
**A brief cognitive
behavioural intervention
for regular
amphetamine users**

A treatment guide

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Background

In 2001, the Australian Government Department of Health and Ageing funded a project entitled “An evaluation of cognitive-behaviour therapy (CBT) among regular amphetamine users” (Baker, Kay-Lambkin, Lee, et al., unpublished), which built on results from a pilot study conducted by Baker, Lewin & Bloggs in 1998.

The current project aimed to evaluate the effectiveness of both a two- and four-session cognitive-behavioural intervention among a sample (N=214) of regular amphetamine users recruited from Brisbane, Queensland and Newcastle, New South Wales. The four-session intervention is detailed in this publication; however practitioners may choose to offer a two-session intervention according to client needs. The development of the CBT intervention was informed by various treatment approaches that were considered appropriate for regular amphetamine users. The sources are acknowledged in Appendix 1.

This manual is divided into five sections:

Section 1. Context

- Key points from *Models of Intervention and Care for Psychostimulant Users*, National Drug Strategy Monograph Series (in press) are included to present the evidence supporting this type of intervention for regular amphetamine users.
- A flow-chart to place the intervention in a treatment context.

Section 2. Background to the study and results of evaluation

- A brief description of how the study was developed, undertaken and evaluated.
- A brief description of the evaluation outcome data (detailed results will be published separately).
- Suggestions for pre-intervention assessment including instruments.

Section 3. The intervention

- The CBT intervention is presented in a clear and easy to use format for practitioners.

Section 4. Suggested alternative brief interventions for those not suitable for the current intervention

- This section provides an overview of recommendations for alternative interventions for psychostimulant users who are unsuitable for the CBT intervention (e.g. those who are not considering change, experimental users etc).

Section 5. Other available resources

- This section lists a range of other resources that are currently available for practitioners working with psychostimulant users.

This intervention guide has not been designed to stand alone. Rather, practitioners are encouraged to:

1. Acquaint themselves with the current research and clinical literature. The recently completed monograph *Models of Intervention and Care for Psychostimulant Users* is an excellent resource for current evidence supporting practice in this area.
2. Undertake training in CBT and motivational enhancement techniques if unfamiliar with these approaches.
3. Obtain ongoing clinical supervision.

Section 1. Context

Section 1. Context

Key Points in the Provision of Interventions for Psychostimulant Users¹

- There are clear signs that amphetamine use is increasing; however, there are few services in Australia that offer amphetamine-specific interventions.
- The literature is very limited in the number of well-conducted, controlled studies, but the available evidence suggests that outpatient cognitive-behaviour therapy appears to be current best practice for psychostimulant users.
- The service context in which interventions are provided is important in attracting and retaining people who present to treatment facilities.
- Psychosocial approaches to psychostimulant dependence include outpatient interventions, residential treatment and therapeutic communities (TCs).
- Completion of treatment is associated with improved client outcomes.
- Enhancement of residential treatment with behaviour therapy or cognitive-behaviour therapy (CBT) is also associated with improved client outcomes.
- Service delivery may be enhanced by considering the following issues: attracting and retaining clients; establishing treatment partnerships; and monitoring and evaluating services.

The use of psychostimulants is increasing in Australia and internationally (see Jenner & McKetin (in press) for a thorough review of these studies). In 2000, nearly one and a half million Australians reported using amphetamines at least once in their life, and half a million people reported use of these drugs at some time during that year (Australian Institute of Health and Welfare (AIHW), 2002). Currently, amphetamines are the second most frequently used illicit drug after cannabis (AIHW, 2002).

Psychostimulants include amphetamine sulphate and amphetamine hydrochloride ('speed'), and the more potent methamphetamine ('base', 'ice', 'pills'). Cocaine and MDMA (ecstasy) are also classed as psychostimulants but as the current treatment was evaluated among regular amphetamine users its efficacy cannot be generalised to users of

¹ These points have been adapted from Baker, Gowing, Lee & Proudfoot, Psychosocial Interventions for Psychostimulant Users, in Baker, Lee & Jenner (eds), *Models of Intervention and Care for Psychostimulant Users*, National Drug Strategy Monograph Series (in press).

other psychostimulants. Hence this guide refers to amphetamines (including methamphetamine) only.

Amphetamines stimulate neurotransmitters (particularly dopamine, noradrenaline and serotonin) in the central nervous system and cause a range of effects both sought after and adverse. Sought after effects of amphetamines include euphoria, mood elevation, a sense of well-being and confidence, increased energy and wakefulness, and increased concentration and alertness (Dean, in press). Adverse effects include severe restlessness, tremor, anxiety, dizziness, tenseness, irritability, insomnia, confusion, and possibly aggression (Dean, in press). At toxic doses amphetamines can produce psychosis, delirium, auditory, visual and tactile illusions, paranoia, hallucinations, loss of behavioural control, alterations in consciousness and severe medical complications such as serotonin toxicity and cardiovascular and neurological events (Dean, in press; Dean & Whyte, in press).

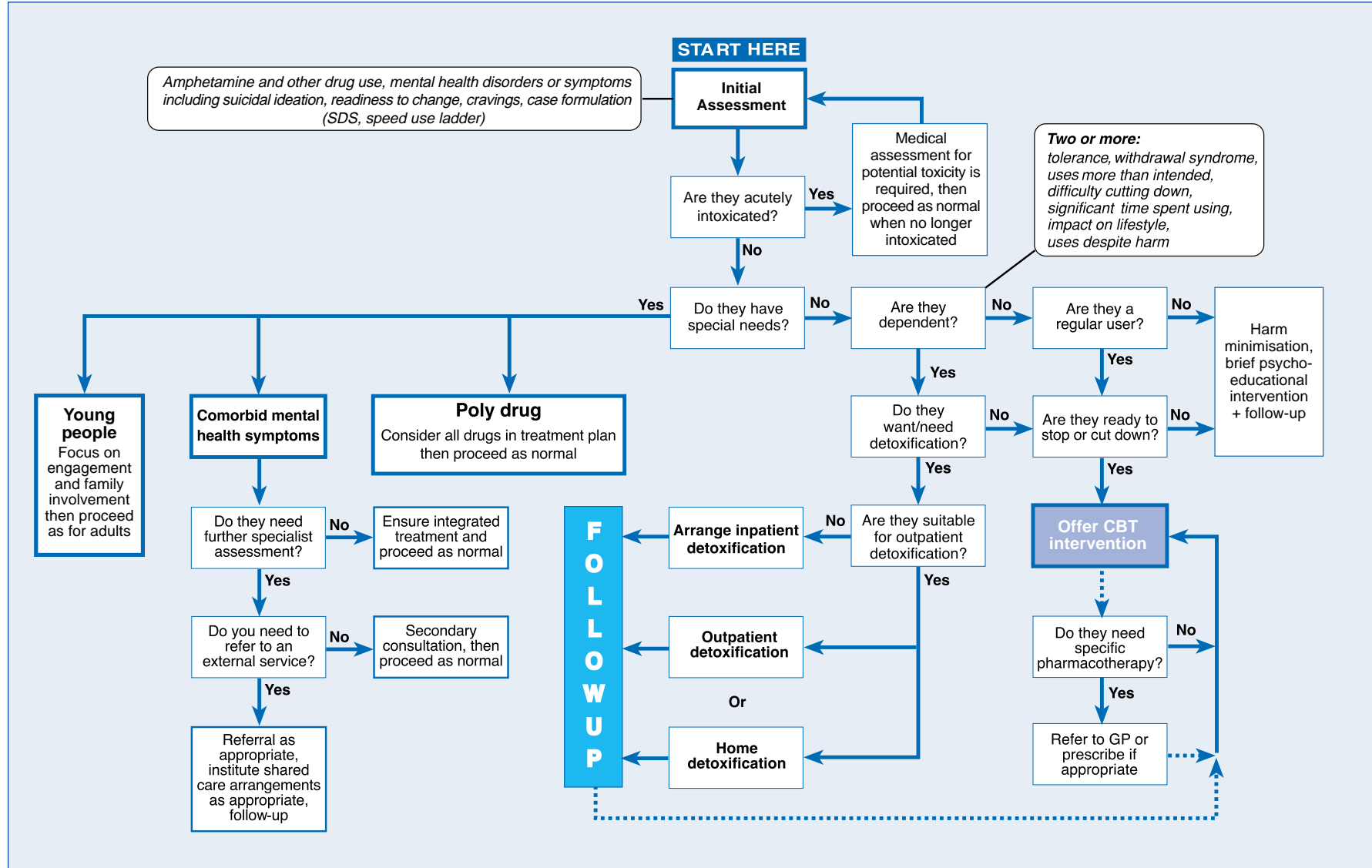
Amphetamine users report a reluctance to seek treatment and a level of dissatisfaction with services currently provided (Kamieniecki, Vincent, Allsop, Lintzeris, 1998). Adverse consequences of amphetamine use such as symptoms of dependence, aggression, depression, hallucinations and panic attacks have been identified as prompts for treatment seeking (see Baker, Gowing, Lee & Proudfoot, in press for a review of relevant studies).

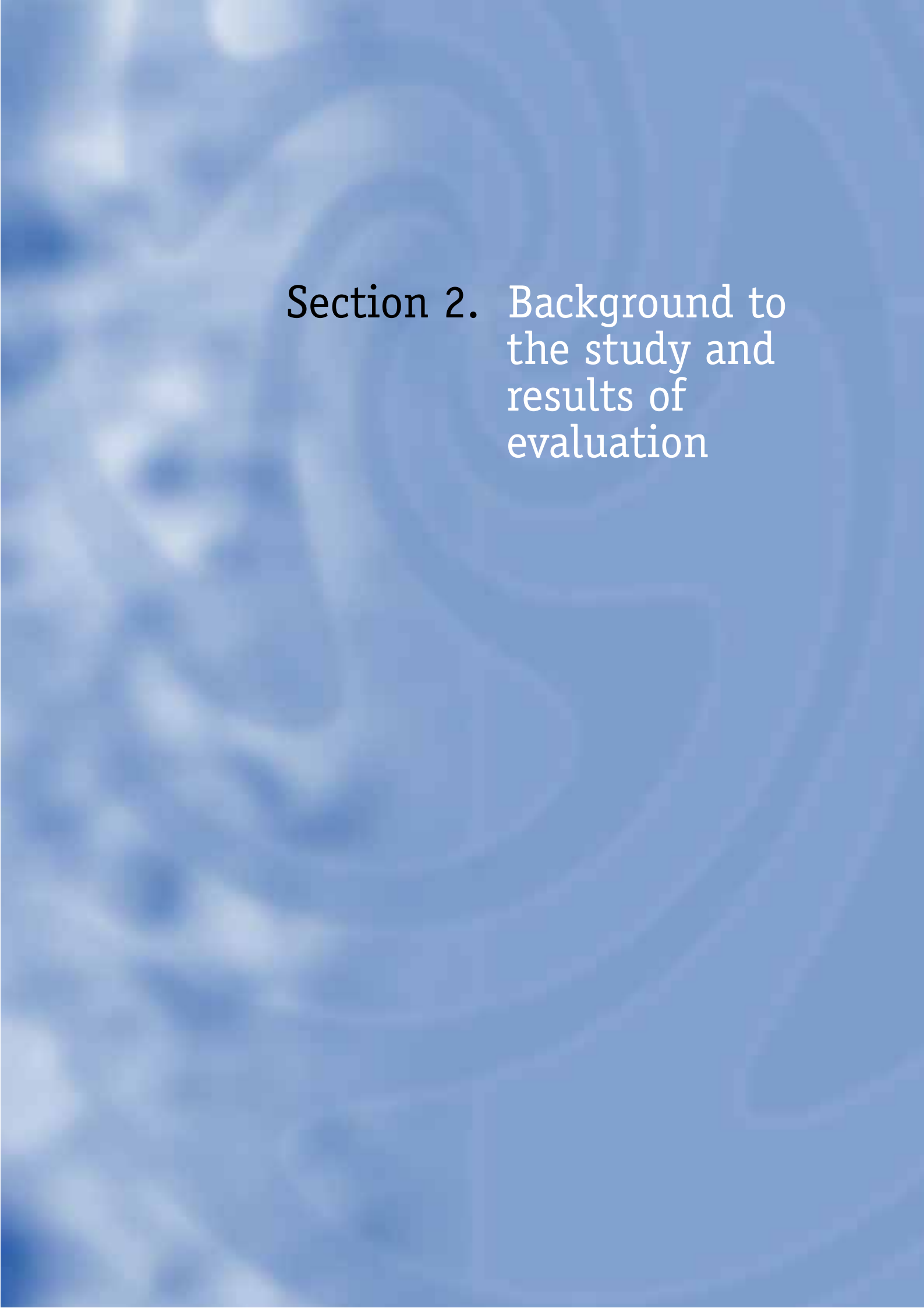
Clinicians and researchers have identified the need for specific treatment approaches for this group to attract and engage clients into treatment (Baker et al., in press). This guide details a brief intervention specifically designed for regular amphetamine users that may be utilised by practitioners working in a wide range of treatment settings.

A flow-chart² that visually depicts the context in which the current CBT intervention could be offered is presented in Figure 1. For further detail please refer to the National Drug Strategy Monograph *Models of Intervention and Care for Psychostimulant Users*.

² Adapted from Chapter 12, Clinical Recommendations in Baker, Lee & Jenner (eds), *Models of Intervention and Care for Psychostimulant Users, National Drug Strategy Monograph Series (in press)*.

Figure 1: Flow-chart for clinical decision making in offering interventions for psychostimulant users





Section 2. Background to the study and results of evaluation

Section 2. Background to the study and results of evaluation

Study Methodology³

Subjects A total of 214 regular users of amphetamines were included in the evaluation of the current CBT intervention. Participants were recruited from the Newcastle area of NSW (n=98) and from Brisbane and the Sunshine Coast of Queensland (n=116).

Potential participants were assessed for regular amphetamine use with the Opiate Treatment Index (OTI, Darke, Hall, Heather, Wodak & Ward, 1991) and were included in the study if they scored at least 0.14 for amphetamine use (ie. at least weekly use). Due to the high levels of polydrug use among regular amphetamine users, participants receiving maintenance pharmacotherapy for heroin dependence (ie. methadone maintenance treatment or buprenorphine) and/or polydrug users were also included.

Potential participants were considered to be inappropriate, and therefore excluded from the study if they were expressing current suicidal ideation that was assessed as posing high risk for client safety, were acutely psychotic, showed evidence of acquired cognitive impairment or were receiving other counselling for amphetamine use. All potential participants who were excluded because of psychosis or suicidal ideation were referred to an appropriate mental health agency.

Written, informed consent was obtained from each suitable participant and interviews took approximately one hour to complete.

Measures Domains measured by the research team using a range of screening and assessment instruments included:

- demographic characteristics;
- alcohol and other drug use history including treatment history;
- psychiatric history;
- quality of life;
- risk-taking behaviours; and
- general health, including mental health symptomatology.

All participants were assessed at pre-treatment and again at five weeks and six months post treatment.

³ A paper reporting the details of methodology and outcome data is in preparation and will be published separately from this guide.

Procedure Consenting participants assessed as suitable for inclusion in the study were randomly assigned to one of three conditions and received:

- A two-session CBT intervention (n=74, or 35% of participants)
- A four-session CBT intervention (n=66, or 31% of participants)
- A self-help manual only⁴ (control condition) (n=74, or 35% of participants)

Pre-Intervention A snapshot of the relevant characteristics of the sample is presented in Table 1.

The age of participants ranged from 16-55 years and 63% were men. Duration of use of amphetamines ranged from one year to 34 years, with regular use of amphetamines ranging from four months to 31 years.

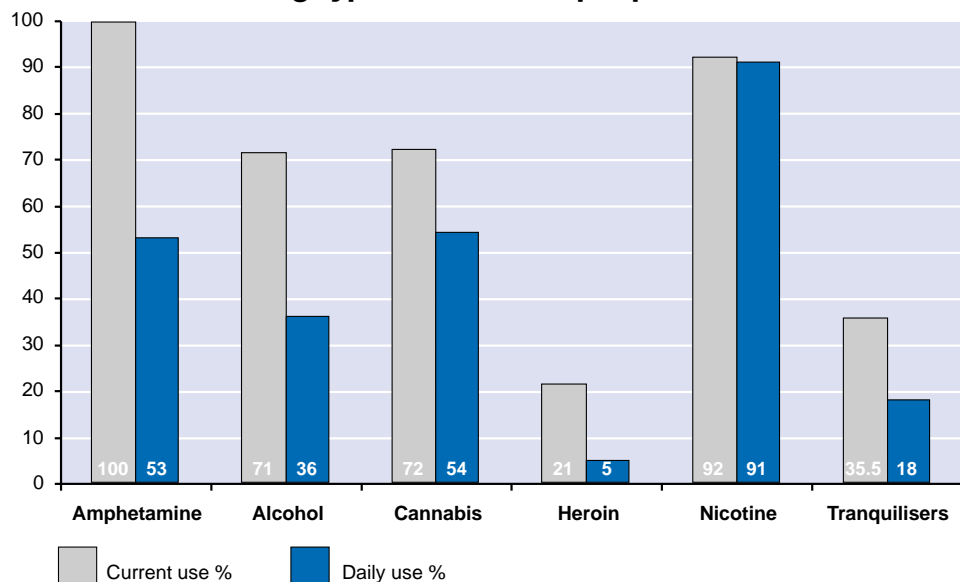
Nearly all participants (96%) met six-month criteria for amphetamine dependence at first assessment (Structured Clinical Interview for Dependence-I, Research Version, First et al., 1996).

At the time of first interview, nearly all participants had made the transition to injecting amphetamines every time (58.9%) or most times (32.7%).

The rate of comorbid mental health disorders among the participants was considerable (47.7%), and many were taking prescribed medication such as anti-depressants, anxiolytics and anti-psychotics (see Table 1).

Polydrug use was common among study participants. Levels of drug use prior to the intervention are graphically presented in Figure 2.

Figure 2. Per cent of current and daily drug use according to drug type: whole sample pre-intervention



⁴ *A user's guide to speed*. National Drug and Alcohol Research Centre (NDARC).

Table 1. Characteristics of participants at initial assessment (N=214)*

Demographic characteristics		
% Born in Australia	92.1	(197)
% Aboriginal or Torres Strait Islander	6.1	(13)
% Male	62.6	(134)
Mean age (years)	30.2	(range 16-55 years)
% Unemployed	74.8	(160)
% Never married	64.5	(138)
% With children	47.2	(101)
% Residing in same accommodation past year	44.4	(95)
% Receiving Government Financial Assistance	76.6	(164)
Treatment History		
% Previous treatment for substance use	23.8	(51)
Mean number of times in previous treatment	4.2	(range 1-20 times)
% Current treatment for substance use	31.8	(68)
Of these, % methadone treatment (MMT)	70.6	(48/68)
Of these, % buprenorphine	8.8	(6/68)
Mean duration of MMT enrolment (months)	37.9	(range 1-240 months)
Amphetamine Use		
Mean age at initiation to speed use	18.7	(range 9-40 years)
Mean age at regular use (years)	21.2	(range 11-43 years)
Mean age at first injecting amphetamine	20.6	(range 11-42 years)
Mean duration of amphetamine use (years)	11.5	(range 1.40-34.61 years)
Mean duration of regular use (years)	9.0	(range 0.27-31.07 years)
Mental Health Issues		
% Ever diagnosed/treated mental health condition	47.7	(102)
% Currently taking medication for mental health problem	41.6	(89)
Mood stabilizers/anti-depressants	29.0	(62)
Anti-psychotics	15.0	(32)
Anxiolytics	14.5	(31)
% Ever admitted to psychiatric unit	29.0	(62)
Mean age first diagnosed with mental health problem	23.7	(range 7-40 years)

* Tabled values are percentages (and frequencies) or mean scores (with ranges).

Results

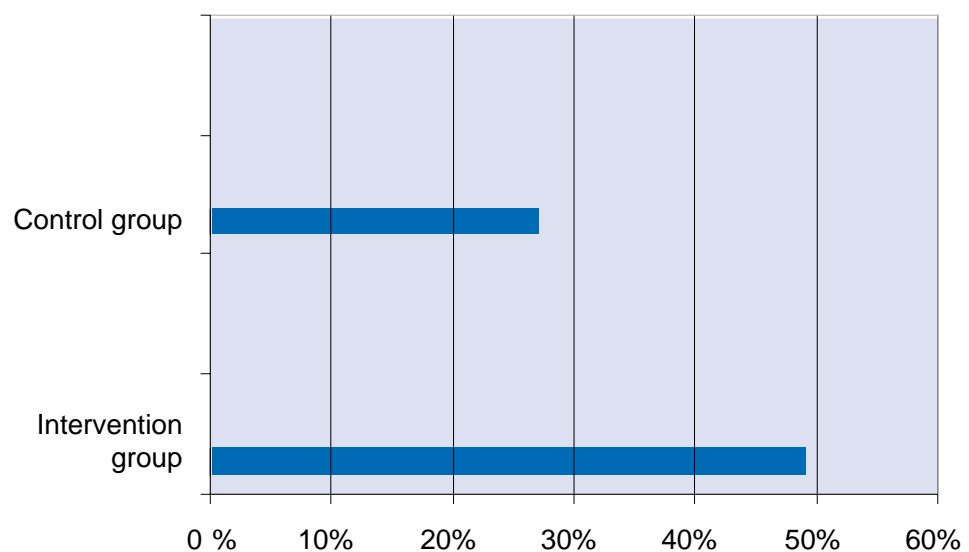
Completion rates Of the 74 participants assigned to the two-session CBT intervention, 56 (75.7%) completed the treatment. Of the 66 assigned to four sessions, 45 (68.2%) completed 3 or 4 sessions. Females were more likely than males to have completed the allocated interventions (86% of females versus 61% of males, $\chi^2(1) = 8.152, p < 0.004$). No other differences were found between completers and non-completers.

Depression There was a significant overall improvement for participants in levels of depression as measured by the BDI-II (Beck, Steer & Brown, 1996) between pre-treatment and 5-week follow-up ($t(154) = 7.074, p < 0.000$). This was also true for pre-treatment and 6-month follow-up assessments ($t(152) = 8.281, p < 0.000$). Depression levels among the control group also reduced to a level comparable with the intervention group at the 6-month follow-up. It is pertinent to note, however, that participants who reported an increase in symptoms of depression at the 6-month follow-up (ie. increase in BDI-II scores) also reported increased levels of amphetamine use.

Amphetamine use Approximately one-quarter (13/38, 27.1%) of the participants in the control group were abstinent from amphetamine use at the 6-month follow-up, compared to 49.4% (42/85) of those who participated in two or more treatment sessions (see Figure 3). Adjusting for the effects of duration of regular amphetamine use, this represents a significant increase in the likelihood of abstinence among those receiving two or more treatment sessions [Adjusted Odds Ratio (AOR) = 3.00, $p < .01$, 99% Confidence Interval: 1.06 to 8.44].

Similar reductions in polydrug use were also reported, initially at the 5-week follow-up, and sustained at the 6-month follow-up⁵.

Figure 3. Abstinence rates at 12-month follow-up*



* $p < 0.01$

Conclusion The participants in the evaluation study comprised a group of regular amphetamine users with long histories of amphetamine use. They had high levels of dependence on amphetamines, and reported high levels of injecting risk-taking behaviour and polydrug use. Rates of depression and other mental health disorders were also high. Many participants reported poor quality of life.

Although only 35% of the initial sample was assessed as being in the action stage of change (Prochaska & DiClemente, 1986) for reducing amphetamine use, 71.5% were retained at 6-month follow-up. In addition, almost three-quarters (72.14%) of all participants who received either the 2- or 4-session CBT intervention (detailed in the next section of this guide) attended all sessions. This demonstrates that regular users of amphetamines, many of whom are ambivalent about change, can be engaged in and complete treatment.

There was a marked reduction in amphetamine use among all participants over time, including those in the 2- and 4-session interventions and the control group. This reduction was likely related to a commitment to being involved in a research project and possibly to undertaking a series of detailed assessments over time that might be considered a brief intervention in itself. However, being in active treatment (compared to the control condition) was associated with significantly greater rates of abstinence from amphetamine use that was sustained at the 6-month follow-up period. Therefore it appears that active therapy gave subjects an added incentive for abstinence. In addition, being in active treatment had a significant short-term effect on symptoms of depression.

The results of this study undertaken among a group of mostly dependent amphetamine users with long drug use histories indicate that the intervention described in this guide might provide a significant proportion of similar users the incentive and skills required to achieve abstinence from amphetamine use in the future.

⁵ A detailed analysis of these subgroups is in progress and will be reported separately.

Section 3. The intervention

Section 3. The intervention

Rationale and principles of treatment

Throughout this guide the term 'speed' is used to encompass all forms of amphetamines.

This treatment is based on the assumption of the motivational enhancement therapy (MET) approach that the responsibility for change lies within the client (Miller, Zweben, DiClemente & Rychtarik, 1995). The therapist's task is to create a set of conditions that will enhance the client's own motivation and commitment for change. The therapist does this by following the five basic motivational principles:

1. express empathy
2. develop discrepancy
3. avoid argumentation
4. roll with resistance
5. support self-efficacy

Following the development of the client's commitment to change, the therapist assists the client in learning skills that will help him/her achieve change.

Goals of treatment

The main goal of treatment is to reduce the level of drug use and the harm (e.g., mental and physical health, financial, social, occupational) associated with regular amphetamine use. The client will be assisted to identify specific goals. If the client has a concurrent mental health problem (e.g., depression or a psychotic illness) then an important goal is to enhance the client's understanding of possible interactions between their use of amphetamines and other drugs and any current psychiatric symptoms they might be experiencing.

Format of therapy

Guidelines for the delivery of the treatment sessions are given for each of the interventions in this guide. These guidelines are general and a practitioner can modify the guidelines to be consistent with his or her own counselling experience. The suggestions for practitioner statements throughout this guide are taken from the MET manual (Miller et al., 1995).

This publication presents the guide for a four-session intervention; however the decision to offer either a two- or four-session intervention may be made by the practitioner in accordance with individual client needs.

The content of the four sessions is listed below and each session should last approximately one hour. The first session will begin following the initial assessment.

1. Motivational interviewing (session 1)
2. Coping with cravings and lapses (session 2)
3. Controlling thoughts about amphetamine use and pleasurable activities (session 3)
4. Amphetamine refusal skills and preparation for future high-risk situations (session 4)

Although weekly sessions are preferable, there will be occasions when clients cannot attend or forget their appointment. In this case, an attempt should be made to reschedule for the same week in an effort to maintain engagement and the client's motivation to change drug use behaviours. If this is not possible, the session should be carried over to the regular time the following week.

Initial assessment

The assessment package that was developed for the evaluation study would not be practical in the context of routine clinical care. However, specific elements are required in the initial assessment so the sessions can be tailored to individual needs. The essential elements of the initial assessment include:

1. A thorough alcohol and other drug use history that includes use of amphetamines and other drug classes, quantity, frequency, route of administration and associated risks, duration of current use, age of initiation, severity of dependence, experience of previous treatment, and history of withdrawal symptoms.
2. A thorough mental health assessment including past mental health history and assessment of current symptoms (presence and severity) with an emphasis on psychosis, depression and suicidal ideation (see Figure 3 for suggested questions for assessing suicidal ideation).
3. Client's readiness to change amphetamine (and other drug) use (see Figure 4, 'speed ladder' below).

A practitioner's initial assessment will inform the decision regarding which aspects of the four-session CBT intervention to emphasise with each client. For example, if the client is assessed as being in the *action* stage of change (Prochaska & DiClemente, 1986), session 1 that concentrates on motivational interviewing may be kept to a minimum so that more time is available for other issues that require emphasis such as coping with cravings to use amphetamines.

To enable the development of a thorough assessment and formulation, the following assessment instruments are recommended as an adjunct to routine assessments:

- The amphetamine version of the Severity of Dependence Scale (SDS) (Gossop, Darke, Griffiths, et al., 1995), which is a five-item scale that measures dependence. Australian researchers reported that a cut-off score of greater than four corresponded to a diagnosis of severe amphetamine dependence (Topp & Mattick, 1997) (see Figure 2).
- The Speed Use Ladder adapted from Biener and Abrams (1991), used to assess readiness for changing or reducing amphetamine use (see Figure 3).⁶
- Questions for assessing suicide risk (Treatment Protocol Project, 2000) (see Figure 4).

Figure 2. Severity of Dependence Scale (Gossop et al., 1995)

1. Have you ever thought your speed use is out of control?	Never (0)	Sometimes (1)	Often (2)	Always (3)
2. Has the thought of not being able to get any speed really stressed you at all?	Never (0)	Sometimes (1)	Often (2)	Always (3)
3. Have you worried about your speed use?	Never (0)	Sometimes (1)	Often (2)	Always (3)
4. Have you wished that you could stop?	Never (0)	Sometimes (1)	Often (2)	Always (3)
5. How difficult would you find it to stop or go without?	Never (0)	Sometimes (1)	Often (2)	Always (3)
Total Score: _____				
Note: A cut-off score of greater than four corresponds to a diagnosis of severe amphetamine dependence (Topp & Mattick, 1997)				

⁶ The readiness to change model (see Prochaska & DiClemente, 1986) provides a framework to understand and identify a client's readiness to change drug use behaviours. The model describes six broad categories of the change process, and relapse can occur at any stage:

1. pre-contemplation: not considering change
2. contemplation: thinking about change
3. determination: has made a decision to change
4. preparation: getting ready for change
5. action: is in the early stage of change
6. maintenance: is maintaining changes made

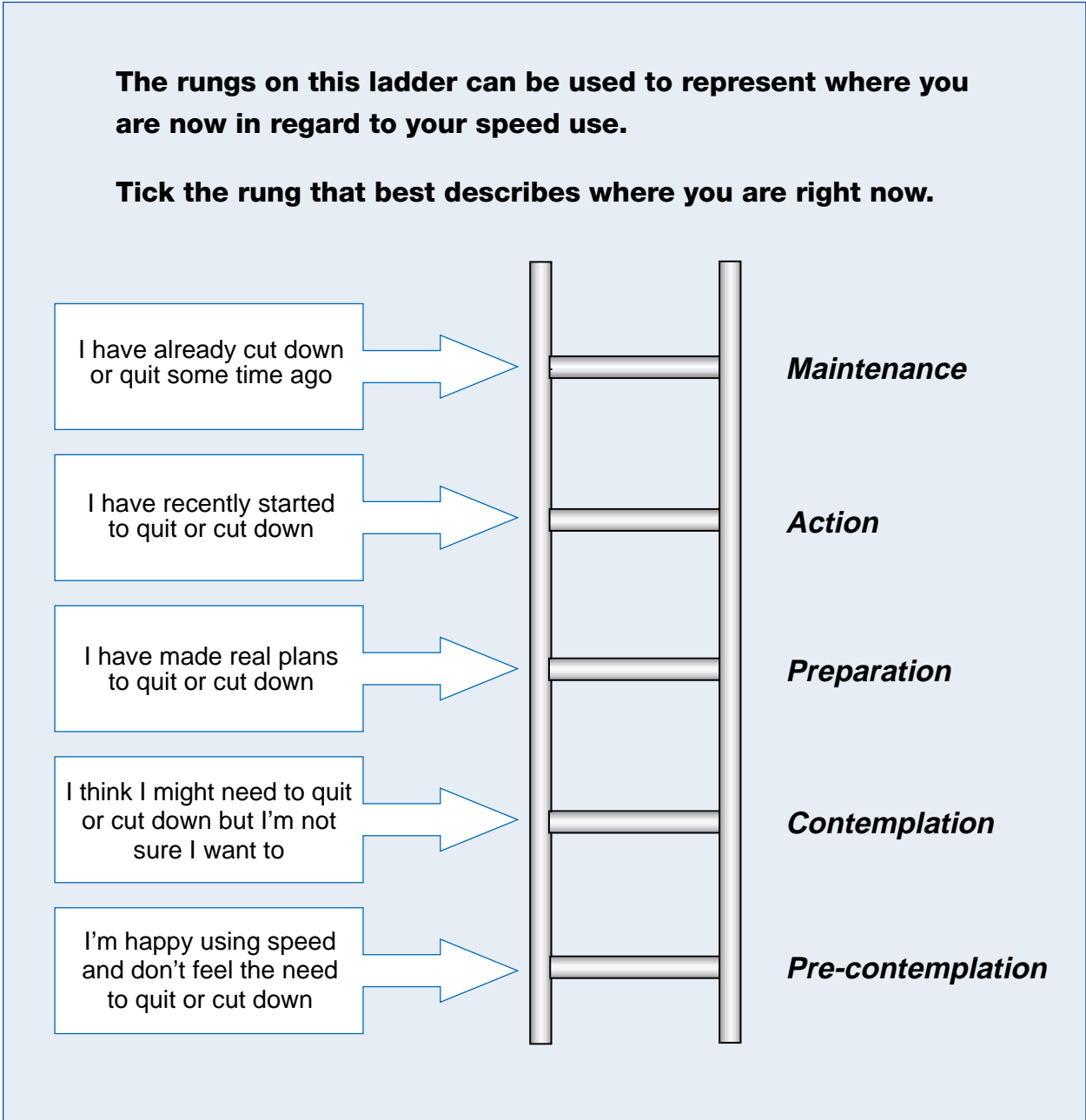
Figure 3. Questions for assessing suicidal ideation

1. Have you been feeling depressed for several days at a time?
2. When you feel this way, have you ever had thoughts of killing yourself?
3. When did these thoughts occur?
4. What did you think you might do to yourself?
5. Did you act on these thoughts in any way?
6. How often do these thoughts occur?
7. When was the last time you had these thoughts?
8. Have your thoughts ever included harming someone else as well as yourself?
9. Recently, what specifically have you thought of doing to yourself?
10. Have you taken any steps toward doing this? (e.g. getting pills/buying a gun?)
11. Have you thought about when and where you would do this?
12. Have you made any plans for your possessions or left any instructions for people for after your death such as a note or a will?
13. Have you thought about the effect your death would have on your family or friends?
14. What has stopped you from acting on your thoughts so far?
15. What are your thoughts about staying alive?
16. What help could make it easier to cope with your problems at the moment?
17. How does talking about all this make you feel?

Reproduced with permission from the Treatment Protocol Project (2000), *Management of Mental Disorders*, pp. 22-23, Third Edition, Sydney: World Health Organisation Collaborating Centre for Mental Health and Substance Abuse.

If you feel that a client fits in the 'high-risk' suicide category, follow the suicide policy in place at your workplace. If a decision is made to manage a high-risk suicidal client, the client should be given written information about how to seek 24-hour assistance if required, and they should be closely monitored throughout the intervention.

Figure 4. Speed use ladder (client to complete)



Session 1: Motivational Interviewing

THERAPIST SUMMARY SHEET

- Aims**
- Engagement and building motivation for change in relation to speed use.
 - Prepare to quit/cut down on speed use.
 - Introduction to behavioural self-monitoring.

Materials needed for Session 1

- A photocopy of Exercise 1: Grid to explore the pros and cons of using speed
- A photocopy of Exercise 2: Urge diary (or alternative)
- A photocopy of Exercise 3: Case Formulation
- A blank piece of paper and a pen.
- Feedback from the initial assessment.

Key elements of Session 1 *(may be photocopied for quick reference).*

PHASE 1: Building motivation to change.

After presenting rationale for treatment, use the following strategies for eliciting self-motivational statements:

- presenting the rationale treatment
- a typical day
- personal feedback from assessment
- impact on lifestyle
- explore the pros and cons of using speed (complete exercise 1 grid)
- explore concerns
- explore health risks
- financial costs of using
- looking back
- looking forward
- self vs self as a user
- encountering ambivalence
- summarise

PHASE 2: Strengthening commitment.

Use the following strategies:

- ask a transitional question
- communicate free choice
- address fears
- provide information and advice
- setting goals

PHASE 3: Behavioural self-monitoring.

Use the following strategies:

- introduce rationale for behavioural self-monitoring
- elicit concerns about high risk situations and triggers for using
- introduce link between triggers, thoughts about using and urges to use
- use urge diary
- summarise

PHASE 4: Formulation.

- explain rationale for formulation
- agree on the elements of the formulation
- jointly develop a treatment plan

PHASE 5: Session termination.

- summarise
- shoring up commitment
- establishing a contract
- set homework, including:
 - identify triggers for using
 - start cutting down if appropriate
 - complete an urge diary for the next week

DETAILED INTERVENTION

Engagement and building motivation for change in amphetamine use

Familiarise yourself with motivational approaches. Clients will be at various stages of change for their amphetamine use and associated harms. A motivational approach will address each harm the client is experiencing during the course of the intervention. You will need to gauge how quickly you can move to discussing amphetamine use with each individual client.

PHASE 1: Building Motivation to Change

The goals of motivational interviewing (Rollnick et al. 1999) are to:

- (i) Maintain rapport;
- (ii) Accept small shifts in attitude as a worthy beginning;
- (iii) Promote some concern about risk (e.g. for health, legal problems);
- (iv) Avoid increasing resistance;
- (v) Promote self-efficacy and responsibility; and
- (vi) View lifestyle holistically (each aspect usually affects the other).

Critical conditions for promoting change are empathy, warmth and genuineness. Strategies to promote motivation to change include:

- removing BARRIERS to change;
- providing CHOICE;
- decreasing DESIRABILITY of substance use;
- practising EMPATHY;
- providing FEEDBACK;
- clarifying GOALS; and
- active HELPING.

Presenting the rationale for treatment

The following is an example of what you might say:

“Before we begin, let me just explain a little about how we will be working together. You have already spent time completing the assessment that we need, and we appreciate the effort you put into that process. We’ll make good use of that information from those questionnaires today. This is the first of four sessions that we will be spending together, during which we’ll take a close look at your situation. I hope that you’ll find the sessions interesting and helpful.

I should also explain right up front that I’m not going to be changing you. I hope that I can help you think about your present situation and consider what, if anything, you might want to do, but if there is any changing, you will be the one who does it. I’ll be giving you a lot of information about yourself and maybe some advice, but what you do with all of that after our sessions together is completely up to

you. I couldn't change you if I wanted to. The only person who can decide whether and how you change is you. How does that sound to you?"

A typical day

Presenting the client with feedback from your assessment is important; however doing so this early in the first treatment session could elicit resistance and hinder engagement in the treatment program. To minimise this, an important first step in raising the issue of your client's speed use is to understand how they see their situation. Proceed with strategies for eliciting self-motivational statements about change by approaching health/lifestyle issues first and gently fit your questions about their speed use into this perspective. Miller et al. (1995), in their MET manual, suggest the following approach is a useful way to stimulate a discussion about the client's current issues:

"The information we have talked about in this session has given me a bit of an idea about what is going on in your life at the moment. But I really don't know a lot about you and the kind of life you lead. I wonder if I could ask you to tell me a little more about your life and the problems you are coping with right now? It would help me to understand the situation better if you could pick a typical day in your life and take me through it from the time you woke up. Tell me about the things you struggled with and how you felt at the time".

(later)

"Can you tell me where your using speed fits in? Can you think of a typical recent day from beginning to end? You got up..."

Allow the person to continue with as little interruption as possible. If necessary, prompt with open-ended questions:

"What happened then?"

Review and summarise, and if required ask:

"Is there anything else at all about this picture you have painted that you would like to tell me?"

Personal feedback from assessment

Once you have a reasonably clear picture of how the client's speed use fits into their typical day and their current concerns, ask the client's permission to provide feedback from your assessment in the following way:

"In getting a feel for what's going on in your everyday life at the moment, you've mentioned several things that are concerning you (summarise these problem areas briefly, using those issues raised by the client in the "typical day" discussion, e.g. quality of life, health, mood, speed use). Would it be OK if I gave you some feedback from the assessment we completed together, because I think it fits into some of these issues?"

Discuss the client's level of dependence and other salient results from the initial assessment. Talk about the diagnosis of dependence and the implications of this, including physical and psychological dependence. Check whether the client feels this is an accurate reflection by asking the following questions:

"How do you feel about this?"

"Does it surprise you?"

Impact on lifestyle

Once you have provided the client with feedback (or "your impression" of their areas of concern), raise the issue of how their use of amphetamines impacts on their lifestyle. The MET manual suggests the following approach:

"I've been wondering what you think is the most important thing to concentrate on to improve your health and lifestyle at the moment ... What do you think the priority should be?"

If appropriate...

"I think it would help a lot if you could have a closer look at your use of speed ... How does it seem to you?"

In conjunction with the client and using the information gained from the assessment, discuss their pattern of amphetamine use (regular, binge, etc) and any concerns they have about this.

Explore the pros and cons of using speed

Now, begin to explore further the client's concerns about their speed use. Ask about their reasons for using speed, the pros and the cons, writing these down together as you go (Exercise 1).

Exercise 1: Grid to explore the pros and cons of using speed

1. Provide the client with the following grid:
 - Good things about using/less good things about using
 - Good things about using less/less good things about using less

2. Elicit from the client all the positives they associate with using speed and write them down in the relevant quadrant. Use the following questions as a guide:

“Tell me about your speed use. What do you like about it? What’s positive about using for you?”

3. Consider with the client how important these positive aspects are, and ask the client to write their importance rating next to the relevant aspect. Use the following questions as a guide:

“How IMPORTANT is this to you personally? If ‘0’ was ‘not important’ and ‘10’ was ‘very important’ what number would you give this aspect of your speed use?”

4. Repeat this exercise with the less good things associated with speed use and assess how important these are to the client. Ask the client to write these issues down in the relevant quadrant of the grid. Use the following as a starting point:

“And what’s the other side? What are your concerns about your speed use?”

5. Finally, continue with a discussion of the good/less good things the client associates with changing their speed use. Record the issues raised in the relevant quadrant. For each issue raised, discuss the importance to the client.

Exercise 1: Grid to explore the pros and cons of using speed *(continued)*

Good things about continuing to use	Less good things about continuing to use
Less good things about using less	Good things about using less

Establish whether positive reasons outweigh the negative in terms of the number of issues listed for and against change, but also the importance ratings provided by the client for the positives and negatives. This is an important step in assessing the need to continue with motivational interviewing during this session.

If at this stage the good things associated with using speed at the current level and the less good things associated with cutting down/quitting outweigh the other quadrants (i.e. the perceived benefits of using still outweigh the perceived costs), use the following techniques to tip the balance in the other direction. If however, the client determines that the costs associated with continuing to use outweigh the perceived benefits, proceed to PHASE 2: Strengthening Commitment.

You may encounter resistance during this discussion. Miller and Rollnick (1991) have identified four categories of resistance behaviour in clients:

- arguing about the accuracy, expertise or integrity of the therapist (challenging, discounting, hostility);
- interrupting in a defensive manner (talking over, cutting off);
- denying or unwillingness to recognise problems, take responsibility or co-operate (blaming, disagreeing, excusing, claiming impunity, minimising, pessimism, reluctance); and
- ignoring or not following the therapist (inattention, non-answer, no response, sidetracking).

If you pick up on this, use the following techniques in response:⁷

- *Reflection* – simply reflect what the client is saying;
- *Reflection with amplification* – reflect but exaggerate what the client is saying to the point where the client is likely to disavow it. (However do not overdo this and elicit hostility);
- *Double-sided reflection* - reflect a resistant statement back with the other side (based on previous statements made in the session);
- *Shift focus* - shift attention away from the problematic issue; and
- *Roll with resistance* (rather than opposing it) - gentle paradoxical statements that will often bring the client back to a balanced perspective.

Once the client raises a motivational topic, it is also useful to ask them to elaborate on it (Miller & Rollnick, 1991). This will reinforce the power of the statement and can often lead to more motivational statements about change. Miller and Rollnick (1991) suggest that one useful way to do this is to ask for specific examples and/or for the client to clarify why this particular issue is a concern.

⁷ Miller et al. (1995, pg 24)

Explore concerns

“You’ve said that these are the less good things about using speed (relate to grid), do these things concern you?”

“What other concerns do you have about speed?”

“I wonder how you feel about using speed ... What can you imagine happening to you?”

“How much does that outcome concern you?”

Explore health risks

“Can you tell me some reasons why using speed may be a health risk (check psychological and physical health)?”

“Would you be interested in knowing more about the effects of speed on the body (or on the brain)?”

“Some people find that changing their speed use can improve their depression. What do you think?”

“How does your use of speed affect your mental health?”

Record those risks that the client is most concerned about. Avoid the use of terms such as “problem”, “abuse” etc. as these can elicit resistance from the client at this early stage.

If appropriate, ask the client for permission to provide them with some information about the health risks associated with using speed. You may like to photocopy the “Information about Speed” handout on page 23 for the client to review.

Financial costs of using

If the client raises the cost of using speed as a factor in their decision to quit/cut down, ask the client:

“Do you have any idea just how much you think you would save if you didn’t use speed?”

If appropriate, calculate how much money they will save in one month or one year by quitting, and with the client determine the important things that could be purchased or bills paid with the money saved.

Looking back

“What were things like before you started using?”

Looking forward

“How would you like things to be different in future?”

“What’s stopping you from doing what you like now?”

“How does using affect your life at the moment?”

“If you decide to quit/cut down, what are your hopes for the future?”

Self vs self as a user

This step helps to develop discrepancy.

“What would your best friend/mum say were your best qualities?”

“Tell me, how would you describe the things you like about yourself?”

“And how would you describe you as a speed user?”

“How do these two things fit together?”

Information about speed

- When you take speed, it melts into your bloodstream, and is carried to your brain. Once in the brain, speed joins to certain sites called receptors. These receptors will trigger brain cells to start or stop different brain and body tasks.
- Speed joins to receptors in the brain that trigger the release of dopamine and adrenaline in the body. Dopamine and adrenaline are chemicals that produce positive feelings when released. When speed enters the brain, it causes the artificial release of these chemicals, leading to short-term feelings of satisfaction, well-being, relief, increased attention, lots of energy etc. But these effects are not without cost. The problem is that when the effects of speed wear off, it leaves a person with the opposite feelings – radical mood swings, depression, lack of energy, confusion, total exhaustion, uncontrolled violence etc. The greater the stimulation effects of speed, the greater the negative effects (or rebound) from speed.
- Speed is a stimulating drug. It quickens activity in many parts of the body, including the messages sent from the brain to the body. But, because it does this unnaturally, it must “borrow” from the energy reserves of the brain and body rather than creating new energy for you to use. That’s why you get the rebound effects after taking speed.
- As you continue to use, your body needs to work harder to burn up the speed that you put into it. It also starts to cut down the amount of dopamine and other chemicals it releases from the receptors in the brain. This means that your body won’t give you as good a feeling as when you first started to use speed, and you’ll rebound harder each time.
- Frequent, heavy use can cause hallucinations, paranoia and bizarre behaviour (psychosis). Your appetite will be reduced, and you will be less likely to eat properly, making you run down and more likely to get infections. Heavy speed users may become violent for no apparent reason, and you may also experience constant sleep problems, anxiety and tension, high blood pressure and rapid, irregular heartbeat. Another common side effect is depression.
- Because speed quickly fires up pleasurable feelings, you gain confidence in being able to feel good just by using it. You lose confidence in the people, places and activities that used to give you these feelings, because the effects don’t happen so quickly. You may find yourself spending more time trying to get speed, being with people who also use, and resenting those people and activities that don’t fit in with using speed. The problem, however, is that speed only gives you a false sense of well-being, along with serious side effects.

Information taken from these publications:

High Times: www.pdxnorml.org/brain1.html

Speed – Psychological & Physical probs: www.kci.org/meth_info/sites/meth_psychos.htm

Australian Drug Foundation: www.adf.org.au/drughit/facts/hdayam.html

A primer of drug action. By Robert Julien

Encountering ambivalence

If the client is ambivalent, attempt to explore the reasons that underlie this. Re-establish the initial reasons for wishing to quit/cut down. Incorporate information on health and psychological effects of continued use. Guide the client through a rational discussion of issues involved, and carefully challenge faulty logic or irrational beliefs about the process of quitting. Positive reinforcement and encouragement are crucial. You may be able to tip the balance in favour of the positives of quitting/cutting down and the negatives of using speed, but if you encounter resistance from the client, don't push them. Remember, the client needs to argue for his or her own change. A "yes but..." statement from the client may indicate you have met resistance and is a sign to gently redirect the conversation to other relevant issues.

Summarise

Briefly summarise all of the information gained from Phase 1.

PHASE 2: Strengthening Commitment

The next phase in motivational interviewing is to consolidate all the issues raised by the client in the first phase, and build on their motivation to change. This works best when the person has moved to the late contemplation or early determination stage of change. Be aware that ambivalence will still be present, and if encountered use Phase 1 strategies as appropriate.

Ask a transitional question

Shift the focus from reasons to change to negotiating a plan for change. After summarising above, use the following questions:

"I wonder where this leaves you now?"

"Where do we go from here?"

"What does this mean about your speed use?"

"How would your life be different if..."

"What can you think of that might go wrong with your plans?"

Communicate free choice

Although abstinence is one possible goal, some people may not be ready to stop completely and may opt for reduced or controlled use. In a motivational enhancement paradigm, the client has the ultimate responsibility for change and total freedom of choice to determine their goal for treatment. The therapist's role is to assist the client to determine an initial treatment goal (see Setting Goals below). Be aware that such goals are likely to alter during the course of the intervention, and an initial goal of cutting down may become a goal of abstinence as the client's confidence increases.

Address fears

"You've told me that (refer to grid) ... are the less good things about reducing your speed use. What is your biggest fear if you do decide to cut down or quit?"

Explore any fears that are identified and assist the client with problem solving for each fear raised. Explore concerns with the management of

withdrawal symptoms if this is raised. For example, withdrawal symptoms can include irritability, insomnia, mood disturbances, lethargy and cravings to use. Symptoms are time limited; however in severe cases medications can be prescribed for a short period to assist clients during the acute phase. Education and support are essential components of getting through withdrawal.

Provide information and advice

Provide accurate, specific information when it is requested. When clients seek advice, provide qualifiers and permission to disagree.

“If you want my opinion I can certainly give it to you, but you’re the one who has to make up your mind in the end”.

It may be useful to ask for the client’s response to the information provided:

“Does that surprise/make sense to you?”

Setting goals

The client needs to choose his or her own goal(s) for therapy. In assisting the client to reach a goal, consider the degree of dependence, recent patterns of speed use, and previous attempts to control use, and discuss these issues with the client. Keep in mind the experience from cannabis intervention trials, which suggest that restricting use to weekends or social occasions leads to a slow but steady increase in use over time. Clients must have a firm, personal rule for recreational use (e.g. only use a designated amount (maximum) only once per week, or to never buy speed).

Talk through the characteristics of good, realistic goals with the client. Make sure you cover the following points:

- Goals will help regardless of whether you achieve them. Goals the client reaches can be celebrated/rewarded, but others that aren’t achieved can be used as learning experiences for future goal setting.
- Goals need to be short term, concrete, specific, measurable and realistically achievable. For example, the goal of *“quitting speed”* is not as specific or concrete as *“I will stop using completely by ... date.”*

Commend abstinence and offer the following points in all cases:

“Successful abstinence is a safe choice. If you don’t use you can be sure that you won’t have problems related to your use. There are good reasons to at least try a period of abstinence (e.g., to find out what it’s like to live without speed, and how you feel, to learn how you have become dependent on speed, to break your old habits, to experience a change and build some confidence, to please your partner).”

If the assessment information indicates the need to advise a goal of abstinence (ie. previous episode of amphetamine-induced psychosis, current mental health disorder etc):

“It’s your choice of course. I want to tell you, however, that I’m worried about the choice you’re considering, and if you’re willing to listen, I’d like to tell you why I’m concerned.”

PHASE 3: Behavioural self-monitoring

Introduce rationale for behavioural self-monitoring

The first step in learning to manage daily life without speed is to first identify those situations in which the client is most likely to use/experience the urge to use. Explain that keeping tabs on speed use over time helps to make conscious the apparent 'automatic' nature of a habit or behaviour related to dependence. Self-monitoring assists a client to see patterns of behaviour previously unidentified. Identifying patterns allows clients to more easily identify high-risk situations and triggers for using, and provides an opportunity for people to practise a range of strategies to reduce the likelihood of using.

Elicit concerns about high risk situations and triggers for using

Explain that an important first step in quitting or cutting down speed use is to become aware of the circumstances that tempt the client to use. These circumstances are called "triggers". Triggers can be external or environmental such as bumping into friends who use or being exposed to the drug itself. Internal triggers can include mood states such as feeling depressed or even excited and physical states such as feeling tired and run down. Triggers are very personal and should be identified in detail.

Go through the triggers the client thinks lead to his/her use of speed. Elicit the client's concerns about high-risk situations for using speed and discuss circumstances surrounding these.

Introduce link between triggers, thoughts about using and urges to use

Introduce the link between the personal triggers identified and explain how these triggers promote thoughts (cognitions) about using and often lead to an increase in urges to use. This pattern is often seen in relapse and should be uncovered for each person so a management plan can be developed. Use the following rationale for the client:

"In working out how to better manage your speed use, we first need to find out which situations are most likely to lead you to use and what you are thinking and feeling in those situations. What we want to learn is what kinds of things are triggering or maintaining your urges to use. Then, we can try to develop other ways you can deal with these "high-risk" situations without using speed. An important first step in managing these trigger situations and urges to use is to monitor those times of the day and night when they occur. Quite often, this whole process happens so quickly we don't even realise what has happened – it's almost like we've gone into automatic pilot and are suddenly having a speed craving. But a whole series of thoughts and reactions take place between the trigger situation and our urge to use speed. So, in becoming aware of this process, we put ourselves in a better position of being able to cope."

Use urge diary

Set the client the homework task of monitoring themselves over the next week and writing down the situations in which he/she feels the urge to use and the feelings associated with those situations. The following is an example that could be used:

Exercise 2: The urge diary

Where were you?	Who were you with?	Did any significant events happen?	What were you thinking?	What were you feeling?	What did you actually do?

Summarise Toward the end of the commitment process, offer a broad summary. Include a repetition of the issues of concern, the client's self-motivational statements, the client's plans for change, and the perceived consequences of changing and not changing. Ask:

“Do I have it right?”

“What have I missed?”

Record any additional information that is offered.

PHASE 4: Formulation

It is at this point in therapy that you may like to introduce case formulation to the client. Whilst you may have already made your own formulation, it is suggested that you work with your client and establish a collaborative formulation on the sheet below for your client's record (Exercise 3). This will help empower the client, allowing him/her to be an active part of his/her treatment.

The following guidelines for case formulation (Persons, 2001), if used, will add to the initial assessment, and are consistent with the cognitive behavioural approach of this intervention.

The formulation assists in the development of working hypotheses or clinical assumptions about how the client's beliefs (underlying mechanisms) shape their thoughts, mood and behaviour (overt level).

Environmental factors play a key role in eliciting and triggering beliefs and thoughts, feelings and behaviours. One important area of consideration is the link between beliefs about mental illness (psychotic symptoms, paranoia, depression) and amphetamine use (behaviour).

A formulation therefore is a summary of the client's presentation, gained from the thorough assessment, which draws together important features to facilitate the development of a treatment plan. Information gained from the initial assessment recommended above is utilised in the formulation. The main areas a formulation should cover are:

1. Summary of the presenting problem/s (might include a problem list);
2. Main concern;
3. Predisposing factors;
 - These are the factors that increase a client's vulnerability to drug use such as having parents who used drugs, having a mental health disorder, and holding certain core beliefs about themselves.
4. Precipitating factors;
 - These are the factors that are immediate triggers for drug use, such as feelings of anger or depression, being exposed to drugs, and experiencing withdrawal symptoms.

5. Maintaining factors;
 - These are the factors that maintain use, such as having a circle of drug-using friends, reasons for using (drug expectancies), having a partner who uses, previous failed attempts to stop, not contemplating change, and alleviation of withdrawal symptoms with drug use.
6. Relationship between mental health problems and drug use;
 - What is the relationship between the client's substance use and mental health problem?
 - What are the links in the beliefs the person holds about their drug use and mental health problems?
7. A treatment plan that addresses each of the above areas.

Use the following worksheet to guide your case formulation with the client (Exercise 3).

The case formulation should be constantly revisited and revised throughout treatment to monitor client's progress and evaluate the effectiveness of the intervention.

Explain rationale for formulation

Explain to the client that the development of a formulation provides the foundation for a mutually agreed treatment plan, and allows the key areas that require emphasis during the intervention to emerge.

Agree on the elements of the formulation

- predisposing factors (increase a client's vulnerability to drug use);
- precipitating factors (triggers for drug use as determined previously);
- maintaining factors (maintain use such as drug-using friends etc);
- relationship between mental health problems and drug use.

Make a joint treatment plan

Based on the information gained from the assessment and the formulation, jointly develop an individualised treatment plan that emphasises the relevant aspects of the intervention as appropriate for the person's readiness to change drug use, level of motivation, level of commitment, skills, and goals for treatment.

Exercise 3: The Case Formulation

- Presenting problem/s:

- Problem List:
 - 1.
 - 2.
 - 3.
 - 4.
 - 5.

- Main problem of concern:

- How did these problems develop (predisposing factors)?

- What are the identified triggers (precipitating factors)?

- What factors maintain drug use?

- What is the relationship between speed use and mental health problems (if present)?

- Treatment Plan:

PHASE 5: Session termination

Summarise Summarise all of the information gained so far, including treatment plan and goals.

Shoring up commitment Ask for commitment to the identified treatment goals using the suggested strategies:

- Obtain a verbal, concrete plan;
- Clarify what the client intends to do to bring about change;
- Reinforce perceived benefits of change and consequences of not changing;
- Elicit concerns or doubts they have that might interfere with carrying out the plan;
- Identify other obstacles to the plan. How could the client deal with these?

Establishing a contract It is important to stress to the client that the therapist is capable of helping facilitate change in the client, but ultimately it requires the commitment from the client. This requires certain ground rules (Graham, 2000, p 24):

- *Agree* on the number of future sessions, frequency and location;
- *Attendance* – the client should be able to explain the reasons for missing a session;
- *Promptness* – the client should be on time for sessions or contact the therapist if they cannot be on time;
- *Completion of homework* – treatment relies on the therapist/client making a decision about the appropriate skills to learn and how best to learn them.

Setting homework Throughout sessions 1, 2, 3 and 4, set homework appropriate to the level of the client's motivation and participation in sessions. Work collaboratively with your client, using prompts if necessary to help the client through the homework process. Compliance with, and completion of, homework should set the precedent for the homework to be undertaken in forthcoming sessions.

Session 1 Homework:

- Identify any additional triggers for use that may become apparent during the week and bring to session 2.
- Begin to cut down the speed use (in preparation for quitting completely or reaching lower level of use) if that is appropriate to the agreed treatment goal.
- Complete an urge diary for the week and bring to session 2.

Session 2: Coping with cravings and lapses

THERAPIST SUMMARY SHEET

- Aims**
- Reinforcing motivation to maintain abstinence/reduced level of use.
 - Coping with cravings to use.
 - Preparation for a lapse.

Materials needed for Session 2

- Blank paper and a pen
- Photocopied craving plan or alternative
- Photocopied urge diary (or alternative) for next week

Key elements of Session 2 *(may be photocopied for quick reference).*

PHASE 1: Session introduction

- review week
- review homework tasks
- set agenda for the session

PHASE 2: Introduction to coping with cravings

- complete exercise 1: describing a craving or urge

PHASE 3: Information about cravings

Provide information about cravings and urges to use:

- provide information from 'some facts about craving' section

PHASE 4: Strategies to cope with cravings

Discuss the following strategies to cope with cravings:

- behavioural (3Ds)
- cognitive (self talk)
- relaxation and imagery

PHASE 5: Developing a craving plan

- complete exercise 2: devising a craving plan

PHASE 6: Dealing with a lapse –

use the following strategies

- give 'coping with a lapse' information
- discuss steps involved in coping with a lapse
- discuss abstinence violation effect
- discuss how to reframe relapse as a lapse

PHASE 7: Session 2 termination

- set homework, including:
 - implement craving plan
 - continue cutting down
 - complete urge diary for the week
 - utilise craving plan strategies as required

DETAILED INTERVENTION

PHASE 1: Session introduction

Review of the week, homework exercise, set agenda

Start with an informal discussion about general activities, and also determine whether there are any important issues that have arisen, or any additional questions.

Review the homework activity with the client, and discuss the additional triggers for using that the client may have identified throughout the week. If the client has not completed the homework task, review the triggers identified in Session 1 together now.

Review the client's speed use for the week. Did the client meet the planned goals for tapering? Reinforce positive changes and address minor problems.

Review the client's urge diary. Are there any patterns that emerge? Are there any internal triggers for using that have emerged? Use any information gained from the week to reinforce motivation and commitment to change.

Be aware that ambivalence about changing speed use may still be present and, if encountered, use strategies from session 1 as appropriate (e.g. reflective listening, open-ended questions, affirming, summarising, managing resistance etc.). If your client has not yet moved to the action stage of change, continue to enhance their motivation to change using the techniques and issues covered in previous sessions. Modify the session 2 agenda as appropriate.

Set the agenda for the session by explaining the issues that will be covered.

PHASE 2: Introduction to coping with cravings

Completing an urge diary over the past week will have given the client insight into the trigger situations that lead them towards experience of a craving. They will have practised identifying the elements of the trigger situation itself, along with their responding thoughts, feelings and behaviours. Now it is time to put those observations to use in helping them to better manage their craving situations. By learning techniques to cope with each aspect of the client's experience of a craving, they can be more confident of "surviving" that situation without acting on their urge to use speed.

Exercise 1: Describing a craving/urge⁸

- Ask the person to explain what their experience is of a craving/urge for amphetamines.
“Tell me a bit more about your cravings – what are they like?”
- You may like to refer back to their urge diary, which they completed for homework following session 1, for additional information.
- On a spare piece of paper, write down the headings: Behaviours, Physical Feelings, Thoughts.
- Write down each of the feelings/thoughts/physical responses that the person uses to describe their urge. Group together those responses that are behavioural (e.g. fidgety, pace the floor), thoughts (e.g. *“I must have a hit”*), and physical (e.g. heart races, feeling sick) in nature and write them under each column as appropriate.

Explain that it is possible to fit the person’s experience of cravings into the following model.

BEHAVIOURS + PHYSICAL + THOUGHTS = CRAVING

In better coping with craving situations, explain to your client that it is important to use coping techniques that address each of these elements.

An important first step in this process is to educate the client about the nature of withdrawal from speed, and particularly that cravings are a key aspect of withdrawal and are to be expected.

PHASE 3: Information about cravings

Provide the following information about cravings and urges to use

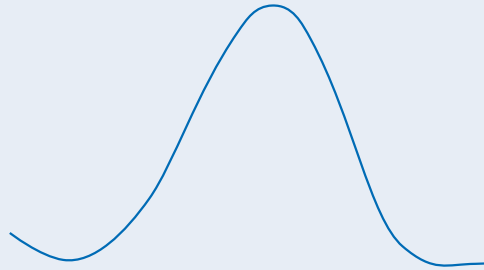
Speed cravings and urges are the sense of wishing to have a hit of speed, or experiencing an impulse to seek out and use it. Urges and cravings tend to increase during withdrawal or in the absence of using. Therefore if your client is trying to abstain from speed, he/she will experience more intense cravings and urges.

The extent of his/her cravings and urges will also be determined by how much he/she dwells on thoughts about using speed. Often, providing the client with some basic facts about cravings can assist their ability to endure them. Use the following “Facts about Cravings” summary as a stimulus for this discussion. If appropriate, you may like to photocopy the following summary sheet and pass on to the client for their reference.

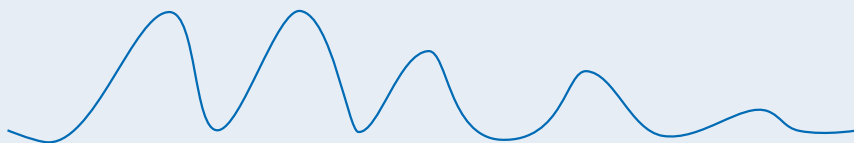
⁸ Adapted from Monti, Abram, Kadden & Cooney, 1989

Some facts about cravings (Marlatt & Gordon, 1985)

1. Cravings/urges to use are a natural part of modifying speed use. This means that you are no more likely to have any more difficulty in altering your speed use than anybody else does. Understanding cravings helps people to overcome them.
2. Cravings are the result of long-term speed use and can continue long after quitting. So, people with a heavier history of use will experience stronger urges.
3. Cravings can be triggered by: people, places, things, feelings, situations or anything else that has been associated with using in the past.
4. Explain a craving in terms of a wave at the beach. Every wave/craving starts off small, and builds up to its highest point, and then it will break and flow away. Each individual craving rarely lasts beyond a few minutes.



5. Cravings will only lose their power if they are NOT strengthened (reinforced) by using. Using occasionally will only serve to keep cravings alive. That is, cravings are like a stray cat – if you keep feeding it, it will keep coming back.
6. Each time a person does something other than use in response to a craving, the craving will lose its power. The peak of the craving wave will become smaller, and the waves will be further apart. This process is known as extinction.



7. Abstinence from speed is the best way to ensure the most rapid and complete extinction of cravings.
8. Cravings are most intense in the early parts of quitting/cutting down, but people may continue to experience cravings for the first few months and sometimes even years after quitting.
9. Each craving will not always be less intense than the previous one. Be aware that sometimes, particularly in response to stress and certain triggers, the peak can return to the maximum strength but will decline when the stress subsides.

PHASE 4: Strategies to cope with cravings

Although cravings are time limited, it is important to equip your client with the tools he/she needs to endure their urges to use speed. This is especially true, given that sometimes, cravings cannot be avoided. Below are listed a number of strategies that seem helpful in managing cravings and urges to smoke. These correspond to the behavioural, physical and cognitive (thought) aspects of cravings described above. You will need to identify with your client the strategies he/she has used and found helpful in the past and add in some of the strategies listed below. Discuss these strategies with your client and identify those that they think they might find useful in managing their experiences of cravings. If time allows, practise each of these techniques during the session. In addition, provide your client with written reminders of each of these techniques as appropriate.

- (a) Behavioural** Discuss the “3Ds” of coping with cravings:
1. **D**elay – encourage the client to avoid situational triggers, particularly during the early phase of modifying their use; however this will not stop cravings from coming altogether. When a craving does hit, delay the decision to use for a minute at a time or longer if the client can manage. During this time, ask the client to say to themselves: *“I will not act on this craving right away. I’ll DELAY my decision to act on this craving for...minutes”*. This will help the client to break the habit of immediately reaching for speed when a craving hits. Refer back to assessment (precipitation factors/triggers) to discuss real-life examples with your client.
 2. **D**istract – once the decision to use is delayed, the client needs to distract themselves from thoughts about using. Generate some ideas for strategies to use as a distraction technique such as going for a brisk walk, calling a support person, listening to music etc. Write these down for the client and ask him/her to keep this list handy and accessible for ease of reference when the craving begins. Explain to the client that once they are interested in, or actively doing, something else, they will find the urges will reduce in intensity until they have gone altogether.
 3. **D**ecide – after the craving has passed, revisit all the reasons why the client wanted to stop using speed in the first place. Decide then and there not to use again and ask the client to congratulate himself or herself on not giving in to something that is, after all, only a THOUGHT or a FEELING.
- (b) Cognitive** Positive talk – by asking the client to remind themselves about the short-term nature of cravings (e.g. *“this feeling will pass”, “I can cope with this”, “I don’t have to act on this because it will go away on its own”*), the urges themselves will be easier to deal with. It is important to “decatrophise” the experience of cravings – acknowledge that they are uncomfortable/unpleasant but also that they WILL pass.

(c) Relaxation and imagery

1. Relaxation/deep breathing – if cravings develop in response to stressful situations, relaxation techniques and deep breathing exercises can be useful (if a person is relaxed then they cannot be stressed).
2. The urges that some clients experience can often be in the form of images or even dreams. For example, a particular client (Irene) found that after a period of four months abstinence from speed she started to have images flash into her mind that involved her walking past a house where she knew speed was available. These images had started to increase her cravings to use.
3. Some strategies Irene found to be helpful in managing/transforming such images are listed below. Talk through each of these strategies with your client and then rehearse and practise in the session.

These strategies can be adapted to suit each individual client's disturbing images as they arise.

Mastery (imagine not using in the given situation).

For example, Irene was asked to conjure up the image of the house in which speed was available. She was then asked to imagine herself walking past the house instead of going in and buying speed. She was then asked to imagine how good she would feel about her achievement.

Alternative (replace the image with an alternative "healthy" image).

For example, Irene was asked to conjure up the house image and then to replace it with an alternative image, such as walking along the beach on her last holiday when she was not using speed and was feeling relaxed and happy.

"Fast forward" (unfreeze the image and move it on in time, a few minutes, hours, days etc. to enable the client to see that he/she is looking at only a part of the picture which may in fact be a distortion of the whole picture).

For example, Irene was asked to conjure up the house image and then to unfreeze it and fast forward (almost as if pressing a fast forward button on a video player) and imagine in detail the usual consequences that follow scoring speed from this house. She was asked to describe the immediate, short and long-term consequences in detail. Having done this, Irene found that the negative consequences of scoring and using outweighed the short-term benefits and she was able to apply this realisation to future positive self-talk when cravings emerged.

"Surfing the Urge" (the craving is a wave that can be surfed until it passes).

Irene was asked to see her craving to use speed as a wave. She was then asked to imagine herself surfing the wave (craving) in the way in which a surfer would surf a wave, and to see herself successfully riding the wave (and managing her craving) until it finally broke on the beach (reduced in intensity and passed away without being reinforced).

PHASE 5: Developing a craving plan

Now that you and your client have discussed different types of strategies to better manage their cravings for speed, it is time to summarise the preceding discussion and develop an action plan for the client to implement at times of craving. Spelling out exactly which techniques to use in particular trigger situations removes the obstacle of having to think of something else to do in the heat of the moment when the craving is intense. This increases their chance of successfully not giving in to cravings as they arise.

Exercise 2: Devising a craving plan (Kadden et al., 1995)

- Write down the high-risk situations for speed use generated by the client during the session, or from the homework activities (urge diary), on the following sheet – “My craving plan” (exercise 2).
- Ask the client to circle the triggers he/she feels they can simply avoid or reduce their exposure to (e.g. not having speed in the house, not buying it, thereby reducing the likelihood of experiencing a craving).
- Of the remaining triggers that cannot be avoided, go through the coping strategies described above with your client and jointly identify those that he/she can put in place when he/she experiences cravings and urges to use.
- If your client has not tried any of the coping strategies before (e.g. urge surfing, relaxation, nominating a support person to call on), encourage them to practise the technique in the session with you now. This will make it easier for them to use this strategy later if required.
- Assist the client to generate ideas: “*What things will I do to help me stay off speed?*”
- Record the final plan on the following sheet – “My craving plan” for the client to take home.
- Ask the client to refer to the plan throughout the week when a craving develops and act on all the strategies generated during the session. Some may work better for the client than others and once a strategy is found to be helpful, it may be used again and again.

Exercise 2: My Craving Plan

High risk situations (circle those that you can avoid)	My coping plan	What will help me stay off speed?

PHASE 6: Dealing with a lapse

Coping with a lapse: the abstinence/rule violation effect

Slips and lapses are common in the recovery process. While they are disappointing, they do not mean failure or indicate an inability to change. The client's challenge is to find ways to overcome slips and maintain goals as best as possible. Treat a slip as a learning experience.

It is important to talk about how to deal with a lapse with your client in this session to start them thinking about how to prevent a relapse to regular use of speed. This is particularly important if this is to be your final session (ie. you have decided to deliver the two-session rather than the four-session intervention).

Often people will feel very bad about themselves if they have a lapse, and will see it as the end of the world and an end to their attempts at abstinence (or other goal). The *abstinence violation* effect is said to be your client's reaction if he/she had made a decision to stop using, and then did. Alternatively, a *rule violation* effect is said to be your client's reaction if he/she had decided to change his/her pattern of speed use (e.g. to cut down or to stop) and he/she then had a "slip" and used. If the client returns to using on one or two occasions as they previously were, then this is called a LAPSE. However, if following this "lapse" the client completely returns to their previous levels of speed use, this is called a RELAPSE. If your client has a lapse, it is more likely to turn into a relapse if he/she engages in particular distorted styles of thinking and feelings about him/herself (called the *abstinence/rule violation effect* or "*breaking the rule effect*"). Explain to your client:

The 'Breaking the Rule Effect' could happen if you have a slip and "break your rules". By this I mean your goal or rule about staying off speed completely (or cutting down to a lesser level if reduction is your client's goal). The "breaking the rule effect" happens when you have a slip and break your rules, and then think something like "oh stuff it, I've had a hit – broken my rule, I might as well keep going..."

"But, there are other ways of looking at the situation. Slips will happen – everybody makes mistakes, and it doesn't mean that you have failed completely. You can stop at one hit, and go again from there – you can start with a clean slate. A slip doesn't mean you are getting worse, or headed for a relapse, rather that you are experiencing what everybody does – a simple slip. But, if you have a slip, it is more likely to turn into a relapse if you give into the "breaking the rule effect".

The main strategy to help your client cope with the abstinence/rule violation effect is to re-evaluate and modify the thinking errors that contribute to the effect. The aim is for your client to firstly identify the distortions in his/her thinking that occur in relation to his/her speed use (e.g. minimisation, all or nothing, overgeneralisation); and secondly to generate a more helpful, less catastrophic and more realistic way of

viewing the situation (e.g. a slip/mistake rather than a complete failure).
For example:

Unhelpful thought:

“I’ve blown it”.

Helpful thought:

“I’ve just had a slip and I can get back on track”.

Unhelpful thought:

“I knew I wouldn’t be able to stop”.

Helpful thought:

“I have been able to make a change...this is only a slip and I will keep on trying”.

Unhelpful thought:

“I’ve messed up already so I might as well keep going”.

Helpful Thought:

“I’ve just made a mistake and I can learn from it and get back on course”.

Discuss these alternative thoughts with your client during the session.

PHASE 7: Session termination

- Homework**
- Implement the craving plan throughout the week in response to a craving to use speed.
 - Continue to cut down/maintain abstinence.
 - Complete urge diary for the next week.
 - Utilise craving plan as required, and record which strategies were helpful and which were not.

Session 3: Controlling thoughts about using speed

THERAPIST SUMMARY SHEET

- Aims**
- Introduction to the concept that thoughts influence behaviour.
 - Develop a plan of achievement and pleasurable tasks to carry out through the week.
 - Continue to cut down/maintain abstinence.

Materials needed for Session 3

- Photocopy of the “Self Monitoring Record” (this now replaces the urge diary from Sessions 1 and 2).
- Photocopy of the “Activities List”.
- Photocopy of “The Activity Record”.
- Photocopy of “Seemingly irrelevant decisions” sheet.
- Blank pieces of paper and a pen.

Key elements of Session 3 *(may be photocopied for quick reference).*

PHASE 1: Session introduction

- review week
- review homework tasks
- set agenda

PHASE 2: Link between thoughts and behaviour

Use the following strategies:

- explain rationale for this exercise
- demonstrate on paper the link between thoughts, feelings and behaviours (using Ellis’s ABC model)
- complete exercise: demonstrating link between thoughts and behaviour

PHASE 3: Triggers

Use the following strategies:

- discuss challenges to unhelpful thinking patterns
- complete exercise: monitoring thoughts about triggers (self-monitoring record)

PHASE 4: Seemingly irrelevant decisions

Use the following strategies:

- discuss rationale behind seemingly irrelevant decisions
- complete exercise: review last relapse for seemingly irrelevant decisions
- give seemingly irrelevant decisions sheet to client to take away

PHASE 5: Pleasant event and activity scheduling

Use the following strategies:

- discuss rationale behind activity scheduling
- complete exercise: identifying pleasant activities and achievement tasks
- complete exercise: the activity record

PHASE 6: Homework

Set homework, including:

- complete self-monitoring record
- practise identifying seemingly irrelevant decisions as they occur
- implement activity record
- continue cutting down

DETAILED INTERVENTION

PHASE 1: Session introduction

Review of the week, homework exercise and set agenda

Start with an informal discussion about general activities, and also determine whether there are any important issues that have arisen, any questions so far.

Review the homework activity with the client, and discuss the triggers for using the client has identified throughout the week. If the client has not completed the homework task, ask them to do so now with your assistance.

Review the client's speed use pattern for the week. Did the client meet the planned goals for tapering?

Review their urge diary. Address any important aspects.

Review their cravings plan and discuss aspects of management plan that were helpful and unhelpful.

Reinforce positive changes and address minor problems. Set the agenda for the session by explaining to the client the issues that will be covered.

PHASE 2: The link between thoughts and behaviours⁹

Rationale for the exercise

Explain to your client that it was important to gather information about the situations in which they are more likely to use speed because it helps to establish what kinds of things are triggering or maintaining their use. The next step is to develop other ways to deal with these "high-risk" situations without resorting to using speed.

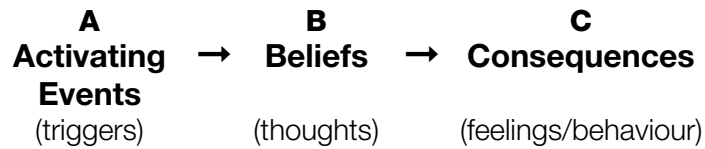
Use the following rationale with your client:

"All people who are trying to reduce their speed use will have thoughts about using, and will increasingly experience urges to seek it out. These thoughts and feelings are quite common, and in themselves do not create problems. Rather, it is important to focus on how you deal with, and respond to, these thoughts and feelings."

⁹ Exercises in Phases 2 and 3 are based on Jarvis, Tebbutt & Mattick, 1995

Link between thoughts, feelings and behaviour

Explain to your client the link between thoughts, feelings and behaviour using the cognitive model illustrated below (Ellis, 1975). This will enable your client to begin to see the links between their thoughts, feelings and subsequent behaviour (e.g. speed use).



Explain to your client that their thinking influences the way they feel and behave. Events/situations that occur in the outside world do not usually cause feelings or behaviour; rather it is an individual's interpretation (or thoughts) about those events that will directly lead to their feelings and subsequent actions. In some cases, the thoughts that they have about a particular situation can be quite unhelpful, and lead to them feeling the urge to use speed to help them cope.

Often, the unhelpful thoughts happen so quickly in response to trigger events that people do not even realise what is happening. That is why these thoughts are often referred to as "automatic." Usually, people suddenly realise that they are experiencing a craving/urge to use. These feelings are often a signal that they have slipped into automatic pilot and allowed a trigger situation to lead to an unhelpful thought about that situation, which has then resulted in a craving.

Exercise 1: Demonstrating the link between thoughts and behaviour

- Take one of the situations from the homework task in which the client experienced strong urges/cravings to use speed or did use speed.
- Help the client to identify the A's, B's and C's surrounding that event/situation. Include any unhelpful self-talk/thoughts the client experienced, such as *"I can't cope without speed"*.
- Explain to the client that an important part in managing those situations that trigger cravings to use speed is to become aware of their unhelpful thinking patterns associated with these situations. The client can then better recognise the patterns associated with a relapse, and develop alternative thoughts or interpretations for those situations.
- Explain to your client that the thoughts that usually lead to cravings and urges to use characteristically fall into one of five *unhelpful patterns of thinking*:
 - 1. Black and White Thinking:** this pattern of thinking is characterised by the interpretation that things are either all good or all bad – with nothing in between, no balance, no shades of grey. For example, because something has gone wrong once, black and white thinking dictates it will always go wrong. Does your client have strict rules about themselves and their lives? Are they rigid in their need to stick perfectly to their goals? If so, black and white thinking might be an unhelpful thought pattern that your client is using. Examples of black and white thinking include: *"If I fail partly, it is as bad as being a complete failure"*, or *"I never get what I want so it's foolish to want anything"*. In particular, *"even if I use once this week, I'm a failure, so why bother"* or *"I can't change, so it's pointless trying at all"*.
 - 2. Jumping to Negative Conclusions:** does your client automatically draw a negative conclusion about an issue more times than not? People who "jump to negative conclusions" sometimes act like "mind readers". They think they can tell what another person is **really** thinking, often without checking it out or testing the conclusion. Other times, people who "jump to negative conclusions" may engage in "fortune telling". They believe that things will turn out badly, and are certain that this will always be the case. For example, they might think: *"Things just won't work out the way I want them to"*, or *"I never get what I want so it's stupid to want anything"*, or *"There's no use in really trying to get something I want because I probably won't get it"*. In relation to their speed use, people with this pattern of thinking may believe *"I'll never be able to change my drug using, it'll never be any different"*.

Exercise 1: Demonstrating the link between thoughts and behaviour (continued)

- 3. Catastrophising:** People with this pattern of unhelpful thinking tend to give too much meaning to situations. They convince themselves that if something goes wrong, the result will be totally unbearable and intolerable. For example, *“If I get a craving, it will be unbearable and I will be unable to resist it”*. If “catastrophisers” have a disagreement with someone, they may think that *“the person hates me, doesn’t trust me, and things will never change”*. Or, *“if I don’t have a hit, I’ll never be able to cope with this.”*
 - 4. Personalising:** “Personalisers” will blame themselves for anything unpleasant that happens. They take a lot of responsibility for other people’s feelings and behaviour, and often confuse facts with feelings. For example, *“My brother has come home in a bad mood, it must be something that I have done”* or *“I feel stupid, so I am stupid”*. People with this pattern of thinking often put themselves down, and think too little of themselves, particularly in response to making a mistake. They may think things like *“I’m weak and stupid, there’s no way I’ll be able to resist my craving”*. In response to a slip, personalisers will often say to themselves: *“see, I knew I’d never be strong enough to resist, I’m such a terrible person.”*
 - 5. Shoulds/Oughts:** People with this pattern of thinking use ‘should’, ‘ought’ and ‘must’ when they think about situations. This often results in feelings of guilt. *Shoulds* and *oughts* quite often set a person up to be disappointed, particularly if these thoughts are unreasonable. For example, *“I must not get angry”*, *“He should always be on time”*, and especially, *“I should be strong enough to never even experience a craving – I should just be able to stop.”* ‘Should’ statements can cause a person to experience anger and frustration when that person directs these statements at others.
- In helping your client to better cope in these craving situations, it is important for them to identify the unhelpful thought patterns they are likely to engage in, and then learn ways to deal with these thoughts directly, without using speed.
 - Help the client to identify from their urge diary, which unhelpful thinking patterns they are likely to use.

PHASE 3: Triggers

Challenges to unhelpful thinking patterns

The aim of the remaining session time is to help the client better manage those unhelpful patterns of thinking that are associated with their cravings/use of speed. You will then help the client to learn ways to challenge these unhelpful thoughts and replace them with more helpful ones. In this way the client will learn how to manage their thoughts about stressors and also cope with any cravings they might experience.

Exercise 2: Recognising unhelpful patterns of thinking

- It is important for the client to challenge any unhelpful thinking patterns by asking themselves the following four questions (Jarvis, Tebbutt & Mattick, 1995):
 1. ***“What is the evidence to support this thought? Is this 100% true?”***
It is common for people to mistake their feelings for evidence/fact, when in reality feelings are not facts. Often the evidence is contradictory to the client’s thought.
 2. ***“What are the advantages/disadvantages of thinking in this way?”***
Unhelpful thoughts will have some advantages for the client, particularly when they help him/her avoid a difficult situation. In considering the disadvantages, such as anxiety or increase in speed use, it may be that the disadvantages outweigh the advantages and possibly pave the way for the person to develop new ways of thinking.
 3. ***“Is there a thinking error?”***
Is the client able to identify whether they are falling into the habit of an *unhelpful pattern of thinking* described above? For example, are they personalising, catastrophising, jumping to negative conclusions, or using black/white thoughts or should/ought statements? If so, this is a sign that the client is putting himself or herself at risk of using speed.
 4. ***“What alternative ways of thinking about the situation are there?”***
There will always be more than one way to interpret any trigger situation. Often these alternatives will be more helpful than the interpretations and consequences encouraged by unhelpful patterns of thinking. Brainstorm with the person some alternative ways of thinking/reacting to the stressful/trigger situations.
- Practise these steps with the client using the trigger situations listed on their urge diary from last week.

Exercise 3: Monitoring thoughts about triggers

- Photocopy the self-monitoring record on the next page and give it to the client.
- Ask the client to take home the self-monitoring sheet and fill it in over the week. Explain how to use the sheet, e.g. ***“over the next week, every time you have a craving to use speed, say to yourself STOP, SLOW DOWN, and then fill in the sheet. Make sure you complete all columns on the form, identify the unhelpful thinking pattern you are using in this situation, and ask yourself the four questions listed here on the sheet to challenge these thoughts.***
- Ask the client to either do this for every craving they experience, or to complete the form at the end of each day, and bring it in next session.

Self-monitoring record

Use this form to record any time this week when you experience a craving to use. Try to fill it in at least once a day to help you remember clearly what was happening.

Time & Date	What was happening? A	What were you thinking? B	What were the consequences? (cravings?) C	What is the evidence to support your thoughts about this situation?	What are the positives and negatives of thinking in this way?	Are you falling into an unhelpful pattern of thinking? If so, what?	Is there another way of looking at this situation?

PHASE 4: Seemingly irrelevant decisions¹⁰

Rationale behind seemingly irrelevant decisions (SIDs)

Previous exercises have helped the client to identify situations in which they are most likely to use speed. Explain to the client that one useful way of avoiding these situations, and hence the trigger for a speed craving, is to become aware of the ‘seemingly irrelevant decisions’ they make that can lead to them being in a situation of high-risk for using. Present the following rationale for the client:

*“Many of our daily decisions and choices **on the surface** seem to have nothing to do with using speed. Although your decisions may not directly involve choosing whether or not to use, they may slowly move you closer to such behavioural/emotional states that are associated with using. It is often through seemingly irrelevant decisions that we gradually work our way closer to entering high-risk situations that may lead to using speed.*

*People often fall victim to their situations (e.g. “I always end up using at parties and can’t help it”). Although it is difficult to recognise choices made when in the middle of the decision-making process, each small decision you make over a period of time can gradually lead you closer to your predicament. The best way to combat this is to **think about each choice you make**, no matter how seemingly irrelevant it is to using speed, so you anticipate potential dangers ahead.*

***Choose the lowest-risk option** when faced with a decision, to avoid putting yourself in a risky situation. When you become aware of seemingly irrelevant decisions, you will be better able to avoid high-risk situations. It is easier to simply avoid the high-risk situation before you are actually in it.”*

Exercise 4: Seemingly irrelevant decisions

- Ask the client to think about their last relapse and to describe the situation/events that preceded the relapse.
- With the client, determine what seemingly irrelevant decisions led up to the relapse.
- Photocopy the reminder sheet on the next page and take the client through the steps. Then, give the sheet to the client to take away with them.

¹⁰ Exercises in Phase 4 are based on Monti, Abrams, Kadden & Cooney (1989)

Exercise 4: Seemingly irrelevant decisions *(continued)*

When making any decision, whether large or small, do the following:

- Think about what different options you have.
- Think ahead to the possible results of each option. What are the positive or negative effects you can think of, and what is the risk of relapse?
- Select one of the options. Choose one that will give you the lowest chance of relapse. If you decide to choose a high-risk option, plan how to protect yourself while in the high-risk situation.

Practise Exercise

Think back to your last lapse to speed use and describe the situation/events that preceded the lapse.

What situations led up to the lapse? _____

What decisions led up to the lapse? _____

What stopped me from recognising these signs? _____

What would have been a more low-risk option? _____

Plan to manage high-risk situations: _____

PHASE 5: Pleasant event and activity scheduling

Rationale behind activity scheduling

For people trying to cut down or stop using speed, planning pleasant and/or meaningful tasks into their day, means they may be able to distract themselves from thinking about using. Often, when people have been using speed for longer periods of time, they focus all their energies on making sure they have access to speed, using it, or recovering from its effects. This is often to the detriment of other activities, which may help bring enjoyment or a sense of achievement to the person's life. Thus the idea of decreasing their speed use often means a decrease in enjoyment in the life of your client. But, by planning "pleasurable" activities into the day, people will realise that they can enjoy themselves without using speed and also, by completing achievement tasks, can gain a sense of control or mastery over important aspects of their life.

Explain these ideas to your client and discuss the importance of formally structuring and prioritising these pleasurable and achievement activities into their day.

It is important to acknowledge that it is impossible to plan every moment of every day in advance. Indeed there will be times when unpredictable things happen and the client will not be able to carry out the pleasurable and achievement tasks set down for that day. Discuss this with the client, and explain that the activity record is not a rigid plan, and they should not feel guilty or bad if they cannot stick exactly to the plan.

In addition, they are able to substitute alternative activities into the record if something prevents them from doing what they planned. For example, on the day a client plans to go for a walk it may be raining. So, explain to the client that in these cases, they are free to substitute an alternative pleasurable task into that timeslot. During the session, complete the activity record for the following day with the client's help.

Active scheduling of pleasurable and achievement tasks

Exercise 5: Identifying pleasant activities and achievement tasks

- Refer to the "Activities List" sheet on page 62.
- Ask the client to list activities they like and enjoy doing that do not involve using speed. For example, going for a walk, taking time for themselves, visiting friends, going to the beach, shopping, reading, having a cup of coffee etc. Make sure these activities are broken down into concrete components. For example, "*time to myself*" needs to be broken down into the actual activities that constitute time to oneself. These could include listening to the radio, practising relaxation etc.
- List these tasks in the "Pleasurable Activities" column.
- Next, ask the client to list the things he/she needs to do. This could include attending treatment sessions, taking medication,

keeping appointments, therapy homework, looking after children, housework etc. It is important to list the components (smaller, discrete and concrete tasks). For example, break housework down into all the different activities that need to be done around the house (e.g. washing dishes etc). *“Looking after the children”* should also be broken down into concrete tasks (e.g. bathing), and include doing fun things with them.

- List these tasks in the “Achievement Activities” column.

The Activity Record

Exercise 6: The Activity Record

- Refer to the sheet titled “The Activity Record” on page 63.
- Using the list of pleasurable and achievement activities developed during the last exercise, complete with the client a schedule for the following day. Be sure to include both pleasurable and mastery activities for that day.
- In the “Evening” section of the record, schedule in time to complete the Activity Record for the following day, along with any other daily homework you have set for the client to complete over the following week. Mark these activities as “Achievement Tasks”.
- Ask the client to sit down at the end of each day during the following week and complete the Activity Record for the next day. Whilst in the session, schedule in your next appointment with the client, and enter this into the Activity Record. If the client is aware of any appointments they must keep throughout the following week, add those to the Activity Record during the session.
- Make sure the client understands the importance of including a balance of both pleasurable and achievement tasks into each day. For example, each achievement activity should be followed by a pleasurable activity to help enhance and maintain motivation.

PHASE 6: Homework

1. Complete self-monitoring record.
2. Become aware of the potential for seemingly irrelevant decisions that put the client at risk for using speed, and identify them when they do occur.
3. Complete activity record and begin to use activity plan.
4. Maintain abstinence/reduced level of use of speed.

Activities List

Pleasurable Activities <i>(Things I like to do)</i>	Achievement Activities <i>(Things I have to do)</i>

The Activity Record

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
LUNCH							
Afternoon							
DINNER							
Evening							

Session 4: Relapse prevention

THERAPIST SUMMARY SHEET

- Aims**
- Learn and practise speed refusal skills.
 - Identify potential high-risk situations that may occur in the future.
 - Develop a specific relapse prevention/relapse management plan for anticipated high-risk situations.
 - Encourage use of relapse prevention/relapse management plan to prevent use of speed.
 - Learn how to deal with a lapse.

Materials needed for Session 4

- Photocopy the “Refusal Skills” sheet and give to client.
- Photocopy “Preparing for High-Risk Situations” sheet and give to client.

Key elements of Session 4 *(may be photocopied for quick reference).*

PHASE 1: Session introduction

- review week
- review homework tasks
- set agenda

PHASE 2: Speed refusal skills

Use the following strategies:

- discuss rationale for learning speed refusal skills
- discuss non-verbal measures
- discuss verbal measures
- complete exercise 1: rehearsing speed refusal skills
- give client refusal skills reminder sheet

PHASE 3: Relapse prevention

Use the following strategies:

- Identify high-risk situations by –
 - discussing a rationale for relapse prevention
 - identifying high-risk situations from self-monitoring
 - completing exercise 2: identify high-risk situations
- Prepare for high-risk situations by –
 - identifying people and means of maintaining skills
 - completing exercise 3: preparing for high-risk situations

- Regulate consequences by –
 - discussing behavioural self-rewards for abstinence or maintaining goals
 - completing exercise 4: regulate consequences
- Devise a relapse prevention plan by –
 - discussing a written relapse prevention plan
 - discussing when and where to use the plan
 - discussing need to monitor early warning signs
 - discussing refining and updating the plan as necessary

PHASE 4: Session termination

- Terminate session, including:
 - reconfirm important motivating factors from session 1
 - elicit self-motivational statements
 - summarise commitments and changes so far
 - affirm and reinforce changes so far
 - explore potential additional areas of change raised previously
 - support self-efficacy to change
 - deal with any special problems (including referral)

DETAILED INTERVENTION

PHASE 1: Session introduction

Review the week, homework tasks and set agenda

Start with an informal discussion about general activities, and also determine whether there are any important issues that have arisen, any questions so far.

Review the homework activity with the client, and discuss how the client was able to manage/challenge their thoughts about using speed. If the client has not completed the homework task, ask them to do so now. In addition, check how well the client was able to use the Activity Record and list of Pleasurable Activities.

Review the client's speed use pattern for the week. Did the client meet the planned goals for tapering? Reinforce positive changes and address minor problems if convenient.

Set the agenda for the session by explaining to the client the issues that will be covered.

PHASE 2: Speed refusal skills

Rationale for learning speed refusal skills

As previously stated, in the early stages of modifying use of speed, it is important to consider avoiding high-risk situations completely. However, it is acknowledged that avoidance is not a long-term solution, nor is it always a practical one. One particularly unavoidable situation might involve a person offering your client speed. There are a number of strategies that can make saying NO easier. Discuss the following elements of speed refusal with your clients.

Non-Verbal Measures for Refusing Speed

(Monti et al., 1989)

1. Make direct eye contact with the other person to increase the effectiveness of your message.
2. Stand or sit up straight to create a confident air.
3. Do not feel guilty about the refusal and remember, you will not hurt anyone by not using.

Verbal Measures for Refusing Speed

(Monti et al., 1989)

1. Use a clear, firm, confident and unhesitating tone of voice.
2. "NO" should be the first word out of your mouth. A direct statement is more effective when refusing the offer.
3. Suggest an alternative (e.g. something else to do/eat/drink).
4. Request a behaviour change so that the other person stops asking (e.g. ask the person not to offer speed anymore).
5. Change the subject to something else to avoid getting involved in a drawn out debate about using/drinking.
6. Avoid using excuses and avoid vague answers, which will imply that at a later date you may accept an offer to use.

Exercise 1: Rehearsing speed refusal (Monti et al., 1989; NIDA, 1998)

- Select a concrete situation in the recent past, where the client was offered speed.
- Ask the client to provide some background on the person involved in the situation (the “offerer”).
- For the first role-play, have the client take the part of the “offerer”, so they can convey a clear picture of the style of that person, and the therapist shall model the speed refusal skills outlined above.
- Discuss the role-play. The therapist should say, *“That was good, how did it feel to you?”* Be sure to praise any effective behaviours and offer clear constructive criticism.
- Repeat the role-play, with the therapist playing the role of the “offerer” and the client playing himself or herself.
- Discuss the second role-play using the same guidelines as above.

Photocopy the “Refusal skills reminder sheet”¹¹ on page 67 and give to the client. Go through the refusal skills at the top of the page to help summarise the previous exercise.

Explain the rationale for learning and practising refusal skills to the client. Use the following information:

“It is often difficult to refuse someone who is offering you speed. This is particularly the case if you don’t want to offend the other person. It can be tough to say “no”, particularly when you have said “yes” before. But, equally important are your feelings and your goals, so it is a good idea to practise what you might say in these situations before they happen. To help you say “NO” comfortably, take some time to prepare some responses you might make to different people who might offer you speed.”

Ask the person to fill in the table on the sheet and nominate some responses they may use when confronted by “a friend they used to use with”, “a co-worker”, “a party”, or other potentially “high-risk” situations. Write down the exact words the client feels they can use in each of these situations, using the key principles. This sheet can then be taken with the client.

Note – if appropriate, the client may want to practise saying these responses out loud during the session, or you may like to conduct a role-play around one of the nominated scenarios.

¹¹ NIDA, 1998

Refusal skills reminder sheet

Tips for responding to offers of speed:

1. Say no first.
2. Make direct eye contact.
3. Ask the person to stop offering speed.
4. Don't be afraid to set limits.
5. Don't leave the door open to future offers.
6. Remember there is a difference between being assertive and being aggressive. Assertiveness means being direct but not bossy, being honest but not big-headed, and being responsible for your own choices without forcing your opinions onto others.

People who might offer me drugs	What I'll say to them
A friend I used to drink or use with:	
A co-worker:	
At a party:	
Other:	

PHASE 3: Relapse prevention

Rationale for relapse prevention

Once clients have learned the skills and behaviours to help them quit/cut down on the use of speed, they are ready to begin preparing for life after therapy where they must manage on their own. The rest of this session is concerned with anticipating future situations that pose relapse risks to the client. This session can be a way of increasing the client's self-efficacy about how they will cope in these high-risk situations, perhaps circumventing a relapse in the process (Wilson, 1992).

At this stage, both you and the client have the benefit of hindsight to assist you in collaboratively preparing for future high-risk situations. That is, you know how the client has responded to the different skills/techniques taught in previous sessions, as well as how they relate to events, thoughts and behaviours. In addition, the client has hopefully incorporated some of the skills/techniques into their repertoire of coping strategies, and will have a greater understanding of their problem (Wilson, 1992).

Identification of high-risk situations from self-monitoring

It is inevitable that certain events will occur in the client's life that will pose threats to maintaining abstinence or reduced use. Indeed Wilson (1992) reports that the average person will experience at least one adverse event in a 12-month period.

A vital first step in preventing relapse is to identify those high-risk situations in advance and allow the client time to prepare for them when they occur. Take time in the session to revisit the self-monitoring record the client has been completing for homework as a guide to the types of situations that have posed problems for them in the past. In addition, probe for additional life events the client anticipates will probably pose difficulties for them. These might include loss events (social, financial, failure to complete tasks, loss of status etc.) or even happy events that can also increase risk of relapse (celebrations, completion of projects etc).

Exercise 2: Identify/anticipate high-risk situations (Wilson, 1992)

- Ask the client to brainstorm high-risk situations or changes that they can anticipate in the future (e.g. adjustment to new situations, financial changes, and social separation).
- Use the following questions to assist the client to generate the list: *What kinds of people/places/things will make it difficult for you to stay on top of things/feel good about yourself? What situations do you consider to be high-risk for relapsing? How will you know when a slip occurs?* Alternatively, use the client's self-monitoring forms completed in previous sessions as a prompt.
- Write these situations down in the space provided on the "Relapse Prevention Plan" handout (below).

Preparation for high-risk situations

In preparing for the high-risk situations that will inevitably occur, it is useful for the client to take stock of everything he or she has learned during the entire four-session intervention. This will also help the client to generalise the lessons learned during the sessions to real life situations.

Documenting which strategies are most useful in dealing with specific high-risk situations can also be useful, and can serve as a reference for the client at a later stage.

Exercise 3: Preparing for high-risk situations (Wilson, 1992)

- Look at the list made in the previous activity that will detail the client's anticipated high-risk situations.
- Ask the client to think back about all the different skills they have learned during the therapy sessions, and nominate which ones are appropriate to use in each of the high-risk situations. Examples may include: speed refusal, coping with cravings, challenging unhelpful thoughts, relaxation etc.
- Write these coping behaviours down on the space provided on the "Relapse Prevention Plan" handout on page 64.
- Explain to the client that not all situations can be anticipated in advance. Therefore it is useful to think about some generic coping strategies that the client can employ regardless of the situation. Write these down in the space provided on the handout ("General coping strategies for any situation").
- Also ask the client whether there are any additional skills they think they may need to assist them in future situations. Record these on the form ("Additional Skills Required") and discuss options for referral with the client to ensure he/she receives the necessary intervention.

Regulate the consequences of thoughts and behaviours

Finally, discuss with the client how they intend to reward themselves for remaining abstinent. It is important for the client to create their own rewards as reinforcement for their behaviour, as this may not always come from other sources (e.g. family, friends).

Ask the client what it is that they enjoy doing. By planning time/criteria for participation in these activities the client can learn to regulate the consequences of their behaviour/thoughts for themselves.

Exercise 4: Regulate consequences (Wilson, 1992).

- Refer back to the "Relapse Prevention Plan" handout on page 71.
- Ask the client the following questions: *How will you know that you are successfully maintaining your behaviours? How can you reward yourself for a job well done?*
- Write these "rewards" down on the "Relapse Prevention Plan" handout.

Identify support people and additional means of maintaining skills

An important step in preventing relapse is identifying key people in the person's life who can help encourage them to keep to their goals, and support them through the challenges they will face. Thus, at this point it is also important to ask the client:

“Who can help you to maintain these skills you have learned?”

Record a list of support people on the second page of the Relapse Prevention Plan. It can be very useful to record contact phone numbers on this sheet to enable clients to contact support people (including agencies) quickly if a high-risk situation is encountered and support is required rapidly. Some clients find it useful to carry a purse or wallet-sized card with support people/agencies and contact telephone numbers.

If the client chooses to list relatives/friends on their support list, remind them it is a good idea to talk to these people about their plans sometime over this next week, and explain to their relatives/friends what type of support they are hoping to receive from them (e.g. distraction, general chat etc.)

Using the relapse prevention plan

Now that you have collaboratively worked out a relapse prevention plan for high-risk situations with the client, you need to ensure the client uses his/her plan effectively (Graham, 2000). To do this, Graham (2000) suggests you talk with the client about the following things:

- When to use his/her plan;
- How to regularly monitor their early warning signs of relapse;
- Refining and updating the plan as necessary (ie. coping strategies, forms of intervention and supports) and as circumstances change.

Discuss this information with your client, and document your client's "early warning signs of relapse" on the second page of the Relapse Prevention Plan.

PHASE 4: Session termination

Formal termination should be acknowledged and discussed at the end of this session. Reinforce the client's progress and situation through the sessions and include:

- Reconfirmation of the most important factors motivating the client that were identified in Session 1.
- Summarise commitment and the changes made so far.
- Affirm and reinforce changes already made.
- Explore additional areas of change that might now be identified.
- Elicit self-motivational statements for maintenance of change and further change.
- Support self-efficacy.
- Deal with any special problems that might emerge during termination, including referral to other agencies as required.

Relapse Prevention Plan

Anticipated High-Risk Situations	Coping Strategies	Reward
<p>General Coping Strategies for any situation:</p>		
<p>Additional Skills Required:</p>		

My early warning signs of relapse are:

- More moody or irritable
- Just not wanting to see people
- Sleep more
- Sleep less
- Eat more
- Eat less
- Getting easily tired
- Giving up on exercise
- Not wanting to deal with day-to-day things (opening mail, paying bills etc.)
- Putting deadlines off
- Putting off housework/other responsibilities
- Craving more
- Not keeping up the skills and techniques learnt during treatment
- _____
- _____
- _____
- _____
- _____
- _____

If I see these early warning signs I will take some action immediately and refer to my Relapse Prevention Plan.

Support people I can call on are:

Support Person / Agency	Contact number
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Section 4. Suggested alternative brief interventions for those not suitable for the current intervention

Section 4. Suggested alternative brief interventions for those not suitable for the current intervention

Some psychostimulant users might be unsuitable for the current CBT intervention. These clients might include regular users who are not contemplating change and experimental or irregular users who might not see a need for formalised treatment. The flow-chart on page 7 of this guide provides a context for various alternative interventions, which may include the following strategies.

Experimental, recreational, occupational and non-injecting users who are not dependent on psychostimulants and are not considering change

Harm reduction strategies are appropriate for this group, and clinical recommendations might include:

- cut down the amount of speed used at any one time;
- use in the presence of other people;
- continue to practise alternatives to injecting (e.g. 'snort', swallow, etc).

In addition, education about the range of possible adverse consequences of use such as mood disturbances, paranoid ideation, irritability and health consequences have been recommended to encourage early intervention by users if adverse consequences do arise (Hando, Topp, & Hall, 1997).

A recommendation that the person receive vaccination for hepatitis B might be appropriate as are brief interventions to reduce the risk of transition to regular use or injecting.

The essential elements of a brief intervention are included in the FRAMES model first developed by Miller and Sanchez (Hulse, G. et al., in press).

Feedback: involves feedback to clients of findings from your assessment

Responsibility: Patient is responsible for acting on the feedback given

Advice: Advice from a health professional to change behaviour may be effective

Menu: Offer the patient a menu of options for change


Empathy: Showing empathy has been shown to enhance motivation for change

Self-efficacy: Reinforce the patient's optimism by identifying their skills and ability to change.

**Regular users
and dependent
users who are
not considering
change**

Regular psychostimulant users may experience a range of adverse psychological, physical and social problems. Individual management plans will be informed by the patient's treatment goals, but might include the harm reduction strategies described above in addition to:

- a recommendation to use sterile injecting equipment when continuing to inject;
- education regarding signs and symptoms of severe adverse consequences including toxicity;
- recommend 'rest' periods from the psychostimulant to enable the body to recover;
- encourage adequate nutrition and fluid intake;
- offer ongoing reviews of the person's physical and mental health to ensure early intervention if problems should occur, which may also provide an opportunity for engagement into a formal intervention such as the CBT sessions described in this guide; and
- the client might benefit from information to take home, for example *A user's guide to speed* (NDARC) is an excellent resource.



Section 5. Other available resources and useful websites

Section 5. Other available resources and useful websites

1. *A user's guide to speed*. National Drug and Alcohol Research Centre (NDARC) ndarc.med.unsw.edu.au/ndarc.nsf/website/Publications.resources (to order a copy).
2. *Alcohol and Other Drugs: A Handbook for Health Professionals*. Australian Government Department of Health and Ageing, 2003.
3. Australian Drug Foundation: www.adf.org.au/drughit/facts/hdayam.html
4. Australian Drug Information Network (ADIN) www.adin.com.au
5. Barry, K.L. (1999). *Brief interventions and brief therapies for substance abuse*. *Treatment Improvement Protocol (TIP) Series No. 34*. US Department of Health and Human Services: Rockville, Maryland.
6. Beck, A.T., Wright, F.D., Newman, C.F. and Liese, B.S. (1993). *Cognitive therapy of substance abuse*. New York: Guilford Press.
7. Carroll, K.M. (1998), *A cognitive-behavioural approach: treating cocaine addiction*, National Institute on Drug Abuse (NIDA). *Therapy Manuals for Drug Addiction*. U.S. Department of Health and Human Services, National Institute of Health, Maryland.
8. Centre for General Practice Integration Studies, University of NSW www.commed.unsw.edu.au/cgpis/
9. Clinical skills training series: effective approaches to alcohol and other drug problems, modules 1-5. Newcastle: University of Newcastle: Training, Health and Educational Media, 1998. (National Teaching Grant held by Amanda Baker and National Centre for Education and Training on Addiction).
Module 1: *Motivational interviewing: how to encourage motivation for change*.
Module 2: *Relapse prevention*.
Module 3: *Raising the issue and assessment: triggers to learning*.
Module 4: *Brief intervention: triggers to learning*.
Module 5: *Brief intervention strategies among Aboriginal and Torres Strait Islander people*.
Each module consists of 1-3 videotapes and a booklet including summation of the script, training questions and exercises, and student assessment and evaluation forms.
10. Clinical Treatment Guidelines Series, Turning Point Alcohol and Drug Centre, www.turningpoint.org.au/service_information/si_ctgs.html (to order a copy).

11. Davies, J. (2000) *A Manual of Mental Health Care in General Practice*. Commonwealth Department of Health and Aged Care. Canberra.
12. Hulse, G. et al. (in press). *Alcohol and other drug clinical presentations and management – a case series exercise and record book*. Oxford University Press.
13. *Motivational interviewing: a resource for clinicians, researchers and trainers*. www.motivationalinterview.org/
14. Orford, J. (2001). *Excessive Appetites: A Psychological View of Addiction* (Second Edition). John Wiley & Sons: New York.
15. *Models of intervention and care for psychostimulant users*. National Drug Strategy Monograph Series. Baker, A., Lee, N. K. & Jenner, L. eds. (in press), Australian Government Department of Health and Ageing.
16. *Treatment Approaches for Alcohol and Drug Dependence: An Introductory Guide*. ndarc.med.unsw.edu.au/ndarc.nsf/website/Publications.resources (to order a copy).

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Appendix 1. Sources and acknowledgements

The CBT intervention in this guide has been adapted from the following sources:

- *A user's guide to speed*. National Drug and Alcohol Research Centre (NDARC)
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Notes