

The Addiction Counselor's Desk Reference

**Robert Holman Coombs
William A. Howatt**



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John Wiley & Sons, Inc.

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For
CARLA CRONKHITE VERA,
our esteemed associate at UCLA,
with appreciation for all you have contributed.

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PREFACE

We prepared this book to provide addiction counselors—and others whose work involves them with addicted people—with useful, easily accessible, up-to-date information.

Since addicted clients challenge even the most highly skilled counselor, every available skill and resource helps. How does one help a client who does not think he needs help? Of the more than 19 million Americans who currently use illicit drugs (8.3% of the U.S. population 12 years of age or older) and the 54 million who are regular binge drinkers, *many think they do not need help* (Office of Applied Studies, 2003). According to the federal government's *Household Survey* (recently renamed the *National Survey on Drug Use and Health*), more than 94% of those with substance abuse disorders thought they did not need treatment. "A denial gap of over 94% is intolerable," noted John Walters, White House Director of National Drug Control Policy (<http://www.hhs.gov/neews/2003pres/20030905.html>, 2003, para 4).

The federal Office of Management and Budget estimates that drug abuse costs the United States more than \$300 billion a year. Substance abuse devitalizes American industries, where an estimated \$60 billion to \$100 billion is lost each year in work productivity—absenteeism, drug-related accidents, medical claims, and theft. Other drug-related problems include family disintegration, health care costs, and drug-related crime. Because of the problem's enormity, a veritable army of personnel—some better trained than others—now make their living dealing, directly or indirectly, with addicted people. More than 115,000 drug counselors make up the combined membership of *only two* of several prominent drug-counseling organizations. Drug counselors work in private treatment facilities (both inpatient and outpatient), detoxification facilities, halfway houses, prisons and jails, the courts, schools, hospitals, churches, and governmental facilities.

A resource book describing programs and giving contact information can help counselors locate appropriate treatment centers for their addicted clients. The *Household Survey* found that of the 362,000 Americans who recognized they needed treatment for substance abuse, 266,000 had tried to find treatment for alcohol abuse, but were unable to do so, and another 88,000 had been unsuccessful in getting treatment for an addiction to other psychoactive drugs. "There is no other medical condition for which we would tolerate such huge numbers unable to obtain the treatment they need," said Tommy G.

Thompson, HHS Secretary during George W. Bush's first administration (<http://www.hhs.gov/neews/2003pres/20030905.html>, 2003, para 4). Could this problem be ameliorated if all counselors had easily accessible information to direct everyone who comes to them for help—men, women, adolescents, family members, older adults, people from diverse cultures, and gays and lesbians—to the most appropriate treatment center or support groups? With fingertip access to such basic information—heretofore scattered among hundreds of publications and Internet web sites—counselors can more quickly and efficiently help their clients.

Until fairly recently, an addiction was perceived as a problem of imbibing alcohol and other chemical substances. But advances in neuroscience show that other behaviors besides using psychoactive drugs affect the pleasure centers of the brain in the same way as psychoactive chemicals. Today's addiction counselors must be sophisticated about sex addiction; compulsive gambling, working, and buying; food and body-image addiction; and Internet addiction (Coombs, 2004). Counselors having access to practical descriptions and contact information about programs that address these overlapping problems will greatly improve their effectiveness (Carnes, Murray, & Charpentier, 2004).

To make addiction counseling even more difficult, some addicted clients have co-existing psychiatric disorders. According to federal statistics, more than 4 million adults concurrently have a substance use disorder *and* serious mental illness. In 2002, 8.3% of all adults (17.5 million people) had a serious mental illness. Adults who used illicit drugs are more than twice as likely to have serious mental illness as those who do not (Office of Applied Studies, 2003). Addiction counselors relatively unsophisticated about the variety and scope of these disorders can find a quick overview in this book of the American Psychiatric Association's latest edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*.

In each section of this book, we have tried to include everything that will be practical and useful to an addiction counselor, and screened out everything that is not.

This book is organized into eight parts, each covering key practical topics. Part I, "Abused Substances and Their Effects," describes the various drugs of abuse, their street and pharmaceutical names, medical uses, methods of administration, indices of misuse, health consequences, overdosing, withdrawal symptoms, and physical and psychological dependency. It includes the five federal schedules for psychoactive drugs, explains how the U.S. Drug Enforcement Administration (DEA) determines these standards, and discusses controlled substance analogues.

Part II, "Conceptual Tools," highlights the basic concepts that underlie addiction: the various ways addiction has been defined and the three C's that characterize all addictions: compulsive use, loss of control, and continued use despite adverse consequences. Classification schemes are reviewed, such as the treatment stages that addicts typically pass through, the various levels of drug use, and the stages of predictable behavioral change. Prevention principles (including relapse prevention) are also explored.

Part III, "Treatment Planning and Assessment Resources," reviews treatment planning, screening and assessment, diagnostic summaries, treatment, client placement criteria, writing a treatment plan, and the various levels of care. This section provides assessment tools for diagnosing alcohol and drug abuse, instruments for assessing other addictive disorders, mental health measurements, recovery assessments, and multiple measures resources. Also included is information on dual diagnosis (i.e., addicts with diagnosable psychiatric illness) from *DSM-IV-TR*.

Part IV, "Clinical Skills and Resources," reviews the approaches of key clinical theorists, describes basic counseling techniques and clinical microskills, and provides homework assignments and exercises designed to enhance a client's health and stress management capabilities.

Part V, "Treatment Resources," details the various recovery tools and provides directories of recovery programs. This section also identifies harm-reduction programs and support groups (twelve-step and twelve-step alternatives) that are available to assist women, adolescents, family members of addicts, dually diagnosed patients, HIV/AIDS patients, and gays and lesbians who suffer from an addictive disorder.

Part VI, "Professional Management," discusses clinical management skills and responsibilities such as record keeping (sample forms are provided). Practical information is given about managing challenging issues (e.g., clinical crises, difficult clients) and dealing with legal and ethical dilemmas.

Part VII, "Career Enhancement Resources," offers information to enhance the counselor's career: the basic knowledge, skills, and attitudes expected of an addiction counselor, characteristics of a good training program, an overview of certification and licensing, continuing education requirements, and contact information for continuing education providers. Also included are practical business decisions (such as setting and discussing fees and making referrals). Pointers for developing a personal wellness plan and obtaining malpractice insurance are also featured.

Part VIII, "Information Resources," describes and gives specific contact information about organizations that offer drug abuse and addiction counseling services. This section provides an overview of federal, state, educational, professional, and grassroots organizations that deal with addictions. It identifies and describes grant funding resources and publications in the addictions, and provides information about policy organizations whose views differ from these of the federal government.

The Glossary lists the most frequently used terms in drug abuse and addiction.

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PART I

Abused Substances and Their Effects

Part I describes drugs that are frequently abused: opiates, depressants, stimulants, cannabis, hallucinogens, inhalants, steroids (anabolic-androgenic) and designer drugs. An easy-to-use reference table of these psychoactive drugs covers their common name, pharmaceutical name, street names, medical uses, methods of administration, indices of misuse, health consequences (both short- and long-term effects), overdosing, withdrawal symptoms, and physical and psychological dependency. The Control Schedules for Abused Drugs describes the five schedules that are controlled and monitored by the U.S. Drug Enforcement Administration (DEA).

ABUSED DRUGS

- Opiates
- Depressants
- Stimulants
- Cannabis
- Hallucinogens
- Inhalants
- Steroids (Anabolic-Androgenic)
- Designer Drugs

PSYCHOACTIVE DRUGS QUICK SCREEN TABLE

- Common Name
- Pharmaceutical Name
- Street Names
- Medical Uses
- Methods of Administration
- Indices of Misuse

Short-Term Effects on Health

Long-Term Effects on Health

Overdosing

Withdrawal Symptoms

Physical Dependency

Psychological Dependency

CONTROL SCHEDULES FOR ABUSED DRUGS

Prescribing Drugs

The Five Control Schedules

Controlled Substance Analogues

Government Decision Making

ABUSED DRUGS¹

OPIATES

Opiates (also called narcotics) include heroin, an illicit substance, and such prescription medications as morphine, Demerol, codeine, fentanyl, and OxyContin (used to treat severe pain). Once in the bloodstream, opiates can have a variety of negative side effects—labored breathing, nausea, vomiting, difficulty urinating, constipation, abdominal pain, dizziness, blood disorders, anxiety, mood changes, restlessness, and skin rashes.

HEROIN

A naturally occurring substance extracted from the seedpod of certain varieties of poppy plants, heroin was commercially marketed in 1898 as a new pain remedy. It was used medicinally until 1914 when, under the Harrison Narcotic Act, it was designated as a controlled substance. A highly addictive Schedule I drug, heroin is the most abused and rapidly acting opiate. (See “Controlled Schedules for Abused Drugs” later in Part I.)

¹This section was adapted from www.whitehousedrugpolicy.gov and www.drugabuse.gov/DrugPages; National Institute on Drug Abuse (NIDA; May 1999a; #99-4342); Simoni-Wastila and Strickler (2004); NIDA (2000); U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies (2001).

Usually sniffed/snorted or smoked, heroin is also injected intravenously (IV). The greatest intensity and most rapid onset of euphoria (7 to 8 seconds) result from IV use; when smoked, peak effects are usually felt within 10 to 15 minutes.

After ingestion, heroin crosses the blood-brain barrier, converts to morphine, and rapidly binds to opioid receptors in the brain. Users feel a “rush,” a surge of pleasurable sensations and euphoria varying in intensity depending on the quantity and mode of ingestion. This rush is usually accompanied by a warm flushing of the skin, dry mouth, and a heavy feeling in the user’s limbs. Nausea, vomiting, and severe itching may follow as well as drowsiness for several hours.

Heroin abuse is associated with serious health conditions, including fatal overdose, collapsed veins, cardiac depression, and blood-borne infectious diseases from sharing needles (HIV/AIDS and hepatitis). Health and social consequences—HIV/AIDS, violence, tuberculosis, fetal effects, crime, and disruptions in family, workplace, and educational environments—have a devastating impact on society, costing billions of dollars each year.

Chronic heroin users may also develop infection of the heart lining and valves, abscesses, liver disease, and pulmonary complications, including pneumonia. Because heroin abusers do not know the actual strength of the drug or its true contents, they are at great risk of overdose (slow and shallow breathing, convulsions, coma) or death. Street heroin is often cut with substances, such as sugar, starch, powdered milk, strychnine, or other types of drugs. These additives may not dissolve when injected into a user’s system and can clog blood vessels that lead to the lungs, liver, kidneys, or brain, infecting or killing patches of cells in these vital organs.

Addiction, the most detrimental long-term effect of chronic heroin use, involves compulsive, drug-seeking behaviors. As higher doses are used, neurochemical and molecular changes in the brain reinforce physical dependence.

Within a few hours after ingestion, withdrawal may occur, manifested by drug craving, restlessness, muscle and bone pain, and vomiting. Major withdrawal symptoms peak between 48 and 72 hours after the last dose and subside after about a week.

PRESCRIPTION OPIATES

The abuse potential of injected morphine is just as high as that of heroin. Another commonly used and abused agent, fentanyl, exists in two formulations: (1) an injectable form used with other agents during induction of anesthesia, and (2) a skin patch used as a sustained-release form to treat pain.

The higher potency prescription opioids such as morphine, fentanyl, and meperidine (Demerol) usually appear as prepared injection forms that have been diverted from legal medical use. They may be injected either intravenously or subcutaneously (skin popping). The lower potency prescription opioids (codeine, propoxyphene) usually come in pill form and are taken orally.

Soon after ingestion, opioids cross the blood-brain barrier to produce a rush, or feelings of euphoria. The intensity of these feelings depends on how much

drug was used and mode of ingestion. After the initial effects wear off, users become sleepy.

Regardless of how ingested, opioid use can cause respiratory complications and death through respiratory or cardiac depression. Physical dependence on narcotics develops dramatically as soon as regular use begins, whether from appropriate clinical use or self-administration. Narcotic withdrawal symptoms include restlessness, irritability, nausea, diarrhea, sweating, and gooseflesh.

DEPRESSANTS

Depressants include alcohol and prescription drugs taken orally, such as barbiturates, methaqualone, tranquilizers, chloral hydrate, and glutethimide. Prescribed to help relieve anxiety, irritability, and tension, depressants are informally called “downers” because they calm users down. With regular use, they have a high potential for abuse and development of tolerance. They produce a state of intoxication similar to alcohol, and these effects are intensified when combined with alcohol. Although small amounts cause calmness and relaxed muscles, large amounts cause slurred speech, impaired judgment, and loss of motor coordination; doses that are even larger may cause decreased breathing rate, coma, and death.

ALCOHOL

Alcohol is produced by fermentation that occurs when yeast reacts with the sugar in grains, fruit, or vegetable juice. Products are wine, beer, and distilled drinks.

Some beverages have more alcohol content than others (beer has about 4.5% alcohol; table wines average from 11% to 14%; “fortified,” or dessert, wines have 16% to 20%; distilled spirits range from 40% to 50%). However, in a normal portion, each drink (i.e., 12 ounces of beer, 5 ounces of wine, and 1½ ounces of distilled spirits) contains approximately the same amount of alcohol.

Because alcohol is a depressant, the more one drinks, the more depressed and adversely affected one’s brain activity becomes. The cerebrum, the part of the brain that controls advanced functions such as recognition, vision, reasoning, and emotion, is slowed. At the lowest levels, alcohol impacts inhibitions, and affects judgment. As alcohol levels increase, vision, movement, and speech are impaired (at a blood alcohol level of 0.01% to 0.30%). Alcohol also affects the part of the brain that coordinates movement, causing problems with coordination, reflexes, and balance (at a blood alcohol level of 0.15% to 0.35%). The medulla, the part of the brain that controls basic survival functions such as breathing and heartbeat, is also affected, reducing the brain’s ability to control respiration and heart rate. Death can result when blood alcohol levels reach 0.30.

When a person drinks an alcoholic beverage, about 20% is absorbed in the stomach and 80% in the small intestine. Alcohol absorption depends on:

- *The concentration of alcohol in the beverage:* The greater the concentration, the faster the absorption.

- *The type of drink:* Carbonated beverages tend to speed up the absorption of alcohol.
- *Whether the stomach is full or empty:* Food slows down alcohol absorption.

Alcohol leaves the body in three ways: (1) the kidneys eliminate 5% of alcohol in the urine, (2) the lungs exhale 5% of alcohol (detected by Breathalyzer and similar devices), and (3) the liver chemically breaks down the remaining 90% of alcohol into acetic acid.

The liver can oxidize only a certain amount of alcohol each minute; for example, the oxidation rate of alcohol in a person weighing 150 pounds is about 7 grams of alcohol per hour. This is equivalent to about $\frac{3}{4}$ of an ounce of distilled spirits, $2\frac{1}{2}$ ounces of wine, or $7\frac{3}{4}$ to 8 ounces of beer per hour. If a person drank no more than $\frac{3}{4}$ of an ounce of whiskey or half a bottle of beer every hour, the alcohol would never accumulate in the body; the person would feel little of the effects and would not become intoxicated. Oxidation continues until all the alcohol has left the body. Since the body can remove only a small amount of alcohol at a time, those who choose to drink are advised to drink slowly.

Alcohol affects virtually every organ system in the body. Both acute and chronic intoxication have unique consequences on physiology and quality of life.

Alcohol increases the risk for injuries through the impairment of cognitive and psychomotor functioning. It decreases reaction time and impairs sensory processing, motor control, attention, and the use of seat-belt devices. Drunken driving accidents kill about 16,000 people per year, with many more than that number injured. Alcohol also increases the risk for injury or death from fire and suicide. It causes social and legal problems, interacts with medications, and creates birth defects as well as the long-term health problems listed here:

- *Liver disease:* Epidemiological data show that alcohol abuse is the leading cause of liver-related mortality in the United States.
- *Cardiovascular disease:* The deterioration of heart muscle (alcoholic cardiomyopathy) is one of the most serious consequences of chronic heavy drinking. Similarly, there is a well-documented association between heavy alcohol consumption and increased blood pressure, or hypertension.
- *Cancer:* Those who consume more than three drinks per day (21 drinks per week) have an almost tenfold higher risk of esophageal cancer than do those who drink less than one drink per day.

Physiological dependence on alcohol leads to alcoholism—a condition with the following symptoms:

- *Craving:* A strong need, or urge, to drink
- *Loss of control:* Not being able to stop drinking once drinking has begun
- *Tolerance:* The need to drink greater amounts of alcohol to get “high”
- *Physical dependence:* Withdrawal symptoms, such as nausea, sweating, shakiness, and anxiety after stopping drinking

Alcohol abuse and alcoholism cut across socioeconomic status, gender, race, and nationality. Nearly 14 million people in the United States—1 in every 13 adults—abuse alcohol or are alcohol dependent. In general, more men than women are alcohol dependent or have alcohol problems. Those who start drinking at age 14 or younger greatly increase their chances of having alcohol problems in their adult lives.

BARBITURATES/SEDATIVE-HYPNOTICS

Barbiturates, taken orally as pills or sometimes in liquid form or suppositories, include secobarbital (Seconal) and pentobarbital (Nembutal). Like alcohol, these chemicals affect the central nervous system (CNS) by slowing or decreasing neurological activity in the mind and body.

Short-term effects, lasting 15 hours after ingestion, include relief of tension and anxiety, sleepiness, feeling of intoxication, slurred speech, memory impairment, emotional instability, and inability to control simple bodily functions. Long-term effects are chronic tiredness, general lack of coordination, vision problems, dizziness, slowed reflexes and response time, sexual dysfunction, menstrual irregularities, and breathing disorders.

Barbiturates are prescribed for treatment of such disorders as sleeplessness, anxiety, tension, and epileptic seizures. These drugs also are used illegally for euphoria and relaxation.

Barbiturates in combination with other drugs can be dangerous, especially when used with other CNS depressants such as Demerol, heroin, morphine, and codeine. It is important to be aware that any combination of these is often lethal. Antihistamines, found in most allergy, cold, and sinus medicines, are another type of CNS depressant that can cause respiratory arrest when taken with barbiturates.

Since barbiturates produce both physical and psychological dependence, continued use may result in tolerance (i.e., one needs ever larger doses to achieve the desired effects). When regular users suddenly discontinue these drugs, withdrawal symptoms may include restlessness, insomnia, anxiety, or even convulsions and death. Psychologically dependent users feel they need the drugs to function. Procuring them then becomes an all-encompassing endeavor.

BENZODIAZEPINES SUCH AS DIAZEPAM (VALIUM) ABUSE

Antianxiety medications (also known as anxiolytics, tranquilizers, or sleeping pills) are benzodiazepines. They come in pills of various colors, in liquid form, or in suppositories. Typically prescribed for anxiety, acute stress reactions, and panic attacks, the more sedating benzodiazepines, such as triazolam (Halcion) and estazolam (ProSom), are prescribed for short-term treatment of sleep disorders.

During the first few days of taking a prescribed CNS depressant, a person usually feels sleepy and uncoordinated, but as the body becomes accustomed to