Content

Session	Topic	Trainer	Date
1.	**吸毒的趨勢及理論** 1A：Powerpoint file by David Cheung (The Trends of Drug Abuse & Drug Policy) 1B：Powerpoint file by David Cheung (World drug trend) 1C：Powerpoint file by Dr Lo (Various Forms of Addiction) 1D：Reference	David Cheung & Dr Lo Chun Wai	8/9
2	**藥物濫用、治療及驗毒相關之法律、中國禁毒法** 2A：Powerpoint file by Mr. Kong (吸食毒品的禍害、檢測和刑事責任)	Lawyer Mr Kong Chung Yan	8/9
3.	**香港多元化的戒毒治療及匹配服務** 3A：Powerpoint file by David Cheung (The UK Models of care for treatment of adult drug misusers) 3B：Reference--香港為吸毒者而設的治療及治療服務分級多模式架構(二零一零年十二月，第一版) 3C：Reference--Treatment Outcomes Profile(TOP) 3D：Reference--持牌自願性質的住院式戒毒中心及中途宿舍名單	David Cheung	15/9
4.	**藥物濫用做成的傷害** 4A：Powerpoint file by Dr Tse Man Li (Harm of Psychotrophic Substance)	Dr Tse Man Li	15/9
5.	**British Drug Policy and Present situation in Harrow** 5A：Powerpoint file by Dr Rosanna Cowan (Review of Treatment Effectiveness and the Implication on service commissioning and development in England - A Case Study in Harrow)	Dr Rosanna Cowan	22/9
6.	**A review of the Effectiveness of drug and alcohol treatment in England** 6A：Powerpoint file by Dr Rosanna Cowan (British Drug Treatment Policy and its Implementation)	Dr Rosanna Cowan	22/9

7.	**Addiction and offender Management policy in England** 7A：Powerpoint file by Dr Rosanna Cowan (Addiction and offender Management policy in England)	Dr Rosanna Cowan	6/10
8.	**Mobilizing resources-writing Proposals** 8A：Powerpoint file by Dr Rosanna Cowan (Mobilizing Resources by Writing Funding Proposals: the Essentials)	Dr Rosanna Cowan	6/10
9.	**吸毒者家人服務及互累症** 9A：Powerpoint file by Water (吸毒者家人服務及互累症) 9B：Powerpoint file by Water (有關家人之研究) 9C：Powerpoint file by Water (互累症) 9D：Powerpoint file by Water (Satir 不同家庭角色的輔導需要) 9E：Reference--個案討論 9F：Reference--Codependency test pack	Mr Water Lai	13/10
10.	**實證為本服務及研究工作** 10A：Powerpoint file by Dr Shek (Evidence Based Practice and Research Work) 10B：Powerpoint file by Dr Shek (Quantitative vs. Qualitative Research Designs) 10C：Reference	Daniel TL Shek, PhD	20/10
11.	**預防重吸及動機式晤談法** 11A：Powerpoint file by May (Therapeutic Community) 11B：Powerpoint file by May (Relapse Prevention) 11C：Reference -- Incident sheet 11D：Reference --戴托普信條 11E：Reference -- Relapse Prevention 11F：Powerpoint file by Water (動機式晤談法訓練) 11G：Reference --Effective Elements of Brief Intervention 11H：Reference --濫用藥物境況測量表	May Ngai & Mr Water Lai	20/10

12.	**靈性治療及同輩輔導** 12A：Powerpoint file by Eric Siu (靈性治療及同輩輔導) 12B： Powerpoint file by Eric Siu (福音戒毒治療綱要) 12C：Reference --得基輔康會(恩慈之家事工點滴一、二) 12D：Reference --詩歌 (奇異恩典) 12E：Reference	Mr Eric Siu	27/10
13.	**藥物測試及藥物濫用的評估** 13A：Powerpoint file by 政府代驗所 (Forensic Drug Testing of Biological Specimens) 13B：Powerpoint file by Dr S P Leung (Assessment of drug/alcohol abusers) 13C：Reference	政府代驗所 & Dr S P Leung	3/11
14.	**改進參與治療的合作性及降低損害** 14A：Powerpoint file by David Cheung (降低損害的概念) 14B：Powerpoint file by David Cheung (提昇接受治療者的合作) 14C：Powerpoint file by David Cheung (Improving Treatment Compliance) 14D：Powerpoint file by David Cheung& May Ngai (The role of coercion in drug treatment-Probation Order maker a difference)	David Cheung	3/11

動機式晤談法訓練
(精要版)

明愛樂協會資深社工
黎子中先生(Mr. Water LAI)

電話：23820267

基本輔導技巧
SOACE

1. **Summary** 適當的**撮要**

- **中途歸納，整理方向或內容**
- **完結時，幫助對方清晰是日重點，鞏固學習，亦可帶出功課**

基本輔導技巧
SOACE

2. **Open-ended Question 開放式問題**
- **非只問「是否」**
- **鼓勵思考**
- **容許空間發揮**
- **微觀技巧：不宜問「點解」**

基本輔導技巧
SOACE

3. **Active Listening 用心聆聽**

聆聽的重要——非講授
- 專注 (身體語言：面向、眼神、身體傾向)
- 招請社工的「貼士」

『用心』——同理心 Empathy

基本輔導技巧
SOACE

- 4. **Clarification & Probing 澄清與追問**

例如：「你剛才話『都係咁啦』，意思是……」

- **用於刻度問句 (Scaling Question)：**

***例如：「你話你信心有7分，咁無比到果3分係D甚麼？」**

***又如：「你會做甚麼來幫自己由7分去到9分？ 」**

基本輔導技巧
SOACE

- 5. **Empathy 同理心**

反映感受 (Reflection of Feelings)

- **能設身處地：「人同此心，心同此理」**
- **與「同情心」有分別**

講出案主的感受

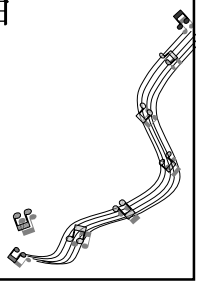
- **避免鸚鵡式的模仿 (parroting)**

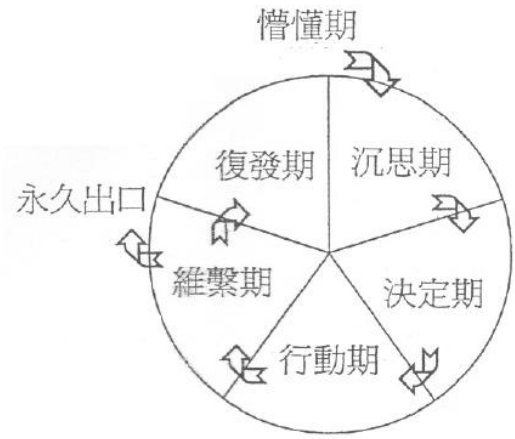
動機式晤談法

之

重點介紹與示範篇

改變六階





改變六個階段 (簡稱[改變六階])

階段	特點	工作員的任務	給家人的建議
懵懂期 Pre-Contemplation	**尚未考慮改變**	**使當事人產生疑問 —— 增加當事人對目前處境問題所在及危險性的認知**	▪ **給予壓力，讓當事人更體會不變的代價** ▪ **自己保重，爲長遠而作戰**

改變六個階段 (簡稱[改變六階])

階段	特點	工作員的任務	給家人的建議
沉思期 Contemplation	內心矛盾， 有掙扎： 感到有問題	促使當事人思考改變的好處， 不改變要受哪些代價，強化當事人對自我能力的信心	▪ 以良好關係作基礎 ▪ 繼續讓其感受不改變時要付出的代價 ▪ 預備相關資料 (例如有用的資訊)

改變六個階段 (簡稱[改變六階])

階段	特點	工作員的任務	給家人的建議
決定期 Determination	- 機會之窗 - 有計劃 - 有決心	幫助當事人選擇最適合其境況的行動策略	▪ 配合行動，給予信心和鼓勵 (可陪伴見醫療人員、輔導人員或參與有關活動)； ▪ 等待期間與有關治療體系配合，推行減低傷害策略

改變六個階段 (簡稱[改變六階])

階段	特點	工作員的任務	給家人的建議
行動期 Action	- 實行計劃 - 接受療程之中，實踐改變	幫助當事人採取適當步驟，邁向改變	▪ 關係重建 (或進一步改進)； ▪ 留意對當事人的說話，與治療單位之同工配合； ▪ 一起訂立康復計劃

改變六個階段 (簡稱[改變六階])

階段	特點	工作員的任務	給家人的建議
維繫期 (康復期) Maintenance	- 正常生活； - 克服心理障礙，防止復發 - 若能長久保持，可達致永久出口 (Permanent Exit)	幫助康復者辨識復發的跡象，並採取防範措施	▪ 家庭關係鞏固； ▪ 著重接納、信任與溝通

改變六個階段 (簡稱[改變六階])

階段	特點	工作員的任務	給家人的建議
復發期 Relapse	- 倒退 - 重復舊日的行爲模式	幫助當事人重新開始，由沉思、決定、而行動，不要因復發而停滯或喪志	▪ 支持其汲取教訓，再站起來； ▪ 如階段壹 (懵懂期)； ▪ 自己情緒要妥善處理

有關改變(成癮行爲)之輔導

- 常用之輔導策略： (視乎階段)
- (一) 動機式晤談法 (Motivational Interview, MI)
- (二) 預防重吸 (Relapse Prevention, RP)
- (三) 減低傷害 (Harm Reduction, HR)
- (四) 家庭治療 (Family Therapy)
- (五) 其他
  (如宗教治療、工作治療、藝術治療、歷奇輔導等)

〈留意MI之位置〉

動機式晤談法
(Motivational Interview)

相信 (假設)：

(一) 在行爲與改變背後，當事人是有掙扎或兩難(ambivalence)的；

(二) 人在聽到自己所講的說話時，會愈加相信自己所言！

(可以來個辯論試試看！)

動機式晤談法
(Motivational Interview)

(一) **預設一隱藏的談話議程** (hidden agenda) ：

請君入甕 ！ (有方向性 , directive)

(二) **利用選擇性的專注聆聽技巧**
(selective attentive listening skills)

「大原則」與「微觀技巧」

大原則：SARDE

- **1. Support Self-efficacy** 支持自我效能感
- **2. Avoid Argumentation** 避免爭拗
- **3. Roll with Resistance** 柔對抗拒
- **4. Develop Discrepancy** 展現不一致
- **5. Express Empathy** 表達同理心

精要介入的框架 FRAMES

- ***Feedback 回應——要個別化，不宜太一般***
- ***Responsibility 著重當事人自身的選擇和責任***
- ***Advice 建議——支持性，非權威性***
- ***Menu 可供選擇的方案清單***
- ***Empathy 同理心——溫暖、支持性、反映性***
- ***Self-efficacy 自我效能感：***
  強化信念——
  當事人是
  可以改變的！

動機式晤談 ：

供參考使用之問題

甲、保持現狀之拉力 **(**概問已可**)**

1. **現時的狀況(或它在當初)有甚麼吸引你？**
2. **你繼續保持(或你嘗試改變之後又再回舊路)的原因是…**
3. **若你改變了，生活上有甚麼不習慣呢？**
4. **還有甚麼喜歡現狀的原因呢？**

乙、現狀(保持不變)帶給你的困擾——要仔細地問

1. 現時的情況(或行爲)帶給你甚麼你不喜歡的東西？
2. 它曾給你的麻煩有…
3. 是甚麼使你想到要處理下現時的情況，今日願意來(或留下)見我(護士、社工或輔導員)呢？
4. 它還有甚麼使你困擾、不開心呢？

丙、上述各點對你的意義

1. 上述各點，對你最重要的是…
2. 最困擾你的是…
3. 最令你不能接受的是…
4. 其他？

丁、你的矛盾

A. 想及自己和他人

- 你覺得_____(受訪者的名字或稱號)這個人的優點是…
- 你覺得你的_____(家人或對受訪者重要的人)欣賞你的甚麼？
- 如你聽見你的好友有此情況以致(覆述乙部)，你的感覺是…
- 當人提起「　　」(描述這情況的不雅詞語)，你的腦海浮現甚麼呢？
- 當有人把你和「　」比較時，你感覺如何？

丁、你的矛盾

B. 想及將來

- 未來3到5年，你最想達到的生活目標是…
- 你現在的行爲或習慣如何影響你邁向這目標？

丁、你的矛盾

C. 看到矛盾處

- 一方面(覆述丁部A1至3及B1至2)，另一方面你又繼續這樣以致(覆述乙部)，你如何可以容忍這矛盾？
- 如用1到10分代表這情況帶給你的困擾程度(10分爲最困擾)，你會給_____分，原因是…
- 基於這分數，現在你會選擇做甚麼？
  原因是…

參考書目

- 區祥江 (2009)。《輔導小百科》。香港：突破。
- 黃惠惠 (2010)。《助人歷程與技巧》(增訂版)。台北：張老師。
- Miller, W.R. & Rollnick, S. (著)，楊筱華 (譯) (1995)。《動機式晤談法——如何克服成癮行爲戒除前的心理衝突》。台北：心理。

謝謝

31

CERTIFICATE COURSE IN DRUG ABUSE TREATMENT

RELAPSE PREVENTION TRAINING AT WONG YIU NAM CENTRE

Caritas Wong Yiu Nam Centre
Social Worker
NGAI MEI MEI

Relapse

Definition of relapse (Marlatt & Gordan(1985)

- Relapse is a process that begins long before the person takes a drug.
- Abstinence=>Lapse=>Relapse
- Learning relapse prevention like learning to wear life jacket or know the fire exit

Relapse Process

Life style imbalance
↓
Desire for indulgence
↓
Urges and cravings
↓
Cognitive processes：rationalization,denial
↓
High risk situations
↓
No coping response
↓
Cognitive processes：decreased self-efficacy + Positive outcome expectancies
↓
Initial indulgence
↓
Cognitive processes：rule violation effect + Dissonance conflict
↓
Increased probability of relapse

Relapse Prevention Group Framework (Wong Yiu Nam Centre)

Cognitive restructuring(4)

Recovery (1) => Early relapse warning signs(2) => High risk situations(3) => Relapse(2) => Relapse intervention(6)

Assertive training(5) + New lifestyle(6) + => Recovery(1)

Relapse Prevention Group Outline (Wong Yiu Nam Centre)

- Session 1
  Introduction and Recovery and Relapse
- Session 2
  Relapse and Early relapse warning signs
- Session 3
  High risk situations
- Session 4
  Cognitive restructuring
- Session 5
  Assertive training
- Session 6
  Relapse intervention and new lifestyle

Whole Person Recovery

- Commitment to a drug-free life
- Acceptance of higher values
- Adaptation to work and responsibility
- Social reintegration
- De-addiction and re-joyment
- Personal growth and self-acceptance

Early Relapse Warning Sign : (TerenceT. Gorski (2000)

1/Internal change
2/Denial
3/Avoidance and defensiveness
4/Crisis building
5/Immobilization
6/Confusion and overreaction
7/Depression
8/Loss of control
9/Thinking about relapse
10/Relapse

Different Types Of High Risk Situation

IDTS :The Inventory of Drug Taking Situation (Annis, H.M., Turner, N.E. & Sklar, S. (1991)

a) Intrapersonal – environmental determinants

1/Coping with negative emotional states
2/Coping with negative physical-physiological states
3/Enhancement of positive emotional states e.g. happy
4/Testing personal control (e.g. Overconfidence, going back to places of using drug, getting along with drug addict friends)
5/Giving in to temptations or urges

Different Types Of High Risk Situation

IDTS :The Inventory of Drug Taking Situation (Annis, H.M., Turner, N.E. & Sklar, S. (1991)

b) Interpersonal determinants

1/Coping with interpersonal conflict
2/Social pressure
3/Enhancement of positive emotional states

Cognitive Restructuring

1. Types of irrational thought (McKay, Davis, Fanning 1981)
   - Filtering, Polarized thinking, Overgeneralisation, Personalization, Blaming etc.
2. Methods of Cognitive Restructuring

Assertive Training

1. Techniques for behaving assertively
2. Situations for our clients to practise how to say no (Role Play)
3. Definition of Friends

Relapse Intervention

a) Relapse attitude

- Relapse should be seen as a mistake, not a failure
- Control can be regained
- False attitude:
- Abstinence is an absolute and once it is reached there is no going back
- If a client returns to drinking it is often seen as a failure rather than a mistake
- Often it is seen as a lack of will power or control over temptation rather than a lack of coping ability in a high-risk situation

Relapse Intervention

b) The reaction to relapse depends on
- The degree of personal/support/staff commitment and effort
- Duration of abstinence

c) Frequency and duration of using drugs

d) Family and peer support

e) Professional counselling

f) Safe living place

g) If withdrawal symptoms exist, please consult a doctor or seek a drug treatment immediately (e.g. methadone clinic, residential treatment)

New Lifestyle

a) New goal and plan your future
b) Balanced daily lifestyle (Weekly planner)
c) Self-confidence
d) Face problems rather than escape
e) Build up permanent and supportive relationship
f) Good and harmonious family life
g) Good working habit
h) Enough leisure time and activities

預防重吸小組錦囊

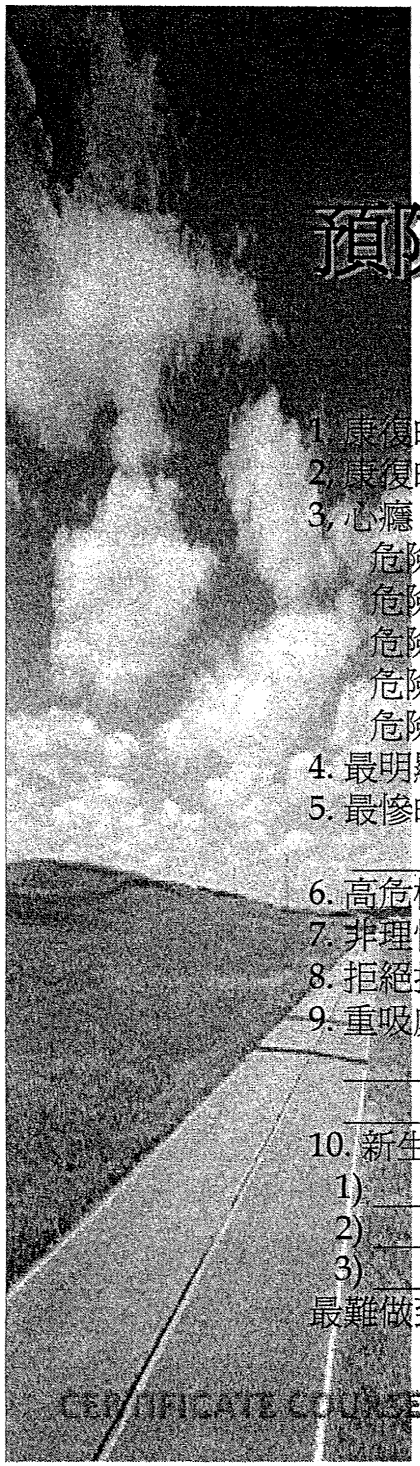
姓名: ____(誤用藥物種類：_____)

1. 吸食的階段：_____
2. 康復的意義最難做到的地方: _____
3. 危險：
   - 危險的地方：_____
   - 危險的人物：_____
   - 危險的時間：_____
   - 危險的物件：_____
   - 危險的情緒：_____
4. 最明顯重吸警告訊號：_____
5. 最壞的大結局：

   _____
6. 高危機情況：_____
7. 非理性想法：_____
8. 拒絕技巧：_____
9. 重吸處理方法(如求助的人/方法/時間)

   _____
   _____
10. 新生活的問題
    1) _____
    2) _____
    3) _____

最難做到的新生活方式：_____



RELAPSE PREVENTION

預防重吸小組錦囊

姓名: _____(誤用藥物種類：_____)

1. 康復的階段：_____
2. 康復的意義最難做到的地方: _____
3. 心癮：
   - 危險的地方：_____
   - 危險的人物：_____
   - 危險的時間：_____
   - 危險的物件：_____
   - 危險的情緒：_____
4. 最明顯重吸警告訊號：_____
5. 最慘的大結局：

   _____
6. 高危機情況：_____
7. 非理性想法：_____
8. 拒絕技巧：_____
9. 重吸處理方法(如求助的人/方法/時間)

   _____

   _____
10. 新生活的問題
    1) _____
    2) _____
    3) _____

最難做到的新生活方式：_____

CERTIFICATE COURSE IN DRUG ABUSE TREATMENT

動機式晤談法訓練
(精要版)

明愛樂協會資深社工
黎子中先生(Mr. Water LAI)

電話：23820267

基本輔導技巧
SOACE

1. **Summary** 適當的**撮要**

- **中途歸納，整理方向或內容**
- **完結時，幫助對方清晰是日重點，鞏固學習，亦可帶出功課**

基本輔導技巧
SOACE

2. **Open-ended Question 開放式問題**
- **非只問「是否」**
- **鼓勵思考**
- **容許空間發揮**
- **微觀技巧：不宜問「點解」**

基本輔導技巧
SOACE

3. **Active Listening 用心聆聽**

聆聽的重要——非講授
- 專注 (身體語言：面向、眼神、身體傾向)
- 招請社工的「貼士」

『用心』——同理心 Empathy

基本輔導技巧
SOACE

- 4. **Clarification & Probing 澄清與追問**

例如：「你剛才話『都係咁啦』，意思是……」

- **用於刻度問句 (Scaling Question)：**

***例如：「你話你信心有7分，咁無比到果3分係D甚麼？」**

***又如：「你會做甚麼來幫自己由7分去到9分？ 」**

基本輔導技巧
SOACE

- 5. **Empathy 同理心**

反映感受 (Reflection of Feelings)

- **能設身處地：「人同此心，心同此理」**
- **與「同情心」有分別**

講出案主的感受

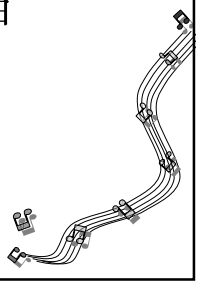
- **避免鸚鵡式的模仿 (parroting)**

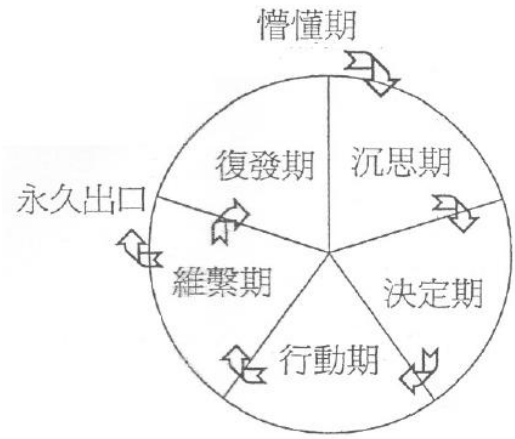
動機式晤談法

之

重點介紹與示範篇

改變六階





改變六個階段 (簡稱[改變六階])

階段	特點	工作員的任務	給家人的建議
懵懂期 Pre-Contemplation	**尚未考慮改變**	**使當事人產生疑問 —— 增加當事人對目前處境問題所在及危險性的認知**	▪ **給予壓力，讓當事人更體會不變的代價** ▪ **自己保重，爲長遠而作戰**

改變六個階段 (簡稱[改變六階])

階段	特點	工作員的任務	給家人的建議
沉思期 Contemplation	內心矛盾， 有掙扎： 感到有問題	促使當事人思考改變的好處， 不改變要受哪些代價，強化當事人對自我能力的信心	▪ 以良好關係作基礎 ▪ 繼續讓其感受不改變時要付出的代價 ▪ 預備相關資料 (例如有用的資訊)

改變六個階段 (簡稱[改變六階])

階段	特點	工作員的任務	給家人的建議
決定期 Determination	- 機會之窗 - 有計劃 - 有決心	幫助當事人選擇最適合其境況的行動策略	▪ 配合行動，給予信心和鼓勵 (可陪伴見醫療人員、輔導人員或參與有關活動)； ▪ 等待期間與有關治療體系配合，推行減低傷害策略

改變六個階段 (簡稱[改變六階])

階段	特點	工作員的任務	給家人的建議
行動期 Action	- 實行計劃 - 接受療程之中，實踐改變	幫助當事人採取適當步驟，邁向改變	▪ 關係重建 (或進一步改進)； ▪ 留意對當事人的說話，與治療單位之同工配合； ▪ 一起訂立康復計劃

改變六個階段 (簡稱[改變六階])

階段	特點	工作員的任務	給家人的建議
維繫期 (康復期) Maintenance	- 正常生活； - 克服心理障礙，防止復發 - 若能長久保持，可達致永久出口 (Permanent Exit)	幫助康復者辨識復發的跡象，並採取防範措施	▪ 家庭關係鞏固； ▪ 著重接納、信任與溝通

改變六個階段 (簡稱[改變六階])

階段	特點	工作員的任務	給家人的建議
復發期 Relapse	- 倒退 - 重復舊日的行爲模式	幫助當事人重新開始，由沉思、決定、而行動，不要因復發而停滯或喪志	▪ 支持其汲取教訓，再站起來； ▪ 如階段壹 (懵懂期)； ▪ 自己情緒要妥善處理

有關改變(成癮行爲)之輔導

- 常用之輔導策略： (視乎階段)
- (一) 動機式晤談法 (Motivational Interview, MI)
- (二) 預防重吸 (Relapse Prevention, RP)
- (三) 減低傷害 (Harm Reduction, HR)
- (四) 家庭治療 (Family Therapy)
- (五) 其他
  (如宗教治療、工作治療、藝術治療、歷奇輔導等)

〈留意MI之位置〉

動機式晤談法
(Motivational Interview)

相信 (假設)：

(一) 在行爲與改變背後，當事人是有掙扎或兩難(ambivalence)的；

(二) 人在聽到自己所講的說話時，會愈加相信自己所言！

(可以來個辯論試試看！)

動機式晤談法
(Motivational Interview)

(一) **預設一隱藏的談話議程** (hidden agenda) ：

請君入甕 ！ (有方向性 , directive)

(二) **利用選擇性的專注聆聽技巧**
(selective attentive listening skills)

「大原則」與「微觀技巧」

大原則：SARDE

- **1. Support Self-efficacy** 支持自我效能感
- **2. Avoid Argumentation** 避免爭拗
- **3. Roll with Resistance** 柔對抗拒
- **4. Develop Discrepancy** 展現不一致
- **5. Express Empathy** 表達同理心

精要介入的框架 FRAMES

- ***Feedback 回應——要個別化，不宜太一般***
- ***Responsibility 著重當事人自身的選擇和責任***
- ***Advice 建議——支持性，非權威性***
- ***Menu 可供選擇的方案清單***
- ***Empathy 同理心——溫暖、支持性、反映性***
- ***Self-efficacy 自我效能感：***
  強化信念——
  當事人是
  可以改變的！

動機式晤談 ：

供參考使用之問題

甲、保持現狀之拉力 **(**概問已可**)**

1. **現時的狀況(或它在當初)有甚麼吸引你？**
2. **你繼續保持(或你嘗試改變之後又再回舊路)的原因是…**
3. **若你改變了，生活上有甚麼不習慣呢？**
4. **還有甚麼喜歡現狀的原因呢？**

乙、現狀(保持不變)帶給你的困擾——要仔細地問

1. 現時的情況(或行爲)帶給你甚麼你不喜歡的東西？
2. 它曾給你的麻煩有…
3. 是甚麼使你想到要處理下現時的情況，今日願意來(或留下)見我(護士、社工或輔導員)呢？
4. 它還有甚麼使你困擾、不開心呢？

丙、上述各點對你的意義

1. 上述各點，對你最重要的是…
2. 最困擾你的是…
3. 最令你不能接受的是…
4. 其他？

丁、你的矛盾

A. 想及自己和他人

- 你覺得_____(受訪者的名字或稱號)這個人的優點是…
- 你覺得你的_____(家人或對受訪者重要的人)欣賞你的甚麼？
- 如你聽見你的好友有此情況以致(覆述乙部)，你的感覺是…
- 當人提起「　　」(描述這情況的不雅詞語)，你的腦海浮現甚麼呢？
- 當有人把你和「　」比較時，你感覺如何？

丁、你的矛盾

B. 想及將來

- 未來3到5年，你最想達到的生活目標是…
- 你現在的行爲或習慣如何影響你邁向這目標？

丁、你的矛盾

C. 看到矛盾處

- 一方面(覆述丁部A1至3及B1至2)，另一方面你又繼續這樣以致(覆述乙部)，你如何可以容忍這矛盾？
- 如用1到10分代表這情況帶給你的困擾程度(10分爲最困擾)，你會給_____分，原因是…
- 基於這分數，現在你會選擇做甚麼？
  原因是…

參考書目

- 區祥江 (2009)。《輔導小百科》。香港：突破。
- 黃惠惠 (2010)。《助人歷程與技巧》(增訂版)。台北：張老師。
- Miller, W.R. & Rollnick, S. (著)，楊筱華 (譯) (1995)。《動機式晤談法——如何克服成癮行爲戒除前的心理衝突》。台北：心理。

謝謝

31

靈性治療 及 同輩輔導

邵日坪 27.10.2011

靈性治療 => 福音戒毒

何謂 What　　何人 Who
何時 When　　何解 Why
何處 Where　　如何 How

同輩輔導 (強弱危機)

福音戒毒

⌘採用引伸自聖經手法去協助藥物濫用者戒斷其對藥物依賴的住院式療程。

福音戒毒的特質

⌘由基督教團體所營辦住院式戒毒服務
⌘視藥物濫用為「罪」所帶來的後果
⌘要求去除其他生活陋習如煙/酒/粗口
⌘引伸自聖經的手法：如讀聖經、向神禱告、詩歌敬拜、個人靈修及團契
⌘以傳福音為介入方法或最終目的
⌘自稱提供福音戒毒服務

對成癮問題的理解

可以是物質(煙/酒/毒)
亦可以是行為(性/上網/暴力)
信念：「罪」與成癮行為

因為我所做的，我自己不明白*；我所願意**的，我並不做；我所恨惡的，我倒去做。(羅 7:15) *認同 **立志

內地會與天招局

⌘在中國土地上
⌘最早的福音戒毒所
⌘19世紀 80年代初開始
⌘先在山西省
⌘戒鴉片煙癮
⌘戒煙洋藥/戒煙丸
⌘洋人宣教士 J H Taylor

席勝魔牧師 (1835-1896)

- 本名席子直
- 山西平陽人士
- 是一名秀才
- 上了鴉片煙癮
- 一八七九年接觸基督教並成了信徒
- 憑信仰自行靠禱告支持戒了煙癮
- 1886年在平陽按立為牧師

「天招局」

- 起初在山西一帶
- 山西省 洪洞 西莊村 范村
- 陝西省 西安
- 河南省 彰德府、懷慶府、溫縣、永寧縣
- 直隸省 順德府、南和縣
- 共有四十五間分局

「女天招局」

- 為女煙民服務
- 由洪洞開始
- 從北邊太原
- 到接近黃河一帶
- 由席師母創辦

香港早期的發展 (50'-70')

- 鄭錫安牧師 (挪威信義差會)
- 陳保羅牧師 (晨曦會)
- 宋和樂牧師 (互愛中心)
- 潘靈卓博士 (聖士提反會)

信義會戒毒所

- 一九五六年在調景嶺創辦
- 內地到港的難民
- 成方中/西藥協助脫癮
- 宣教士按時到所內傳福音 聖經 詩歌
- 全盛時可容納廿四男和十女
- 工作治療、個人及小組輔導
- 戒毒過程一般為三個月
- 最後於一九八八年停辦

香港晨曦會

- 於一九六八年創辦
- 看到個別吸毒者遺體被棄置於廢物堆
- 於西貢浪茄灣開展
- 於一九七六年將戒毒所遷往伏頭墳洲
- 命名為晨曦島福音戒毒
- 現存福音戒毒機構之中歷史最悠久

互愛中心

- 於一九七三年開始
- 在大埔沙羅洞設立戒毒所
- 芝麻灣半島下徑村
- 西貢浪茄　運作至今
- 女戒毒村
- 青少年訓練中心
- 中途宿舍

聖士提反會

- 在一九六八年成立
- 為露宿者及釋囚人士服務
- 七四年在半山區開始福音戒毒
- 城門之源 / 屯門家庭
- 目前擁有床位最多的機構

天招局療康程序

- 藥物協助脫癮
- 背聖書
- 唱讚美/戒毒詩歌
- 早晚敬拜神(聚會)
- 祈禱(禁食)

福音本是上帝的大能

- 一不靠人 (他人、席某)
- 二不靠丸子
- 三不靠自己掙扎
- 到主跟前認罪、單單靠主引領、加力
- 若有人在基督裏，他就是新造的人，舊事已過，一切都變成新的了。 (林後5：17)

福音戒毒的現況

香港晨曦會　聖士提反會　互愛中心

靈愛青年中心　正生會　得生團契

得基輔康會　榮頌團契　全備團契

巴拿巴　新生協會　Remar

愛心服務團　方舟行動　Hong Kong

http://www.nd.gov.hk/tc/list_tr_services.htm

福音戒毒治療綱要

聖經 - 讀書認知療法
祈禱 - 靜思默想療法
詩歌 - 敬拜音樂療法
服侍 - 操練經歷療法

聖經讀書認知療法

主題研習（罪｜福音｜律法｜誡命）
自省反思（讀經｜操練）
經驗分享（見證｜靈修）
基礎教育（文字及語言修為）

祈禱靜思療法

禱告分類
禱文｜公禱｜私禱｜代禱｜默觀
內容 (FACTS)
認信｜崇拜｜認罪｜感恩｜祈求
禁食操練

詩歌敬拜音樂療法

詩歌：感情分享釋放輕鬆
作曲填詞編曲分析錄音
樂器拍子律動排舞溝通
（奇異恩典｜回頭）

愛心服侍操練療法

復和（神、人、自己）
團契聚會
服務｜利他
自我肯定

福音治療建議參考文章

聖經讀書認知療法
Spiritual Reading as Bibliotherapy by Rojann R. Alpers, PhD, RN
祈禱靜思默想療法
Prayer & Meditation in Addiction Recovery by Robert J. Kus, RN, PhD
詩歌敬拜音樂療法
Music Therapy, Spirituality, and Chemically Dependent Clients
by Joey Walker, MA, RMT-BC
服侍操練療法
Applied Spirituality: Expressing Love & Service by Douglas J. King, MArch

同輩輔導

自助組織(AA/NA/培康)
各治療康復機構職員
各級防治輔工/ 義工

同輩輔導(強項)

康復動力/同行有機
與康復員關係建立快
較易得到康復員認同
較易認出危機

同輩輔導(弱項)

易受主觀經驗限制
角色(受助 => 施行幫助)轉移不良
隊工合作障礙/信任
與康復員關係轉變快

同輩輔導(危險)

復吸
公務私了
錯用關係
角色轉移引起的心理障礙

同輩輔導(機遇)

助人自助/個人成長
工作/事業發展路向
成功踏板/起步
重建自信心和圈子/網絡
社會/機構/家人/成癮者融合契機

同輩輔導(建議)

善用不良經歷
角色轉移=新角度=》各方學習接納
有容為大/失敗在成功之前多次出現
同心方可以同行

香港晨曦會

- 於一九六八年創辦
- 看到個別吸毒者遺體被棄置於廢物堆
- 於西貢浪茄灣開展
- 於一九七六年將戒毒所遷往伏頭墳洲
- 命名為晨曦島福音戒毒
- 現存福音戒毒機構之中歷史最悠久

互愛中心

- 於一九七三年開始
- 在大埔沙羅洞設立戒毒所
- 芝麻灣半島下徑村
- 西貢浪茄　運作至今
- 女戒毒村
- 青少年訓練中心
- 中途宿舍

聖士提反會

- 在一九六八年成立
- 為露宿者及釋囚人士服務
- 七四年在半山區開始福音戒毒
- 城門之源 / 屯門家庭
- 目前擁有床位最多的機構

天招局療康程序

- 藥物協助脫癮
- 背聖書
- 唱讚美/戒毒詩歌
- 早晚敬拜神(聚會)
- 祈禱(禁食)

福音本是上帝的大能

- 一不靠人 (他人、席某)
- 二不靠丸子
- 三不靠自己掙扎
- 到主跟前認罪、單單靠主引領、加力
- 若有人在基督裏，他就是新造的人，舊事已過，一切都變成新的了。 (林後5：17)

福音戒毒的現況

香港晨曦會　聖士提反會　互愛中心

壹愛青年中心　正生會　得生團契

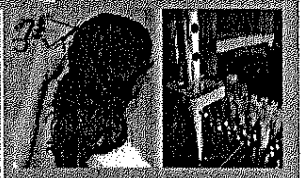
得基輔康會　榮頌團契　全備團契

巴拿巴　新生協會　Remar

愛心服務團　方舟行動　Hong Kong

http://www.nd.gov.hk/tc/list_tr_services.htm

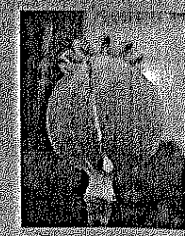
Forensic Drug Testing of Biological Specimens

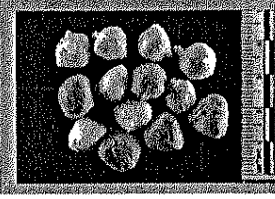


HT Augustina HUI
Chemist
Forensic Toxicology A Section
Government Laboratory
November 3, 2011

Abused Drugs in HK

- Heroin
- Codeine



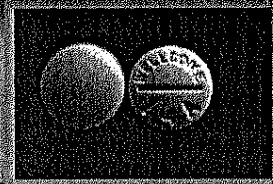


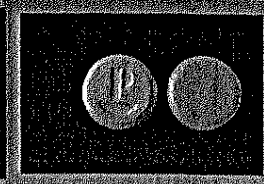
Content

- Background on Drug Testing
- Urine/Hair Specimens Sampling
- Laboratory Analysis of Urine/Hair
- Urinalysis vs Hair Drug Testing

Abused Drugs in HK

- Methadone

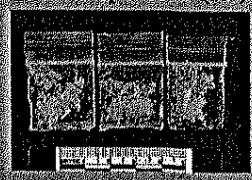




Background on Urine/Hair Drug Testing

Abused Drugs in HK

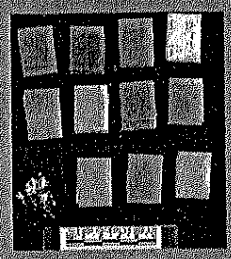
- Cocaine (Crack)
- Methamphetamine (Ice)
- MDMA (Ecstasy)

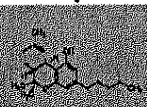


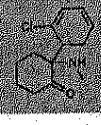
Abused Drugs in HK

- Cannabis

- Ketamine







Drugs in the body

Abused Drug & Metabolites in blood

Excreted from the kidney

Incorporated into hair

Urine

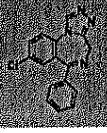
Hair

Abused Drugs in HK

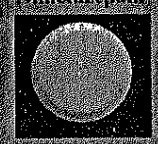
- Benzodiazepines

Midazolam

Estazolam



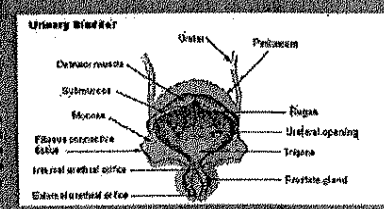
Nimetazepam



...etc

Urine

- Average adult : ~1-2 litre / day
- Urinary bladder: ~ 300 mL



Drugs in the body

- Inhalation
- Snorting
- Ingestion
- Injection

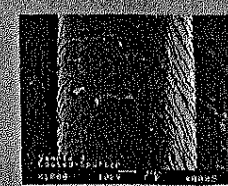
BLOOD

Drug Metabolism

Metabolites

Hair Growth

Average growth rate:
0.32 - 0.46 mm/day
(i.e. 1 - 1.4 cm/month)

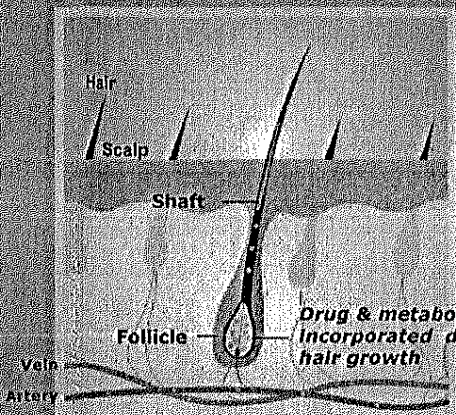


Growth cycle:

- ◆Anagen (active) 4-8 years 85%
- ◆Catagen (slowing) 2 weeks
- ◆Telogen (rest) 10 week } 15%

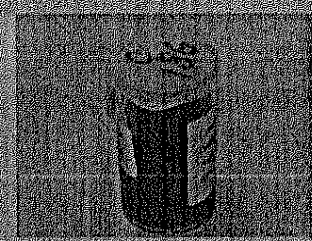
➢ MOSAIC growth pattern

Drug incorporation in hair



Urine Sampling

- Convenient
- Typical : ~20-30 mL



Drug incorporation in hair

- From blood through hair follicle
- Passively from
  - (i) Sebaceous excretions
  - (ii) Sweat
  - (iii) External contamination

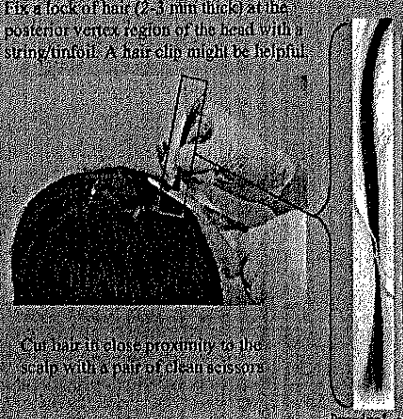
Hair Sampling – International Guidelines

- ◆USA: 100 mg [SAMHSA(2001)]
- ◆EU: A lock of hair with the thickness of a pencil's core (c.a 2-3 mm)
  - ✓Sufficient for re-confirmation by another accredited laboratory

Urine/Hair Specimens Sampling

Hair Sampling

Fix a lock of hair (2-3 mm thick) at the posterior vertex region of the head with a string/tinfoil. A hair clip might be helpful.

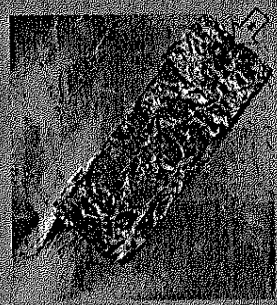


Cut hair in close proximity to the scalp with a pair of clean scissors.

A cut hair in close proximity to the scalp can show the drug use history of the previous 3 months.

Proximal end

Hair Sampling



* Mark the proximal end of the hair

Similarity

- Typically, two different techniques used in Urine/Hair Drug Testing:
  - Immunoassay (simple but lacks selectivity)
  - Chromatography-Mass Spectrometry (high selectivity and sensitivity but higher cost)

Hair Sampling

* Mark the proximal end of the hair

Difference

	URINE	HAIR
Sample treatment	Simpler and ease of automation	More complicate and labour intensive
Drug concentration in sample	Higher	Lower
Instrumental & Environmental Requirements	Less demanding	More stringent

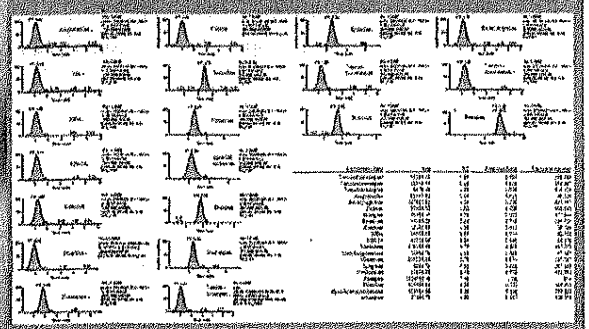
Laboratory Analysis of Urine & Hair

A comparison on the workflow of Urinalysis and hair drug testing

Urine		Hair	
Immunoassay	LC-MS/MS	Immunoassay	LC-MS/MS
Pipetting	Pipetting	Rinsing & Drying	Rinsing & Drying
Instrumental Analysis	Extraction	Cutting	Cutting
	Instrumental Analysis	Weighing	Pulverizing
		Extraction	Weighing
		Instrumental Analysis	Extraction
			Instrumental Analysis

Urinalysis

LC-MS : Typical results

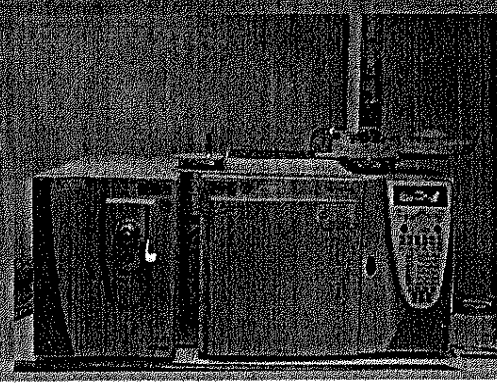


Hair Drug Testing

Sample extraction – for ELISA

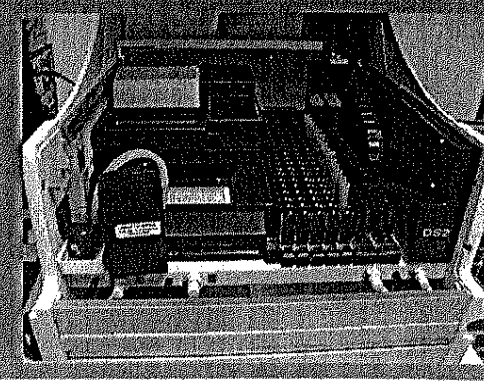
Urinalysis

GC-MS



Hair Drug Testing

ELISA (Enzyme-Linked ImmunoSorbent Assay)



Hair Drug Testing

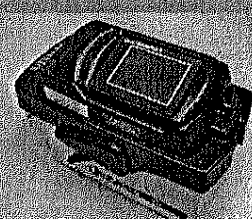
Pretreatment

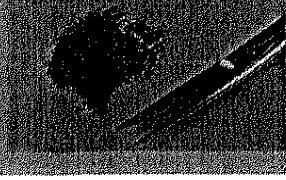
-Washing

- Drying

- Cutting

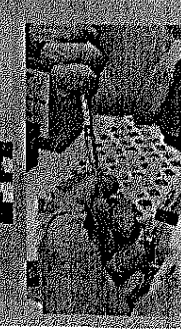
- Pulverisation



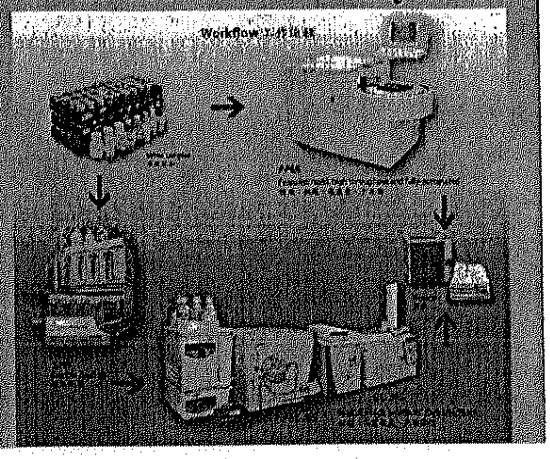


Hair Drug Testing

Sample extraction – for LC-MS

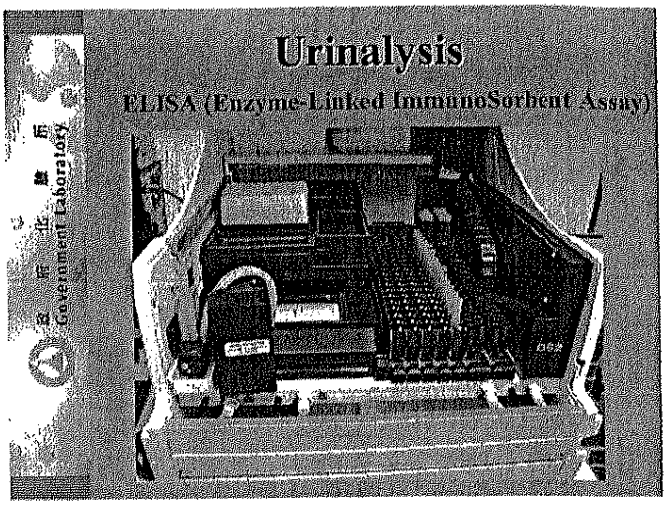


Workflow of Urinalysis

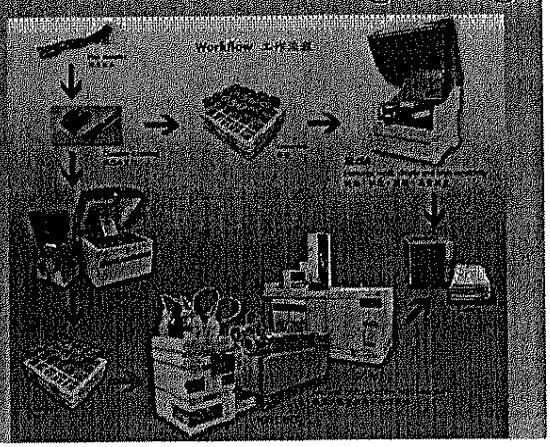


Urinalysis

ELISA (Enzyme-Linked ImmunoSorbent Assay)

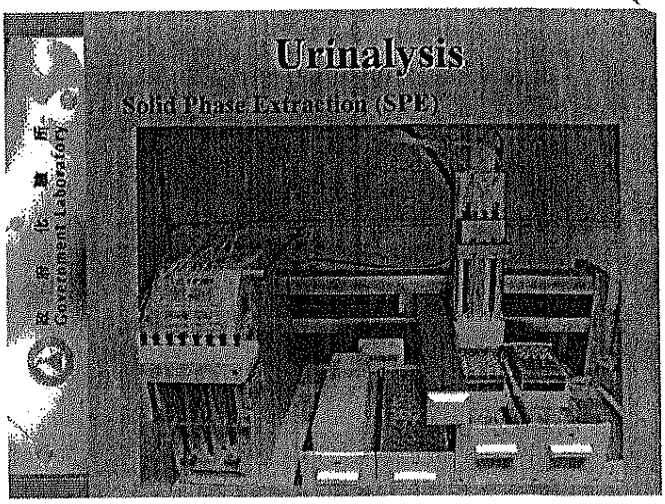


Workflow of hair drug testing



Urinalysis

Solid Phase Extraction (SPE)

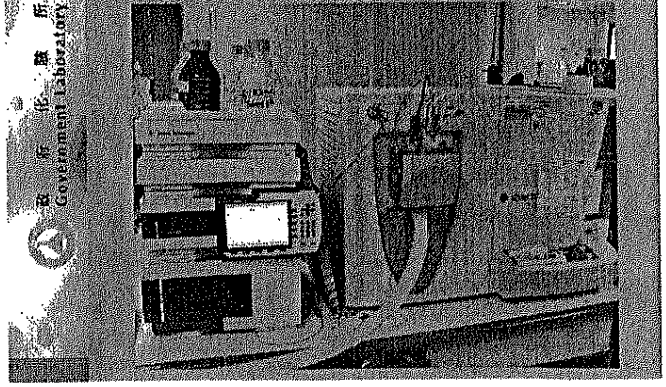


Urinalysis

FPIA (Fluorescence Polarization Immunoassay)

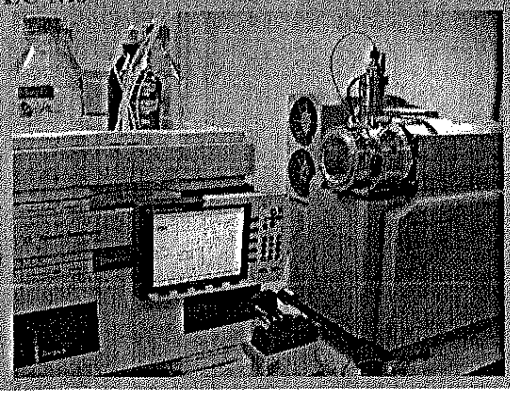
Urinalysis

LC-MS



Hair Drug Testing

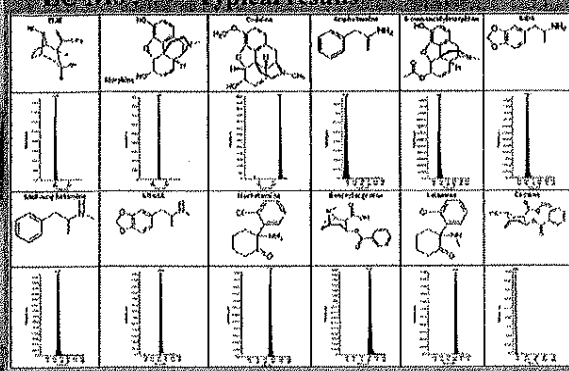
LC-MS



Urinalysis vs Hair Drug Testing

Hair Drug Testing

LC-MS : Typical results

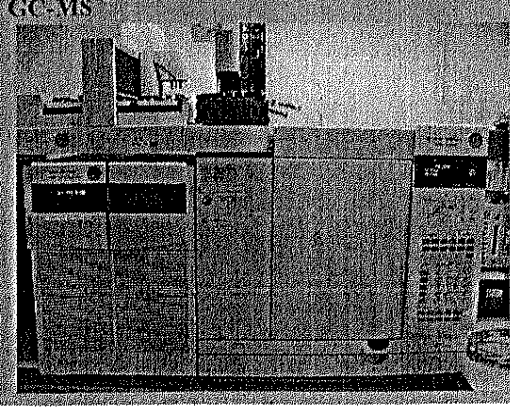


Urine vs Hair

	URINE	HAIR
Collection	Invasive	Less invasive Readily resampled
Storage	• Refrigerate • Biohazard	•Ambient •No known risk
Adulteration/ Substitution	Possible	Unlikely
Detection window	Days	Weeks to months

Hair Drug Testing

GC-MS



Urine & Hair Drug Testing

- **Limitations:**
  - Urine: Recent drug use
    No correlation with dosage/frequency
  - Hair: Use vs. Exposure
    No correlation with dosage/frequency

Assessment of drug/alcohol abusers

Dr. S P Leung

3rd November 2011

- **Assessment:**
  - corner stone of management of substance abuse problems
  - must be comprehensive, on the severity and range of problems associated with client's substance use
  - adherence to assessment guideline is important

- **Assessment guideline**

  Example:

  refer to "Protocol of screening and assessment of polydrug abusers"

  (Narcotic Division, Security Bureau, December 2005)

  A. History

  B. Examination

  C. Investigation

A. History

1. reason(s) for presentation
2. drug use/abuse
3. any history of injection & risks of HIV/AIDS, and hepatitis?
4. medical history
5. psychiatric history
6. forensic history
7. social history
8. past contact with treatment agencies

B. Examination

1. assess motivation
2. assess general health
3. assess mental state
4. assess social and family situation

C. Urine testing and other relevant investigations

- **Difficulties noted in assessment:**

  1. With **abuse of multiple substances** like cannabis, LSD, ketamine, cocaine, methamphetamine (Ice), various sedatives and analgesics, opiates and others, it is difficult to assess the acute effects and sequelae which arise from abuse of such drugs and their numerous combinations.

2. The **age of induction** of drug use has been dropping. Substance abuse in young people is associated with higher levels of comorbid psychiatric disturbances – which may or may not conform to a mental illness diagnosis. The problem behaviours interfere with development processes, particularly with concepts of self and identity.

3. Substance abuse and dependence is an affliction from which **the clients initially do not want to recover**. They typically deny and minimize their impairment until they cannot bear family, financial, legal or occupational pressures .

4. **Nearly all psychiatric syndromes can be precipitated by substance abuse** – depression, anxiety disorder, psychosis, and personality disorders. Psychiatric symptoms might be incorrectly regarded as the cause of drug abuse when they actually result from intoxication, withdrawal or protracted withdrawal. While self-medication of underlying psychiatric symptoms is sometimes an important factor in the perpetuation of drug abuse, it is seldom more powerful than euphoria and craving.

5. **Dual diagnosis** is defined as the occurrence of one, or more, mental disorders in addition to a substance use disorder. In those cases in which the co-occurring disorders are directly related, the substance use disorders can be either an antecedent or a consequence of the psychiatric disorders.

(Studies have shown that among adolescents diagnosed with a substance use disorder, almost ¾ of them had between 2 and 4 diagnosable mental disorders

Dual diagnosis:

A. Depression
B. Anxiety disorder
C. Psychosis
D. Personality disorder
E. Others

A. Depression:

- The **most common** psychiatric disorder that occur concurrently with drug abuse.
- Either an antecedent or consequence of drug abuse (particularly the use of any of the CNS depressants which include alcohol and sedative-hypnotics, e.g. BZDs). Reasons of the latter can be physiological symptoms of withdrawal and the state of chronic intoxication.

- The self medication of underlying depression with addictive drugs is a widely held belief, but probably over-rated.
- Evaluating depressive symptoms in **CNS depressant abusers** is difficult since many depressive symptoms, e.g. insomnia, anergia, decreased libido, guilt and suicidality are also characteristics of chronic abuse of such drugs. These can be distinguished from major depression when spontaneous remission usually occur within a two week period of abstinence in most cases.

- **Opiates abusers** have been reported to have high rates of depression. Prevalence rates of 17% were found for major depression in patients maintained on methadone, while recently detoxified heroin and methadone dependent patients had rates of 25% and 60%.

  It must be pointed out that although there were proposals in literature that opiate addicts are medicating underlying depression, depression is often opiate-induced, based on available neuro-chemical evidence.

- In opiate abusers, depression does not usually resolve rapidly with abstinence, as seen in the case of alcohol and sedative-hypnotics. Persistent depression after completion of detoxification should be treated vigorously. The high rate of recidivism in opiate abusres may be related to depression.

- **Central stimulants**, particularly amphetamines and cocaine, produce severe withdrawal states ("crash") that share many characteristics with major depression – anergia, depressed mood, irritability, low self esteem, guilt, psychomotor retardation, and suicidality. Hyperphagia and hypersomnia are found with withdrawal (while depression usually involves anorexia and insomnia). Stimulant withdrawal generally remits within several days of abstinence after drug binging.

- **Cannabis** abuse on a regular basis produces an amotivational state that could be confused with major depression. Psychomotor retardation, decreased concentration, decreased libido, paranoia, and guilty rumination may be seen during intoxication states. Cannabis induced mood effects usually last for several days and mild in severity.

B. Anxiety:

- Anxiety is often found in the early recovery phase from addiction. At the onset of treatment, drug abusers often face difficulty in their family, with their jobs and financial security.
- Many abstinence syndromes and intoxication states involve anxiety that should not be diagnosed as independent anxiety disorders.
- Patients with anxiety disorders may become drug dependent through self-medication (esp. with alcohol, sedative-hypnotics).

- Sedative, alcohol and opiate withdrawal include anxiety and should be recognized on clinical grounds. Complaints of anxiety may be feigned to procure drugs during detoxification. Protracted anxiety syndromes associated with insomnia may last for several months. Efforts should be made to avoid medicating the patients, and especially the use of addictive sedatives.

- Panic symptoms and anxiety arise from intoxication with amphetamines, cannabis, ephedrine, pseudoephedrine in cough medicine, hallucinogens, MDMA, phencyclidine, and ketamine. Urine and blood testing, a careful history and physical examination can help to evaluate. A washout period corresponding to duration of action of the drug in question is essential before anxiety disorders can be diagnosed.

- Methadone dependent patients may experience protracted withdrawal which includes anxiety for several months after detoxification. They may seek addictive sedatives &/or alcohol, which can re-activate their opiate reinstatement.

C. Psychosis:

- Psychosis may result from drug intoxication, withdrawal, and medical complication of addiction.
- Psychosis is seen during **intoxication states** with amphetamines, MDMA, cocaine, ephedrine, phencyclidine, ketamine, hallucinogens, and cannabis. Cocaine and amphetamine classically produce paranoid psychosis. The persistence of psychosis beyond several days of drug cessation generally rules out drug induced psychosis.

- Psychotic symptoms may be found in **alcohol and sedative-hypnotic withdrawal**. Normally psychotic symptoms tend to wear off rapidly.
- Certain **complications** of drug abuse may produce psychosis. Organic psychotic states may arise from lowered seizure threshold or neurotoxic effects of the abused drugs.

- **Schizophrenic** patients often have comorbidity with addiction and pose a difficulty in treatment. They usually have great difficulty in interacting in self-help groups and cannot settle in standard addiction rehabilitation services.

D. Personality disorders:

- Characteristic features of PD are very common in drug abusers **during active drug use**. Antisocial behaviours directed toward drug procurement, impulsivity during intoxication and lying are typical of active addiction but they may disappear entirely with recovery.
- To diagnose PD, these features should precede substance abuse and not result from the addictive life style. Diagnosis should be deferred until early recovery.

- It is important to note that individuals with antisocial and borderline personality disorder have greater risk for substance abuse disorders. Both these PD have onset during adolescence and include a proclivity for potentially self damaging impulsive behaviour, which include the binging of substance abuse.

- Diagnosing personality disorders are of great importance with regard to addiction treatment because they interfere with engagement and recovery in drug rehabilitation. Although psychotherapy may help recovery, it should never be the focus of treatment because the wrong message might be given that drug use results entirely from psychological conflict and will cease once conflict has resolved.

E. Others:

- Attention-deficit hyperactivity disorders (ADHD), when combined with conduct disorder appears to be a robust risk factor for later drug abuse than conduct disorder alone.
- Eating disorders are often associated with substance abuse. There is a higher incidence of drug abuse among bulimic patients to anorexia nervosa.

- Adolescents who have been victims of sexual abuse during childhood or who have gender identity disorders are at risk for substance abuse disorder.

Remember the following:

- A challenge is posed for drug workers when psychiatric symptoms are often encountered in substance abusers, as this special client group often resists and interferes with the evaluation process by denial, minimization, distortion and an outright lying strategy.
- Drug workers should be familiar with psychiatric manifestation of intoxication, withdrawal, protracted withdrawal and other complications of various abused substances.

  (frequent referral to guideline protocol)

- It may be impossible to distinguish primary from secondary psychiatric syndromes solely on the basis of current symptom profile. Longitudinal observation during a controlled washout period is often necessary.
- Drug workers need a healthy skepticism, attentiveness to detail, and use of objective information which includes collateral information, physical examination and laboratory tests.

- Shared information between drug workers, adolescents and family social workers, general practitioners and psychiatrists specializing in drug abuse is the key to success in management.

END

降低損害的概念

張大衛

瑞士服務片面觀

- 吸毒者中心
- 外展巴士
- 美沙酮診所
- 打針房

海洛英代用計劃

- 全瑞士有1500位
- 每天兩至三劑
- 打針或吸服
- 全民投票贊成延續

針鋒相對

贊成觀點	反對觀點
• 協助吸毒者改善	• 會使戒毒困難
• 投其所好，有何不可	• 派白粉予道友
• 減低損害，減少風險	• 阻礙求變
• 吸毒者不好受，會求變	• 減低改變動機
• 不吸者自然不吸	• 引人犯罪
• 人命關天，幫助不少人士	• 浪費人力物力

降低損害定義

廣義 所有禁毒政策和活動

聚焦 以降低有關濫用藥物的損害，而非強要完全禁絕藥物濫用為目的的策略或活動

Harm reduction = harm minimization
= risk reduction = risk minimization

基本信念

降低損害手法基於以下信念：

1. 濫藥行為必有風險，只是有些較危險，另一些相對較低風險。
2. 改變成癮行為須按步就班，完全操守是最後一步。
3. 並非每個人都可以完全健康。

降低損害：達到目的之途徑

- 用比較安全的途徑使用藥物
- 用比較安全的藥物取代危險的藥物
- 減少濫用藥物的次數
- 減少濫用藥物的份量
- 減少濫用藥物的時間
- 減少濫用藥物的傷害性後果

降低損害手法的特質

「如果一個人不願意停止濫藥，我們應該協助他/她降低其濫藥行為對自身或他人的傷害」

降低傷害的原理有以下特點：

A. 實用主義
B. 人道主義
C. 針對損害
D. 平衡成本效益
E. 按步就班，訂定優先次序

降低損害的活動和策略：例子

A. 交換針筒或增加針筒供應
B. 美沙酮計劃
C. 教育和外展活動
D. 執法政策
E. 醫生處方協助濫藥者
F. 打針房
G. 防止酗酒政府及活動
H. 有關煙草的政策及活動
I. Instant drug test

香港現有的降低損害政策及活動

A. 美沙酮計劃
B. 教育資料
C. 執法政策
D. 醫生處方
E. 禁煙政策

重要概念

減低損害

≠

藥物濫用合法化

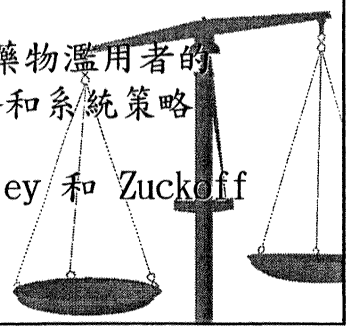
你怎樣看這些降低損害的服務和政策？

反對

提昇接受治療者的合作

針對藥物濫用者的
輔導和系統策略

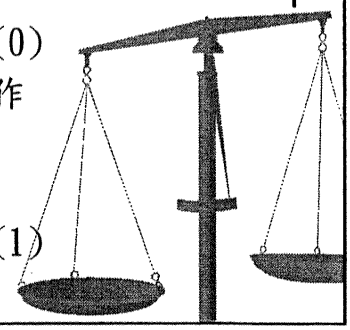
- 作者：Daley 和 Zuckoff



合作程度

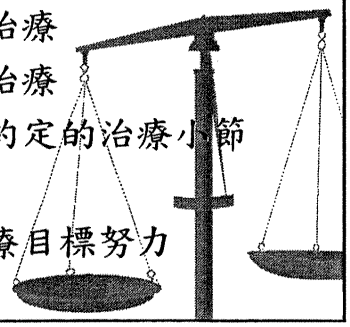
0 → 1

- 全不合作(0)
- 低程度合作
- 半推半就
- 非常合作
- 完全合作(1)



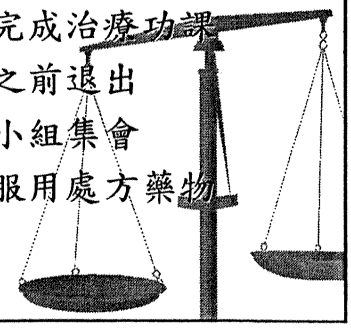
顯示不合作的跡像

- 延遲接受治療
- 未能進入治療
- 缺席預先約定的治療小節
- 遲到
- 未能就治療目標努力



顯示不合作的跡像(II)

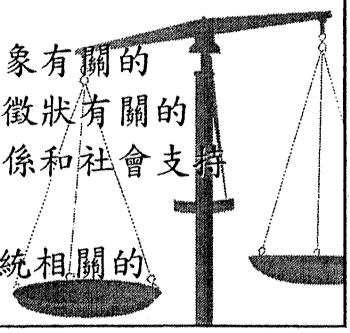
- 不做或未完成治療功課
- 完成治療之前退出
- 缺席自助小組集會
- 不按指示服用處方藥物
- 過早停藥



影響合作的因素

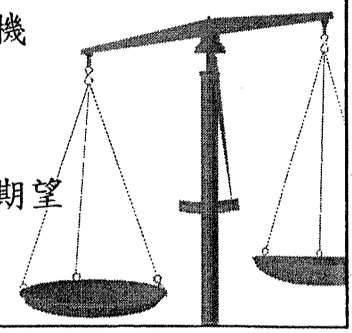
<u>四項變數</u>

1. 與服務對象有關的
2. 與疾病和徵狀有關的
3. 與人際關係和社會支持有關的
4. 與治療系統相關的



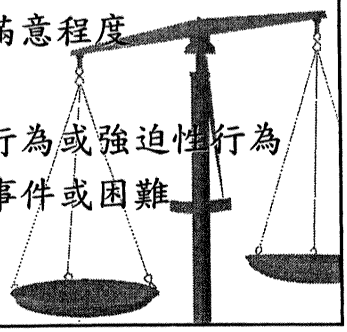
服務對象變數(I)

- 改變的動機
- 信念
- 怕被恥笑
- 對治療的期望



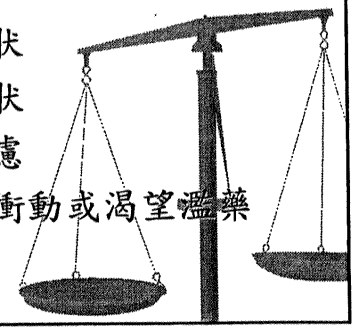
服務對象變數(II)

- 對治療的滿意程度
- 性格
- 其他成癮行為或強迫性行為
- 其他生命事件或困難



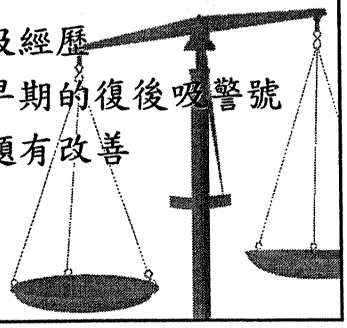
疾病/徵狀相關變數(I)

- 依賴的徵狀
- 精神病徵狀
- 社會性焦慮
- 強迫性的衝動或渴望濫藥



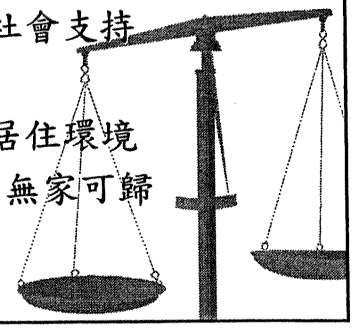
疾病/徵狀相關變數(I)

- 疾病和復吸經歷
- 未能抓住早期的復後吸警號
- 徵狀或問題有改善



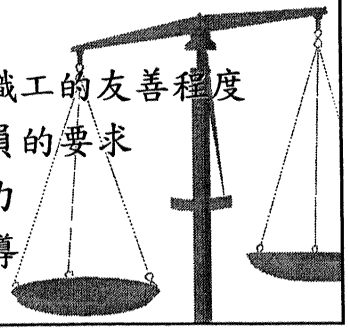
人際關係和社會支持變數

- 損害性的社會支持
- 家庭問題
- 不穩定的居住環境/貧窮和無家可歸



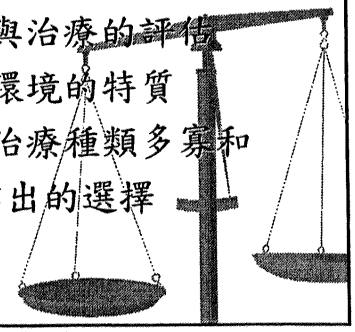
治療和系統的變數(I)

- 治療聯盟
- 治療中心職工的友善程度
- 對輔導人員的要求
- 職工的能力
- 職工的督導



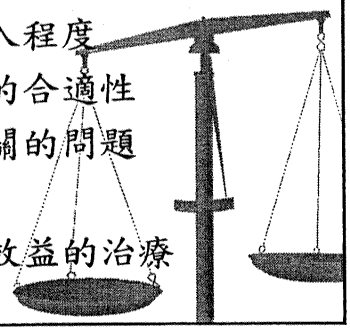
治療和系統的變數(II)

- 是否會參與治療的評估
- 治療中心環境的特質
- 可選擇的治療種類多寡和實際可作出的選擇
- 療程長短



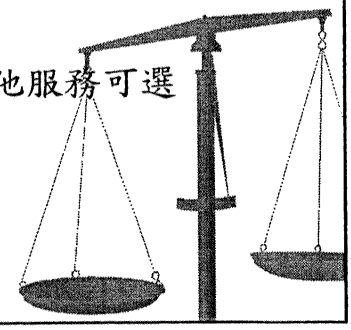
治療和系統的變數(III)

- 治療的深入程度
- 治療建議的合適性
- 與服藥有關的問題
- 治療費用
- 無效或低效益的治療



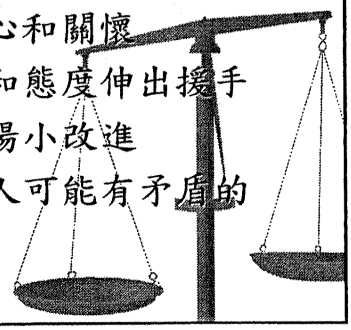
治療和系統的變數(IV)

- 延續關顧
- 是否有其他服務可選



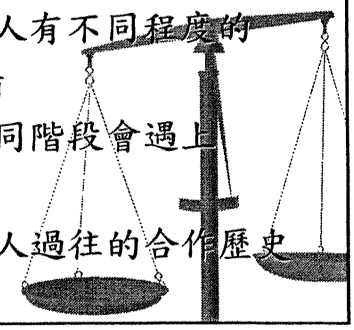
改進合作的輔導策略(I)

- 表達同理心和關懷
- 透過行為和態度伸出援手
- 接納和表揚小改進
- 接納受助人可能有矛盾的表現



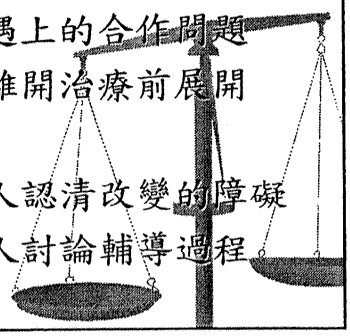
改進合作的輔導策略(II)

- 接納受助人有不同程度的改變準備
- 預期在不同階段會遇上不合作
- 討論受助人過往的合作歷史



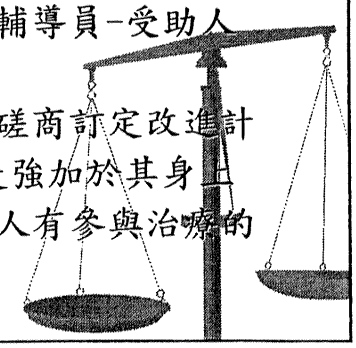
改進合作的輔導策略(III)

- 即時處理遇上的合作問題
- 在受助人離開治療前展開善後關顧
- 協助受助人認清改變的障礙
- 鼓勵受助人討論輔導過程



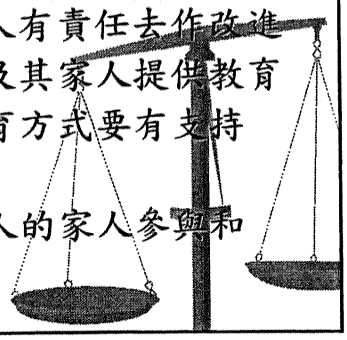
改進合作的輔導策略(IV)

- 鼓勵討論輔導員-受助人關係
- 與受助人磋商訂定改進計劃，不是強加於其身上
- 強調受助人有參與治療的責任



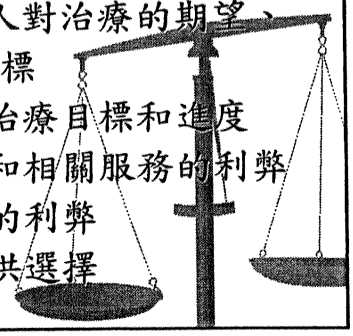
改進合作的輔導策略(V)

- 強調受助人有責任去作改進
- 為受助人及其家人提供教育
- 提供的教育方式要有支持理據
- 推動受助人的家人參與和支持



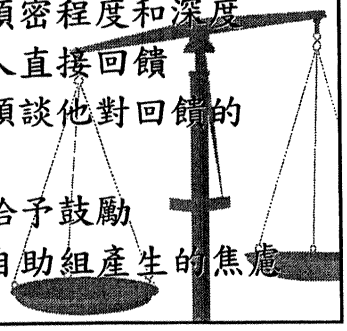
改進合作的輔導策略(VI)

- 探索受助人對治療的期望、希冀和目標
- 定期檢討治療目標和進度
- 討論治療和相關服務的利弊
- 討論操守的利弊
- 就治療提供選擇



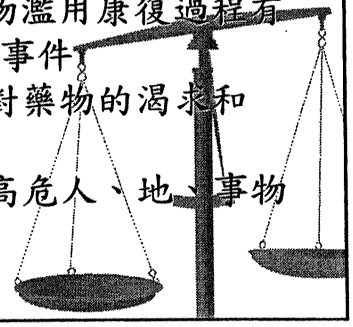
改進合作的輔導策略(VII)

- 改動治療頻密程度和深度
- 給予受助人直接回饋
- 與受助人傾談他對回饋的反應
- 向合作者給予鼓勵
- 處理參與自助組產生的焦慮



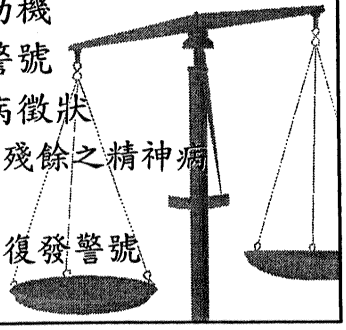
改進合作的輔導策略(VIII)

- 處理與藥物濫用康復過程有關的各種事件
- 討論有關對藥物的渴求和想法
- 認定那些高危人、地、事物和呼召



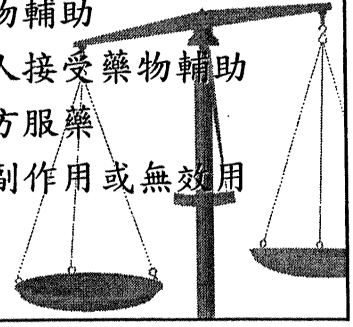
改進合作的輔導策略(IX)

- 評估改進動機
- 處理復吸警號
- 處理精神病徵狀
- 處理持續或殘餘之精神病徵狀
- 處理精神病復發警號



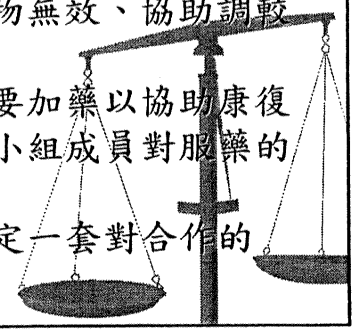
改進合作的輔導策略(X)

- 考慮用藥物輔助
- 預備受助人接受藥物輔助
- 確保按處方服藥
- 處理藥物副作用或無效用



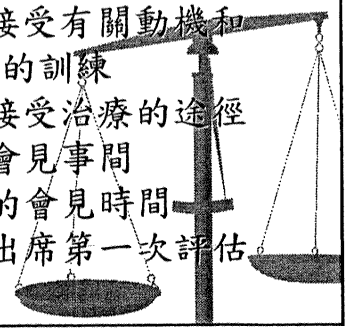
系統策略(I)

- 若所服藥物無效、協助調較藥物
- 預備可能要加藥以協助康復
- 預備自助小組成員對服藥的抗拒
- 為中心制定一套對合作的哲學



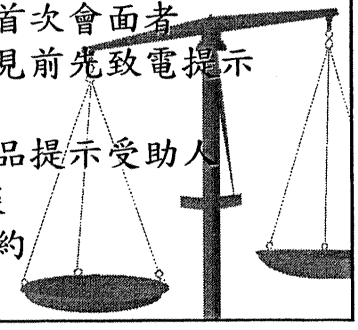
系統策略(II)

- 鼓勵員工接受有關動機和合作輔導的訓練
- 提供及早接受治療的途徑
- 提供彈性會見事間
- 提供一致的會見時間
- 致電提醒出席第一次評估



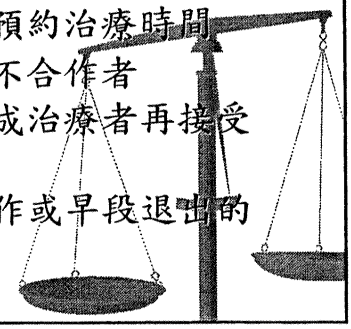
系統策略(III)

- 致電缺席首次會面者
- 在定期會見前先致電提示受助人
- 用輔助物品提示受助人出席會談
- 用書面合約



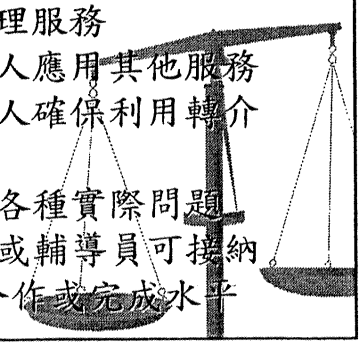
系統策略(IV)

- 用創意去預約治療時間
- 外展接觸不合作者
- 鼓勵未完成治療者再接受服務
- 找出不合作或早段退出的原因



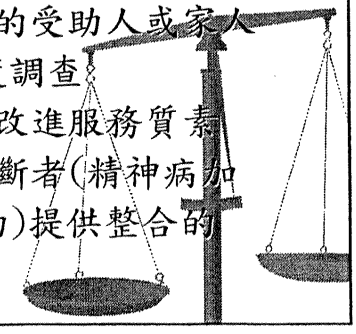
系統策略(V)

- 用個案管理服務
- 協助受助人應用其他服務
- 聯絡受助人確保利用轉介服務
- 協助處理各種實際問題
- 定出中心或輔導員可接納之最低合作或完成水平



系統策略(VI)

- 進行定期的受助人或家人滿意程度調查
- 不斷尋求改進服務質素
- 為雙重診斷者(精神病加濫用藥物)提供整合的治療



IMPROVING TREATMENT COMPLIANCE

counseling and systems strategies for substance abuse and dual disorders

Abstract from the book written by Daley and Zuckoff

Continuum of Compliance

Non (0) — Minimally — Partially — Mostly — Total (1)

Ways Poor Compliance Shows

- Delay in Entering Treatment
- Failure to Enter treatment
- Missing Treatment Sessions
- Lateness for Treatment Sessions
- Failure to Work on Treatment Goals
- Failure to Work on or Complete Therapeutic Assignments

Ways Poor Compliance Shows(II)

- Dropping Out of Treatment before Completion
- Missing Self-help Meetings
- Failure to Take Medications as Prescribed
- Stopping Medications Prematurely

Factors Affecting Compliance

Four types of variables:

- CLIENT VARIABLES
- ILLNESS- AND SYMPTOM- RELATED VARIABLES
- RELATIONSHIP AND SOCIAL SUPPORT VARIABLES
- TREATMENT AND SYSTEMS VARIABLES

CLIENT VARIABLES

- Motivation
- Beliefs
- Stigma
- Expectations
- Satisfaction with Treatment
- Personality
- Other Addictions or Compulsions
- Other Life Events or Problems

ILLNESS/SYMPTOMS RELATED VARIABLES

- Symptoms of Addiction
- Symptoms of Psychiatric Illness
- Social Anxiety
- Obsessions or Cravings to use Substances
- Previous History of Illness and Relapse
- Failure to Catch Early Warning Signs of Relapse
- Improvement in Symptoms or Problems

RELATIONSHIP & SOCIAL SUPPORT VARIABLES

- Negative Social Supports
- Family Problems
- Unstable Living Situation/ Poverty and Homelessness

TREATMENT AND SYSTEMS VARIABLES

- Therapeutic Alliance
- Friendliness of Treatment Staff
- Demands on the Counselor
- Competence of Staff
- Supervision of Staff
- Access to Treatment Evaluation
- Characteristics of Treatment Setting
- Type of Treatment Offered and Choices Available

TREATMENT AND SYSTEMS VARIABLES(II)

- Duration of Treatment Regimen
- Intensity of Treatment Program
- Appropriateness of Treatment Recommendations
- Medication-Related Problems
- Expense of Treatment
- Ineffective or minimally Effective Tx
- Continuity of Care
- Availability of Other Services

COUNSELING STRATEGIES TO IMPROVE COMPLIANCE

- Express Empathy and Concern
- Convey Helpfulness in Attitudes and Behaviours
- Accept and Appreciate Small Changes
- Accept Ambivalence as Normal
- Accept Varying Levels of Readiness to Change
- Anticipate Noncompliance at Various Stages of Treatment

COUNSELING STRATEGIES (II)

- Discuss the Client's Prior History of Compliance
- Discuss Current Compliance Problems Immediately
- Provide Aftercare Counseling Prior to Discharge from Residential or Inpatient care
- Help the Client Anticipate Roadblocks to Change

COUNSELING STRATEGIES(III)

- Encourage Discussions of the Counseling Process
- Encourage Discussions of the Client-Counselor Relationship
- Negotiate Rather Than Dictate Change Plans
- Emphasize the Client's Responsibility to Participate in Treatment

COUNSELING STRATEGIES (IV)

- Emphasize the Client's Responsibility to Change
- Provide Education to the Client and Family
- Provide Interventions Based on Empirical Support
- Elicit Family Support and Involvement
- Explore the Client's Expectations, Hopes, and Goals for Treatment

COUNSELING STRATEGIES(V)

- Regularly Review Treatment Goals and Progress
- Discuss The Pros and Cons of Treatment and Self-Help Programs
- Discuss the Pros and Cons of Abstinence
- Provide Options Regarding Treatment
- Change Treatment Frequency and Intensity

COUNSELING STRATEGIES(VI)

- Provide Direct Feedback to Client
- Discuss the Client's Reactions to Feedback
- Provide Reinforcement for Treatment Compliance
- Address Anxiety about Treatment or Self-Help Group Attendance
- Monitor Substance Abuse Recovery Issues

COUNSELING STRATEGIES(VII)

- Discuss Cravings and Thoughts of Using Substances
- Identify People, Places, Events, and Close Calls
- Assess Motivation to Change
- Monitor Substance-Use Relapse Warning Signs
- Monitor Psychiatric Symptoms

COUNSELING STRATEGIES(VIII)

- Address Persistent or Residual Psychiatric Symptoms
- Monitor Psychiatric Relapse Warning Signs
- Consider the Use of Medications
- Prepare the Client for Taking Medications
- Monitor Medication Compliance

COUNSELING STRATEGIES(IX)

- Address Adverse Side Effects or Lack of Efficacy
- Facilitate Medication Changes for Ineffective Medicines
- Facilitate Augmentation Therapy
- Prepare for Negative Reactions from Self Help Group Members to Medications

SYSTEMS STRATEGIES TO IMPROVE COMPLIANCE

- Develop a Clinic Philosophy on Compliance
- Encourage Staff Training on Motivational and Compliance Counseling
- Provide Early Access to Treatment
- Offer Flexible Appointment Times
- Offer Consistent Appointment Times

SYSTEMS STRATEGIES(II)

- Call and Remind Clients of the Initial Evaluation Session
- Call Clients Who Fail to Show Up for the Initial Evaluation
- Call Clients or Family Members Prior to Regularly Scheduled Treatment Sessions
- Use Prompts to Remind Clients of Scheduled Sessions

SYSTEMS STRATEGIES(III)

- Use Written Compliance Contracts
- Use Creative Ways of Scheduling Treatment Appointments
- Provide Outreach to Poorly Compliant Clients
- Encourage Treatment Dropouts to Return for Services
- Determine the Reasons for Poor Compliance or Early Treatment Dropout

SYSTEMS STRATEGIES(IV)

- Use Case Management Services
- Help the Client Access Other Services
- Contact Client to Make Sure Referrals Were Followed Up
- Provide Assistance with Practical Problems
- Establish Clinic and Counselor Thresholds for Acceptable Levels of Treatment Compliance or Completion

SYSTEMS STRATEGIES(V)

- Conduct Regular Client and Family Satisfaction Surveys
- Continuously Seek Quality Improvement
- Offer Integrated Treatment for Clients with Dual Disorder