"

The basic objectives of psychoeducation are:

- Providing factual information about various facets of substance use disorders, its signs, symptoms, course, outcome and prognosis.
- Dispelling myths and misconceptions.
- Imparting knowledge about dos and don'ts while taking care of the client.
- Treatment options.
- Helping client and significant others identify early signs of relapse and seek treatment.

3.3.1 Delivery settings

Mode of delivery

Psychoeducation can be provided on a one-to-one basis with the client or along with significant other(s), but often it is done in a group setting. The group usually has eight to 10 members who use the same primary substance. The group can also be composed of family members of substance users.

Setting

An ideal setting for delivering psychoeducation should have a comfortable sitting space for clients, family members and the counsellor. The room should have adequate ventilation and lighting. It can also be delivered in an informal setting or community.

Number of sessions

Usually, one to two sessions suffice in providing psychoeducation.

Required training

Intensive training for delivering psychoeducation is not required. However, the individual providing psychoeducation should be well versed in the concepts of addiction, substance use, associated complications and available treatments.

Notes

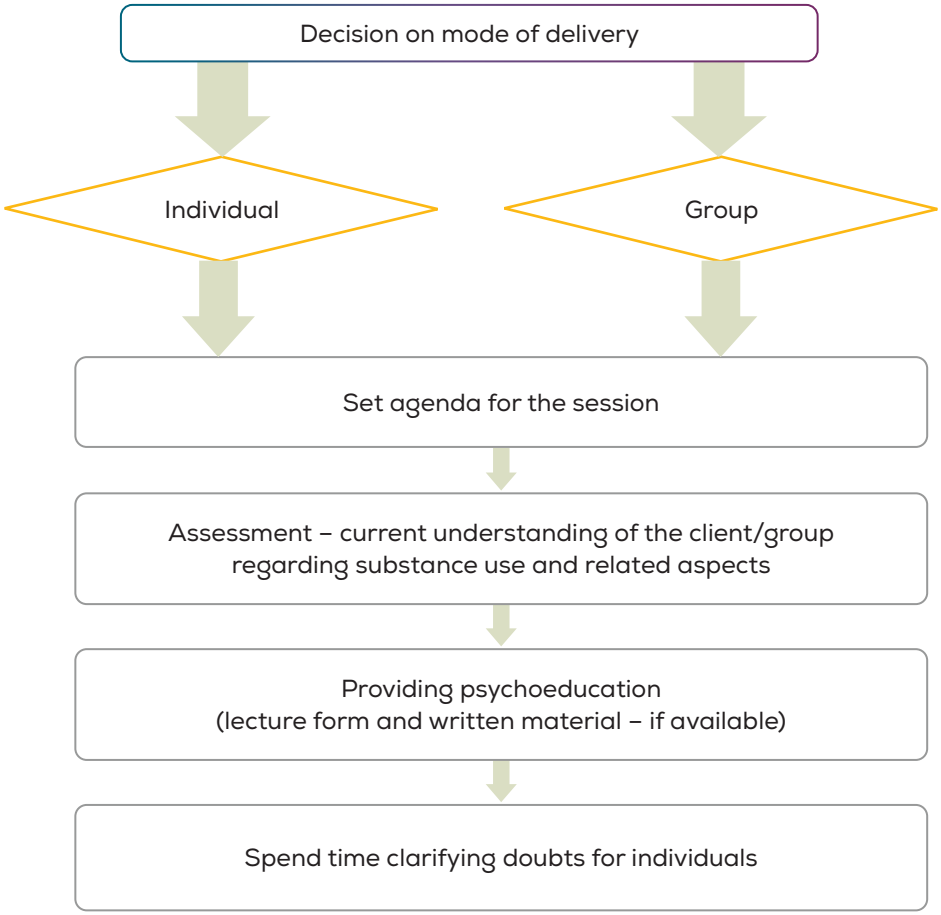
3.3.2 Methods

Depending on the target audience (substance-using client, family members of substance users or a mixed group), the following aspects need to be covered in both lecture form and on written materials:

- **Effects of each substance of use**: Factual information needs to be provided regarding the short- and long-term effects of the substances used.
- **Concepts of craving and withdrawals**: It is important for clients and family members to understand that lack of willpower is not the sole determinant of continued drug use and it is craving and withdrawal symptoms that serve as major barriers to abstention from drug use.
- **Stages of change:** Sometimes both the client and family members go through a cycle of hope (during abstinence) and misery (during relapse) and often feel nothing will work out. It is very useful to explain the process of change and how all individuals trying to make a change go through the same process. Examples of this in our daily lives can be given, for example: starting to exercise, trying to abstain from tea or coffee, or managing our time appropriately. The wheel analogy can be used: *"Even with the highly motivated client, relapse may occur. To understand this, imagine a wheel. When you apply brakes, the wheel rotates a couple of times before stopping completely. It's the same with addiction. The person may have a few lapses or relapse, but that does not mean that he/she will not improve. Sometimes, it's a good idea to not focus on drug use and instead to pay more attention to the positive aspects of life and improvements in other areas."*
- **Treatment process:** The counsellor needs to provide information about the types of treatments available (detoxification, abstinence-based, harm-reduction, counselling, self-help groups). Also, it is important to reinforce the fact that treatment is long term. It can be compared with chronic physical illnesses, like hypertension or diabetes, which require life-long medication and significant lifestyle changes to prevent deterioration.
- **Clarification of myths and misconceptions**: Both clients and family members hold misconceptions about substance use and its treatment, for example: *"Drug use happens because of a lack of will power," "He/she is not trying enough to leave it," "I can leave it any time I want," "Treatment ends at detoxification. If one goes through it, the body will not need drugs," "If one starts using again after treatment, he/she is a failure and can never recover again."* These and many other myths need to be clarified as they hamper the treatment process and recovery.
- **Role of family members/significant others:** The therapist needs to highlight the role of family members or significant others in the recovery process. It may not be possible to go into detail about how and what needs to be done. It might suffice to highlight some of the important issues that need to be discussed and dealt with.

3.3.3 Step-by-step guide

Figure 8: Step-by-step guide (Psychoeducation)



Dos and Don'ts

- Give only scientifically relevant information
- Stick to facts
- If the client has a question that you cannot answer, tell them you will get back to them when you have more information
- Do not use technical jargon or long lectures. Keep sessions short
- Do give written material in the local language that has all the information discussed in the session

Notes

3.4 Relapse prevention

Substance use disorders are chronic conditions that are characterized by lapses and relapses. *Lapse* is the first episode of drug intake after a period of abstinence (at least two weeks). *Relapse* can be broadly defined as an episode of backsliding or worsening wherein the previous patterns of drug use are resumed. This is true for any chronic illness or attempt at lifestyle change. For example, an individual trying to lose weight might exercise and restrict their diet for a few days and then have a slip, that is, they do not exercise for a couple of days or they may eat a slice of cake. That would be a lapse. If the person resumes their previous dietary patterns and stops exercising completely, leading to weight gain, it would be considered a relapse.

At the time of remission, a number of factors (*internal* and *external)* play an important role in determining whether the individual remains abstinent or relapses back to drug use. Apart from these factors, how an individual deals with them plays a pivotal role.

Thus, relapse prevention counselling aims to enable an individual in identifying the internal and external factors that can be termed 'triggers' or 'high-risk situations', and help them understand how to cope with each of them.

3.4.1 Delivery settings

Modes of delivery

Relapse prevention can be provided on a one-to-one basis with the client or in a group setting. The advantage of individual sessions is that some triggers that are personal to the client may not be mentioned if he/she is not comfortable in the group setting. The advantage of group settings is that many of the coping skills, like resisting peer pressure or handling conflicts, can be learned through role play and practice. A combination of individual and group sessions can be used, wherein certain high-risk situations can be discussed in one-on-one settings, while others can be taught in group formats.

Setting

An ideal setting for delivering relapse prevention should have a comfortable sitting space for clients and the counsellor. The room should have adequate ventilation and lighting. It is preferably done in a closed space that allows for audio-visual privacy.

Number of sessions

Usually, eight to 10 sessions are required, followed by two or three booster sessions.

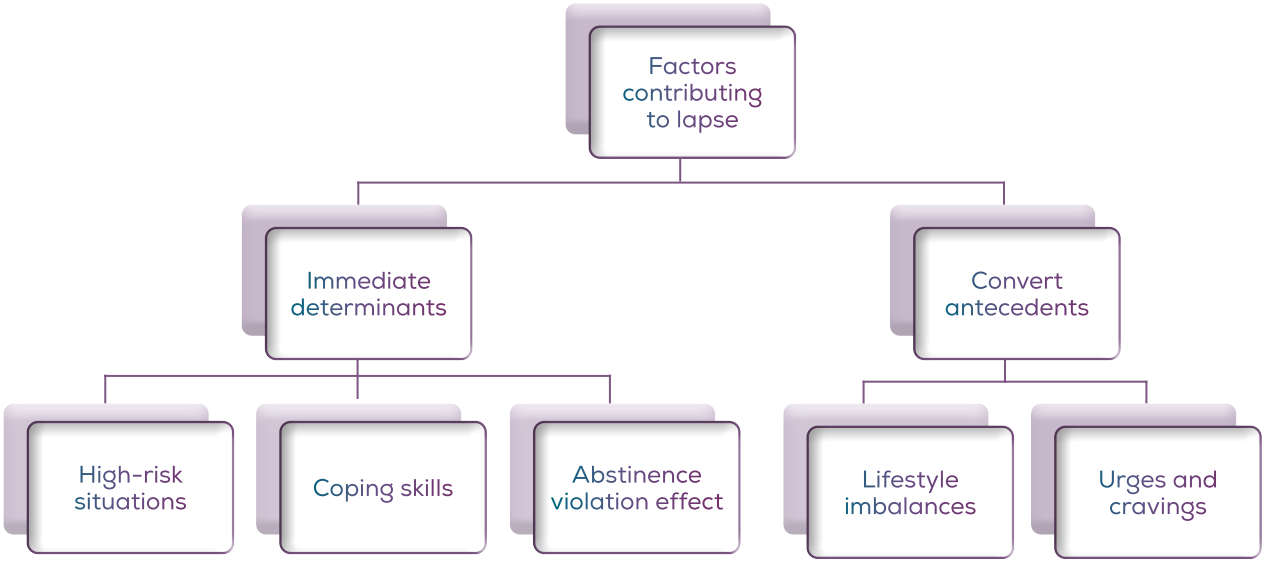
Required training

The individual providing relapse prevention should be well-versed in the concepts of lapse, relapse and coping strategies. A moderate amount of training is required to be able to effectively deliver relapse prevention therapy.

3.4.2 Methods

In figure 9 below delineates some of the major components of relapse prevention therapy that need to be incorporated into treatment.

Figure 9: Major components of relapse prevention therapy



There are some immediate determinants of lapse/relapse that are triggers/high-risk situations. How the individual deals with them and how he/she feels when they are not adequately dealt with when a lapse occurs is known as 'abstinence violation effect'. There are also some factors that are not obviously visible but do lead to lapse/relapse – these include lifestyle choices and cravings (described later in the chapter). A comprehensive relapse prevention plan would cover all these aspects over eight to 10 sessions.

- **Identifying high-risk situations or 'triggers':** High-risk situations, or triggers, are factors within an individual or in the external environment that may lead to a lapse or relapse. It is important to identify these factors as early warning signs and learn ways to deal with them. One of the ways of identifying high-risk situations is to discuss previous lapses or relapses. The counsellor should ask the following questions: "Where were you at the time of lapse/relapse?" "Whom were you with?" "What were you doing?" "What were your thoughts/feelings?" "What exactly happened?" An example is given below.

Example of eliciting information about high-risk situations

Date and time	Situation	What did client do?	Consequences
29/06/2014; 10:30 PM	I came back from work. No one was at home. I was feeling lonely and frustrated that my boss wasn't satisfied with my work. I felt that no one really cared, and I had to bear everything alone. I just wanted to forget everything and relax.	I went out to meet my friend with whom I used to smoke and, despite knowing that it would harm me, I smoked two joints.	I had not smoked in days, so I felt a little dizzy initially, but gradually I started to have a floating, light sensation and the pleasurable effect was more intense than I remember ever feeling. My tension decreased and I started feeling more and more relaxed.

Another option is to ask the client about potential situations that can act as triggers for them. The box below provides a list of common triggers.

Note: While some triggers are common to all individuals, it is important to explore specific triggers for each individual client.

High-risk situations or triggers

- **Mood states**
  - Positive (for instance "Feeling happy after passing an exam and need to celebrate.")
  - Negative (for instance "Feeling sad." "Feeling irritable." "Boredom." "Loneliness." "Feeling stressed." "Feeling frustrated.")
- **Thoughts** (for instance "Let me smoke this once. I will leave after that." "I am a loser, I will not ever be able to quit, so why even try?" "I have not had it for many days, let me test my will-power." "I have not used in a month. I'll celebrate with one joint. I won't get hooked on it again")
- **Cravings**
- **Place where drugs were used**
- **Peer pressure**
- **Situations** (like weddings and parties)
- **Constant criticism or lack of social support**
- **Stressful situations**
- **Having money in hand**

- **Coping with triggers:** The client needs to be taught how to deal with each trigger or high-risk situation. Once the triggers are identified, the first step is avoidance. For example, the client reports that he has a strong craving to smoke a joint whenever he passes the building where he and his friends used to smoke cannabis. He can be asked if there are alternative routes that he can take in order to avoid passing the triggering building, or if someone can accompany him whenever he passes that building. However, it may not be possible to avoid triggers all the time and hence clients need to be prepared to cope or deal with them. To develop the client's coping skills, the counsellor should use **direct instructions**, that is, guiding the client on preparing strategies for each high-risk situation. This can be done by imagining the triggering situation in vivid detail and then imagining how it could be adequately dealt with. Also helpful is making the individual practice the skill in a controlled setting, such as acting the situation out in group or with family members.

Notes

Techniques to deal with triggers/high-risk situations

High-risk situation/trigger	Coping with triggers
Craving	» Five Ds » Urge surfing
Mood states (negative)	» Indulge in pleasurable activities » Distraction » Meet non-using friends » Positive addictions » Relaxation/meditation » Positive thinking
Mood states (positive)	» Remind oneself of the negative consequences of using drugs » Celebrate with non-using peers
Peer pressure	» Assertiveness or refusal skills
Stressful situations	» Plan in advance to avoid last minute stress » Problem-solving
Thoughts	» Challenge thoughts that enable drug-using behaviour » Remind oneself of negative consequences of drug use
Criticism by family members	» Family counselling » Conflict resolution and communication skills

- **Abstinence violation effect (AVE):** After a lapse, the client may feel loss of control, guilt, shame and hopelessness. These negative emotions are termed as the abstinence violation effect. The client needs to be made aware of these mood states and negative thoughts. The counsellor can elicit them by asking the client how they felt about a lapse and what they were thinking. Then the client is taught to challenge these thoughts. Some examples of challenging thoughts are shown below:

  "It's ok. I had a slip, but I can come out of it."

  "It does feel bad to have a lapse, but if I continue to feel bad, it will lead to worse consequences."

  "I should go and visit the counsellor or call her immediately to discuss what should be done."

  "I can come out of it. I have not been using for so many days and I can gain abstinence again."

3.4.5 Step-by-step guide

Step 1: Make the client aware that substance use disorder is a chronic, relapsing condition. Define lapses and relapses and the processes that lead to a lapse and eventually a relapse.

Step 2: Identify the high-risk situations or triggers specific to the client.

Step 3: Assess the underlying thoughts, emotions and behaviours accompanying each high-risk situation.

Step 4: Assess existing coping skills. For example, identify times when the client effectively

dealt with high-risk situations and came out of them without a lapse/relapse. Reinforce those skills.

Step 5: For each high-risk situation, teach the client coping skills. This should be done through direct instruction and discussion with the client. Each skill should be practiced in controlled settings.

Step 6: Evaluate how confident the client feels with each skill.

Dos and Don'ts

- Do not generalize high-risk situations for all clients. Instead, conduct a detailed assessment for each individual client
- Do not just talk about skills. Help the client practice them in the session
- Be genuine and accepting at time of lapse/relapse. Do not say: "But I taught you how to deal with this."
- Do not dismiss any trigger, no matter how small or insignificant it sounds
- Reinforce existing coping skills
- Praise the client each time he/she succeeds in dealing with a high-risk situation
- Reassure the client that lapses/relapses are part of the recovery process and can be dealt with

3.5 Dealing with craving

A craving is a subjective experience that has been defined as: "A powerful desire for something." Often, the terms 'craving' and 'urge' are used interchangeably. Various factors or cues can lead to cravings. Some of these cues can be internal, such as a negative mood state, or they can be external. The external cues can be direct, like smell or sight of the drug of preference, or indirect, like seeing a friend with whom the person used drugs.

There seems to be a strong relationship between craving and maintenance of substance use. Craving is also found to be strongly associated with lapses/relapses. Therefore, it is important to teach the client how to recognize craving sensations and deal with them.

3.5.1 Delivery settings

Mode of delivery

Craving management should be done on a one-to-one basis, that is, in individual counselling sessions.

Setting

An ideal setting for delivering counselling on coping with cravings should have a comfortable sitting space for both the client and counsellor. The room should have adequate ventilation and lighting. It is preferably done in a closed space that allows for audio-visual privacy.

Number of sessions

Usually, two sessions are helpful in teaching craving management skills to the client. Often two to three booster sessions are required to reiterate the skills as well as to troubleshoot when the client actually experiences cravings.

Required training

The individual providing craving management should have some understanding of the concepts of craving and its role in drug use. A minimum amount of training is required to be able to effectively teach craving management to clients.

3.5.2 Methods

- **Identification of craving sensations**: As mentioned earlier, craving is a subjective experience. However, the client may or may not be aware of the craving sensations. The counsellor should first teach the client to recognize and rate the craving experience. The counsellor should ask the client to recall the times when they really wanted to use the drug: how they felt at that time and how their body reacted. The exercise given below can help the client understand how he/she feels at the time of the craving. Once the client has learned to recognize their craving sensations, they are asked to rate them on a scale of 0-10, with "0" meaning "No Craving" and "10" meaning "Maximum or Unbearable Craving".

Recognize a craving

1. Use your imagination to think about how you experience a craving. Try to use a simple example such as one of your favourite foods, a cigarette, or a cup of coffee. Sit comfortably with your feet flat on the floor and your hands in your lap. Take a few deep breaths and focus your attention inward. Move your attention to your body and notice where you experience the sensation of the craving and what the sensation is like. Notice each part of your body involved in experiencing the urge: where it originates, how it travels through your body and affects your mood.
2. Notice the exact sensation. Do you feel hot, cold, tingly or numb? Are your muscles tense or relaxed? Notice any changes that happen with the sensation. For example, "*My mouth feels dry and I'm thirsty. I am trying to swallow a lot. As I exhale, I can imagine the smell of hot coffee on a cold day. I feel restless and irritable. I just want that cup of coffee right now and I don't care how.*"
3. Keep focusing on each part of the body that is experiencing the craving. Describe to yourself the changes in sensation that take place, and how your thoughts change as the craving increases: *"I need to have that coffee. If I don't then I will have an unbearable headache and I hate it when I get those headaches."*

- **Understand the craving:** It is important for clients to understand that the craving grows stronger every time one gives into it. On the other hand, the craving grows weaker on each occasion that one is able to withstand it without resorting to drug use. In this respect, craving can be likened to a monster that keeps growing in size whenever he eats something. The only way to kill the craving monster is to starve it to death!

- **Deal with craving – urge surfing:** Once the client has been taught to recognize and rate the craving associated with drugs, they should be taught ways of dealing with these sensations. One of the methods they can be taught is known as 'Urge Surfing'. The client can be asked to imagine the following: ***"A craving is like a wave in the ocean. You are on a surfboard riding the wave. You need to maintain your balance and stay on top of the wave. You notice that gradually the wave is going down until it becomes flat, and you reach the shore safe and sound. You feel more confident that next time the wave peaks up, you will be able to ride it effectively. You also notice that as you succeed, the waves appear less dangerous and decrease in frequency and intensity."*** This exercise should be conducted in a counselling session. The client should be asked to sit comfortably and imagine his/her preferred drug of use. He/she is asked to rate their craving, then is walked through the wave surfing exercise and, after, asked to rate their craving again. This experiential exercise needs to be repeated until the client subjectively feels that his/her craving has become bearable.

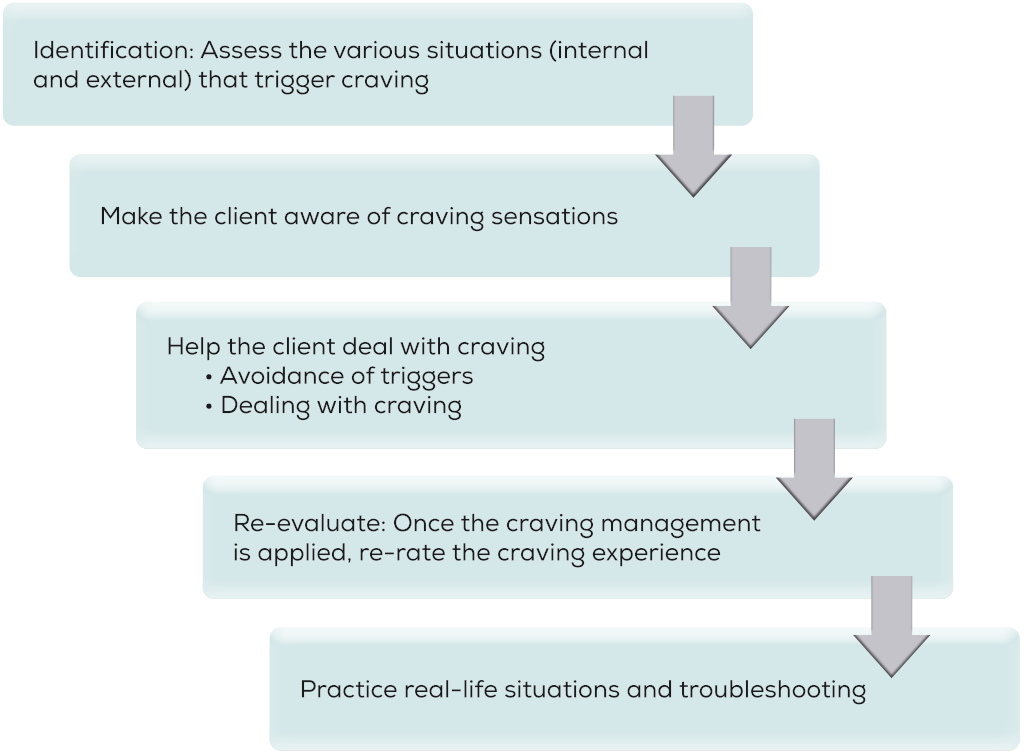
- **Deal with craving – the five Ds:** Another technique that needs to be taught to the client is the five Ds of craving management:
    - DELAY: The client should be taught to delay the urge to use, for instance: *"I will not use it right now. I will wait for a few hours and then use if need be."*
    - DISTRACT: The counsellor should discuss with the client ways to distract him-/herself when experiencing cravings. These should be doable and decided upon beforehand in the session.
    - DRINK/DIET: The counsellor can tell the client to consume their favourite food or non-alcoholic beverage when they experience a craving.
    - DISCUSS: The counsellor and client prepare a list of people who can be contacted at the onset of a craving. These individuals should also be taught to be supportive and to gently remind the client of the adverse effects drug use.
    - DEEP BREATHING: The counsellor should teach the client relaxation/deep breathing techniques that the client can practice to reduce cravings or urges.

3.4.6 Step-by-step guide

The counsellor and client should work together to make a list of all internal and external triggers that have led to or can lead to cravings. The client is then made to go through an experiential exercise to understand the sensations that craving can lead to. This exercise also indirectly helps the client to understand that craving is not dangerous and can be controlled. The client should also be taught to rate his/her craving on a scale of 0-10. The client should be told that

the first step in craving management is avoidance of triggers. However, since avoidance may not be possible all the time, he/she should be taught ways to deal with cravings. In the session, the client is asked to apply the technique and re-rate the craving. **NOTE:** It is important to keep the client in the session until the craving subsides. Means of distraction and emergency contacts should be written down and the client should be encouraged to carry the list with him/her. Once the skills have been taught, the client is asked to practice in a real-life setting and report successes and failures. Booster sessions can be planned accordingly.

Figure 10. Steps to deal with craving



Dos and Don'ts

- Ask the client to maintain a daily diary of craving experiences
- Do not just discuss the skills. Help the client practice them in the session
- Reiterate that craving is normal and needs to be dealt with

3.6 Lifestyle modifications

As discussed above, unhealthy lifestyles can act as covert antecedents to a lapse/relapse. The clients need to be taught that apart from identifying and managing immediate triggers, they also need to make changes to restore or achieve balance in their lives. They should be made aware that a healthy lifestyle helps in decreasing stress levels and promotes a healthy mind and body. Examples can be given from other chronic medical conditions such as diabetes. A

client seeking to control their diabetes would need to change their lifestyle by decreasing sugar intake, exercising and monitoring sugar levels.

3.6.1 Delivery settings

Mode of delivery

Lifestyle modification can be taught in group settings or individual sessions.

Setting

An ideal setting for delivering lifestyle modification counselling should have a comfortable sitting space for both the client and counsellor. It can also be done in the community and does not require audio-visual privacy.

Number of sessions

Usually, one session is helpful in teaching these skills to the client. Often, another booster session may be required to assess whether the changes have been implemented and, if they have not been put into practice, to troubleshoot.

Required training

A minimum amount of training is required to be able to effectively teach lifestyle modification to clients.

3.6.2 Methods

- **Assessment:** The first step is to assess current lifestyle patterns, which can be done by asking about the client's daily activities, how they spend their time, sources of stress, balance between pleasure and external demands, exercise, how they relax, interpersonal activities and religious beliefs. The counsellor should also try to understand how drug use has affected the client's lifestyle, which can be done by asking the client about their lifestyle before the initiation of drug use and the changes thereafter.
- **Lifestyle modifications:** The client should be given tips and suggestions on healthy lifestyles. The counsellor and client should also discuss the feasibility of making lifestyle changes, probable obstacles in implementing these changes, troubleshooting, dealing with obstacles and a timeline for implementing changes. Some of the examples of healthy lifestyle tips are given below.

Notes

Examples of healthy lifestyle tips

- Be positive – a good attitude is the key
- If you believe in God, begin your day with a prayer. If you are an atheist, reflect upon your own strengths and positive aspects of life
- Stay away from friends who use drugs and instead spend time with friends who do not
- Stay away from negative, critical people
- Spend time with family
- Eat well and get enough sleep
- Follow a regular fitness regimen
- Practice meditation or relaxation daily
- Take one day at a time
- Plan your day and make a list of to-do activities
- Try to create a balance between the things that are pleasurable and the things that need to be done but are not so pleasurable
- Praise yourself for work well done
- Pick up old hobbies or learn new ones

Step-by-step guide

The counsellor should follow these steps in the session:

Step 1: Set an agenda for the session and make the client understand the need to discuss and implement lifestyle changes. Use examples from chronic medical illnesses.

Step 2: Conduct a thorough assessment of current lifestyle patterns as well as changes that have taken place due to drug use.

Step 3: Suggest lifestyle changes to the client.

Step 4: Discuss the feasibility of making positive behavioural changes (for example, exercise and hobbies) and how to overcome the obstacles to implementing these changes. Include a significant other, if required. Also, make a timeline for implementation of behavioural changes.

Step 5: Follow up on whether lifestyle modification has been initiated and praise the client for efforts made. If the client has not initiated any lifestyle changes, inquiry needs to be made as to why.

Dos and Don'ts

- Prepare a list of healthy lifestyle tips with the client
- Empathize with the client that making lifestyle changes is not easy
- Reiterate the importance of lifestyle balance in the process of recovery
- Reinforce each effort made in a positive direction
- Involve significant others, if necessary
- Do not be overly critical if no change occurs. Try to understand the client's reasons for not making changes

3.7 Stress management

Stress is a normal and inevitable part of life. Many situations or emotions in our lives can trigger stress responses. Sometimes, stress is mild and does not last long, like being stuck in traffic jam or before an interview. Other times, it may be severe and prolonged, like a difficult relationship in the family or suffering physical or emotional trauma. There are individual differences in the ways people react to stress. Some are able to manage stress effectively while others feel hopeless and overwhelmed.

A strong correlation has been found between stress and substance use. It is generally believed that stress can lead to initiation and maintenance of substance use. Moreover, stress can also act as a trigger for lapse/relapse. As drugs and alcohol have natural calming properties, they are often used as ways to deal with stress.

Thus, it is important that each client should be taught stress management techniques as a way of preventing lapses/relapse.

3.7.1 Delivery settings

Mode of delivery

Ideally, stress management should ideally be taught in individual sessions. However, group sessions can be undertaken when time and resources are constrained.

Setting

An ideal setting for delivering stress management should have a comfortable sitting space for both client and counsellor. The room should be well lit and adequately ventilated. It should allow for audio-visual privacy and be quiet, especially when relaxation is being taught.

Number of sessions

Usually, two sessions are enough for teaching these skills to the client. Often another booster session may be required for troubleshooting.

Required training

A minimum amount of training is required to effectively teach stress management to clients. However, knowledge of psychological principles is useful.

3.7.2 Methods

- **Identifying stress:** The counsellor needs to teach the client how to identify certain behavioural, psychological and physiological signs of stress. The client should be told that it is important to be aware of these stress reactions so that steps can be taken to manage them at an early stage rather than waiting for them to escalate. The table below provides a list of various signs of stress that can be taught to the client.

Behavioural, emotional and physiological signs of stress

Physiological	Psychological/Emotional	Behavioural
» Changes in appetite » Changes in sleep patterns » Unexplained pains and aches » Sweating; cold and clammy hands » Frequent urination » Heartburn, nausea, stomach pain » Dry mouth and difficulty swallowing » Low energy » Frequent colds and infections » Loss of sexual desire	» Becoming easily agitated, frustrated, and moody » Feeling overwhelmed, like you are losing control or need to take control » Having difficulty relaxing or calming your mind » Feeling bad about yourself (low self-esteem), lonely, worthless, and depressed » Increase in craving » Constant worrying » Forgetfulness and disorganization » Being pessimistic or seeing only the negative side	» Difficulty concentrating on tasks » Procrastination » Avoiding others » Restarting or increasing use of alcohol and drugs » Exhibiting nervous behaviours, such as nail biting, fidgeting and pacing

- **Teaching stress management**: The client should be taught various ways to deal with stress and be made aware that most of these techniques need to be built into their lifestyle to prevent stress from occurring, but some techniques can be applied at the time of stress. Several examples of stress management are given below:
  - **Lifestyle changes** as mentioned in the previous section.
  - **Time management**: It is useful to maintain a diary of tasks that need to be completed. The counsellor can teach the client to rank tasks according to their importance and urgency and prioritize accordingly.
  - **Distraction:** Listening to music, engaging in a hobby, meeting a non-drug-using friend, spending time with family and children.
  - **Diary:** Maintaining a diary about stressful events. Sometimes the act of writing may relieve stress.
  - **Assertiveness or the practice of saying "No".**
  - **Reframing the situation by focusing on positive aspects.**
  - **Being expressive** about how one feels.

3.7.3 Step-by-step guide

The counsellor should follow the below steps in each session:

Step 1: Set an agenda for the session and make clients understand the need to recognize signs of stress and work on stress management.

Step 2: Help clients understand the various signs and symptoms associated with stress in general and those specific to themselves.

Step 3: Discuss various stress management techniques that clients can implement.

Step 4: Follow up on whether clients have integrated stress management into their lives and validate progress they have made. Offer advice and troubleshoot if clients have not been able to initiate any changes. Also, remind clients that they should immediately contact you if they feel overwhelmed by stress rather than returning to drug use.

3.8 Managing interpersonal relationships, including peer pressure

An interpersonal relationship is a strong, deep, or close association or acquaintance between two or more people that may range in duration from brief to enduring. This can include family, friends and business acquaintances. Substance use has a strong impact on interpersonal relationships. It can lead to conflicts and miscommunication between family members, distancing from non-drug-using peers and disharmony at the workplace. At the same time, it may lead to stronger bonds with drug-using peers. Some of the common issues that can emerge in interpersonal relationships are: lack of proper communication, difficulty resolving conflicts and lack of assertiveness.

The difficulties in interpersonal relationships often act as motivating factors for drug use. For example, Kayode wants to quit using drugs. But after fighting with his family, he gets stressed and smokes a joint, which makes him feel better.

Peer pressure also plays an important role in initiation and maintenance of drug use. Moreover, as mentioned above, peer pressure can also be a significant trigger for lapse/relapse. For example, Jamie decides he wants to reduce his cannabis use. But when he hangs out with his friends and they offer him a joint, he is unable to say no and therefore maintains his pattern of drug use.

Thus, clients need to be taught effective ways of dealing with interpersonal relationships and, in particular, handling peer pressure.

3.8.1 Delivery settings

Mode of delivery

Interpersonal management skills can be taught in group settings wherein the individual also gets a chance to practice the skills they have learned in a controlled environment. Private sessions may be undertaken upon a client's request. If possible, a significant other can also be included in private sessions.

Setting

An ideal setting for delivering this counselling session would have a comfortable sitting space for the clients and counsellor. The room should be adequately ventilated and lit and provide audio-visual privacy.

Number of sessions

Usually, three or four group sessions are required to teach and practice interpersonal management skills. Additionally, if required, several private sessions with a client may prove helpful.

Required training

A counsellor with some understanding of psychological concepts and with good communication skills can be trained to help clients acquire the skills for managing interpersonal relationships and handling peer pressure.

3.8.2 Methods

- **Identifying issues in interpersonal relationships:** The counsellor needs to identify the areas in which the client faces problems. This can be done using a situational analysis for each problematic interpersonal situation. The situational analysis includes **A-B-C** charting (below), wherein "A" refers to **Antecedent**, that is, what exactly happened; "B" refers to **Behaviour**, or what the client did, and "C" refers to **Consequences** of client's behaviour.

Example of situational analysis

Date and time	Antecedent	Behaviour	Consequences
30 March 2014 10:00 PM	I came home from college and wanted to go to a party at my friend Yusuf's house. I told my mother that I was going, and she started yelling at me, saying that I never help with housework, I only think about myself, and when I go out, I never tell her when I'll be home. I yelled back that it was none of her business and I wasn't a kid anymore. She got really angry and told me to go to my room..	I was furious. I had not had any drugs for five days, but I thought it was of no use. I got the joint I had hidden in the bathroom and smoked it.	I felt good and miserable at the same time. Mum discovered what I had done and grounded me for a week.

- **Communication skills:** The counsellor should teach effective communication skills to the client. The client needs to be taught about both verbal as well as non-verbal communication skills. The box below highlights some of the important communication skills that need to be taught.

- ✓ Adequate eye contact
- ✓ Non-threatening body language
- ✓ Tone of voice
- ✓ Listening effectively
- ✓ Being aware of other people's emotions and bodily reactions
- ✓ Concept of personal space
- ✓ Clarity of content
- ✓ Talking directly to the person for whom the message is intended
- ✓ Negotiation

- **Conflict resolution skills:** The counsellor needs to teach the client skills for resolving conflicts. The first step is to make the client understand why a conflict occurs (for example, a perceived threat to one's needs/freedom/demands). The second is to help the client recognize healthy and unhealthy reactions to conflicts, as shown below. The third is to practice healthy ways of responding during role play or group sessions.

Examples of healthy and unhealthy ways of conflict resolution

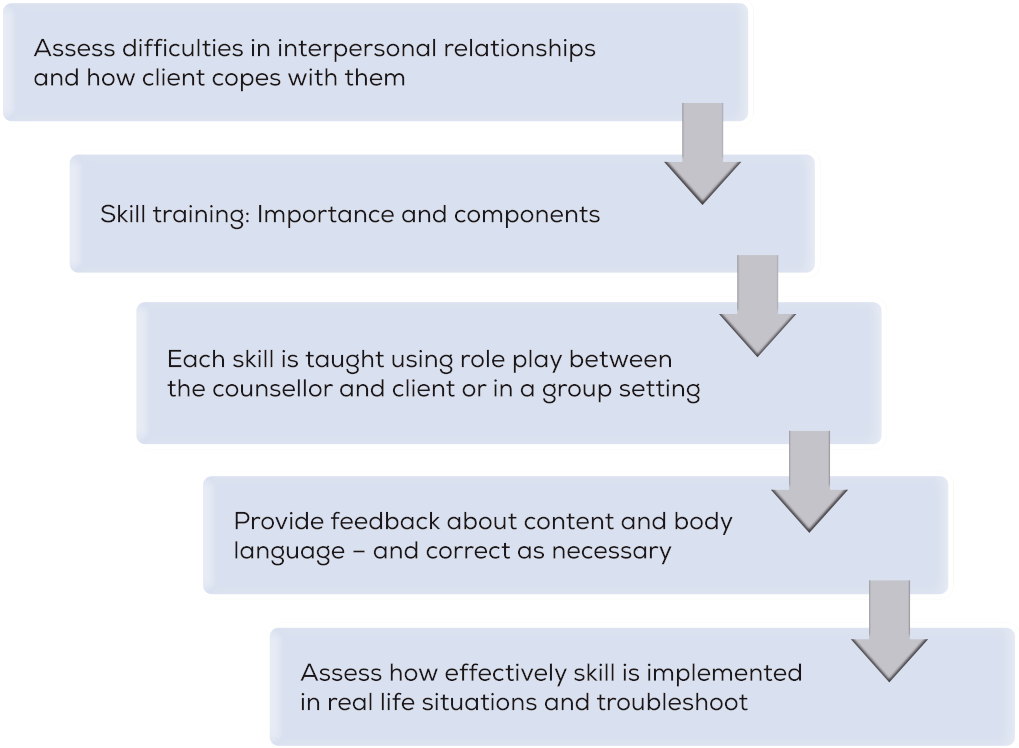
Unhealthy	Healthy
– Non-empathic attitude to another person – Explosive, angry, hurtful reaction – Withdrawal of love or rejection – Not dealing with conflicts – Bringing all past fights into the current situation	– Describing clearly what one wants – Trying to see things from others' perspectives – Calm and non-defensive reactions: be mindful of your reactions – Not showing resentment or making threats – Be willing to negotiate: win-win situation – Sticking to the current issues

- **Drug refusal skills:** Often, clients say that they would like to abstain from drug use but are unable to say no when peers offer them drugs. The counsellor therefore needs to teach clients skills for saying no. When teaching these skills to clients, it is important that the counsellor specifically model desired body language (for example, standing with good but non-threatening posture, maintaining eye contact and speaking with a stable and calm voice). Here are ways to teach the client how to say no:
  - **Avoid the situation:** The best strategy is to avoid situations where peer pressure may occur.
  - **Say "no thanks" and walk away:** Do not stop to explain.
  - **Give a reason, fact or excuse:** For example, *"My mum just called, and I have to go." "I forgot that I have a doctor's appointment this evening." "I lost a week's pocket money last time. If I get caught again, they'll never give me any more money." "My mum has just started trusting me a bit, if she finds out that I am smoking again, she will never forgive me."*
  - **Change the subject:** The client can suggest a different activity. For example, watching a movie, going to a nearby coffee shop or playing a game.
  - **Use humour:** The client can make a joke. For example, *"Nah! This stuff affects my brain cells. I don't want to be like my old grandpa who doesn't remember anything." "Pot makes you fat, stupid and gives you yellow teeth. I'll pass."*
  - **Acting like a "broken record":** The client needs to keep saying "no" again and again.
  - ***Cold shoulder or ignore*:** Instead of confrontation with someone applying peer pressure, the client can simply turn away and talk to someone else.

3.8.3 Step-by-step guide

The counsellor should follow these steps to teach interpersonal skills: After setting the agenda for the session, the counsellor conducts an assessment of the interpersonal difficulties faced by the client. It is also important to assess their existing skill set (that is, how the client has been handling their relationships until now) and the deficits that need to be addressed in the sessions. Using examples from their lives, clients are taught how to effectively manage conflicts in interpersonal relationships.

Figure 11. Guide for teaching interpersonal skills



After the counsellor explains and provides information about each individual skill, the client and counsellor practice them. This can be done through role play, where the counsellor plays the client, and the client plays the person they are trying to learn how to interact with. The counsellor then demonstrates both healthy and unhealthy ways of navigating a situation. This can also be done in a group setting. After role playing, the client is asked to practice the skill in a controlled environment. Feedback is then provided to the client on their verbal and non-verbal language. Booster sessions will need to be held to re-assess how effectively the client is able to implement the skills into their life and troubleshoot as necessary.

Dos and Don'ts

- Empathize with the client by agreeing that making improvements to interpersonal relationships is not easy and requires effort and time
- Reiterate the importance of effective interpersonal relationship skills in the recovery process and for life in general

- Recognize and reinforce each step in a positive direction
- Involve significant others, if necessary
- Do not use moralistic grounds to analyse client's behaviours towards others
- Role playing and practicing the fundamental elements of skills should be done for each new skill

3.9 Managing finances

As discussed in the relapse prevention section, having cash in hand can be a trigger for lapse or relapse. Clients need to be taught how to manage their finances adequately for two reasons. First, they should not be spending money on drugs. Second, they need to have money to buy things that are necessary, or that they like, and should be saving money for emergency situations.

3.9.1 Delivery settings

Mode of delivery

Financial management can be taught in private or group settings. In some cases, it is a good idea to have a private session with a client and their significant other.

Setting

An ideal setting for a session on financial management would have comfortable sitting space for the clients and counsellor. The room should have adequate lighting and ventilation and provide audio-visual privacy.

Number of sessions

Usually, one session is enough for teaching about financial management. Booster sessions may be required to assess whether the client has been able to implement the skills and also to troubleshoot, if necessary.

Required training

With minimal training and supervision, a counsellor, social worker or outreach worker can be trained to help the client learn money management skills.

3.9.2 Methods

- **Identify situations**: The counsellor needs to elicit information about all situations and times when the client has access to money. For example, at the end of the month when they get their paycheck, the beginning of the month when they are given pocket money, when they get a year-end bonus, or when they receive money as a gift or for winning a bet.
- **Appoint a 'teller'**: The counsellor and client decide on a person who can act as a 'teller' for the client. Depending on the client's preference, the 'teller' can serve either of two functions: First, the 'teller' gets access to all the client's money (for instance their salary

and gifts) and only provides what is necessary to the client. Second, the 'teller' serves as a joint bank account holder with the client. It is important that the 'teller' is a person of authority whom the client respects and trusts. The client may also be asked to bring their 'teller' along with them to collect their check on pay day.

- **Train to self-manage:** The role of the counsellor is to help the client become independent; therefore, the client needs to be taught how to effectively manage finances. Here are some of the tools the client can use:

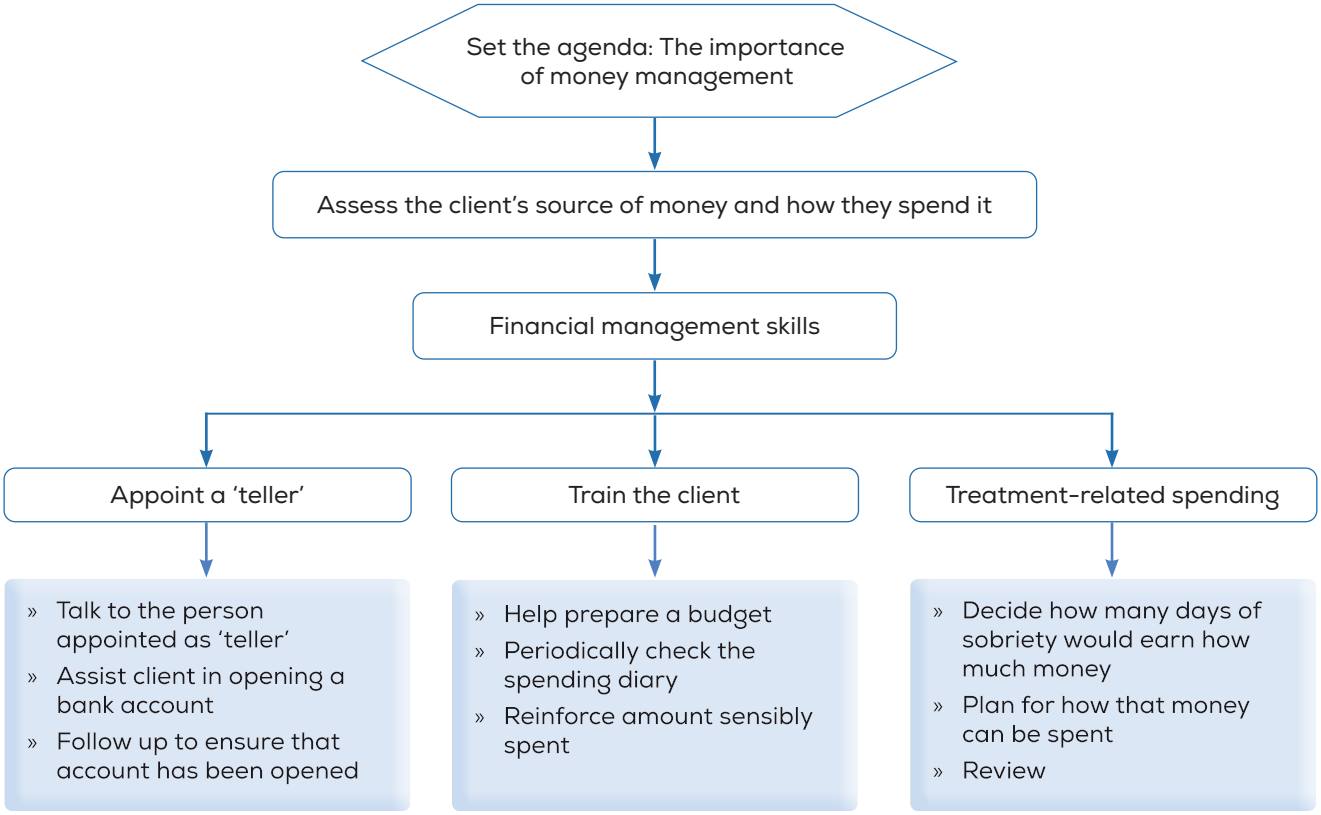
  - ✓ Make a budget that covers essential expenditures, leisure activities and savings
  - ✓ Put some money aside for investment and life insurance
  - ✓ Make a 'spending diary' to see where the money goes
  - ✓ Try to pay off a portion of debts/loans (if any) every month

- **Treatment-linked spending:** Clients can also be rewarded with cash allowances from their finances for maintaining sobriety. However, a plan for how that money can be used should be agreed upon before the money is distributed.

3.9.3 Step-by-step guide

The counsellor should follow these steps (see figure 12) when teaching financial management:

Figure 12: Financial management flow chart



Dos and Don'ts

- It is important to not just teach the skill, but also to make a precise plan of action
- It is helpful to be aware of governmental schemes and banks where accounts can be opened
- The counsellor should meet with the person appointed as 'teller' to ensure that he/she is able to adequately manage the client's finances and can be trusted

3.10 Crisis intervention

A crisis can be defined as a temporary state of emotional turmoil and disorganization, following a very sudden and significant stressful situation. The individual's psychological response during the crisis may include feelings of loneliness and being lost, tension and fear, confusion and restlessness, being stuck, desperation to resolve the crisis immediately and helplessness. For an individual recovering from addiction, crisis can be precipitated by a number of factors, as shown below.

Situations that can precipitate a crisis

Family/social	» Lack of family support » Single parent families » Violence at home » Chronic illness of a family member » Ostracism from community
Economic/job-related	» Joblessness » Pressure to repay debt » Inability to provide financially for the family
Personal	» Legal action » Separation from spouse » Physical/social/emotional abuse » Illness (like HIV)

A person in crisis usually goes through the following stages:

Stage 1 Precipitating event: An unanticipated, stressful event that is perceived as threatening.

Stage 2 Disorganized response: Individual shows signs of distress and emotional turmoil.

Stage 3 "Blow-up": Individual loses control of thoughts, emotions and behaviours. At this time, he/she may become dangerous to self/others.

Stage 4 Stabilization: With help, the individual may calm down and start considering alternatives.

Stage 5 Adaptation: Gradually, the individual calms down completely and takes control of him/herself.

Crisis intervention is, thus, an immediate and active entry by the service provider into the client's life during the stressful situation.

3.10.1 Delivery settings

Mode of delivery

Crisis intervention is done in an individual setting.

Setting

An ideal setting for delivering this counselling intervention should have a comfortable sitting space for both the client and counsellor. The room should be adequately lit and ventilated and provide audio-visual privacy.

Number of sessions

At least two sessions, conducted in quick succession (during the same day or within 24 hours), are required. If possible, a significant other can be involved in the second session.

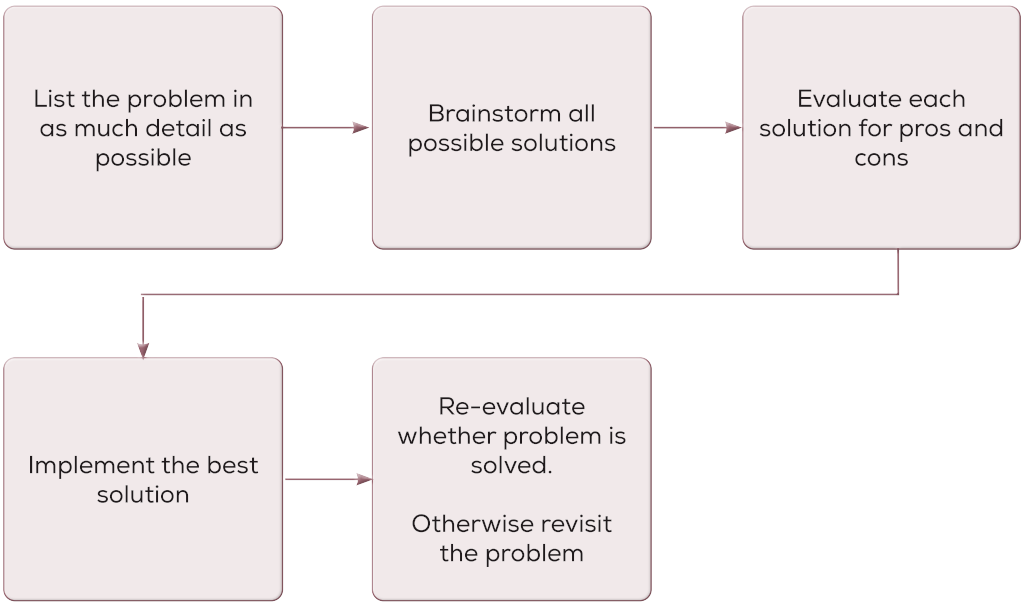
Required training

With minimal training and supervision, a counsellor, social worker or outreach worker can be trained to deliver crisis intervention for clients.

3.10.2 Methods

- **Supportive work:** The counsellor needs to act like a mentor and guide at time of crisis. Supportive work includes the following:
  - Actively listen to the client's issues.
  - Allow the client to vent their feelings and thoughts, and to speak without interruption.
  - Validate client's experience. For example, *"I understand what you are going through. Anybody would be very upset if they were in your situation."*
  - Instil hope and provide reassurance.
- **Ensure client safety:** The counsellor needs to remember that a client in a state of emotional turmoil can become a threat to him/herself. This includes suicidal or self-injurious behaviour. Thus, the counsellor should ensure the client is safe either by getting in touch with a significant other who can stay with the client until the crisis has passed or by getting the client admitted into a safe environment like a halfway home or rehab centre.
- **Problem solving:** The client needs to be taught that, at times, the stressful situation may occur despite proper planning. They need to be aware that if they do not know how

to solve the problem at hand, resorting to drug use might seem like a tempting option. Simple problem solving techniques can be taught to the client as shown in the chart below:

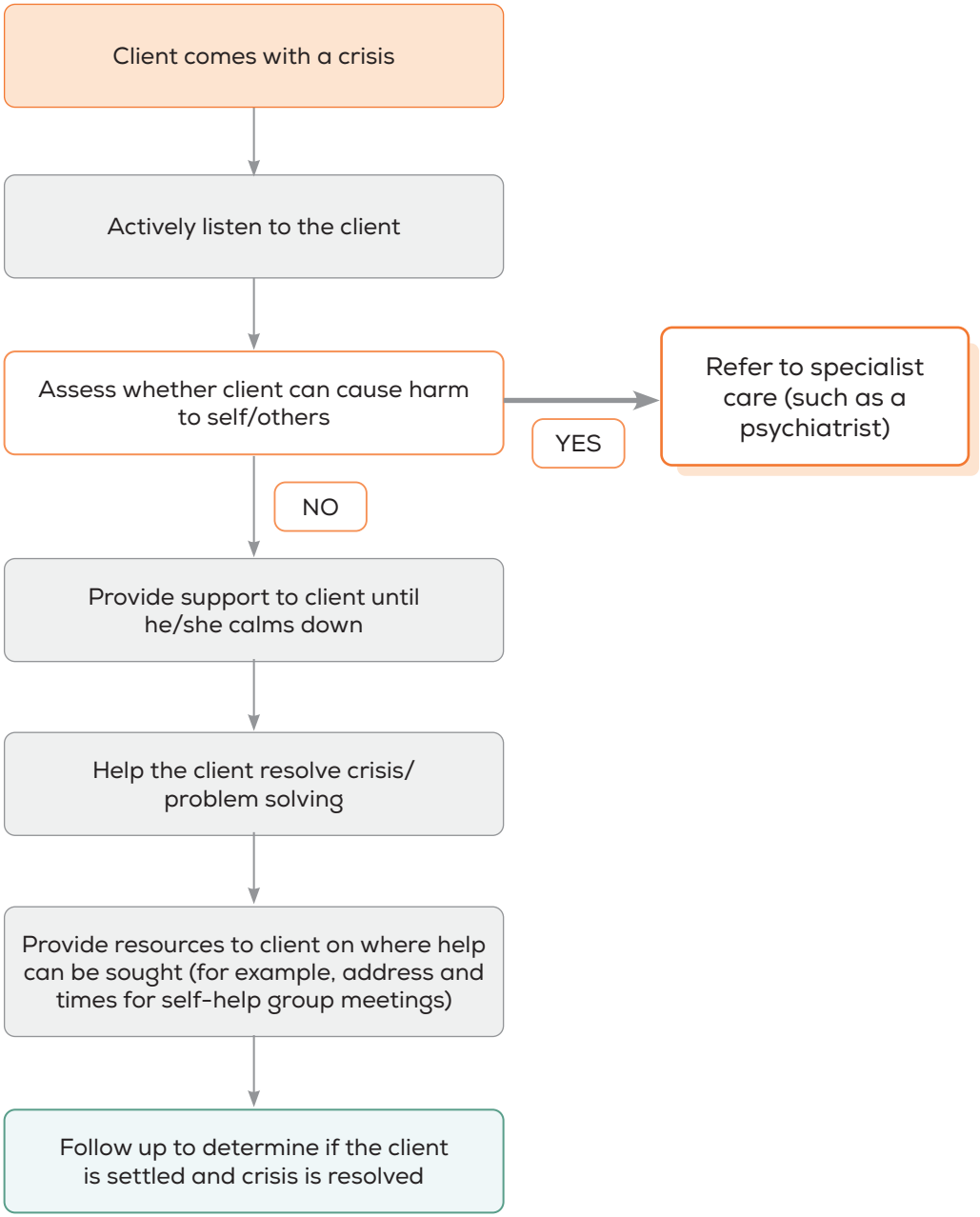


- **Define the problem:** To understand the problem, the counsellor should ask open-ended questions like, *"Tell me exactly what happened."* The counsellor should keep the following questions in mind when trying to understand what is going on: What is the problem? Who is contributing to it? When exactly did it happen? What made it happen?
- **Brainstorm all possible solutions and evaluate each:** Once the problem has been adequately defined, the counsellor and client need to look for all possible solutions. Each solution is then evaluated for advantages, disadvantages and feasibility.
- **Implement the best solution:** After evaluation, the best possible solution is selected and implemented.
- **Re-evaluation:** Both counsellor and client need to re-evaluate whether the solution actually worked or not. If it did not, then the problem needs to be revisited and different solutions generated.

Notes

3.10.3 Step-by-step guide

Figure 13. Step guide to crises resolution



As seen in the flowchart, when the client is in crisis, the first task of the counsellor is to listen, to empathize and understand what exactly happened and what the client might be going through. It is also important to assess whether the client is in danger of causing harm to him/herself or others. This can be done by directly asking, for example, *"You must be feeling awful. What do you want to do right now?" "Are you having any thoughts of ending your life?" "Do you feel so angry that you would want to hit that person?" "Have you made any plans?" "How strong is this feeling?"*

If the counsellor feels that the client may be in danger of causing harm to him/herself or others, he/she must be referred for specialist care. If that is not the case, the counsellor should proceed with providing support to the client, engaging in problem solving and helping the client resolve the crisis. The counsellor should also provide the client with resources that can help during such times. Once the client is calm and a solution has been found, the counsellor should ensure that the crisis is resolved before sending the client out of the centre.

Dos and Don'ts

- Do empathize with the client
- Do not be moralistic or judgmental even if the crisis was foreseen
- Listen actively to what the client is saying and what he/she is NOT saying
- Assess carefully if there are suicidal or homicidal tendencies
- Brainstorm with the client ways to resolve the crisis situation
- Have a list of resources that might be useful to clients for all types of crises (such as addresses of halfway homes, antiretroviral therapy (ART) centres, mental health professionals, first aid care)
- Ensure that the client is calm, and solutions are in hand before sending the client out
- If client agrees, contact a significant other to ensure client safety and well-being

3.11 Minimizing negative consequences of substance use

Many groups working with individuals using legal or illegal drugs believe that drug use cannot be eliminated in its totality and therefore they endorse the idea of 'harm reduction'. At its essence, harm reduction aims to minimize the negative consequences of drugs use. The proponents of this approach have proposed a variety of strategies that can be employed to reduce the harms associated with drug use. The role of the treating team is to ensure that a client knows about the various ways in which he/she can minimize the harmful consequence of drug use and also utilize them.

3.11.1 Delivery settings

Mode of delivery

The session on minimizing negative consequences of drug use can be conducted in a group setting. However, it should be a homogenous group, that is, people only using alcohol should not be combined with those only using cannabis.

Setting

An ideal setting for delivering this intervention would have a comfortable sitting space for both clients and the counsellor. The room should have adequate lighting and ventilation and provide audio-visual privacy. This session can also be delivered in a community setting during early intervention or as part of a prevention programme.

Number of sessions

One session is required to provide information and resources related to harm reduction approach.

Required training

With minimal training and supervision, a counsellor, social worker or outreach worker can be trained to help the client reduce the negative consequences of their drug use.

3.11.2 Methods

- **The centre should have a directory of facilities in the area that provide harm reduction services**
- **Educate the client about strategies involved in harm reduction:** The counsellor needs to inform the clients about the various ways in which they can reduce the negative consequences of their drug use. Some of the important aspects that need to be covered are given in the box below:

  - The need to regularly follow up at a treatment centre or with the outreach worker to prevent acute effects of substance use or emergencies
  - Availability of pharmacological treatment such as opioid substitution therapy, or medicines to reduce craving or manage anxiety
  - The need for early identification and management of infections, abscess, hepatitis
  - Provision of vaccination for hepatitis
  - Early identification and management of HIV
  - Need to prevent and manage drug overdose
  - Provision of needle-syringe exchange programs and shooting galleries
  - Importance of practicing safe sex
  - The need to reduce amount of drugs consumed

- **The counsellor should provide written material to clients about local resources** (for example ART centres, centres for needle syringe programmes, emergency departments, centres where opioid substitution therapies are available).
- **The centre should provide the following:**
  - Free condoms
  - Fresh needles
  - Needle disposal system
  - First aid kits
  - Medication to manage overdose
- **The centre should plan and implement prevention programmes** in communities, academic institutions and among high-risk groups such as truck drivers and female sex workers.

3.11.3 Step-by-step guide

Step 1: The counsellor should set the tone of the session by providing the rationale or importance of strategies to minimize harm.

Step 2: The counsellor should assess the knowledge of the group regarding the various steps that can be employed to minimize harm.

Step 3: The clients should be provided information about the various strategies and available local resources in the centre as well as elsewhere in the community (along with handouts).

Step 4: If necessary, the counsellor should help the client access these facilities.

Dos and Don'ts

- Ensure that the client understands that abstaining from drug use is the best strategy; however, if they are not able to do so, then harm reduction strategies should be employed
- The counsellor should not reveal their personal biases regarding treatment options (a counsellor who does not believe in harm reduction should not abstain from telling the client about it)
- The counsellor should have a comprehensive list of nearby centres that provide harm reduction services

3.12 Dealing with drug-use affected individuals in the family

The family structure is comprised of complex sets of relationships, which include sub-units like the marital dyad, siblings and parent-child. Changes in one unit lead to changes in other units as well. Substance use by one family member can imbalance the entire family structure. It adversely affects the family's emotional state, financial stability, and its identity and relationships within family members. Families often do not know how to deal with the drug-using member and their attitudes are clouded by various myths and misconceptions. Some of the ways in which family members can react to a substance-using member include:

- Being overly critical or abusive.
- Being overprotective or engaging in 'enabling' behaviour. For example, John missed school because he was intoxicated, but his mother called the teacher to say that he had a stomach infection and therefore would not be able to attend school.
- Co-dependency, which is usually seen in spouses of substance users wherein the spouse tolerates all behaviours of the substance user due to fear of being abandoned.
- Blaming all family conflicts on the substance-using member, thereby making them a scapegoat for other problems.

Families suffer because of drug use but at the same time may play a protective role in the family member's life. Thus, it is important to deal with families and help them develop ways of coping with their relative's drug use.

3.12.1 Delivery settings

Mode of delivery

The session on dealing with a family member who uses drugs should ideally be conducted in private sessions so that issues particular to families can be dealt with. However, if time and resources are constrained, the session can be delivered in group settings.

Setting

An ideal setting for delivering this intervention should have a comfortable sitting space for family members and the counsellor. The room should be adequately lit and ventilated and provide audio-visual privacy.

Number of sessions

Two to three sessions are required to help family members the understand issues surrounding substance use and the ways of interacting and coping with drug use in the family.

Required training

With some amount of training and supervision, a counsellor, social worker or outreach worker can be trained to help the family of a person who uses drugs. The counsellor should have an empathic attitude and be comfortable dealing with more than one individual in a session.

3.12.2 Methods

- **Assessment**: The counsellor should do a brief assessment of the family, including:
  - Type of family: Nuclear/joint
  - Number of family members
  - Relationship with client
  - Understanding among family members of substance used by client, its effects, treatments available, course of substance use disorder and recovery
  - Issues faced by family with respect to the client's behaviour
  - Attitude of family members towards the client (are they overly critical, overprotective, withdrawn, etc.)

- **Psychoeducation:** Similar to the psychoeducation provided to the client, family members need to be educated about each aspect of substance use disorder with special reference to the substance used by their family member. They should also be informed about the recovery process and the important role they play in helping the client work towards abstinence or less problematic use and ensuring treatment compliance. The counsellor also needs to tell family members about various approaches to treatment: including abstinence-based treatment, harm reduction, self-help groups, etc. The box below highlights some of the ground rules that need to be taught to family members.

- Trust is a major issue and will take time to build. Constant doubting of the client may lead to negative outcomes (that is, relapse, anger outbursts, other high-risk behaviours).
- Family members need to learn: "When in doubt, ask."
- Communication is a critical tool. It should be done in a positive manner, that is, fighting is not constructive communication, talking is.
- Blame games need to be avoided by all family members.
- Criticism should be constructive, for example, avoid saying: "*I know you will never improve. You are always lying to me. You never make an effort*." Instead say: "*I know you are trying to quit, but if you keep meeting your drug-using friends, that will be very difficult for you.*"
- Understand that it may take time for the client to completely change. It will not happen overnight or immediately after treatment. Thus, it is important to appreciate/reinforce even a slight change in behaviour.
- Encourage the client to come in for regular follow-up sessions.
- Problems can be solved – one just needs to remain calm and think of alternative solutions. Don't panic.
- It is important to listen supportively to the client as that can encourage him/her to reduce drug use.
- Remind the family that lapses and relapses are part of the process of recovery and do not mean failure.

- **Expressing emotions:** The counsellor needs to facilitate the 'unburdening' of the family's emotions, thoughts and feelings by listening empathically and providing non-judgmental support.
- **Dealing with a family member who is intoxicated/in withdrawal:** The counsellor needs to make family members understand that advising or fighting with the client when he/she is intoxicated only makes matters worse. Family members need to be taught to refrain from providing advice or speaking angrily at that time and to only talk to the client when he/she is calm.
- **Dealing with cravings:** Family members need to understand that craving is a reality for substance users, even when they are abstinent. The counsellor should teach family members that when the client says they are experiencing a craving, the family should not be overly critical or lose hope. Instead, the family should normalize the experience for the client, try to distract them and remind them about the harmful effects of the substance.
- **Dealing with lapse/relapse:** The counsellor needs to explain the concepts of lapse and relapse and that they part of recovery process. Family members should be taught not to panic or feel miserable or angry after a lapse. Rather, they should encourage the client to seek help immediately or come to the centre to meet with their counsellor.

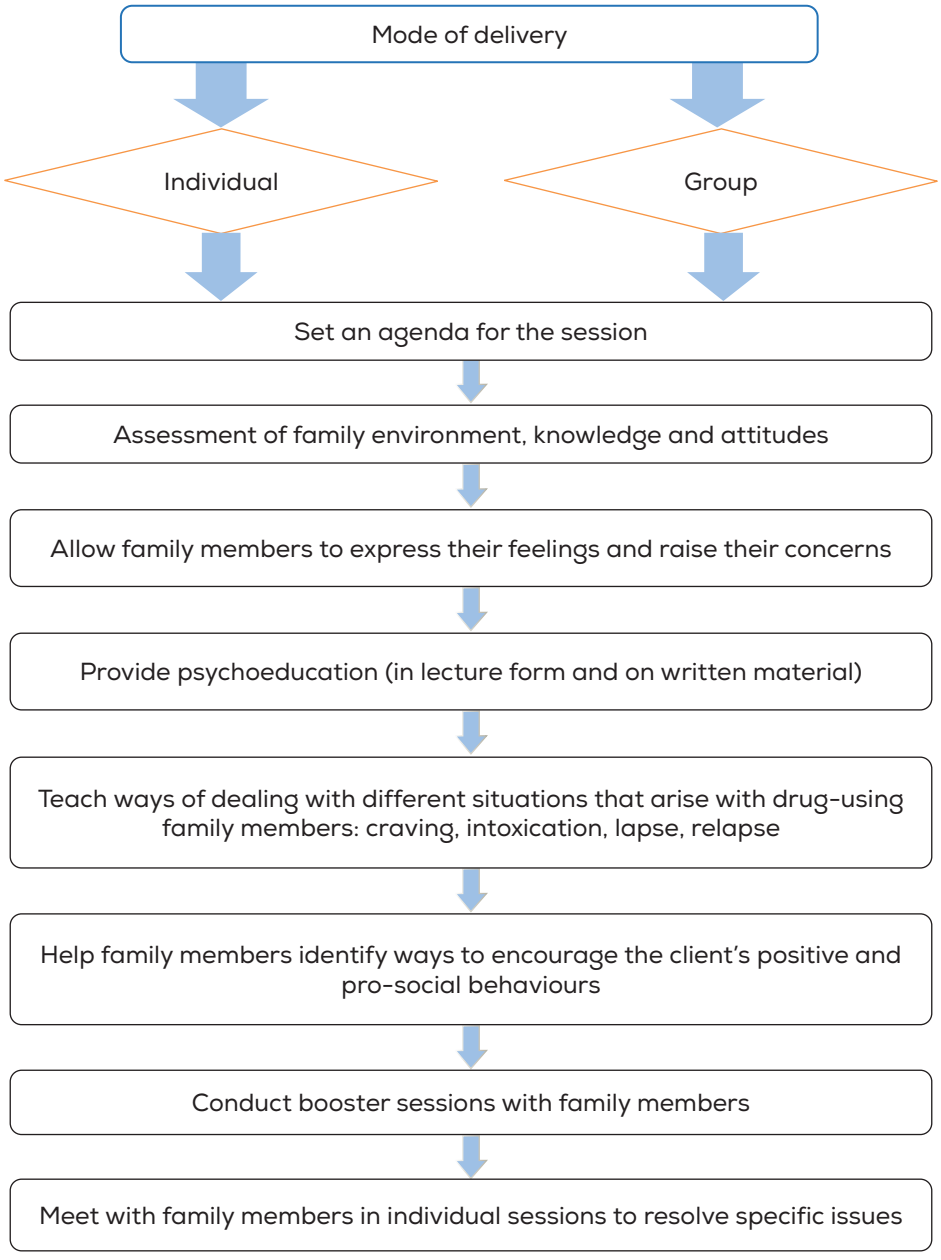
- **Rebuilding trust and resolving conflict:** The counsellor should try to build trust by focusing on existing strengths in family relationships. The following questions can be asked to address this issue:

  To the family: *"Tell me about a time when you had success in dealing with substance abuse?"* *"If he/she is no longer using drugs, what kind of a person do you think he/she will be?"*

  To the parents: *"Tell me about a time when you felt proud of your son/daughter?"*

- **Building prosocial activities:** The counsellor should encourage family members to do meaningful and positive rewarding activities together. For example, going out for a picnic or watching a movie together. They should also be encouraged to focus more on positive behaviours and reinforce them.

Figure 14. Step-by-step guide



Dos and Don'ts

- The counsellor should ensure that family members get a chance to express their emotions and thoughts
- The counsellor should actively listen to the concerns of each family member
- The counsellor should be able to maintain a balance between family members and the client so that neither feels the counsellor is taking sides
- A thorough assessment of the family situation is important to determine the role played by family members in the client's behaviours and what can be changed
- Provide resources or direct the family to where they can receive professional help, including family therapy
- The counsellor should be genuine and empathic towards family members

3.13 Summary

Various psychosocial approaches are available to deal with substance use and improve outcomes. The majority of these interventions do not require a high level of expertise and can be taught to outreach workers or social workers with minimum training and supervision.

4. Life as a Counsellor

4.1 Introduction

People who work in the area of addiction treatment tend to encounter a number of challenges and special issues. Some counsellors are themselves in recovery from substance use disorders and may find themselves confronting their own experiences while in professional situations. Individuals with substance use disorders are often mistrustful, but in many cases cling to counsellors for support, resulting in a 'push-pull' relationship. The counsellor may become overinvolved and then start to feel like nothing is working and give up on the client. Separately, issues related to expectations from families can cause additional burden. The job is challenging and can lead to burnout or other unpleasant situations if not dealt with adequately.

This chapter highlights some of the important issues faced by counsellors working with clients with substance use disorders and how they need to be addressed.

4.2 Transference and countertransference

As the name suggests, transference generally refers to feelings and issues from the client's past that get transferred onto the counsellor.

"Jamie, a 21-year-old male with cannabis dependence syndrome has been taking individual sessions for the last six months. He has been abstinent and started looking for a job. His counsellor informed him that she would be leaving town in another three months and would be referring his case to another therapist. After that session, Jamie shows signs of deterioration. He starts occasional use of cannabis, stops looking for jobs and shows moodiness in subsequent sessions."

Countertransference refers to the range of reactions and responses that the counsellor has towards the client based on counsellor's background and personal issues. *"Jamie's counsellor gets irritated with his behaviour and shouts at him for being difficult, threatening to terminate sessions if he does not change."*

Notes

Dealing with transference

Some of the ways of dealing with transference are highlighted below.

Dealing with transference

Types of transference	Typical thoughts	Typical behaviour	What to do
Moderate positive	The counsellor wants to help me, understand me, is human and helpful, is doing his/her job very well.	Cooperative, willing to change.	» Nothing.
Admiring/ dependent	Counsellor is great. Only he/she can help me. I am lost without him/her. I cannot do anything with his/her support.	Being overly cooperative, bringing presents, trying to please counsellor.	» Strengthen independent decision-making. » Refrain from giving too much advice or being too nurturing.
Erotic	Counsellor is a perfect (ideal) partner. A relationship with him/ her will save me. It would be wonderful to be with him/her.	Flirting or shy, wearing revealing clothes, amorous looks towards the therapist, they need to look better than they really are.	» Usually goes away on its own. » If it interferes with therapy, discuss it as a problem, where it stems from and how it can be resolved.
Shy (apprehensive)	Counsellor can comment about me or hurt me. When he/she finds out who I am, he/she will refuse me, make fun of me and reject me.	Problems with eye contact, censorship of what he / she is willing to share with the counsellor.	» Usually goes away on its own. » If it interferes with therapy, discuss it as a problem, where it stems from and how it can be resolved.
Aggressiveness	I must show my power (dominance) otherwise I will be deprived of my freedom. I must put him/her down!	Aggressive voice verbal rage, accusations, blaming, threatening.	» Let client talk. » Give feedback that he/she understands. » Remain calm. » If there is physical threat, call a guard. » Once the client calms down, discuss.
Jealous	He/she prefers others. He/she does not care for me.	Withdrawal or regrets, sometimes outbursts of anger, measuring the time of sessions (others and his/hers), monitoring of favour (himself and others).	» Discuss it as a problem, where it stems from and how it can be worked on.

Dealing with countertransference

Types of counter-transference	Typical thoughts	Typical behaviour	What to do
Moderate positive	I like him/her. He/she is nice. I have good cooperation with him/her, and he/she will do well.	Cooperative, supportive, empathic.	» Nothing.
Overprotective	He/she cannot make decisions on his/her own, needs help, advice. It will be my fault if something bad happens to him/her.	Gives advice, protects, ensures, takes control over the patient, does not allow client's independent decision-making, doubts patient's abilities.	» Clarify one's own beliefs and background. » Refrain from giving advice and playing a nurturing role. » Let client be independent.
Erotic	He/she is attractive. I would feel nice with him/her. Has sexual fantasies about the patient.	Flirts, is overprotective, accidental touches, speaks often about sex, offers 'sexual therapy' and, in the worst case, has an affair with the patient.	» Clarify one's own beliefs and background. » Stop rationalizing one's behaviour; seek supervision. » If an affair has ensued, ask client to change counsellors.
Apprehensive	He/she can hurt me, make fun of me, rouse me, show me I am worthless, stupid, etc.	Speaks quietly, is distant, the therapy burden falls to the patient, is not active in the therapy.	» Work on self-confidence and self-acceptance. » Seek supervision.
Aggressiveness	He/she is a psychopath, an ignorant person, does not try hard enough. He/she is annoying.	Moralizes, preaches, minimizes the needs of the patient, does not have time for the client. He/she is rude to the client, yells at him/her.	» Clarify one's own beliefs and background. » Seek supervision. Learn how to stay calm in a session.

Notes

4.3 Ethics

Counsellors working with drug-using clients tend to face a number of ethical dilemmas that can affect the therapeutic relationship and cause harm to the client. Just to site two examples that highlight common ethical dilemmas faced by counsellors dealing with adolescent substance users.

Emeka, a 15-year-old boy, recently completed his detoxification programme and began therapy with his counsellor Sarah. His parents accompanied him and demanded that every week Sarah prepare a written report about Julian's progress and give them a copy. They also demand that she tell them what Julian has said about his problems.

Mia, a 17-year-old girl with cannabis dependence, has been coming to therapy for the past two months. In the last session, she reported to her counsellor that she feels suicidal and has gotten a gun. She says that she just wants to inform the counsellor and does not want the counsellor to tell anyone.

Thus, counsellors must understand and follow ethical principles. Ethical principles are the rudder that guides the behaviour of the counsellor; they are the principles that direct the moral and value-based decisions of the counselling process. It is important that counsellors request ethical guidelines from their respective professional organizations or licensing authorities. Some of the general ethical principles inherent in counselling are:

- **Autonomy**: The counsellor should recognize the client's independence and ability to make their own decisions.
- **Justice**: The counsellor must treat each client fairly.
- **Beneficence**: The counsellor must act in the best interest of the client.
- **Nonmaleficence**: The counsellor must do no harm to the client, either intentionally or unintentionally.
- **Fidelity:** The counsellor must be loyal, faithful and honour commitments.
- **Obedience**: The counsellor has a responsibility to observe and obey legal and ethical directives.
- **Conscientious refusal**: The counsellor has a responsibility to refuse to carry out directives that are illegal and/or unethical.
- **Competence**: The counsellor should possess the necessary skills and knowledge to treat the client.
- **Honesty and candor**: The counsellor should always tell clients the truth.
- **Diligence**: The counsellor should work hard, be mindful, careful and thorough.
- **Self-improvement**: The counsellor should strive for professional and personal growth.

These principles will be explained in greater detail in Chapter 5: Legal and Ethical Issues in Counselling.

THE AMERICAN COUNSELLING ASSOCIATION'S CODE OF ETHICS (2005)

1. **Counselling relationship**
   a. No dual relationship with the client or his/her family members.
   b. Informed consent for treatment.
2. **Confidentiality, privileged communication**
   a. No information about the client is disclosed without written permission from client.
   b. Confidentiality can be broken in the event of a homicidal/suicidal client or if a child has been abused.
3. **Professional responsibility**
   a. Make sure the client does not suffer because of personal issues.
   b. Case referral to another counsellor should be done properly.
4. **Relationship with other professionals**
   a. Develop positive relationships with counsellors working in this area.
   b. Respect different point of views.
   c. Report malpractice.
5. **Evaluation, assessment and interpretation**
   a. Be aware of social and cultural influences when dealing with clients.
6. **Supervision, training and teaching**
   a. Foster professional relationships and create appropriate boundaries with students.
   b. Be accurate, honest, and fair during the training and assessment of students.
7. **Research and publication**
   a. Do not disclose client information in any research paper or data set.
   b. Do not plagiarise.
8. **Resolving ethical issues**
   a. Seek supervision.
   b. Refer to code of ethics in one's state/legislation.
   c. Be informed about the legal nuances of one's decisions.

4.4 Professional issues

Counsellors dealing with drug-using clients embrace objectivity and integrity and strive to maintain the highest standards of care. They should recognize that they are responsible for those in their care and that their actions should never harm a client. When a mistake is made, they should be able to recognize the mistake, learn from it and rectify it. Some of the professional responsibilities of counsellors include:

- Make regular appointments. Follow-up appointments should be specified at the end of the session.
- Keep appointments. In case of cancellations, inform clients well in advance.
- Enforce the start and end time for each session.
- Establish and enforce a clear policy with regards to payment.

- Have no personal contact with clients outside the therapy sessions except in case of crisis.
- Have no sexual contact with either clients or their family members.
- Make appropriate referrals, if need be. For example, if a client is depressed, refer them to a mental health professional and follow up.
- Do not provide counselling services to a client who is already undergoing counselling with another professional until that service is terminated.
- Do not discriminate on the basis of race, ethnicity, national origin, colour, gender, sexual orientation, age, marital status, political beliefs, religion, immigration status, or mental or physical challenges.
- Be aware of personal and professional limitations and acting accordingly.

Burnout

Professionals working in the field of addiction treatment are prone to stress, which may lead to burnout, making the job tedious, draining and frustrating. A professional experiencing burnout may feel exhausted and worn out. He/she may feel physically and emotionally exhausted and that attitude may turn into bitterness and apathy. Some of the reasons for burnout include:

- Unresolved issues at workplace.
- Lack of role clarity.
- Frequent relapses in clients.
- Uncooperative and manipulative clients.
- Personal issues like stress at home and interpersonal conflicts.

Burnout is a common phenomenon in addiction treatment and therefore needs to be addressed before it becomes unmanageable and irreversible. Some of the ways burnout can be dealt with are:

- The whole team shares the responsibility for client care and therefore good interpersonal relationships with other team members can prevent burnout.
- Professionals should care for their physical health.
- Professionals should take time away from work for themselves and their families in order to de-stress.
- In the case of unresolved personal issues, help should be sought from another professional.
- Peer discussions and supervision can reduce the feeling of nihilism that comes when clients do not improve or relapse.
- Professionals should understand that burnout can happen and learn to recognize signs of stress so that it can be taken care of at an early stage.
- Professionals should attend self-development programmes to enhance their creativity, self-esteem and to meet other people with similar issues.
- On a personal level, he/she should indulge him/herself to de-stress.
- He/she should re-evaluate their goals and priorities and take time away from work.

Suggested reading

- http://www.sulross.edu/sites/default/files/sites/default/files/users/docs/education/counselling-ethics_6.pdf. Accessed on 21 April 2015.
- Prasko, J; Diveky, T; Grambel, A; Kamaradova, D et al. (2010). Transference and Counter-transference in Cognitive Behavior Therapy. Biomed Pap Med Fac Univ Palacky Olomouc Czech Repub. 154:XX.
- Ranganathan, S; Jayaram, R and Thirumagal, V. Counselling for Drug Addiction-Individual, Family and Groups. T T Ranganathan Clinical Research Foundation Iv Main Road, Indira Nagar, Chennai, India. http://www.addictionindia.org/images-ttkh/undcp-manual2-counselling-for-drug-addiction.pdf. Accessed on 21st April 2015.

5. Legal and Ethical Issues of Counselling

Counselling is much more than just a conversation based on commonsense or the wisdom of the counsellor. It is a precise, professional intervention. Counselling in any context is bound by and follows certain ethical and legal issues. In the context of counselling for people who use drugs (PWUDs), however, the ethical and legal issues become particularly vital, because (a) using drugs is an illegal and socially deviant behaviour and (b) people who use drugs are especially vulnerable and their rights are often impinged upon.

In the case of counselling services being offered by NDLEA counselling centres, the ethical and legal issues have a special significance since NDLEA is a paramilitary force with a specific mandate to enforce Nigeria's drug laws. The power equation between the PWUD and NDLEA is obviously tilted heavily towards the latter. Thus, it is imperative that NDLEA counsellors remain aware of various ethical and legal issues relevant to the process of counselling.

5.1 Counselling for people who use drugs: Basic ethical principles

In the previous chapter we highlighted 11 general ethical principles inherent in a counselor. Here we are going to discuss five of these principles in greater detail. These include:

Justice

Justice simply means adhering to the values of impartiality and equality. In other words, a counsellor is expected to treat all clients equally without any bias or prejudice. However, in practice it is a challenge to achieve true impartiality. Often, more motivated clients who sought treatment on their own are favoured by counsellors, in contrast to poorly motivated clients who were pressured into seeking services. Ironically it is these poorly motivated clients who require more intensive attention from counsellors.

Though such biases are expected, counsellors should strive to minimize them and, importantly, they should recognize when and how these biases are affecting their ability to conduct their work within the principle of justice. It should be ensured that no client is discriminated against on the basis of their perceived or actual gender, race, socioeconomic status, belief system, religion, tribe or legal status.

Autonomy

According to the principle of autonomy, all clients have the right to decide on treatment for themselves, as long as their behaviour does not seriously interfere with the wellbeing of others. This principle is based upon the concepts of self-rule and self-determination, which are basic foundations of modern, free, democratic societies. However, in traditional societies such as Nigeria, the family still plays a large role in making decisions about

how individual family members live and conduct themselves. Consequently, it is not uncommon to find situations in which the family members coax and pressure a person who uses drugs to undergo the treatment, even against his/her wishes. Such cases present an obvious dilemma for the counsellor.

Two important issues should be considered concerning the principle of autonomy:

- Does the client have the competence to make a decision?
- Does the client have all the necessary information to make a decision?

If it is determined that a client does not have the competence to make a rational decision – because of mental health issues – then the NDLEA counselling centre is not the suitable source of treatment for the client. Such clients should be referred to the nearest health facility that is equipped to deal with such cases, even if the client agrees to treatment. If the client is deemed competent to make a rational decision but still refuses help at an NDLEA centre, then all the attempts must be made to provide him/her with complete information about the treatment process. A motivational enhancement session can be conducted with such clients. Ideally, the client should only be admitted to a residential facility only after the client understands the process and signs the informed consent form. The practice of succumbing to family pressure should be avoided to the extent possible.

Beneficence

Simple speaking, the term beneficence means doing good for others. However, what we see as doing good may be seen as harmful by the client. All of the counsellor's practices and behaviours should be geared towards achieving the best possible outcome for the client (as opposed to the best possible outcome for the family/society/agency).

Nonmaleficence

Like beneficence (which is about doing good), nonmaleficence is about doing no harm. Practices that amount to obvious exploitation of the client, such as sexual favours or financial exploitation, must be strictly avoided. These are obvious and clear examples of doing harm to a client. Sometimes, doing harm is not so obvious and can be subtle. One example of such a dilemma would be the choice between complete abstinence versus harm reduction. For instance, a client is not yet ready to be admitted into a counselling centre. The client is someone who uses alcohol heavily and works as a driver. With an abstinence-only approach, the counsellor may insist that the client be admitted today, even without consent. Through harm reduction, the counsellor may advise the client to return for admission next week and to avoid driving under the influence of alcohol until then. Which of these approaches is beneficial or harmful? This is a true ethical dilemma.

Fidelity

Fidelity simply means honesty on the part of the counsellor and the counsellor's commitment to keeping promises. When an NDLEA counsellor begins working with

a client, there is an implicit contract between them. It is assumed that the counsellor will enable the client to achieve his/her goals and that information will be shared by both the parties in a truthful manner. Confidentiality is a significant part of this contract between the client and the counsellor.

If a counsellor is forced to break certain promises, the client should be told about the incident and receive an explanation for why promises were broken. For instance, if the client is found to break some rules of the centre, the relationship ('contract') may be terminated by the NDLEA.

In the context of fidelity, it is also important to remember that the counsellor is responsible for the person using drugs. That individual is the client (not the family or the society). Thus, the counsellor's primary fidelity is to the individual client.

5.2 Legal issues

According to the NDLEA Act of Nigeria, consumption and possession of narcotic drugs and psychotropic substances is a crime. As such, most clients receiving services at NDLEA counselling centres could be deemed to have committed a crime. However, NDLEA counsellors should avoid regarding clients as criminals under the law. Instead, they should see clients as individuals who need help and care. It is pertinent to note that the NDLEA Act also contains a mandate of Drug Demand Reduction in addition to Drug Supply Reduction. Thus, counsellors should focus on providing help and care to clients affected by the substance use disorders and not treat them as criminals who deserve punishment. NDLEA counselling centres should strive to be the best health care facilities providing substance use treatment services in Nigeria and in the world.

Therefore, the rules and regulations of counselling centres must be clearly formulated, displayed and followed. Contravention of these rules by any staff or client must result in punishment according to the rules and regulations of the agency.

Difference between law and ethics

ETHICS	LAW
Ethics are social guidelines based on moral principles and values.	Laws are rules and regulations that have specific penalties and consequences when violated.
Made by 'people'.	Made by 'Government'.
"Doing the right thing in the right situation" is the foundation of ethics.	Based on society's ethics, laws are created and enforced by governments to mediate our relationships with each other.
Generally, ethics do not have punishments when people do not follow them. However, specific organizations or agencies may develop their own mechanisms for punishment if ethics are violated.	Laws provide for specific punishments if they are not followed. Sometimes punishments may break the perceived ethical standards.

6. Standard Operating Procedures (SOPs) for Managing NDLEA Counselling Centres

This chapter provides an overview of the Standard Operating Procedures (SOPs) that should be followed at NDLEA counselling centres. Adherence to the specifications and procedures described in this chapter will result in a degree of standardization and uniformity of services provided by the NDLEA. However, it must be noted that there will be a degree of variation in terms of the procedures followed at individual counselling centres as a result of local contexts and situations.

These SOPs are primarily meant for personnel managing NDLEA counselling centres (for the purpose of implementation) and for senior officials of NDLEA (for the purpose of monitoring and evaluation).

The chapter is divided into the following sections:

1. **Infrastructure**
2. **Staff**
3. **Service delivery**
4. **Record maintenance**
5. **Reporting, monitoring and evaluation**

6.1 Infrastructure

All NDLEA counselling centres must have adequate infrastructure for provision of counselling services to clients. This includes the following types of rooms:

a. Intake room/office space/counselling room

This room will be primarily utilized by counsellors for:

- Conducting their office work
- Interviewing clients and family members during intake
- Conducting individual counselling sessions with clients and family members

The room should be adequately furnished and have storage space (for records), a computer and a printer.

b. Waiting area

This is a space (outside the counselling room) for clients and family members to wait for their turn to speak to the counsellor.

c. Activity room/group discussion room

This is a large space where group meetings/discussions and recreational or occupational

activities can be conducted. Furniture in this room should be able to be quickly moved around for different sitting arrangements.

d. Residential area/ward

This is the space where residential clients stay. The residential area should have adequate furniture for sleeping (beds with mattresses, sheets, pillows and blankets) as well as small cupboards for clients to keep their belongings. This should be a secure area with thorough checking and frisking facilities at the entrance.

Each counselling centre should accommodate clients only up to capacity (i.e., availability of beds). Overcrowding or accepting clients beyond capacity and allowing them to sleep on mattresses on the floor should be avoided.

e. Toilets

Clean toilets with basic amenities for clients (separate for males and females) should be provided.

f. Kitchen

It is well known that space is scarce at NDLEA counselling centres, and in particular at centres offering counselling/DDR activities. Thus, all attempts must be made to:

- Prioritize counselling/DDR activities in allocation of infrastructure
- Efficiently utilize available infrastructure for counselling/DDR activities

6.2 Staff

Every counselling centre should have at least **one trained counsellor**. The ideal ratio would be one counsellor for every four residential clients. NDLEA should ensure that there is an adequate number of counsellors based on the capacity of each facility. Counsellors should have undergone specific training for working with people who use drugs and should have proof in the form of documentation.

In ideal situations, a doctor should be available at the counselling centre. The doctor may be contracted on a **part-time basis,** expected to devote at least three hours two times a week at the counselling centre. In addition, there should be an agreement that the doctor is on call for medical emergencies (or, alternatively, the centre should have a plan in place to transfer clients to the emergency department of the nearest health facility). In addition, **support staff** are needed in the form of attendants/caregivers/housekeepers.

6.3 Service delivery

The services provided at NDLEA counselling centres should include:

a. **Assessment and intake of clients**
b. **Home-based counselling intervention (for clients and family members)**
c. **Residential counselling intervention**

d. After-care services
e. Referral services
f. Recreational and occupational rehabilitation services

A brief description of each of these services follows.

a. Assessment and intake of clients

Upon arrival at the counselling center, each client must undergo assessment (according to the process explained in Chapter 2).

b. Home-based counselling intervention (for clients and family members)

These counselling interventions can be scheduled as per the convenience of clients and counsellors. In general, the counsellors should be able to decide the specific time slots for various activities (counselling for home-based clients, counselling for residential clients, office work). These timings should be prominently displayed at the centre.

c. Residential counselling intervention

These counselling interventions are meant for the clients who are receiving residential care and hence are expected to be both more intensive in nature and provide more flexibility in terms of timing for counsellors.

The specific types of counselling interventions (as well as their frequency) should be determined based on the requirements of individual cases. General descriptions as well as the 'how to' of various types of counselling interventions can be found in Chapter 3.

d. After-care services

In the case of residential clients, even after discharge, it is important not to assume that treatment is complete, and that the client no longer requires services from the centre. After discharge, counsellors should encourage clients to maintain contact with the centre and keep visiting to receive after-care counselling services (the exact types of these counselling interventions should be determined based on the specific requirements of the individual case).

e. Referral services

People who use drugs have multiple needs and requirements. NDLEA centres are not all encompassing and therefore are not realistically expected to meet all the requirements of all clients. Thus, it is necessary for all centres to maintain a current directory of various services to which the NDLEA clients can be referred. These referrals may include the following types of services:

- Health care services
- Legal aids and services
- Social welfare services
- Educational or vocational services
- Financial services
- Religious/spiritual services

It would be helpful to maintain a ***Directory of referral services***, where a counsellor could easily find details of various service providers to refer clients to.

f. Recreational and occupational rehabilitation services

All NDLEA centres should strive to provide some recreational and occupational rehabilitation services, especially for clients in residential care. Recreational services may include healthy indoor games, a library of books, magazines and newspapers, a television and movies. Similarly, occupational rehabilitation services may include short-term vocational trainings (with the aid of other agencies/organizations).

6.4 Record maintenance

A simple and user-friendly record maintenance system is recommended to ensure that all client-related activities are recorded. This aids in the efficient delivery of services as well as in monitoring and evaluation. The records that each counselling centre should keep are listed below.

RECORD/FORMAT	DESCRIPTION
Client Register-NEW	For registering the details of all NEW clients. Each client gets a unique and permanent registration number. The centre should keep count of all new clients accessing services in a given calendar year.
Client Register-FOLLOW UP	For registering the details of all clients that are to be followed up with/or scheduled for subsequent visits. The centre should keep a count of all follow-up visits made by registered clients in a given calendar year (indicating the workload).
Client Register-RESIDENTIAL	For registering the details of all the clients who choose to receive services as residential clients. The centre should keep a count of all residential clients accessing services in a given calendar year.
Client file	To be made for each registered client. The identification data of the client (name, age, address, registration number) should be listed on the cover. The file should contain the intake form, consent form, counselling records and the discharge summary. At any point in time, a person going through the client file should be able to determine the status of the client at intake as well as the client's progress through counselling interventions.
Intake form	To be used for the intake assessment of all clients at the time of first visit. The information obtained will be systematically recorded and retained by the centre. The form also helps the counsellor make decisions regarding the intervention plan for the client.
Consent form	When signed by the client, witness and counsellor, this form serves as proof that the client understood the process of care and agreed to receive the services voluntarily. This needs to be periodically reviewed and updated for residential clients.

RECORD/FORMAT	DESCRIPTION
Counselling file records	This is a systematic record of all the counselling sessions received by the client from the centre (both home-based and residential clients). This record provides the details of counselling interventions received by the individual client.
RESIDENTIAL Client discharge summary	This is a summary, to be prepared at the time of discharge, of all counselling interventions received by residential clients. One copy is given to the client and another remains in the client's file at the centre.
Counselling register	This register lists all the counselling interventions provided by the counsellors chronologically. Thus, it is an at-a-glance record of counselling-related work being done by the counsellor/centre.
Referral register	This is a record of all referrals counsellors made for clients to various other services.
Monthly reporting form	All centres are to use this form to collate data (with the help of the above-mentioned registers) and systematically send it to NDLEA on a monthly basis. This will aid the process of monitoring and evaluation.

6.5 Reporting, monitoring and evaluation

All NDLEA counselling centres are expected to prepare monthly reports and submit them to Headquarters through the appropriate channels. All reports should be submitted to NDLEA Headquarters both digitally and in hard copy. Reports from all centres will be compiled and collated every month for review and implementation of policy.

In addition, senior DDR officials may visit centres for monitoring and evaluation purposes, and conduct the following activities:

- Inspection and observation of the centre
- Interaction with staff
- Interaction with clients (residential and home-based)
- Review of records

Based upon these observations, the evaluating officers may submit specific recommendations to improve the functioning of the centre.

APPENDICES

STANDARD POLICY
AND PRACTICE
GUIDELINES FOR
NDLEA
COUNSELLING
CENTRES

APPENDIX 1. CLIENT INTAKE REGISTER: NEW CLIENTS

Date	Client registration / ID number	Name	Age	Sex	Address	Source of Referral

APPENDIX 2. CLIENT REGISTRATION FORM: NEW CLIENTS

DESCRIPTION

Name of Field	Description
Date	Date of registration
Client registration/ID number	Registration number to be provided as “NNN/XXXX/YY” Where, • NNN is a three-letter code for the name of centre • XXXX is a four-digit number from 0001 to 9999 • YY is the year (such as 15, 16 and so on)
Name	Full name of the client
Age	Age in years
Sex	Male or female
Address	Complete address along with contact phone number
Source of referral	1. Self 2. Family 3. Police/law enforcement/judiciary 4. Other service providers

APPENDIX 3. CLIENT FOLLOW-UP REGISTER

DATE:

S/No.	Client registration / ID number	Name	Age	Sex	Diagnosis	Accompanied by	Next appointment

APPENDIX 4. CLIENT FOLLOW-UP FORM

DESCRIPTION

- This register is to be used for all clients visiting the counselling centre on subsequent visits (the second visit onwards)
- Once a registration number has been assigned, it stays with the client forever
- A new page should be used on each new day

Name of Field	Description
Date	Date of follow-up visit
Client registration/ID number	The original registration number given to the client on first visit
Name	Full name of the client
Age	Age in years
Sex	Male or female
Diagnosis	Diagnosis of the client as per the initial intake assessment
Accompanied by	Who is the client accompanied by today? 5. Self/alone 6. Family 7. Friends/peers 8. Other

APPENDIX 5. CLIENT INTAKE REGISTER: RESIDENTIAL CLIENTS

Date	Client registration/ ID number(NEW)	Name	Age	Sex	Address	RESIDENTIAL registration number

APPENDIX 6. CLIENT REGISTRATION FORM: RESIDENTIAL CLIENTS

DESCRIPTION

- This register is to be used for all RESIDENTIAL clients admitted to the counselling centre
- Once a registration number has been assigned, it stays with the client forever

Name of Field	Description
Date	Date of registration
Client registration/ID number	Registration number to be provided as "NNN/XXXX/YY" Where, • NNN is a three-letter code for the name of centre • XXXX is a four-digit number from 0001 to 9999 • YY is the year (such as 15, 16 and so on)
Name	Full name of the client
Age	Age in years
Sex	Male or female
Address	Complete address along with contact phone number
RESIDENTIAL registration number	RESIDENTIAL Registration number to be provided as "NNN/RXXXX/YY" Where, • NNN is a three-letter code for the name of centre • RXXXX is a four-digit number from R0001 to R9999 • YY is the year (such as 15, 16 and so on)

APPENDIX 7. CLIENT INTAKE FORM

(To be signed by the client in the presence of a witness. Please strike out whatever is not applicable.)

I, ... aged ..... years, resident of ....., hereby consent to (receive) help from the NDLEA counselling centre at ..... on a RESIDENTIAL BASIS/HOME-BASED CARE.

Regarding counselling and treatment, (it has been explained to me and) I understand that:

- My drug use pattern has been causing harm/damages/problems to me and my near and dear ones. I also understand that if I continue to use drugs in a similar manner, it will cause even more harm and problems to me and to those around me.
- My drug use pattern DOES NOT need immediate medical attention at the moment.

or

- My drug use pattern NEEDS immediate medical attention and hence I have been asked to get specific help at a suitable health facility.

Regarding RESIDENTIAL CARE, I have understood that:

- I need to stay at the counselling centre for an optimum duration of time to obtain the maximum benefit.
- I will be required to participate in various activities of the centre and follow the advice of the counsellor.
- I should be honest about all issues, especially related to drugs, with my counsellors.
- Support from family is extremely important for the successful completion of treatment and I should involve them in the treatment process.
- If I discontinue treatment in the middle of the process and leave the centre against professional advice, I will be the one responsible for any untoward consequences. Similarly, if I am not able to follow disciplinary rules and procedures, I will be the only one responsible for any untoward consequences.
- Even if I leave the centre against professional advice, I will have the option to continue meeting my counsellors as a home-based client.

Regarding the HOME-BASED CARE process, I have understood that:

- I need to remain in active contact with the counselling centre for an optimum duration of time to obtain the maximum benefit.
- I will be required to participate in counselling sessions and follow the advice of the counsellor.
- I should be honest about all issues, especially related to drugs, with my counsellors.
- Support from family is extremely important for the successful completion of treatment and I should involve them in the treatment process and bring them with me for follow-up visits when required.
- If I discontinue treatment in the middle of the process, I will be the one responsible for any untoward consequences. Similarly, if I am not able to follow disciplinary required rules and procedures, I will be the only one responsible for any untoward consequences.
- Even if I discontinue the treatment, I will still have the option to visit the centre.

I understand that my treatment may be stopped without my consent for reasons such as:

- Violence, threatened violence or verbal abuse towards other clients or staff
- Carrying prohibited materials with me
- Unlawful entry into the premises
- Presenting to the centre intoxicated with alcohol or other drugs
- Engaging in unlawful activity such as drug dealing around the centre
- And any other behaviour that may not be in my best interest or in the interest of the centre

I have fully understood the above information. I am willing to start treatment and follow the instructions explained to me.

Client's signature Date and time	Signature of family member/witness Name of the family member/witness Relationship with the client Date and time
Name and signature of counsellor Phone number Date and time	Director, DDR Sign and date (For NHQs) State commander Sign and date (For State Commands)

Note: For administrative purposes, assistants to the Director or State Commanders can sign for the Director or State Commanders as the case may be.

APPENDIX 8: CLIENT INTAKE FORM

NATIONAL DRUG LAW ENFORCEMENT AGENCY (NDLEA)

Name of counsellor and rank: .....

1. REGISTRATION DETAILS

Client registration/ID number:	N	N	N	X	X	X	X	Y	Y
	City code				Number			Year	

Date of registration:						
	D	D	M	M	Y	Y
Date of interview:						
	D	D	M	M	Y	Y

Source of referral: (select one)		
	1.	Self
	2.	Family and friends
	3.	Doctor/nurse
	4.	Social services
	5.	Workplace
	6.	School
	7.	NDLEA
	8.	Police/other law enforcement agencies/judiciary
	9.	Other service providers (specify): .....
	99.	Not known/decline to answer

Accompanied by:	

Type of admission: (select one)		
	1.	Voluntary
	2.	Involuntary
	99.	Not known/decline to answer

2. PERSONAL DETAILS

Surname:	
Maiden name (for women only)	
First name	

Father's /mother's / spouse's name:	
Age:	Years
Sex	M F
Year of Birth:	Y Y Y Y
Place of birth (city / town / village)	
Residential address:	
Phone number:	
Alternate phone number:	

3. SOCIODEMOGRAPHIC PROFILE

3.1 Current accommodation

- ☐ Home/stable accommodation
- ☐ Dormitory/institution
- ☐ No stable accommodation
- ☐ Other (specify): .....
- ☐ Not known/decline to answer

3.2 Current living arrangement

- ☐ Alone
- ☐ With parents, family or relatives
- ☐ With spouse/partner
- ☐ With friends
- ☐ With children (no spouse)
- ☐ Other (specify): .....
- ☐ Not known/decline to answer

3.3 Area of residence

- ☐ Urban
- ☐ Semi-urban
- ☐ Rural
- ☐ Not known/decline to answer

3.4 Education

- ☐ No formal education
- ☐ Some primary education (not completed)
- ☐ Completed primary education (six years of schooling)
- ☐ Some secondary education
- ☐ Completed secondary education
- ☐ Some tertiary/graduate
- ☐ Completed tertiary/graduate
- ☐ Post-graduate
- ☐ Others (specify): .....
- ☐ Not known/decline to answer

3.5 Employment status

- ☐ Regular employment
- ☐ Occasional employment
- ☐ Pupil/student
- ☐ Unemployed
- ☐ Housewife
- ☐ Others (pensioner, retired etc.): ....
- ☐ Not known/decline to answer

3.6 Profession/occupation (if employed presently or in the past):

3.6a Brief occupational history

3.7 Monthly income (in naira):

- ☐ <10,000
- ☐ 10,000 – 20,000
- ☐ 20,000 – 30,000
- ☐ 30,000 – 40,000
- ☐ 40,000 – 50,000
- ☐ > 50,000
- ☐ Not known/decline to answer

3.8a Marital status

- ☐ Single (never married)
- ☐ Married
- ☐ Widow/widower
- ☐ Divorced/separated
- ☐ Not known/decline to answer

3.8b Number of living children ☐☐

3.8c Family type*

- ☐ Monogamous
- ☐ Polygamous
- ☐ Single parent
- ☐ Not known/decline to answer

3.9 Religion

3.10 Nationality

*** If the patient is single, indicate the family type of his/her parents**

4. DETAILS OF SUBSTANCE USE

4.1 Pattern of substance use

Substance	Ever use (Y/N)	Code/ name of substance (s) (1)	Use in the last 3 months (Y/N	Use in the last 30 days (Y/N)	Usual dose	Usual route of administration (2)					Current pattern/ frequency of use (3)					Age at first use	Injecting use-ever (Y/N)	Duration of injecting drug use
1. Alcohol						1	2	3	4	5	1	2	3	4	5			
2. Cannabis						1	2	3	4	5	1	2	3	4	5			
3. Cocaine						1	2	3	4	5	1	2	3	4	5			
4. Crack cocaine						1	2	3	4	5	1	2	3	4	5			
5. Stimulant(s) other than cocaine (*)						1	2	3	4	5	1	2	3	4	5			
						1	2	3	4	5	1	2	3	4	5			
6. Opioid(s) (*)						1	2	3	4	5	1	2	3	4	5			
						1	2	3	4	5	1	2	3	4	5			
7. Sedative-hypnotics (barbiturates, benzodiazepines/ Rohypnol) (*)						1	2	3	4	5	1	2	3	4	5			
						1	2	3	4	5	1	2	3	4	5			
8. Hallucinogens (*)						1	2	3	4	5	1	2	3	4	5			
9. Organic solvents/glue (*)						1	2	3	4	5	1	2	3	4	5			
10. Other (excluding tobacco) (specify name) (*)						1	2	3	4	5	1	2	3	4	5			
11. Tobacco						1	2	3	4	5	1	2	3	4	5			

(*) If several substances of the same drug category are used by the patient, please indicate for each substance, name and related pattern of use.

(1) For some drug category, please specify the substance according to the coding:

5. *stimulants other than cocaine: 5.1 amphetamines, 5.2 methamphetamines, 5.3 MDMA and derivatives, 5.4 synthetic cathinones, 5.5 other stimulants (specify name in column)*
6. *opioids: 6.1 heroin, 6.2 methadone misused, 6.3 buprenorphine misused, 6.4 fentanyl misused, 6.5 tramadol misused, 6.6 pentazocine misused, 6.7 codeine misused, 6.8 other opioids (specify name in column)*
7. *sedative-hypnotics: 7.1 barbiturates misused, 7.2 benzodiazepines misused, 7.3 GHB/GBL, 7.4 other sedative-hypnotics misused (specify name in column). Please note that Rohypnol is a benzodiazepine and should be declared under 7.2*
8. *hallucinogens: 8.1 LSD, 8.2 ketamine, 8.3 other hallucinogens (specify name in column).*

(2) Specify the usual route of administration route in the last 30 days: 1=Swallow/eat/drink, 2=Smoke/inhale, 3=Snort/sniff, 4=inject, 5=other (specify).

(3) Specify the frequency of use in the last 30 days: 1=daily, 2=4-6 days per week, 3=2-3 days a week, 4=once a week or less, 5=not used in the past month.

APPENDIX 9. WHO ASSIST

Sl. No.	Item	Response				
1.	**TOBACCO PRODUCTS (CIGARETTES, CHEWING TOBACCO, CIGARS, ETC.)**					
1.1	**In your life, have you ever used tobacco products?**	**No (0)**		**Yes (3)**		
		NEVER	ONCE OR TWICE	MONTHLY	WEEKLY	DAILY OR ALMOST DAILY
1.2	In the past three months, how often have you used the tobacco products you mentioned?	0	2	3	4	6
1.3	During the past three months, how often have you had a strong desire or urge to use tobacco products?	0	3	4	5	6
1.4	During the past three months, how often has your use of tobacco products led to health, social, legal or financial problems?	0	4	5	6	7
		No, never	Yes, in the past three months		Yes, but not in the past three months	
1.5	Has a friend, relative or anyone else ever expressed concern about your use of tobacco products?	0	6		3	
1.6	Have you ever tried and failed to control, cut down or stop using tobacco products?	0	6		3	

2.	ALCOHOLIC BEVERAGES (BEER, WINE, SPIRITS, ETC.)					
2.1	**In your life, have you ever used alcoholic beverages?**	**No (0)**		**Yes (3)**		
		NEVER	ONCE OR TWICE	MONTHLY	WEEKLY	DAILY OR ALMOST DAILY
2.2	In the past three months, how often have you used the alcoholic beverages you mentioned?	0	2	3	4	6
2.3	During the past three months, how often have you had a strong desire or urge to use alcoholic beverages?	0	3	4	5	6
		NEVER	ONCE OR TWICE	MONTHLY	WEEKLY	DAILY OR ALMOST DAILY
2.4	During the past three months, how often has your use of alcoholic beverages led to health, social, legal or financial problems?	0	4	5	6	7
2.5	During the past three months, how often have you failed to do what was normally expected of you because of your use of alcoholic beverages?	0	5	6	7	8
		No, never	Yes, in the past three months		Yes, but not in the past three months	
2.6	Has a friend, relative or anyone else ever expressed concern about your use of alcoholic beverages?	0	6		3	
2.7	Have you ever tried and failed to control, cut down or stop using alcohol beverages?	0	6		3	

Sl. No.	Item	Response				
3.	**CANNABIS (MARIJUANA, POT, GRASS, HASH, ETC.)**					
3.1	**In your life, have you ever used cannabis?**	**No (0)**		**Yes (3)**		
		NEVER	ONCE OR TWICE	MONTHLY	WEEKLY	DAILY OR ALMOST DAILY
3.2	In the past three months, how often have you used the cannabis product you mentioned?	0	2	3	4	6
3.3	During the past three months, how often have you had a strong desire or urge to use cannabis?	0	3	4	5	6
3.4	During the past three months, how often has your use of cannabis led to health, social, legal or financial problems?	0	4	5	6	7
3.5	During the past three months, how often have you failed to do what was normally expected of you because of your use of cannabis?	0	5	6	7	8
		No, never	Yes, in the past three months		Yes, but not in the past three months	
3.6	Has a friend, relative or anyone else ever expressed concern about your use of cannabis?	0	6		3	
3.7	Have you ever tried and failed to control, cut down or stop using cannabis?	0	6		3	

4.	OPIOIDS (HEROIN, MORPHINE, METHADONE, TRAMADOL, CODEINE, PENTAZOCINE, ETC.)					
4.1	**In your life, have you ever used opioid drugs?**	**No (0)**		**Yes (3)**		
		NEVER	ONCE OR TWICE	MONTHLY	WEEKLY	DAILY OR ALMOST DAILY
4.2	In the past three months, how often have you used the opioids you mentioned?	0	2	3	4	6
4.3	During the past three months, how often have you had a strong desire or urge to use opioids?	0	3	4	5	6
4.4	During the past three months, how often has your use of opioids led to health, social, legal or financial problems?	0	4	5	6	7
4.5	During the past three months, how often have you failed to do what was normally expected of you because of your use of opioids?	0	5	6	7	8
		No, never	Yes, in the past three months		Yes, but not in the past three months	
4.6	Has a friend, relative or anyone else ever expressed concern about your use of opioids?	0	6		3	
4.7	Have you ever tried and failed to control, cut down or stop using opioids?	0	6		3	

Sl. No.	Item	Response				
5.	**SEDATIVES OR SLEEPING PILLS (VALIUM, SEREPAX, ROHYPNOL, ETC.)**					
5.1	**In your life, have you ever used sedatives?**	**No (0)**		**Yes (3)**		
		NEVER	ONCE OR TWICE	MONTHLY	WEEKLY	DAILY OR ALMOST DAILY
5.2	In the past three months, how often have you used the sedatives you mentioned?	0	2	3	4	6
5.3	During the past three months, how often have you had a strong desire or urge to use sedatives?	0	3	4	5	6
5.4	During the past three months, how often has your use of sedatives led to health, social, legal or financial problems?	0	4	5	6	7
5.5	During the past three months, how often have you failed to do what was normally expected of you because of your use of sedatives?	0	5	6	7	8
		No, never	Yes, in the past three months		Yes, but not in the past three months	
5.6	Has a friend, relative or anyone else ever expressed concern about your use of sedatives?	0	6		3	
5.7	Have you ever tried and failed to control, cut down or stop using sedatives?	0	6		3	

6.	COCAINE (COKE, CRACK COCAINE, ETC.)					
6.1	**In your life, have you ever used cocaine?**	**No (0)**		**Yes (3)**		
		NEVER	ONCE OR TWICE	MONTHLY	WEEKLY	DAILY OR ALMOST DAILY
6.2	In the past three months, how often have you used cocaine?	0	2	3	4	6
6.3	During the past three months, how often have you had a strong desire or urge to use cocaine?	0	3	4	5	6
6.4	During the past three months, how often has your use of cocaine led to health, social, legal or financial problems?	0	4	5	6	7
6.5	During the past three months, how often have you failed to do what was normally expected of you because of your use of cocaine?	0	5	6	7	8
		No, never	Yes, in the past three months		Yes, but not in the past three months	
6.6	Has a friend, relative or anyone else ever expressed concern about your use of cocaine?	0	6		3	
6.7	Have you ever tried and failed to control, cut down or stop using cocaine?	0	6		3	

Sl. No.	Item	Response				
7.	**AMPHETAMINE-TYPE STIMULANTS (SPEED, DIET PILLS, ECSTASY, MDMA, ETC.)**					
7.1	**In your life, have you ever used amphetamine-type stimulants?**	**No (0)**		**Yes (3)**		
		NEVER	ONCE OR TWICE	MONTHLY	WEEKLY	DAILY OR ALMOST DAILY
7.2	In the past three months, how often have you used the amphetamine-type stimulants you mentioned?	0	2	3	4	6
7.3	During the past three months, how often have you had a strong desire or urge to use amphetamine-type stimulants?	0	3	4	5	6
7.4	During the past three months, how often has your use of amphetamine-type stimulants led to health, social, legal or financial problems?	0	4	5	6	7
7.5	During the past three months, how often have you failed to do what was normally expected of you because of your use of amphetamine-type stimulants?	0	5	6	7	8
		No, never	Yes, in the past three months		Yes, but not in the past three months	
7.6	Has a friend, relative or anyone else ever expressed concern about your use of amphetamine type stimulants?	0	6		3	
7.7	Have you ever tried and failed to control, cut down or stop using amphetamine-type stimulants?	0	6		3	

8.	INHALANTS (NITROUS, GLUE, PETROL, PAINT THINNER, ETC.)					
8.1	**In your life, have you ever used inhalants?**	**No (0)**		**Yes (3)**		
		NEVER	ONCE OR TWICE	MONTHLY	WEEKLY	DAILY OR ALMOST DAILY
8.2	In the past three months, how often have you used the inhalants you mentioned?	0	2	3	4	6
8.3	During the past three months, how often have you had a strong desire or urge to use inhalants?	0	3	4	5	6
8.4	During the past three months, how often has your use of inhalants led to health, social, legal or financial problems?	0	4	5	6	7
8.5	During the past three months, how often have you failed to do what was normally expected of you because of your use of inhalants?	0	5	6	7	8
		No, never	Yes, in the past three months		Yes, but not in the past three months	
8.6	Has a friend, relative or anyone else ever expressed concern about your use of inhalants?	0	6		3	
8.7	Have you ever tried and failed to control, cut down or stop using inhalants?	0	6		3	

Sl. No.	Item	Response				
9.	**HALLUCINOGENS (LSD, ACID, MUSHROOMS, PCP, SPECIAL K, ETC.)**					
9.1	**In your life, have you ever used hallucinogens?**	**No (0)**		**Yes (3)**		
		NEVER	ONCE OR TWICE	MONTHLY	WEEKLY	DAILY OR ALMOST DAILY
9.2	In the past three months, how often have you used the hallucinogens you mentioned?	0	2	3	4	6
9.3	During the past three months, how often have you had a strong desire or urge to use hallucinogens?	0	3	4	5	6
9.4	During the past three months, how often has your use of hallucinogens led to health, social, legal or financial problems?	0	4	5	6	7
9.5	During the past three months, how often have you failed to do what was normally expected of you because of your use of hallucinogens?	0	5	6	7	8
		No, never	Yes, in the past three months		Yes, but not in the past three months	
9.6	Has a friend, relative or anyone else ever expressed concern about your use of hallucinogens?	0	6		3	
9.7	Have you ever tried and failed to control, cut down or stop using hallucinogens?	0	6		3	

10.	OTHER – SPECIFY:					
10.1	**In your life, have you ever used any other drugs apart from those mentioned above?**	**NO (0)**		**Yes (3)**		
		NEVER	ONCE OR TWICE	MONTHLY	WEEKLY	DAILY OR ALMOST DAILY
10.2	In the past three months, how often have you used ..... (the drugs you mentioned)?	0	2	3	4	6
10.3	During the past three months, how often have you had a strong desire or urge to use .....(any other drugs you mentioned)?	0	3	4	5	6
10.4	During the past three months, how often has your use of .....(any other drugs you mentioned) led to health, social, legal or financial problems?	0	4	5	6	7
10.5	During the past three months, how often have you failed to do what was normally expected of you because of your use of ..... (any other drugs you mentioned)?	0	5	6	7	8
		No, never	Yes, in the past three months		Yes, but not in the past three months	
10.6	Has a friend, relative or anyone else ever expressed concern about your use of ..... (any other drugs you mentioned)?	0	6		3	
10.7	Have you ever tried and failed to control, cut down or stop using ..... (any other drugs you mentioned)?	0	6		3	

GUIDE TO INTERVENTION PLANNING BASED ON TOTAL ASSIST SCORES

NOTE:

A. Score 0–3 → No intervention

B. Score 4–26 → Counselling at NDLEA

C. Score > 27 for any substance → Referral to health facility

Substance/drug	ASSIST SCORE (*)	Intervention planned
1. Tobacco		
2. Alcohol (**)		
3. Cannabis		
5. Sedatives or sleeping pills		
6. Cocaine		
7. Amphetamines-type stimulants		
8. Inhalants		
9. Hallucinogens		
10. Other drugs :		

(*) The global ASSIST score for each substance is computed by adding the scores from question X.2 to X.7.
E.g.: for cannabis, add questions 3.2 to 3.7. For tobacco, add 1.2 to 1.7.

(**) The interventions to be planned for alcohol are based on a different scoring:
0-10 → No intervention,
11–26 → Counselling at NDLEA,
> 27 → Referral to health facility.

4.2 RECENT INJECTING PRACTICES

Ever injected

- ☐ Never injected
- ☐ Injected but not in the past 12 months
- ☐ Injected in the last 12 months but not in the last 30 days
- ☐ Currently injecting (in the last 30 days)
- ☐ Not known/decline to answer

If the patient has ever injected in his/her lifetime, please answer all the following questions:

Age at first injection (in years) ☐☐

Frequency of injecting:

- ☐ Daily
- ☐ 3-4 times per week
- ☐ 1-2 times per week
- ☐ Less than once per week
- ☐ None
- ☐ Not known/decline to answer

Number of injections per day (usual range): ☐☐

Route of administration: ☐ Intravenous (IV) ☐ Intramuscular (IM) ☐ Any other

Injecting practices: ☐ Alone ☐ Group ☐ Unknown

Ever shared syringe/needle:

- ☐ Never shared
- ☐ Shared but not in the past 12 months
- ☐ Shared in the last 12 months but not in the last 30 days
- ☐ Currently sharing (in the last 30 days)
- ☐ Not known/decline to answer

If ever shared syringe/needle, frequency of sharing:

- ☐ Never
- ☐ Rarely
- ☐ Sometimes (1-2 times in 10 injecting episodes)
- ☐ Often (>2 times in 10 injecting episodes)
- ☐ Every time
- ☐ Not known/decline to answer

Ever shared paraphernalia:

- ☐ Never shared
- ☐ Shared but not in the past 12 months
- ☐ Shared in the last 12 months but not in the last 30 days
- ☐ Currently sharing (in the last 30 days)
- ☐ Not known/decline to answer

If ever shared paraphernalia, frequency of sharing:

- ☐ Never
- ☐ Rarely
- ☐ Sometimes (1-2 times in 10 injecting episodes)
- ☐ Often (>2 times in 10 injecting episodes)
- ☐ Every time
- ☐ Not known/decline to answer

Number of people shared with: ☐☐ ☐ Unknown

Sharing during last injecting act: ☐ Yes ☐ No ☐ Unknown

5. SEXUAL HISTORY (SEE COMMENT)

COMMENT: Sexual, financial and legal history may be difficult to elicit at intake. Administration may be delayed until rapport and a reasonable level of confidence and trust have been established between the client and the counsellor.

5.1 Age at sexual debut (in years): ☐☐

5.2 History of:

Paid sex	☐	Yes	☐	No	☐	Unknown
Homosexual intercourse	☐	Yes	☐	No	☐	Unknown
Sex in exchange for money/drugs	☐	Yes	☐	No	☐	Unknown

5.3 Recent sexual practices

Currently sexually active (last 1 month or last 30 days)	☐	Yes	☐	No	☐	Unknown

If the patient has been sexually active in the last month, answer all the following questions:

	Sex in last month with		Number of partners	Sexual frequency – last month	Condom usage	Condom use during last sex act	
Regular partner/ spouse	1. Yes	2. No			1. Always	1. Yes	2. No
					2. Sometimes		
					3. Never		
Irregular/casual partner	1. Yes	2. No			1. Always	1. Yes	2. No
					2. Sometimes		
					3. Never		
Female sex worker	1. Yes	2. No			1. Always	1. Yes	2. No
					2. Sometimes		
					3. Never		
Paying partner (in exchange of money/ drugs)	1. Yes	2. No			1. Always	1. Yes	2. No
					2. Sometimes		
					3. Never		
Same-sex partner	1. Yes	2. No			1. Always	1. Yes	2. No
					2. Sometimes		
					3. Never		

6. COMPLICATIONS DUE TO DRUG USE (SEE COMMENT)

Comment: Sexual, financial and legal history may be difficult to elicit at intake. Administration may be delayed until rapport and a reasonable level of confidence and trust have been established between the client and the counsellor.

6.1 Psychological details if any ☐ Yes ☐ No ☐ Unknown/decline to answer

6.2 Marital details if any ☐ Yes ☐ No ☐ Unknown/decline to answer

6.3 Familial details if any ☐ Yes ☐ No ☐ Unknown/decline to answer

6.4 Occupational details if any ☐ Yes ☐ No ☐ Unknown/decline to answer

6.5 Financial (see comment)

Average daily expenditure on substance use (in naira): _____

Primary source of financing substance use:

☐ Legal earnings
☐ Illegal activities
☐ Borrowings from family
☐ Other means
☐ Borrowings from others
☐ Not known/decline to answer

Any other relevant details:

6.6 Legal (see comment)

Usual source of primary drug (the drug with highest ASSIST score):

☐ Friends
☐ Other: _____
☐ Street dealers
☐ Not known/decline to answer
☐ Prescription/pharmacy

Nature of illegal activities:

☐ Stealing
☐ Gang activities
☐ Pick pocketing
☐ Other: _____
☐ Selling drugs
☐ None
☐ Vehicular theft
☐ Not known/decline to answer

History of incarceration: ☐ Yes ☐ No ☐ Unknown/decline to answer

Details of last incarceration:

Any legal cases pending: ☐ Yes ☐ No ☐ Unknown/decline to answer

Details of pending cases:

Ever booked under drug laws: ☐ Yes ☐ No ☐ Unknown/decline to answer

7. PSYCHOSOCIAL STATUS

7.1 Predisposing factors (Select up to 3)

- ☐ Peer influence/pressure
- ☐ Drug use in the family/relatives
- ☐ Dysfunctional family/lack of parental supervision
- ☐ Mental health disorder
- ☐ Anxiety, depression, low self-esteem
- ☐ Accessibility of drugs
- ☐ School drop out
- ☐ Deviance/antisocial or aggressive behavior
- ☐ Self-medication
- ☐ History of drug use for medical treatment
- ☐ Other: _____
- ☐ None
- ☐ Not known/decline to answer

7.2 Motivating factors (Select up to 3)

- ☐ Well-being/feeling better
- ☐ Induce sleep
- ☐ Reduce stress/feel relaxed
- ☐ Pleasure/sensation seeking
- ☐ Enhance performance
- ☐ Feel high
- ☐ Prevent boredom
- ☐ Curiosity
- ☐ To be fashionable
- ☐ Escape reality of life
- ☐ Treat disease
- ☐ Other: _____
- ☐ Not known/decline to answer

7.3 Psychosocial support

Relationship with family members	
Relationship with spouse	
Relationship with non-drug-using friends	

7.4 Source of financial support

- ☐ Own legal earning
- ☐ Own earning through illegal activities
- ☐ Family earning
- ☐ Friends
- ☐ Others (specify): _____
- ☐ Not known/decline to answer

7.5 Who will pay for counseling-related costs (in case of admission)?

- ☐ Own earnings/personal income
- ☐ Family/friends
- ☐ Employer
- ☐ Insurance
- ☐ Other(specify): _____
- ☐ Not known/decline to answer

8. HEALTH ISSUES

8.1 Ever been tested for HIV?

- ☐ Yes – in the past 12 months
- ☐ Yes – but not in the past 12 months
- ☐ No
- ☐ Not known/decline to answer

If the patient has ever been tested for HIV, please answer the following question:

8.2 Result of HIV test

- ☐ Tested positive
- ☐ Tested negative
- ☐ Results unknown
- ☐ Decline to answer

8.3 Ever been tested for hepatitis C virus (HCV)?

- ☐ Yes – in the past 12 months
- ☐ Yes – but not in the past 12 months
- ☐ No
- ☐ Not known/decline to answer

If the patient has ever been tested for HCV, please answer the following question:

8.4 Result of HCV test

- ☐ Tested positive
- ☐ Tested negative
- ☐ Results unknown
- ☐ Decline to answer

8.5 Ever been diagnosed with any of the following? (Select up to 3)

- ☐ Cardiovascular disease
- ☐ Diabetes
- ☐ Respiratory disease
- ☐ Mental health problems
- ☐ Hypertension
- ☐ Liver disease
- ☐ Tuberculosis
- ☐ HIV
- ☐ Sickle cell disease
- ☐ Other (specify)_____
- ☐ No other diagnosis besides the substance use disorder
- ☐ Not known/decline to answer

9. ABSTINENCE ATTEMPTS

9.1 Ever attempted to give up drug use ☐ Yes ☐ No ☐ Unknown

9.2 If yes, details of previous abstinence attempts

Year of attempt	Duration of abstinence (number of months)	Type of help/ intervention	Reasons of relapse

10. TREATMENT ATTEMPTS

10.1 Any previous treatment for drug abuse / dependence ☐ Yes ☐ No ☐ Unknown

10.2 If client reports any previous treatment, details of that treatment:

Year of treatment	Duration of treatment (number of months)	Type of treatment/ interventions	Reasons of relapse

10.3 If client has previously gone through treatment, answer questions on opioid substitution treatment (OST):

Any previous OST received? ☐ Yes – ever been in OST ☐ Not known/decline to answer
☐ No – never been in OST

10.4 If ever been in OST, age at first OST: ☐☐

11. MOTIVATION

Reasons for wanting to quit:

Recent significant abstinence attempts **1. Yes** **2. No**

ASSESSING MOTIVATION (Based on READINESS TO CHANGE QUESTIONNAIRE)[2]

The following questions are designed to identify how you personally feel about your drug use right now. Please think about your current situation and drug-use habits, even if you have given up drug use completely. Read each question below carefully and then decide whether you agree or disagree with the statements. Please select one answer to each question. If you have any problems, please ask the questionnaire administrator.

	Strongly disagree –2	Disagree –1	Unsure 0	Agree +1	Strongly agree +2	FOR OFFICE USE ONLY
1. It's a waste of time thinking about my drug use because I do not have a problem.						PC
2. I enjoy my drug use but sometimes use drugs too much.						C
3. There is nothing seriously wrong with my drug use.						PC
4. Sometimes I think I should quit or cut down on my drug use.						C
5. Anyone can talk about wanting to do something about their drug use, but I'm actually doing something about it.						A
6. I am a fairly normal user of drugs.						PC
7. My drug use is sometimes a problem.						C
8. I am actually changing my drug use habits right now (either cutting down or quitting).						A
9. I have started to carry out a plan to cut down or quit drug use.						A
10. There is nothing I really need to change about my drug use.						PC
11. Sometimes I wonder if my drug use is out of control.						C
12. I am actively working on my drug use problem.						A

Total pre-contemplation score	Total contemplation score	Total action score

- To calculate the score for each category, simply add the item scores for each category question.
- If two or more categoryscores are equal, then the category furthest along the continuum of change (pre-contemplation/ contemplation/action) represents the client's stage of change designation.

Overall grading of motivation as assessed by the counsellor:

1. Good 2. Fair 3. Poor

[2] Heather, Nick and Honekopp, Johannes (2008), A revised edition of the readiness to change questionnaire (treatment version). Addiction Research & Theory, 16 (5). pp. 421-433. ISSN 1606-6359.

Diagnosis (as per WHO ICD 10 guidelines)

ICD 10 guidelines for harmful use of substance (for reference)

- The diagnosis requires that actual damage should have been caused to the mental or physical health of the user.
- Harmful patterns of use are often criticized by others and frequently associated with adverse social consequences of various kinds. The fact that a pattern of use or a particular substance is disapproved of by another person or by society, or may have led to socially negative consequences such as arrest or marital arguments, is not in itself evidence of harmful use.
- Acute intoxication, or 'hangover', is not in itself sufficient evidence of the damage to health required for coding harmful use.
- Harmful use should not be diagnosed if dependence syndrome, a psychotic disorder, or another specific form of drug- or alcohol-related disorder is present.

ICD 10 guidelines for dependence syndrome (for reference)

- A strong desire or sense of compulsion to take the substance.
- Difficulties in controlling substance-taking behaviour in terms of its onset, termination or levels of use.
- A physiological withdrawal state when substance use has ceased or has been reduced, as evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms.
- Evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses (clear examples of this are found in alcohol- and opiate-dependent individuals who may take daily doses sufficient to incapacitate or kill nontolerant users).
- Progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects.
- Persisting with substance use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking, depressive mood states consequent to periods of heavy substance use, or drug-related impairment of cognitive functioning; efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and extent of the harm.

DIAGNOSIS OF THE CLIENT AS MADE BY THE COUNSELLOR

10. COUNSELLOR'S NOTES

Drugs use issues

Psychosocial issues

Occupational issues

Facilitating factors and barriers to recovery

11. PLAN FOR TREATMENT AND PSYCHOSOCIAL REHABILITATION

12. COMMENTS/REMARKS

13. LESSON LEARNED

Signature of the counsellor

APPENDIX 10. COUNSELLING RECORD

COUNSELLING RECORD

Client name:

Client registration/ID number:

Date of registration:

MOTIVATIONAL ENHANCEMENT

SERIAL NUMBER	DATE	ISSUES DISCUSSED	REMARKS

Attach extra sheets if necessary

COUNSELLING RECORD

Client name:

Client registration/ID number:

Date of registration:

PSYCHOEDUCATION

SERIAL NUMBER	DATE	ISSUES DISCUSSED	REMARKS

Attach extra sheets if necessary

COUNSELLING RECORD

Client name:

Client registration/ID number:

Date of registration:

RELAPSE PREVENTION

SERIAL NUMBER	DATE	ISSUES DISCUSSED	REMARKS

Attach extra sheets if necessary

COUNSELLING RECORD

Client name:

Client registration/ID number:

Date of registration:

DEALING WITH CRAVING

SERIAL NUMBER	DATE	ISSUES DISCUSSED	REMARKS

Attach extra sheets if necessary

COUNSELLING RECORD

Client name:

Client registration/ID number:

Date of registration:

STRESS MANAGEMENT

SERIAL NUMBER	DATE	ISSUES DISCUSSED	REMARKS

Attach extra sheets if necessary

COUNSELLING RECORD

Client name:

Client registration/ID number:

Date of registration:

LIFESTYLE MODIFICATIONS

SERIAL NUMBER	DATE	ISSUES DISCUSSED	REMARKS

Attach extra sheets if necessary

COUNSELLING RECORD

Client name:

Client registration/ID number:

Date of registration:

INTERPERSONAL RELATIONSHIP

SERIAL NUMBER	DATE	ISSUES DISCUSSED	REMARKS

Attach extra sheets if necessary

COUNSELLING RECORD

Client name:

Client registration/ID number:

Date of registration:

MANAGING FINANCES

SERIAL NUMBER	DATE	ISSUES DISCUSSED	REMARKS

Attach extra sheets if necessary

COUNSELLING RECORD

Client name:

Client registration/ID number:

Date of registration:

CRISIS INTERVENTION

SERIAL NUMBER	DATE	ISSUES DISCUSSED	REMARKS

Attach extra sheets if necessary

COUNSELLING RECORD

Client name:

Client registration/ID number:

Date of registration:

MINIMIZING NEGATIVE CONSEQUENCES

SERIAL NUMBER	DATE	ISSUES DISCUSSED	REMARKS

Attach extra sheets if necessary

COUNSELLING RECORD

Client name:

Client registration/ID number:

Date of registration:

FAMILY COUNSELLING

SERIAL NUMBER	DATE	ISSUES DISCUSSED	REMARKS

Attach extra sheets if necessary

COUNSELLING RECORD

Client name:

Client registration/ID number:

Date of registration:

OTHER COUNSELLING

SERIAL NUMBER	DATE	ISSUES DISCUSSED	REMARKS

Attach extra sheets if necessary

APPENDIX 11: REFERRAL REGISTER

Serial Number	Date	Name	Client registration/ ID number	Referred to	Diagnosis of the referred client	Reason for referral / remarks	Referred by (signature)

APPENDIX 12: COUNSELLING REGISTER

Serial Number	Date	Name of the client	Client registration/ ID number	Type(s) of counselling		Signature of Counsellor
				☐ Motivation enhancement ☐ Psychoeducation ☐ Relapse prevention ☐ Dealing with craving ☐ Lifestyle modifications ☐ Stress management ☐ Interpersonal relationship	☐ Managing finances ☐ Crisis intervention ☐ Minimizing negative consequences ☐ Family counselling ☐ Other	
				☐ Motivation enhancement ☐ Psychoeducation ☐ Relapse prevention ☐ Dealing with craving ☐ Lifestyle modifications ☐ Stress management ☐ Interpersonal relationship	☐ Managing finances ☐ Crisis intervention ☐ Minimizing negative consequences ☐ Family counselling ☐ Other	
				☐ Motivation enhancement ☐ Psychoeducation ☐ Relapse prevention ☐ Dealing with craving ☐ Lifestyle modifications ☐ Stress management ☐ Interpersonal relationship	☐ Managing finances ☐ Crisis intervention ☐ Minimizing negative consequences ☐ Family counselling ☐ Other	
				☐ Motivation enhancement ☐ Psychoeducation ☐ Relapse prevention ☐ Dealing with craving ☐ Lifestyle modifications ☐ Stress management ☐ Interpersonal relationship	☐ Managing finances ☐ Crisis intervention ☐ Minimizing negative consequences ☐ Family counselling ☐ Other	

NATIONAL DRUG LAW ENFORCEMENT AGENCY (NDLEA)

APPENDIX 13: DISCHARGE SUMMARY: RESIDENTIAL CLIENTS

Two copies are to be prepared. One for client and one for NDLEA records.

Client registration/ ID number (NEW)	Name	Age	Sex	Address	RESIDENTIAL registration number

Date of Admission	**Date of discharge** .....
Diagnosis	**Type of discharge** ☐ Routine ☐ Against professional advice ☐ On disciplinary grounds
Type(s) of counselling sessions received (even if once)	
☐ Motivational enhancement ☐ Psychoeducation ☐ Relapse prevention ☐ Dealing with craving ☐ Lifestyle modifications ☐ Stress management ☐ Interpersonal relationship	☐ Managing finances ☐ Crisis intervention ☐ Minimizing negative consequences ☐ Family counselling ☐ Other .....
Remarks and advice	

Signature and name of counsellor

APPENDIX 14: MONTHLY REPORTING FORM FOR COUNSELLING CENTRES

MONTHLY REPORTING FORM FOR COUNSELLING CENTRES

Name of centre	
Complete address	
Code of centre	
Name of person incharge	
Phone number	
Mobile number	
Email	
Reporting month/year	

	Male	Female	Total
Number of new clients registered by the centre			
Number of clients ADMITTED to the centre			
Number of new clients – voluntary/self			
Number of new clients – family			
Number of new clients – law enforcement			
Number of new clients – others			
Number of clients referred by the centre			
Number of clients discharged by the centre – routine			
Number of clients Discharged by the centre – APA			
Number of clients Discharged by the centre – disciplinary			
Total number of counselling sessions held at the centre			

Clients referred for rehabilitation (e.g., to NDE)

Any significant event worth reporting	

Name and signature of reporting officer .....

APPENDIX 15: NDLEA DRUG DEMAND REDUCTION: COUNSELLING FORM

1. BIODATA

Place of counselling _____

Client registration/ID number _____

Date of interview ☐☐ ☐☐ ☐☐
D D M M Y Y

Date admitted for counselling ☐☐ ☐☐ ☐☐
D D M M Y Y

Date discharged from counselling ☐☐ ☐☐ ☐☐
D D M M Y Y

Still in treatment/counselling ☐ Yes ☐ No ☐ Unknown

Type of counselling setting ☐ Residential ☐ Non-residential ☐ Unknown

Source of referral

☐ Self
☐ Family/friends
☐ Doctor/nurse
☐ Social services
☐ Workplace
☐ School
☐ NDLEA
☐ Other law enforcement/court
☐ Other: .....
☐ Not known/decline to answer

Type of admission

☐ Voluntary
☐ Involuntary
☐ Not known/decline to answer

Surname _____

Maiden name _____

First name _____

Sex ☐ Male ☐ Female

Age ☐☐ Years

Year of birth ☐☐☐☐
Y Y Y Y

Place of birth (city/town/village) _____

Current accommodation

☐ Home/stable accommodation
☐ Dormitory/institution
☐ No stable accommodation
☐ Other: .....
☐ Not known/decline to answer

Current living arrangement

☐ Alone
☐ With parents/family/relatives
☐ With spouse/partner
☐ With friends
☐ With children (no spouse)
☐ Other: .....
☐ Not known/decline to answer

1. BIODATA (contd)

Area of residence

- ☐ Urban
- ☐ Semi-urban
- ☐ Rural
- ☐ Not known/decline to answer

Education

- ☐ No formal education
- ☐ Some primary education (not completed)
- ☐ Completed primary education
- ☐ Some secondary education
- ☐ Completed secondary education
- ☐ Some tertiary/graduate
- ☐ Completed tertiary/graduate
- ☐ Postgraduate
- ☐ Other: .....
- ☐ Not known/decline to answer

Employment status

- ☐ Regular employment
- ☐ Occasional employment
- ☐ Pupil/student
- ☐ Unemployed
- ☐ Housewife
- ☐ Other (specify) .....
- ☐ Not known/decline to answer

Profession/occupation ☐

Monthly income (self, in naira)

- ☐ <10, 000
- ☐ 10,000 – 20,000
- ☐ 20,000 – 30,000
- ☐ 30,000 – 40,000
- ☐ 40,000 – 50,000
- ☐ >50,000
- ☐ Not known/decline to answer

Marital status

- ☐ Single (never married)
- ☐ Married
- ☐ Widow/widower
- ☐ Divorced/separated
- ☐ Not known/decline to answer

Number of living children ☐☐

Family type

- ☐ Monogamous
- ☐ Polygamous
- ☐ Single parent
- ☐ Not known/decline to answer

Religion ☐

Nationality ☐

2. DETAILS OF SUBSTANCE USE, INJECTION AND COMPLICATION DUE TO DRUG USE

Substance (*)	Code of the substance (**)	Name of the substance (1)	Use in the last 3 months (Y/N)	Use in the last 30 days (Y/N)	Usual route of administration in the last 30 days (***)					Current pattern/ frequency of use in the last 30 days (****)					Age at first use
1. Primary drug					1	2	3	4	5	1	2	3	4	5	
2. Secondary drug					1	2	3	4	5	1	2	3	4	5	
3. Secondary drug					1	2	3	4	5	1	2	3	4	5	
4. Secondary drug					1	2	3	4	5	1	2	3	4	5	
5. Secondary drug					1	2	3	4	5	1	2	3	4	5	

(*) Only oneprimary drug and up to foursecondary drugs can be reported. It is not possible to declare tobacco as a primary drug (only as secondary).

(**) 1. alcohol 2. cannabis 3. cocaine 4. Crack cocaine 5. stimulants other than cocaine 6. opioids 7. sedative-hypnotics (barbiturates, benzodiazepines) 8. hallucinogens 9. organic solvents/glue 10. other (excluding tobacco) (specify name in column (1)).
For some drug categories, please specify the substance according to the coding:

5. stimulants other than cocaine: 5.1 amphetamines, 5.2 methamphetamines, 5.3 MDMA and derivatives, 5.4 synthetic cathinones, 5.5 other stimulants (specify name in column (1)).
6. opioids: 6.1 heroin, 6.2 methadone misused, 6.3 buprenorphine misused, 6.4 fentanyl misused, 6.5 tramadol misused, 6.6 pentazocine misused, 6.7 codeine misused, 6.8 other opioids (specify name in column (1)).
7. sedative-hypnotics: 7.1 barbiturates misused, 7.2 benzodiazepines misused (e.g.: Rohypnol), 7.3 GHB/GBL, 7.4 other sedative-hypnotics misused (specify name in column (1)).
8. hallucinogens: 8.1 LSD, 8.2 ketamine, 8.3 other hallucinogens (specify name in column (1)).

For secondary drugs, it is possible to also declare: 11. tobacco.

(***) Specify the usual route of administration route in the last 30 days: 1=swallow/eat/drink, 2=smoke/inhale, 3=snort/sniff, 4=inject, 5=other (specify).

(****) Specify the frequency of use in the last 30 days: 1=daily, 2=4-6 days per week, 3=2-3 days perweek, 4=once a week or less, 5=not used in the past month.

ASSIST score

Tobacco			Cocaine		
Alcohol			Amphetamines-type stimulants		
Cannabis			Inhalants		
Opioids			Hallucinogens		
Sedatives or sleeping pills			Other:		

Polydrug use problem existing ☐ Yes ☐ No ☐ Not known/decline to answer

3. INJECTING PRACTICES

Ever injected

- ☐ Never injected
- ☐ Injected but not in the last 12 months
- ☐ Injected in the last 12 months but not in the last 30 days
- ☐ Currently injecting (last 30 days)
- ☐ Not known/decline to answer

If injected, age at first injection ☐☐ Years

If injected, ever shared any equipment

- ☐ Never shared
- ☐ Shared but not in the last 12 months
- ☐ Shared in the last 12 months but not in the last 30 days
- ☐ Currently sharing (last 30 days)
- ☐ Not known/decline to answer

4. SEXUAL HISTORY

History of paid sex ☐ Yes ☐ No ☐ Not known

5. COMPLICATIONS DUE TO DRUG USE

Primary source of financing substance use

- ☐ Legal earning
- ☐ Borrowing from family
- ☐ Borrowing from others
- ☐ Illegal activities
- ☐ Other means
- ☐ Not known

Usual source of drug (for the drug with highest ASSIST score)

- ☐ Friends
- ☐ Street dealers
- ☐ Prescription/pharmacy
- ☐ Other: .....
- ☐ Not known/decline to answer

Nature of illegal activities

- ☐ Stealing
- ☐ Pick pocketing
- ☐ Selling drugs
- ☐ Vehicular theft
- ☐ Gang activities
- ☐ Other: .....
- ☐ None
- ☐ Not known/decline to answer

History of incarceration ☐ Yes ☐ No ☐ Not known

Ever booked under drug law ☐ Yes ☐ No ☐ Not known

6. PSYCHOSOCIAL STATUS

Predisposing factors (Select up to 3)

- ☐ Peer influence/pressure
- ☐ Drug use in the family/relatives
- ☐ Dysfunctional family/lack of parental supervision
- ☐ Mental health disorder
- ☐ Anxiety, depression, low self-esteem
- ☐ Accessibility to drugs
- ☐ School drop out
- ☐ Deviance/antisocial or aggressive behavior
- ☐ Self-medication
- ☐ History of drug use for medical treatment
- ☐ Other: .....
- ☐ None
- ☐ Not known/decline to answer

Motivating factors (Selectup to 3)

- ☐ Well-being/feeling better
- ☐ Induce sleep
- ☐ Reduce stress/feeling relaxed
- ☐ Pleasure/sensation seeking
- ☐ Enhance performance
- ☐ Feel high
- ☐ Prevent boredom
- ☐ Curiosity
- ☐ To be fashionable
- ☐ Escape reality of life
- ☐ Treat disease
- ☐ Other: .....
- ☐ Not known/decline to answer

Who will pay for counseling-related costs (in case of admission)

- ☐ Own earnings/personal income
- ☐ Family/friends
- ☐ Employer
- ☐ Insurance
- ☐ Other: .....
- ☐ Not known/decline to answer

7. HEALTH ISSUES

Ever tested for HIV?

- ☐ Yes – in the past 12 months
- ☐ Yes – but not in the past 12 months
- ☐ No
- ☐ Not known/decline to answer

If tested for HIV, result of the HIV test

- ☐ Tested – positive
- ☐ Tested – negative
- ☐ Results unknown
- ☐ Decline to answer

Ever tested for hepatitis C virus (HCV)?

- ☐ Yes – in the past 12 months
- ☐ Yes – but not in the past 12 months
- ☐ No
- ☐ Not known/decline to answer

If tested for HCV, result of the HCV test

- ☐ Tested – positive
- ☐ Tested – negative
- ☐ Results unknown
- ☐ Decline to answer

7. HEALTH ISSUES (contd)

Ever diagnosed for any of the following (select up to 3)

- ☐ Cardiovascular disease
- ☐ Diabetes
- ☐ Respiratory disease
- ☐ Mental health problems
- ☐ Hypertension
- ☐ Live disease
- ☐ Tuberculosis
- ☐ HIV
- ☐ Sickle cell disease
- ☐ Other (specify): _____
- ☐ No other diagnosis besides the substance use disorder
- ☐ Not known/decline to answer

8. TREATMENT ATTEMPTS

Any previous treatment for drug abuse/ dependence ☐ Yes ☐ No ☐ Not known

If previously treated, number of times in treatment ☐☐ Times

If previously treated, any previous opioid substitution treatment (OST) received ☐ Yes ☐ No ☐ Not known

If ever been in OST, age at first OST ☐☐ Years

9. MOTIVATION AND DIAGNOSIS

Recent significant abstinence attempts ☐ Yes ☐ No

Overall grading of motivation ☐ Good ☐ Fair ☐ Poor

Diagnosis (ICD 10)

10. FOLLOW UP

Intervention ☐ No intervention ☐ Counselling ☐ Referral

In case of counselling, please provide details (setting, duration, etc.)

Assessment at discharge

11. COMMENTS/REMARKS

12. LESSON LEARNED