HIV CO U N S E L O R
PERSPECTIVES

SUBSTAN C E A B U S E T R E A T M E N T S

The use of alcohol and other drugs becomes abusive when it interferes with a person’s physical, psychological, or social well-being over time. Although it is not the HIV test counselor’s role to assess whether or not a client abuses substances, knowledge of treatment approaches and procedures can be helpful when counseling clients who are in treatment, who have undergone treatment, or who state that they have a substance abuse problem. This issue of PERSPECTIVES provides an introduction to substance abuse treatment and its effect on HIV risk. The Implications for Counseling section explores stages of change related to substance use and presents strategies for providing referrals for clients who might be abusing substances or who are at risk for substance abuse.

Research Update

In 1995, two million people entered publicly funded substance abuse treatment programs in the United States—54 percent for alcohol treatment and 46 percent for other drug treatment.\(^1\)

A substance can be alcohol or another drug, whether it is illegal, sold by prescription, or sold as an over-the-counter medication.\(^2\) Substance use can increase HIV risk either directly, through the sharing of drug injection equipment, or indirectly, by lowering inhibitions and affecting judgment.*

According to a national survey, 82 percent of people who are at least 12 years old have consumed alcohol at some time in their lives, and 36 percent have used illegal drugs.\(^3\) A 1996 study found that half of all new HIV infections in the United States occurred among injection drug users.\(^4\)

Substance Use and Abuse

Although substance use is common, it is not always problematic; most people who use substances do not abuse them. “Substance abuse” is a pattern of repeated use that causes harmful consequences.\(^2\)

After heavy and prolonged use of some substances, a person who discontinues or reduces use may experience physical or psychological withdrawal, which can cause distress or impair important areas of functioning. People who experience withdrawal are likely to crave and use the substance to prevent or diminish withdrawal symptoms.\(^2\)

Heavy and prolonged substance use can also increase levels of tolerance, that is, the need for increasing amounts of a substance to achieve the same level of intoxication or effect.\(^5\)

Tolerance and withdrawal are two indicators of the pattern of compulsive substance abuse that is characteristic of “substance dependence.” The definition of dependence also includes behavioral components, such as making unsuccessful efforts to stop or control use and continuing use despite awareness of the substance’s persistent or recur-
rent detrimental effects. Substance abuse may or may not lead to substance dependence.²

Various factors, such as socio-economic status, age, gender, or occupation, are statistically associated with substance abuse.² Research also indicates that a pre-disposition to substance abusing behaviors can be genetically inherited.⁵ Substance abuse can result from a combination of any number of genetic, cultural, behavioral, and adaptive factors. Substance abuse, however, is not limited to people with recognized risk factors; it can affect anyone.

Many people who abuse substances are undergoing substance abuse treatment, are considering treatment, or have attempted treatment. Relapse is common among people who have completed treatment, and many substance abusers have undergone treatment several times, often trying different programs.⁶ According to a national study, half of treatment clients had previously received treatment. Clients also reported first entering treatment an average of seven years after they began using their primary substance.⁷

Many people who abuse substances, however, are not interested in treatment, do not believe treatment can be effective for them, or are not able to access treatment for financial or other reasons.⁸ For people who have insurance, access is often more difficult now than it was a decade ago because insurance plans are now more restrictive in their coverage of substance abuse treatment, particularly for residential programs.

Goals of Treatment
The goal of substance abuse treatment has traditionally been abstinence, not only from the user’s primary substance, but from all substances. If successful, this strategy prevents the substitution of one substance for another. People who have stopped using heroin or cocaine, for example, often use alcohol as a substitute. In addition, the probability of relapsing to primary substance use increases when a person is under the influence of any substance, even if it is not the person’s substance of choice.⁹

In the 1990s, harm reduction has gained popularity among substance abuse treatment programs. Rather than trying to eliminate substance use altogether, harm reduction aims to reduce harm and risk. Needle exchange programs and moderating substance use are forms of harm reduction.⁹ Effective harm reduction involves acknowledging the sociocultural factors of substance use and reducing HIV risks.¹⁰

Basic Elements of Treatment
There are various types of substance abuse treatment programs, many of which employ different combinations of the same basic services.

When substance abuse is severe and when the client is likely to experience withdrawal, detoxification is often necessary to achieve sobriety and to prepare a client for treatment. The process of detoxification includes clearing a substance from a client’s body and allowing time for the client to adjust to the absence of the substance.¹¹

Detoxification is especially common for severe alcohol and opiate withdrawal¹² and often includes pharmacological therapy, which is the use of medication to alleviate withdrawal symptoms.¹¹ A common pharmacological therapy for heroin and other opiate withdrawal is methadone, a pain relieving substitute for opiates.¹² Methadone is also a common long-term treatment for opiate dependence after detoxification.

Group therapy is an integral part of most treatment programs. Groups usually consist of five to 10 clients who meet regularly under the guidance of a therapist or addiction counselor. Many addiction counselors are themselves recovering from substance abuse.¹³ Group therapy provides social support, immediate feedback, positive peer pressure, structure, discipline, and instillation of optimism and hope.¹⁴

Peer-facilitated self-help groups are another kind of group activity common to many treatment programs. Self-help groups are often based on the 12-step approach used by Alcoholics Anonymous (AA) and related groups.¹⁵ This approach involves studying and following AA’s 12 steps, which include admitting powerlessness over alcohol and other drugs and believing that a “higher power” can make recovery possible. Twelve-step programs also teach people to accept their own limitations, serve others, take responsibility for their actions, and make amends for past wrongs.¹⁶ The 12-step approach is helpful for many people, but for those who reject it, perhaps because of its philosophy or spiritual focus, other types of self-help groups are also available.¹⁵

Most treatment programs also educate clients about addiction, relapse, recovery, and the effects of substances. Lectures, films, reading, and discussion are common educational activities. Some programs also require clients to write a daily journal, which may include thoughts, problems, feelings, and coping strategies for recovery.¹³

Types of Treatment Programs
The most intensive type of treatment is the inpatient residential program. Inpatient treatment provides 24-hour supervision during a
fixed-length stay at a substance dependency unit, either within a hospital or in a specialized facility. The most common inpatient treatment modality used in the United States, the Minnesota Model, usually lasts four weeks and consists of an initial detoxification phase, followed by intensive group therapy, educational lectures, and meetings with addiction counselors. Inpatient treatment is often effective because it interrupts the cycle of substance use and provides intense and constant supervision and safety. There are, however, disadvantages. Because craving is largely the result of a substance’s availability, the substance-free nature of an inpatient environment may be the main reason clients do not experience cravings. This may leave clients unprepared to cope with the cravings they are likely to experience when they return to settings in which substances are available. To prevent this outcome, some inpatient programs gradually expose clients to such “triggers” by allowing them to take short breaks from their residencies. Research indicates that inpatient treatment is most effective for people who have severe substance abuse disorders, serious health or psychiatric problems, and relatively little social stability, as well as for people who are married and older. However, inpatient treatment is expensive, and clients are often unable to work, care for their families, or conduct other daily activities.

Another type of residential treatment program is the therapeutic community (TC), a short- or long-term residential substance abuse treatment program that traditionally lasts 15 months to 24 months. The principal goal is to change a client’s substance-abusing identity and lifestyle in order to achieve abstinence, eliminate antisocial activity, and develop employment skills. To accomplish this goal, the therapeutic community provides medical, clinical, mental health, vocational, educational, family, fiscal, administrative, and legal services.

Because returning to society after completing a residential substance abuse treatment program can be difficult, particularly for people who were homeless before entering treatment, some people enroll in halfway houses, which provide transitional residential facilities and services. Halfway houses are generally small, informal, and staffed with recovering substance abusers. Residents tend to have limited social or environmental support outside of the halfway house, and they can come and go as they wish, which allows them to work and perform other daily activities. Most people who complete a residential program continue treatment on an outpatient basis in aftercare. Outpatient treatment services, however, are not limited to people who have completed residential treatment. Outpatient treatment programs provide many of the same services as inpatient programs. Most outpatient programs last four to eight weeks, and groups generally meet in the evenings.

For opiate addiction, particularly heroin, methadone maintenance therapy is available on an outpatient basis. Methadone reduces cravings for opiates, helps daily functioning, has negligible side effects, and can be taken orally once a day. Another advantage of methadone maintenance therapy is the nearly daily contact between clients and their providers. Some clients gradually reduce methadone intake until they achieve abstinence, while others remain dependent on the treatment indefinitely. Methadone maintenance therapy is controversial, partly because it substitutes dependence on one addictive drug for another.

Some treatment approaches work well for some people but not for others, and different treatment programs and approaches have varying rates of success. In a study of 96 treatment programs in 11 U.S. cities, substance use among subjects who completed treatment decreased by about 50 percent. Rather than entering a treatment program, some people who abuse substances attempt self-treatment, either on their own or under the supervision of a counselor, therapist, or other service provider. A common approach to self-treatment is “cold turkey,” which is a sudden termination of substance use. Other self-treatment approaches involve gradual stages that may be more
Discontinuation or reduction in frequency of substance use may also reduce their HIV risk, substance abuse treatment can itself be a form of HIV prevention.

Implications for Counseling

It is important for HIV test counselors to ask all clients about substance use to determine the extent to which it affects risk taking. This will also allow counselors to provide the most appropriate referrals for clients who want further support or information. Because clients may not expect to discuss substance use, integrating this subject into the counseling session is a delicate process. Often, it is most timely to introduce substance use after first discussing other HIV risk behaviors. By first establishing rapport and credibility in this way, the counselor is better able to explain the relevance of discussing substance use.

To introduce substance use, a direct approach is often effective. For example, ask a client, “How do you think substance use affects your HIV risk behavior?” As with other subjects, ask open-ended questions, suspend any judgments, and be careful never to label a client’s substance use as a “problem” or as “abusive.” It is not within the counselor’s role to assess whether or not a client is abusing substances.

Intervention

If the client’s substance use appears to affect his or her risk behavior, ask if the client sees this relationship. A client who fails to see this may be in the pre-contemplation stage of changing substance-use behavior. If, even after further exploration, the client still sees no relationship, refrain from further questioning. Instead, point out any patterns of substance use that appear to be influencing the client’s HIV risks. If the client does not wish to explore the subject further, honor this and continue the session in another direction.

For clients who recognize that their substance use affects HIV risk behavior or are otherwise consider-
ing changing their substance-using behavior, ask what the change could be, what would help to make such a change, what the next step in making this change would be, and how realistic it is for the client to make this change. If a client who acknowledges substance use to be a problem states that he or she is not ready to stop using substances, ask which changes the client wants to make.

Some clients may say that they have their substance-using behavior under control despite past incidents in which it has placed them at risk. For instance, when a person says, “I got loaded one night and had sex without a condom, but it’ll never happen again,” explore the context of this behavior. What were the circumstances? What leads the client to be sure it will never happen again? Is he or she saying this to appease the counselor? Remain neutral, and learn if there are things the client might do to ensure it will never happen again. Ask, for instance, “The next time you get ‘loaded,’ how can you ensure that you can have safer sex?”

Be aware that changing HIV risk behaviors can be especially difficult for substance abusing clients because they may not consider change to be possible. Some clients who recognize that they abuse substances may also state that they have no hope of changing their behaviors. Acknowledge such a client’s feelings and that the client may not be ready to stop using substances at this time, and encourage the client not to give up hope, perhaps by saying, “I know people who got sober late in life. It’s never too late.”

Referrals
In the limited scope of the HIV test counseling session, a counselor’s primary intervention for a client’s substance-abuse is to provide referrals. Referrals are especially useful for clients who are contemplating change, ready to make change, or seeking to maintain change. When a client expresses concern about substance use and HIV risk but is uncertain about how to reduce these risks, a counselor might say, “You’ve talked about having unsafe sex when you drink, and you say you drink nightly. I’m wondering if you feel like your drinking is a problem?”

Be direct in making referrals. For instance, state, “I know a place where you can get help for this. Would you like a number?” Some clients may say that they do not want referrals, but it is better to ask and find this out from them than to avoid the discussion. Explain to clients who do not want referrals that they can find substance abuse treatment services in the Yellow Pages of a telephone directory if they change their minds. When clients want to stop substance use without support from others, offer congratulations, if appropriate, and let them know support is available if they want it.

Referrals can include case management services, outpatient substance abuse programs, methadone maintenance clinics, needle exchange programs, and 12-step meetings, such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). If a current meeting list—which provides a schedule of local 12-step meetings—is not available, offer the telephone number of AA and NA hotlines. To maintain current meeting lists, call the hotlines and ask to be added to their mailing lists. Also give clients the local telephone number of the National Council on Alcoholism and Other Drug Problems, an assessment and referral organization with offices throughout California. Acknowledge that recovering from substance abuse is difficult and that people generally need a lot of support in such situations.

As with discussions about sexual risks, a client in the counseling session might express a desire to avoid certain behaviors, but this feeling may change in another situation. When offering referrals, be prepared for this and for the possibility of a client saying, “I’m ready for treatment right now, and I can’t wait until tomorrow.” In such cases, provide information about 12-step meetings and the telephone numbers of outpatient substance abuse services and hotlines.

When clients say they are unable to follow-up on a specific referral, explore reasons for this, and consider options, such as other service providers, family, or friends. When clients claim that no treatment services will help them, perhaps saying, “I’ve tried every-
thing,” explore their feelings about this. Does the client feel hopeless, frustrated, defeated, or angry? Is the client making a matter-of-fact statement without actually feeling this way?

**Maintaining Change**

People in early stages of treatment or recovery may struggle with negotiating for safer sex, even if they have been effective in doing this previously. The removal of substance use as a defense mechanism can lead to a period of vulnerability in which a person has lowered self-esteem and limited social or communication skills. For many people who stop using substances, the idea of having sex without alcohol or other drugs can be terrifying; for others, sex and other behaviors can become compulsive.

Ask clients in early recovery when they last had sex without also using alcohol or other drugs. If it has been a long time, acknowledge the difficulty of such a change, explain that it becomes easier over time, and ask what the client thinks about this. Explore the client’s support system and if he or she feels comfortable discussing sex during the period of early recovery. Provide counseling referrals when appropriate, and encourage the client to be patient and gentle with him or herself.

People in early stages of recovery often gain a heightened awareness of aspects of their past that they previously dismissed, such as unsafe sex, injection drug use, or sexual abuse. They may have used substances to “cover up” the resulting feelings, which they may now need to discuss. In the counseling session, this discussion, as it relates to HIV risk taking, is important. For more in-depth counseling, provide referrals for individual or group support, such as psychotherapy or group counseling. Validate clients for their willingness to talk about their histories, explain the role of these forms of support, and, if necessary, address the limitations of the test counseling session.

Be aware that relapse to substance use can be a part of the process of recovery. If a client

**References**

states that he or she has relapsed, learn more about this. What are the consequences of the relapse? If the client wants help with problems related to relapse, offer referrals to treatment services. Be compassionate, and acknowledge that relapse can occur when a person is trying to stop using.

Clients in the early stages of recovery may think and speak in absolute terms about their substance use, for instance, saying that they will never use again. Honor such statements by saying that many people stop using substances permanently, but that an important part of recovery can involve being aware of or preparing for relapse in case it ever occurs. Continue by covering the basics of safer sex and harm reduction, such as needle cleaning, if appropriate. Also, consider stating that returning to substance use does not need to mean returning to HIV risk behaviors.

Counselor Discomfort

For a variety of reasons, counselors may feel uncomfortable about raising the subject of substance use, even within the specific context of HIV risk behaviors. This may be a result of the stereotype that people who abuse substances look or act a certain way or because of a counselor’s personal experience of being harmed by substance abusers. In addition, a counselor’s own patterns of substance use can affect the way he or she perceives other people’s substance use. For example, a counselor who considers his or her “social” or recreational substance use to be harmless may not recognize that it may be a problem for others.

Counseling Intervention

After completing the risk assessment, ask Sylvia if there are occasions when she has protected sex. Because of her history with alcohol abuse, Sylvia may not have answers to all of these questions or may not recognize the extent of her risks. Focus on strategies to help Sylvia avoid HIV infection when she drinks and uses other drugs. This harm-reduction approach demonstrates to Sylvia that the counselor’s primary goal is to help her reduce her HIV infection risks rather than to focus on her substance use.

Ask Sylvia if she wants help dealing with her substance use. If she says she does not want help, emphasize concern about her risk, and ask her how she feels about her recent crack use and related unsafe sex. In addition, explore the possible detrimental effects alcohol use may have on her life, such as financial difficulties and losing work. If Sylvia continues to say that she does not want help, work with her to create a risk-reduction plan that fits into the context of her substance use. If she has ever engaged in safer sex after using a substance, discuss how these occasions were different from the times she had unprotected sex.

If Sylvia expresses a desire to stop using substances and wants help, provide her with a referral or linkage to a substance abuse agency, or give her the name and phone number of a case manager at a local health center. Also offer her a list of Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings in the area. If she does not express a desire to stop using substances, ask if she is willing to accept referrals that she might use, if she decides in the future that she wants assistance.

Explore with Sylvia how she feels about contacting these referrals. Support her in developing a plan of action, which may involve asking her to state specifically when and how she will contact the referral sources. Ask Sylvia if she sees any obstacles to pursuing this plan. Emphasize the importance of seeking help as soon as possible, explaining that people can become distracted from this goal. Depending on the environment of the counseling session, the counselor may offer to let Sylvia use the telephone during the session to contact a referral.

Case Study

Sylvia is a 28-year-old single woman who is testing for HIV because she has engaged in unprotected vaginal and anal sex numerous times in the last year. She says she does not remember all the occasions of unprotected sex because she often “blacked out” from alcohol use. Sylvia is also having financial difficulties after recently losing two different jobs. She says she was fired from these jobs because she didn’t go to work after drinking too much “the night before.” Sylvia also says that she has recently started smoking crack, and to obtain it, she has been having sex with crack dealers.
Test Yourself

Review Questions
1. What percentage of people in the United States who are at least 12 years old have used illicit drugs at some time in their lives? a) 10 percent; b) 36 percent; c) 60 percent; d) 90 percent.

2. True or False: According to a national study, half of clients enrolled in substance abuse treatment programs have previously received treatment.

3. Which of the following are signs of substance dependence? a) increased tolerance to a substance; b) making unsuccessful efforts to control or discontinue use of a substance; c) continuing to use a substance despite awareness of the substance’s detrimental effects; d) all of the above.

4. True or False: The goal of all substance abuse treatment programs is abstinence.

5. True or False: Research indicates that undergoing substance abuse treatment tends to reduce risk for HIV infection.

6. Methadone maintenance therapy a) reduces cravings for opiates; b) can be taken orally once a day; c) provides regular contact between clients and providers; d) all of the above.

7. True or False: All substance use is abusive.

8. True or False: Half of all new HIV infections in the United States occur among injection drug users.

Discussion Questions
1. How can counselors respond when clients say their substance use is a problem but that they do not want to change their substance using behaviors?

2. How can counselors appropriately focus a counseling session on HIV risk behaviors while also discussing substance use behaviors that may or may not always relate to HIV risks?

3. What are your beliefs about substance use and abuse? What are your beliefs about recovery? How do your beliefs affect your impressions, opinions, values, and strategies while counseling clients who use or abuse substances?

4. If you use substances yourself, how does this impact your willingness and ability to counsel clients who use substances?

5. If alcohol or other drug abuse was part of your family of origin, how does this affect your ability to discuss substance abuse during counseling sessions?

6. How should counselors respond to clients who ask, “Do you think I have a substance abuse problem?”

Answers to Test Yourself
1. b.
2. True.
3. d.

4. False. Although abstinence has traditionally been the goal of substance abuse treatment programs, many programs now emphasize harm reduction.

5. True.
6. d.

7. False. Most people who use substances do not abuse them. Substance abuse is a pattern of repeated substance use that causes harmful consequences.

8. True.
DID YOU KNOW?

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