

# I'm an Addict...now what?

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# OUTLINE

- Substance ABUSE vs. DEPENDENCE
- Statistics and General Information
- Assessment Tools
- Alcohol Withdrawal
- Opioid Withdrawal
- Benzodiazepine Withdrawal
- Stimulant Withdrawal
- Levels of Involvement Framework
- Transtheoretical Model/Stages of Change Framework
- 4-A's Model of Intervention
- Resources and References

# DSM IV CRITERIA

## Substance Abuse

A maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by one or more of the following:

1. Recurrent use resulting in failure to fulfill major roles.
2. Recurrent use in situations where it is hazardous.
3. Recurrent substance related legal problems
4. Continued use despite problems.

## Substance Dependence

A maladaptive pattern of substance Use leading to clinically significant Impairment or distress as manifested by **three or more** of the following:

1. Tolerance
2. Withdrawal, or using another substance to alleviate withdrawal.
3. Using more than was intended.
4. Trying to or wanting to quit.
5. Time spent in procuring, using or recovering from use.
6. Giving up previously enjoyable activities because of use.
7. Continued use despite adverse consequences.

# Main Features of Addiction

- ✦ Preoccupation with the drug or using behaviour
- ✦ Impaired control — using more than intended or using more frequently than intended
- ✦ Continue to use despite negative consequences — health, interpersonal and legal
- ✦ Denial — justification or minimizing of use and behaviours
- ✦ Verbalization of a desire to quit and repeated attempts to quit without success
- ✦ Craving substance
- ✦ Withdrawal from substance
- ✦ Adverse physical effects from continued use

# STATISTICS

- 78% of adult men drink
- 67% of adult women drink
- 42.1% of past year drinkers report consuming 5 or more drinks on a single occasion
- 23.4% exceeded low risk guidelines for alcohol drinking (14 drinks for men and 9 drinks for women per week)
- 9.2% of drinking Canadians report problems with their drinking (some estimates are as high as 22%)

# STAT'S CONT'D

- 2/3 of homicides are committed by people who drink prior to the crime
- 2-3% of driving population is legally drunk at any one time. This rate DOUBLES at night & on week-ends
- Rate of separation & divorce in families with alcohol dependency problems is 7 times the average
- 40% of family court cases are related to alcohol problems
- Alcoholics are 15 times more likely to commit suicide than are other segments of the population
- More than 60% of burns, 40% of falls, 2/3 of boating accidents and  $\frac{3}{4}$  of private aircraft accidents are alcohol related
- 55% of arrests are related to alcohol
- 36% of pedestrian accidents involve alcohol
- 22% of home accidents involve alcohol
- 80% of fire deaths related to alcohol
- 65% of drownings related to alcohol
- As many as 90% of reported child abuse cases implicated alcohol

# OPIOID STATS

- Majority of users are using oxycontin, about 20% codeine, 10-20% morphine and fentanyl
- 10% suffer from chronic pain/? addiction
- 70% are male
- Initially saw cohort of young middle-class adults aged 17-30, predominantly male, who often had education, employment and supportive family, but who rapidly decompensate socially over a period of 6-24 months
- Now there is a shift to the inner city and rural areas
- Major increase in incidence in Winnipeg over the last 2 years
  - In 2005 Dr. Lee saw less than 20 complex opiate assessments (in the whole year)
  - In 2009 she sees about 25-30/month (over 300 for the year)
  - MINE (methadone clinic) went from 0 wait list (July 2008) to 170 on wait list (Oct 2009)
- Mortality rate is over 5% per year (in 2009 there have been several deaths especially from fentanyl)

# ASSESSMENT TOOLS

- The Brief Michigan Alcoholism Screening Test (BMAST)
- CAGE or TACE or TWEAK
- Clinical Institute Withdrawal Assessment – Alcohol (CIWA-A)
- The Alcohol Use Disorders Identification Test (Audit)
- Alcohol Risk Assessment & Intervention (ARAI)
- Minneapolis Detoxification Scale (MINDS)
- The Drug Abuse Screening Test (DAST or the DAST-10)
- South Oaks Gambling Scale
- The Canadian Problem Gambling Index (CPGI)
- The Manitoba Gambling Involvement Scale (MGIS)
- The Mentally Ill Drug and Alcohol Screening (MIDAS)

# CAGE

- C** Have you ever felt that you should **Cut** down your drinking or drug use?
- A** Have people **Annoyed** you by criticizing your drinking or drug use?
- G** Have you ever felt badly or **Guilty** about your drinking or drug use?
- E** Have you ever had a drink or used drugs upon waking to steady your nerves or relieve a hangover (**Eye-opener**)?

The TACE has the same questions for A, C, and E, the T is for tolerance (like the TWEAK)

# TWEAK

- T** How many drinks can you hold? OR How many drinks does it take before the alcohol makes you fall asleep or pass out? If you never drink until you pass out, what is the largest number of drinks you have? (3+ suggests **Tolerance**)
- W** Have close friends or relatives **Worried** or complained about your drinking the past year?
- E** Do you sometimes take a drink in the morning when you first get up? (**Eye-opener**)
- A** Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember? (**Amnesia** or blackouts)
- K** Do you sometimes feel the need to **K/cut down** on your drinking?

# MILD or EARLY SYMPTOMS OF ALCOHOL WITHDRAWAL

## Gastrointestinal Disturbances

- # Nausea
- # Vomiting – any hematemesis?
- # Abdominal discomfort
- # Diarrhea – any melena?
- # Loss of appetite

## Muscular Symptoms

- # Weakness
- # Cramps
- # Tremors

## Sleep Disturbances

- # Insomnia
- # Nightmares or vivid dreams

## Autonomic Imbalance (Excess sympathetic activity)

- # Tachycardia
- # Systolic hypertension
- # Diaphoresis
- # Fever

## Behaviour Changes

- # Irritability
- # Hostility
- # Restlessness
- # Agitation
- # Exaggerated startle response

## Impaired Cognitive Function

- # Inability to concentrate
- # Easily distracted
- # Impairment of memory
- # Impairment of judgment and other higher mental functions

# SEVERE or LATE SYMPTOMS of ALCOHOL WITHDRAWAL

## DELIRIUM

- ✦ Clouding of sensorium
- ✦ Fluctuation from hour to hour in nature and severity
- ✦ Impairment of cognitive function
- ✦ Disorientation to time and place

## HALLUCINATIONS

- ✦ Auditory, visual, or tactile
- ✦ Can be threatening in nature

## DELUSIONS

- ✦ Merge with and are reinforced by hallucinations
- ✦ Can create agitation and terror
- ✦ Usually paranoid in nature

## SEIZURES

- ✦ Usually nonfocal and generalized
- ✦ Occasionally have lateralizing or nonfocal beginnings
- ✦ Prior seizure disorder is not necessary
- ✦ Occur within 48 hrs. of cessation of drinking
- ✦ Usually self-limiting
- ✦ Precedes severe agitation, delirium and hallucinations

# ALCOHOLIC DEMENTIA

- ▣ In contrast to Alzheimer's disease, *Alcoholic Dementia* is partially reversible in some cases with abstinence
- ▣ Repeated CT scans show partial regrowth of anions over time

# WERNICKES ENCEPHALOPATHY and KORSAKOFFS SYNDROME

- ◆ Alcohol increases the metabolism of thiamine
- ◆ Caused by inadequate supply of vitamin B1 (thiamine)
- ◆ Deficiency results in:
  - ◆ confusion
  - ◆ drowsiness
  - ◆ ataxia
  - ◆ abnormal eye movements
- ◆ Medical emergency requiring IV thiamine
- ◆ If Wernicke's is not treated then *Korsakoffs Syndrome* may develop
- ◆ Characterized by:
  - ◆ Severe dementia
  - ◆ Lack of short term memory (often confabulate)
  - ◆ Incapability to understand or interpret their environment
  - ◆ Need lots of supervision – possible institutionalization

# LONG TERM ALCOHOL ABUSE

- ◆ Damage to axons of neurons
- ◆ Causing fewer interconnections between the neurons
- ◆ Liver damage
- ◆ Cirrhosis and portal hypertension
- ◆ Ascites
- ◆ Esophageal varices
- ◆ Acute acetaminophen toxicity (due to liver damage)
- ◆ Multiple losses – social, physical
- ◆ Eventual death

# IMPORTANT BLOODWORK TO CHECK FOR HEAVY DRINKING

- NA & K** – decrease only if dehydrated, r/t fluid shifts, 2% diarrhea and vomiting
- Glucose** – increase slightly d/t drinking and with severe liver disease  
- decrease d/t not eating
- BUN & Cr** – NOT affected by ETOH unless severe liver disease
- Calcium** - 80% is bound to albumin (so depends on albumin)
- PO4** - have to be really not eating to decrease
- Mg** - if decreased the body excretes PO4 and causes metabolic effects  
– agitation, seizures, confusion, muscle twitching, tremors  
(key element in all cells)
- Albumin** - Decreases
- Cholesterol** – may increase or decrease
- Triglycerides** – increase
- PT & PTT** - if increased need vitamin K

*Albumin PT & PTT tell you how the liver is functioning (with or without inflammation)*

# MAIN TESTS TO INDICATE HEAVY DRINKING

**MCV** - Increased cell size

**Mg** - Decreased

**HDL** - Cholesterol fraction (inc. or dec.)

**GGT** - Increased

**Osmolality** – The number of active particles in blood

- Check the osmo. Gap (Na & K x 2 + Gluc. + BUN could be d/t ETOH if no other reason)

**Bili (T & D)** – Increased

**ALT (SGOT)** – Increase indicates the degree of inflammation

**AST (SGPT)** – Increase (specific for inflammation up to 4)

*If higher, suspect viral hepatitis or gall bladder*

**ALP (Alk Phos)** – Increase

**LD** - Increased

**CK** - Increase (muscle agitation), check trip. and myoglobin to rule out MI

**Uric Acid** – Increase

**HGB** - Decrease

**PLT** - Decrease

*If Hgb and Plt are severely decreased you must worry about bleeding if pt. falls*

# URINE TESTS FOR ABUSED SUBSTANCES

Alcohol - Less than 24 hours

Amphetamines – 1 to 4 days

Barbituates (short-acting) – 1 to 3 days

Barbituates (long-acting) – 1 to 3 weeks

Benzodiazepines – 1 to 3 days (casual use)

- 1 to 3 weeks (long-term use)

Cannabinoids (THC) – 1 to 7 days (casual use)

- 1 to 6 weeks (long-term use)

Cocaine – 2 to 5 days

LSD – 1 to 2 days

Methadone – 3 to 7 days (will not make an opiate screen positive)

Methaqualone – 2 weeks

Opiates – 1 to 5 days

Phencyclidine – 1 to 7 days (casual use)

- 1 to 4 weeks (long-term use)

Propoxyphene – 6 hrs to 2 days

Steroids (anabolic) – up to 6 months

# OPIATES

- ◆ The class of drugs known as opiates has been around for thousands of years and originally were made from opium poppies.
- ◆ Today they consist of man-made or synthetic drugs as well as those from plants
- ◆ Opiates include:
  - ◆ Opium
  - ◆ Heroin
  - ◆ Morphine, MS Contin, Hydromorphone
  - ◆ Codeine, Codeine Contin, Tylenol # 1, 2, 3
  - ◆ Demerol
  - ◆ Methadone
  - ◆ Oxycodone, Oxycontin
  - ◆ Percocet (there is talk of removing this from the market due to accidental acetaminophen OD or toxicity)
  - ◆ T's & R's (Talwin and Ritalin)

# WHAT HAPPENS TO OPIATES IN THE BODY

- ◆ Opiates can be taken by mouth, sniffed/snorted, smoked, injected or transdermally
- ◆ Usually there is a rapid high or “rush” as the person’s own natural opiate system is activated
- ◆ All drugs of abuse directly or indirectly target the brain’s reward system by flooding the circuit with dopamine
- ◆ Dopamine is a neurotransmitter that regulates movement, emotion, cognition, motivation and feelings of pleasure
- ◆ The overstimulation of this system produces the euphoric effects desired by people who abuse drugs and teaches them to repeat this behaviour
- ◆ Some drugs release 2 – 10 times the amount of dopamine that natural rewards do
- ◆ In some cases, this occurs almost immediately (smoked or injected), and the effects can last much longer than the effects of natural rewards



- ◆ The resulting effect on the pleasure circuit is a minimizing of naturally rewarding behaviours (such as eating or sex)
- ◆ The brain begins to adjust to the increased surges in dopamine and starts to decrease its production of dopamine or decreasing the number of receptors that can receive and transmit signals
- ◆ The ability to experience any pleasure is drastically reduced leading to feelings of depression, or lifelessness
- ◆ Keep using to get dopamine levels back to normal and then have to use increasing amounts of the drug to get the initial “high” they liked so much (chasing)



# OPIATE WITHDRAWAL

- ◆ Severity of opiate withdrawal varies depending on the dose and how long a person has been taking the opiates
- ◆ Length of withdrawal depends on the drug being taken (due to half life)
- ◆ Withdrawal usually starts 6 – 12 hrs. after reducing or stopping use
- ◆ The most common symptoms:
  - ◆ Sweating
  - ◆ Muscle aches, pains and cramps (flu-like symptoms)
  - ◆ Yawning
  - ◆ Nausea, vomiting and diarrhea
  - ◆ Goose bumps or “cold turkey”
  - ◆ Enlarged pupils
  - ◆ Decreased sleeping
- ◆ These symptoms last about 3 – 14 days
- ◆ Can be tapered in the community (slow taper) in consultation with the doctor to make withdrawal more tolerable OR go on methadone

# RISKS ASSOCIATED WITH DRUG USE

- ◆ Often needles or pipes are shared increasing a persons risk of contracting Hepatitis, HIV/AIDS, or a STI
- ◆ Often unsafe sex practices or having to perform sexual acts to get money or the drug itself
- ◆ Sometimes resort to criminal activity to get money or the drug (i.e. breaking into pharmacy's or attacking pharmacists, stealing, etc.)
- ◆ Loss of supports from family and friends (often stealing from them)
- ◆ Loss of job, spouse, housing
- ◆ Death



# METHADONE

- ◆ Some people choose to go on methadone maintenance therapy (MMT)
- ◆ This usually requires the person to attend a specialty clinic (MINE or CARI) because most doctors do not prescribe methadone (a special license is required)
- ◆ Methadone provides stability and structure to the persons lifestyle because they are no longer using time, energy and/or criminal activity to get opiates
- ◆ Stop the health risk potential by not sharing needles or pipes or unsafe sexual practices
- ◆ Often able to return to work (or find employment)
- ◆ Can be used to taper off of opiates
- ◆ MMT patients
  - ◆ Ontario > 20,000
  - ◆ Saskatchewan – 2,000
  - ◆ Manitoba – 500
- ◆ Barriers to MMT
  - ◆ Almost no rural availability
  - ◆ Stigma and misconceptions
  - ◆ Pay is not rewarding for care provided to complex patients
  - ◆ Lack of organized clinics and support staff

# BENZODIAZEPINES

- ◆ Classification of drugs usually used to treat anxiety/panic disorders and insomnia
- ◆ Common drugs:
  - ◆ Diazepam (valium), Chlordiazepoxide (librium), Oxazepam (serax), Lorazepam (ativan), Temazepam (restoril), Alprazolam (xanax), Clonazepam (revotril)
- ◆ They are absorbed through the stomach, muscle or blood stream (depending on route of administration)
- ◆ They are processed through the liver
- ◆ Benzo's have a rapid (30 min), intermediate (30 min – 2 hrs) or slow (2hrs +) onset of action
- ◆ If injected it is always rapid (15 sec. to few minutes)
- ◆ Cause muscle relaxation, decrease in anxiety and a sleepy or relaxed feeling
- ◆ If taken in high doses and/or with alcohol the effects are more intense
  - ◆ Potential to lose consciousness
  - ◆ Decreased respiratory rate
  - ◆ Possible death

# LONG-TERM EFFECTS

- ◆ Low dose benzo's doesn't usually result in addiction, but could lead to it once tolerance builds up
- ◆ Also, if previous addiction to another substance exists the individual is at increased risk of developing a cross addiction
- ◆ Over time tolerance may develop
- ◆ Tolerance may occur over a period of 3 weeks to 3 months
- ◆ Physical dependence may develop (withdrawal will occur if stopped or reduced)
- ◆ Use caution in long-term use especially if the individual has a preexisting addiction to this or another drug/alcohol (most of these medications are designed for short-term use, however they are often prescribed long-term)

# BENZODIAZEPINE WITHDRAWAL

- ◆ Dependent on the medication used, the dosage, and length of time using the medication
- ◆ Low-dose benzo withdrawal consists of some or all of these symptoms:
  - ◆ Extra awareness (such as hearing or vision)
  - ◆ Anxiety
  - ◆ Feeling depressed or sad
  - ◆ Feeling of being 'outside of yourself'
  - ◆ Muscle twitching and tremors (similar to alcohol)
- ◆ High-dose benzo withdrawal consists of these symptoms:
  - ◆ Increased vital signs (temp, pulse, BP)
  - ◆ Tremor
  - ◆ Anxiety or agitation
  - ◆ Problems sleeping or insomnia
  - ◆ Nightmares
  - ◆ Hallucinations
  - ◆ Paranoia
  - ◆ Seizures
- ◆ Very similar presentation to alcohol withdrawal
- ◆ Require a taper off of the medication (see the Ashton Manual for tapering schedules)

# STIMULANTS

- + This includes cocaine, crack, crystal meth, 'E', T's & R's (talwin and Ritalin), rave drugs, speed, 'special K' (ketamine)
- + These drugs release excess amounts of dopamine and other neurotransmitters in the brain (similar to opiates) and short-circuit the brain's usual way of working
- + Prolonged/chronic use causes irreversible structural brain damage that doesn't get better and may include symptoms that look like Parkinson's Disease
- + Immediate effects on the individual are a feeling of euphoria or 'high', carefree, increased energy, increased confidence, enhanced sexual feeling, decreased hunger and therefore weight loss (used by teenage girls for this effect)
- + Also causes:
  - ✦ Increased heart rate, vasoconstriction, chest pains, severe agitation and anxiety, heart disease, pulmonary edema, muscle spasms, erectile difficulties
  - ✦ Paranoia, hallucinations, blurred vision, headaches
  - ✦ Rapid shallow breathing, nausea, fever, seizures, sudden death
  - ✦ Stuffed, runny or bleeding nose and holes in the septum (from snorting), risk of hepatitis, HIV/AIDS, or other infection from sharing straws or needles

# WITHDRAWAL

- + Usually not life threatening (risk is actually while using) and therefore do not usually require hospitalization
- + Person may present as depressed with:
  - + Suicidal gestures/thinking
  - + Loss of ability to feel pleasure
  - + Fatigue/desire to sleep + + +
  - + Cravings for the drug
  - + Mood swings, irritability/anger
  - + Increased appetite
- + These feelings may be quite intense in the first few days after stopping use, but over time (weeks or months in some cases) these feelings will decrease in intensity and become easier to cope with
- + With crystal meth use there could be psychosis lasting several days or weeks
- + The depressed mood could be long-lasting (years for some)
- + In this case medications may be necessary as well as long-term follow-up with a doctor or psychiatrist and addictions treatment
- + Using cocaine while pregnant can cause miscarriage or premature birth
  - + Baby could have a small head, low birth weight, blocked vessels in the brain and other physical problems
  - + Baby may cry a lot due to feeding and sleep problems
  - + If use continues while breast feeding the baby could have seizures and extreme irritability

# STAGES OF CHANGE

This model/framework is designed to assist individuals through the change process. Understanding the client's readiness to change and helping them to understand the change process is an integral part of rehabilitation.

**Precontemplation** The stage where the client is NOT considering change as there is no perceived need for any change.

**Contemplation** The stage where the client is thinking about making some changes.

**Preparation** The stage where the client is preparing or becoming determined to make changes.

**Action** The stage where the client is actively making changes through modifying behaviours.

**Maintenance** The stage where the client is consistently maintaining changes made over a period of time.

**Recycle** The stage where the client falls back to an earlier stage of change.

**Termination** The stage where the client no longer needs to attend to the task of maintaining the change.

# LEVELS OF INVOLVEMENT

This model focuses on behaviours (not the individual) and avoids labeling people. This framework will assist people to identify degrees of concern based on descriptive criteria. The problem is defined collaboratively by the individual and counselor.

## Non-Involvement

Where a person has:

- never gambled, used alcohol or drugs
- chosen a non-involved lifestyle following some involvement

## Irregular Involvement

Where a person has:

- random or infrequent involvement, usually confined to specific occasions or situations
- little or no evidence of any harmful or adverse consequences (involves experimental use)

## Regular Involvement

Where a person has:

- regularly recurring involvement (patterns evident)
- some evidence of adverse, related consequences may be apparent (minor or isolated)
- often characterized by individuals who actively seek involvement, or where involvement has become a regular feature of their lifestyle

## Harmful Involvement

Where a person has:

- evidence of recurring adverse consequences (failure to fulfill major role obligations at home, school or work)
- financial or legal problems
- continued use despite repeated or persistent problems, in one or more life areas, which are caused by or made worse as a result of the involvement

## Dependent Involvement

In addition to the characteristics of Harmful Involvement, at this level involvement/use tends to be patterned and is characterized by particular features:

- the individual experiences a physiological and/or psychological need for continued involvement/use; and
- the individual experiences some loss of control over his/her involvement/use

Evidence of dependent involvement may include:

- *impaired control*

use frequently exceed original intentions

unsuccessful efforts have been made to cut down or control involvement

the individual experiences a compelling need to continue involvement/use

- *preoccupation*

increasing amounts of time, money and energy are devoted to activities r/t maintaining involvement or recovering from it

individual has given up or has significantly reduced involvement in other previously valued/enjoyed activities

- *adverse consequences*

continued use despite knowledge that the persistent physical, mental, social or financial problems they experience have been caused or made worse as a result of their use

attempts to cope with losses through continued involvement

- *withdrawal distress*

experience physical or mental distress as a result of abstaining from use and may continue use in order to avoid experiencing that distress (eye-opener)

- *progression*

increased levels of involvement (frequency, quantity or duration) are required over time to achieve or maintain the desired effect

## Transitional Abstinence

Where an individual with past involvement at harmful or dependent levels:

- has chosen to abstain from alcohol, other drugs, or gambling, but has yet to achieve a sense of comfort with, or confidence in, that decision
- although usually regarded as a positive step toward personal growth and development, it is at the same time often characterized by some apprehension, anxiety, ambivalence or uncertainty
- will typically occur in relation to the Action stage of change, but could occur at other stages of change

(it should be noted that although transitional abstinence may occur as an initial period of abstinence prior to the achievement of a more stabilized abstinence, periods or episodes will also occur in conjunction with harmful or dependent levels of involvement)

## Stabilized Abstinence

Where an individual with past experience at harmful or dependent levels:

- has chosen to abstain from alcohol, other drugs or gambling *and* has achieved a sense of comfort with the decision, or a measure of confidence in the ability to maintain an abstinent lifestyle
- will occur in relation to the Maintenance stage of change

# 4-A'S MODEL OF INTERVENTION

## **ASK**                      Screen patients/clients

Identify people at risk because of their substance use by ASKING all people over 12 years of age about their use habits.

## **ADVISE**                      Provide feedback and advice

Intervene appropriately by ADVISING people if you are concerned about their substance use. Advise by providing personalized feedback. Advise to reduce or stop use.

## **ASSIST**                      Offer help to motivate to make changes

Continue the intervention by ASSISTING people through brief interventions and referrals as appropriate. Assist by providing materials to facilitate change, and motivational interviewing to promote contemplation.

## **ARRANGE** follow-up      Monitor progress in change efforts

Monitor progress towards behaviour change and ARRANGE follow-up.

Component

Activity

Target

| Component | Activity  | Target                                 |
|-----------|---|--|
| ASK       | Screening                                       | All clients                            |
| ADVISE    | Feedback (personal)                             | All clients                            |
|           | Education                                       | All clients                            |
|           | Advise to change                                | Increased risk and harmful involvement |
|           | Intervention statement                          | Harmful & dependent involvement        |
| ASSIST    | Brief counseling matched to the Stage of Change | Harmful & dependent involvement        |
| ARRANGE   | Follow-up &/or referral                         | Harmful & dependent involvement        |

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<http://counsellingresource.com/quizzes/alcohol-cage/index.html>

<http://counsellingresource.com/quizzes/drug-abuse/index.html>

<http://www.addictioninfo.org/articles/11/1/Stages-of-Change-Model/Page1.html> (transtheoretical model)

<http://www.afm.mb.ca/>

<http://www.afm.mb.ca/Learn%20More/Levels%20Invol.pdf>

<http://www.benzo.org.uk/manual/index.htm>

<http://www.ccsa.ca/Eng/Priorities/Gambling/CPGI/Pages/default.aspx>

<http://www.drugabuse.gov/parent-teacher.html>

<http://www.hsc.mb.ca/addictions/>

<http://familydoctor.org/online/famdocen/home/common/addictions/alcohol/130.html> (naltrexone info)

<http://alcoholism.about.com/od/meds/a/campral.htm>

<http://www.camh.net/>

<http://www.minddisorders.com/Br-Del/Clonidine.html>

<http://www.whitehousedrugpolicy.gov/publications/factsht/methadone/index.html>