MEEHAN INSTITUTE

FOR
COUNSELOR TRAINING

SPRING 2018

Meehan Institute

Welcome to the Spring of 2018 Meehan Institute for Counselor Training class. For the next 12 weeks you will have the opportunity to prepare yourself for what will hopefully be a long and joyful career in the field of alcohol and drug abuse counseling. The staff at Insight will do everything in our power to share with you our experience in counseling and how to deal with the personal issues that come up when working in this field. We realize that you have no frame of reference for what to expect so please ask any questions and voice any concerns that come up. It is our responsibility to respond to your needs and it is your responsibility to communicate your needs. Above all apply the principles of honesty, open mindedness, and willingness in order to maintain the level of humility necessary to learn everything that is available to you. We are glad you are here and hope you enjoy your experience.

God Bless,

Clint Stonebraker
Executive Director
The Meehan Institute / The Insight Program

MEEHAN INSTITUTE
FOR CONSELOR TRAINING

MISSION STATEMENT

Dedicated to excellence in the education of professional addiction counselors. Committed to following the principals of the Twelve Steps and the belief in God to enable our clients and us to achieve recovery.

Resolved to bringing unity, love, and understanding to all those with whom our lives come in contact. Devoted to our personal recovery first, and the need to be accountable to God and those we serve. Following the principles of Enthusiastic Recovery and strictly adhering to the highest ethical standards of our profession. Being willing to live in "a glass house" in our personal and professional lives. Maintaining always that our clients' best interest and welfare come first.

A SACRED PLACE

"I perform at my best when the gray is gone, where there is minimal tolerance for mediocrity, where the philosophy or mission is clearly stated, where my beliefs are challenged, where praise is minimal but authentic and heartfelt, where the truth prevails, where people have worked on themselves to be the best women/men they can be, and most important to me, an environment where I cam grow beyond what I thought I was capable of."

Meehan Institute Instructors

Glenn Schendel CAC II, CSAC, II CADC, CCS: Alternate Clinical Supervisor, Volunteer Senior Counselor of The Insight Program. Recovery Residence Manager of Step Two South and Step One. Administrator for the Meehan Institute for Counselor Training.

Clint Stonebraker CAC II, CSAC, CADC, LISAC, CCS: Executive Director of Stonebraker's Inc.

Steven Jaffe, M.D. Board certified Child and Adolescent Psychiatrist, 30 years experience as a Child and Adolescent Psychiatrist, President of the Georgia Council for Child and Adolescent Psychiatry, and the Associate Professor of Child and Adolescent Psychiatry at Emory University in Atlanta, Georgia.

Matt Meyer CAC I, CSAC, CADC, LISAC, CCS: Program Director, Alternate Clinical Supervisor of The Insight Program.

Frank Szachta, CRAADC, ICADC, CAC II: Executive director of the Cornerstone Program in Denver Colorado.

Amy Weiland CRADC, ICADC, CRPS, CPS: Director of the Crossroads Program in St. Louis Missouri.

Josh Azevedo LISAC, CAC: Executive Director of the Pathway Program in Gilbert Arizona

Steve Winkelmann CSAC: Director of the Charlotte N.C. Insight Program

The 12 Core Functions of the Substance Abuse Counselor and the 46 Global Criteria

Certain credentialing organizations including the *International Certification & Reciprocity Consortium* use the "12 Core Functions of the Substance Abuse Counselor" as a reference for skills utilized by the addiction professional. They are as follows:

1. Screening

The process by which the client is determined appropriate and eligible for admission to a particular program.

1. Evaluate psychological, social, and physiological signs and symptoms of alcohol and other drug use and abuse.
2. Determine the client's appropriateness for admission or referral.
3. Determine the client's eligibility for admission or referral.
4. Identify any coexisting conditions (medical, psychiatric, physical, etc.) that indicate the need for additional professional assessment and /or services.
5. Adhere to applicable laws, regulations, and agency policies governing alcohol and other drug abuse services.

2. Intake

The administrative and initial assessment procedures for admission to a program.

6. Complete required documents for admission to the program.
7. Complete required documents for program eligibility and appropriateness.
8. Obtain appropriately signed consents when soliciting from or providing information to outside sources to protect client confidentiality.

3. Orientation

Describing to the client the general nature and goals of the program; the rules governing client conduct and infractions that can lead to disciplinary action or discharge from the program; the hours during which services are available; the treatment costs, if any, that are to be borne by the client, if any; and the client's rights.

9. Provide an overview to the client by describing program goals and objectives for client care.
10. Provide an overview to the client by describing program rules, and client obligations and rights.
11. Provide an overview to the client of program operations.

4. Assessment

Those procedures by which a counselor / program identifies and evaluates and individual's strengths, weaknesses, problems, and needs for the development of the treatment plan.

12. Gather relevant history from the client including but not limited to alcohol and other drug abuse using appropriate interview techniques.
13. Identify methods and procedures for obtaining corroborative information from significant secondary sources regarding the client's alcohol and other drug abuse psychosocial history.
14. Select appropriate assessment tools. 15. Explain to the client the rationale for the use of assessment techniques in order to
facilitate understanding. 16. Develop a diagnostic evaluation of the client's substance abuse and any coexisting conditions based on the results of all assessments in order to provide an integrated approach to treatment planning based on the client's strengths, weaknesses, and identified problems and needs.

5. Treatment Planning

The process in which the counselor and the client identify and rank problems resolution, establish agreed upon immediate and long-term goals, and decide on the treatment methods and resources to be used.

17. Explain assessment results to the client in an understandable manner. 18. Identify and rank problems based on individual client needs in the written treatment
plan.
19. Formulate agreed upon immediate and long-term goals using behavioral terms in the written treatment plan.
20. Identify the treatment methods and resources to be utilized as appropriate for the individual client.

6. Counseling

The utilization of special skills to assist individuals, families, or groups in achieving objectives through of a problem and its ramifications; examination of attitudes and feelings; consideration of alternative solutions; and decision making.

21. Select the counseling theories that apply.
22. Apply techniques to assist the client, group, and/or family in exploring problems and ramifications.
23. Apply techniques to assist the client, group, and/or family in examining the client's behavior, attitudes, and/or feelings if appropriate in the treatment setting. 24. Individualize counseling in accordance with cultural, gender, and lifestyle
differences.
25. Interact with the client in an appropriate therapeutic manner.
26. Elicit alternative solutions and decisions from the client.
27. Implement the treatment plan.

7. Case Management

Activities intended to bring services, agencies, resources, or people together within a planned framework of action toward the achievement of established goals. It may involve liaison activities and collateral contacts.

28. Coordinate services for client care.
29. Explain the rationale of case management activities to the client.

8. Crisis Intervention

Those services which respond to an alcohol and / or other drug abuser's needs during acute emotional and / or physical distress.

30. Recognize the elements of the client crisis
31. Implement an immediate course of action appropriate to the crisis.
32. Enhance overall treatment by utilizing crisis events.

9. Client Education

Provision of information to individuals and groups concerning alcohol and other drug abuse and the available services and resources.

33. Present relevant alcohol and other drug use/abuse information to the client through formal and/or informal processes.
34. Present information about available alcohol and other drug services and resources.

10. Referral

The identification of client's needs that cannot be met by the counselor or agency and assisting the client to use the support system and community resources available.

35. Identify needs and/or problems that the agency and/or counselor cannot meet. 36. Explain the rationale for the referral to the client.
37. Match client needs and/ or problems to appropriate resources.
38. Adhere to applicable laws, regulations, and agency policies governing procedures related to the protection of the client's confidentiality.
39. Assist the client in utilizing the support systems and community resources available.

11. Reports & Record Keeping

Charting the results of the assessment and treatment plan; writing reports, progress notes, discharge summaries, and other client - related data.

40. Prepare reports and relevant records integrating available information to facilitate the continuum of care.
41. Chart pertinent ongoing information pertaining to the client.
42. Utilize relevant information from written documents for client care.

12. Consultation

Relating with counselors and other professionals in regard to client treatment (services) to assure comprehensive quality care for the client.

43. Recognize issues that are beyond the counselor's base of knowledge and/or skill.
44. Consult with appropriate resources to ensure the provision of effective treatment services.
45. Adhere to applicable laws, regulations, and agency policies governing the disclosure of client-identifying data.
46. Explain the rationale for the consultation to the client, if appropriate.

Eight Basic Skill Groups for Addiction Counselors

Certain credentialing organizations including the *Georgia Addiction Counselors Association* use the "eight basic skill groups for addiction counselors" as a reference for skills utilized by the addiction professional. They are as follows:

1. Treatment Admission

The interaction with the client to determine suitability for alcoholism and/or drug abuse treatment. Information necessary for admission, appropriate assessment and appropriate treatment is collected; the client is oriented to the counseling process, rules, and expectations including financial responsibilities.

2. Clinical Assessment

To synthesize and interpret the data collected during the treatment admission in order to determine the client's immediate problems, internal/external resources that may facilitate or inhibit the treatment process. This assessment forms the basis for the treatment goals and program established for the client.

3. Ongoing Treatment Planning

A specific, individualized plan that addresses the therapeutic needs of the client and places him/her in the appropriate placement on the continuum of care. The client's strengths and weaknesses must be considered in setting priorities for long and short-term goals and treatment. This plan must ultimately be formulated with the client.

4. Counseling Services

The interactive process providing assistance to a client to help him/her change and maintain attitudes, beliefs, and behaviors that are more constructive. The counselor must determine the most appropriate type of assistance and the counseling intervention to
Eight Basic Skill Groups p. 1facilitate the change in behaviors, attitudes, and beliefs. Counseling services include individual, family, group and crisis intervention counseling.

5. Documentation

This encompasses maintaining and recording the results of the treatment process accurately, descriptively, and in a timely fashion. The legal document describes treatment including forms, releases, and consent forms and records.

6. Case Management

This encompasses case consultation, and interfacing with other agencies and professionals to provide the services needed by the client in order to achieve treatment goals. Consultation and case review by a clinical supervisor is a vital component of managing the counseling process and providing quality care.

7. Discharge and Continuing Care

Discharge involves the reinforcement of the changed attitudes, beliefs, and behavior's, assessment that there are no other pressing needs, following up on the client's status, making appropriate referrals for continuing services if necessary, and assessing the adequacy of support systems. Information on relapse prevention, continuation of self- help programs and other support mechanisms should be provided to the client as a part of the termination process.

8. Legal, Ethical, and Professional Growth Issues

This skill group includes the Federal or State legislation governing the counselor/client relationship, adherence to the Code of Ethics for AODA counselors are expected to follow in their practice and areas of continuing self-education and growth. The dynamic nature of the therapeutic process demands continual self-evaluation, monitoring and self- awareness.

CLASSROOM PROGRAM

The Meehan Institute is a program designed for individuals interested in a counseling career and learning in an enthusiastic environment. The Meehan Institute has been providing training since 1992.

The Meehan Institute is an approved NAADAC, GACA, and ADACB-GA education provider and its students gain many of the classroom education hours required for certification in most states. A unique characteristic of The Meehan Institute is the opportunity students have to gain valuable experience while participating in the training program. Working in conjunction with The Insight Program in Georgia students "shadow" staff members in individual and group counseling situations. This gives the students a feel for counseling while in training. The Meehan Institute does not guarantee that all students will gain employment.

SHADOW DAYS

The purpose of "Shadow Days" is for students to have the opportunity to observe counseling situations. Throughout training students will be assigned to various counselors. The counselors will determine which tasks the students will observe. The students will be informed each week which counselor they are assigned to. These tasks include: individual appointments, parent appointments, interventions, outpatient counseling, meeting facilitation, parent meeting facilitation, parent treatment meetings, function planning and facilitation, and shift counseling. While shadowing the students will not provide any counseling, they are there to observe only.

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS

The confidentiality of Alcohol and Drug Abuse Patient Records maintained by Insight is protected by Federal Law and regulation. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose information identifying a patient as an alcohol or drug abuser unless:

1. The patient consents in writing;

2. The disclosure is allowed by a court order;

3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal Law and regulations by the program is a crime. Suspected violations may be reported to appropriate authorities in accordance to Federal regulations.

Federal Law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal Law and regulations do not protect any information about suspected child abuse or neglect from being reported under State Law to appropriate State or local authorities.

(See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal Laws and 42 C.F.R., part 2 for Federal regulations)

(Approved by the Office of Management and Budget under Control No. 0930-0099.)

READING LIST

Overview of Addiction

The following must be read PRIOR to the class:

1. Getting Ready to Test: A Review / Preparation Manual for Drug and Alcohol Credentialing Examinations
(pp 3-24, pp 151 – 160, 8th Edition)

2. Drugs, Society, and Human Behavior
Section 1, Chapter 1 (*Drug Use, an Overview*), 2 (*Drug use as a Social Problem*)

READING LIST

Documentation

The following must be read PRIOR to the class:

1. Getting Ready to Test
(pp 364 – 367, 8th Edition)

2. Global Criteria
Chapter 12, Reports and Record Keeping

CHARTING ABBREVIATIONS AND TERMS

1. Client- Cl
2. Treatment- Tx.
3. Discharge- DC, d/c
4. Positive- ⊕
5. Negative- ⊖
6. With- $\bar{c}$
7. Parents- P
8. Mom- M
9. Dad- F
10. Sister- S
11. Brother- B
12. Grandmother- GM
13. Grandfather- GF
14. Step- add an "s"- (SM SF)
15. For example- ie.
16. Regarding- re:
17. Alcohol- etoh
18. Meeting- mtg.
19. Group- grp.
20. Participate- ptcpt.
21. One on one- 1:1
22. Yourself or I- staff
23. Discussion- disc.
24. He/she- cl.
25. His/her- own
26. They saw- identified
27. They seemed- presented
28. They said- reported/stated/verbalized
29. They didn't- failed/struggled/lacked
30. S.O. - family amends mtg
31. Dating game- orientation activity
32. Goodbye group- d/c activity
33. Problems- issues
34. Do/did- demonstrated
35. Use- apply
36. Told them to…- directed to…/encouraged
37. Get or got- Gained/developed
38. Stay sober- maintain sobriety
39. Work a program- apply tools of recovery
40. Friend(s) - peer(s)
41. Old friends- "using" peers
42. Helped- aided
43. Ripped off/ got into- confronted or mildly confronted
44. Functions- social activities

CHARTING ABBREVIATIONS AND TERMS

45. Self esteem lists/ gratitude lists- positive writing exercises
46. God memo/ Big Book- AA lit. (Literature)
47. Need to deal with- address
48. Facilitated- "Staff facilitated grp. disc. on…"
49. Attended- "Cl. Attended grp. session…"
50. Initiated- "Cl. initiated disc. on…"
51. Participated- "Cl. ptcpt. in 12 step mtg"
52. Working knowledge- "Cl. lacks working knowledge of step one."
53. Refrain from- "Staff directed cl. to refrain from…"
54. Aftercare – AC
55. Approximately- approx
56. Behavior- Bx.
57. Continue- Cont
58. Continued- Cont.d'
59. Decreased-
60. Increase-
61. Group therapy- GT
62. History- Hx
63. Inpatient- In-Pt
64. Individual Therapy- IT
65. Information- Info
66. Intensive Outpatient- IOP
67. None- 0
68. Not applicable- N/A
69. Times- x

Affects

Upbeat – Optimistic, happy, cheerful.

Excited – Stirred emotionally.

Anxious – Worries, uneasy.

Depressed – Sad, Gloomy.

Labile – Up and down, likely to change.

Tearful – Crying.

Cheerful – In good spirits, cheerful, bright.

Withdrawn – Removed from.

Flat – Without vitality or animation, lifeless, dull.

Timid – Full of fear, shy.

Warm – Lively feelings, emotions or sympathies.

Attentive – Observant, giving attention.

Distant – Reserved, at a distance in feeling or interest.

Pensive – Thoughtful.

Closed – Not open to new ideas.

Sad – Unhappy, sorrowful.

Angry – Showing anger.

DOCUMENTATION SPELLING REFERENCE

1. Adderall
2. Ambien
3. Amitriptyline Hydrochloride (Elavil)
4. Amphetamine
5. Ativan
6. Barbituate
7. Benzodiazepine
8. "Buspar" (aka Buspirone)
9. Celexa
10. Clonazepam (Klonopin)
11. Clonidine
12. Clozapine
13. Cocaine
14. Codeine (Tylenol 3)
15. Concerta
16. Coricidin
17. Cymbalta (~~duloxatine~~) Duloxetine
18. Darvocet
19. Demerol
20. Depakote
21. Dexedrine
22. Dextromethorphan (DXM)
23. Dilaudid
24. Dramamine
25. Ecstasy, see MDMA
26. Eskalith -see Lithium
27. Fentanyl
28. Formaldehyde
29. Freon
30. Gamma-Hydroxybutyric acid (GHB)
31. Haldol
32. Heroin
33. Hydrocodeine
34. Hydrocodone
35. Ketamine
36. Klonopin
37. Lamictal
38. Lexapro
39. Librium
40. Lithium
41. Lorazepam
42. Lortab
43. Lorcet
44. Lysergic acid diethylamide (LSD)
45. Lyrica
46. Marijuana
47. Mescaline
48. Methadone

DOCUMENTATION SPELLING REFERENCE

49. Methamphetamine
50. MDMA (ecstasy)
51. Morphine
52. Mushrooms; see Psilocybin
53. Nardil
54. Nitrous Oxide (laughing gas)
55. Opium
56. OxyCodone
57. OxyContin (pronounced "oxycotton")
58. Oxymorphone
59. Pamelor
60. Paxil
61. PCP (aka "angel dust")
62. Percocet
63. Percodan
64. Peyote
65. Propoxyphene (Darvon) brand name
66. Prozac
67. Psilocybin
68. Quaalude
69. Remeron
70. Risperdal
71. Ritalin
72. Robitussin
73. Rythmol
74. Salvia Divinorum
75. Seroquel
76. Steroid
77. Soma
78. Sonata
79. Strattera
80. Suboxone
81. Subutex
82. Tofranil
83. Tramadol
84. Trazodone
85. Trileptal
86. Ultram
87. Valium
88. Vicodin
89. Vistaril
90. Wellbutrin
91. Xanax
92. Zoloft
93. Zyprexa

Charting Example Situations

1. Kid comes into group, cops to hanging out with old friends and says I don't think it's a big deal. Counselor gets into the 2nd step, group starts giving to kid, kid starts to get it and decides to be willing to stop hanging out with people who get high.

in charting terms- Cl. attended 4 hr. open grp. disc. Cl reported spending time with drug using peers. Cl stated "I don't think it's a big deal." Staff explained importance of spending time with sober peers. Cl listened to feedback from GT peers. Cl reported understanding and expressed desire to cut ties with drug using peers.

2. Kid in op hasn't been doing good, rarely talks in group. Counselor starts asking kid how they've been doing. Kid says I'm good. Counselor gets into how kid hasn't been talking in group and didn't do treatment plan. Kid starts talking about being scared and feeling like no one likes him. Op group loves on him and he talks about being more real in group.

in charting terms- Cl attended 4 hr. grp. disc. Staff questioned cl's progress. Cl. stated "I'm good." Staff disc. cl's failure to complete tx plan and demonstrate honesty in GT. Cl. disc. own fear of being disliked by GT peers. Cl listened to feedback from GT peers. Cl. reported own willingness to begin demonstrating honesty in GT.

3. Kid starts talking about not having a higher power. Counselor explains the jar and 3DHP. Kid starts to get it, counselor tells kid to try hitting their knees.

in charting terms- Cl attended 4 hr. grp. disc. on Higher Power. Cl disc own lack of understanding of Higher Power. Staff explained steps 3 and 4. Cl. reported understanding. Staff encouraged cl to begin utilizing prayer daily.

4. During the how chart, kid talks about being a 9 on honesty, another guy in group says that's bullshit, I know you've been hanging out with your girlfriend . Kid gets mad, says fuck you guys, storms out of group, and refuses to come back.

in charting terms- Cl. attended 2 hr. grp. disc. on honesty, open-mindedness, and willingness. Cl. reported doing well with honesty. GT peer confronted cl's failure to demonstrate honesty re: maintaining romantic relationship while in tx. Cl stated "fuck you guys" and left GT. Cl refused to return to grp. disc.

5. Monday in group, dating game and an SO. People share about their weekends, kid doesn't get to share, but is apart of conversation.

in charting terms- Cl attended 4 hr. grp. disc. on wknd. activities. Cl listened to GT peers share. Cl part. in GT peer's orientation activity and GT peer's family amends mtg.

6. Day of group on safety net. Kid starts crying about being afraid to get close to people. Kid talks about never having a lot of friends and thinking people won't like her once they get to know her. Counselor gave kid some people to talk to and got into facing fears.

in charting terms- Cl attended 4 hr. grp. disc. on building + peer relationships. Cl. became tearful while discussing own lack of peer relationships in the past and fear of rejection. Staff encouraged cl. to initiate 1:1 disc. with 3 + peers re: taking + risks in relationships.

READING LIST

Treatment Admission

The following must be read PRIOR to the class:

1. Getting Ready to Test
(pp 193-201, 8th Edition)

2. Global Criteria
Chapter 2, *Screening*
Chapter 3, *Intake*
Chapter 4 *Orientation*

3. Loosening the Grip
Chapter 9, *Evaluation and Treatment Overview*

READING LIST

Assessment

The following must be read PRIOR to the class:

1. Getting Ready to Test
(pp 202 – 242, 8th Edition)

2. Global Criteria
Chapter 5, *Assessment*

READING LIST

Treatment Planning

The following must be read PRIOR to the class:

1. Getting Ready to Test
(pp 339 – 341, 8th Edition)

2. Global Criteria
Chapter 6, *Treatment Planning*

3. Loosening the Grip
Chapter 8, *Effects of Alcohol Problems on the Family*

Staff Meeting Examples

1. 17-year-old male, drug of choice-pot. Been in IOP for 1 week, assessment has been completed, started tx because it was needed for probation, says he likes the group, is really shy, somewhat willing, but doesn't really know what's going on yet.

2. 19-year-old female, drug of choice alcohol. Been in IOP for 5 weeks, last tx plan was step 3. Struggles with guys, has been gaming with a guy in the group, has very few female friendships and dresses inappropriately provocative.

3. 15-year-old male, drug of choice Coricidin. Been in IOP for 4 weeks, understands steps 1-2, has an alright safety net. Came to tx after getting caught getting high at school, parents are very unhappy with him staying out too late, never calling and being mean when he is home. With the group he is loud and obnoxious, rarely supports in meetings and is starting to annoy people.

4. 21-year-old male, drug of choice heroin. Been in IOP for 8 weeks, has worked on steps 1-4 and has a solid safety net. Came to tx after asking parents for help, has been very willing, talks in group all the time, has recently been talking about his fear of saying what he thinks to people he is in group with.

5. 18-year-old male. drug of choice cocaine. Been in tx for 3 weeks, he knows his life was unmanageable and isn't hanging out with people who get high anymore. He attends all the mtgs. and functions, but doesn't hang out much outside of required activities. He talks about not liking a lot of people in the group. He's arrogant and treats people bad if he doesn't think you're cool.

6. 23-year-old female, drug of choice Xanax and alcohol, been using for the last 10 years. Has been in IOP for 7 weeks and has 4 weeks sober, relapsed after breaking up with boyfriend of 3 years 3 weeks into IOP. Has had steps 1-4 on tx plans but is not very solid with working a program. She is extremely emotional, talks in group all the time, almost to the point of monopolizing group. She doesn't really take action on the solutions she is given.

7. 16-year-old male, drug of choice alcohol, pot and pills. Been in IOP for 5 weeks, has done steps 1-3 and safety net tx plans. He has a really good personality, funny, hangs out with the group all the time, the group likes him a lot. Counselor just got a call from his Mom because she had a bad feeling that he is still getting high(not with any real evidence). Another person in the group talked to the counselor about thinking he was high at the function last weekend. When he talks in group he always says he's doing good.

8. 20-year-old female, drug of choice OxyContin. Been in IOP for 2 weeks, has a solid step 1 really wants to be sober. Her Dad died a year ago, she's really sad, has been using mostly alone for the last 6 months.

READING LIST

Overview of the Counseling Process

The following must be read PRIOR to the class:

1. Getting Ready to Test
(pp 243 – 267 8th Edition)

2. Global Criteria
Chapter 7 - *Counseling*

READING LIST

Ethics

The following must be read PRIOR to the class:

1. Getting Ready to Test
(pp 541-572, 8th Edition)

2. Loosening the Grip

Read *Ethics* and *Counselors with "Two Hats"* in Chapter 14

READING LIST

Functions of Counseling

The following must be read PRIOR to the class:

1. *Getting Ready to Test*
(pp 151 – 186, 367 - 368, 342 – 343, 360 – 364, 8th Edition)

2. *Global Criteria*
Chapter 8 - *Case Management*, Chapter 11 – *Referral,* Chapter 13 - *Consultation*

READING LIST

Counseling Theories

The following must be read PRIOR to the class:

1. Getting Ready to Test
(pp 373 – 413, 573 - 622, 8th Edition)

READING LIST

Crisis Intervention

The following must be read PRIOR to the class:

1. Getting Ready to Test
(pp 344 - 355, 8th Edition)

2. Global Criteria
Chapter 9 – *Crisis Intervention*

3. Loosening the Grip
Chapter 12 – *Other Psychiatric Considerations*

Crisis Example #1

Sara is a 13-year-old girl that you have just begun seeing for individual counseling. You have already strongly recommended a higher level of care to her parents based on the observation of Sara's desire to build up some experience and drug using stories. Her parents do not believe that Sara needs a higher level of care. She seems to enjoy gaining attention from peers by presenting herself as a little crazy and dangerous. Sara tells peers that she worships the devil and does not have a soul. She is however attending support group meetings and you know that a few positive peers have taken an interest in reaching out to her.

On night at about 11 pm on a Tuesday night, you receive a phone call from one of these support group peers letting you know that Sara in falling down and mumbling. They also found 2 empty boxes of Corecedin Cough and Cold in the trashcan. Sara denies knowing anything about it. They have also noticed fresh small, shallow scrapes or cuts on her forearms. She is wearing a tank top.

How do you proceed?

What steps are the most important?

Is there a response that her parents could make that would result in you terminating treatment?

How could treatment be enhanced as a result of this event?

Assuming Sara has been stabilized, develop the next treatment plan.

Crisis Example #2

Cassy is a 19-year-old female that has been involved in group therapy for a month. She has three weeks sober after one relapse with her drug using "ex" boyfriend. You know from her assessment that Cassy assumed that her and her "ex" boyfriend would be married someday. You also note the lack of involvement of her father in her life and extreme need for male attention. She has developed some strong relationships with positive peers within her outpatient and support group.

One night Cassy is checking up on her "ex" boyfriends Facebook page, a regular and secret habit to this point, and discovers pictures of hem with another girl in his arm. She arrives at group the following day very distraught revealing her intentions of getting sober so that she could then go get him sober and they could be together. Now it seemed that her choices were to get sober and loose him, or go back to her previous life trying to "stay sober with all she's learned" and convince him to do the same quickly, before this hussy succubus makes him forget that he is really supposed to be with Cassy. You are able to discern that Cassy is serious, that these events may actually not only lead her toward relapse, but a decision to leave treatment all together. Based on her drug use history, you know that Cassy is a severe meth addict and this boyfriend was her main connection.

How would you stabilize Cassy?

Where is the opportunity to enhance treatment? What tools does she need to develop based on her reaction to these events?

Assuming Cassy is stable and committed to attend group and stay sober, develop her next treatment plan.

Crisis Example #3

Jimmy is a twenty four year old male that has been in group therapy on an outpatient level for two weeks for alcohol dependence. Jimmy has about sixteen days sober. It became clear through the assessment process that Jimmy has a pattern of feeling hopeless, isolating, and then binge drinking. He has a history of becoming quite erratic in emotion during these binges and even violent. His treatment plan so far has focused on developing an understanding of the first step and defining unmanageability in his own life. Jimmy will speak in-group, but is otherwise minimally sociable. He has selected a sponsor, but a real relationship is yet to be developed. He is very reluctant to rely on others. Jimmy lives in a halfway house and has regular contact with his divorced mother and father in the same town.

One evening Jimmy's mother is hit by a drunk driver and dies in the impact. His upset and concerned father calls you as Jimmy's counselor to let you know that he will not be coming home to the halfway house or attending group due to funeral arrangements.

Assuming you meet little resistance to your suggestions, how would you proceed?

How would you enhance treatment as a result of this event?

Develop Jimmy's next treatment plan assuming he is stabilized and not a risk to himself or others.

READING LIST

Neurobiology, Alcohol, and Drugs of Abuse

The following must be read PRIOR to the class:

1. Loosening the Grip
Chapter 1 - *Alcohol,* Chapter 3 - *Alcohol and the Body,* Chapter 4 - *Alcohol Dependence,* Chapter 6 - Medical *Complications*

2. Drugs, Society, and Human Behavior
Section Two: *How Drugs Work,* Section Three: *Stimulants, Depressants and Inhalants*
Section Six: *Opiates, Hallucinogens, Marijuana and Performance-Enhancing Drugs*

3. Getting Ready to Test
(pp 25 – 149, 8th Edition)

Study: Alcohol more lethal than heroin, cocaine

MARIA CHENG
From Associated Press
October 31, 2010

LONDON (AP) — Alcohol is more dangerous than illegal drugs like heroin and crack cocaine, according to a new study.

British experts evaluated substances including alcohol, cocaine, heroin, ecstasy and marijuana, ranking them based on how destructive they are to the individual who takes them and to society as a whole.

Researchers analyzed how addictive a drug is and how it harms the human body, in addition to other criteria like environmental damage caused by the drug, its role in breaking up families and its economic costs, such as health care, social services, and prison.

Heroin, crack cocaine and methamphetamine, or crystal meth, were the most lethal to individuals. When considering their wider social effects, alcohol, heroin and crack cocaine were the deadliest. But overall, alcohol outranked all other substances, followed by heroin and crack cocaine. Marijuana, ecstasy and LSD scored far lower.
The study was paid for by Britain's Centre for Crime and Justice Studies and was published online Monday in the medical journal, Lancet.

Experts said alcohol scored so high because it is so widely used and has devastating consequences not only for drinkers but for those around them.

"Just think about what happens (with alcohol) at every football game," said Wim van den Brink, a professor of psychiatry and addiction at the University of Amsterdam. He was not linked to the study and co-authored a commentary in the Lancet.

When drunk in excess, alcohol damages nearly all organ systems. It is also connected to higher death rates and is involved in a greater percentage of crime than most other drugs, including heroin.

But experts said it would be impractical and incorrect to outlaw alcohol
"We cannot return to the days of prohibition," said Leslie King, an adviser to the European Monitoring Centre for Drugs and one of the study's authors. "Alcohol is too embedded in our culture and it won't go away."

King said countries should target problem drinkers, not the vast majority of people who indulge in a drink or two. He said governments should consider more education programs and raising the price of alcohol so it isn't as widely available.

Experts said the study should prompt countries to reconsider how they classify drugs. For example, last year in Britain, the government increased its penalties for the possession of marijuana. One of its senior advisers, David Nutt - the lead author on the Lancet study - was fired after he criticized the British decision.

"What governments decide is illegal is not always based on science," said van den Brink. He said considerations about revenue and taxation, like those garnered from the alcohol and tobacco industries, may influence decisions about which substances to regulate or outlaw. "Drugs that are legal cause at least as much damage, if not more, than drugs that are illicit," he said.

Neurobiology Key Terms

Acetylcholine – An excitatory neurotransmitter found in the parasympathetic branch in the cerebral cortex.

Autonomic System - One of the two subdivisions of the peripheral nervous system comprised of nerves that connect the central nervous system to various organs. These nerves function automatically.

Axon – Nerve fiber extending from the neuron that carries impulses away from the cell body. Each neuron has only one Axon.

Basal Ganglia – A part of the brain containing a large number of dopamine synapses. Responsible for maintaining proper muscle tone as part of the *extrapyramidal motor system.* Damage to the basal ganglia, as in Parkinson's disease, produces muscle rigidity and tremors.

CNS – Central nervous system; consist of the brain and spinal chord.

Dendrites – Nerve fiber that extends from the neuron and sends nerves impulses toward the cell body. There are several dendrites extending from each neuron.

Dopamine – A neurotransmitter found in the basal ganglia and other regions associated with body movement and pleasure.

Endorphins and enkephalins – Compounds with pain killing properties that are more powerful than morphine.

Enzymes – A large molecule that assist in either the synthesis or metabolism of another molecule.

GABA (Gamma-aminobutyric acid) – An inhibitory neurotransmitter substance (one that blocks the transfer of a nerve impulse to an adjoining neuron in the brain) when the normal function of GABA is disrupted, convulsions may occur. GHB is similar to GABA. Many sedative drugs act by enhancing GABA inhibition.

Glycine – An inhibitory neurotransmitter found in the spinal chord.

Homeostasis – A state of physiological balance maintained by various regulatory mechanisms.

Hormones – A chemical substance formed in one part of the body that stimulates action in another part of the body.

Mesolimbic Dopamine Pathway – A group of dopamine containing neurons that have their cell bodies in the midbrain and their terminals in the forebrain, on various structures associated with the limbic system. Believed by some theorist to be important in explaining the therapeutic effects of antipsychotic medications. Also believed by some theorist to be important for many types of behavioral reinforcers.

Metabolize – To break down or inactivate a neurotransmitter or drug through enzymatic action.

Neuron – The basic unit of the nervous system capable of both receiving stimuli and transmitting electrical messages or impulses through the system.

Neurotransmitters – A chemical that is released by one neuron that alters the electrical activity in another neuron.

Nigrostriatal Dopamine Pathway – A group of dopamine containing neurons that have their cell bodies in the *substantia nigra* of the midbrain and their terminals in the basal ganglia, which is part of the extrapyramidal motor system. It is the pathway that deteriorates in Parkinson's disease and on which antipsychotic drugs act to produce side effects resembling Parkinson's disease.

Norepinephrine – A neurotransmitter associated with regulating waking, appetite, arousal reactions and moods.

Parasympathetic division – The branch of the autonomic nervous system that has acetylcholine as its neurotransmitter and, for example, slows the heart rate and activates the intestine. This division aids the body in returning to normal after a period of expending energy.

Peripheral Nervous System – The other major part of the nervous system besides the CNS; consist of all the nerves that branch out from the central nervous system and connect the system to other body parts.

Precursors – Chemical that are acted on by enzymes to form neurotransmitters.

Receptors – Locations at which neurotransmitters or drugs bind, perhaps triggering a physiological response.

Reuptake – The taking back of recently released neurotransmitter molecules into a neuron.

Serotonin – A neurotransmitter found in the raphe nuclei associated with sensory perception, sleep, depression, and body temperature. Alterations in the serotonin functioning have been found to be related to mental illness and certain drug-induced hallucinations.

Somatic System – One of the two subdivisions of the peripheral nervous system comprised of cranial and spinal nerves which connect the CNS to the skin and the skeletal muscles.

Sympathetic division – The branch of the autonomic nervous system that contains norepinephrine as its neurotransmitter and, for example, increases heart rate and blood pressure. This division prepares the body for activities that expend energy.

Synapse – The junction between the axon of one cell and the dendrite of another.

Synaptic Cleft – A gap in the synapse filled with a special type of fat that acts as an insulator between cells. The message sent across the synaptic cleft is chemical rather than electrical. This is where psychoactive drugs have their effect. Depressant drugs thicken this medium slowing down transmission while stimulant drugs thin this medium causing a more rapid transmission.

Synaptic Knob – A tiny sac-like structure at the end of an axon that manufactures chemicals called neurotransmitters.

Synthesis – The forming of neurotransmitters by the action of enzymes on precursors.

Uptake – Energy requiring mechanism by which selected molecules are taken into cells

NIDA NATIONAL INSTITUTE ON DRUG ABUSE
The Science of Drug Abuse & Addiction

Drug Facts: Salvia

Salvia (*Salvia divinorum*) is an herb common to southern Mexico and Central and South America. The main active ingredient in Salvia, salvinorin A, is a potent activator of kappa opioid receptors in the brain.[1] These receptors differ from those activated by the more commonly known opioids, such as heroin and morphine.

Traditionally, *S. divinorum* has been ingested by chewing fresh leaves or by drinking their extracted juices. The dried leaves of S. divinorum can also be smoked as a joint, consumed in water pipes, or vaporized and inhaled. Although Salvia currently is not a drug regulated by the Controlled Substances Act, several States and countries have passed legislation to regulate its use.[2] The Drug Enforcement Agency has listed Salvia as a drug of concern and is considering classifying it as a Schedule I drug, like LSD or marijuana.

Health/Behavioral Effects

People who abuse Salvia generally experience hallucinations or "psychotomimetic" episodes (a transient experience that mimics a psychosis).[3,4] Subjective effects have been described as intense but short-lived, appearing in less than 1 minute and lasting less than 30 minutes. They include psychedelic-like changes in visual perception, mood and body sensations, emotional swings, feelings of detachment, and importantly, a highly modified perception of external reality and the self, leading to a decreased ability to interact with one's surroundings.[5] This last effect has prompted concern about the dangers of driving under the influence of salvinorin. The long-term effects of Salvia abuse have not been investigated systematically. Recent experiments in rodents demonstrated deleterious effects of salvinorin A on learning and memory.[6]

"Bath Salts" – Emerging and Dangerous Products

February 2011

"Bath Salts", the newest fad to hit the shelves (virtual and real), is the latest addition to a growing list of items that young people can obtain to get high. The synthetic powder is sold legally online and in drug paraphernalia stores under a variety of names, such as "Ivory Wave," "Purple Wave," "Red Dove," "Blue Silk," "Zoom," "Bloom," "Cloud Nine," "Ocean Snow," "Lunar Wave," "Vanilla Sky," "White Lightning," "Scarface," and "Hurricane Charlie." Because these products are relatively new to the drug abuse scene, our knowledge about their precise chemical composition and short- and long-term effects is limited, yet the information we do have is worrisome and warrants a proactive stance to understand and minimize any potential dangers to the health of the public.

We know, for example, that these products often contain various amphetamine-like chemicals, such as methylenedioxypyrovalerone (MPDV), mephedrone and pyrovalerone. These drugs are typically administered orally, by inhalation, or by injection, with the worst outcomes apparently associated with snorting or intravenous administration. Mephedrone is of particular concern because, according to the United Kingdom experience, it presents a high risk for overdose. These chemicals act in the brain like stimulant drugs (indeed they are sometimes touted as cocaine substitutes); thus they present a high abuse and addiction liability. Consistent with this notion, these products have been reported to trigger intense cravings not unlike those experienced by methamphetamine users, and clinical reports from other countries appear to corroborate their addictiveness. They can also confer a high risk for other medical adverse effects. Some of these may be linked to the fact that, beyond their known psychoactive ingredients, the contents of "bath salts" are largely unknown, which makes the practice of abusing them, by any route, that much more dangerous.

Unfortunately, "bath salts" have already been linked to an alarming number of ER visits across the country. Doctors and clinicians at U.S. poison centers have indicated that ingesting or snorting "bath salts" containing synthetic stimulants can cause chest pains, increased blood pressure, increased heart rate, agitation, hallucinations, extreme paranoia, and delusions.

"Bath Salts" – Emerging and Dangerous Products Continued:

It is noteworthy that, even though we are barely two months into 2011, there have been 251 calls related to "bath salts" to poison control centers so far this year. This number already exceeds the 236 calls received by poison control centers for all of 2010. In response to this emerging threat, several states, including Hawaii, Michigan, Louisiana, Kentucky, and North Dakota, have introduced legislation to ban these products, which are incidentally labeled as "not fit for human consumption." In addition, several counties, cities, and local municipalities have also taken action to ban these products.
We will continue to monitor the situation and promote research on the extent, pharmacology, and consequences of "bath salts" abuse. In the meantime, I would like to urge parents, teachers, and the public at large to be aware of the potential dangers associated with the use of these drugs and to exercise a judicious level of vigilance that will help us deal with this problem most effectively.

Sincerely,
Nora D. Volkow, M.D.
Director
National Institute on Drug Abuse

NIDA NATIONAL INSTITUTE ON DRUG ABUSE
The Science of Drug Abuse & Addiction

DrugFacts: Spice (Synthetic Marijuana)

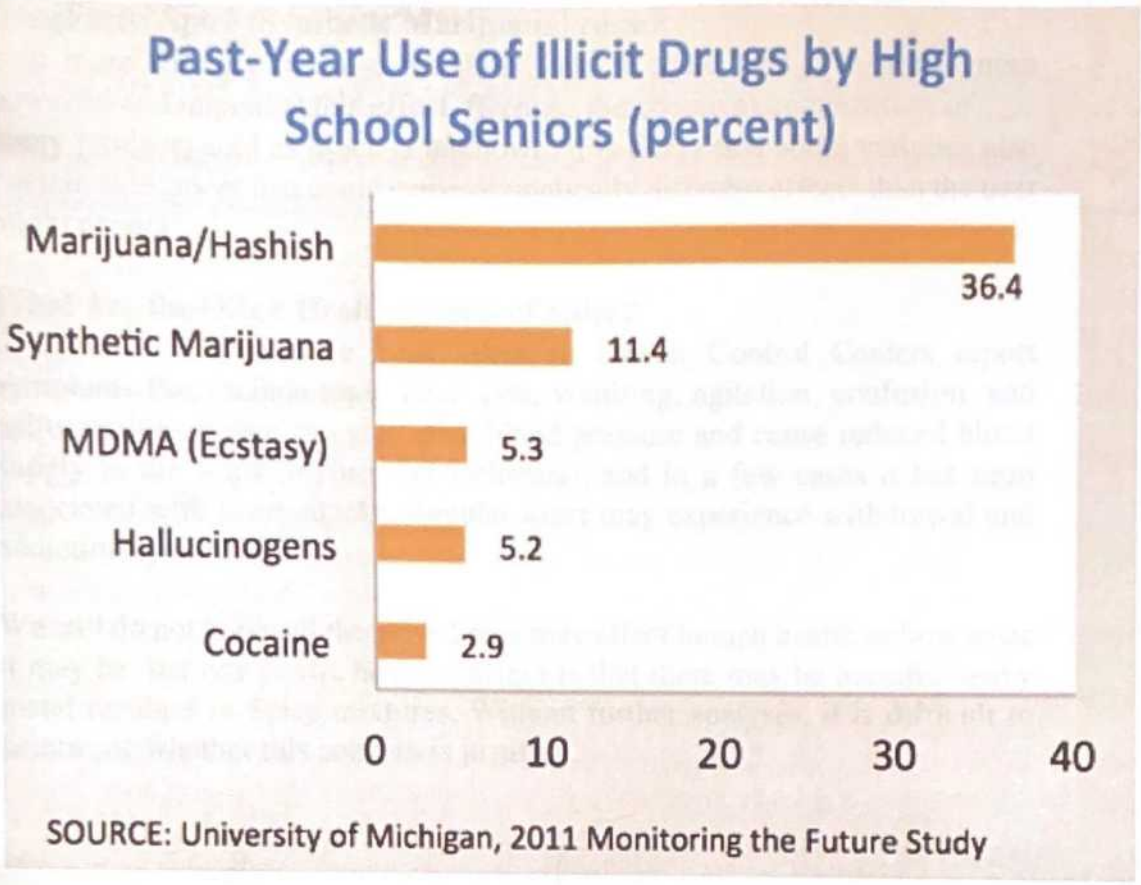
"Spice" refers to a wide variety of herbal mixtures that produce experiences similar to marijuana (cannabis) and that are marketed as "safe," legal alternatives to that drug. Sold under many names, including K2, fake weed, Yucatan Fire, Skunk, Moon Rocks, and others—and labeled "not for human consumption"—these products contain dried, shredded plant material and chemical additives that are responsible for their psychoactive (mind-altering) effects.

False Advertising

Labels on Spice products often claim that they contain "natural" psychoactive material taken from a variety of plants. Spice products do contain dried plant material, but chemical analyses show that their active ingredients are synthetic (or designer) cannabinoid compounds.

For several years, Spice mixtures have been easy to purchase in head shops and gas stations and via the Internet. Because the chemicals used in Spice have a high potential for abuse and no medical benefit, the Drug Enforcement Administration (DEA) has designated the five active chemicals most frequently found in Spice as Schedule I controlled substances, making it illegal to sell, buy, or possess them. Manufacturers of Spice products attempt to evade these legal restrictions by substituting different chemicals in their mixtures, while the DEA continues to monitor the situation and evaluate the need for updating the list of banned cannabinoids.

Spice products are popular among young people; of the illicit drugs most used by high-school seniors, they are second only to marijuana. Easy access and the misperception that Spice products are "natural" and therefore harmless have likely contributed to their popularity. Another selling point is that the chemicals used in Spice are not easily detected in standard drug tests.



How Is Spice Abused?

Some Spice products are sold as "incense," but they more closely resemble potpourri. Like marijuana, Spice is abused mainly by smoking. Sometimes Spice is mixed with marijuana or is prepared as an herbal infusion for drinking.

How Does Spice Affect the Brain?

Spice users report experiences similar to those produced by marijuana—elevated mood, relaxation, and altered perception—and in some cases the effects are even stronger than those of marijuana. Some users report psychotic effects like extreme anxiety, paranoia, and hallucinations.

So far, there have been no scientific studies of Spice's effects on the human brain, but we do know that the cannabinoid compounds found in Spice products act on the same cell receptors as THC, the primary psychoactive component of marijuana. Some of the compounds found in Spice, however,

DrugFacts: Spice (Synthetic Marijuana) contd:

bind more strongly to those receptors, which could lead to a much more powerful and unpredictable effect. Because the chemical composition of many products sold as Spice is unknown, it is likely that some varieties also contain substances that could cause dramatically different effects than the user might expect.

What Are the Other Health Effects of Spice?

Spice abusers who have been taken to Poison Control Centers report symptoms that include rapid heart rate, vomiting, agitation, confusion, and hallucinations. Spice can also raise blood pressure and cause reduced blood supply to the heart (myocardial ischemia), and in a few cases it has been associated with heart attacks. Regular users may experience withdrawal and addiction symptoms.

We still do not know all the ways Spice may affect human health or how toxic it may be, but one public health concern is that there may be harmful heavy metal residues in Spice mixtures. Without further analyses, it is difficult to determine whether this concern is justified.

Suboxone: concerns behind the miracle

November 1, 2010 by Steven R. Scanlan, MD

One addiction may be traded for another as the FDA-approved opiate addiction treatment Suboxone is becoming one of the most prescribed medications in the country (#41 overall in sales in 2009 according to drugs.com). Called a "miracle drug" by some, Suboxone is estimated to be 25 to 40 times more potent than morphine.

I am board-certified in psychiatry by the American Academy of Psychiatry and Neurology and board-certified in addiction medicine by the American Board of Addiction Medicine. I am the co-founder of Palm Beach Outpatient Detox (P.B.O.D.) in Boca Raton, Fla. I once was addicted to opiates during my medical residency in anesthesiology and was detoxed with the help of Suboxone. Now I successfully detox my patients from opiates (e.g., morphine, OxyContin) using regulated amounts of Suboxone, and I also detox my patients from Suboxone addiction when that drug has been misused.

I have found that the optimal time to have someone on Suboxone is between 20 and 25 days, tapering down on the medication every few days. This makes the physical symptoms of detox very manageable, without causing the patient to become cross-addicted to Suboxone. I have found that Suboxone use for a longer period than this begins to cause a strong dependence on the medication.

Once a patient is stabilized with Suboxone and no longer getting high, he/she has to be convinced that recovery is possible. A detailed program is then created at the P.B.O.D. office, focused on abstinence and better coping techniques. P.B.O.D. prepares patients for the restlessness, irritability and discontent they will experience when they are off all narcotics, including Suboxone.

Suboxone detox makes the physical aspect of the disease manageable, but does not help with the emotional and spiritual consequences of addiction. Often patients are concerned about coming off Suboxone, but I educate them about how Suboxone is a tool to get them clean but not a suitable maintenance drug if a patient wants to get into recovery.

Suboxone: concerns behind the miracle

Suboxone is a powerful opiate-an anesthetic to emotional pain. It immediately alleviates anxiety and depression, and makes a person feel more emotionally stable. A lesser dose of Suboxone (2 mg a day) will block an estimated 80 percent of a person's feelings, while higher doses can make a patient practically numb. Patients often say they feel great on Suboxone and since they are not getting high they want to continue on it. I tell them, "You are not dealing with your feelings because you are still not feeling-you are still numb. You need to start experiencing emotions to understand what you were trying to self-medicate in the first place. It's time to live life on life's terms."

Duration of use

When used in the short term, Suboxone is the best detox drug I have ever seen-it can immediately stabilize a patient's life, and this can be done in an outpatient setting. When used long-term, though, it is the hardest medication I have ever dealt with in terms of detoxing a patient from it.

Suboxone does not work like natural opiates; it is created in a lab and interacts with the receptors in the brain unlike any other opiate. I speculate, based on treating hundreds of patients who have been on Suboxone maintenance, that when Suboxone is given long-term it causes abnormal adaptations to opiate receptors and other brain receptors. In my experience, long-term use can cause emotional deregulation, loss of libido, hair loss, and an abnormality in how the body regulates its response to stress.

Suboxone is a mixture of buprenorphine and naloxone. Buprenorphine is a powerful opiate, and naloxone is an opiate blocker used to resuscitate people in the ER from an opiate overdose. With no other opiates in the addict's system in the last few days, he/she can either snort or intravenously shoot up Suboxone and become extremely high since it easily dissolves in water, making it easier to shoot up than heroin. The combination of there not being enough naloxone in Suboxone and the fact that Suboxone binds to the opiate receptor so strongly means that there is no built-in deterrent to keep a patient from abusing Suboxone. Dozens of my patients have discussed using Suboxone intravenously, and there are hundreds of reports about this on the Internet.

Suboxone: concerns behind the miracle

The misuse of Suboxone and the lack of attention to the problem are causing physicians untrained in addiction medicine to feed into overprescribing. Many do not understand the long-term ramifications of Suboxone addiction, and it also is a very lucrative business for the prescribing physician. Many doctors charge $200 to $300 monthly, per patient, for a 5-to-10 minute checkup to renew a Suboxone prescription.

Most places prescribing Suboxone maintenance do not offer any addiction treatment because the doctor is not trained in addiction medicine and because it is not time- or cost-effective to do so. Furthermore, the lucrative nature of Suboxone on a maintenance basis creates a disincentive to tapering the drug and its income-generating potential.

As a point of comparison I charge $2,000 for a detox from OxyContin or methadone, taking about three weeks. A detox from Suboxone dependence costs $5,000 because it takes four to five months, incorporating about 10 different medications to detox the patient successfully. The success rate for detox from Suboxone is much lower than that for detox from other opiates because patients tend to give up hope during the lengthy withdrawal process.

Dearth of research

Most Suboxone studies follow post-detox patients for only a month and are often funded by the drug company that manufactures Suboxone. There are no long-term studies of Suboxone maintenance. I learned myself about the potential disadvantages of Suboxone maintenance from meeting people in my practice who have been on it for years.

I am concerned that the medical profession has allowed this situation to develop. I wish I knew how to fix this problem. I only know how to prevent it from happening to my patients in the first place or how to correct previous Suboxone treatment.

Suboxone: concerns behind the miracle

Only time will tell what role Suboxone will play in the field of addiction medicine. Will it one day be used only in the short term as a detox tool, or will it continue to be prescribed as a maintenance treatment? Supporters of maintenance treatment will state that the manageability of an addict's life improves tremendously with Suboxone maintenance, and there is an abundance of research to back this up. Nonetheless, I believe that an individual on maintenance treatment is not experiencing the full range of emotions, good or bad. It is imperative, in the least, that all physicians prescribing this medication become more educated about Suboxone and the pros and cons of short-term and chronic use.

SAMSHA advisory on Vivitrol offers comparison with other opioid addiction treatments

March 22, 2012 by Gary A. Enos, Editor *Addiction Professional*

Guidance included on individuals most likely to benefit from medication

The Substance Abuse and Mental Health Services Administration (SAMHSA) is prominently displaying on its website an advisory outlining a number of prescribing considerations associated with use of extended-release injectable naltrexone to treat opioid dependence. The eight-page document features a table that highlights differences between injectable naltrexone (sold under the brand name Vivitrol) and the medications buprenorphine and methadone, including that Vivitrol is the only one of the three drugs with no diversion and abuse potential.

The opening paragraph of the advisory states about Vivitrol, which was federally approved for the treatment of opioid dependence in the fall of 2010, "This medication provides patients with opioid dependence the opportunity to take effective medication monthly, as opposed to the daily dosing required by other opioid dependence medications." Vivitrol has been used in the treatment of alcohol dependence since 2006.

The document also addresses safety risks that Vivitrol shares with the other opioid dependence treatments (such as accidental overdoses among some individuals who take opioids while on the medication treatment), as well as risks exclusive to the injectable medication for opioid dependence (such as injection site reactions that in some cases have warranted surgery).

SAMHSA on March 21 did not reply to e-mailed questions from Addiction Professional to elaborate on the context and timing of the advisory's release. The advisory is titled "An Introduction to Extended-Release Injectable Naltrexone for the Treatment of People With Opioid Dependence."

SAMHSA states that while generalizations about which patient will fare best under a certain medication are difficult to make, the opioid antagonist properties of naltrexone might make Vivitrol's anti-craving effects particularly successful for individuals who are facing high levels of stress and relapse risk.

Other groups that might benefit most from Vivitrol, according to the advisory, include individuals who have not had success with methadone or buprenorphine treatment; those who have succeeded with agonist therapies but might prefer a more convenient and less stigmatized treatment; and those who have a high level of motivation for abstinence.

The advisory also cites Vivitrol as a possible alternative for adolescents or young adults who have limited access to the other medication therapies, though it adds that the Food and Drug Administration (FDA) has not approved Vivitrol for use in patients under 18.

SAMSHA advisory on Vivitrol offers comparison with other opioid addiction treatments (continued)

The advisory's side-by-side comparison of Vivitrol, buprenorphine and methadone also highlights a number of other distinct features about Vivitrol, including that prescribing non-physicians such as nurse practitioners are allowed to order its administration.
The advisory's section on adverse events focuses mainly on injection site reactions from the gluteal intramuscular injection and on liver toxicity. The document recommends always administering Vivitrol injections using the specially designed 1.5- or 2-inch needles included in the medication packaging, and the document also cites warnings on the medication labeling about the risk of liver effects when Vivitrol dosing exceeds recommended levels.

Regarding access to the respective medications available in the market, the advisory mentions the limited geographical locations of methadone clinics and the relative lack of physicians specially trained to prescribe buprenorphine.

SAMHSA adds, citing a 2011 study, "Extended-release injectable naltrexone has a higher pharmacy cost than buprenorphine and methadone, but some data suggest that its use may reduce inpatient admissions, emergency room visits, and other health system costs. Nonetheless, the higher pharmacy cost of extended-release injectable naltrexone may limit access for patients who lack health insurance or other financial resources."

FDA OKs Vivitrol to treat heroin, narcotic addictions

By Rita Rubin, USA TODAY
The Food and Drug Administration has approved a new treatment for addiction to heroin or prescription narcotic painkillers.

Vivitrol differs in two main ways from methadone and buprenorphine (Suboxone), the two other drugs used to treat narcotic, or opioid, addiction. About 810,000 Americans are addicted to heroin, 1.85 million to opioid painkillers such as OxyContin, the National Institute on Drug Abuse says.

Vivitrol is injected monthly, not taken daily by mouth, so it's easier to stick to. Though patients can obtain buprenorphine at a pharmacy, they must go to clinics daily to get methadone. And, unlike methadone and buprenorphine, Vivitrol isn't an opioid but a long-acting form of naltrexone, which blocks opioids. "There are treatment programs that really oppose using methadone or buprenorphine," says Nora Volkow, director of the drug abuse institute. "I predict that naltrexone may be acceptable."

The FDA approved Vivitrol in 2006 for treating alcohol addiction. More than 45,000 people have been on it, some for more than four years, according to Alkermes, the Waltham, Mass., company that markets Vivitrol.
Doctors can prescribe drugs "off-label," but few have used Vivitrol, which lists for $1,100 per shot, to treat opioid addiction, Alkermes CEO Richard Pops says. "This is such a new market."

The study that led to FDA approval of Vivitrol for opioid addiction involved 250 patients in Russia, the only other country in which it is approved for treating alcohol addiction. Russia has rejected methadone or buprenorphine, Volkow says, leaving heroin "a major driver" of its HIV epidemic.
After six monthly shots, 70% of those who got Vivitrol hadn't gone back to using narcotics — double the rate of patients who had received a placebo. "I was concerned that the patients would not go back for their monthly injections, but they did, which was surprising," Volkow says. Also surprising, she says, was that Vivitrol reduced cravings for narcotics, for reasons that aren't yet clear.

T.J. Voller, 29, of Westborough, Mass., tried buprenorphine with "sporadic success." By last December, he says, he cashed in his 401(k) and spent $17,000 on heroin in a month. He then found a doctor who'd give him Vivitrol. "It takes the cravings away," says Voller, who has had eight shots and now works and attends college. "I've had (heroin) in front of my face and haven't had the urge to do it. It shocked the hell out of me."

Cultural Diversity Terms

Goal: define the following-

· African American – Refers to Black individuals living in the U.S. with African ancestry.

· Aleut – Native people of the Aleutian Islands and mainland Alaska.

· Asian American – A widely accepted term in the U.S. referring to individuals living in the U.S. with Asian ancestry. Includes Hawaiian, Chinese, Filipino, Japanese, Korean, Asian Indian, and Vietnamese.

· Black – Replaced the term Negro in the 1960's. Used interchangeably with African American.

· Class – Category of division based on economic status.

· Culture – A dynamic construct that includes the values, beliefs, and behaviors of a people who have lived together in a particular geographic location for at least three or four generations.

· Diversity – Human qualities that are different from our own and outside to which we belong, yet are present in other individuals and groups (variety).

· Ethnicity - a person's group (ethnic group) sharing a common and distinctive culture, religion, language, or the like.

· Feminism – Movement advocating equal rights, status, ability, and treatment of women, based on the belief that women are not in any way inferior to men.

· Gay – A male homosexual.

· Gender – System of sexual classification based on the social construction of the categories "men" and "women," as opposed to sex which is based on biological and physical differences which form the categories "male" and "female".

· Hispanic American – Individuals living in the U.S. with ancestry from Hispanic, or Spanish speaking countries.

· Latino – Generally preferred over "Hispanic" by Spanish speaking people of the U.S., especially in California because it emphasizes their Latin American origins.

· Lesbian – Female homosexual.

· Multiculturalism – The practice of acknowledging and respecting the various cultures, races, ethnicities, attitudes and opinions within an environment.

· Oriental – Still used in many parts of the world to refer to people form Asia. In disfavor among Asian Americans in many parts of the U.S.

· People of color – Refers to everyone who is not white.

· Platinum rule – Treat others as they would like to be treated.

· Primary dimensions – Dimensions we are born with such as age, ethnicity, gender, physical abilities, race, and sexual orientation.

· Secondary dimensions – Dimensions that can be changed such as educational background, geographic location, income, marital status, religious beliefs, and work experiences.

READING LIST

Group Counseling

The following must be read PRIOR to the class:

1. Getting Ready to Test
(pp 303 - 338, 8th Edition)

2. Loosening the Grip
Chapter 10 - *Treatment Techniques and Approaches*

READING LIST

Eight Counseling Communication Skills

The following must be read PRIOR to the class:

1. *Getting Ready to Test*
   (pp 267 - 302, 8th)

The following is an article from Newsweek written by Sharon Begley January 29th, 2010

The Depressing News About Antidepressants

Studies suggest that the popular drugs are no more effective than a placebo. In fact, they may be worse.

Although the year is young, it has already brought my first moral dilemma. In early January a friend mentioned that his New Year's resolution was to beat his chronic depression once and for all. Over the years he had tried a medicine chest's worth of antidepressants, but none had really helped in any enduring way, and when the side effects became so unpleasant that he stopped taking them, the withdrawal symptoms (cramps, dizziness, headaches) were torture. Did I know of any research that might help him decide whether a new antidepressant his doctor recommended might finally lift his chronic darkness at noon? The moral dilemma was this: oh, yes, I knew of 20-plus years of research on antidepressants, from the old tricyclics to the newer selective serotonin reuptake inhibitors (SSRIs) that target serotonin (Zoloft, Paxil, and the granddaddy of them all, Prozac, as well as their generic descendants) to even newer ones that also target norepinephrine (Effexor, Wellbutrin). The research had shown that antidepressants help about three quarters of people with depression who take them, a consistent finding that serves as the basis for the oft-repeated mantra "There is no question that the safety and efficacy of antidepressants rest on solid scientific evidence," as psychiatry professor Richard Friedman of Weill Cornell Medical College recently wrote in *The New York Times*. But ever since a seminal study in 1998, whose findings were reinforced by landmark research in *The Journal of the American Medical Association* last month, that evidence has come with a big asterisk. Yes, the drugs are effective, in that they lift depression in most patients. But that benefit is hardly more than what patients get when they, unknowingly and as part of a study, take a dummy pill—a placebo. As more and more scientists who study depression and the drugs that treat it are concluding, that suggests that antidepressants are basically expensive Tic Tacs.

Hence the moral dilemma. The placebo effect—that is, a medical benefit you get from an inert pill or other sham treatment—rests on the holy trinity of belief, expectation, and hope. But telling someone with depression who is being helped by antidepressants, or who (like my friend) hopes to be helped, threatens to topple the whole house of cards. Explain that it's all in their heads, that the reason they're benefiting is the same reason why Disney's Dumbo could initially fly only with a feather clutched in his trunk—believing makes it so—and the magic dissipates like fairy dust in a windstorm. So rather than tell my friend all this, I chickened out. Sure, I said, there's lots of research showing that a new kind of antidepressant might help you. Come, let me show you the studies on PubMed.

It seems I am not alone in having moral qualms about blowing the whistle on antidepressants. That first analysis, in 1998, examined 38 manufacturer-sponsored studies involving just over 3,000 depressed patients. The authors, psychology researchers Irving Kirsch and Guy Sapirstein of the University of Connecticut, saw—as everyone else had—that patients did improve, often substantially, on SSRIs, tricyclics, and even MAO inhibitors, a class of antidepressants that dates from the 1950s. This improvement, demonstrated in scores of clinical trials, is the basis for the ubiquitous claim that antidepressants work. But when Kirsch compared the improvement in patients taking the drugs with the improvement in those taking dummy pills—clinical trials typically compare an experimental drug with a placebo—he saw that the difference was minuscule. Patients on a placebo improved about 75 percent as much as those on drugs. Put another way, three quarters of the benefit from antidepressants seems to be a placebo effect. "We wondered, what's going on?" recalls Kirsch, who is now at the University of Hull in England. "These are supposed to be wonder drugs and have huge effects."

The study's impact? The number of Americans taking antidepressants doubled in a decade, from 13.3 million in 1996 to 27 million in 2005.

To be sure, the drugs have helped tens of millions of people, and Kirsch certainly does not advocate that patients suffering from depression stop taking the drugs. On the contrary. But they are not necessarily the best first choice. Psychotherapy, for instance, works for moderate, severe, and even very severe depression. And although for some patients, psychotherapy in combination with an initial course of prescription antidepressants works even better, the question is, *how* do the drugs work? Kirsch's study and, now, others conclude that the lion's share of the drugs' effect comes from the fact that patients expect to be helped by them, and not from any direct chemical action on the brain, especially for anything short of very severe depression.

As the inexorable rise in the use of antidepressants suggests, that conclusion can't hold a candle to the simplistic "antidepressants work!" (unstated corollary: "but don't ask how") message. Part of the resistance to Kirsch's findings has been due to his less-than-retiring nature. He didn't win many friends with the cheeky title of the paper, "Listening to Prozac but Hearing Placebo." Nor did it inspire confidence that the editors of the journal *Prevention & Treatment* ran a warning with his paper, saying it used meta-analysis "controversially." Al-though some of the six invited commentaries agreed with Kirsch, others were scathing, accusing him of bias and saying the studies he analyzed were flawed (an odd charge for defenders of antidepressants, since the studies were the basis for the Food and Drug Administration's approval of the drugs). One criticism, however, could not be refuted: Kirsch had analyzed only some studies of antidepressants. Maybe if he included them all, the drugs would emerge head and shoulders superior to placebos.

Kirsch agreed. Out of the blue, he received a letter from Thomas Moore, who was then a health-policy analyst at George Washington University. You could expand your data set, Moore wrote, by including everything drug companies sent to the FDA—published studies, like those analyzed in "Hearing Placebo," but also unpublished studies. In 1998 Moore used the Freedom of Information Act to pry such data from the FDA. The total came to 47 company-sponsored studies—on Prozac, Paxil, Zoloft, Effexor, Serzone, and Celexa—that Kirsch and colleagues then pored over. (As an aside, it turned out that about 40 percent of the clinical trials had never been published. That is significantly higher than for other classes of drugs, says Lisa Bero of the University of California, San Francisco; overall, 22

percent of clinical trials of drugs are not published. "By and large," says Kirsch, "the unpublished studies were those that had failed to show a significant benefit from taking the actual drug.") In just over half of the published and unpublished studies, he and colleagues reported in 2002, the drug alleviated depression no better than a placebo. "And the extra benefit of antidepressants was even less than we saw when we analyzed only published studies," Kirsch recalls. About 82 percent of the response to antidepressants—not the 75 percent he had calculated from examining only published studies—had also been achieved by a dummy pill.

The extra effect of real drugs wasn't much to celebrate, either. It amounted to 1.8 points on the 54-point scale doctors use to gauge the severity of depression, through questions about mood, sleep habits, and the like. Sleeping better counts as six points. Being less fidgety during the assessment is worth two points. In other words, the clinical significance of the 1.8 extra points from real drugs was underwhelming. Now Kirsch was certain. "The belief that antidepressants can cure depression chemically is simply wrong," he told me in January on the eve of the publication of his book *The Emperor's New Drugs: Exploding the Anti-depressant Myth*.

The 2002 study ignited a furious debate, but more and more scientists were becoming convinced that Kirsch—who had won respect for research on the placebo response and who had published scores of scientific papers—was on to something. One team of researchers wondered if antidepressants were "a triumph of marketing over science." Even defenders of antidepressants agreed that the drugs have "relatively small" effects. "Many have long been unimpressed by the magnitude of the differences observed between treatments and controls," psychology researcher Steven Hollon of Vanderbilt University and colleagues wrote—"what some of our colleagues refer to as 'the dirty little secret.' " In Britain, the agency that assesses which treatments are effective enough for the government to pay for stopped recommending antidepressants as a first-line treatment, especially for mild or moderate depression.

But if experts know that antidepressants are hardly better than placebos, few patients or doctors do. Some doctors have changed their prescribing habits, says Kirsch, but more "reacted with anger and incredulity." Understandably. For one thing, depression is a devastating, underdiagnosed, and undertreated disease. Of course doctors recoiled at the idea that such drugs might be mirages. If that were true, how were physicians supposed to help their patients?

Two other factors are at work in the widespread rejection of Kirsch's (and, now, other scientists') findings about antidepressants. First, defenders of the drugs scoff at the idea that the FDA would have approved ineffective drugs. (Simple explanation: the FDA requires two well-designed clinical trials showing a drug is more effective than a placebo. That's two, period—even if many more studies show no such effectiveness. And the size of the "more effective" doesn't much matter, as long as it is statistically significant.) Second, doctors see with their own eyes, and feel with their hearts, that the drugs lift the black cloud from many of their depressed patients. But since doctors are not exactly in the habit of prescribing dummy pills, they have no experience comparing how their patients do on them, and therefore never see that a placebo would be almost as effective as a $4 pill. "When they prescribe a treatment and it works," says Kirsch, "their natural tendency is to attribute the cure to the treatment." Hence the widespread "antidepressants work" refrain that persists to this day.

Drug companies do not dispute Kirsch's aggregate statistics. But they point out that the average is made up of some patients in whom there is a true drug effect of antidepressants and some in whom there is not. As a spokesperson for Lilly (maker of Prozac) said, "Depression is a highly individualized illness," and "not all patients respond the same way to a particular treatment." In addition, notes a spokesperson for Glaxo-Smith-Kline (maker of Paxil), the studies analyzed in the *JAMA* paper differ from studies GSK submitted to the FDA when it won approval for Paxil, "so it is difficult to make direct comparisons between the results. This study contributes to the extensive research that has helped to characterize the role of antidepressants," which "are an important option, in addition to counseling and lifestyle changes, for treatment of depression." A spokesperson for Pfizer, which makes Zoloft, also cited the "wealth of scientific evidence documenting [antidepressants'] effects," adding that the fact that antidepressants "commonly fail to separate from placebo" is "a fact well known by the FDA, academia, and industry." Other manufacturers pointed out that Kirsch and the *JAMA* authors had not studied their particular brands.

Even Kirsch's analysis, however, found that antidepressants are a little more effective than dummy pills—those 1.8 points on the depression scale. Maybe Prozac, Zoloft, Paxil, Celexa, and their cousins do have some non-placebo, chemical benefit. But the small edge of real drugs compared with placebos might not mean what it seems, Kirsch explained to me one evening from his home in Hull. Consider how research on drugs works. Patient volunteers are told they will receive either the drug or a placebo, and that neither they nor the scientists will know who is getting what. Most volunteers hope they get the drug, not the dummy pill. After taking the unknown meds for a while, some volunteers experience side effects. Bingo: a clue they're on the real drug. About 80 percent guess right, and studies show that the worse side effects a patient experiences, the more effective the drug. Patients apparently think, this drug is so strong it's making me vomit and hate sex, so it must be strong enough to lift my depression. In clinical-trial patients who figure out they're receiving the drug and not the inert pill, expectations soar.

That matters because belief in the power of a medical treatment can be self-fulfilling (that's the basis of the placebo effect). The patients who correctly guess that they're getting the real drug therefore experience a stronger placebo effect than those who get the dummy pill, experience no side effects, and are therefore disappointed. That might account for antidepressants' slight edge in effectiveness compared with a placebo, an edge that derives not from the drugs' molecules but from the hopes and expectations that patients in studies feel when they figure out they're receiving the real drug.

The boy who said the emperor had no clothes didn't endear himself to his fellow subjects, and Kirsch has fared little better. A nascent collaboration with a scientist at a medical school ended in 2002 when the scientist was warned not to submit a grant proposal with Kirsch if he ever wanted to be funded again. Four years later, another scientist wrote a paper questioning the effectiveness of antidepressants, citing Kirsch's work. It was published in a prestigious journal. That ordinarily brings accolades. Instead, his department chair dressed him down and warned him not to become too involved with Kirsch.

But the question of whether antidepressants—which in 2008 had sales of $9.6 billion in the U.S., reported the consulting firm IMS Health—have any effect other than through patients' belief in them was too important to scare researchers off. Proponents of the drugs have found themselves making weaker and weaker claims. Their last stand is that

antidepressants are more effective than a placebo in patients suffering the most severe depression.

So concluded the *JAMA* study in January. In an analysis of six large experiments in which, as usual, depressed patients received either a placebo or an active drug, the true drug effect—that is, in addition to the placebo effect—was "nonexistent to negligible" in patients with mild, moderate, and even severe depression. Only in patients with very severe symptoms (scoring 23 or above on the standard scale) was there a statistically significant drug benefit. Such patients account for about 13 percent of people with depression. "Most people don't need an active drug," says Vanderbilt's Hollon, a coauthor of the study. "For a lot of folks, you're going to do as well on a sugar pill or on conversations with your physicians as you will on medication. It doesn't matter what you do; it's just the fact that you're doing something." But people with very severe depression are different, he believes. "My personal view is the placebo effect gets you pretty far, but for those with very severe, more chronic conditions, it's harder to knock down and placebos are less adequate," says Hollon. Why that should be remains a mystery, admits coauthor Robert DeRubeis of the University of Pennsylvania.

Like every scientist who has stepped into the treacherous waters of antidepressant research, Hollon, DeRubeis, and their colleagues are keenly aware of the disconnect between evidence and public impression. "Prescribers, policy-makers, and consumers may not be aware that the efficacy of [antidepressants] largely has been established on the basis of studies that have included only those individuals with more severe forms of depression," something drug ads don't mention, they write. People with anything less than very severe depression "derive little specific pharmacological benefit from taking medications. Pending findings contrary to those reported here … efforts should be made to clarify to clinicians and prospective patients that … there is little evidence to suggest that [antidepressants] produce specific pharmacological benefit for the majority of patients."

Right about here, people scowl and ask how anti-depressants—especially those that raise the brain's levels of serotonin—can possibly have no direct chemical effect on the brain. Surely raising serotonin levels should right the synapses' "chemical imbalance" and lift depression. Unfortunately, the serotonin-deficit theory of depression is built on a foundation of tissue paper. How that came to be is a story in itself, but the basics are that in the 1950s scientists discovered, serendipitously, that a drug called iproniazid seemed to help some people with depression. Iproniazid increases brain levels of serotonin and norepinephrine. Ergo, low levels of those neurotransmitters must cause depression. More than 50 years on, the presumed effectiveness of antidepressants that act this way remains the chief support for the chemical-imbalance theory of depression. Absent that effectiveness, the theory hasn't a leg to stand on. Direct evidence doesn't exist. Lowering people's serotonin levels does not change their mood. And a new drug, tianeptine, which is sold in France and some other countries (but not the U.S.), turns out to be as effective as Prozac-like antidepressants that keep the synapses well supplied with serotonin. The mechanism of the new drug? It *lowers* brain levels of serotonin. "If depression can be equally affected by drugs that increase serotonin and by drugs that decrease it," says Kirsch, "it's hard to imagine how the benefits can be due to their chemical activity."

Perhaps antidepressants would be more effective at higher doses? Unfortunately, in 2002 Kirsch and colleagues found that high doses are hardly more effective than low ones, improving patients' depression-scale rating an average of 9.97 points vs. 9.57 points—a

difference that is not statistically significant. Yet many doctors increase doses for patients who do not respond to a lower one, and many patients report improving as a result. There's a study of that, too. When researchers gave such nonresponders a higher dose, 72 percent got much better, their symptoms dropping by 50 percent or more. The catch? Only half the patients really got a higher dose. The rest, unknowingly, got the original, "ineffective" dose. It is hard to see the 72 percent who got much better on ersatz higher doses as the result of anything but the power of expectation: the doctor upped my dose, so I believe I'll get better. Something similar may explain why some patients who aren't helped by one antidepressant do better on a second, or a third. This is often explained as "matching" patient to drug, and seemed to be confirmed by a 2006 federal study called STAR*D. Patients still suffering from depression after taking one drug were switched to a second; those who were still not better were switched to a third drug, and even a fourth. No placebos were used. At first blush, the results offered a ray of hope: 37 percent of the patients got better on the first drug, 19 percent more on their second, 6 percent more improved on their third try, and 5 percent more on their fourth. (Half of those who recovered relapsed within a year, however.)

So does STAR*D validate the idea that the key to effective treatment of depression is matching the patient to the drug? Maybe. Or maybe people improved in rounds two, three, and four because depression sometimes lifts due to changes in people's lives, or because levels of depression tend to rise and fall over time. With no one in STAR*D receiving a placebo, it is not possible to conclude with certainty that the improvements in rounds two, three, and four were because patients switched to a drug that was more effective for them. Comparable numbers might have improved if they had switched to a placebo. But STAR*D did not test for that, and so cannot rule it out.

It's tempting to look at the power of the placebo effect to alleviate depression and stick an "only" in front of it—as in, the drugs work *only* through the placebo effect. But there is nothing "only" about the placebo response. It can be surprisingly enduring, as a 2008 study found: "The widely held belief that the placebo response in depression is short-lived appears to be based largely on intuition and perhaps wishful thinking," scientists wrote in the *Journal of Psychiatric Research*. The strength of the placebo response drives drug companies nuts, since it makes showing the superiority of a new drug much harder. There is a strong placebo component in the response to drugs for pain, asthma, irritable-bowel syndrome, skin conditions such as contact dermatitis, and even Parkinson's disease. But compared with the placebo component of antidepressants, the placebo response accounts for a smaller fraction of the benefit from drugs for those disorders—on the order of 50 percent for analgesics, for instance.

Which returns us to the moral dilemma. In any year, an estimated 13.1 million to 14.2 million American adults suffer from clinical depression. At least 32 million will have the disease at some point in their life. Many of the 57 percent who receive treatment (the rest do not) are helped by medication. For that benefit to continue, they need to believe in their pills. Even Kirsch warns—in boldface type in his book, which is in stores this week—that patients on antidepressants not suddenly stop taking them. That can cause serious withdrawal symptoms, including twitches, tremors, blurred vision, and nausea—as well as depression and anxiety. Yet Kirsch is well aware that his book may have the same effect on patients as dropping the magic feather did for Dumbo: without it, the little elephant began crashing to earth. Friends and colleagues who believe Kirsch is right ask why he

doesn't just shut up, since publicizing the finding that the effectiveness of antidepressants is almost entirely due to people's hopes and expectations will undermine that effectiveness. It's all well and good to point out that psychotherapy is more effective than either pills or placebos, with dramatically lower relapse rates. But there's the little matter of reality. In the U.S., most patients with depression are treated by primary-care doctors, not psychiatrists. The latter are in short supply, especially outside cities and especially for children and adolescents. Some insurance plans discourage such care, and some psychiatrists do not accept insurance. Maybe keeping patients in the dark about the ineffectiveness of antidepressants, which for many are their only hope, is a kindness.

Or maybe not. As shown by the explicit criticism of drug companies by the authors of the recent *JAMA* paper, more and more scientists believe it is time to abandon the "don't ask, don't tell" policy of not digging too deeply into the reasons for the effectiveness of antidepressants. Maybe it is time to pull back the curtain and see the wizard for what he is. As for Kirsch, he insists that it is important to know that much of the benefit of antidepressants is a placebo effect. If placebos can make people better, then depression can be treated without drugs that come with serious side effects, not to mention costs. Wider recognition that antidepressants are a pharmaceutical version of the emperor's new clothes, he says, might spur patients to try other treatments. "Isn't it more important to know the truth?" he asks. Based on the impact of his work so far, it's hard to avoid answering, "Not to many people."

READING LIST

CO-Occurring Disorders (Psychopharmacology)

The following must be read PRIOR to the class:

1. Getting Ready to Test
(pp 443 – 481, 8th Edition)

2. Drugs, Society, and Human Behavior
Chapter 8 – *Medication for Mental Disorders*

READING LIST

HIV / AIDS

The following must be read PRIOR to the class:

1. Getting Ready to Test
(pp 485 – 514, 8th Edition)

Phone Etiquette / General Conversation Manners

1. Speak clearly. A picture paints a thousand words but the caller on the other end of the phone can only hear you. They cannot see your face or body language. Therefore, taking the time to speak clearly, slowly and in a cheerful, professional voice is very important.

2. Use your normal tone of voice when answering a call. If you have a tendency to speak loud or shout, avoid doing so on the telephone.

3. Do not eat or drink while you are on telephone duty. Only eat or drink during your coffee break or lunch break.

4. Do not use slang words or Poor Language. Respond clearly with "yes" or "no" when speaking. Never use swear words.

5. Address the Caller Properly by his or her title. (i.e. Good morning Mr. Brown, Good afternoon Ms. Sanders). Never address an unfamiliar caller by his or her first name.

6. Listen to the Caller and what they have to say. The ability to listen is a problem in general but it is very important to listen to what the caller has to say. It is always a good habit to repeat the information back to the client when you are taking a message. Verify that you have heard and transcribed the message accurately.

7. Be patient and helpful. If a caller is irate or upset, listen to what they have to say and then refer them to the appropriate resource. Never snap back or act rude to the caller.

8. Always ask if you can put the caller on hold. If you are responsible for answering multiple calls at once, always ask the caller politely if you may put them on hold. Remember that the caller could have already waited several minutes before getting connected to you and may not take lightly to being put on hold. Never leave the person on hold for more than a few seconds or they may become upset and hang up.

9. Always focus on the call. Try not to get distracted by people around you. If someone tries to interrupt you while you are on a call, politely remind them that you are on a call and that you will be with them as soon as you are finished.

Making Calls:

1. Always identify yourself properly. When calling a parent or community contact, whether in person or when leaving a message, always identify yourself properly by providing your name, program name and contact telephone number. For example, "Good afternoon Mr. Brown, this is Ms. Brown from (name of Program). My telephone number is 770-555-1212." Always be aware of confidential information when leaving messages. Also, be aware of people around you while talking on the phone. Be discreet! Someone next to you might overhear confidential information.

2. Avoid leaving long winded messages. Remember, someone has to listen to your message, write it down and then act upon it. Your message may be just one of many messages that need to be handled. It is often a good habit to write down or type out your message in advance. Keep it brief and to the point.

Cell Phone Etiquette:

1. Don't text or check your phone when speaking with others. Give your full attention.
2. Be aware of your conversations in enclosed public spaces
3. Deliver important news in person or call. Do not text.
4. Just quit playing on your phone so much in general.

Mother Teresa's *Anyway* Poem

People are often unreasonable, illogical and self centered;

Forgive them anyway.

If you are kind, people may accuse you of selfish, ulterior motives;

Be kind anyway.

If you are successful, you will win some false friends and some true

enemies;

Succeed anyway.

If you are honest and frank, people may cheat you;

Be honest and frank anyway.

What you spend years building, someone could destroy overnight;

Build anyway.

If you find serenity and happiness, they may be jealous;

Be happy anyway.

The good you do today, people will often forget tomorrow;

Do good anyway.

Give the world the best you have, and it may never be enough;

Give the world the best you've got anyway.

You see, in the final analysis, it is between you and your God;

It was never between you and them anyway.

If
By Rudyard Kipling

If you can keep your head when all about you
  Are losing theirs and blaming it on you,
If you can trust yourself when all men doubt you,
  But make allowance for their doubting too;
If you can wait and not be tired by waiting,
  Or being lied about, don't deal in lies,
Or being hated, don't give way to hating,
  And yet don't look too good, nor talk too wise:

If you can dream—and not make dreams your master;
  If you can think—and not make thoughts your aim;
If you can meet with Triumph and Disaster
  And treat those two impostors just the same;
If you can bear to hear the truth you've spoken
  Twisted by knaves to make a trap for fools,
Or watch the things you gave your life to, broken,
  And stoop and build 'em up with worn-out tools:

If you can make one heap of all your winnings
  And risk it on one turn of pitch-and-toss,
And lose, and start again at your beginnings
  And never breathe a word about your loss;
If you can force your heart and nerve and sinew
  To serve your turn long after they are gone,
And so hold on when there is nothing in you
  Except the Will which says to them: 'Hold on!'

If you can talk with crowds and keep your virtue,
  Or walk with Kings—nor lose the common touch,
If neither foes nor loving friends can hurt you,
  If all men count with you, but none too much;
If you can fill the unforgiving minute
  With sixty seconds' worth of distance run,
Yours is the Earth and everything that's in it,
  And—which is more—you'll be a Man, my son!