CLINICAL TREATMENT GUIDELINES
FOR ALCOHOL AND DRUG CLINICIANS

Turning Point
Alcohol & Drug Centre

14

METHAMPHETAMINE DEPENDENCE AND TREATMENT

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Published by Turning Point Alcohol and Drug Centre under funding provided by the Drug Treatment Services Unit, Department of Human Services Victoria. The views expressed in this material are not necessarily those of the Victorian Government.

This document may also be downloaded from the Department of Human Services web site at:
www.dhs.vic.gov.au or www.health.vic.gov.au/drugservices/pubs/index.htm
More information on the *Clinical Treatment Guidelines for Alcohol and Drug Clinicians* series is available at:
www.turningpoint.org.au

The correct citation for this publication is: Lee, N., Johns, L., Jenkinson, R., Johnston, J., Connolly, K., Hall, K. & Cash, R. (2007). *Clinical Treatment Guidelines for Alcohol and Drug Clinicians. No 14: Methamphetamine dependence and treatment*. Fitzroy, Victoria: Turning Point Alcohol and Drug Centre Inc.

ISBN: 1 74001 109 0

OVERVIEW

Methamphetamine Dependence and Treatment is part of the *Clinical Treatment Guidelines* series developed by Turning Point Alcohol and Drug Centre.

Methamphetamines such as speed, base and crystal methamphetamine are a group of synthetic substances which have the effect of stimulating the central nervous system. Methamphetamines are the second most commonly used drug by Australians after cannabis. With an increase in the availability of methamphetamine and the use of more potent forms such as 'crystal meth' or 'ice', clinicians are now required to manage a range of complex presentations that include methamphetamine dependence, polydrug use, mental health symptoms and sometimes acute behavioural disturbances such as psychosis and aggression.

Counselling, withdrawal and pharmacotherapy options for methamphetamine users are not as readily available as heroin or alcohol treatment methods and with no standard pharmacotherapy in place for the management of methamphetamine withdrawal, clients may be less inclined to seek help or access services. Practice guidelines for clinicians contained within *Methamphetamine Dependence and Treatment* include a set of useful tools to address acute presentations as well as dependence and harms. Worksheets for the clinician and the client have also been developed to help monitor drug use, improve decision-making and problem solving skills and plan for relapse prevention.

While *Methamphetamine Dependence and Treatment* is a valuable resource in its own right, current drug treatment practice utilises multiple interventions. As a result, and reflecting the holistic approach to working with people with drug problems, these guidelines should be used in conjunction with other publications in the Clinical Treatment Guidelines series.

Other publications in the series to date are:

1. Key Principles and Practices
2. Motivational Interviewing
3. Relapse Prevention
4. Reducing Harm for Clients Who Continue to Use Drugs
5. Controlled Drug Use Interventions
6. Effective Weed Control: Working with cannabis users
7. Working with Polydrug Users
8. Assertive Follow-up
9. Prescribing for Drug Withdrawal
10. Managing Difficult and Complex Behaviours
11. Working with Families
12. Smoking Cessation: Working with clients to quit
13. Youth Alcohol and Drug Outreach

Key Principles and Practices provides a theoretical and practical overview of what is considered to be 'best practice' when working with drug clients. The authors deal with issues such as identifying and assessing drug problems and the client's readiness for change; the factors underpinning and influencing drug treatment such as models of dependence and harm minimisation; as well as highlighting approaches involving behaviour change, withdrawal and substitution pharmacotherapies. In addition, Key Principles and Practices addresses professional issues such as general counselling skills, consultation, casework supervision and ethical practice.

* The term 'drug' is used interchangeably with 'alcohol and drug' and 'alcohol and other drug'. The term refers to tobacco, alcohol, prescribed pharmaceutical products, illicit drugs and any chemical that changes the mental state and that may be used repeatedly for that effect.

WELCOME

Welcome to the *Clinical Treatment Guidelines* series, which Turning Point Alcohol and Drug Centre hopes will be an important resource for alcohol and drug clinicians.

There is much talk of 'best practice' these days, but trying to work out just what this means can be complex. Often findings from clinical research are published in journals – and stay there – reflecting the difficulties faced in the dissemination of research and its subsequent application in day-to-day practice.

Clinicians sometimes evolve their own practice from case studies and experience. However, the constant monitoring of research worldwide and its subsequent integration into working with clients is often beyond the resources of many clinicians and clinical organisations whose focus is practice, not research.

As a result, Turning Point has published the *Clinical Treatment Guidelines* series to help address the need for up-to-date alcohol and drug treatment resources for clinicians.

At Turning Point, our core business is to interface research, clinical practice, education and training. We explore what research suggests should be effective interventions, or 'best practice', and then we try to determine whether or not they are feasible and practical for clinicians in their day-to-day work with clients. We are committed to exploring new treatment approaches. However, we hold firm to tried and true practices until there is concrete evidence of a more effective method.

The *Clinical Treatment Guidelines* series represents the distillation of these efforts and combines practical and theoretical knowledge which can be adapted to specific work environments where necessary. The series:

- is suited to a variety of professional practitioners
- conveys practical information as well as covering some theoretical advances
- can be applied across many settings

The series reflects what is considered to be 'best practice' at the date of publication. However, new knowledge is inevitable and should be incorporated accordingly. Workforce development is integral to supporting changes in practice through education, training, staff supervision and management.

I trust that the *Clinical Treatment Guidelines* series, in its entirety or publication by publication, will be useful to you in your work with people who have alcohol and drug-related problems.

Professor Nick Crofts

Director, Turning Point Alcohol and Drug Centre

ACKNOWLEDGMENTS

Methamphetamine Dependence and Treatment is part of the *Clinical Treatment Guidelines* series developed by Turning Point Aclohol and Drug Centre under funding from the Drugs Policy and Services Branch, Department of Human Services Victoria.

This publication was made possible by the input of many people who willingly gave of their time and expertise. Their contributions, in the form of professional advice, suggestions and critical commentary, are greatly valued.

The authors would especially like to thank several experts who have reviewed these guidelines during their development:

Associate Professor Amanda Baker, University of Newcastle

Dr Catherine McGregor, University of Adelaide

Ms Robin Fisher, Department of Human Services

Dr Frances Kay-Lambkin, University of Newcastle

Dr Rebecca McKetin, National Drug and Alcohol Research Centre

Dr Ingrid van Beek, Kirketon Road Centre

Mr Simon Ruth, PenDAP

Ms Katherine Walsh-Southwell, PenDAP

Ms Sue White, Salvation Army Crisis Services

Some resource material has been informed by other drug treatment guidelines, including Baker et al.'s amphetamine treatment guide and publications in the *Clinical Treatment Guidelines for Alcohol and Drug Clinicians* series.

CONTENTS

INTRODUCTION

Methamphetamine use is of growing concern within the community. The increased use of more potent forms of the drug, in particular crystal meth and ice, has resulted in concerns about increasing harms to individuals and the community, and in reports of presentations to emergency and primary care services. Methamphetamine users pose unique challenges for these treatment services, often presenting in crisis, with acute behavioural disturbances or psychotic symptoms. Clinical and referral pathways are often unclear between the emergency/primary care services and the specialist alcohol and other drug services, with the latter often not well oriented to manage methamphetamine-related problems.

These guidelines were designed to help clinicians and services develop better clinical pathways and services that meet the needs of methamphetamine users. The guidelines outline both acute and longer term interventions. Ideally services and clinicians would identify those interventions that are relevant to their service provision and establish clinical and referral pathways that improve services for methamphetamine users. The aim of these guidelines is to provide key interventions that will assist confidence and skill in managing methamphetamine related presentations.

What is methamphetamine?

Amphetamines are a group of substances, mostly synthetic, that have the effect of stimulating the central nervous system. They can be injected, snorted, smoked, or ingested orally.

The term 'amphetamines' is often used to refer to a group of amphetamine-related drugs, including amphetamine and methamphetamine. In Australia, amphetamines are almost entirely methamphetamine. These guidelines use the term 'methamphetamine' for this reason.

The term "crystal meth" or "ice" refers to a high purity, smokeable form of methamphetamine. Other forms include "base" and "speed". Table 1 outlines characteristics of the various forms. Other amphetamine-type stimulants include appetite suppressants, medications for hyperactivity and other illicit drugs such as MDMA ("ecstasy") and cocaine.

Table 1: Forms of methamphetamine

	Methamphetamine		
	Powder (speed)	**Base**	**Crystal methamphetamine**
Street names	Speed, goey, whiz, velocity	Paste, point, pure, wax	Ice, Shabu, crystal, crystal meth
Appearance	Fine or coarse powder	Sticky, waxy or oily form of damp powder, paste	Crystal or coarse crystalline powder
Colour	Can be white, pink, yellow, orange, brown	Often has a yellow or brown tinge, strong odour	Usually translucent or white, may have green, blue or pink tinge
Route of administration	Usually snorted, ingested or injected	Usually injected or swallowed, but can be smoked or snorted	Usually injected or smoked but can be snorted or swallowed

Properties and effects of methamphetamine

Both amphetamine and methamphetamine are synthetic substances. Methamphetamine differs from amphetamine only in the addition of a methyl group on the chain (Dean, 2004). Both can exist in two different chemical forms (+ or -). Amphetamine is a metabolite of methamphetamine (i.e. a product of the metabolism of methamphetamine in the body). Both are thought to inhibit dopamine metabolism and reuptake and increase the release of noradrenaline and serotonin (Dean, 2004).

The psychological effects of amphetamines are dependent on dose, the characteristics of the individual and the context of drug use. Methamphetamine is known to produce similar effects to amphetamines but at smaller doses. It produces significant CNS stimulation but fewer peripheral effects (Dean, 2004). Table 2 shows the typical effects at different doses. The acute effects of methamphetamine can last for 8-24 hours

Table 2: Dose effects of amphetamines

	Low dose	High dose
Physical	• Increases in systolic and diastolic blood pressure • Sweating • Palpitations • Chest pain • Shortness of breath • Headache • Tremor • Hot and cold flushes • Increases in body temperature • Reduced appetite	• High blood pressure • Rapid or abnormal heart action • Seizures • Cerebral haemorrhage • Jaw clenching and teeth-grinding • Nausea, vomiting
Psychological	• Euphoria • Elevated mood • Sense of wellbeing • Increased alertness and concentration • Reduced fatigue • Increased talkativeness • Improved physical performance	• Confusion • Anxiety and agitation • Performance of repetitive motor activity • Impaired cognitive and motor performance • Aggressiveness, hostility and violent behaviour • Paranoia including paranoid hallucinations • Common delusions including being monitored with a hidden electrical device, and preoccupation with 'bugs' on the skin

Long term use can result in a number of physical and psychological effects including:

- weight loss and malnutrition
- neurological changes including memory loss and dizziness
- menstrual problems including pain, irregular periods or absent periods
- seizures
- dependence
- poor cognitive functioning in dependent users; highly-dependent individuals show poorer performance on tests of cognitive functioning, especially with memory and concentration
- extreme mood swings, anxiety, paranoia
- delirium and depression
- psychotic symptoms, including perceptual distortions, hallucinations and delusions
- chronic sleeping problems

Prevalence and patterns of methamphetamine use

Globally, amphetamines are the most commonly used illicit drugs after cannabis (UNODC, 2005). The number of methamphetamine users worldwide is estimated to be approximately 26 million (or 0.6% of the global population aged 15-64). Whilst almost two-thirds of methamphetamine users reside in Asia (east and south-east), prevalence of use is reportedly highest in Oceania (Australia and NZ) (UNODC, 2005).

Patterns of methamphetamine use in Australia reflect those internationally. Methamphetamine is now the second most frequently used illicit drug in Australia after cannabis. Patterns of use have been generally increasing since the early 1990s, with levels of recent use increasing by 60 per cent over the 1993–2004 period. In 2004, 9% of the population had ever used methamphetamine and 3 per cent reported having used in the last 12 months. The 2004 National Drug Strategy Household Survey indicates a small downward trend from previous surveys.

The highest rates of use are among people under 30. The 20-24 year old age group has the greatest proportion of users (20% having ever used and 11% recently used), followed by the 18 to 19 year old age group. Users in the 20-24 year old age group are also more frequent users. The median age of first methamphetamine use is 20.8 years (Australian Institute of Health and Welfare, 2005). Most users do not use very often, but polydrug use is common with alcohol and cannabis the most widely used drugs taken in conjunction with methamphetamine.

Use among injecting drug users (IDUs) is high with 97% having ever used methamphetamine powder (speed), 64% ice, 28% base, 15% liquid amphetamine and 20% pharmaceutical stimulants, and over three quarters (79%) of respondents reported using at least one form of methamphetamine in the past six months. Recent injection of methamphetamine powder (speed) (last six months) was reported by 71% of injecting drug users, crystal meth by 25% and base by 13%, with up to 93% having ever injected.

Types of methamphetamine use

Methamphetamine is used by a wide cross-section of society and its use is not limited to any particular group. There are several distinct patterns of use, which are also seen in other drug users.

Experimental use

Experimental methamphetamine use generally occurs in late adolescence/early adulthood and is typically short lived. Experimental use is motivated by curiosity to experience new feelings/moods or as a result of influence from peers.

Recreational use

Recreational methamphetamine use usually occurs in a social setting. The amount and duration of use may vary depending on the occasion. Recreational use is perceived as enjoyable with few negative consequences or effects on social functioning. Methamphetamine is frequently used on a recreational basis, where users limit their use to the weekend or special occasions.

Circumstantial use

Circumstantial methamphetamine use occurs when specific tasks have to be performed, which may require special degrees of alertness or endurance. Examples of this include long distance driving or shift work. Circumstantial methamphetamine use may also serve a specific function, such as suppressing appetite and promoting weight loss.

Intermittent or binge use

Intermittent or 'binge' use, occurs when methamphetamines are used intensively for a long period of time, anywhere from two to ten days, with significant breaks in between these intense periods of use.

Regular use

Regular use is characterised by frequent, habitual use and is often accompanied by a physical and/or psychological dependence syndrome. For regular users, methamphetamine plays a significant role in their day-to-day life and may impair or impact on health, psychological or occupational functioning.

Approximately 3% of methamphetamine users will use on a regular basis. This is often in the context of polydrug use, where methamphetamines may be used in combination with other drugs such as alcohol, cannabis or other psychostimulant drugs including ecstasy.

Polydrug use

Polydrug use is very common amongst methamphetamine users, with alcohol, cannabis and other psychostimulant drugs (such as ecstasy) being the most frequently used drugs in combination with methamphetamine. Users may do this to enhance or prolong the effects of methamphetamine, or to alleviate unpleasant side effects.

Methamphetamine dependence

For many years dependence on methamphetamine was thought to be largely psychological (Baker et al., 2004). However, it is now acknowledged that prolonged use of methamphetamine may lead to an increase in tolerance and dependence.

Dependence is a pattern of substance use that leads to clinically significant impairment or distress (American Psychiatric Association, 1994). Using this definition from the DSM-IV, dependence is measured by three or more of the following criteria, occurring at any time in the same 12 month period:

1. Tolerance, as defined by either:

   (a) a need for markedly increased amounts of the substance to achieve intoxication or the desired effect; or

   (b) a markedly diminished effect with continued use of the same amount of the substance.

2. Withdrawal, as manifested by either of the following:

   (a) a characteristic withdrawal syndrome; or

   (b) the same or closely related substance is used to relieve or avoid withdrawal symptoms.

3. The substance is taken in larger amounts or for a longer period than intended.
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance, use the substance or recover from its effects.
6. Important social, occupational or recreational activities are reduced or given up because of substance use.
7. Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

Degree and severity of dependence is primarily influenced by:

- the type and potency of methamphetamine being used. Use of crystal methamphetamine ('ice'), which is usually more potent, may lead to dependence more quickly than methamphetamine base or powder; or
- the mode of administration. Injecting methamphetamine may lead to higher levels of dependence than with other forms of administration such as snorting or ingesting.

Methamphetamine users who use several times per week are considered to be heavy users and are likely to manifest at least some symptoms of dependence (Lee, 2004). Dependence on methamphetamine has been associated with poor nutrition, poor sleep and susceptibility to illness, including mental health problems such as delusions, paranoia, depression and anxiety (Allen & Tresidder, 2003).

Methamphetamine withdrawal

Methamphetamine withdrawal syndrome is predominantly characterised by adverse psychological symptoms, such as extreme fatigue and irritability. The DSM-IV characterises methamphetamine withdrawal as including dysphoric mood (sadness) plus two of the following:

- fatigue
- insomnia
- hypersomnia (over-sleeping)
- psychomotor agitation
- increased appetite
- vivid, unpleasant dreams

(American Psychiatric Association, 1997)

Other symptoms commonly associated with methamphetamine withdrawal include drug cravings, paranoid or suspicious thoughts, and feeling angry, aggressive or emotional.

Withdrawal symptoms from methamphetamine can appear to mimic the symptoms of acute intoxication, particularly agitation and hyper-arousal (Jenner & Saunders, 2004). The duration and severity of a typical withdrawal syndrome for methamphetamine remains unclear (Jenner & Saunders, 2004), although there is some evidence to suggest that the majority of symptoms will resolve within a week of ceasing methamphetamine use, with sleep and appetite related symptoms persisting for a further 1 to 2 weeks (McGregor et al., 2005).

The duration and severity of withdrawal may also be influenced by:

- age (older and more dependent users may experience a more severe withdrawal)
- general health
- mode of administration
- quantity and purity of methamphetamine being used prior to cessation
- polydrug use

Dependent users are likely to undergo withdrawal many times as use fluctuates between heavy use, regular use and periods of intermittent or binge use, and self-detoxification is common. Withdrawal from methamphetamine is relatively safe, provided there are no additional factors involved such as polydrug use or co-existing mental or medical health conditions (Jenner & Saunders, 2004).

Although the 'crash' has been associated with withdrawal, there is no clear evidence that this is part of the withdrawal experience. Many dependent users do not experience a 'crash' and where it does exist, it should be viewed as a recovery period rather than constituting a clinically significant withdrawal syndrome (Jenner & Saunders, 2004). Further, non-dependent users may experience a crash period which is not considered withdrawal. Crash symptoms, which include extreme fatigue and restlessness, are likely to resolve within a day or so without causing significant psychological or physical distress or impairment.

Risks and harms associated with methamphetamine use

There are a number of physical, psychological and social risks associated with the use of methamphetamine, including risks from:

- **Mode of administration**: Frequent injecting can result in vein and skin damage as well as higher risk of dependence.
- **Polydrug use**: Poly-drug users are more likely to engage in risk behaviours, including unsafe sex under the influence of drugs. They are also at increased risk of adverse effects, such as increased heart rate and blood pressure and cardio and cerebrovascular toxicity. However, much uncertainty remains regarding potential drug interactions, especially for illicit drugs (such as methamphetamine) where the purity and composition are often unknown.
- **Bingeing**: Using continuously for 48 hours or more without sleep is a common pattern of use. Binge users of methamphetamine are at higher risk of social, behavioural and health problems than non-binge users of these drugs, while others report that bingeing greatly increases the risk of health problems such as psychosis.
- **Drug driving**: Is reported by one in five methamphetamine users. Users who drive while intoxicated are at increased risk of accidents and injury, as well as legal consequences. Random roadside drug testing was approved in 2004 in several states of Australia, and includes tests for methamphetamine.
- **Unsafe sex**: Methamphetamine use is correlated with increased sexual activity, particularly among gay and bisexual men and men who have sex with men (MSM). It has been associated with increased numbers of sexual partners and more sexual activity, decreased condom use, high numbers of anonymous partners and high rates of unprotected vaginal and oral sex.
- **Agitation and aggression**: Methamphetamine use has been associated with increased aggression and agitation, which may result in increased injury.
- **Poor nutrition**: Users are likely to have poor or irregular eating patterns due to the appetite suppression effects of methamphetamine. This can lead to malnutrition in the longer term.
- **Accidents**: An increase in accidents has been attributed to methamphetamine use.
- **Mental health problems**: Methamphetamine use can result in adverse psychological effects during intoxication, 'come down' and withdrawal, such as anxiety, panic attacks, paranoia, mood swings, mania, hallucinations, aggression, suicidal thoughts and depressed mood. These symptoms may also be enduring. Methamphetamines can also exacerbate an existing mental health problem or trigger an underlying disorder.
- **Neurocognitive impairment**: There is some evidence to support that heavy use of methamphetamine can lead to cognitive deficits such as impaired decision-making and working memory.
- **Overdose/toxicity**: Methamphetamine use can lead to a range of toxic presentations. Whilst toxic effects are most often associated with higher and more frequent doses of methamphetamine, there may be occasions where relatively low doses can lead to toxicity. Toxic responses to methamphetamine may include psychosis and seizures or cardiovascular conditions such as arrhythmias (abnormal heart beat). Toxicity can also lead to stroke and cerebral haemorrhage, which may result in permanent impairment.

- **Other risks**: General risks that are associated with dependent drug use also apply to methamphetamine users. These include crime, poverty, unemployment, conflict, family breakdown and social dislocation.

Mental health problems associated with methamphetamine use

Mood and anxiety disorders

In the case of methamphetamine, both intoxication and withdrawal states have many similarities with mood and anxiety disorders.

A disturbance in mood after methamphetamine use, which is considered to be in excess of the symptoms usually associated with use of the drug, and which is of sufficient severity to warrant clinical attention has been recognised as a diagnostic category in the DSM-IV (American Psychiatric Association, 1997).

Methamphetamine-induced mood disorder is characterised by a prominent and persistent disturbance in mood, which has developed during or within 1 month of methamphetamine intoxication or withdrawal. The disturbance in mood can be characterised by either depressed, irritable, elevated or expansive mood or a markedly diminished interest or pleasure in most activities (American Psychiatric Association, 1997).

Methamphetamine-induced anxiety disorder, similarly, is characterised by prominent anxiety, panic attacks, obsessions or compulsive behaviours, which are of sufficient severity to impair usual occupational, social or other important areas of functioning and which developed during or within 1 month of methamphetamine intoxication or withdrawal. A more complex issue for treatment of mood and anxiety disorders in methamphetamine users is in relation to individuals who have a pre existing disorder, which requires longer-term mental health intervention.

It is clinically relevant to ascertain whether an individual has a pre-existing mood or anxiety disorder which has influenced their methamphetamine use, (e.g. an individual who uses ice when they experience a major depressive episode) or whether the mood or anxiety disorder occurs as a result of methamphetamine use (e.g. an individual who suffers from a manic episode after a methamphetamine binge). These two diagnostic pictures differ from the case where both the methamphetamine use and mood or anxiety disorder coexist and are chronic, and interact in a cyclical fashion to sustain both disorders. The assessment of the potential interactions between methamphetamine and mood or anxiety disorders is essential in treatment planning and relapse prevention. Dawe and McKetin, (2004) provide a comprehensive guide for assessment and clinical management of these comorbidities.

The risk of developing a mood or anxiety comorbidity has been investigated. Hall et al. (1996) found that the best predictors of psychological comorbidity in methamphetamine users were frequency of use, injecting rather than swallowing or snorting, and pre-existing psychological symptoms. Other risk factors include a family history of mood or anxiety disorders.

Psychotic disorders

Methamphetamine-induced psychosis represents a significant mental health risk in relation to methamphetamine use and is well documented (Baker & Dawe, 2005). It is most frequently associated with chronic high-dose use of methamphetamine, multiple binge patterns with

escalating doses or use of more potent forms of methamphetamine such as crystal meth or ice. Methamphetamine-induced psychosis is symptomatically indistinguishable from the symptom profile of non-drug related psychotic episodes. It resolves after the acute effects of the drug have subsided, usually in a matter of days (Baker & Dawe, 2005).

Methamphetamine-induced psychosis is characterised by prominent hallucinations or delusions. These can take the form of delusions of grandeur or omnipotence or paranoia, such as persecutory delusions. Auditory, visual or tactile hallucinations and repetitive, ritualised and bizarre behaviours have also been associated with methamphetamine-induced psychosis. (Perceptual disturbance recognised by the individual as relating to their drug use are not classified as hallucinations). The symptoms of hallucinations or delusions developed during or within 1 month of methamphetamine intoxication or withdrawal.

As a result of methamphetamine use, psychotic symptoms can be induced in individuals who have no history of psychotic illness and psychotic relapse can be triggered in individuals with schizophrenia (see section on Considerations for Specific Groups of Methamphetamine Users on page 56). Finally, methamphetamine use may trigger a psychotic illness such as schizophrenia in predisposed individuals. Risk factors for development of a psychotic illness include a family history of schizophrenia or past experiences of psychotic episodes or phenomena. Research has demonstrated that methamphetamine-induced psychotic symptoms resolve rapidly for most people, however, there are a proportion of individuals whose psychotic symptoms are protracted and may require antipsychotic medication to resolve their symptoms.

Organisational issues

Demand for methamphetamine treatment

Although there is considerable variability in the figures calculated from different data sources, current estimates suggest that in 2004 there were 72,700 dependent methamphetamine users in Australia (McKetin, McLaren et al., 2005).

Substantial proportions of individuals with harmful or dependent substance use never seek or enter treatment (Teesson, Hall et al., 2000) and concerns have been raised in relation to low rates of treatment utilisation, which are considerably lower than those only using opiates or those using both stimulants and opiates. Local data has estimated treatment penetration at between 6 and 11% (Ritter et al., 2003).

Barriers to accessing treatment

There are a number of barriers to treatment that impact on service utilisation for methamphetamine users. These include:

- Negative attitudes towards treatment.
- Not believing that treatment will help.
- Concerns about not receiving appropriate treatment.
- A belief that available treatment options are inappropriate.
- Low levels of confidence in treatment services and staff.
- A perception that treatment will be ineffective.
- A perception that it will make the addiction worse.

- Concerns about confidentiality, especially for those seeking treatment for the first time.
- Concerns that attending a treatment service and spending time with other users might act as cues for relapse to drug use.
- Organisational barriers such as opening times, waiting times, location and lack of a timely response.

Challenges for treatment services

As a result of these concerns, methamphetamine users may prefer to manage their use on their own, with the support of friends and family, or with their GP. There are few resources to assist in self management and GPs are often not in a position to provide intensive interventions for complex problems.

Specialist services are most likely to see methamphetamine users who have suffered from depression, experienced psychotic symptoms such as hallucinations and paranoia or have experienced behavioural problems, such as aggressive outbursts. These clients require skilled clinicians and a range of resources in order to manage these complexities.

Methamphetamine withdrawal also appears to be quite different from the withdrawal syndromes associated with other drugs, such as opiates and alcohol. This has significant implications for treatment services, which are generally better oriented to manage opiate and alcohol withdrawal.

Services need to offer treatments that meet the multiple and specific needs of methamphetamine users.

Effectiveness/efficacy of methamphetamine treatment

Assessment as the start of treatment

Addy et al. (2000) are clear that a comprehensive assessment is essential for determining the most appropriate and potentially effective treatment intervention for the client. It is important to have a baseline of information from which clinically relevant suggestions can be developed and offered to the client. It is also important to remember that assessment is not a single event. It is an evolving process 'that identifies problems as they emerge' (Addy et al., 2000).

Harm reduction

There is significant evidence to support the effectiveness of many harm reduction strategies in Australia. An example of this is the utilisation of needle and syringe programs (NSP's), which have contributed significantly to a reduction in the sharing of injecting equipment. This has lowered the risks of contracting HIV and other blood borne viruses (Addy & Ritter, 2000) for intravenous drug users.

Some users choose to abstain from methamphetamine altogether, while continuing to use other drugs on either a dependent or recreational basis. Others may feel that a goal to control their use of methamphetamine is more realistic and achievable. Research by Shakeshaft et al. (2002) suggests that approximately half of all methamphetamine users presenting to treatment are wanting to reduce their use rather than abstain completely.

Harm reduction strategies can be incorporated into other treatment interventions, such as relapse prevention which may be undertaken at the beginning of treatment as a 'soft' entry to intervention, or may be delivered by a variety of health care professionals such as GPs and other health care

workers. This is especially relevant for methamphetamine users, as many methamphetamine users prefer to present to non-alcohol and drug services for assistance.

Harm reduction involves working with the client to develop treatment goals that are achievable and sustainable. Treatment goals should not be limited to drug use only. Other goals may include monitoring of mental health and assisting the client to develop greater awareness about the relationship between methamphetamine use and psychiatric symptoms. Supporting a goal of remaining engaged in treatment may be important, as research shows that methamphetamine users often drop out of treatment prematurely.

Pharmacotherapy

To date, there is no standard pharmacotherapy treatment for the management of methamphetamine withdrawal or dependence. Medications such as antidepressants, dopamine agonists (which have properties similar to methamphetamine) and antagonists (which block the effects of stimulant drugs, Herman et al., 2005), have been trialled for their effectiveness in managing methamphetamine withdrawal or dependence.

Whilst there may be some role for limited use of medication for people with complex medical or psychiatric conditions, there is little evidence regarding the overall benefits of medication for the management of methamphetamine withdrawal. Much of the research conducted to date on management of psychostimulant withdrawal has been from US studies related to cocaine. Whilst the withdrawal symptoms for methamphetamine and cocaine are very similar, it is thought that methamphetamine withdrawal may be more protracted given the longer lasting action of methamphetamine.

Despite a number of trials currently underway examining a range of drugs such as modafinil, buproprion and methylphenidate, there is no substitution pharmacotherapy treatment that has been demonstrated to be effective for the management of methamphetamine dependence or abuse (Baker, Lee & Jenner, 2004). The use of dexamphetamine (prescribed oral methamphetamine) is commonly used for the treatment of attention deficit hyperactive disorder in children, as well as narcolepsy (sleep disorder) and epilepsy. It is also used in some parts of the UK to treat methamphetamine dependence. The rationale for its use is similar to methadone maintenance for opiate-dependent clients, aiming to replace illicit methamphetamine use with a safer medication which avoids withdrawal, reduces cravings and regulates dose and mode of administration (Shearer et al., 2002). There is some evidence to suggest that dexamphetamine substitution may be of value to a small group of people – primarily those with more severe dependence and complex presentations (Shearer et al., 2002). The efficacy and safety of this treatment, however, has not yet been established.

Psychological interventions

The evidence to date indicates that cognitive behavioural therapy (CBT), including relapse prevention is the most effective treatment for methamphetamine users (Baker & Lee, 2003).

Baker et al. (2004) completed a comprehensive review of the literature regarding the effectiveness of psychological interventions for methamphetamine users. They noted that there are specific interventions that may be effective for differing levels of methamphetamine use. The approach to working with regular methamphetamine users – including hazardous, harmful or dependent users – may include a combination of interventions, such as motivational interviewing techniques in

conjunction with cognitive behavioural interventions. Related research shows that CBT for cocaine use is effective at reducing the risk of relapse and may be more effective with severely dependent cocaine users, although it does not appear to be superior to other interventions in achieving abstinence (Carroll, 1998).

CBT interventions have been found to be most likely to guard against relapse and are considered best practice for methamphetamine users. Both Carroll (1998) and Monti et al. (1989) have devised longer interventions based on CBT principles. Baker et al. (2004) have found that a brief CBT intervention can improve abstinence among regular amphetamine users. These guidelines outline options for providing treatment using both brief and longer interventions. These interventions should be offered on a stepped care basis.

Kay-Lambkin et al. (2004) propose a stepped care approach to the provision of CBT interventions, moving from the least to the most intensive. Each incremental step is made available on the basis of the client's response to the previous one. This graduated approach to treatment has been shown to be effective in better matching treatment to the client's needs and readiness to change. It can also increase services to a greater number of people, by reducing unnecessarily intensive interventions, and optimise use of resources such as practitioner time. Baker et al. (2005) confirm that a stepped care approach, utilising psychosocial (CBT) interventions, is useful for deciding what level of intervention may be appropriate for a particular client and provides a valuable approach to integrating assessment, case formulation and treatment planning into the treatment process. Although further evidence is required to support the stepped care approach, expert consensus suggests that this approach is a positive basis for intervention.

PsyCheck is not specifically targeted at methamphetamine users but may be useful to address comorbid conditions in clients with mental health symptoms. *PsyCheck* is a system of screening and brief intervention for comorbid AOD and anxiety or depression, based on a brief CBT approach. An implementation trial has shown that clinicians found it a helpful tool for managing clients with comorbid conditions and increased their confidence in caring for this group. Detection and intervention rates also increased. Further trials examining outcomes for clients are currently underway.

Complementary therapies

There is little scientific evidence to suggest that the use of complementary therapies, such as acupuncture or herbal medicines, are of benefit to the management of methamphetamine dependence or withdrawal. Although the efficacy of complementary therapies may not be established, they may, like substitution treatments, provide a means of attracting methamphetamine users into treatment (Baker & Lee, 2003). There is certainly a need for further research in this area to establish whether complementary therapies are beneficial, as users do express interest in applying them to help reduce symptoms of methamphetamine withdrawal (Baker & Lee, 2003).

PRINCIPLES OF APPLICATION

Working with clients who use methamphetamine

- Assessment should be considered integral to the engagement and treatment process rather than an independent process.
- Early engagement is vital for methamphetamine users and working with consideration of the stages of change or other engagement models is important.
- Intervention specific to methamphetamine should be negotiated with the client, as with other drug use intervention, and incorporated into a comprehensive treatment plan.
- Each individual is different and requires a tailored response.
- The pattern and extent of use should be considered when deciding on intervention or management strategies.
- Methamphetamine use should be addressed in the context of other drug use, given the high prevalence of polydrug use amongst methamphetamine users.
- Methamphetamine use should be addressed in the context of mental health and other psychosocial factors.
- Drug use, including methamphetamine, is a cyclical and relapsing condition. Interventions may need to be applied repeatedly, before significant change is achieved.

Stepped care approach

Stepped care involves the provision of a series of interventions, from the least to the most intensive, with each incremental step made available on the basis of the client's response to the previous one. A stepped care approach provides a best practice framework for integrating assessment, case formulation and treatment planning into the treatment process. It should be used when deciding what level of intervention may be appropriate for a particular client. For example, a regular user may benefit from a two-session intervention when they first present to a treatment agency, while dependent or heavy intermittent users (who may have additional problems such as depression) may require longer intervention.

Since individuals with co-occurring problems are a very heterogeneous group in terms of type, severity and readiness to address their various problems in treatment, a stepped care approach to treatment can allow for flexibility in intervention. This graded approach to treatment can:

- Allow for flexibility in intervention and match the treatment to the client's needs.
- Accommodate differences between individuals with co-occurring problems in terms of type and severity of use and readiness to change.
- Increase services to a greater number of people by reducing unnecessarily intensive interventions.
- Optimise use of resources such as practitioner time.

Harm reduction approach

Harm reduction underpins all drug and alcohol treatment in Australia. The principles of harm reduction focus on reducing drug related harms to both individuals and the community. It recognises the individual's choice to continue their drug use, whilst providing strategies to reduce the physical, psychological and social harms that may be a consequence of their continued use. These strategies may vary significantly depending on the individual, type of drug being used and the potential harms (Addy & Ritter, 2000).

Harm reduction strategies can be incorporated into other treatment interventions, such as relapse prevention or may be delivered by a variety of health care professionals, such as GP's and other health care workers. This is especially relevant for methamphetamine users, as many prefer to present to non-alcohol and drug services for assistance.

Details of general harm reduction principles and practices are outlined in the fourth volume of the Turning Point Clinical Treatment Guidelines series: Clinical Treatment Guidelines for Alcohol and Drug Clinicians: Reducing harm for clients who continue to use drugs (Addy & Ritter, 2000b).

Being familiar with the specific harms and risks associated with methamphetamine abuse and dependence (e.g. polydrug use, behavioural and psychological disturbances) is essential in order to provide targeted and relevant interventions.

These guidelines outline six steps in assessing and intervening to reduce harm:

1. Be familiar with the potential harms.
2. Assess harm and risks associated with the client's use.
3. Provide information and personalised feedback about potential harms.
4. Use a collaborative approach to develop harm reduction strategies with the client.
5. Have the client identify goals to reduce harm.
6. Monitor behaviour, reinforce positive changes and address difficulties.

It is also important to remember that polydrug use is common amongst methamphetamine users and therefore interventions should aim to reduce harms associated with any drug use, not only the primary drug of choice. Other harm reduction strategies may include monitoring mental health and assisting the client to develop greater awareness about the relationship between methamphetamine use and psychiatric symptoms. Supporting a goal of remaining engaged in treatment may be important, as research shows that methamphetamine users often drop out of treatment prematurely.

PRACTICE GUIDELINES

Given the increasing use of methamphetamine in Australia, and particularly the use of more potent forms, a corresponding increase in dependence and harms is likely. However, methamphetamine and other psychostimulant users are reluctant to present at specialist alcohol and other drug services. It is commonly understood that the reasons are primarily due to the perception that AOD treatment agencies do not offer specialist treatment for this group. It is, therefore, important for AOD services to offer treatment environments that will attract and retain methamphetamine users. Those who attend AOD services are likely to be longer term or polydrug users and to have experienced a range of problems, including mental health symptoms.

In order to respond effectively, services will benefit from developing an array of treatments that include both acute and longer-term responses. These guidelines outline acute interventions, such as managing intoxication and toxicity, as well as treatments for use and dependence, such as withdrawal plans, brief interventions and longer-term psychological interventions.

Conducting a comprehensive assessment is an integral first step in any AOD treatment and provides a key opportunity for client engagement, treatment planning and early intervention. For this reason, these guidelines also include assessment and treatment planning as an integral part of pre-intervention preparation, designed to ready the clinician and their client to undertake treatment.

A stepped care approach is recommended, where the most acute problems are managed immediately and where the least intensive intervention is tried first, moving to more intensive interventions only if they are required. The interventions offered in these guidelines are designed to allow agencies to undertake a comprehensive approach to the management and treatment of methamphetamine use.

Methamphetamine users presenting to AOD agencies are likely to require a combination of these options and treatment should be tailored to address their specific needs. Clinical pathways should be developed within services so that the treatment options available are clear to both clinicians and clients.

The most effective known treatments for chronic conditions are psychological interventions, but these may be accompanied by symptomatic medication if required. To date there are no known specific medications to treat methamphetamine dependence or withdrawal, although many have been tested and continue to be trialled.

The treatment options outlined in these guidelines are drawn from best available practice and cover a range of interventions that may require the specialist input of medical, nursing, psychology or other staff depending upon the structure of the agency.

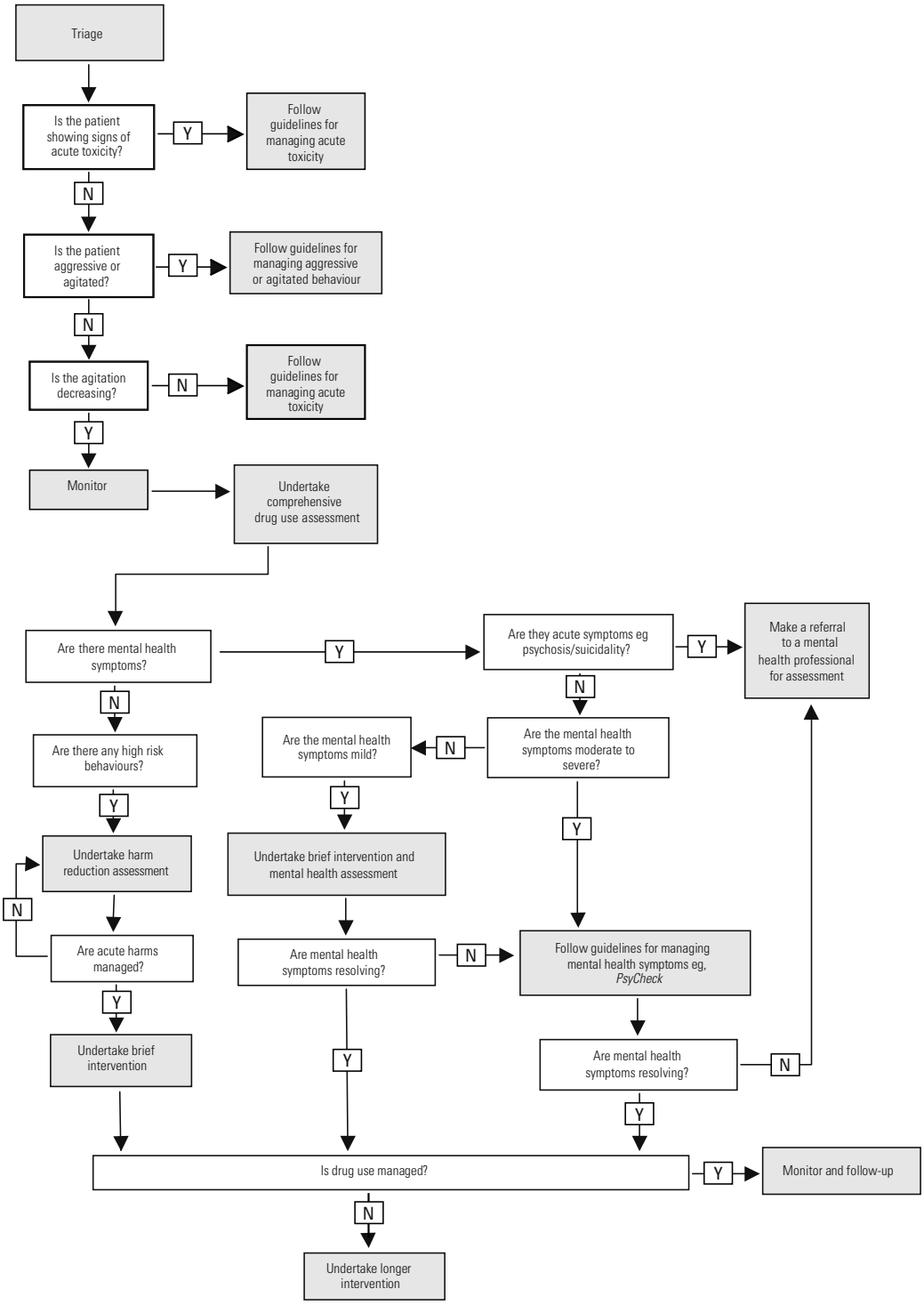


Figure 1: Clinical practice overview

PART 1: MANAGEMENT OF ACUTE PRESENTATIONS

Managing acute toxicity

Recognising and responding to potentially toxic presentations can be challenging.

Step 1: Observe clinical signs of toxicity

Clinical observation of toxic signs is more important than attempting to determine the ingested dose (Dean & White, 2004). Whilst it may be helpful to elicit information regarding the amount of methamphetamine consumed when assessing potentially toxic presentations, it is important to remember that some individuals may experience these symptoms after relatively low doses of methamphetamine.

Symptoms which may alert clinicians to potential toxicity include:

- Chest pain
- Rapid increase body temperature
- Psychotic features (such as hallucinations, paranoia or delusions)
- Behavioural disturbances which may put the individual or others at risk
- Seizures
- Uncontrolled hypertension

Step 2: Monitor vital signs

- Check temperature and pulse

Step 3: Attempt verbal de-escalation of the situation if required

- Talk quietly and calmly to the patient.
- Do not raise your voice or become agitated.
- Take the person to a quiet place where there are no distractions or potential weapons.
- If acute behavioural disturbance is a feature of toxicity, reliance on physical restraint is not recommended and may worsen the situation.

Step 4: Sedation if necessary

A titrated dose of midazolam is recommended until acute behavioural disturbance is controlled. Patient should not be sedated until unconscious.

Step 5: Regular hydration and observation

For significantly elevated vital signs, more intensive intervention may be required, including IV line and cardiac monitoring.

For mild cases of serotonin toxicity, supportive care, regular observation and consideration of sedation with a benzodiazepine or antipsychotic may be required. For more serious serotonin toxicity, supportive care in an emergency department setting with an emergency medicine specialist is advised (DAO, 2006).

Dean and White (2004) note that potential neurological and cardiovascular complications can arise during gastric decontamination ('stomach pumping') and there is no evidence of benefit from its use.

Managing aggressive or agitated behaviour

Some methamphetamine users experience an increase in aggressive behaviour as a consequence of their methamphetamine use. It is essential that clinicians and services are clear about the safety procedures and appropriate response to managing clients who present in an agitated or aggressive state. Regular training, which includes role plays, can be invaluable in effectively responding to these situations and ensuring the safety of the client, staff and others in the vicinity.

Behaviours associated with agitation that may become a concern include:

- pacing
- being unsettled
- paranoia/suspiciousness
- delusions (persecutory or grandiose)
- argumentative with little or no provocation
- easily upset over trivial things
- threatening others
- dissatisfied with everyone
- offering unwarranted criticism
- criticising surroundings
- condemning staff of inadequate sensitivity, training or qualifications
- claiming that everyone is out to make things difficult for them
- feeling unsupported

When responding to difficult behaviours such as these, it is important to remain aware that the person's judgement might be impaired and that they may not be experiencing the situation the same way you are. This may be an indicator of the presence of psychotic behaviour that may make them a risk to themselves or others.

- Keep your voice low and controlled.
- Listen to the person.
- Avoid insincerity, ridicule or smiling.
- Avoid taking their behaviour personally.
- Explain to the person what is happening, what you are doing and why you are doing it.
- Avoid movements or actions which may be perceived as threatening, such as quick movements or moving towards the person suddenly.
- It is essential that you consider your own occupational health and safety at all times.
- Where possible, manage the physical environment so that you are able to leave if necessary.
- Make sure you advise others if you are about to enter a high-risk situation.

In the case of extreme agitation or aggression, the escalating threat of physical injury to the client, yourself or others will make it necessary to take more immediate action. Follow protocols appropriate to your organisation and request police or emergency service attendance if appropriate.

When using sedatives to manage difficult behaviour, the DAO (2006) guidelines recommend:

Mild arousal (person is alert, may be irritable but cooperative, able to engage in assessment, normal vital signs): Sedate by oral medication – diazepam 5-10 mg or clonazepam 0.5-2 mg or lorazepam 1-2.5 mg, repeating after 30-60 min if necessary. Escalate to olanzepine 5-10 mg or haloperidol 2.5-5 mg if no effect.

Moderate arousal (person is restless, hostile and uncooperative, raised vital signs): Sedate with intramuscular medication if oral medication is refused – midazolam 5-10 mg or clonazepam 1-2 mg, repeating after 30-60 min if necessary. Escalate to olanzepine 5-10 mg or haloperidol 2.5-5 mg if no effect. Flumazenil should be available for reversal of respiratory depression risk from administration of midazolam.

High arousal (person is distressed, highly agitated, uncooperative and potentially violent): Sedate with intravenous medication if oral or intramuscular medication is refused and the situation is urgent. A free running IV line is preferred to dispense medication over several minutes – diazepam 5-10 mg, repeating in 5mg increments until adequately sedated. Escalate to haloperidol 2.5-5mg or midazolam 2.5-5mg if no effect. Resuscitation equipment and flumazenil should be available for reversal of respiratory depression risk from administration of midazolam.

Adapted from DAO (2006). Clinical Guidelines: *Management of Acute Amphetamine Related Problems*.

Comprehensive guidelines on the principles and application of responding to difficult behaviours is outlined in Turning Point's *Clinical Treatment Guidelines for Alcohol and Drug Clinicians No. 10: Managing Difficult and Complex Behaviours* (Lee et al., 2003). These guidelines include information regarding effective communication skills and the principles of behaviour modification as well as providing a range of strategies for managing aggressive, violent and difficult behaviour (such as manipulative and antisocial behaviour).

Managing acute psychotic symptoms

Sedatives (if the person is particularly agitated) and antipsychotics have been shown to be effective in managing the acute symptoms of methamphetamine-induced psychosis. Maximum sedation should be to the point of rousable sleep not unconsciousness with the aim of controlling disturbing symptoms and erratic behaviour, so that assessment and further management are possible (DAO, 2006). Benzodiazepines are the first line treatment, preferable over antipsychotics as they have secondary benefits for serotonin toxicity.

PART 2: INTERVENTIONS FOR USE AND DEPENDENCE

Assessment

Conducting a comprehensive assessment is an essential requirement of determining the most appropriate and potentially effective treatment intervention for the client (Addy et al., 2000). It provides a baseline of information from which clinically relevant suggestions can be offered. Remember that assessment is not a single event, but rather an evolving process that identifies problems as they emerge. This way, assessment is both the beginning of treatment and an ongoing part of treatment and should be reviewed throughout the treatment process.

The majority of people who use methamphetamines do so in conjunction with other drug use so a thorough clinical assessment of all drug use is essential. Mental health symptoms are common and at least require screening for all methamphetamine users. Engagement is often sited as a barrier to treatment for methamphetamine users so an assessment of readiness for treatment and monitoring engagement is important.

Comprehensive drug use assessment

Core elements of the drug use component of assessment for methamphetamine users include:

- accurate information about all aspects of methamphetamine use
- indicators of severity of dependence, withdrawal symptoms and significant periods of abstinence
- evidence of dependence on or withdrawal from other drugs
- risk behaviour associated with mixing drugs, including overdose or toxicity
- psychosocial factors
- treatment goals

Accurate information should be gathered through clinical interview about:

- type/s of methamphetamine being used
- the quantity and frequency of use
- the route of administration
- duration of use

Information about other drug use should be gathered in the same way, with a particular emphasis on the pattern of drug use in relation to methamphetamine use, such as mixing other drugs with methamphetamines and using other drugs (particularly depressants) to alleviate the 'come down' effects of methamphetamine.

The timeline follow back (TLFB) is a validated method of understanding the recent pattern of drug use in relation to methamphetamine use and may be used in conjunction with the clinical interview (see *Work sheet 1: Timeline follow back*). The TLFB is a calendar that records the last 30 days of use. Provide anchors for the client by indicating public holidays, significant personal events and other dates on the calendar. Then assist the client to work back from the last day of use and complete all drug use for each day.

Assessing dependence

Information should be gathered about significant symptoms of dependence and compared to the DSM-IV criteria for dependence (see page 14 of the introduction). A combination of any three of these, occurring at any time in the same 12-month period, is a good indication of dependence. Assessment for dependence includes:

- tolerance
- withdrawal
- intended vs actual use
- persistent efforts or desire to cut down
- increased time spent on activities related to substance use
- significant impact on non-substance-related activities
- continued substance use regardless of impact or risk

Use *Work sheet 3: Severity of dependence scale* to measure the client's degree of dependence over time. This scale has been validated with an amphetamine-using population and includes cut-offs that have been identified for dependence.

Remember, dependence is often affected by the type and potency of methamphetamine used and the mode of administration. Increased or early dependence may be also associated with:

- injecting methamphetamine
- use of crystal methamphetamine ('ice')
- frequent and repeated ('heavy') use

A number of other instruments have been designed to measure dependence and may be helpful in measuring the degree of dependence over time. These are outlined in Dawe et al. (2002).

Psychosocial factors impacting on drug use

Assessment of methamphetamine users should also include the standard information that would be gathered for any client. Assessing the general health and psychosocial characteristics of the client (for example, legal, financial, employment, relationships, supports) is important, not only in being able to offer comprehensive and integrated treatment (including referrals to other relevant services) but also to help identify potential barriers to change (for example, partner's continued drug use).

Goals for treatment

Given the prevalence of polydrug use among methamphetamine users, it is important to be clear about what the treatment goals are for each drug type. Some users may choose to abstain from methamphetamine altogether, while continuing to use other drugs on either a dependent or recreational basis. Others may feel that a goal to control their use of methamphetamine is more realistic and achievable. In fact, approximately half of methamphetamine users presenting to treatment are wanting to reduce their use rather than abstain completely.

Treatment goals should not be limited to drug use only. Other goals may include monitoring of mental health and assisting the client to develop a greater awareness about the relationship between methamphetamine use and psychiatric symptoms; as well as goals of remaining engaged in treatment (remembering that methamphetamine users often drop out of treatment prematurely).

Assessing readiness for change

It is particularly important to explore readiness for change and other factors that may impact on engagement with this group. Explore the client's concerns or reservations they have about making changes to their methamphetamine use and reservations about treatment and the treatment setting. *Work sheet 2: Stages of change ladder* can be used to discuss readiness to change with the client. Monitor engagement closely throughout treatment and adapt interventions accordingly. Motivational enhancement and assessment techniques may be useful (see *Clinical Treatment Guidelines for Alcohol and Drug Clinicians: Motivational Interviewing* and www.motivationalinterview.com.au).

Harm reduction assessment

It is important to identify potential harms associated with methamphetamine use. *Work sheet 7: Harm reduction goals* and *Work sheet 8: Drug related harm identification* may assist in identifying harms associated with amphetamine use and also set some goals to manage and reduce harms. In addition, transition to injecting is a significant risk for non-injectors and their thoughts about injecting should be assessed.

Mental health assessment

Given the high incidence of mental health problems amongst methamphetamine users, it is highly recommended that clinicians develop the skills to effectively assess and manage comorbidity (Vincent et al., 1998). Addressing only one of the conditions may increase the risk of relapse and abandoning treatment. Baker et al. (2003) recommend a comprehensive mental health assessment that focuses on:

- identifying symptoms of depression, anxiety and psychosis (the most common psychiatric symptoms associated with methamphetamine use)
- the duration of symptoms
- whether symptoms are present during use or persist after methamphetamine use has ceased
- previous treatment for mental health problems

Conduct an assessment of the comorbidity of substance use disorder and psychiatric illness, using the following prompts:

- Consider the range of symptoms caused by each identified substance.
- Determine whether substance use predated the psychiatric symptoms, using questions such as:
  - How old were you when you first experienced (symptoms)?
  - How old were you when you started using (substance) regularly (at least weekly)?
- Determine duration and patterns of use and affect on psychiatric symptoms, using questions such as:
  - Has there been a time when you have not used (substance)?
  - If yes, how long was this for and how did this affect your symptoms?

- Determine duration and patterns of psychiatric symptoms and affect on substance use, using questions such as:
  - Has there been a time when you have not experienced (symptoms)?
  - If yes, how did this affect your use of (substance)?

Adapted from Dawe & McKetin (2004)

Screening for depression and anxiety

There are no screening instruments specifically for methamphetamine use and mental health problems. However, the recently developed *PsyCheck Screening Tool* is an instrument that can be used to screen for high prevalence mental health problems among alcohol and other drug populations as well as address the most prevalent disorders among amphetamine users. It has the advantage of an accompanying 4-session intervention to assist clinicians to manage depression and anxiety symptoms among AOD clients.

Other instruments that are commonly used to screen for mental health symptoms, but are not specifically intended for methamphetamine users include the Kessler-10 (Kessler et al, 2002) and the General Health Questionnaire (Goldberg & Williams, 1998). A report by Dawe et al (2002) outlines a number of screening tools suitable for AOD populations and is available from the Australian Government Department of Health and Ageing (www.health.gov.au)

Remember that screening is just a first pass indicator that further clinical assessment and intervention is required.

The PsyCheck Screening Tool

The *PsyCheck Screening Tool* is a mental health screening instrument designed for use by clinicians who are not mental health specialists. It detects the likely presence of mental health symptoms that are often seen, and can feasibly be addressed, within specialist AOD treatment services. It is not designed to be a diagnostic assessment and will not yield information about specific disorders.

It is designed to detect potential mental health problems that may be missed if not specifically investigated by the clinician or raised by the client. For this reason, it is important that all clients are given the screening instrument if possible, even if they do not appear to have a mental health problem.

The *PsyCheck Screening Tool* has three sections and can be used at any point in the assessment and treatment of a client presenting to AOD services once they are stabilised (i.e. no withdrawal symptoms and/or stabilised on pharmacotherapy). It can be readily incorporated into the regular assessments conducted at entry to services and should also be re-administered throughout treatment, whenever other reviews of progress are conducted. The SRQ can be self or clinician-administered, while the other sections are administered by the clinician. You may not need to go through all the questions if you already have some of the information (for example, hospitalisation, past history).

Section 1: General mental health screen

Section 1 of the *PsyCheck* has five questions designed to identify clients who have been previously diagnosed or treated for mental health problems. Question 5 in Section 1 of the *PsyCheck* is a prompt for the presence of suicidal ideation: 'Has the thought of ending your life ever been on

your mind?' If the client answers 'Yes', a full suicide/self-harm risk assessment is conducted as indicated in Section 2 of the *PsyCheck*.

Section 2: Suicide/Self-harm risk assessment
If the client answered 'Yes' to suicide ideation in Section 1, a full suicide/self-harm risk assessment is required. Clinicians should follow organisational protocols if high risk of suicide is identified; however Table 3 outlines potential responses to levels of risk.

Table 3: Risk levels and response to suicidality

Level of risk	Action
No or minimal risk	• Monitor as required.
Low risk: some thoughts but minimal risk factors, no previous attempts, no specific plan, intention or means, evidence of minor self-harm, protective factors (e.g. available supports)	• Monitor closely and agree on a verbal or written contingency plan with client. • Provide support numbers. • Obtain commitment to follow the contingency plan should feelings escalate.
Moderate risk: thoughts, some risk factors, plan has some specific detail, means are available, intention to act in near future but not immediately, some protective factors (e.g. inconsistent supports)	• Offer or refer for further assessment/contact with metal health or other appropriate service. • Agree on a written contingency plan with client, clearly outlining relevant supports to be contacted if feelings escalate. • Request permission to inform emergency monitoring team (CATT) and/or family. • Consult with supervisor as necessary.
High risk: thoughts, previous attempts, risk factors, clear and detailed plan, immediate intent to act, means are available (and lethal), social isolation	• Limit confidentiality. • Immediately refer to hospital mental health services or emergency mental health team. • Call ambulance/police if necessary. • Obtain support from supervisor if required.

Section 3: Self reporting questionnaire (SRQ)
The SRQ was developed by the World Health Organization to screen for symptoms of the more common mental health problems, such as anxiety and depression, among clients in primary care settings. There are 20 questions related to common symptoms of depression, anxiety and somatic complaints (such as sleep problems, headaches and digestive problems).

The client is first asked to tick any symptoms that they have experienced in the past 30 days. For every 'yes' answer, the client is asked to tick whether they have experienced that problem when they were not using alcohol or other drugs. The clinician then counts the total number of ticks in the circles and places the score at the bottom of the page.

The clinician should interpret scores on Section 3: Self Reporting Questionnaire of the *PsyCheck* as indicated in Table 4. The actions recommended here are to be considered as an adjunct to usual practice.

The *Psycheck Screening Tool* is the basis of a stepped care model in which the treatment response is contingent upon the initial *Psycheck Screening Tool* score. Table 4 below outlines the incremental responses recommended and the *PsyCheck Clinical Treatment Guidelines* outline the specific intervention.

PsyCheck screening materials, including a user's guide with details of administration and scoring are available through the Australian Government Department of Health and Ageing (www.health.gov.au).

Table 4: Interpretation of the SRQ score

Total score on SRQ	Interpretation	Action
0*	No symptoms of depression, anxiety and/or somatic complaints indicated at this time	• Re-screen using the *PsyCheck* Screening Tool after 4 weeks if indicated by past mental health questions or other information
1–4*	Some symptoms of depression, anxiety and/or somatic complaints indicated at this time	• Offer Session 1 of the *PsyCheck* Brief Intervention • Provide self-help material • Re-screen using the *PsyCheck* Screening Tool after 4 weeks
5 or above*	Considerable symptoms of depression, anxiety and/or somatic complaints indicated at this time	• Offer Sessions 1–4 of the *PsyCheck* Brief Intervention • Re-screen using the *PsyCheck* Screening Tool at the conclusion of 4 sessions • If no improvement in scores evident after re-screening, consider referral

* Regardless of the client's total score on the SRQ, consider referral if significant levels of distress are present.

Screening for psychosis

Florid psychotic symptoms are usually easy to identify, however, methamphetamine users may present with a range of low grade psychotic symptoms that are unusual but more difficult to pinpoint. These include:

- Paranoia: suspicions about treatment, friends or acquaintances, such as other people plotting to harm them.
- Delusions: extreme beliefs that are unsupported by evidence, such as the client is invincible or someone is trying to contact them through the television.

- Hallucinations: seeing, hearing, smelling or feeling things that other people cannot. Methamphetamine users often report tactile hallucinations like ants under their skin and sometimes hearing voices or seeing things out of the corner of their eye.

Clinical interview is the most effective way to uncover these symptoms. Allow the client to feel comfortable enough to disclose symptoms. Ask about details in a way that indicates that you understand the symptoms and reflect feelings back appropriately without reinforcing these symptoms (for example: 'that must make you feel scared').

An instrument designed to measure psychotic symptoms is the Psychosis Screener and may be a helpful adjunct to the clinical interview (see *Work sheet 5: Psychosis screener*). If you are unsure about how to assess for psychotic symptoms, consult with a mental health professional.

Managing withdrawal

There is no standard pharmacotherapy treatment for the management of methamphetamine withdrawal to date. Managing withdrawal from methamphetamine consists primarily of psychosocial interventions, which may be supplemented with medications, such as (short acting) benzodiazepines, to reduce symptoms of insomnia and anxiety during the first few days.

Methamphetamine withdrawal is relatively safe and most often occurs at home. If there is evidence of significant polydrug use, psychotic symptoms, severe depression, or the potential for medical complications, an inpatient setting may be more appropriate (Kamieniecki, 1998). Otherwise it is recommended that outpatient or ambulatory (home) detoxification is offered (Jenner & Saunders, 2004)

Planning is the key to the success of any treatment. The clinician should help the client prepare for methamphetamine withdrawal by discussing:

- Previous attempts to withdraw from methamphetamine, identifying what was and was not helpful.
- The likely course of methamphetamine withdrawal, (including symptoms, duration and severity).
- Dependence on other psychoactive drugs.
- The environment the client will be in during withdrawal (home or supervised detoxification).
- Avenues of support (friends/family) who may provide assistance.
- Ways of maintaining motivation.
- The role of withdrawal medication if appropriate and referrals to GP or specialist AOD doctors for assessment.
- Any additional factors that may need consideration during withdrawal, such as psychiatric or other health issues (symptoms of psychosis, depression and anxiety or behavioural problems such as agitation or aggression which may worsen during the course of methamphetamine withdrawal).
- Potential treatment options following withdrawal (which may reduce the risk of relapse and provide an opportunity to engage clients in ongoing treatment.

As methamphetamine withdrawal can be longer and more protracted than withdrawal from other drugs (such as alcohol and opioids), the environment and support play key roles in the client's ability to maintain motivation for change and complete withdrawal. Clinicians should also normalise the experience of prolonged anxiety and depression as a result of a protracted recovery period and provide support and assistance in managing these feelings.

Once a withdrawal plan has been agreed, clinicians should regularly monitor the progress of their client's withdrawal. Providing a withdrawal scale so clients can monitor and review their progress may be a useful adjunct to psychosocial supports.

The amphetamine withdrawal questionnaire is a 10-item self-administered questionnaire, designed to detect severity of withdrawal symptoms (see *Work sheet 6: Amphetamine withdrawal questionnaire*). It is based on the DSM-IV criteria for withdrawal. It may be a useful tool to use with clients to record and monitor withdrawal symptoms over time.

The use of medication for methamphetamine withdrawal should preferably be only one to two weeks duration, to avoid developing dependence on these drugs. Symptoms of sleep disturbance and anxiety may persist for several weeks or sometimes months.

Table 5: Examples of drug-related harm and intervention strategies

Drug-related behaviour	Drug-related harm	Intervention
Obtain drugs	Legal problems resulting from being caught possessing or purchasing illicit drugs, assaults from other users, not attending to regular activities when obtaining drugs.	Avoid unfamiliar drug dealers and locations, know about legal rights and access to legal assistance.
Finance drug use	Financial debt, income-generating crime.	Develop financial planning strategies, avoid purchasing drugs on credit, restrict (or avoid) drug dealing, avoid or reduce criminal activity.
Mode of administration	Transmission of HIV, hepatitis B and hepatitis C, infection of injecting sites or systemic infection.	Use needle exchange programs, obtain information on safe-injecting techniques, inhale or ingest substances.
Intoxication	Overdose, physical or psychological effects of the drug.	Obtain information on prevention of overdose.
Intoxicated behaviour	Poor performance or absenteeism at work, in relation to study or home duties, aggression or violence, participation in high-risk activities such as unsafe sex, needle sharing, intoxicated driving and crime.	Plan drug use or other drug-related activities in such a way as to allow obligations to be met, change environment conditions, for example, avoid over-crowded nightclubs, raves or other events, avoid severe intoxication, reduce polydrug use, carry condoms, leave car at home.
Hangover/crash	Poor performance or absenteeism at work, in relation to study, home duties or driving.	Plan drug use or other drug-related activities in such a way as to allow social obligations to be met, attend to nutritional and sleep requirements.
Withdrawal	Withdrawal complications such as seizures and hallucinations, discomfort arising from withdrawal.	Use withdrawal interventions to alleviate withdrawal severity and prevent complications, plan withdrawal.

Adapted from Linzteris & Spry-Bailey, 1998

Reducing harms

Details of general harm reduction principles and practices are outlined in the fourth volume of the Turning Point Clinical Treatment Guidelines series: Clinical Treatment Guidelines for Alcohol and Drug Clinicians: Reducing harm for clients who continue to use drugs (Addy & Ritter, 2000b).

It is important to remember that the perception of what is considered potentially harmful behaviour is subjective (Addy & Ritter, 2000b). The client may not share the clinician's ideas about what is considered potentially harmful. It is therefore important for the clinician to find the balance between offering information and education regarding methamphetamine related harm, whilst also working with the client's identified goals.

Clinicians are encouraged to develop a harm reduction plan with the client and monitor progress regularly. An example of a plan for reducing methamphetamine related harm is outlined in *Work sheet 7: Harm reduction goals*.

There are three main methods outlined here to address harms and risks among methamphetamine users: advice and feedback, brief motivational enhancement and brief CBT to address transition to injecting.

Advice and feedback

Methamphetamine users are relatively naïve about the risks and harms associated with methamphetamine use. Assessing harms can be used as a basis for addressing any specific gaps in knowledge by providing further information and advice. Users should be given advice about potential risks using factual but not sensationalised information. Feedback from formal assessment, such as risk of dependence, may help the user understand the potential consequences of use. Table 5 on page 28 outlines examples of harms and associated interventions.

Motivational approaches

Strategies for reducing the harms associated with methamphetamine use include limiting use to specified amounts or times of day, or using only on specific occasions (e.g. at a party, on weekends). If a client is not ready to stop using methamphetamine altogether, discussing ways of reducing potential harms is appropriate. Brief motivational interviewing may be helpful in assisting the user to make changes to their behaviour to reduce harms. Motivational interviewing should be directed at the risk behaviour. Potential strategies for single session motivational interviewing can be found in the following sections. *Work sheet 9: Harm reduction review* may assist in weighing up the harmful consequences of drug use.

Transition to injecting

There is a high risk of transition to injecting among this group, but there is limited work in this area to guide interventions. CBT techniques of identifying and managing unhelpful thought patterns which address beliefs about injecting have been shown to be helpful. These general strategies are outlined in detail in the following sections and are not repeated here. These strategies should focus on beliefs, such as injecting is a clean method of using and that it comes with few risks, and be tailored to the client's own perceptions about routes of administration.

Other strategies may focus on providing advice to those who do inject to encourage them not to pass on information or to glamourise injecting to non-injectors. This may be particularly important for partners where both use methamphetamines but only one partner injects.

Brief intervention

This section has been adapted with permission from the only brief intervention specifically developed and evaluated for methamphetamine users (Baker et al., 2003; Baker et al. 2004). The intervention is based on motivational interviewing and cognitive behaviour therapy. Results of the trial of this intervention (Baker et al., 2004) suggested that two or four sessions are effective in increasing abstinence among regular methamphetamine users.

The 4-session intervention should be offered with stepped care principles in mind. The treatment manual for this intervention may be downloaded from www.health.gov.au.

Session 1: Motivational interviewing

Step 1: Building motivation to change

There are a number of strategies that may be used to build motivation to change that have been developed around the motivational interviewing (MI) process. Details of motivational interviewing approaches are outlined in Baker et al. (2004), Rollnick and Miller (2005) and Addy and Ritter (2000).

Strategies for precontemplators

- Present the rationale for treatment, emphasising that change is in the client's hands.
- Personal feedback from assessment, checking with the client whether they feel this is an accurate reflection.

Strategies for contemplators

- Impact on lifestyle.
- Pros and cons of using.

Strategies for preparation, action and maintenance stage

- Explore concerns about the cons, negatives or less good things about using.
- Explore health risks.
- Explore financial costs of using.
- Looking back/looking forward, describing what life was like before using and what the future looks like in terms of using.
- Self vs user, creating discrepancy between qualities as a father/husband/wife/son/sister etc. and qualities as an methamphetamine user.

Step 2: Strengthening commitment

The next step in MI is to draw together all the motivational elements touched on in the first step. This is best undertaken in the preparation stage of change. Ambivalence may still be present and a return to earlier strategies may be required. This is achieved by:

- Setting up the conditions that allow the client to state the need for change (eg 'where do we go from here?').
- Communicating free choice about goals and strategies.

- Exploring and addressing fears about change.
- Assisting the client in setting some realistic goals for change.

Step 3: Self monitoring

Self monitoring is important to assist the client in becoming aware of their behaviours, thoughts and feelings and to identify patterns of use, high risk situations and triggers for using. There are a number of ways and means for self monitoring. It is recommended for this brief intervention that monitoring of urges and cravings is most useful. Use *Work sheet 10: Monitoring craving* here.

Step 4: Assessment

As cognitive behaviour therapy (CBT) is a collaborative therapy with a focus on self help, it is important to spend some time reflecting on the client's assessment in private or with a supervisor if required, but it is also essential to share the information with the client to ensure ongoing commitment to change. Explain that the assessment provides the basis for a mutually agreed treatment plan. The client should be given the opportunity to comment on and modify the treatment goals. The goals should be checked, and updated if required in each session.

Session 1 Homework

- Practice monitoring craving using *Work sheet 10: Monitoring cravings*

Session 2: Coping with cravings and lapses

Step 1: Information about cravings

- Go through *Work sheet 10: Monitoring cravings* completed during the week. If it is not completed, complete it retrospectively at the beginning of the session. *Use Work sheet 13: My cravings* to help the client describe what their experience of craving is like. Remind the client that cravings are a normal part of withdrawal from methamphetamine, are expected and can be managed. Emphasise that coping strategies need to address each of these elements of craving.
- Go through *Work sheet 11: Facts about cravings* with the client. The important point to emphasise is that craving is a normal part of using methamphetamine, that cravings will eventually go away if not reinforced by using.

Step 2: Strategies to cope with cravings

- Use *Work sheet 12: Strategies to cope with cravings* to discuss how to cope with cravings using the 3Ds, positive self talk and relaxation and imagery techniques.
- Use *Work sheet 14: Cravings plan* to discuss how the client will put the strategies from *Work sheet 12: Strategies to cope with cravings* into practice during high risk situations.

Step 3: Dealing with a lapse

- Explain the 'breaking the rule' effect to the client. The 'breaking the rule effect' can happen if a client breaks their own rules (e.g. I won't use), has a slip and then thinks, 'Oh stuff it, I've used now, I might as well keep using".

- Help the client understand the thinking errors in the 'breaking the rule effect' and work out more helpful ways of thinking in those situations. Use *Work sheet 15: Breaking the rule effect* to identify typical rule breaking effects and more helpful ways of thinking.

Session 2 Homework

- Continue monitoring cravings.
- Implement craving plan and use strategies.

Session 3: Controlling thoughts about using

Step 1: Identifying unhelpful thinking

- Describe the CBT model to the client using *Work sheet 16: Thinking-feeling-doing cycle*. Use a general example that is easy to understand and then use an example from the client. Assist them by using the information in the assessment as a prompt if they have difficulty.
- Use *Work sheet 17: Identifying unhelpful thought patterns* to help explain how to become more aware of unhelpful thoughts. This work sheet labels styles of unhelpful thinking to make it easier to identify unhelpful thoughts.
- Explain how to use *Work sheet 18: Self monitoring* as a way to identify unhelpful thoughts.

Step 2: Challenging unhelpful thinking

- Use *Work sheet 19: Analysing unhelpful thoughts* to help the client think through alternatives to the unhelpful thoughts. The focus is on reflecting on the thought that has been identified, understanding the pitfalls of thinking that way, and generating alternative thoughts.

Step 3: Seemingly irrelevant decisions (SIDs)

- Use *Work sheet 20: Seemingly irrelevant decisions* to practice identifying SIDs. Further information about SIDs is in Session 5 in the Longer Intervention section.

Step 4: Pleasant activities

- Methamphetamine use is often associated with depression or anxiety. In addition, longer term methamphetamine users have often neglected other activities in favour of accessing, using or recovering from methamphetamine. Planning pleasant activities can assist in relieving boredom during withdrawal, ease some symptoms of anxiety and depression and help the user to find regular activities that are enjoyable without methamphetamine. Explain these ideas to the client and emphasise the importance of formally structuring these activities.
- Use *Work sheet 21: Pleasant activities* to assist the client to identify activities that they find enjoyable and that they can feasibly implement regularly.
- Use *Work sheet 22: Activity record* to help the client schedule pleasant activities.
- Emphasise that it is impossible to plan every minute of every day in advance and there will be unpredictable times. It is important to try to maintain pleasant activities, but not to feel

guilty if activities are sometimes not possible. The plan should be reviewed by the client regularly to make sure the activities are still motivating.

Session 3 Homework

- Self monitoring using *Work sheet 18: Self monitoring.*
- Practice identifying seemingly irrelevant decisions as they occur using *Work sheet 20: Seemingly irrelevant decisions.*
- Implement activity scheduling using *Work sheet 22: Activity record.*

Session 4: Relapse prevention

Step 1: Methamphetamine refusal skills

- Use *Work sheet 23: Refusal skills* to help the client identify high risk people and how they might respond effectively to not using.
- It is important to practice these skills during the session using role play. The client might find it helpful to play the 'high risk' person first, while the clinician models the refusal skills. Go through what they might say before the practice, then ask them how it felt. Identify any areas of uncertainty and practice these during the session.

Step 2: Relapse prevention

- Use *Work sheet 24: Relapse prevention plan* to identify early warning signs of relapse. These can be based on an analysis of previous relapses.
- Use the same work sheet to help the client identify situations that are high risk for relapse.
- Help the client to think about the coping skills they have acquired and how they would use them to prevent relapse.
- Ask the client to identify a set of rewards for not using, especially in high risk situations.
- Remind the client that not all situations can be anticipated in advance and on the same work sheet, help them to identify some general coping skills that they can quickly put into action in an emergency. These will be the skills they are best at and that are most effective for them.
- Identify with the client any additional skills required to help prevent relapse and offer suggestions about how to acquire these.
- To consolidate the use of the plan, discuss with the client when to use the plan and how to monitor early warning signs.

Step 3: Termination

- Reconfirm commitment to change from Session 1 by revisiting motivational factors and eliciting self-motivational statements.
- Summarise and affirm commitments and changes so far.

- Explore other potential areas of change that may have been identified during treatment and offer and discuss suggestions about addressing these.
- Deal with any specific requirements, such a referral.

Session 4 Homework

- Encourage the client to continue monitoring cravings and thoughts as required, either using the work sheets or, as they get more practice, in their head.
- Encourage the client to return for booster sessions if required.
- Make an appointment for follow-up, by telephone if not in person.

Longer intervention

CBT interventions are most likely to guard against relapse and are considered best practice in the area. The intervention outlined below has been adapted from Carroll (1998) and Monti et al. (1989). Where sessions are similar to the brief intervention outlined in the previous section, they are not repeated in detail here.

Session 1: Introduction to treatment and CBT

Step 1: Enhance motivation to change

Use material from Brief Interventions Session 1, Step 1 to build motivation to change.

There are a number of strategies that may be used to build motivation to change that have been developed around the Motivational Interviewing (MI) process.

Strategies for precontemplators

- Present the rationale for treatment, emphasising that change is in the client's hands.
- Personal feedback from assessment, checking with the client whether they feel this is an accurate reflection.

Strategies for contemplators

- Impact on lifestyle.
- Pros and cons of using.

Strategies for preparation, action and maintenance stage

- Explore concerns about the cons, negatives or less good things about using.
- Explore health risks.
- Explore financial costs of using.
- Looking back/looking forward, describing what life was like before using and what the future looks like in terms of using.
- Self vs user, creating discrepancy between qualities as a father/husband/wife/son/sister etc. and qualities as an methamphetamine user.

Step 2: Negotiate treatment goals

Motivational enhancement exercises such as the decisional balance and looking back/looking forward can be used to prompt clients to nominate treatment goals, such as controlled use or abstinence. Care should be exercised to match the goals to the client's level of preparedness for change to maximise opportunities for success. Clinicians may find that achievements in early goals such as monitoring and cutting down may lead to increased motivation to change.

Appropriate goals for precontemplation and contemplation may include behaviours to minimise risks or harms associated with substance use, to monitor or record substance use, or to engage in other protective behaviours.

Clients in preparation and action may need practical assistance with approaching goals in manageable steps. Clinicians may model problem-solving strategies to assist clients with working

through practical issues with goal selection and attainment. Continued use of motivational interviewing strategies, particularly supporting self-efficacy are important to maintain commitment. Goal monitoring should be encouraged to assist clients to recognise successes and setbacks.

Step 3: Explain the CBT model

Clinicians should outline the CBT model as the framework for the intervention, explaining the core components of how learned behaviours are rewarded and strengthened, the relationship between thoughts, feelings and behaviours, and the skill-building approach of CBT. Clients are advised that treatment will proceed from an assessment – a description of the client's patterns of substance use and general functioning which leads to practical interventions to manage moods and behaviours.

Step 4: Establish treatment ground rules

In addition to the model of therapy and the client's specific goals, it is important to also communicate clear expectations around the structure of treatment sessions, client and clinician responsibilities. As CBT sessions tend towards a planned format and set structure it is important to establish shared understandings around the following topics:

- Scheduling of appointments and the duration of treatment.
- Boundaries for attendance, cancellation or rescheduling.
- The need for clients to attend sessions without having used alcohol or other substances.
- Requirements for homework and out of session rehearsal.
- Confidentiality and the limitations of the therapeutic relationship.

Step 5: Introduce functional analysis

Functional analysis involves a careful review of the circumstances of substance use within the CBT model, as well as exploring the skills and resources the client can bring to bear in managing the behaviour. Functional analysis assesses the client's thoughts and feelings in circumstances where substance use behaviour is likely. It can be used to plan strategies for high-risk situations, and monitor the effectiveness of continuing behaviour change.

'Lets put together our model of your substance use by working through an example of the last time you used. It is sometimes helpful if we imagine working though the whole process from before you used – where you were, who you were with, what you were thinking and feeling, and when the idea to use first occurred to you. Next we can look at what was happening whilst you were using, what steps did you need to go through to use, what was the experience like at the beginning, and later on? What effects did using have on your thinking, emotions and behaviour? Were there any positive or negative outcomes of your use on this occasion?'

Use *Work sheet 25: Functional analysis* as a tool to assist with functional analysis of substance use behaviour, its antecedents and consequences.

Session 2: Coping with cravings

Cravings and urges to use are frequently cited as one of the most difficult problems for clients attempting to modify or cease methamphetamine use. Intense cravings can persist for weeks and months following cessation of use. A lack of understanding of cravings, their triggers and strategies to manage them is a major factor in relapse. This session seeks to provide clients with a comprehensive understanding of the reasons for cravings, how to normalise the experience as 'time-limited', identify cues and triggers for cravings, and develop skills to manage cravings where they occur.

Step 1: Understanding cravings

Normalising craving as a typical feature of methamphetamine use is crucial in equipping clients to manage their experiences effectively. Depending on the client's pattern of use, a variety of situational, psychosocial and internalised conditions may have been powerfully associated with methamphetamine use via mechanisms of conditioning and reinforcement. Situational triggers may include certain locations, travel routes, and venues. Psychosocial triggers may include interpersonal cues such as certain individuals or groups of people associated with use, as well as time markers such as weekends, holidays and paydays. Internalised cues may include certain patterns of thinking, and certain affective states, such as depression or anxiety, as well as positive mood states.

Clinicians should seek to convey an understanding of mechanisms of conditioning and reinforcement via psychoeducation, using examples of classical conditions such as 'Pavlov's Dog' (how animals and humans can be trained to respond in a certain way to a particular stimulus) to clarify and demystify the experience. Encouraging clients to tolerate conditioned cravings is also facilitated by stressing the time-limited nature of cravings. For most people, cravings peak and dissipate within an hour. Without further methamphetamine use, the mechanism of extinction will lead to the weakening of the conditioned craving response over time.

Step 2: Describing cravings

It is crucial to establish the client's own experience of cravings directly, either via retrospective work (describing the last incidence of craving), or via prospective measures (having a client describe or record a craving experience whilst it is happening. Both methods have advantages and disadvantages, with the prospective measures usually eliciting more information.

The following assessment areas will elicit comprehensive information about a client's experience of cravings.

- What is a craving like for you?

Cravings may be experienced in a variety of ways including cognitive experiences "I've gotta have some right now or else…", emotional experiences such as heightened anxiety or boredom, somatic experiences such as muscle tension, racing heart, and sensory experiences like smelling or tasting the substance. Identifying the early stages of cravings can be particularly helpful for initiating immediate management strategies.

- How intense are your cravings?
- How much do they bother you?
- How long do they last?

Clients experience cravings along a continuum, with considerable variability in intensity. Some clients find it difficult to identify overt craving experiences, and may in fact be misinterpreting other experiences or ignoring cravings until they "suddenly use". Identifying and monitoring these experiences is a major step towards experiencing more control over substance use.

Other clients may experience powerful cravings which can lead to feelings of powerlessness and lack of control, despite the fact that these cravings eventually pass. Exploring examples of where cravings were not acted upon is a more effective measure of craving length than where substance use was the outcome of a craving.

- How do you cope with cravings?

Exploring coping strategies may help the clinician identify a general coping style (e.g. avoidance), and assist with a selection of appropriate coping strategies. Existing techniques for coping may need elaboration or refinement, or may in fact be unhealthy (such as the use of other substances) and need replacement.

Step 3: Identifying triggers

Identification of cravings, particularly using functional analysis, should provide clinicians and clients with a list of triggers associated with substance use. Triggers may be many and varied, and can be prioritised on the basis of frequency of occurrence, or the level of association with use. Dealing with the most salient and risky triggers first may be indicated, although for clients with low self-efficacy, managing the 'easiest' triggers first may lead to greater engagement with treatment. Clients are encouraged to self-monitor triggers and high risk situations as an ongoing part of their work, meaning they may identify many more subtle triggers as they arise.

Step 4: Avoiding cues

Avoidance of triggers and cues to use is an important early skill in managing substance use behaviour. Clients are encouraged to "recognise, avoid and cope", with the clinician assisting in deciding to what extent cues may be avoided. Some avoidance goals are relatively non-problematic, such as:

- Reducing contact with substance using peers.
- Minimising travel to areas where the substance is readily available.
- Getting rid of substance use paraphernalia such as pipes, syringes, etc.
- Limiting other substance use.
- Staying away from traditional places where the substance is used.
- Limiting the money available at high risk times and places.

Generalising avoidance as a coping strategy is not without risks however, and care should be taken to emphasise that avoiding all social contact and activity is counter-productive. A problem solving approach to working around cues is helpful, particularly if the clinician and client collaboratively 'reality test' the workability of each strategy.

Step 5: Coping with cravings

The majority of craving management strategies involve some combination of the following techniques:

Distraction

- Activities which draw attention away from the experience of craving and refocus onto practical, engaging, enjoyable and rewarding behaviour.
- Clients may require support to prepare a list of realistic, achievable, alternative behaviours – what is easy to initiate or likely to be chosen as an alternative behaviour.
- Physical activity is more distracting than sedentary activity.
- Choose behaviours which are pleasant, relaxing or otherwise engaging (a warm bath is better than doing chores!)
- Use *Work sheet 21: Pleasant activities* to record and schedule these activities.

Talking through the experience with someone trustworthy

- Sharing craving experiences can be a powerful strategy for blocking using behaviour once a craving has commenced.
- Discussing experiences with a supportive, non-substance using friend or family member can alleviate feelings of anxiety and vulnerability.
- Clinicians may need to assist clients in choosing which friends and family members are appropriate supports – who will be able to understand and be supportive around craving cognitions. For clients with few social supports clinicians might assist with finding appropriate support agencies, telephone counselling and/or peer support groups.

Urge surfing – going through the experience of craving without 'fighting' the experience

- Imagery such as allowing a wave to pass over may assist with clients accepting craving experiences.
- Focusing attention on the attendant feelings and sensations and recording the intensity of cravings before and after the peak may assist with giving clients a sense of control over their experience.
- Use *Work sheet 10: Monitoring cravings* to record these experiences.

Recalling the negative consequences of acting on the craving and using

- Many clients use cognitive distortions in thinking about their substance use which tend to bias their beliefs about the substance towards positive attributions, and diminish the negative attributions. Encouraging clients to remember the advantages of their substance use goals, and the disadvantages of returning to previous patterns of use can help to counter these cognitive distortions and maintain motivation for change.
- To reduce cognitive demands of recalling emotionally incongruent material during cravings, recording these advantages of change / disadvantages of using beliefs on an easily accessible format (like blank business cards stored in the wallet) makes using this strategy easier.

Using positive self-talk to increase the salience of goals and desired outcomes

- Many clients use highly emotive, mustatory or absolute automatic thoughts in relation to cravings (i.e. I must use now or I'll die). For some clients, these black-and-white thoughts are so ingrained they are difficult to recognise.
- Positive self-talk can be used to manage unhelpful automatic thoughts usually associated with craving or using.
- Assist your client to identify automatic thoughts by using a 'verbal videotape" technique, or by using functional analysis exercises.
- Help the client construct useable self-talk phrases which 'decatastrophise' the automatic thought (e.g. I am not going to die if I do not use today), normalise the experience of craving (e.g. I've had these cravings before and I've gotten through them before), and bolster positive expectancies (e.g. The more I learn to cope with these feelings without using, the less intense they will become).

Rewarding self with alternative positive experiences

- Similar to the 'distraction' techniques, but used in a more planned and proactive manner, positive experiences can be 'timetabled' to either represent rewards for periods of non-use, or to bolster the client in known periods of high relapse risk.
- Activities which are highly valued, relaxing, or represent a personally effective self-care behaviour, without risking substitution behaviour can be brainstormed and a schedule or list prepared for the client to choose from.

Whilst these strategies can diminish the intensity and frequency of cravings over time, as well as reduce the associated frustration, it is important to note that they will not stop craving experiences entirely. Encouraging tolerance of non-optimal emotional conditions is an important part of shifting expectations away from substance-use congruent beliefs such as "I shouldn't ever feel unpleasant emotions".

Session 3: Encouraging motivation and commitment to change

This session seeks to maintain the client's motivation for change, and to model skills and strategies for managing ambivalence about change. Motivational assessment should be an ongoing part of assessment and treatment of clients with methamphetamine use problems. Using a visual scale to measure motivation (such as a ladder) can be useful in demonstrating change over time to a client, as well as normalising ambivalence and change in motivation. Assuming that motivation is fixed may lead to clinicians choosing ineffective strategies in treatment, which results in increased resistance to change and disengagement from treatment for the client.

Step 1: Clarify goals

Revisiting goals at the commencement of every session to check whether the client still sees them as positive and achievable should be part of every well-structured session. Clarification of goals is used to maintain good collaborative engagement and strengthen commitment, as well as to restructure a treatment approach where clients goals have shifted. It may be that clients

experiencing early successes will choose to extend their goals (e.g. to move towards abstinence, or to include other substances in their treatment goals). Conversely, clients experiencing fewer problems as a result of abstinence use may wish to return to previous patterns. A non-confrontational approach to draw upon the client's intrinsic values and beliefs is recommended, particularly where motivation to change is low or externally motivated. Supporting self-efficacy and rolling with resistance are useful motivational interviewing techniques to use here. Skillful empathic listening and summarising can be helpful in clarifying the range of physical, emotional and social factors of substance use and their relative impact on the client's level of functioning.

Step 2: Address ambivalence about meeting goals

The process of revisiting goals may identify changes in motivation, ongoing unhelpful beliefs about substance use, or other ambivalence-creating emotional or cognitive states. The decisional balance exercise is a useful tool for revisiting underlying motivation to change and eliciting further potential barriers to successful behaviour change. Re-visiting the pros and cons of making changes to substance use as well as eliciting the pros and cons of maintaining the status quo can clarify further barriers to change, as well as potentially helpful beliefs. Open ended questions are helpful to allow clients to advocate for each positive and negative aspect of their substance use. Clinicians may be tempted to pay less attention to the positive aspects of substance use in order to 'weight' the negatives during a session, although this can potentially damage engagement if the client feels 'led' towards a goal. Furthermore, eliciting the positive aspects of substance use is generally helpful in identifying which positives are based on distorted cognitions (i.e. methamphetamine makes my problems go away), as well as identifying needs which may be met via non-using means (I just like to feel a bit of excitement in my life). Use *Work sheet 26: Decisional balance exercise* to address ambivalence about change.

Step 3: Identifying and coping with thoughts about methamphetamine

Thoughts and beliefs which lead individuals to return to methamphetamine use are idiosyncratic, and based on individual experiences of use, cognitive style, defence mechanisms and even previous treatment experiences. Clinicians can assist clients to identify their own pro-using thoughts, and particularly to identify where cognitive distortions are potentially biasing their decisions to use. The concept of an 'automatic thought' is a crucial one to impart successfully to clients, particularly if they are not intrinsically aware of their own pro-using cognitive processes.

Common automatic thoughts associated with relapse can include the following examples:

- Diminished pleasure: "My life will be so boring without the highs of using crystal meth".
- Identification with self: "Using crystal meth is who I am".
- Testing control: "I can visit the same places and people without using because I am in treatment".
- Abstinence violation: "I've used once since starting treatment, so it's not going to work and I might as well keep using".
- Escape: "This is too hard, I just need a few days off to relax".
- Entitlement: "I deserve a reward, I've been good for a week".

Thought challenging

In many cases, these cognitions represent beliefs that the client can recognise as flawed thinking. The client may, however require assistance with formulating responses which identify the distortion and challenge the belief, ideally reframing the underlying need at the same time.

For example, the diminished pleasure example may be countered with the thought "While using crystal meth has given me some intense experiences, it has prevented me from experiencing a lot of life's real highs". This response highlights the bias and counters the belief, whilst at the same time pointing to positive outcomes of not using. Similarly, the entitlement example may be countered with "I do deserve a reward, however, crystal meth makes me anxious, so I would be better off buying that new pair of jeans I want".

Strategies to help clients stay motivated include those listed for Session 2: Coping with cravings:

- Distraction.
- Talking the craving though with someone supportive.
- Urge surfing.
- Remembering the negative aspects of use.
- Using positive self-talk to increase the salience of goals.
- Rewarding self for not using.

Session 4: Refusal skills and assertiveness

Availability of methamphetamine is a major factor in relapse. Many clients internalise their experience of use and do not pay sufficient attention to the interpersonal factors in making decisions to use or not to use. Discussing modifications to social networks, patterns of interaction with methamphetamine using peers and visits to methamphetamine associated places can often elicit considerable latent resistance to change. Many users play down the importance of distancing themselves from methamphetamine using peers and dealers is unnecessary until they experience a relapse upon being offered substances. This may represent ambivalence about change "finally closing that door", or fear of being exposed as a failure if peers discover that the client has failed to achieve a goal. Clients often report that their 'avoidance' techniques are not able to manage direct peer pressure or the temptation of being directly offered drugs. This session seeks to clarify the availability of methamphetamine and the extent of methamphetamine using peer networks, and assist clients with developing skills to assertively manage future offers.

Step 1: Assess methamphetamine availability

Assessing the current availability of methamphetamine, as well as the availability of other substances allows the clinician and client to map risks and formulate strategies to avoid acquiring the substance. Of particular concern are clients who are engaged in production, dealing or distribution of methamphetamine, as these links are often of financial worth to the client, and making the decision to cease these activities may be bound up with other issues of financial

need, role identity and social status beyond those of the user. A map of contacts for acquiring methamphetamine is a good place to start, including all relevant social and occupational networks. Clients may need to be reminded of the limitations of confidentiality, and encouraged to limit the recording of identities during this work. The following questions may be helpful in further eliciting sources of methamphetamine:

- If you were to use methamphetamine today how would you go about acquiring it?
- Do you have any stashes of methamphetamine, or using paraphernalia such as pipes or syringes at home?
- Let's work through the last few times you used methamphetamine without planning to. Have you considered what you might say or do so you won't have to use every time you see certain people or visit certain places?
- What else could you do to make it harder to get hold of methamphetamine?

Step 2: Handling suppliers

Following the assessment of sources of methamphetamine, clients are assisted in formulating strategies to extricate themselves from their using networks. In some cases where ongoing social contact is inevitable or unavoidable, clients can be coached in how to deliver clear and assertive refusals, or to communicate their intention to not use methamphetamine any more. Clinicians may need to stress the difficulty in refusing substance use where the substance is readily available, or the potential delay between deciding to use and administering the substance is brief. Clinicians may also need to explore covert planning and preparation processes (such as seemingly irrelevant decisions) in order to understand ambiguous behaviour which 'ends up in methamphetamine use'. Avoidance of certain people, venues and places may be the only practicable solution to manage certain patterns of behaviour.

Intimate relationships also constitute a particular type of risk factor for relapse. Changes in substance use may be avoided due to real or imagined consequences for the relationship. Patterns of substance use in intimate relationships may be more entrenched, or more difficult to fully map due to the complex interactions between individuals, their levels of motivation, and shared cognitive distortions. There may be limits to the ability that relationship mediated beliefs and expectations can be modified within time limited treatment, however, clinicians may be of assistance in encouraging clients to recognise the processes which underpin shared substance use, and apply the learnings of their individual therapy to their components of the relationship. For example, a client's beliefs about using within a relationship may be characterised by black and white thinking (e.g. If my partner John uses, I will always use as well), although this belief may be far more amenable to modification than the partner's behaviour. Clients with heavily enmeshed relationships, poor boundaries, or a fragile sense of self may experience more significant challenges in managing substance use in relationships.

Encouraging and role playing the use of rational, assertive problem solving skills when negotiating methamphetamine use with an intimate partner may encourage a more powerful voice in managing other potential use situations with friends.

Step 3: Methamphetamine refusal skills

Methamphetamine refusal skills involve the unambiguous communication of intention not to use to another person in such a way that it reduces the likelihood of future offers without causing unnecessary stress or embarrassment.

Key behaviours involve:

- Responding to the offer as quickly as possible, without hesitation or giving the impression that the offer is being weighed up.
- Communicating the refusal with appropriate, assertive body language – maintaining eye contact, facing the person squarely, maintaining confident posture.
- Making the refusal stick – communicating that future offers are not going to be accepted either.
- Avoiding discussing reasons or justifications as these can lead to embarrassment, or leaving the door open for these reasons to be devalued by the person offering the substance (e.g. mental health – you don't have to worry about this batch making you go crazy, it's top notch stuff).

Role play and rehearsal is crucial to embedding strong methamphetamine refusal skills. Role plays can often generate some resistance as they can seem artificial or contrived, and they also place the client on the spot to 'behave perfectly' and demonstrate the strategies without having had an opportunity to rehearse them. Clinicians can demystify what is expected and model good refusal skills by playing the "client role" first, and asking the client to play the person offering methamphetamine.

Grounding role play exercises in a real or realistic situation, where the relationships are well understood assists clients with the unfamiliarity of acting a part. Once the skill has been demonstrated the roles can be reversed, with the client rehearsing the refusal skill. Clinicians may anticipate the way in which cajoling to use can become more sophisticated and gently probe for how client's may manage more complex situations. Handling enquiries into physical and mental health, managing negative appraisals of drug treatment, and refusing offers of methamphetamine on credit are examples of more complex refusal paradigms.

It may be helpful for some clients to explore communication deficits identified as a result of role-play exercises. Clients often have difficulty demonstrating 'assertive' communication behaviour in relation to difficult issues of behaviour change, with feelings of frustration and ambivalence leading to overly aggressive or passive communication styles. Reviewing and rehearsing assertive behaviour in a separate session may be required, or alternatively clients may be referred to adjunct treatment supporting development of good communication skills. It can be helpful to begin rehearsals of assertive behaviour around less frustrating situations (such as alcohol or cannabis refusal) before transferring the skill onto methamphetamine refusal.

Session 5: Seemingly irrelevant decisions

Working with seemingly irrelevant decisions emphasises the cognitive aspects of treatment. Those who benefit most from this process tend to possess intact cognitive functions and some ability to reflect upon their cognitive and emotional lives. This session is also particularly helpful to individuals who have trouble thinking through their behaviour and its consequences, such as those with residual attention deficit/hyperactivity disorder, antisocial traits or difficulty with impulse control. For such individuals, the material in this session (as well as the session on problem solving) often takes some time to be understood and assimilated, but it is usually valued highly.

Step 1: Introduce the idea of 'seemingly irrelevant decisions'

Explain to the client that they will inevitably encounter high-risk situations for both methamphetamine use. Many of these will be out of their control and will need to be managed with the skills they have developed. However, there are certain decisions that are under the full control of the client, but that are sometimes made unconsciously and may move them closer to a situation in which relapse is inevitable. These decisions are called 'seemingly irrelevant decisions'. Seemingly irrelevant decisions are those decisions, rationalisations, and minimisations of risk that move the client closer to or even into high-risk situations, although they may seem unrelated to using at the time.

Step 2: Provide examples of seemingly irrelevant decision

The critical task is to teach the client how to recognise and interrupt seemingly irrelevant decision chains before the onset of methamphetamine use. While it is possible to interrupt such a chain at any point prior to use or onset of symptoms, it is more difficult toward the end of the chain when they may already be in situations where use is inevitable. It is, therefore, important to detect the decisions that commonly occur toward the beginning of the chain where risk of relapse is lower.

Some examples of seemingly irrelevant decisions for depression and anxiety include:

- Using other drugs.
- Keeping other drugs in the house.
- Not destroying using equipment.
- Going to parties where methamphetamine might be available.
- Interacting with people who use methamphetamine.
- Not telling drug using friends and associates of the decision to stop.
- Not planning to fill free time.
- Having a lot of unscheduled time on nights or weekends that can lead to boredom.
- Getting overtired or stressed.

Step 3: Assist the client to identify personal examples

Look at a previous relapse in the client's past and go through the events leading up to the relapse. Assist the client to identify any seemingly irrelevant decisions they made that may have contributed to the relapse. These decisions are usually very obvious in hindsight but, at the time, the client genuinely did not notice making them. It is important to make sure the client understands that you do not believe they made these decisions deliberately.

Step 4: Practice safe decision making

Stress the notion of safe decision-making with the client. Say something like:

'Getting yourself into the practice of recognising all the small decisions you make every day, and thinking through safe versus risky consequences for those decisions, will make you less vulnerable to high-risk situations.'

In the session, practice identifying seemingly irrelevant decisions and making safe decisions with the client using *Work sheet 27: Practice safe decision making*. Then ask the client to self-monitor decisions over the course of several days and, for each one, identify safe versus risky decisions using the work sheet.

Session 6: An all purpose coping plan

Step 1: Anticipate high risk situations

Assist the client in identifying potential situations that they may encounter in the future that might lead to a lapse. Develop concrete coping plans for each of these situations. Also develop a plan for what to do when an unexpected high risk situation that has not been discussed or rehearsed arises.

Step 2: Develop a coping plan

Use *Work sheet 28: All purpose coping plan*. A coping plan might include:

- A list of emergency numbers.
- A reminder of negative consequences of using (e.g. on a card that the client can keep in their wallet and read when needed).
- A set of positive thoughts that will assist in maintaining gains (e.g. on a card).
- A set of reliable distracters, at least some of which need to be immediately accessible.
- A list of safe places to 'ride out' a crisis.

Session 7: Problem solving

Step 1: Introduce the basic steps

1. Recognise the problem.
2. Identify and specify the problem.
3. Consider various approaches to solving the problem.
4. Select the most promising approach.
5. Assess the effectiveness of the approach.
6. If ineffective, select another approach and assess.

Step 2: Practice problem solving skills

Use *Work sheet 29: Problem solving*. Ask clients to identify two recent problems, one that is closely related to amphetamine use and one less related and work through the problem solving steps for each. It may be necessary to get the client to slow down as there is often a tendency to jump straight to the solution rather than first carefully identifying the problem.

Session 8: Case management

This section is designed to address the range of other problems that are often associated with methamphetamine use. Many of these need to be addressed before therapy starts, such as crises of housing, domestic violence and psychosis, while others are best left until amphetamine use is better managed and the client is stable. These include a range of psychosocial issues that may be supporting use and may be high-risk areas for change.

Step 1: Problem identification

Identify problems that are barriers to treatment success. This information will have been gathered during initial assessment and throughout treatment. Use skills gained in the previous problem solving session.

Step 2: Goal setting

Together set some goals, prioritising three or four main problems areas to focus on during ongoing treatment. Review the basic steps of problem solving here.

Step 3: Resource identification

With goals clarified, brainstorm solutions and resources needed to address each of the target problems areas.

Step 4: Specifying a plan

Once problems have been identified and goals set, begin working on a support plan. Use *Work sheet 30: Support plan* to assist this process. Monitor progress closely.

Session 9: Blood borne virus (BBV) risk reduction

Step 1: Assess risk

Use the BBV TRAQ (see www.turningpoint.org.au/library/bbv_traq_sv_0606.pdf) or a similar instrument to assess BBV risk and history. Techniques from brief motivational interviewing (feedback from assessment) are helpful here.

Step 2: Build motivation to change

From Carroll (1998):

- Affirm the client ("I think its great that you're willing to be honest with yourself and take the time to look at your level of risk").

- Reframe ("You're concerned about your level of risk, but you can't see yourself being celibate either").
- Roll with resistance ("You're jumping ahead a bit here. Right now, we're just getting a sense of where you are regarding drug injection practices and unsafe sex behaviours. Later on, we can talk about what, if anything, you want to do about it").
- Explore consequences of action and inaction.
- Communicate free choice.
- Elicit self-motivational statements ("What do you want to do about this?" or "Tell me why you think you might need to make a change?").

Step 3: Set goals

Once the client is ready, assist them in setting concrete risk reduction goals to change risky behaviour. Also assist the client to identify any potential barriers to reaching these goals.

Step 4: Problem solve barriers

Review problem solving strategies gained in the previous session. Practice solutions to any barriers (e.g. sex refusal skills).

Session 10: Significant other session

This session is an opportunity to offer significant others the opportunity to learn about the treatment in which the client is involved and to explore strategies through which they can help the client to maintain and enhance changes. It is primarily designed for significant others who are not current substance users themselves and who can provide non-drug using support to the client.

Step 1: Provide information and set goals

This is to reinforce the purpose of the session. Limit unhelpful expressions of anger, especially if it involves dredging up past indiscretions or bad behaviour. The significant others may require some personal counseling if they are having difficulty supporting the client because reminders of past behaviours interfere with their ability to support the client. This session is not the place to explore their concerns in detail and a referral to an independent counsellor should be offered.

Step 2: Identify strategies

It is often helpful to explain or reiterate the CBT model as a prelude for identifying strategies to support the client. Provide many opportunities for the client to identify ways in which their significant others can assist them, linking these suggestions back to the CBT model and changes that have been made.

There should also be opportunities for the significant others to make requests about behaviour change (e.g. helping around the house). These requests should be made clearly and specifically.

Develop a contract between the client and their significant others outlining the agreement between them of behaviour change for the client and strategies that have been agreed upon for the significant other to support the client.

Session 11: Termination session

Step 1: Review the treatment plan and goals

Identify areas in which the client's goals were met and progress was made, as well as areas where less progress was made and further attention may be warranted.

Step 2: Provide feedback on client's the progress

Particularly focus on the skills and principles that were mastered and those that the client might continue to focus on. Review any regular outcome measures to reinforce motivation to change. Emphasise that the client can return for booster sessions or in case of relapse if required.

Step 3: Ask the client to provide feedback

Focus on the most and least helpful aspects of treatment. Ask the client if they have any concerns about what will happen after they leave treatment. Some clients, particularly those who have not achieved stable drug use change, should be encouraged to continue in treatment in either a clinical program or inpatient or day-treatment facility, as appropriate.

Managing mental health symptoms

It is highly likely that clients presenting with methamphetamine-related problems will also be experiencing some mental health symptoms. Some may have a cluster of symptoms serious enough to meet criteria for a disorder, but those with lower level symptoms may also be experiencing significant distress. It is important to address these metal health symptoms to reduce the likelihood of relapse to methamphetamine use.

Treatment for clients with comorbid substance use and mental health problems should ideally be provided within an integrated model of treatment – where both conditions are being treated within the one service or treatment plan. This has been shown to be a more effective treatment option than either sequential treatment (treating one disorder and then the other) or parallel treatment (treating both disorders at the same time, but by separate services) (Dawe & McKetin, 2004).

Managing comorbid anxiety and depression using PsyCheck

There are few programs specifically designed for comorbid mental health and alcohol and other drug disorders. There are none to date that specifically address methamphetamine use and the most common mental health problems associated with it. However, PsyCheck is a screening and intervention tool (see page 23) that may be useful for this group. It was designed specifically for use by AOD clinicians and uses similar concepts to those outlined in the section of brief interventions and longer interventions, making it an easily integrated option. The sessions are brief and not designed to be used in isolation from drug and alcohol treatment. The techniques used are deliberately similar to those used in alcohol and other drug treatment to facilitate integration of the intervention and promote familiarity for the client.

Pre-session preparation: Assessment and treatment planning

Before the cognitive behavioural intervention begins, there are a number of things that the practitioner needs to do in preparation for implementing the intervention.

Step 1: Undertake screening and prepare feedback

After screening using the PsyCheck, take some time to score the screening measure(s) and prepare feedback for the client about the meaning of the scores.

Step 2: Undertake cognitive behavioural assessment

A cognitive behavioural assessment is different from a diagnostic assessment, which focuses on classifying symptoms against set criteria. The central principle of a cognitive behavioural assessment is the assumption that the way in which an individual behaves is determined by immediate situations and the individual's interpretations of these situations.

Step 3: Introduce the cognitive behavioural approach to the client

An initial part of the cognitive behavioural assessment involves setting the scene of the therapeutic relationship and the style of the treatment. An important focus of a cognitive behavioural intervention is that it emphasises the possibility of change, rather than dwelling on problems. All this needs to be communicated to the client from the first contact.

Step 4: Prepare a preliminary assessment

Assessment is an important way to link the information gathered from the screening phase to the treatment plan. It is more than a case summary or a summary of the presenting problems. It draws the elements of the case summary into a meaningful pattern. In a cognitive behavioural assessment, the practitioner develops a description of the client's target problem in terms of their core beliefs, thoughts (e.g. interpretations), feelings and behaviours. An assessment is then developed to hypothesise the target problem and will also examine the interrelationship between these factors. Put simply, the assessment will help the client understand how their problem(s) developed and what is maintaining the problem(s) now. It will also shed light on how their AOD use impacts their anxiety, depression or somatic symptoms, and vice versa.

Session 1: Presenting the assessment and beginning psychoeducation and self-monitoring

Step 1: Present assessment

Developing the assessment with the client and actively seeking their feedback encourages collaboration between the client and clinician. The clinician should present the assessment to the client and ask for their feedback, adjusting to incorporate their input as necessary. Educate the client about the nature of their problem in more general terms. Psychoeducation can empower and motivate clients and normalise their problems. Clients should be routinely offered self-help material relevant to their most pressing concerns, as well as contact numbers for emergency help lines and support groups that may be useful.

Step 2: Introducing the CBT model

It helps to explain the model to the client. CBT is an open and collaborative therapy. Explain the CBT model by starting with the simple concept that the way in which we interpret situations determines how we feel and behave. Use the assessment of the client's problem to demonstrate the full CBT model. This may include a hypothesis about why the client has a tendency to interpret situations (unhelpful thoughts) in the way that they do.

Step 3: Self monitoring

Breaking events down into situations, unhelpful thoughts, feelings and behaviours can take practice. It is important to ask the client to practice this skill in between sessions. By asking the client to 'self-monitor', they will begin to gain new awareness about their thoughts and feelings and how they lead to behaviours, including alcohol and other drug use. This new awareness will be the basis for adjusting the assessment and treatment plan if necessary. There are a number of work sheets that can be used to assist. It is vital to communicate the importance of this step to the client and explain clearly how to complete the activity.

Step 4: Develop a joint treatment plan with the client

To do this it is important to articulate the links between the assessment and the treatment. This helps increase commitment to treatment as well as giving the client a rationale. The treatment plan should follow naturally from the assessment. Make a joint treatment plan with the client that is appropriate for the person's mental health symptoms, level of commitment, skills and goals for treatment. The assessment and treatment plan should both be clearly recorded in the client notes.

Session 2: Identifying unhelpful thoughts

Step 1: Review previous week and set agenda

A review of what was covered in Session 1, briefly summarising the assessment and the cognitive model again is a good way to motivate the client. A review of homework is also important to ensure that the client is able to understand the activity that was given to them and to emphasise that it is an important part of treatment. If homework tasks have not been completed, it is important to investigate why. The client may have not understood the task or understood the importance of it, they may not be ready to engage in active therapy or their time management might need addressing.

Step 2: Provide information about unhelpful thoughts

At this point it is important to start interpreting and understanding the pattern of the client's thinking, modelling what will eventually be expected of the client.

Step 3: Practice identifying unhelpful thoughts

Return to *Work sheet 18: Self monitoring* that was completed by the client. Choose an example from the client's self-monitoring and ask the client to generate as many different explanations for this event as they can think of. Write all of these on the handout or on a white board. Many clients will have difficulty generating alternative ways to interpret the situation they were in. You may need to prompt or brainstorm alternatives with them. At this point it is useful to help them label their thoughts – black and white thinking, catastrophising etc – as this can help to make it easier to identify thoughts if they are easy to label. Once a client has identified the 'unhelpful thought patterns' that apply to them, it is important to learn ways to identify them in real life in between sessions.

Session 3: Altering unhelpful thoughts

Step 1: Review and feedback

Ask clients to talk you through their ideas on *Work sheet 18: Self monitoring*. Did they have any difficulties? If so, help them to troubleshoot by going through a few examples with them. If they used the form successfully, ask if the procedure had any impact on their feelings about the situation.

Step 2: Provide information about challenging unhelpful thoughts

Once a client has identified the unhelpful thought patterns that apply to them, it is important to learn ways to identify and challenge them in situations. The main steps to changing unhelpful thought patterns is first to catch yourself thinking in this way, recognise the thought pattern for what it is, and then substitute it with a more helpful or reasonable set of thoughts.

Step 3: Practice challenging unhelpful thoughts

Ask the client to practice the process of challenging unhelpful thoughts over the next week. Explain that this new process of monitoring and managing their thoughts will take time and practice. Assist them to do this during the session as an example.

Session 4: Relapse prevention

Relapse prevention is a plan of action that enables the client to self-manage their depression, anxiety or alcohol or other drug use by replacing existing beliefs with more realistic and accurate ones, by learning new coping skills and by making lifestyle changes.

Step 1: Review and feedback

Review the previous session and the homework tasks.

Step 2: Provide information about preventing relapse

Including information on identifying triggers for relapse and identifying early warning signs. Explain the 'breaking the rule effect'.

Step 3: Practice preventing relapse in the session

Remind your client of the importance of developing a lifestyle that supports the positive changes they have made and one that fits in with their goals. Developing a relapse prevention plan in advance of problematic situations is essential. It is a lot easier for a person to recognise warning signs while their mood is stable. A relapse prevention plan can be as simple as recontacting their AOD counsellor or GP for assistance when they notice early warning signs, or as complex as making lifestyle changes incorporating long-term behavioural change, like daily exercise, relaxation and stress management. There are some key elements that make up a relapse prevention plan:

a) Regulating thoughts and feelings.

b) Recognising the need for additional skills and supports.

c) Self-reward.

d) Taking care of yourself.

Managing comorbid psychosis

Methamphetamine-induced psychosis occurs with a small but significant percentage of users and typically presents following heavy binge or prolonged use. Even though the relationship between methamphetamine use and psychotic symptoms is well established, there is little knowledge of prevalence rates in Australia (Dawe & McKetin, 2004).

The symptoms of a methamphetamine-induced psychosis usually resolve within a few days after ceasing use. For clients, this can be a stressful and frightening time, as they worry that their use of methamphetamine may lead to a permanent psychotic disorder. Clinicians should provide reassurance and education that a period of rest (from methamphetamine) and improved self-care is likely to alleviate many unwanted symptoms without psychiatric intervention.

In a small group of users, symptoms may worsen immediately after cessation of methamphetamine use (during withdrawal) but usually settle over a relatively short period of time – a matter of days or weeks. If symptoms resolve within a month of ceasing methamphetamine use, it is likely to have been a drug-induced psychosis. For others, psychotic symptoms may persist for a month or more (Dawe & McKetin, 2004), which may be suggestive of a more enduring psychiatric condition.

It can be difficult to determine whether the symptoms of psychosis have been triggered by the methamphetamine use itself, or whether there was a pre-existing vulnerability to schizophrenia (Dawe & McKetin, 2004). It may not be particularly important in the acute phase, as the management should be the same – to treat current symptoms. Ongoing monitoring may provide a more precise diagnosis.

Methamphetamine use is likely to worsen psychotic symptoms in a person with schizophrenia and may reduce the effectiveness of anti-psychotic medication.

There is debate about the appropriate management of methamphetamine-induced psychosis, particularly in the presence of continued methamphetamine use. Treatment is similar to that of acute schizophrenia (DAO, 2006). Acute symptoms should be managed as a priority (see Part 1 of the practice guidelines).

Psychological interventions such as CBT, should be offered once the symptoms of psychosis have resolved. These interventions are best delivered by a specialist, so are not outlined here. Appropriate referral to a psychologist or other mental health specialist is recommended.

When and how to refer to mental health services

There are four main reasons for making contact with a mental health service on behalf of your client. These are:

1. If you suspect the client has an undiagnosed or untreated psychotic disorder. For example, if the client appears to hear or see things that others don't (hallucinations) or to hold delusional beliefs or to demonstrate bizarre behaviour – especially if these symptoms persist after a period of detoxification and stabilisation.
2. If you suspect that the client has an undiagnosed or untreated bipolar disorder, as indicated by the presence of manic symptoms such as a decreased need for sleep or food, a marked period of productivity, a rapid flow of thoughts or speech and an exaggerated sense of self-esteem or invincibility.

3. If the client has such a deep depression that there is a high risk of suicide or self-harm.
4. If the client has not responded to brief interventions and you want a second opinion.

Who to contact for mental health services depends on what services are available in your region. Possible contacts include:

- A psychiatrist, clinical psychologist or other mental health professional in your own service, if one is available.
- A specialist dual diagnosis consultant, if available.
- An intake or triage officer at the client's nearest community mental health service.
- A general practitioner or a visiting psychiatrist or clinical psychologist if you are in a rural or remote area where mental health services are not easy to access.

Before you make contact with a mental health professional, explain to the client the reasons for the contact and ask the client's permission to do so. Also discuss your plans with your supervisor if you have any questions or concerns.

When you make contact with a mental health professional, introduce yourself and your service and say that you suspect your client has one of the mental health problems described above and that you would like to arrange for a diagnostic assessment. Indicate that you would like to take a collaborative approach to the client's treatment and clearly describe what role you would like to take in terms of treatment interventions you can provide at your service.

Managing other complex behaviours

Methamphetamine use may lead to an increase in impulsive behaviour in people with a diagnosis of emotionally unstable personality disorder. Clinicians should use motivational techniques which aim to increase insight regarding the impact of methamphetamine use on behaviour, and identify strategies that will help to reduce stress (Holmwood, 2002).

Interventions specifically addressing methamphetamine use and complex behaviours are limited. Techniques and strategies from Young's (2003) schema focused therapy and Linehan's (1993) dialectical behaviour therapy may assist. However these interventions require at least basic training and are too complex to outline in detail here. Clinicians are encouraged to seek out training in one of these methods of intervention for complex behaviours.

The role of peer education

Methamphetamine users in Adelaide were surveyed by Vincent et al. (1999) about their experience of seeking information and treatment. They identified peer support and education to be a potentially important avenue for accessing relevant and timely assistance. There are few studies examining the effectiveness or efficacy of peer support. However, experts have identified a number of potential options for facilitating peer support and education including:

- A collaborative approach with local user groups.
- Providing an environment to support peer groups to meet and exchange information.
- Creating peer positions within an organisation. This approach requires significant commitment from the organisation to support the peer worker.

The role of support people

Baker et al. (2003) emphasise the importance of identifying and utilising the support of key family or friends in maximising the chances of positive change. These support people are also a useful resource for monitoring signs of depression or other mental health or behavioural disturbances such as symptoms of psychosis and aggressive behaviour. It is often the friends and family who are alerted to changes in behaviour before the user becomes aware of this themselves. Appropriate education of support people may be of assistance, but like peer support, little research has been conducted in this area.

Considerations for specific groups of methamphetamine users

Young people

There is a growing trend for young people in Australia to use methamphetamine. The highest rates of methamphetamine use are among people under 30. Young methamphetamine users are more likely to:

- Engage in risky sexual practices increasing their exposure to sexually transmitted infections.
- Use methamphetamine on an experimental or intermittent 'binge' basis.
- Prefer to inject methamphetamine rather than use other modes of administration, which also increases the risks of contracting blood borne viruses.
- Combine methamphetamine use with a variety of other psychoactive drugs, including alcohol, cannabis and other stimulant drugs such as ecstasy.

When working with young people in relation to their methamphetamine use, it is important to place this use in the context of their physical, cognitive and emotional development. Discussing ways to reduce the potential harms associated with methamphetamine use may be the most appropriate starting point, as well as providing information and interventions that will offer flexibility for a variety of cognitive abilities. It is also important to keep in mind that experimenting with methamphetamine in adolescence is not necessarily an early marker for regular use or other drug use. There is, however, some evidence to suggest that pre-existing depression is a strong predictor for whether a young person will continue use of methamphetamine on a regular basis (Sussman, Dent & Stacy, 1999).

A comprehensive assessment is an important first step when working with young people, particularly focussing on risk and protective factors (Baker et al., 2004) as well as an assessment of potential co-existing mental health issues.

A stepped care approach should be adopted when working with young people using methamphetamine, with the least intrusive options offered initially and only moving to more intensive treatment options when these have proved ineffective. As a good deal of methamphetamine use amongst young people is experimental, providing information about risks and strategies to reduce harms may be the most appropriate intervention.

Details of assessment and interventions specific to young people are further outlined by Baker, Lee and Jenner (2004).

Cultural considerations

People from a range of cultural and linguistically diverse (CALD) groups may use methamphetamine. Some of their reasons for using methamphetamine are common to all users, such as curiosity, increasing confidence and coping with particular stressors. However, other factors such as migration, integration and language barriers, may increase the risk of initiation to drug use for people from CALD backgrounds (DCPC, 2004). The stigma associated with drug use may also lead to significant under-reporting in this group of users. CALD groups may also experience even greater difficulties in accessing appropriate information and support regarding treatment options for their drug problems.

For clinicians, it is important to consider a range of issues when working with people from CALD backgrounds (Addy et al., 2000). These include:

- the ways in which people from CALD backgrounds define problems;
- the ways in which people from CALD backgrounds seek help;
- the involvement of family in the treatment process;
- the person's gender and how this may influence the above.

Occupational groups

As methamphetamine inhibits sleep and fatigue, it is sometimes associated with increasing and sustaining work performance (DCPC, 2004). People in a variety of occupations including truck drivers, construction workers, students and business people use methamphetamine. In these circumstances, methamphetamine helps to avoid symptoms of fatigue and enhance the capacity to work for longer periods with little sleep or food. Most of the evidence regarding functional use of methamphetamine focuses on long-distance truck drivers, however, it is important to note that people from a wide range of professions and socio-economic backgrounds may use methamphetamine for this purpose. This may be, in part, due to methamphetamine's comparatively low cost and the (inaccurate) perception that it is relatively harmless and non-addictive (DCPC, 2004). Sex workers are also an occupational group that commonly use methamphetamine and experience added health risks.

Men who have sex with men

The widespread use of methamphetamine by MSM is prevalent in nightclub and party settings and engagement in high risk sexual activity is common during this time (Colfax, Mansergh et al., 2001). Some suggest that methamphetamine use may be a mechanism by which gay and bisexual men cope with the social and sexual demands of their lifestyles, including 'difficult emotions, tensions of socialisation, and the prejudice experienced for being gay' (Halkitis, Fischgrund et al., 2005). High risk behaviours should be addressed and alternatives to reduce harms encouraged. MSM are at high risk of transition to injecting from other routes of administration and interventions aimed at preventing transition to injecting may be useful for this group.

Party and club goers

There are high rates of methamphetamine use among party and club goers. Research highlights the use of these drugs in a poly-drug context (most often in combination with cannabis, ecstasy and

alcohol). Similarly to MSM, party goers are most likely to benefit from harm reduction strategies and education about the effects of the drug. Moderated use may also be a useful goal to reduce the risk of dependence and other harms.

Injecting drug users

In Australia, methamphetamine is reported to be the first drug ever injected by the majority of injecting drug users (IDU), and in some jurisdictions, it is currently the drug injected most often. Primary heroin injectors also report transitions back and forth between heroin and methamphetamine. Harms associated with injecting should be addressed with this group and information about risk of dependence offered.

Methamphetamine users with pre-existing mental illness

Individuals with a pre-existing psychotic illness, such as schizophrenia, represent a particularly vulnerable group in relation to mental health risks of methamphetamine use. Methamphetamine use has been implicated in triggering an acute psychotic relapse in individuals with schizophrenia and other psychotic-like illnesses, such as bipolar affective disorder. Methamphetamine use can also exacerbate many of the symptoms associated with psychosis, such as agitation, paranoia and hallucinations. Furthermore, methamphetamine use may contribute to other factors, which impact on the risk of psychotic relapse, such as medication non-compliance, conflict with family and friends and general loss of psychological resilience to stress. Binge or high-dose use of methamphetamine or first time users often represent the highest risk in those with a pre-existing mental health issue.

Individuals with a depressive illness may use methamphetamine to counter symptoms such as lack of motivation and drive, associated with depressed mood, but they risk exacerbating their depressive illness when the stimulant effect wears off. Methamphetamine use has the potential to increase many symptoms associated with depression, such as depressed mood, agitation, sleep difficulties and appetite disturbances. Methamphetamine may also be used by individuals with eating disorders to reduce their appetite or assist with exercise bingeing, which has the potential to exacerbate the eating disorder.

In these cases, close monitoring and education about the link between symptoms and methamphetamine use is important. Motivational enhancement techniques are useful. While keeping in mind that engagement is important and often fragile with this group, clinicians should provide advice that any methamphetamine use is high risk for those with a pre-existing mental health problem and follow interventions outlined in the Reducing Harms section of the Practice Guidelines.

CLINICAL RESOURCES

1. Timeline follow back
2. Stages of change ladder
3. Severity of dependence scale
4. PsyCheck screening tool
5. Psychosis screener
6. Amphetamine withdrawal questionnaire
7. Harm reduction goals
8. Drug related harm identification
9. Harm reduction review
10. Monitoring cravings
11. Facts about cravings
12. Strategies to cope with cravings
13. My cravings
14. Cravings plan
15. Breaking the rule effect
16. Thinking-feeling-doing cycle
17. Identifying unhelpful thought patterns
18. Self monitoring
19. Analysing unhelpful thoughts
20. Seemingly irrelevant decisions
21. Pleasant activities
22. Activity record
23. Refusal skills
24. Relapse prevention plan
25. Functional analysis
26. Decisional balance exercise
27. Practice safe decision making
28. All purpose coping plan
29. Problem solving
30. Support plan

TIMELINE FOLLOW BACK

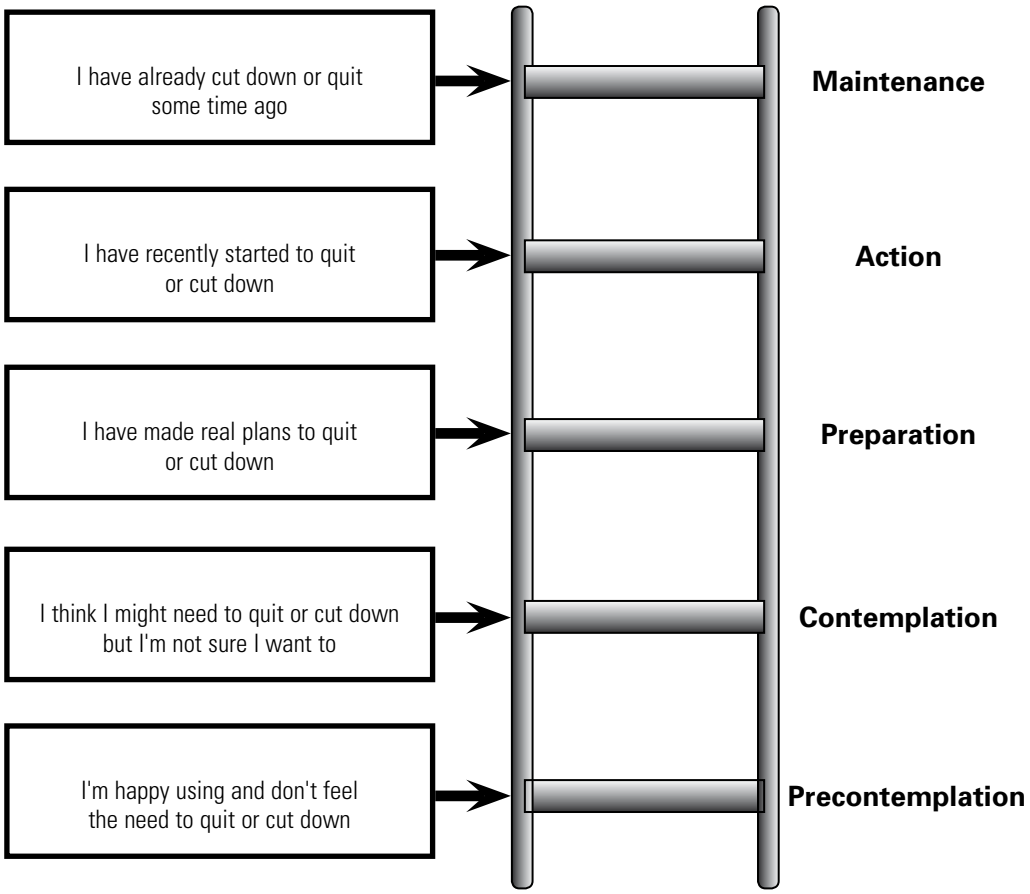
1. Provide anchors for the client by first filling in public holidays, significant personal events and other dates on the calendar.
2. Assist the client to work back from last day of use and complete ALL drug use for each day.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Week 1							
Week 2							
Week 3							
Week 4							
Week 5							

STAGES OF CHANGE LADDER

The rungs on this ladder can be used to represent where you are now in regard to your use.

Tick the rung that best describes where you are right now.



From Baker et al. (2004)

SEVERITY OF DEPENDENCE SCALE

1. Did you ever think your use of (drug) was out of control?

Never or almost never	0
Sometimes	1
Often	2
Always or nearly always	3

---

2. Did the prospect of missing a shot/snort/smoke make you very anxious or worried?

Never or almost never	0
Sometimes	1
Often	2
Always or nearly always	3

---

3. How much did you worry about your use of (drug)?

Never or almost never	0
Sometimes	1
Often	2
Always or nearly always	3

---

4. Did you wish you could stop?

Never or almost never	0
Sometimes	1
Often	2
Always or nearly always	3

---

5. How difficult would you find it to stop or go without (drug)?

Never or almost never	0
Sometimes	1
Often	2
Always or nearly always	3

PSYCHECK SCREENING TOOL

The PsyCheck Screening Tool

Clients Name:		DOB:	
Service:		UR:	
Mental health services assessment required?		No ☐	Yes ☐
Suicide/self-harm risk (please circle):		High	Moderate Low
Date:	Screen completed by:		

Clinician use only

Complete this section when all components of the *PsyCheck* have been administered.

Summary

Section 1	Past history of mental health problems	☐ No	☐ Yes	
Section 2	Suicide risk completed and action taken	☐ No	☐ Yes	
Section 3	SRQ score	☐ 0	☐ 1–4	☐ 5+

Interpretation/score – SRQ

Score of 0* on the SRQ	No symptoms of depression, anxiety and/or somatic complaints indicated at this time. **Action:** Re-screen using the *PsyCheck* Screening Tool after 4 weeks if indicated by past mental health questions or other information. Otherwise monitor as required.
Score of 1–4* on the SRQ	Some symptoms of depression, anxiety and/or somatic complaints indicated at this time. **Action:** Give the first session of the *PsyCheck* Intervention and screen again in 4 weeks.
Score of 5+* on the SRQ	Considerable symptoms of depression, anxiety and/or somatic complaints indicated at this time. **Action:** Offer Sessions 1–4 of the *PsyCheck* Intervention.

Re-screen using the *PsyCheck* Screening Tool at the conclusion of four sessions.

If no improvement in scores evident after re-screening, consider referral.

* Regardless of the client's total score on the SRQ, consider intervention or referral if in significant distress.

Psycheck Screening Tool
SECTION 1: General Screen

Clinician to administer this section

The following questions are about your emotional wellbeing. Your answers will help me get a clearer idea of what has been happening in your life and suggest possible ways that we might work together to relieve any distress you may be experiencing. We ask these questions of everybody, and they include questions about mental, physical and emotional health.

1. Have you ever seen a doctor or psychiatrist for emotional problems or problems with your 'nerves'/anxieties/worries? No ☐ Yes ☐

   Details

2. Have you ever been given medication for emotional problems or problems with your 'nerves'/anxieties/worries?

   ☐ No, never

   ☐ Yes, in the past but not currently Medication(s):

   ☐ Yes, currently Medication(s):

3. Have you ever been hospitalised for emotional problems or problems with your 'nerves'/anxieties/worries? No ☐ Yes ☐

   Details

4. Do you have a current mental health worker, psychiatrist, psychologist, general practitioner or other health provider?
   If 'No', go to Question 5.

☐ **Psychiatrist**	☐ **Psychologist**
Name:	Name:
Contact details:	Contact details:
Role:	Role:
☐ **Mental health worker**	☐ **General practitioner**
Name:	Name:
Contact details:	Contact details:
Role:	Role:
☐ **Other – specify:**	☐ **Other – specify:**
Name:	Name:
Contact details:	Contact details:
Role:	Role:

5. Has the thought of ending your life ever been on your mind? No ☐ Yes ☐ If 'No', go to Section 3
   Has that happened recently? No ☐ Yes ☐ If 'Yes', go to Section 2

Psycheck Screening Tool
SECTION 2: Risk Assessment

Clinician to administer this section

If the person says 'Yes' to recently thinking about ending their life (Question 5), complete the suicide/self-harm risk assessment below. Specific questions and prompts and further guidance can be found in the *PsyCheck* User's Guide.

Risk factor	Low risk	Moderate risk	High risk
1. Previous attempts: Consider lethality and recency of attempts. Very recent attempt(s) with moderate lethality and previous attempts at high lethality both represent high risk. Recent and lethal attempts of family or friends represent higher risk.			
History of harm to self	☐ Previous low lethality	☐ Moderate lethality	☐ High lethality, frequent
History of harm in family members or close friends	☐ Previous low lethality	☐ Moderate lethality	☐ High lethality, frequent
2. Suicidal ideation: Consider how the suicidal ideation has been communicated; non-disclosure may not indicate low risk. Communication of plans and intentions are indicative of high risk. Consider non-direct and non-verbal expressions of suicidal ideation here such as drawing up of wills, depressive body language, 'goodbyes', unexpected termination of therapy and relationships etc. Also consider homicidal ideation or murder/suicide ideation.			
Intent	☐ No intent	☐ No immediate intent	☐ Immediate intent
Plan	☐ Vague plan	☐ Viable plan	☐ Detailed plan
Means	☐ No means	☐ Means available	☐ Means already obtained
Lethality	☐ Minor self-harm behaviours, intervention likely	☐ Planned overdose, serious cutting, intervention possible	☐ Firearms, hanging, jumping, intervention unlikely
3. Mental health factors: Assess for history and current mental health symptoms, including depression and psychosis.			
History of current depression	☐ Lowered or unchanged mood	☐ Enduring lowered mood	☐ Depression diagnosis
Mental health disorder or symptoms	☐ Few or no symptoms or well-managed significant illness	☐ Pronounced clinical signs	☐ Multiple symptoms with no management
4. Protective factors: These include social support, ability or decision to use support, family involvement, stable lifestyle, adaptability and flexibility in personality style etc.			
Coping skills and resources	☐ Many	☐ Some	☐ Few
Family/friendships/networks	☐ Many	☐ Some	☐ Few
Stable lifestyle	☐ High	☐ Moderate	☐ Low
Ability to use supports	☐ High	☐ Moderate	☐ Low

Psycheck Screening Tool
SECTION 3: Self Reporting Questionnaire

Client or clinician to complete this section

First: Please tick the **'Yes'** box if you have had this symptom in the **last 30 days**.

Second: Look back over the questions you have ticked. For every one you answered **'Yes'**, please put a tick in the circle if you had that problem at a time when you were NOT using alcohol or other drugs.

1. Do you often have headaches?	☐ No	☐ Yes →	◯
2. Is your appetite poor?	☐ No	☐ Yes →	◯
3. Do you sleep badly?	☐ No	☐ Yes →	◯
4. Are you easily frightened?	☐ No	☐ Yes →	◯
5. Do your hands shake?	☐ No	☐ Yes →	◯
6. Do you feel nervous?	☐ No	☐ Yes →	◯
7. Is your digestion poor?	☐ No	☐ Yes →	◯
8. Do you have trouble thinking clearly?	☐ No	☐ Yes →	◯
9. Do you feel unhappy?	☐ No	☐ Yes →	◯
10. Do you cry more than usual?	☐ No	☐ Yes →	◯
11. Do you find it difficult to enjoy your daily activities?	☐ No	☐ Yes →	◯
12. Do you find it difficult to make decisions?	☐ No	☐ Yes →	◯
13. Is your daily work suffering?	☐ No	☐ Yes →	◯
14. Are you unable to play a useful part in life?	☐ No	☐ Yes →	◯
15. Have you lost interest in things?	☐ No	☐ Yes →	◯
16. Do you feel that you are a worthless person?	☐ No	☐ Yes →	◯
17. Has the thought of ending your life been on your mind?	☐ No	☐ Yes →	◯
18. Do you feel tired all the time?	☐ No	☐ Yes →	◯
19. Do you have uncomfortable feelings in the stomach?	☐ No	☐ Yes →	◯
20. Are you easily tired?	☐ No	☐ Yes →	◯
		Total score (add circles):	

PSYCHOSIS SCREENER

The psychosis screener is clinician administered.

Only ask the supplementary questions (1a, 2a and 3a) if the client answers YES to the main question.'

---

1. In the past 12 months, have you felt that your thoughts were being directly interfered with or controlled by another person?

☐ Yes (go to 1a) ☐ No (go to 2)

1a. Did it come about in a way that many people would find hard to believe, for instance, through telepathy?

☐ Yes ☐ No

---

2. In the past 12 months, have you had a feeling that people were too interested in you?

☐ Yes (go to 2a) ☐ No (go to 3)

2a. In the past 12 months, have you had a feeling that things were arranged so as to have a special meaning for you, or even that harm might come to you?

☐ Yes ☐ No

---

3. Do you have any special powers that most people lack?

☐ Yes (go to 3a) ☐ No (go to 4)

3a. Do you belong to a group of people who also have these special powers?

☐ Yes (-1 point) ☐ No

---

4. Has a doctor ever told you that you may have schizophrenia?

☐ Yes ☐ No

Scoring:
Each question answered 'yes' is scored 1 point, except question 3a which is scored -1 if answered 'yes'.
Add each score. A cumulative score of 3 or more indicates potential presence of significant psychotic symptoms.

Adapted from Degenhardt et al (2005)

AMPHETAMINE WITHDRAWAL QUESTIONNAIRE

DURING THE PAST 24 HOURS:

(Circle one answer per question)

1. Have you been craving amphetamine or methamphetamine?
   Not at all Very little A little Quite a lot Very much

2. Have you felt sad?
   Not at all Very little A little Quite a lot Very much

3. Have you lost interest in things or no longer take pleasure in them?
   Not at all Very little A little Quite a lot Very much

4. Have you felt anxious?
   Not at all Very little A little Quite a lot Very much

5. Have you felt as if your movements are slow?
   Not at all Very little A little Quite a lot Very much

6. Have you felt agitated?
   Not at all Very little A little Quite a lot Very much

7. Have you felt tired?
   Not at all Very little A little Quite a lot Very much

8. Has your appetite increased or are you eating too much?
   Not at all Very little A little Quite a lot Very much

9. Have you had any vivid or unpleasant dreams?
   Not at all Very little A little Quite a lot Very much

10. Have you been craving for sleep or sleeping too much?
    Not at all Very little A little Quite a lot Very much

Scoring:

Not at all = 0 Very little = 1
A little = 2 Quite a lot = 3
Very much = 4

Possible range of scores is 0–40 with higher score indicating greater severity.

Srisurapanont M, Jarusuraisin N & Jittiwutikarn J (1999) Amphetamine withdrawal: 1. Reliability, validity and factor structure of a measure. *Australian and New Zealand Journal of Psychiatry 33*:89-93.

HARM REDUCTION GOALS

WORK SHEET 7

Use the table below to list drug use patterns and drug-related harms that will be the target for harm reduction strategies. Establish goals and practical strategies to reduce drug-related harm.

Drug use or related behaviour	Goal	How am I going to achieve my goal?
Example: Using too much speed	*Use less speed*	*Use only on certain days (limit use to the weekends)*
Example: Injecting speed	*Reduce the risk of infection and acquiring blood-borne viruses*	*Use needle exchange programs, obtain information on safe-injecting techniques, inhale or ingest speed rather than inject*

DRUG RELATED HARM IDENTIFICATION

Use this table to explore possible harms that result from your drug use. List the harms under each heading.

Acquisition (getting the drug)	Administration (using the drug)	Intoxication (physical effects)	Intoxicated behaviour	Crash or withdrawal
For example, legal problems as a result of being caught buying or in possession of ice	*For example, increased risk of vein damage and transmission of blood-borne viruses (HIV and hepatitis C due to injection*	*For example, seizures*	*For example, aggression or violence*	*For example, unable to work, poor sleep, bad dreams, seizures or hallucinations*

Adapted from Pead, J., Lintzeris, N., & Churchill, A (1996)

HARM REDUCTION REVIEW

Original goal	What are/were the negative consequences of my drug use or behaviour?	What have been the positive consequences of my harm reduction strategies?	What difficulties have I experienced in achieving my goal?	What can I do to overcome these difficulties?	

MONITORING CRAVINGS

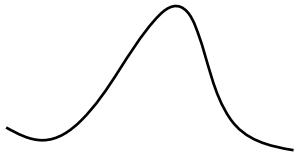
Where were you?	Who were you with?	Did any significant events happen?	What were you thinking?	What were you feeling?	What did you actually do?

FACTS ABOUT CRAVINGS

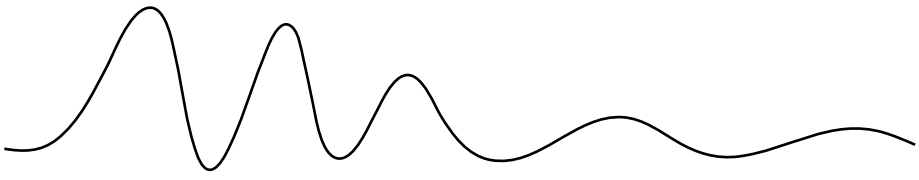
Some facts about cravings

(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 history of heavier 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. Think of 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 rather 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.

STRATEGIES TO COPE WITH CRAVINGS

(a) Behavioural

Discuss the "3Ds" of coping with cravings:

1. **Delay** – 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. **Distract** – 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. **Decide** – 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 "decatastrophise" 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 practice in the session.

These strategies can be adapted to suit each individual client's images or dreams 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 remote control) 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).

MY CRAVINGS

Write down behaviours, physical feelings and thoughts about the experience of craving below

Behaviours	Physical feelings	Thoughts
For example, feeling restless, smoking a lot of cigarettes	*For example, hot and cold flushes*	*For example, If I don't have a pipe I'll die!*

BEHAVIOURS + FEELINGS + THOUGHTS = CRAVING

CRAVINGS PLAN

High risk situations	Coping plan	Things that I will do to stay off methamphetamines

BREAKING THE RULE EFFECT

The 'breaking the rule' effect is an unhelpful thought that might happen if you notice your mood is getting low, you start feeling stressed, anxious or run down, or if you have a craving to use alcohol or other drugs. You may even have a slip-up and use other drugs again.

The 'breaking the rule' unhelpful thought comes into these situations and says: *'I knew you couldn't do this, here you are back at square one'*. It gives you permission to fall back into your old habits of thinking and behaving.

But if you know about the 'breaking the rule' effect, you can be ready for it when it happens. When you notice this effect, try these few simple steps:

1. Practice your relaxation skills to switch off your automatic pilot and concentrate on the moment.
2. Remind yourself that everybody has a slip-up. You haven't failed completely and you are not back at square one.
3. If you notice yourself 'breaking the rule', try these more helpful thoughts instead.

Breaking the rule effect: *'I've blown it, I might as well keep going.'*

More helpful thought: *'I've just had a slip and I can get back on track.'*

Breaking the rule effect: *I knew I wouldn't be able to stop.'*

More helpful thought: *'I have been able to make a change … this is only a slip and I will keep on trying.'*

Breaking the rule effect: *'I've messed up already, so I might as well keep going.'*

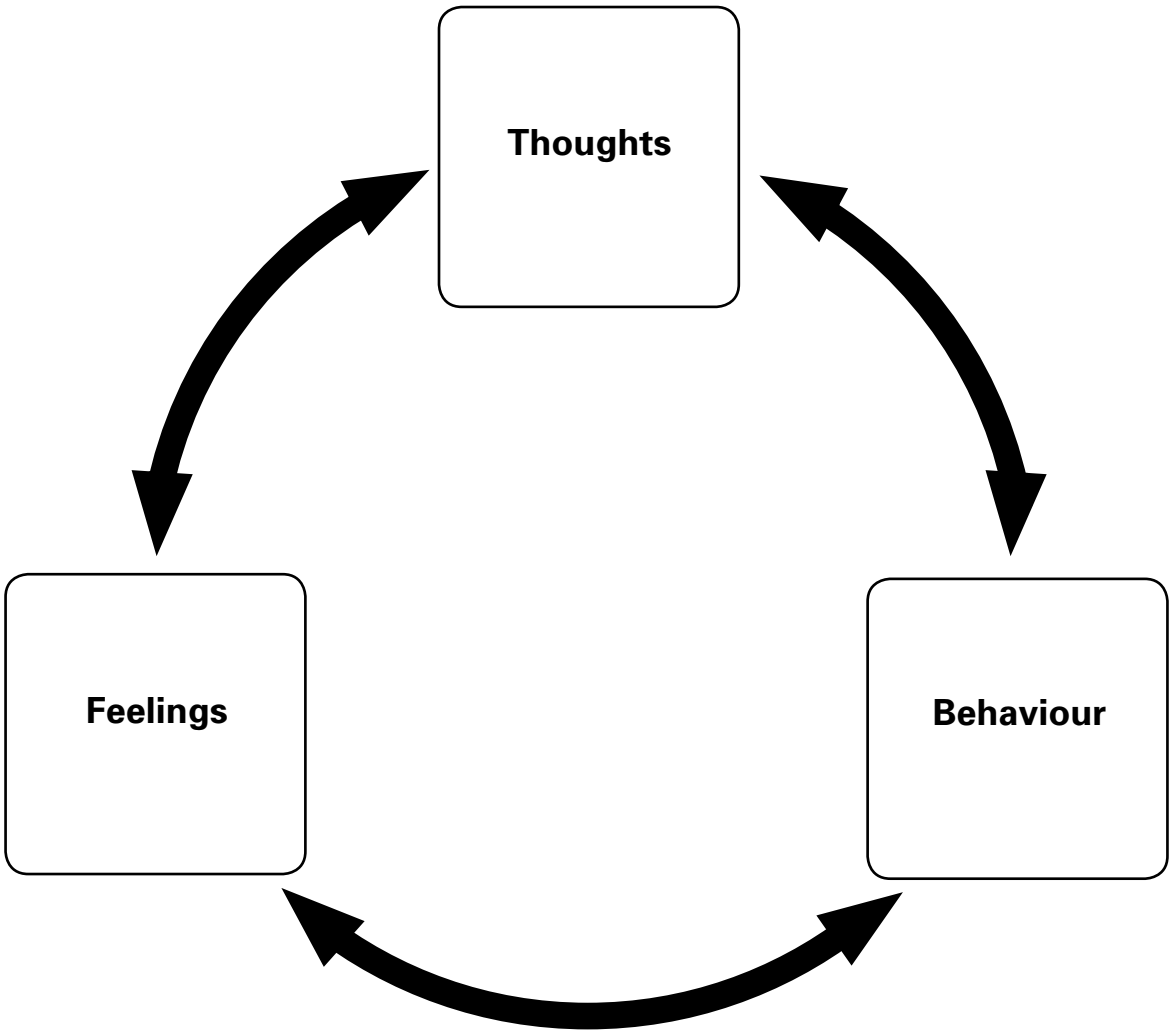
More helpful thought: *'I've just made a mistake and I can learn from it and get back on course.'*

Breaking the rule effect: *'None of this therapy worked, I'm back at square one.'*

More helpful thought: *'This is only a change in my mood, I can handle this. I just need to handle each moment as best as I can.'*

Adopted from Baker et al. (2003)

THINKING-FEELING-DOING CYCLE



IDENTIFYING UNHELPFUL THOUGHT PATTERNS

People with depression and anxiety tend to 'read into' situations in ways that are often quite negative. These thought patterns can lead to stronger feelings of depression and anxiety, and often result in cravings to use alcohol or other drugs.

Do you have any of the following unhelpful thought patterns?

Are you a **'black and white thinker'**?

- Are things either all good or all bad – with nothing in-between? (no balance)
- Do you think that because something has gone wrong once, it will always go wrong?
- Do you have strict rules about yourself and your life? For example, do you think that in order to be good at something, you must do it perfectly or not at all?
- If things don't work out perfectly, do you feel hopeless and like you have failed completely? For example: *'If I fail partly, it is as bad as being a complete failure'*, or *'If a person is not a complete success, then life is meaningless'* or *'I never get what I want so it's foolish to want anything'*.
- Have you ever thought: *'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'*?
- Do you believe that in order to be a good person, everybody must like you all the time? Do you ever think: *'People will probably think less of me if I make a mistake'* or *'If a person I love does not love me, it means I am unlovable'*?
- In thinking about your depression, do you think things like *'Either I'm depressed or I'm completely happy – there is no in-between'* and *'I'm a bad person – there is nothing good about me'*?

Do you **'jump to negative conclusions'**?

- Do you automatically draw a negative conclusion about something more times than not?
- Do you sometimes act like a 'mind reader'? That is, you think you can tell what another person is really thinking, often without really checking it out or testing it.
- Do you do a bit of 'fortune telling'? That is, you believe that things will turn out badly and are certain that this will always be the case. For example: *'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 thinking about your alcohol or drug use, do you believe: *'I'll never be able to change my drinking/drug using. It'll never be any different.'*

Do you **'catastrophise'**?

- Do you tend to give too much meaning to situations, particularly negative ones?
- Do you convince yourself that, if something goes wrong, it 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 you have a disagreement with someone, do you think: '*That person hates me, doesn't trust me, they'll never talk to me again.'*

Are you a **'personaliser'**?

- Do you blame yourself for anything unpleasant that happens?
- Do you 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'*.
- Do you often put yourself down or think too little of yourself, particularly in response to making a mistake. Do you often find yourself thinking things like: *'I'm weak, stupid, ugly'* or *'I'm an idiot'*.

Are you a **'should/ought'** person?

- Do you use 'should', 'ought' and 'must' when you think about lots of situations? This thinking could make you feel guilty if you don't do the things you 'should'.
- 'Shoulds', 'oughts' and 'musts' quite often set a person up to be disappointed, particularly if these thoughts are unreasonable. Do you set unrealistic expectations for yourself or other people? For example: *'I must not get angry' or 'He should always be on time'*.
- 'Shoulds', 'oughts' and 'musts' may make you feel angry if you feel others are not doing what they should, ought or must. Do you find yourself getting frustrated with people when they don't do what you think they 'should'?

SELF MONITORING

	Situation Where were you? Who were you with?	**Thoughts** What was I thinking?	**Feelings** What was I feeling?	**Behaviours** What did I do? What did I drink/use?
Example	*At party, didn't know anyone. A group of people laughing near me.*	*They're laughing at me.* *No one wants to hang out with me.* *I'm a loser. I'm so lonely.*	*Anxious, sad, angry, embarrassed, worthless, lonely.*	*Kept drinking more.* *Got really drunk.* *Stormed off.* *Went home and kept drinking.*
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

ANALYSING UNHELPFUL THOUGHTS

Situation	Thoughts	Feelings		Which unhelpful thought is this?*	Does it fit the facts?	What is another explanation?	Feelings now
Sitting at home, bored, nothing to do	*I should be out doing something, but I've got nothing to do, nobody to do it with, life sucks*	*Sad, angry, useless, worthless*	**This is just a thought**	*Jumping to negative conclusions Personalising Shoulds/oughts*	*Not really – I've got some friends but they are at work, & I do have some things to do that I like*	*My depression is telling me I don't have anything to do. It would be nice if I had someone to do stuff with, but I can choose to do something myself and still enjoy it.*	*A bit happier, a bit more in control, a bit more motivated, worthwhile*
			I am not my thoughts				

* catastrophising, personalising, jumping to negative conclusions, black/white thinking, shoulds/oughts (see *Work sheet 17: Identifying unhelpful thought patterns*)

(Segal et al., 2002; Beck et al., 1979)

SEEMINGLY IRRELEVANT DECISIONS

Think back to your (re)lapse to methamphetamine use and describe the situation/events that preceded the lapse

What led to the lapse?

What decisions led to the lapse?

What stopped me from recognising these signs?

What would have been a lower risk option?

Write a plan to manage SIDs and high risk situations:

PLEASANT ACTIVITIES

1. In the pleasant activities column, list the activities that you enjoy doing, or used to enjoy doing, that don't require the use of speed.
2. In the achievement activities column, list the activities you have to do. Make sure the list is concrete (eg looking after my children, bathing them, making dinner, etc)
3. Go to *Work sheet 22: Activity record* and schedule the things you have to do, then schedule the things you like to do. Make sure you schedule something pleasant every day, even if it is a brief activity.

Pleasant Activities (Things I enjoy)	**Achievements (Things I have to do)**

Adapted from Baker et al. (2004)

ACTIVITY RECORD

Using the list of pleasant and achievement activities you made in *Worksheet 21: Pleasant activities*, plan your day. Include at least one pleasant task (P) and one achievement task (A) in each day of the week.

	Monday (P & A tasks)	Tuesday (P & A tasks)	Wednesday (P & A tasks)	Thursday (P & A tasks)	Friday (P & A tasks)	Saturday (P & A tasks)	Sunday (P & A tasks)
7–8am							
8–9am							
9–10am							
10–11am							
11am–12pm							
12–1pm							
1–2pm							
2–3pm							
3–4pm							
5–6pm							
6–7pm							
Evening							

Adapted from Baker et al. (2004)

REFUSAL SKILLS

People who might offer me drugs	What I'll say to them

Tips for refusing methamphetamine

- Say NO first and assertively (not aggressively)
- Make direct eye contact
- Tell the person you are no longer using
- Ask the person to stop offering methamphetamine
- Don't leave the door open for future offers (eg, 'not right now thanks' or 'I'll think about it')

RELAPSE PREVENTION PLAN

Early warning signs for relapse

-
-
-
-

Anticipated high risk situations	Coping strategies	Reward

General coping strategies in an emergency

Additional skills required	How to get them

FUNCTIONAL ANALYSIS

Trigger	Thoughts and Feelings	Behaviours	Positive Consequences	Negative Consequences
What situation or stimulus set me up to use?	*What was I thinking and feeling?*	*What did I do as a result of the trigger and my thoughts/feelings?*	*What positive things happened as a result of my use?*	*What negative things happened as a result of my use?*

DECISIONAL BALANCE EXERCISE

The following is an example of a decisional balance exercise filled in with numbers to indicate the relative weight of each item. This approach is useful for calculating an overall 'for change' and 'against change' weighting, and the relative weights can be revisited and re-weighted even if the items on the decisional balance exercise themselves do not change with time. The most significant item for each box is bolded to indicate it is the primary factor.

Good things about using methamphetamine	**Less good things about using methamphetamine**
• *Stops me worrying about problems 6/10* • **Enjoy the feeling 8/10** • *Helps me stay awake 4/10*	• *Expensive 5/10* • *Hate coming down 2/10* • **Get angry/paranoid and fight people 10/10**
Good things about stopping using methamphetamine	**Less good things about stopping using methamphetamine**
• *More money for other things 5/10* • **Less fights (esp. with family) 10/10**	• *Get bored 6/10*

Good things about using methamphetamine	**Less good things about using methamphetamine**
Good things about stopping using methamphetamine	**Less good things about stopping using methamphetamine**

PRACTICE SAFE DECISION MAKING

Practice monitoring decisions that you face in the course of the day, both large and small, and consider safe and risky alternatives for each

Decision	Safe alternative	Risky alternative

Adapted from Carroll. 1998

ALL PURPOSE COPING PLAN

Remember that running into problems, even crises, is part of life and cannot always be avoided, but having a major problem is a time to be particularly careful about relapse

If I run into a high-risk situation:

1. I will leave or change the situation.
   Safe places I can go:

2. I will put off the decision to use for 15 minutes. I'll remember that my cravings usually go away in _____ minutes and I've dealt with cravings successfully in the past.

3. I'll distract myself with something I like to do.
   Good distractors:

4. I'll call my list of emergency numbers:

Name:	Number:
Name:	Number:
Name:	Number:

5. I'll remind myself of my successes to this point:

6. I'll challenge my thoughts about using with positive thoughts:

PROBLEM SOLVING

1. Recognise the problem
2. Identify and specify the problem
3. Consider various approaches to solving the problem
4. Select the most promising approach
5. Assess the effectiveness of the approach
6. If ineffective, select another approach and assess

Identify the problem (in detail):

List possible solutions

The best solution seems to be:

Effectiveness:

SUPPORT PLAN

What is my goal?	Who is to be contacted? (Phone, address)	When will the contact be made?	What services will I request?	Outcome
Goal 1				
Goal 2				
Goal 3				
Goal 4				

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Turning Point
Alcohol & Drug Centre

Methamphetamine Dependence and Treatment is the fourteenth in the series of Clinical Treatment Guidelines for Alcohol and Drug Clinicians developed by Turning Point Alcohol and Drug Centre. The series has been produced in response to the need for quality, standardised and broad-based resources for use in day-to-day client care.

People who use methamphetamines regularly or in high doses present to treatment services with a wide range of complex issues, including mental and physical health problems. In addition, methamphetamine users are often reluctant to access specialist treatment services primarily because they are unclear about their treatment options. Services are not well oriented to manage these clients, who are often difficult to engage. These guidelines provide drug and alcohol workers with effective assessment and treatment tools to assist them with meeting the complex needs of clients who use methamphetamines.

Current alcohol and drug treatment practice utilises multiple interventions. Reflecting the holistic approach to working with people with alcohol and drug-related problems, these guidelines should be used in conjunction with other publications in the Clinical Treatment Guidelines series.

Other publications in the series are:

1. Key Principles and Practices
2. Motivational Interviewing
3. Relapse Prevention
4. Reducing Harm for Clients Who Continue to Use Drugs
5. Controlled Drug Use Interventions
6. Effective Weed Control: Working with cannabis users
7. Working with Polydrug Users
8. Assertive Follow-up
9. Prescribing for Drug Withdrawal
10. Managing Difficult and Complex Behaviours
11. Working with Families
12. Smoking Cessation: Working with clients to quit
13. Youth Alcohol and Drug Outreach

Key Principles and Practices provides a theoretical and practical overview of what is considered to be 'best practice' when working with clients. This publication covers fundamental issues underpinning and influencing drug treatment, and highlights approaches involving behaviour change, withdrawal and substitution pharma-cotherapies. In addition, *Key Principles and Practices* contains the Victorian Alcohol and Drug Treatment Services Specialist Assessment Form and the Youth Alcohol and Drug Treatment Services Assessment and Intervention Tool – essential tools for alcohol and drug assessment and treatment planning.

About Turning Point

Turning Point strives to promote and maximise the health and wellbeing of individuals and communities living with and affected by alcohol and other drug-related harms. We aspire to be a world leading service delivery and research and development centre. In working toward our goals we will ensure the safest possible environment in relation to alcohol and other drug problems today and into the future.

How to order publications

Copies of the Clinical Treatment Guidelines can be ordered from Turning Point Alcohol and Drug Centre. Contact Turning Point for a complete catalogue of publications.

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