BANYAN HOUSE
FOR DRUG & ALCOHOL REHABILITATION

The Secretary
'ICE' Select Committee
GPO Box 3721
DARWIN, NT 0801

The Forster Foundation (Banyan House) submission to the Legislative Assembly of the Northern Territory Government (12th Assembly)

Select Committee inquiring into the prevalence, impacts and government responses to illicit use of the drug 'ICE' in the Northern Territory

April 2015

(signed)
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Preamble

The Forster Foundation wishes to acknowledge and express appreciation to the Chief Minister, the Honourable Mr Giles, for the decision to establish the 'ICE' Select Committee. We welcome the invitation to contribute to a discussion about the prevalence, impact and government responses to the use of ICE in the Northern Territory (NT).

Scope of the Submission

Please accept the following submission that will cover the following:

1. Introduction to the Forster Foundation for Drug and Alcohol Rehabilitation trading as Banyan House
2. Inputs related to the Terms Of Reference (TOR) of the ICE Select Committee:
    c. The social and community aspects of ICE in urban, community and remote settings
    d. Government and community responses to ICE in other states and some assessment of the effectiveness of these responses in terms of prevention, education, family and individual support, and withdrawal and treatment modalities
    f. Best practice work place health and safety measures for those in the health system who come into contact with users of ICE
3. Implications for Banyan House
4. Recommendations and invitation

Appendices

Appendix A: High Level Introduction of ICE and its Impact on Users
Appendix B: Treatment Approaches for Users of Methamphetamine
Appendix C: Example of A Brief Cognitive Intervention for Regular Amphetamine Users – A Treatment Guide
Appendix D: Responding to Challenging Situations related to the Use of Psycho stimulants

1. The Forster Foundation for Drug and Alcohol Rehabilitation (Banyan House)

The **Forster Foundation** is a community managed Not-for-Profit / NGO wholly funded by the NT Government (75%) (Department of Health) and Commonwealth Government (Department of Health (25%). We operate in the NT community sector, playing a vital role in creating social wellbeing for all Territorians in building safe and healthy communities by providing services that enable people to access and participate in health services and community and family life.

The **Forster Foundation** trading as **Banyan House** is a residential drug and alcohol rehabilitation centre in Darwin, with modern 26 bed facilities for individuals and families struggling with alcohol and drug issues wanting to rehabilitate from dependency. Banyan House has been in operation since 1978 and was originally located in a small cottage in Rapid Creek. It relocated to its present location in Berrimah in 1992 which was the remnants of an old detention centre. The modern contemporary facilities were updated and completed on 2010 through kind funding by the Northern Territory and the Commonwealth Governments.

Banyan House has a strong Governance structure in place through a competency based volunteering Board and clinical managers with expert Alcohol and Other Drug / Mental Health experience (international and multi-state). The Board operates on fully accredited principles supported by a Clinical Governance Sub-Committee and a Finance, Risk, Audit and Governance Sub-Committee. We are in the process of partnering with related experts with a national and international footprint, which will form the Clinical Advisory Council. Banyan House is fully accredited under ISO 9001:2008.

Over its lifespan, Banyan House has operated as a Therapeutic Community – a drug free residential setting with treatment stages that reflect increased levels of personal and social responsibility with the primary goal to facilitate recovery from dependency and foster personal growth. It denotes the change required in an individual to lead a functional rewarding lifestyle and become a value-adding productive member of society. The methodology being used relies on the premise that client progress, and eventually their stable recovery, involves multi-dimensional changes in terms of lifestyle and personal identity. The community of residents is the major therapeutic force in the residential context.

Banyan House has traditionally offered a 12 - 52 week residential multidimensional program using withdrawal, group therapy, education, therapy / counselling, participation in activities (working groups/social and sport) and values and skills development. Residents are expected to develop the capacity to be positive role models as they progress through the program.

The therapeutic change engendered in the individual follows a complex perspective of the individual and the recovery process, addressing deficiencies in a range of domains and dimensions such as:

Domain	Aspect
• Developmental	Maturity Responsibility Values
• Socialisation	Lifestyle Maintain self image Work attitude Social skills
• Psychological	Cognitive skills Emotional skills Behavioural skills Self esteem
• Community	Program rules Community engagement Role model Leadership

Therapeutic change in the individual encompasses inter alia the capacity to accept personal responsibility for their own destiny; development or renewal of personal values such as truth and honesty, self reliance, responsibility of self and others; learning or re-establishing the behavioural skills, attitudes and values associated with communal living; developing a work ethic; and developing a moral code discerning right from wrong.

Banyan House is a unique Northern Territory Organisation and we understand the prevalence and impact that ICE (crystal methamphetamine) has on the individual, the family unit and society. A contemporised service of late provides alcohol and other drug (AOD) assessment, withdrawal and treatment in a residential and day program setting. As far as we know, Banyan House is the only residential rehabilitation facility in the Northern Territory (specifically the Top End) that offers facilities for individuals, couples as well as families. We have two, two bedroom family units where (single) parents can come and live with a limited number of children to attend our residential programs.

Banyan House currently offers the only medically supervised withdrawal service in Darwin - outside the Royal Darwin Hospital, in collaboration with the NT Department of Health – Alcohol and Other Drug (AOD) Withdrawal Service.

Service scope and operation of Banyan House

It is the expressed intention of the Forster Foundation Board and Executive that our service strives to deliver the best possible service to our clients, their families, our stakeholders and the community. Our priorities recognise that the AOD environment is a dynamic and changing space that requires our organisation to be agile and responsive so that we continue to meet the evolving requirements of our clients, their families, our stakeholders and the community.

Furthermore, our services are being delivered consistently with the following five principles:

- **Individual and Family Centred**: Banyan House will consider the unique circumstances of the individual and their family

- **Recovery Focused**: From the moment an individual steps into treatment there is a focus and expectation on recovery

- **Collaboration**: Banyan House will work in partnership with clients, their families, communities and stakeholders

- **Efficacious**: That Banyan House is effective and delivers a quality accredited best practice service for our clients, families and stakeholders that is focused on outcomes

- **Leading organisation**: Banyan House will advocate and take a leadership role in the context of AOD treatment, advocacy and research

Banyan House offers the following services and programs as part of its current residential rehabilitation service capability:

- Co-managed Residential AOD Withdrawal Program (Detoxification)
- 12 -52 week Residential Rehabilitation Program
- Extended Residential Program
- Aftercare Program
- Parenting Program
- Family Support
- Community Education and Awareness
- Clinical Assessments – AOD as well as Mental Health for Dual Diagnosis purposes
- SMART Court Program
- Legal and Court Reports
- Pre-court and Police Diversion Program – Counselling and Education
- From 1 July 2015 we will also offer

- a 5-10 days outpatient / day AOD program that will be spread across 10 half days or 5 full days;
- a Dual Diagnosis / Integrated Treatment Day Program;
- an Optimum Health Program underwritten by St Vincent's Drug Alcohol & Other Drug Service (Melbourne), as well as
- Self Managed and Recovery Training (SMART) – a CBT alternative to the religious-based 12 step programs of AA and NA or ALANON.

Strategic Priorities

The 2015 appointment of a new CEO, Clinical Services Manager and additional voluntary board members was followed by a 360° review that is timely in the context of a changing service requirement relating to a shift in the presenting issues.

The change in Banyan House Governance structure commenced with a change in strategic intent towards developing and implementing the following Strategic Priorities:

Governance	Financial	Employer of Choice	Treatment Framework	Quality
Implement a best practice Governance Structure: - Finance, Risk, Audit and Governance - Clinical Governance - Clinical Advisory Council with Internationally renowned content specialists	Broaden base of funding	Recruitment & Retention	Best Practice Residential & Day Programs	Quality Management System (QMS) Accreditation
Monitor performance	Efficiency	Professional Development	Collaboration	Consumer, family and stakeholder engagement
Planning	Reporting	Performance Development	Treatment outcomes and clinical practice	National Standards AOD Treatment Services
Risk Management	Delegations	Scope of Practice	Recovery Orientation	Research Partnerships
Supervision	Contractual Obligations	Multi-disciplinary Team	Advocacy	Policy Frameworks

Banyan House Service Data

Our service data demonstrates that there is a definable increase in "ICE users" in the NT. Five years ago Banyan House had only one resident experiencing difficulty with methamphetamine addiction. In the past 12 months there was a 115% increase in people seeking treatment for methamphetamine addiction, and in the last four months specifically crystal methamphetamine (ICE). In January 2015 Banyan House accommodated three residents seeking treatment (15%), in March 2015 there were 11 (55%), and in April we had 14 (70%).

Comparison to similar services suggests that our experience is consistent with national and international trends.

2. Input concerning terms of reference

c. The social and community aspects of ICE in urban, community and remote settings

Indications of increased use and frequency of ICE

Patterns of ICE use have changed since 2010 with the latest household survey indicating ICE use has overtaken powder. While most users, approximately 40%, still use recreationally once or twice a year, 25% use once a week or more. The tables below provide details.

National Drug Household Survey 2013			
Table 27: Form of meth/amphetamine used, recent users aged 14 yours or older, 2007 to 2013 (percent)			
Form of drug	**2007**	**2010**	**2013**
Forms ever used			
Powder	Not Available	83.1	64.9
Liquid	Not Available	15.8	14.1
Crystal, ICE	**Not Available**	**50.8**	**71.5**
Base/Paste/Pure	Not Available	37.8	28.3
Tablet	Not Available	32.9	26.5
Prescription amphetamines	Not Available	15.1	14.1
Capsules	Not Available	Not Available	17.0
Main form used			
Powder	51.2	50.6	28.5
Liquid	1.3	0.9	0.5
Crystal, ICE	**26.7**	**21.7**	**50.4**
Base/Paste/Pure	12.4	11.8	7.6
Tablet	5.1	8.2	8.0
Prescription amphetamines	3.2	6.8	3.0
Capsules	Not Available	Not Available	2.0

Table 28: Frequency of meth/amphetamine use, recent users aged 14 years and older, 2007 to 2013 (percent)			
Frequency of use	**2007**	**2010**	**2013**
All recent meth/amphetamine users			
At least once a week or more	13.0	9.3	15.5
About once per month	23.3	15.6	16.6
Every few months	27.9	26.3	19.8
Once or twice a year	35.6	48.8	48.0
Main form of meth/amphetamine used – ICE			
At least once a week or more	23.1	12.4	25.3
About once a month	24.3	17.5	20.2
Every few months	20.7	23.1	14.3
Once or twice a year	31.8	47.0	40.2
Main form of meth/amphetamine used – Powder			
At least once a week or more	7.7	2.9	2.2
About once a month	22.9	13.8	16.6
Every few months	31.6	29.0	20.0
Once or twice a year	37.6	54.4	61.2

ICE is used by individuals of all ages and strata of life in the NT, but it is commonly used as a "club drug", taken while partying in night clubs or at rave parties. In Darwin it has been reported that various professional groups use it during small social gatherings – amongst professionals in the education fraternity, one or two small groups in the legal professions have been observed using it, medical professionals anecdotally use it often to cope with the pressured work environment and long hours. It has been reported that there is a movement "Rock 4 Cock" in Darwin where young females are being paid by ICE for sexual services to men.

It is a dangerous and potent chemical, and as with all drugs, a poison that first acts as a stimulant but then begins to systematically destroy the body. Thus it is associated with

serious health conditions, including memory loss, aggression, psychotic behaviour and potential heart and brain damage. Highly addictive, ICE burns up the body's resources, creating a devastating dependence that can only be relieved by taking more of the drug.

ICE's effect is highly concentrated, and many users report getting hooked (addicted) from the first time they use it. *"I tried it once and BOOM! I was addicted",* said one ICE addict who lost his family, friends, his profession and ended up homeless. Consequently, it is one of the hardest drug addictions to treat and many die in its grip.

> *"I started using ICE when I was a senior in high school. Before my first semester of college was up, ICE became such a big problem that I had to drop out. I looked like I had chicken pox, from hours of staring at myself in the mirror and picking at myself. I spent all my time either doing ICE, or trying to get it."* Anne Marie (pseudo)

Although Banyan House is situated in Berrimah (Darwin), it accommodates people from all over the NT – large as well as small towns, and small rural and remote villages. Our experience with ICE and its effects on individuals, families and communities has thus been informed by the aetiology of the drug in urban, community and remote settings. We have found that the adverse effects of ICE is similarly devastating to all, regardless of the demographic, geography, cultural or individual setting.

Banyan House has not had the opportunity, neither the need, to develop a specific program that suits Aboriginal and Torres Strait Islander People (ATSI People) *per se*. The cohort of Indigenous People that chooses to engage in our therapeutic community and residential program has reported like successes as all other individuals from culturally diverse or Australian backgrounds. It is generally known that not all Indigenous People choose to access dedicated Aboriginal and Torres Strait Islander People Health Services. Some (at times up to 60%) prefer to access main stream oriented services, and we believe the latter to be the cohort of ATSI People who prefer and thus choose to access Banyan House's programs. All efforts are being made to ensure all our programs are delivered in a culturally sensitive and competent manner.

Challenging situations can arise with providing rehabilitation services to ICE users. These situations can include situations involving hostility, threats of violence and actual violence, and incidents involving people with psycho-stimulant–related psychosis. The vast majority of people, who access health / AOD services, including ICE users, are not aggressive or violent. Rather, research suggests that a small proportion of service users can be involved in a large number of incidents. This may lead to an unsafe workplace.

Challenging situations may be caused by stressful situations, including financial, interpersonal and health problems – in many instances following interaction with the police. Feelings that have been shown to trigger violence or aggression include anger, anxiety and fear. Features of the physical environment and the effects of psycho-stimulants are additional factors that may increase the likelihood of challenging situations. Challenging situations sometimes escalate quickly, but if hostility or violence occurs, it is usually preceded by a progression from relative calm through increasing levels of agitation.

As ICE (Psycho-stimulants) stimulates the central nervous system, the rate of a user's normal bodily processes increase so that the person feels very alert and energetic, and usually will have an intense feeling of wellbeing. A person who has recently used ICE can have fast, loud and difficult-to-interrupt speech; appear agitated (e.g. pace or can't sit still); engage in impulsive or reckless behaviour; appear sweaty; clench the jaw or grind the teeth; have large pupils.

Following a high dose of ICE, users can experience tremors, anxiety, sweating, racing heart (palpitations), and dizziness; tension, irritability, and confusion; intense fear, paranoia and panic states; sleeplessness; seeing or hearing things that other people cannot (illusions or hallucinations); loss of behavioural control and aggression.

Withdrawal from ICE can lead to agitation, irritability, mood swings, disrupted sleep patterns, and poor concentration.

A challenging situation can be triggered by the specific effects of intoxication or withdrawal from ICE, as described above; an exaggerated response to a real event in the person's life or a trigger in the immediate environment; fear or paranoia; psycho-stimulant-related psychosis (a person's contact with reality is grossly impaired); lack of staff training in recognising and responding to escalating hostile behaviour; a seeming or actual long wait for service, or lack of communication that leads to frustration or anger; a range of other environmental stressors.

d. Government and community responses to ICE in other states and some assessment of the effectiveness of these responses in terms of prevention, education, family and individual support and withdrawal and treatment modalities

Australia's National Drug Strategy was first developed in 1985 and is updated every five years. It is based on three pillars:

- Reducing the supply (availability) of drugs through law enforcement
- Reducing the demand for drugs through prevention and treatment
- Reducing the harms related to drugs among people who continue to use them

The Forster Foundation (Banyan House) specifically supports the demand management and the harm minimisation approaches and believes any plan that is developed in (for) the NT must come from a public health perspective.

The NT Government has invested in the development of a range of plans and frameworks including a Domestic and Family Violence Strategy, Suicide Prevention Strategy and has also been developing a Mental Health Plan as well as a Youth Justice Framework. In order for these to be the most effective, we need to ensure that the impact and responses to ICE, and all other drugs and alcohol are recognised in all of the strategies. It is a well-known fact that drugs and alcohol plays a significant role in all the aforementioned challenges in the NT.

As mentioned before, Banyan House has experienced a sharp rise in the number of people accessing services for support to deal with ICE addiction over the past 12 months. Alcohol use remains the primary drug of choice and thus why people seek treatment; and ICE use is now number two – however, of late more than 70% of the current clients seeking help at Banyan House is ICE related, with alcohol an underpinning problem. The NT needs a broad based approach which allows organisations and governments to respond as needed.

Banyan House in its current form and structure is only positioned to provide withdrawal and medium to long term residential rehabilitation services to people 18 years of age and older. We do not offer our services to young people at this stage. It has anecdotally been advised that young people primarily use ICE to heighten sexual experiences – young people as young as 12 years old are allegedly involved in these practices. They also use ICE as a means of weight control – specifically against the backdrop of peer pressure to be fit and thin, and have an admirable physique. ICE is being used to improve endurance, weight control and to push the body past its physical capability. There is a link between ICE use and youth suicide. It has also been reported that specifically young females are being introduced into the habit by paying them for their service to men – the "Rock4Cock" movement that operates covertly in Darwin, specifically the Palmerston area. It has also been reported that young females are being paid by ICE for baby-sitting services by affluent families in Darwin.

Short/medium and long term (residential) rehabilitation services to young people is a growing need as we have been made aware that young people as young as 13 are using ICE. Without age appropriate services the NT is failing in its duty of care towards this cohort of people.

Banyan House has commenced a strategy to source alternative funding towards a feasibility study to develop a youth residential rehabilitation centre for young people. We have the physical space (land) available for that purpose, and will be investigating philanthropic funding supported by Federal and State Government funding support for the ongoing sustainable operation of such a facility.

It needs to be mentioned at this stage that for some time now, many advocates have long called for a public health approach. Currently the majority of money spent on drugs is in the law enforcement area. We would strongly advocate that a significant shift needs to occur so that the majority of resources are invested in early intervention, treatment and education services.

As mentioned in the NTCOSS submission, there is concern amongst a broad spectrum of the community that the current strategy on drugs in Australia is not very effective – we are fighting a war against drugs, and we are not winning. Former AFP Commissioner Mick Palmer wrote as recent as 2012 – *"The reality is that, contrary to frequent assertions, drug law enforcement has had little impact on the Australian drug market. This is true in most countries of the world. In Australia, the police are better resourced than ever, better trained than ever, more effective than ever and yet their impact on the drug trade, on any objective assessment, has been minimal."*

Most other states and jurisdictions in Australia are ahead of the NT in their development of a planned approach to ICE use. As a small jurisdiction, we should take the opportunity to benchmark from the leaders of contemporary ICE management strategies – not only in Australia, but also look at players in the international sphere as informed by the World Health Organisation. The NT is in an ideal situation not having to reinvent the wheel but can adopt state of the art measures that will be transferable to the NT.

The Forster Foundation also supports the Victoria Government's ICE Action Plan, and would like to encourage the NT Government to consider adopting a similar approach. The plan has six key areas:

- Helping families
- Supporting Front Line Workers
- More support where it is needed
- Prevention is better than cure
- Reducing supply on our streets
- Safer, stronger communities

A key element currently missing in the NT is the introduction of a Drug Court. We hold an anecdotally informed opinion that former drug court models in the NT have not been evaluated properly to be able to learn from mistakes and correct same, before just scrapping those initial interventions.

International literature informs that there is a significant amount of evidence that diversion programs work to keep people out of the prison system. It is a far more effective way of supporting people with substance issues as well as being very cost effective. Putting health and community safety first requires a fundamental reorientation of policy priorities and resources, from failed punitive enforcement to proven health and social interventions. Previous stated goals of drug control policies and the criteria, by which such policies are assessed, merit reform. Traditional goals and measures such as eradication of crops, amounts of drugs seized and number of people arrested, prosecuted, convicted and incarcerated for drug law violations have failed to produce positive and desired outcomes. Far more important are goals and measures that focus on reducing both drug-related harms such as fatal overdoses, HIV/AIDS, hepatitis and other diseases, as well as prohibition-related harms such as crime, violence, corruption, human rights violations, environmental degradation, displacement of communities and the power of criminal organisations. Spending on counterproductive enforcement measures should be ended, while proven prevention, harm reduction and treatment measures are scaled up to meet need (Global Commission on Drug Policy).

Banyan House does not have the financial and organisational means to do continued and in-depth research and benchmarking with all other states to determine the extent of all other programs/responses in all other states. However, the recent appointment of a new CEO who has extensive experience working in related fields in Tasmania, Victoria, Queensland and now the NT; as well as the newly appointed Clinical Services Manager who has 20 years experience in a very contemporary AOD organisation in Victoria; the appointment of a new Board member who has extensive experience in AOD Policy development in Victoria - as well as management experience of AOD services in Tasmania and the second largest Community AOD Service in Melbourne; has brought extensive knowledge and experience of contemporary responses to alcohol and other drug service delivery.

The new board and management team has over the past three months completed benchmarking studies on services in Victoria (which is generally known for the contemporaneousness of their services), Canada, USA, United Kingdom and New Zealand, and have incorporated 'best' / good practice principles in the strategic intent and tactical execution of its responses to the ICE problem in the NT.

Current evidence based treatment approaches

1. Withdrawal - Types of withdrawal – Residential, hospital based, home based
2. Brief Opportunistic Interventions
3. Cognitive Behavioural Therapies / Counselling
4. Group Therapy
5. Residential Rehabilitation
6. Mental Health – Dual Diagnosis / Integrated Treatment Modality in Service Delivery

1. Withdrawal

Banyan House has six full time beds used in medically supervised withdrawal responses in partnership and collaboration with NT Government AOD – Withdrawal service. We provide withdrawal services to poly-substance users, including ICE. These six beds are being funded through a grant from the NT Department of Health.

These facilities have over the past five years never been over-used and we hold the opinion that it is sufficient for the current demand. Banyan House does have the capacity and space to increase these beds on a temporary basis. Should the demand continue to rise, a new approach to funding, partnerships and collaborations will have to be investigated and employed.

Banyan House's strategic intent informs us that there is significant scope for research into the phenomenon ICE in the NT. For that purpose, a long term view has been formed to investigate investment (private and/or public) into the establishment of an ICE-ROOM/ICE HOUSE at our current facilities in Berrimah. Banyan House has established excellent collaborative partnerships with Charles Darwin University to collaborate in research as well as operational implementation and evaluation of programs.

The development of similar relationships with The Menzies Institute and the Faculty of Medicine at CDU is underway with the explicit focus of establishing a strong research and evaluation capacity into this challenge.

Research on ICE withdrawal (summary)

- 70% of users have attempted withdrawal
- Attempted times: mean 13 times (0-88 times)
- 73% self-medicate, 20% cold turkey, 1% reduce and stop
- 28% used opioids, 27% benzo's, 29% alcohol, 10% cannabis, 3% herbal remedies
- Last withdrawal attempt – 84% alone, 9% with support from AOD Service
- Only 13% had never sought treatment
- As most ICE use is intermittent, i.e. not daily, users will go through a withdrawal pattern, even for a short time on a regular basis
- It is not necessary for users to binge on ICE for long periods of time to experience withdrawal symptoms
- Withdrawing from ICE is different from withdrawal from depressants (opiates, alcohol, cannabis)
- Withdrawal symptoms are likely to be experienced to some extent after much shorter exposure and may be exacerbated by tiredness associated with lack of sleep or extended partying
- Most users attempting withdrawal will be poly-drug users
- Completed withdrawal is a prerequisite for rehabilitation

2. Brief Opportunistic Interventions

A treatment strategy in which structured therapy of short duration (typically 5-30 minutes) is offered with the aim of assisting an individual to cease or reduce the use of a psychoactive substance or (less commonly) to deal with other life issues.

Sessions can be a single episode ranging from 5-30 minutes (very brief intervention). This allows for opportunistic sessions where information is given to clients about any health issues, or up to 3-5 sessions of 20-30 minutes. This allows for follow up on issues for people willing to accept help and where risks are high, e.g. dependence.

Appropriate settings for this strategy include:

- Primary care settings such as hospitals, or General Practice
- Community Health Services
- AOD Services
- Mental Health Services
- Pharmacies
- Youth Services
- Counselling Services
- Outreach
- Can be integrated into more intensive therapeutic settings such as residential rehabilitation and withdrawal services

Evidence base – a number of studies have confirmed that brief intervention is an effective strategy in reducing harms associated with substance abuse. The evidence confirms it is:

- Cost effective
- Works with alcohol, cannabis, benzodiazepines, opiates and cocaine
- Has long lasting effects (especially when follow-up occurs)
- Able to be used with all age groups
- Applicable across a range of settings
- Rooted in:
  - Condensed Cognitive Behaviour Therapy, and
  - Brief Motivational Interviewing
  - Stages of Change

Brief Interventions *versus* Therapy

The difference between Brief Intervention and Therapy is:
"Brief Intervention aims to motivate a client into action (e.g. enter treatment, change behaviour, think differently), whereas, Therapy is used to address larger concerns (such as altering personality, maintaining abstinence, or addressing long-standing problems that exacerbate substance use".

Limitations of Brief Interventions

It is not appropriate to use Brief Interventions if a client has:

- Additional psychological/psychiatric issues
- Severe dependence
- Poor literacy skills
- Is cognitively impaired
- Acute physical illness

3. Therapy / Counselling

Cognitive Behavioural Therapies (CBT)

Evidence shows CBT is the most effective treatment approach to support withdrawal management, anxiety and depression. It maintains support and engagement, step up intensity of treatment if mental health deteriorates and it encourages nutrition and exercise. It is for that reason that Banyan House applies CBT interventions in both its individual therapies as well as group therapies on offer.

Banyan House uses *"A brief Cognitive behavioural intervention for regular amphetamine users – A treatment guide"* under the following citation:

> Baker, A., Kay-lambkin, F., Lee, N.K., Claire, M. & Jenner, L. (2003). A Brief Cognitive Behavioural Intervention for Regular Amphetamine Users. Australian Government Department of Health and Ageing.

This publication can be sourced from the Publications tab on the website www.health.gov.au.

4. Group Therapies

Group Therapies such as Narcotics Anonymous, peer support groups, SMART (Self Managed Addiction Recovery Training) and peer run groups have been researched and are being used in most states as evidence based responses to the ICE problem.

Banyan House uses CBT based Group Therapies in its residential rehabilitation programs. We are on schedule to implement SMART Recovery Training to all its staff and senior residents towards offering this treatment modality as its After Care Response and Family Support Groups – not only to residents and their families, but to the wider community in the greater Darwin context. Banyan House will be the first and only SMART Group in the NT.

5. Residential Rehabilitation

This is the basic premise of Banyan House. Since inception, Banyan House has been offering a mandated Therapeutic Community (TC) as its response to AOD rehabilitation needs. ICE clients participate as well as those with other drug dependence issues.

Banyan House offers, as part of its current residential rehabilitation service capacity, the following programs:

- 12 -52 week Residential Rehabilitation Program
- Extended Residential Program
- Aftercare program
- Co-managed Residential AOD Withdrawal Program
- Parenting Program
- Family support
- Community education and awareness
- Clinical assessments – AOD as well as Mental Health for Dual Diagnosis purposes
- SMART Court Program
- Legal and Court Reports
- Pre-court and Police diversion program – counselling and education

6. Mental Health – Dual Diagnosis / Integrated Treatment

Population estimates indicate that more than one third of individuals with an AOD use disorder have at least one co-morbid mental health disorder; however, the rate is even higher amongst those in AOD treatment programs. Additionally, there are a large number of people who present to AOD treatment who displays *symptoms* of disorders while not meeting the criteria for a *diagnosis* of a disorder.

The primary goal of AOD treatment services is to address clients' AOD use. However, in order to do so effectively, AOD workers must take into account the broad range of issues clients present with, including their mental health. The high prevalence of co-morbidity means that AOD workers are frequently faced with the need to manage complex psychiatric symptoms or problems, which may interfere with their ability to treat clients' AOD use. As such, it is important that all AOD workers are aware of the mental health symptoms that clients commonly present with, and are aware of how to manage these symptoms.

The first step is to be able to identify mental health problems. Despite high rates of co-morbidity amongst ICE users, it is not unusual for co-morbid mental health conditions to go unnoticed by AOD workers. This is mostly because they are not routinely looking for them. It is a **recommendation** that all clients of AOD treatment services – but specifically those using ICE - be screened and assessed for co-morbidity as part of routine clinical care.

Once identified, these symptoms may be effectively managed while the person is undergoing ICE treatment. Co-morbidity is not an insurmountable barrier to treating people with ICE use disorders. Indeed, research has shown that clients with co-morbid mental health conditions can benefit just as much as those without co-morbid conditions from usual AOD treatment.

Some clients with co-morbidity may require additional treatment for their mental problems. Some interventions have been designed for the treatment of specific co-morbidities; however, these interventions generally have not been well researched. In the absence of specific research on co-morbid disorders, it is recommended that best practice is to use the most effective treatments for each disorder. Both psychosocial and pharmacological interventions have been found to have some benefit in the treatment of many co-morbidities.

In addition to mental health services, AOD workers may need to engage with a range of other services to meet clients' needs. Clients with co-morbid mental health conditions often have a variety of other medical, family and social problems (e.g., housing, employment, welfare, legal problems). A broad, multifaceted and multidisciplinary approach is needed in order to address all of these issues effectively and it is important that AOD services and workers providing services to ICE users develop links with a range of local services. When referring ICE clients to other services, active referral with assertive follow-up is recommended.

Barriers for clients

- Don't think they have a problem
- Perception that there's no treatment
- Patterns of use different than other drugs
- Fatigue and low motivation
- Lack of available pharmacotherapy
- Co-morbidity – mental health issues

Barriers for Service Providers

- Characteristics of ICE users – difficult to engage – aggressive, hostile, depressed
- Stigmas in the field about this group
- Psychosis and paranoia difficult to treat
- No standard treatment regime
- Lack of available and dedicated doctors and psychologists
- High demand, not enough beds / places
- Rural / remote locations
- Under-funded, lacking in experienced staff, coping rather than progressing
- Lost once clients walk out the door – poor follow-up

Treatment Approaches for Users of Methamphetamine – A Practical Guide for Frontline Workers

Banyan House, in its development and delivery of treatments to ICE users, also follows the guidelines as developed by Turning Point on behalf of the Commonwealth Department of Health and Ageing. The work completed by Jenner and Lee in 2008 as published in the following publication:

> Jenner L and Lee N (2008). *Treatment Approaches for Users of Methamphetamine: A Practical Guide for Frontline Workers.* Australian Government Department of Health and Ageing, Canberra.

f. Best practice work place health and safety measures for those in the health system who come into contact with users of ICE

The third pillar of the Australia National Drug Strategy focuses on reducing the harms related to drugs among people who (continue) to use them. Banyan House fully subscribes to supporting and implementing this principle.

Harm Minimisation

The aim of harm minimisation is to reduce the harms of drug use and related harms across the Australian population. Since the 1980's Australia – in line with International Good Practice, has adopted this approach to drug use problems, viewing it as a *public health* issue, not discarding that it is also a *legal issue*.

Principle: *Do no harm: Ensure that any treatment provided does not cause harm to the person,* e.g. a person with substance use problem may require medical supervision during withdrawal if there is a risk of seizure, coma or death. A person with an injecting drug use problem may not be able or ready to stop completely, so health education on Hepatitis C and Needle & Syringe programs may be appropriate. This may also create a pathway for the person to seek help later.

Focus on drug related harms

- *Safer injecting techniques* help users avoid being infected with blood borne viruses and avoid spreading them to others
- *Planning safety while intoxicated*: Behaviour and activity while intoxicated may be harmful to self and / or others, in public or domestic sphere
- *Reducing or controlling use*: Addiction to the drug itself, is a drug related harm
- *Calling an ambulance:* When someone has overdosed or is displaying symptoms of ICE toxicity, psychosis professional help must be accessible in the first instance by calling an ambulance to attend to the person
- *Save a mate:* Community should be educated and empowered to look out for another when using together
- *Abstinence:* Stopping drug use when your use is hurting yourself or your family
- *Safe disposal of needles and syringes:* The public should be educated to dispose of needles and syringes through identified and accessible NSP services or in many of the public needle disposal units

Physical harms

- Skin – lesions from picking (scabs)
- Teeth – eroding gums from little saliva, teeth ground down
- Heart – irregular heart rhythm, cardiac arrest
- Head – stroke
- Psychomotor retardation – reports of long term use increasing risk of Parkinson's disease
- Hyperthermia – overheating lead to seizures
- Kidneys – constriction of blood vessels, lower urine output, infections, kidney stones
- Liver – blood borne viruses, Hep C, HIV
- Sleep irregularities may remain
- Sexual function:
    - Women: weight loss, cessation of menstruation, pregnancy, low birth weight, risk of premature birth and withdrawal
    - Men: ICE use may induce erection but impair ejaculation, some reports of testicles shrinking.

Mental health harms

- Anxiety – dopamine function depleted, reward function reduced
- Depression – serotonin function disrupted which regulates mood evaluation
- Learning, memory and cognition – dopamine function reduced
- Poorer planning and concentration – noradrenalin function depleted
- Psychosis – risk of drug induced psychosis is more likely to reappear after first onset. Domestically produced products appear to induce psychosis more readily

Risks of causing harm

Route of administration	Effect	Risks
Intravenous	Intense peak effect within seconds	Injection risks include: • Inflammation, infection, scarring or abscesses at IV site • Introduction of contaminants which may result in thrombosis • Increased risk of developing tolerance and dependence • Blood borne viruses – Hep C, HIV • Vein damage
Smoking / Inhalation	Slightly less intense onset	• Second to injection for rapidity of effect • May have sore throat, bloody sputum and potential exacerbation of asthma • Damage to lung tissue • Quick route to dependent use
Snorting	Weaker onset and slower reduction slightly longer tasting	• Damage to nasal passages, may cause nasal ulcers, runny nose, sinusitis, septum perforation
Swallowing or 'bombing'	Delayed absorption, slower speed of onset	• Impatience waiting for effect, inability to control dose, seeking stronger more intense effect may result in taking more ICE/drug(s), possibly increasing intoxication risks • Variable effect depending on presence of food, may increase rate of gastric emptying

Aspects in ensuring safety of people coming into contact with ICE users

It is essential to consider the whole person and accept that one approach is not necessarily going to work for all users of ICE. Different clients present with unique psychological and socio-demographic backgrounds and it is important to take these factors into consideration in managing symptoms and presentations. The following key points are important to consider when engaging any ICE user towards providing treatment:

- It is essential to consider the whole person (from psychological, physical and socio-demographic perspectives) when engaging each person.
- Suicide risk should be assessed in the first instance and monitored / managed throughout the engagement / treatment journey.
- Motivational enhancement, simple CBT-based strategies, relaxation and grounding techniques can be useful in managing ICE users as well as their mental health.
- Symptoms of trauma, grief, and loss can be managed through anxiety management strategies and open discussion with the client. It is important to normalise the experience of these symptoms for each client.
- When dealing with more challenging clients, it is necessary to ensure a safe environment, set clear boundaries and place strong emphasis on engagement and rapport building.
- Co-morbid mental health symptoms can be managed and controlled whilst the client undergoes AOD treatment for ICE use.

It needs to be mentioned that Banyan House, in its development and delivery of treatments to ICE users, follow the guidelines as developed by Turning Point on behalf of the Commonwealth Department of Health and Ageing. The work completed by Jenner and Lee in 2008 as published in the following publication:

Jenner L and Lee N (2008). *Responding to Challenging Situations Related to the use of Psycho stimulants: A Practical Guide for Frontline Workers.* Australian Government Department of Health and Ageing, Canberra.

This guide is attached as Appendix A to this Submission. It is intended to be useful to a range of frontline workers, particularly those workers without a professional or clinical background. It offers practical tips for reducing the likelihood of challenging situations, responding during a crisis, and reviewing the management of a challenging situation. The guide also includes considerations for specific service settings such as needle syringe programs, outreach services, withdrawal programs, community health centres; and residential rehabilitation settings.

Below information is taken from the resource mentioned above, and the specific publication is acknowledged.

People in the health system who interact with ICE users include frontline workers, including counsellors, case managers, support workers, administration officers, volunteers from alcohol and other drug services, and workers from a variety of other health, welfare and service settings such as nursing and other medical staff in hospitals' Emergency Departments.

Challenging situations can include situations involving hostility, threats of violence and actual violence, and incidents involving people with psycho-stimulant–related psychosis. The vast majority of people, who access health services, including ICE users, are not aggressive or violent. Rather, research suggests that a small proportion of service users can be involved in a large number of incidents. This may lead to an unsafe workplace.

Challenging situations may be caused by stressful situations, including financial, interpersonal and health problems – in many instances following interaction with the police. Feelings that have been shown to trigger violence or aggression include anger, anxiety and fear. Features of the physical environment and the effects of psycho-stimulants are additional factors that may increase the likelihood of challenging situations. Challenging situations sometimes escalate quickly, but if hostility or violence occurs, it is usually preceded by a progression from relative calm through increasing levels of agitation.

There are early signs that a person is becoming hostile or aggressive, including de-escalation techniques that involve calming the person and managing the physical environment to reduce the risk of harm to him or herself or others. Although few studies have been conducted on de-escalation techniques, they are recommended consistently by national and international guidelines, and expert opinion. Success stories from the literature demonstrate that effective policy responses to challenging situations include strong organisational awareness and support for risk reduction. All workers have a role in reducing the likelihood of a challenging situation. Challenging situations are often underreported in the health workplace, and incident reporting as an important part of establishing a workplace culture that promotes a safe workplace for all.

People who are most at risk of being involved in a challenging situation include those who:

- have been aggressive or violent in the past
- are using multiple drugs with psycho-stimulants (e.g. alcohol, heroin, benzodiazepines, cannabis, or more than one type of psycho-stimulant at once
- are intoxicated with ICE or another drug
- are withdrawing or 'coming down' from ICE
- have multiple difficulties in their life (e.g. financial, legal, health, housing, relationships, etc)
- also have a serious mental illness such as schizophrenia

Young men are more likely to be involved in challenging situations than other users.

How should workers respond to challenging situations?

Workers are often well equipped with the skills and knowledge necessary to respond to challenging situations. Even when ICE use is involved, workers should rely on their experience and feel confidents in their ability to respond appropriately.

Challenging situations should be managed in the same ways that other hazards in the workplace are managed, and workers have a responsibility to familiarise themselves with their agency's existing policy and procedures. Frontline workers and managers alike have key roles to play in reducing the likelihood of challenging situations and in responding skilfully if they do occur - teamwork and a consistent approach are essential.

An effective response to challenging situations involves a linked, three phased approach as described by the National Health and Medical Research Council (NHMRC).

- **Before**: **Risk Management**
  - Assess workplace for potential hazards
  - Determine level of risk for each hazard
  - Rectify and control hazards and ensure adequate staff training
  - Monitor risks and hazards and review regularly

- **During**: **Immediate Response**
  - Focus on safety
  - Rapidly assess and respond
  - Use de-escalation techniques
  - Call for police assistance if situation becomes uncontrollable

- **After**: **Recovery and Review**
  - Meet immediate needs of those involved
  - Re-establish services
  - Submit detailed report
  - Review of incident
  - Develop client re-entry plan

BEFORE – preventing and reducing the likelihood of a challenging situation

The occurrence of challenging situations in which hostility, aggression or violence occur will never be completely eliminated in the workplace, so appropriate and active steps should be taken to reduce and manage risk before it occurs.

Consistent with NHMRC guidelines services should aim to:

- assess the workplace for potential dangers before they arise (hazard identification),
- determine the level of risk associated with each hazard (risk assessment),
- take steps to rectify those hazards that pose the most risk (risk prevention and control), and
- monitor hazards and risks and undertake regular reviews so lessons can be learned and workplace procedures adapted accordingly (monitoring and review).

Hazard identification

Potential workplace hazards are specific to individual services settings and can include:

Hazards relating to staff training and communication:

- Lack of a clear plan for responding to challenging situations
- Staff untrained in recognising and responding appropriately to challenging situations
- Poor communication or lack of communication between workers and service users

Hazards relating to work practices:

- Work practices involving after hours services with limited numbers of staff members
- Lengthy waiting times for service

Hazards relating to environmental and security factors:

- Risk factors related to the building layout or design, including lack of telephone access, poor lighting, areas with unsecured access, awkward or limited number of exits, lack of duress alarms, isolated interview rooms
- Physical environments where service users are crowded or are required to congregate for extended periods
- Too much noise or stimulation in waiting areas (e.g. noisy televisions, radios, mobile phones)
- Furniture or fittings that can be easily moved or thrown
- Unknown effectiveness of existing security measures

Risk assessment

Risk assessment involves identifying which hazards pose the greatest safety risks to workers and service users. The hazards should then be prioritised from the most urgent to the least urgent, taking into consideration the service's budget constraints.

Workers should also ensure that an assessment of the mental state of ICE users who are known to have a psychotic illness is undertaken by a trained clinician so that an individualised plan for preventing and responding to a challenging situation can be developed.

Risk prevention and control

A range of actions could be suitable to tackle the identified hazards and could include the following.

Staff education and training:

- Make sure that workers are familiar with existing policies and procedures regarding challenging situations, or creating policies and procedures or detailed action plans where none currently exists.
- Educate workers about ICE. This can include the effects of ICE intoxication and withdrawal, including accelerated bodily functions and high level of arousal; short attention span; potential for paranoia or psychosis; irritability; mood swings; sleeplessness.
- Train workers to respond to challenging situations including recognising when a service user is becoming hostile or aggressive, and how to calm a person using verbal and non-verbal communication skills (known as 'de-escalation techniques'). Role plays of specific scenarios are useful in helping workers practice their skills. Workers should be encouraged to respond to challenging situations according to their personal ability and level of confidence.
- Provide regular staff training regarding incident reporting and action plans for challenging situations, with an emphasis on the importance of consistently applying the action plan.

Attention to service users:

- Make a visibly clear statement of service users' rights and responsibilities that incorporates clear processes of communication, complaints and advocacy.
- Provide sensitive and timely information to waiting service users.
- Adopt measures to decrease waiting time if possible.
- Aim for a smooth flow of service user movement through the agency if practical or possible.
- Provide flexibility in service delivery to meet the individual needs of ICE users.

Safety issues:

- Provide free access to exits, telephones, and duress alarms.
- Minimise hazards relating to staff members who work alone, particularly at night or when assistance is unavailable.
- Establish links with mental health services to ensure a prompt assessment or secondary consultation should a challenging situation occur.
- Require every worker to report all threats, hostility or incidents of violence to a supervisor or manager, and every worker to keep detailed records and reports of such incidents.
- Establish a liaison with local police to ensure a prompt response, should a serious incident occur.

DURING – responding to challenging situations

General principles

- Safety is paramount.
- Workers need to recognise that reasons for a service user's anger or frustration are often valid so workers should listen and respond sensitively to concerns as they arise.
- Workers need to understand that, in a crisis, they are responsible for managing the situation and avoiding provocation - it is often not realistic to expect an agitated, angry, or intoxicated person to calm down just because he or she is asked to do so.
- Workers should recognise the point at which de-escalation techniques have failed to calm a situation sufficiently, at which time police assistance should be sought urgently.

Aims of the response

When faced with a real or potentially challenging situation, workers should:

- Recognise the signs of impending aggression or violence,
- Intervene early to reduce the chance that a challenging situation will lead to aggression or violence,
- Maintain the safety of everyone involved, AND
- Call for assistance when de-escalation strategies are not effective.

Information on the topics below can be obtained from Banyan House's Operational Procedures or from the specific publication acknowledged and cited above.

- Signs that an ICE user is becoming hostile or aggressive
- What if a person is experiencing psychosis?
- Response strategies
- De-escalation Techniques
  - Initial approach
  - Communication strategies
- When an ICE user does not respond to de-escalation techniques
- When an ICE user does respond to de-escalation techniques

AFTER – Recovery and review

Immediately following an incident, the physical, emotional and psychological needs of staff members, other service users or bystanders should be attended to in a supportive safe environment, particularly if any were victims of aggression or violence. Immediate responses to any worker(s) who was involved, injured or traumatised during the incident include:

- medical care if required,
- the offer of counselling if required (e.g. employee assistance program or on-site counselling if available), and
- an opportunity to seek legal advice if required.

Further information on the following important actions can be obtained from Banyan House's Operational Procedures:

- Recovery: Immediately following the situation
- Review: After the event
  - Ongoing support
  - Preparing for the service user's return to the service
  - When a service user cannot re-enter the service

Intoxication behaviour

- Drug driving – ICE and alcohol, person may think they are OK with excess alcohol
- Unsafe sex – increased libido, increased risk taking
- Agitation and aggression – if in the wrong place at the wrong time, may cause harm to self or others
- Criminal activity
- Intoxicated behaviour – increased risk taking (legal problems), possible harms to others, harm to the body, doing things you later regret
- Poor nutrition – loss of weight, strength, stress on internal organs, immune system
- Mental health problems in withdrawal or cessation – depression, anxiety, cognitive impairment – possible damage to executive brain functioning
- Overdose / toxicity – overheating / seizures, stroke, cerebrovascular accident, drug induced psychosis
- Sleep disturbance – insomnia, disturbed sleep patterns

3. Implications for Residential Rehabilitation in the Northern Territory – by implication Banyan House

- Due to the patterns of ICE use having changed since 2010, Banyan House had to adjust its clinical / therapeutic approaches to providing/facilitating rehabilitation.
- Medically supervised withdrawal capacity has come under pressure due to the changing nature of the drug presentations, length and intensity of withdrawals.
- Levels and breadth of skills required to provide evidence based treatment has changed requiring a different type of workforce to provide effective treatments to residents, education to the community and family members
- The physical facilities Banyan House has is in need for updating to be able to offer varying and diverse groups of individual and group therapies – the current facility was designed and built for a different cohort of people accessing services, and does not have any training rooms to facilitate outpatient / external day programs.
- The sharp increase in Forensic and Corrections mandated clients put an immense amount of pressure on current resources to be able to do court mandated / corrections driven urgent alcohol & drug assessments and to then reserve beds for said client group versus pressure from NT Department of Health NOT to accommodate Corrections/Forensic clients on a preferred / reserved basis as "Banyan House is a Health Facility and not a Correctional Facility".
- Increased requests for community education cannot be satisfied due to lack of skilled / shortage of appropriately trained staff. Banyan House's staff tables have been developed for operational entry level qualifications such as Cert IV in AOD. This caters for very operational support worker type roles in a residential facility and not advanced trained professionals / therapists to deliver professional therapy / community education.
- Banyan House is run on a shoestring budget. The ever-increasing lack of commitment to renew funding by the Commonwealth Government brings job insecurity amongst staff leading to high staff turnover. Continual Reviews of Health Services and service delivery has a destabilising effect on workforce and effectively reducing our capacity to meet service demand and putting our Demand Management Strategy under significant pressure.

4. Recommendations

The Forster Foundation (Banyan House) wishes to make the following recommendations:

4.1 A comprehensive Northern Territory Alcohol and Other Drug Strategy and Plan be developed, with specific reference to ICE.

4.2 The Select Committee considers and make recommendations towards ensuring a significant shift enjoy executive sponsorship ensuring the majority of resources are invested in early intervention, treatment and education services. Consult with relevant organisations in the development of such programs.

4.3 In doing so, recognise the impact of ICE use on the broader social sectors including domestic violence and family violence, youth and housing.

4.4 The Select Committee considers advising the NT Government to invest in an appropriately developed Youth AOD Rehabilitation capacity

4.5 Consider implementing (similar concept) Drug Courts with all the implications that goes with that.

4.6 Consider funding dedicated rooms and staff to accommodate and deliver treatment to Forensic and Corrections clients that are currently not funded by the Department of Health Grants

4.7 As informed by international evidence, increase finding into the development and implementation of Diversion Programs – specifically for youth.

4.8 Utilise the experience of other jurisdictions including Victoria to develop a plan which has a specific public health focus – this plan can include the introduction of a drug court.

4.9 The Select Committee considers advice on developing and implementing an "ICE HOUSE" capability at community level – Banyan House can facilitate that as an adjunct to its current withdrawal unit.

4.10 Develop a comprehensive work health and safety strategy in the NT AOD Strategy and Plan which recognises the broad impact of alcohol and drugs, explicitly the impact of ICE.

Closing remarks and Invitation

The Forster Foundation with to thank the Select Committee for providing us with the opportunity to provide input into the prevalence, impacts and government responses to ICE in the Northern Territory.

The Forster Foundation wishes to invite the Select Committee to visit Banyan House, the Northern Territory's Residential AOD (including ICE) Withdrawal and Rehabilitation Facility towards developing a sound understanding of the practical implications of ICE withdrawal and rehabilitation.

During this visit the Committee will have the opportunity of meeting the Board, management, staff, clients and families, and tour the facility.

(signed)
Chris Franck
Chief Executive Officer

Appendix A: High Level Orientation into the drug ICE (Crystal Methamphetamine)

What is crystal meth - ICE?

Crystal meth is short for crystal methamphetamine – colloquially known as 'ICE'. It is just one form of the drug amphetamine. Methamphetamine is a white crystalline drug that people take by snorting it (inhaling through the nose), smoking it or injecting it with a needle. Some even take it orally, but all develop a strong desire to continue using it because the drug creates a (false) sense of happiness and well-being – a rush (strong feeling) of confidence, hyper-activeness and energy. One also experiences decreased appetite. These drug effects generally last from six to eight hours, but can last up to 24 hours.

The first experience might involve some pleasure, but from the start, methamphetamine begins to destroy the user's life.

ICE is an illegal drug in the same class as cocaine and other powerful street drugs. It has many nicknames – meth, crank, chalk, or speed being the most common.

Street names for Methamphetamine **Methamphetamine (meth) and crystal methamphetamine are referred to by many names:**	
METH • Beannies • Brown • Chalk • Crank • Chicken feed • Cinnamon • Crink • Crypto • Fats • Getgo • Metlies Quik • Mexcan crack • Pervitin (Czech Republic) • Redneck cocaine • Speed • Tick tick • Tweak • Wash • Yaba (Southeast Asia) • Yellow spider	CRYSTAL METH • Batu • Blade • Cristy • Crystal • Crystal glass • Glass • Hot ice • Ice • Quartz • Shanu • Shards • Stove top • Tina • Ventana

What does ICE look like?

ICE usually comes in the form of a crystalline white powder that is odourless, bitter-tasting and dissolves easily in water or alcohol. Other colours of powder have been observed, including brown, yellow-gray, orange and even pink. It can also be compressed into pill form. As covered earlier, it can be snorted, smoked or injected or taken orally. ICE comes in clear chunky crystals resembling ice and is most commonly smoked.

What is ICE made from?

Methamphetamine is a synthetic (man-made) chemical, unlike cocaine, for instance, which comes from a plant.

Meth (ICE) is commonly manufactured in illegal, hidden laboratories, mixing various forms of amphetamine (another stimulant drug) or derivatives with other chemicals to boost its potency. Common pills for cold remedies are often used as the basis for the production of the drug. The meth 'cook' extracts ingredients from those pills and to increase its strength combines the substance with chemicals such as battery acid, drain cleaner, lantern fuel and /or antifreeze.

These dangerous chemicals are potentially explosive and because the meth 'cooks' are drug users themselves and disoriented, they are often severely burned and disfigured or killed when their preparations explode. Such accidents endanger others in nearby homes or buildings.

The illegal laboratories create a lot of toxic waste as well – the production of one kilogram of methamphetamine produces five kilograms of waste. People exposed to waste material can become poisoned and sick.

> *"Welfare money was not enough to pay for our ICE habit and support our son so we turned our rented home into a meth lab. We stored the toxic chemicals in our refrigerator not knowing that the toxins would permeate [go into] the other food in the icebox. When I gave my three-year-old son some cheese to eat, I did not know that I was giving him poisoned food. I was too stoned on ICE to notice, until 12 hours later, that my son was deathly ill. But then I was so stoned it took me two hours to figure out how to get him to the hospital five kilometres away. By the time I got to the emergency room my boy was pronounced dead of a lethal dose of ammonia hydroxide – one of the chemicals used to make ICE".*
> Melanie (pseudonym)

The devastating effects of ICE - The short and long-term impact on the individual

When taken, ICE creates a (false) sense of well-being and energy, and so a person will tend to push his body faster and further than it is meant to go. Thus, drug users can experience a severe "crash" or physical and mental breakdown after the effects of the drug wear off. Because continued use of the drug decreases natural feelings of hunger, users can experience extreme weight loss. A 19 year old male recently admitted to Banyan House was weighing 43kg upon entry and gained 20kg in the first two weeks after following a healthy diet of three small meals per day.

Negative effects can also include disturbed sleep patterns, hyperactivity, nausea, and delusions of power, increased aggressiveness and irritability. Other serious effects can include chronic insomnia, confusion, hallucinations, anxiety and paranoia* (*paranoia: suspicion, distrust or fear of other people).

In the long term, ICE use can cause irreversible harm: increased heart rate and blood pressure; damaged blood vessels in the brain that can cause strokes or an irregular heartbeat that can, in turn, cause cardiovascular * collapse or death; and liver, kidney and lung damage. (* Cardiovascular: related to both the heart and blood vessels. Users may suffer from brain damage, including memory loss and an increasing inability to grasp abstract thoughts. Those who recover are usually subject to memory gaps and extreme mood swings, which plays a significant role in family and domestic violence.

ICE Harm	
Short-term effects	**Long-term effects**
• Loss of appetite • Increased heart rate, blood pressure, body temperature • Dilation of pupils • Disturbed sleep patterns • Nausea • Bizarre, erratic, sometimes violent behaviour • Hallucinations, hyper-excitability, irritability • Panic and psychosis • Convulsions, seizures and death from high doses	• Permanent damage to blood vessels of heart and brain, high blood pressure leading to heart attacks, strokes and death. • Liver, kidney and lung damage • Destruction of tissues in nose if sniffed • Respiratory (breathing) problems if smoked • Infectious diseases and abscesses if injected • Malnutrition, weight loss • Severe tooth decay • Disorientation, apathy, confused, exhaustion • Strong psychological dependence • Psychosis • Depression • Damage to the brain similar to Alzheimer's disease*, stroke and epilepsy. [Alzheimer's disease: a disease affecting some older people that is accompanied by memory loss]

How ICE affects people's lives

When people take ICE, it takes over their lives in varying degrees. There are three categories of abuse:

Low-intensity ICE abuse

Low-intensity abusers swallow or snort ICE. They want the extra stimulation ICE provides so they can stay awake long enough to finish a task or job, or they want the appetite-suppressant effect to lose weight. They are one step away from becoming a "binge" abuser (meaning uncontrolled use of a substance).

Binge ICE abuse

Binge abusers smoke or inject ICE with a needle. This allows them to receive a more intense dose of the drug and experience a stronger "rush" that is psychologically addictive. They are on the verge of moving into high-intensity abuse.

High-intensity ICE abuse

The high-intensity abusers are the addicts, often called "speed freaks". Their whole existence focuses on preventing the crash, that painful letdown after the drug high. In order to receive the desired "rush" from the drug, they must take more and more of it. But as with other drugs, each successive ICE high is less than the one before, urging the ICE addict into dark and deadly spiral of addiction.

Patterns of use

Experimental: This pattern is typically short lived, and is part of a wider range of experimental behaviours in adolescence. People often try a drug and never return to using it.

Recreational: This pattern involves consuming the drug in social or leisure-based settings on weekends, with substantial spaces in between. The user exercises control and choice about

when they use the drug. There may be minimal side effects. However as ICE production, distribution and usage overtakes other forms the risks and harms increase as this form of the drug is usually more potent and the drug effects are stronger.

Circumstantial: this is when the drug is used to perform certain tasks:

- *Enhancing and/or prolonging physical performance*, such as a sport, or in a shift work job, or to dance through the night.
- *Cognition, to enhance learning, concentration and working memory*, some users with ADHD type behaviours report feeling 'normal' when they use the drug
- *Behavioural effects sought:* increased pleasure, motivation, reward and confidence, more confident in social situations.

Binge: This is a pattern of prolonged and intensive use, e.g. from 24 hours to 3-4 days, when the user remains awake for the entire period. Risks and harms of sleep deprivation as well as prolonged drug effects put the user at risk and tolerance to the drug and dependence may develop.

Regular use: this is when the user is taking the drug at least 3 times per week and is most commonly associated with dependence. . The user is likely to develop a tolerance to the drug, requiring more to gain the same effect, and experiencing withdrawal symptoms as it wears off.

Poly drug use: Methamphetamines are usually used in combination with other drugs. It is estimated that 1 in 5 who initiate stimulant use will make the transition to dependence (McKetin, R. Et al. 2012). Patterns of use reflect similar trends to other drugs:

- The earlier the age of initiation (first time of use), the more likely the transition to dependence.
- Injecting is the greatest indication of dependence.
- Smoking ICE is the entry mode for most users and clinical reports across services indicate women prefer this route. ICE took over from heroin in presentation for treatment.

Stages of the ICE "experience"

Stage 1 - The Rush

A rush is the initial response the abuser feels when smoking or injecting ICE. During the rush, the abuser's heartbeat races and metabolism*, blood pressure and pulse soar. (*metabolism: the process in the body that convert food into energy). Unlike the rush associated with crack cocaine, which lasts for approximately two to five minutes, the ICE rush can continue for up to 30 minutes.

Stage 2 - The High

The rush is followed by a high, the abuser often feels aggressively smarter and becomes argumentative, often interrupting their other people and finishing their sentences. The delusional effects can result in a user becoming intensely focused on an insignificant item, such as repeatedly cleaning the same window for several hours. The high can last 4-16 hours.

Stage 3 - The Binge

A binge is uncontrolled use of a drug or alcohol. It refers to the abuser's urge to maintain the high by smoking or injecting more ICE. tThe binge can last 3-15 days. During the binge, the abuser becomes hyperactive both mentally and physically. Each time the abuser smokes or injects more of the drug, he experiences another but smaller rush until finally there is no rush and no high.

Stage 4 - Tweaking

An ICE abuser is most dangerous when experiencing a phase of the addiction called "tweaking" – a condition reached at the end of a drug binge when ICE no longer provides a rush or a high. Unable to relieve the horrible feelings of emptiness and craving, an abuser loses his sense of identity. Intense itching is common and a user can become convinced that bugs are crawling under his skin. Unable to sleep for days at a time, the abuser is often in a completely psychotic state and he exists in his own world, seeing and hearing things that no one else can perceive. His hallucinations are so vivid that they seem real and, disconnected from reality, he can become hostile and dangerous to himself and others. The potential for self-mutilation is high.

Stage 5 - The Crash

To a binge abuser, the crash happens when the body shuts down, unable to cope with the drug effects overwhelming it; this results in a long period of sleep for the person. Even the meanest, most violent abuser becomes almost lifeless during the crash. The crash can last one to three days.

Stage 6 - ICE Hangover

After the crash, the abuser returns in a deteriorated state, starved, dehydrated and utterly exhausted physically, mentally and emotionally. This stage ordinarily lasts from 2 to 14 days. This leads to enforced addiction, as the "solution" to these feelings is to take more ICE.

Stage 7 - Withdrawal

Often 30 to 90 days can pass after the last drug use before the abuser realises that he is in withdrawal. First, he becomes depressed, loses his energy and the ability to experience pleasure. Then the craving for more ICE hits, and the abuser often becomes suicidal. Since ICE withdrawal is extremely painful and difficult, most abusers revert; thus, it is extrapolated that 90% of those in traditional treatment return to abusing ICE.

Pharmokinetics – how quickly the drug takes effect depends in part on the mode of administration:

Mode of admin & drug effect	**Orally**	**Snorting**	**Vapour / Inject**
	15-30 minutes	3-5 minutes	7-15 seconds

Poly drug use

ICE is commonly used in combination with other drugs. Alcohol and cannabis are the most common combinations. As methamphetamines are a stimulant, increasing concentration, users may think they are effective and safe drivers when they are over the limit. Depressants such as cannabis may be used to help the person relax and ease the symptoms of withdrawing from the methamphetamine as the drug wears off. Benzodiazepines, heroin and prescription opioid products may be used for similar effects or to enhance the drug use experience. Ecstasy is also sometimes used.

Effect on Mental Health

Demonstrable link between ICE and mental health suggests that as ICE increase alertness and the 'fight or flight' response, users often experience anxiety or panic during use. Excessive amounts of dopamine can also induce psychosis.

Risks and Harms: Effects on mental health	Low Dose	High Dose
Psychological	• Euphoria • Elevated mood • False sense of wellbeing • Increased alertness and concentration • Reduced fatigue • Increased talkativeness • Improved physical performance • Increased suspiciousness	• Confusion • Anxiety and agitation • Performance of repetitive motor activity • Impaired cognitive and motor performance • Aggressiveness, hostile and violent behaviour • Psychosis: Paranoia, suspiciousness, delusions, hallucinations • Common delusions, being monitored with hidden electrical device, preoccupation with bugs on the skin • Profound mood swings

Observing signs of ICE use

The following are overt observations of someone using ICE:

- **Movement**: twitching, restless, fidgety, moving about
- **Facial**: may be flushed and/or sweating, pupils dilated
- **Speech**: loud, rapid, may be tangential, unable to keep on topic
- **Skin**: in long term users may have scabs, if injecting may have abscesses
- **Body**: long term users may be thin, undernourished and also very active
- **Teeth**: may be discoloured, ground down, gums receded
- **Behaviour**: Irritable, anxious, may be aggressive
    - **Delusions –** often feeling persecuted, others have malicious intent or they are under surveillance. In some instances there may really be people after them with malicious intent.
    - **Hallucinations –** auditory: voices or sounds, sirens, tactile: bugs are crawling under or over the skin
    - **Erratic, uncontrolled or bizarre behaviour** in response to delusions, talking or shouting in response to voices, unnecessary whispering, barricading in a room, checking doors, pulling down blinds, making frantic phone calls, keeping weapons for protection
    - Illogical, disconnected or **incoherent speech**
    - Extreme or rapid **mood swings**

ICE, aggression and violence

ICE users are frequently violent. Users recognise that being intoxicated changes their behaviour:

- Being 'revvy' refers to being a little too intense, talking too frequently and obsessively, and losing awareness of time in ways that individuals unfamiliar with the substance will perceive as aggression or a mental illness.
- Some people using ICE might become verbally and physically aggressive. This sort of behaviour is typically managed well within circles of peers, but is problematic in people who are inexperienced, ICE-ing alone, or in public spaces.
- The incidence of ICE related aggression and violence has reduced since protocols and emergency service training has been put in place.
- The consensus of opinion amongst regular users is that true aggression and violence provoked by intoxication from ICE is largely confined to individuals who would react in a similar way to large doses of alcohol.
- Presentations to hospital are more common with dependent users.

Withdrawal symptoms

- Inactivity fatigue
- Depressed mood
- Anxiety
- Motor retardation
- Agitation
- Vivid dreams
- Craving
- Poor concentration
- Irritability and tension

Phases of Withdrawal

Crash: **1-3 days** - Recovery from exhaustion, lack of sleep and food
Peak: **2-10 days** - Most intense phase of withdrawal symptoms
Residual: **2- 10 weeks** - Symptoms may persist for some time

- Not everyone goes through the Crash phase
- Transition from Peak to Residual not clear cut
- Pattern and timing differ depending on circumstances such as duration and level of use, general and mental health.
- Intensity and duration of symptoms varies, depending on a range of factors including:
  - Duration of use
  - Amount used
  - Route of administration
  - Pre-existing mental health issue such as underlying depression or anxiety
  - General level of health
  - Psychosocial supports, or lack thereof

ICE Withdrawal Pattern

Phase 1: Crash 1-3 Days

Symptoms	Presentation / Experience
• Exhaustion • Insomnia and / or hypersomnia • Craving sleep and food • Vivid unpleasant dreams • Irritability	• Flat, exhausted, depleted • May not participate in programs, in need of sleep and food • Vivid, terrifying dreams are common • Waking at night

Phase 2: Peak 8-10 days

Symptoms	Presentation / Experience
• Strong urges and cravings to use • Severe mood swings • Feeling anxious, irritated or agitated, or feeling flat and lacking energy • Sleeplessness – very poor sleep • Poor concentration • General aches and pains, crippling headaches • Increased appetite (very hungry) • Re-emerging psychosis – strange thoughts such as 'people are out to get me' • Misunderstanding things around you	• May last longer than 10 days • Transition from phase 1 to 2 to 3 not all that apparent – motivation to continue is key • Anxiety and depression are real • May present as 'medication seeking' • Psychosis-like symptoms may appear • Unlikely to present for treatment • Support information for withdrawal will be very useful

<table>
<tr>
<td>(e.g. seeing things that aren’t there).
• Depressive symptoms are likely to increase risk of self-harming behaviour
• Risks in this phase are increased if the withdrawing environment is challenging, anti-social or impoverished
• Withdrawal is significant in relation to the effect the drug has on driving
• Psychomotor retardation
o Unaccountable difficulty with carrying out what are usually considered as ‘automatic’ or mundane, e.g. self-care tasks for healthy people (i.e. without depressive illness) such as taking a shower, putting on clothes, self-grooming, preparing food, brushing teeth and activity
o Real physical difficulty performing activities that normally would require little thought or effort, such as walking up a flight of stairs, getting out of bed, preparing meals and clearing dishes from the table, household chores, returning phone calls, etc.
o Tasks requiring mobility suddenly or gradually and inexplicably seem to be ‘impossible’. Activities such as shopping, getting groceries, caring for the daily needs of one’s children, and meeting the demands pertaining to employment or school are commonly affected adversely. Individuals experiencing these symptoms typically sense that something is wrong and may be confused over their inability to perform these tasks.</td>
<td>Support in the PEAK Phase
• NB to follow organisational protocols for suicidal / self-harm behaviours
• Communicate with the client, ask, inquire, be interested
• Increase consumption of protein, vegetables and fruit: this may help increase the body’s production of tryptophan, a precursor and help to lift the mood
• Monitor and observe their behaviour
• Reassurance and support
• Ask for check-ins
• Discuss ‘urge surfing’ and craving for substance
• Remove sharps/blunts/objects of risk
• Give client as much control and responsibility for self-monitoring as possible
• Seek medical advice regarding medication
• Encourage participation in tasks with others (socialisation)
• Provide encouragement for each stage and day
• Provide relaxation strategies
• Provide structured activities which do not require high levels of concentration (meal preparation, gardening, games, walks)</td>
</tr>
</table>

Phase 3: Residual – 2-10 WEEKS

Symptoms	Presentation / Experience
• Craving for drugs – may be very strong • Insomnia • Poor concentration • Fluctuate between restlessness and lethargy	• Lack of motivation (general and to push through with this difficult phase = early relapse) • Low mood • Depression • Anxiety • Psychomotor retardation

Challenging behaviours related to ICE use/misuse/abuse

ICE users can cause people to behave with more aggression than usual, often leading to interpersonal, family and domestic violence. ICE changes brain chemistry and affects normal bodily processes. Users often experience:

- Superior alertness and energetic
- Fast, loud and difficult to interrupt speech
- Agitation – unable to sit still
- Engaging in impulsive or reckless behaviour
- Going without sleep for extended periods of time
- Hallucinations or delusions
- Losing control over behaviour and aggression

Triggers for challenging behaviours

The following generally triggers challenging behaviours in ICE users:

- Intoxication or withdrawal
- Exaggerated response to a real event such as personal conflict, relationship breakdown, threat to job/employment or finances
- Fear or paranoia
- Psychosis
- Sleep deprivation (e.g. awake for more than 24 hours)
- Lack of staff training in recognising and responding to escalating behaviour
- Seemingly long wait for service
- Other environmental stressors

Appendix B: Treatment Approaches for Users of Methamphetamine

Appendix C: Example – A Brief Cognitive Intervention for Regular Amphetamine Users – A Treatment Guide

Appendix D: Responding to Challenging Situations related to the Use of Psychostimulants

TREATMENT APPROACHES FOR USERS OF **METHAMPHETAMINE**

a practical guide for frontline workers

TREATMENT APPROACHES FOR USERS OF METHAMPHETAMINE

a practical guide for frontline workers

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ISBN: 1-74186-632-4
Online ISBN: 1-74186-633-2
Publications Approval Number: P3-3917

Suggested citation:
Jenner L and Lee N (2008). *Treatment Approaches for Users of Methamphetamine: A Practical Guide for Frontline Workers.* Australian Government Department of Health and Ageing, Canberra.

Acknowledgments

This publication was made possible by the input of many people who willingly gave of their valuable time, expertise, and experience to offer suggestions and critical commentary. The project team would especially like to thank the members of the Steering Committee:

Steve Allsop
Amanda Baker
Adrian Dunlop
Linda Gowing
Rebecca McKetin
Annie Madden
Katherine-Walsh Southwell

We would also like to thank the workers from the following organisations for their valuable participation in focus groups that were undertaken in various locations throughout Australia:

ACT Health, Drug and Alcohol Services

Addiction Medicine Clinic, Southern Health Service, Victoria

Byron Place Community Centre, Adelaide

Canberra Alliance for Harm Minimisation and Advocacy (CAHMA)

Cyrenian House, Perth

Drug and Alcohol Services South Australia (DASSA)

Drug and Alcohol Withdrawal Network (DAWN), Perth

Directions ACT

Galambila Aboriginal Health Service Inc, Coffs Harbour

Gold Coast Alcohol Tobacco and Other Drug Services (ATODS)

Gold Coast Drugs Council, Mirikai

Goldbridge Rehabilitation Services, Gold Coast

Next Step Drug and Alcohol Services, Perth

Palmerston Assoc Inc, Perth

Peninsula Drug and Alcohol Program (PenDAP)

Pilbara Aboriginal Alcohol and Drug Project

Queensland Injectors Health Network (QuIHN), Brisbane

QuIHN, Gold Coast

SHARPS Needle Syringe Program, Melbourne

Streetlink Youth Health Service, Adelaide

Tedd Noffs Foundation, ACT

The Link Youth Health Service, Hobart

Vietnamese Community in Australia, South Australia Chapter

Western Australia Substance Users Association (WASUA)

Wirraka Maya Aboriginal Health Service, South Hedland

Yirra Program, Mission Australia, Perth

Youth Substance Abuse Services (YSAS), Victoria

We also wish to thank the user representatives from CAHMA for their generosity in sharing personal stories, which contributed to the development of the content of this guide; and the Western Australian Network of Alcohol and Other Drug Agencies (WANADA), and Drug and Alcohol Office Western Australia (DAO), for assisting with the organisation of focus groups in WA.

Finally, we wish to thank Jeremy Williams and Linda Rigby from the Australian Government Department of Health and Ageing for their assistance with the project.

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Introduction

Stimulants such as amphetamine have been used by some people in Australia for many years. However, a more potent form, methamphetamine, has come to dominate the illicit stimulant market over the past decade. Because of its potency, many users have experienced a range of significant physical and psychological health problems.

Alcohol and other drug (AOD) workers from a variety of service settings are now frequently required to respond to methamphetamine users who are experiencing the harmful effects of methamphetamine, going through withdrawal or seeking methamphetamine-specific treatment.

Clinical treatment guidelines that provide a step-by-step guide to structured counselling are available for trained AOD workers such as *A Brief Cognitive Behavioural Intervention for Regular Amphetamine Users* (Baker et al 2003) and *Clinical Treatment Guidelines for Alcohol and Drug Clinicians. No 14: Methamphetamine Dependence and Treatment* (Lee et al, 2007). However, the Australian Government Department of Health and Ageing recognises that clear and up-to-date information is required by all AOD workers, not just those with a clinical or professional background; hence, this publication has been developed to bridge an identified gap in available resources.

The guide is based on recent research, national and international guidelines, and expert opinion. Because a comprehensive review of the research literature was undertaken for the Commonwealth Monograph *Models of Intervention and Care for Psychostimulant Users* (Baker et al 2004) and published in 2004, the literature from 2003 to the present was reviewed for this guide. Databases including PubMed and PsychInfo were used to find studies on relevant topics. Guidelines from Australia and overseas were also consulted and form the basis for a range of topics.

The signs of methamphetamine overdose are now well recognised and frontline workers are advised to familiarise themselves with the emergency management techniques detailed in Chapter 4 *Recognising and managing overdose*.

Best practice in methamphetamine treatment involves a clear, mutually acceptable treatment plan that is designed to meet the needs of the individual. Early engagement, good communication and the development of a strong helping relationship between the worker and service user or client are important to attract methamphetamine users into treatment and to keep them engaged.

Numerous high-quality studies have suggested that psychosocial treatments, especially cognitive behaviour therapy (CBT), should be a standard intervention in methamphetamine treatment. CBT also assists with mental health problems, such as depression and anxiety, which are common among methamphetamine users.

Dependent psychostimulant users experience withdrawal symptoms when they stop using the drug. Although we do not know a lot specifically about methamphetamine withdrawal yet, evidence suggests that, for mild cases of withdrawal, medication is not usually required and most symptoms resolve within two weeks. In contrast, users with more severe dependence might go on to have a longer and more intense withdrawal, and need targeted ongoing support.

In circumstances where a methamphetamine user does not wish to stop using the drug, harm reduction interventions are recommended and a range of suggestions are offered in the guide.

Finally, where research evidence is lacking regarding issues such as methamphetamine use among young people and those from culturally and linguistically diverse backgrounds, the Indigenous community and pregnant women, advice based on good practice and expert opinion is included to provide a starting point to guide workers' responses.

Summary of important points from each chapter

Chapter 1: About methamphetamine (p.13)

- Methamphetamine is a strong **stimulant** that comes in various forms such as 'ice' (a potent, crystal form that can be smoked or injected), base (an oily powder or paste that can be injected), powder ('speed' or 'louie' that can be injected or 'snorted' into the nasal passage) and tablets that are usually swallowed.
- All methamphetamine forms quickly raise and sustain levels of the brain's chemical messengers (**neurotransmitters**), particularly **dopamine**, which is responsible for memory, attention, purposeful behaviour and pleasurable feelings.
- Over time, neurotransmitters become depleted, leading to poor concentration, low mood, lethargy and fatigue, sleep disturbances and lack of motivation.

Chapter 2: Effects, risks and harms, and how these can be reduced (p.19)

- Although there is variation between individuals, **short-term effects** include euphoria, alertness, increased confidence and wakefulness. Higher doses can cause agitation, sweating, tremors, irritability, teeth grinding, anxiety or panic, paranoia and hallucinations (seeing or hearing things that others cannot).
- **Longer-term effects** of regular use can include weight loss; dehydration; poor appetite or malnutrition; kidney problems; mood swings including depression; anxiety; paranoia; chronic sleep disturbance; changes in brain structure and function leading to memory, thinking, and emotional disturbances; disrupted decision making ability; grossly impaired contact with reality (psychosis); and dependence on methamphetamine.
- Due to the high potency of crystal methamphetamine, smoking and injecting ice can rapidly lead to **dependence** in some users.

- **Risks of use** include vein infections from injecting; blood-borne virus (BBV) transmission; heart infection (endocarditis); heart attack; brain haemorrhage; lung and skin infections; poor oral health including tooth decay and gum disease; poor nutrition; psychosis and other mental health problems; and social, occupational and legal problems.
- **Harm reduction approaches** include good diet; regular fluids; adequate rest; regular breaks from using; good oral hygiene (brush and floss regularly); contact with supportive and stable friends and family; education about effects, signs of overdose and psychosis; and advice to seek professional help if psychotic symptoms emerge.
- **Pregnant** methamphetamine users should receive regular antenatal care to reduce risks and to improve outcomes for both mother and baby. Even if psychostimulants have been used in the earlier stages of pregnancy, there are possible benefits of reducing or ceasing use in the later stages. Pregnant users should avoid use of other drugs, such as alcohol and tobacco.

Chapter 3: Recognising and managing intoxication (p.25)

- **Signs of methamphetamine intoxication** can include rapid or difficult-to-interrupt speech; restlessness or agitation; jaw clenching and teeth grinding; sweatiness; large pupils; irritability.
- **An appropriate response** involves sound communication skills; prompt response to a service user's needs; avoidance of lengthy questioning; provision of written materials for later reference; opportunistic brief interventions if possible; and the maintenance of a calm, safe, supportive and helpful environment.
- Do not attempt to interview or counsel an intoxicated client, offer another appointment if required.

Chapter 4: Recognising and managing overdose (p.27)

- Methamphetamine **overdose** (toxicity) is a medical emergency.
- Signs of **toxicity** include hot, flushed or very sweaty skin, which may indicate high fever or overheating; severe headache; chest pain; changes in consciousness; muscle tremor, spasm or fierce jerky movements; severe agitation or panic; difficulty breathing; changes in mental state (eg confusion, disorientation); seizures (fits); and symptoms of psychosis can also occur.
- First aid includes **calling an ambulance immediately** even if unsure of cause; providing a non-stimulating and safe environment; making sure the person can breathe; cooling the body (loosen restrictive clothing, use ice

packs); removal of dangerous objects if the person has a seizure; continual reassurance and waiting with the person until the ambulance arrives.

Chapter 5: Recognising and responding to a person with mental health problems (p.29)

- Methamphetamine users can experience **mental health problems** such as depression, anxiety or psychosis. Symptoms often resolve when the user cuts down or stops using, but some people experience longer-lasting symptoms.
- **Symptoms of psychosis** may be low-grade or 'subacute' and can include: deterioration in general functioning in day-to-day life; expression of unusual thoughts or ideas, strange, inappropriate or out-of-character conversational style; fear or paranoia; a sense of self, others or the world being different or changed in some way; suspiciousness or constant checking for threats in an exaggerated way; over-valued ideas (ordinary events have special significance or are more meaningful than usual); illusions (misinterpretation of surroundings); and erratic behaviour.
- Psychosis in its acute form describes a disorder in which a person's contact with reality is grossly impaired. Symptoms include hallucinations (hearing, seeing or feeling things that other people cannot); delusions (fixed, false beliefs); disordered thought processes; disturbance in mood; and strange, disorganised or bizarre behaviour.
- Methamphetamine can cause a psychotic episode in healthy people with no previous history of mental health problems. It can also trigger a mental health problem such as schizophrenia in vulnerable people, which will endure even after they stop using the drug (for a diagnosis of schizophrenia at least one obvious psychotic symptom must persist for longer than a month in the absence of drug use or withdrawal).
- Psychosis is more likely among dependent methamphetamine users, injectors, and those with other health problems.
- Many people will spontaneously recover from psychosis within hours, as the effects of the drug wear off, while some will go on to experience symptoms for some time.
- **Immediate management of psychosis** includes reducing risk to the person, other workers and bystanders; a calming environment; effective communication (eg never argue, calm voice, repetition of key messages); calling an ambulance to facilitate an emergency assessment if the person remains acutely disturbed; or calling police if risk of harm to self or others is high.

- **Longer-term management of psychosis** includes interventions aimed at discontinued use; education regarding sensitivity to future psychotic episodes; lifestyle management; and harm reduction strategies for those who do not want to stop using (eg regular breaks from using; advice not to use more than small amounts; avoidance of use of multiple drugs; and early intervention should symptoms recur).
- **Depression** commonly occurs among methamphetamine users. Symptoms of depression (eg withdrawal from social contact; negative thoughts; feelings of sadness, guilt, pessimism; changes in appetite, libido and energy) may persist for weeks, months or in some cases even several years after stopping methamphetamine use.
- Workers and clients should regularly review symptoms of depression and seek specialist help if symptoms worsen, especially if suicidal thoughts occur.
- A depressed person might be at high risk for suicide if he or she has tried before; has a clear and lethal plan with the means to carry it out; has a lot of stressors; feels hopeless; has psychotic symptoms; continues to use alcohol and other drugs; or has few or no social supports.
- Clients considered to be at high risk should have an urgent and thorough specialist assessment by mental health services. Workers should keep the contact number for emergency mental health services on hand and refer appropriately.
- **Anxiety** can occur in many forms and usually involves excessive worry. Other features of anxiety can include agitation; racing heart; sweatiness; difficulty breathing; tightness in the chest or chest pain; fear or panic; and sleep disturbance.
- Anxiety symptoms often subside when the drug is no longer used, but if symptoms persist after stopping, a mental health specialist should assess the client. Cognitive behaviour therapy is an effective intervention for anxiety disorders.
- Anxious clients should be provided with a low-stimulus environment and encouraged to take slow, deep, calming breaths. Other relaxation strategies include tensing and relaxing all the large muscle groups in the body; and actively imagining a peaceful, safe place of the client’s own choosing.
- Workers should keep the contact numbers for both emergency and non-emergency mental health services on hand at all times and familiarise themselves with procedures for appropriate referral or consultation.

Chapter 6: Helping a person get through withdrawal (p.43)

- Many **recreational users** will experience a 'crash' period after they stop using, which lasts a few days. During this time, they often sleep and eat a lot, can become irritable, and might feel 'flat', tired and lethargic or generally out of sorts. They usually do not require specialist assistance during this 'coming down' period.
- Some **dependent users**, however, will experience full-scale methamphetamine withdrawal, which often lasts for about a week or two. For some people, certain symptoms, such as depression, can linger for several weeks, months or even longer.
- During **withdrawal**, a person can feel depressed; irritable or anxious; be agitated; have difficulty sleeping; be unable to experience pleasure; have poor concentration and memory; have aches and pains; and strong cravings to use methamphetamine.
- Support includes written materials and education about typical length of withdrawal and common symptoms; the need for self-monitoring symptoms of depression and intervention if severe; management of cravings; relapse prevention; and relevant referral to a general practitioner for medical support if insomnia, symptoms of anxiety or depression linger or place the client at risk of relapse.

Chapter 7: Use of other drugs and possible effects of mixing drugs (p.47)

- Use of **multiple drugs** with methamphetamine, particularly **alcohol**, **nicotine**, **cannabis**, **heroin** and **benzodiazepines**, is common.
- Dangerous effects can result when medications for depression (antidepressants) are taken within two weeks of using methamphetamine and can include overheating, high blood pressure, and seizures (serotonin toxicity).
- **Heroin** used in conjunction with methamphetamine increases risk of heroin overdose.
- Methamphetamine can stop people from feeling drunk after drinking alcohol, even when blood alcohol levels are high. Therefore, the risk of accident and injury is increased, as is the potential for driving while intoxicated. Clients with problems related to the use of alcohol need targeted interventions.

- Methamphetamine can also stop people from feeling the full effects of benzodiazepines, leading to increased risk of accident and injury. There is also the potential to take large quantities of benzodiazepine, which increases risk of dependence and subsequent withdrawal. Some people can experience withdrawal symptoms if benzodiazepines are stopped abruptly after just one month. Signs of benzodiazepine withdrawal include sensitivity to loud noises/light/touch; feelings of unreality; numbness; anxiety, fear of open spaces (agoraphobia) and panic states; metallic taste in the mouth; pain, stiffness and muscular spasms resulting in headaches and muscle twitching; and seizures.
- Methamphetamine reduces the effectiveness of **antipsychotic medication** and increases risk of seizures.
- Users should be informed of the potential for harmful effects of mixing methamphetamine and medications and advised to **seek advice from the prescribing doctor**.

Chapter 8: Overview of the range of treatment options (p.53)

- Approaches to methamphetamine users should be individually tailored and match each client's goals for treatment.
- **Cognitive behaviour therapy** has been evaluated most extensively and is effective for a range of problems related to methamphetamine use, including mental health problems such as depression and anxiety. Medicare pays for up to 12 sessions of counselling by a registered psychologist if a general practitioner refers clients.
- Other approaches include brief interventions; counselling (eg narrative therapy, solution-focused therapy); residential rehabilitation; self-help groups; and behavioural therapy.
- Assessments should be offered in the context of a safe, reassuring, supportive, nonjudgemental environment to enhance a client's engagement with the service. In the early stages, this may be more important than the specific drug treatment.
- No medications have yet proven to be more effective than others in treatment (eg for withdrawal or to prevent relapse). However, research is continuing into several medications including dexamphetamine and modafinil. Following a specialist assessment, the appropriate prescription of medications to treat mental health and medical problems is strongly recommended.

- **Young people** can benefit from a thorough assessment of factors such as leisure and social functioning; family relationships; peer interactions; hobbies; and educational history. Intensity of treatment should be matched to the severity of problematic methamphetamine use. Treatment approaches should be youth friendly and include easy access, drop-in capability, follow-up, collaboration between service providers and family therapy.
- Workers should be sensitive to the cultural and social needs of **Indigenous** clients and those from **culturally and linguistically diverse (CALD)** backgrounds. Considerations include the provision of culturally appropriate information including media other than print (eg art or video); role of family in the client's life; need for translation services; outreach service and case management; and culturally appropriate harm reduction messages.
- Services should respond promptly to all clients' requests for help; provide support and assistance with immediate concerns before offering targeted interventions for methamphetamine use; have information readily available; attempt to address a range of user's needs; and actively assist clients to access other services as required.

Chapter 9: Assisting families, carers and significant others (p.71)

- Disruption to **family and other relationships** is common in the context of methamphetamine use.
- Families should be encouraged to access support for their own needs (eg mutual support groups; telephone support and advice; educational materials) and ensure that they continue to live their own lives while they continue to care for their family member.
- Families should be provided with information on how methamphetamine works including the range of possible effects. This should include information about the 'crash' period and withdrawal symptoms, how regular methamphetamine use can adversely affect a person's mood, concentration, and decision-making abilities, and the risks of dependence and psychosis.
- Families require assistance with developing an emergency plan should serious consequences such as hostility or violence, or psychosis arise (see Appendix 2, *Example family emergency plan*).
- Methamphetamine use can sometimes affect the ability to parent, so others might take on the role of caring for a client's children until he or she is better equipped to do so. In this case carers should be encouraged to access ongoing support and practical assistance (eg financial support).

- **Young carers** should also be encouraged to pay attention to their own lives and pursue interests appropriate to their age. They should be encouraged to seek support from appropriate sources (eg school counsellor, teacher, trusted relative, kids help line, or dedicated websites such as http://www.youngcarers.net.au), and to develop an emergency plan (see Appendix 3, *Example young carer's emergency plan*).

Chapter 10: Legal issues (p.79)

- **Interventions** tend to be as effective for people who are pressured to enter treatment (coerced clients) as for those who seek help voluntarily.
- **Coercion** can be formal (eg court ordered) or informal (pressure from a spouse or family).
- Clients who have been formally coerced into treatment should be informed of which agencies and under what circumstances workers are legally obliged to disclose information regarding the client's progress without his or her consent.
- Informally coerced clients should give consent before any information about their progress can be shared with their spouse, family member or significant other.
- **Mandatory reporting** describes legislation that requires some workers to report all cases of suspected or confirmed child abuse and neglect. As legislation varies across each state and territory, workers have a duty to be familiar with mandatory reporting requirements in their own state or territory.
- Although there is a perception that all methamphetamine users are violent, this is not the case. Rates of violent crime, although higher than the general population, tend to be restricted to methamphetamine-dependent, multiple-drugs users with a history of violence. Violence, when it does occur, usually happens when people are paranoid or psychotic. Therefore, hostility and violence is often time-limited, and tends to occur only when symptoms are acute.

Chapter 11: Making links and creating partnerships (p.83)

- **Service partnerships** can help facilitate timely, appropriate and targeted responses to a client's needs, minimise access barriers for clients, and ultimately improve client outcomes.
- Services should identify appropriate or helpful agencies for potential partnerships; decide on the level of cooperation or collaboration that would be useful; initiate contact; agree on a desired outcome for cooperation; ensure regular liaison, prompt responses, support, and ongoing education for partner agencies; and evaluate the effectiveness of partnerships.
- Staff members should learn and use **appropriate terminology** when referring a client to other agencies, particularly mental health services and general practitioners.
- **Referral** can be improved by ensuring that workers address the client's pressing needs first, before suggesting referral to another agency for assistance with less important matters; enhancing awareness of other useful agencies or services including location, hours of opening, cost, who is eligible for assistance, and waiting times for service; understanding the needs of the client (eg financial resources; access to transport; requirement for child care; cultural and social issues; level of ability to advocate for self; literacy level; mental health concerns) prior to making a referral; and matching referral to a client's need.

1
About methamphetamine

What is methamphetamine?

Methamphetamine is a synthetic substance that can come in various forms:

- crystalline ('ice', 'crystal', 'crystal meth', 'shabu', 'glass')
- oily powder or paste ('base')
- coarse or fine powder ('speed', 'louie')
- tablet ('pills')
- oil (base) is the least commonly available form, but it is the purest form that is converted by manufacturers into the other forms; base is stronger than powder forms and nonadulterated crystal is estimated to be about 80% pure.

The chemical structure is similar to amphetamine, but methamphetamine tends to be more potent than amphetamine sulphate and amphetamine hydrochloride (also called 'speed'), which were typically used before the mid-1990s. The stimulant effects of methamphetamine can last from 7 to 24 hours or even longer, depending on the form used (for photographs of methamphetamine forms see the fact sheets at http://ndarc.med.unsw.edu.au).

Methamphetamine can also be mixed with a range of other substances or drugs. For example, methamphetamine is sometimes mixed with ketamine, a powerful anaesthetic, to form a tablet that is then commonly sold to users as *ecstasy* (for information on ecstasy, see http://www.druginfo.adf.org.au/article.asp?ContentID = ecstasy).

How many people use methamphetamine?

Every three years, the Australian Government undertakes a study in which a representative sample of Australians, aged 14 years and over, is asked about

their use of drugs. This survey is known as the National Drug Strategy Household Survey. In 2007:

- meth/amphetamine had been used at some time in the life of 6.3% of those surveyed
- the highest proportion of recent meth/amphetamine users were those in the 20–29-year age group (9% males and 4.8% females)
- two-thirds of injecting drug users identified meth/amphetamine as the drug injected most recently, compared with heroin at 39.7%.

How and why people use methamphetamine

People use methamphetamine for different reasons and in a variety of patterns:

- Experimental — many people, often adolescents and young people, try a range of drugs once or twice out of curiosity.
- Instrumental — some people use methamphetamine for specific purposes, for example, to stay awake (eg long-distance truck drivers), improve concentration (eg students), reduce weight and enhance endurance (eg for sporting events), or boost energy for a range of other activities.
- Recreational — some people use occasionally, for enjoyment or socialising, at private parties, clubs or dance parties.
- Binge — others use moderate to high doses in an on–off pattern.
- Regular — some people use weekly, several times weekly or daily. Regular users are more likely to be dependent on methamphetamine and have problems with their mental health.

The way that people take methamphetamine generally depends on the form used:

- Powder is often ‘snorted’ into the nasal passage.
- Ice is often smoked by heating the crystal in a pipe until it is vaporised or by mixing it with cannabis and smoking it (‘snow cone’).
- Ice and base can also be injected or swallowed (known as ‘bombing’).
- Smoking methamphetamine, although considered less harmful than injecting by some users, has high potential to lead to dependence due to the rapid onset of euphoria (a strong feeling of wellbeing or elation) and subsequent intense cravings for more of the drug. It is also difficult for smokers to know how much they have used, which can lead to toxic (poisonous) effects.
- Bombing and snorting are common among experimental and recreational users; injecting is typically associated with regular users, and both recreational and regular users smoke methamphetamine.

- Methamphetamine powder is typically purchased by gram or half-gram weights, whereas ice and base are usually bought in a much smaller amount, known as a 'point' or one-tenth of a gram, because of their high potency.

People rarely use methamphetamine exclusively, and the use of multiple drugs, known as polydrug use, is common (see Chapter 7, *Use of other drugs and possible effects of mixing drugs*).

How does methamphetamine work?

The way methamphetamine works is complex, but it is extremely important for workers to understand how this drug works in the body so they can help inform their clients. Understanding the mechanism of methamphetamine's actions, the short- and long-term effects of methamphetamine use, and the impact on a person's mental health helps the worker understand the user's behaviour and treatment options. The end of this section contains a suggested plain language explanation that can be used by workers to help clients better understand the effects of methamphetamine.

Information for workers

Methamphetamine disrupts the brain's chemical messengers known as 'neurotransmitters'. The main neurotransmitters involved are *dopamine, noradrenaline* and *serotonin,* which have a broad range of important functions.

Dopamine controls movement, attention and memory, and purposeful behaviour. It is the main neurotransmitter involved in feelings of pleasure and euphoria when a person engages in activities that are essential for human survival, such as eating, drinking, and sexual activity. Dopamine encourages these behaviours by making people feel good so they are motivated to repeat them. This system is referred to as the 'reward pathway' and, because dopamine is also linked to cravings to use all drugs, it is thought to be involved in the development and maintenance of drug dependence in general.

Noradrenaline is involved primarily in preparing individuals to either run away from, or stand and fight against, perceived threats ('fight or flight' response): it stimulates the central nervous system, and is involved in heart function and blood circulation, concentration, attention, learning and memory.

Serotonin is involved in a variety of important activities including control of mood; appetite; sleep; thinking and perception; physical movement; regulation of temperature, blood pressure and pain; and sexual behaviour.

Short-term use

Methamphetamine quickly and substantially raises the levels of these neurotransmitters and stops them from being cleared (known as 're-uptake'), so their levels remain high for a much longer time than usual. (Selective serotonin reuptake inhibitor [SSRI] antidepressants also work in this way, but this is beneficial in depressed people who have low levels of these transmitters without treatment.) Methamphetamine causes the brain cells to be awash with dopamine, which markedly accelerates the normal bodily processes. A person will be alert and energetic, and have an intense feeling of wellbeing (euphoria). The euphoria is usually much more intense and lasts longer than that felt from natural survival behaviours. For example, in animal studies, dopamine level increases by around 50% after eating, but increases tenfold after administration of methamphetamine (see Chapter 2, *Effects, risks and harms, and how these can be reduced*).

After a while, stores of these neurotransmitters peter out, and the levels drop from too high to too low, like overdrawing a savings account. When the level is low, a person can experience a range of symptoms of varying intensity that are mostly the opposite to those of intoxication: low mood, lethargy and fatigue, poor concentration, disturbed sleep, increased appetite, and lack of motivation for daily tasks. It takes some time for the neurotransmitters to be replenished (adequate diet, rest and avoidance of methamphetamine are critical for this), during which time the person might continue to feel out of sorts and have difficulty taking pleasure in normal activities. Recovery or 'coming down' from short-term or binge exposure might take the person a couple of days to a week (see Chapter 6, *Helping a person get through withdrawal*).

Long-term use

Both animal and human studies have shown that long-term exposure to heavy methamphetamine use leads to both short-term neurotransmitter depletion and changes in brain structure and function. To reduce overexposure to neurotransmitters, particularly dopamine, the body responds by reducing both the number of receptors (receivers) and transporters (carriers) of these neurotransmitters in certain parts of the brain. In addition, brain cells themselves can be killed (neurotoxicity) as they struggle to break down excess dopamine. The result is chronic dopamine *underactivity*, resulting in damage to memory, concentration, decision-making, impulse control, and emotional balance.

The recovery period after long-term use, during which complete avoidance of methamphetamine should be maintained, can take many months or even years. Some researchers believe that certain individuals, particularly long-term regular users who began using methamphetamine at an early age, may never recover completely (see Chapter 2, *Effects, risks and harms, and how these can be reduced*).

Information for clients

The following explanation could be helpful for some clients. Workers could also use visual images or drawings to aid understanding:

> Methamphetamine causes the brain to release a huge amount of certain chemical messengers, which, as you probably know, make people feel alert, confident, social, and generally great. Some of these messengers help us to respond to threats by preparing us to either fight or run away, so they increase energy, keep us awake, stop hunger and raise blood pressure and heart rate.
>
> The problem is that there are only so many of these messengers stored at any one time. Think of a glass full of 'happy' messengers, so when people have been using methamphetamine for a while, the glass empties and no matter how much methamphetamine they use, they just can't get the 'rush' they want and will still feel awful. There are just too few messengers left to tell the brain to feel good. It's like overdrawing a bank account — no matter how many times you go back to the bank, the balance is still zero until a deposit is made.
>
> It takes rest, a good diet, and most of all TIME for the glass to become full again. During this period, people can feel flat, moody, irritable, forgetful, and restless, but exhausted, which is opposite to the feelings people have while using. This is when people often get strong cravings to use methamphetamine because these cravings are caused by the same brain chemical messengers, which are being produced, but in only small amounts.
>
> Researchers think that, after using methamphetamine regularly over several years, some people experience a long-term or chronic lack of these 'happy' messengers, which can cause people to feel moody, have trouble concentrating and making decisions, and either lack motivation to do usual things or behave in reckless ways. This can sometimes last for months or even a year or two.
>
> The main issues in treatment are to make sure that your mood doesn't get too low; improve your general health by eating a good diet and getting plenty of rest; manage cravings; and take things day by day so you don't get frustrated with your progress and go back to using.

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2
Effects, risks and harms, and how these can be reduced

What are the short-term effects?

The effects of methamphetamine depend upon a range of factors including the quality and purity of the drug; amount used; how it is used; the person's tolerance to methamphetamine (eg new or regular user); where it is used (eg crowded, hot dance party or person's home); and the person's general physical and mental health. Although there is individual variation in the effects of the drug, the following points serve as a guide:

During intoxication

During *intoxication*, the person usually feels a sense of wellbeing or euphoria and is alert, energetic, wakeful, extremely confident — sometimes invincible— with a sense of heightened awareness and increased concentration. Libido (sex drive) and blood pressure often increase. The person may be talkative and fidgety or restless, and will have large (dilated) pupils. Appetite is reduced. Wakefulness varies, but might continue for 12 hours or more.

At higher doses

At *higher doses*, the person might experience tremors, anxiety, sweating, palpitations (racing heart), dizziness, tension, irritability, confusion, teeth grinding, jaw clenching, increased respirations (breathing); auditory (hearing), visual or tactile (touch) illusions; paranoia and panic state; loss of behavioural control; or aggression.

In overdose

In *overdose* (toxicity), the person can experience intense paranoia involving hallucinations (hearing or seeing things that are not there) and delusions (eg having a fixed false belief often that people or things mean the person harm). The person can also experience chest pain and shortness of breath; severe headache; tremors; hot and cold flushes; dangerously increased body temperature; muscle spasms; brain haemorrhage; heart attack; or seizures (fits) (see Chapter 4: *Recognising and managing overdose*).

What are the long-term effects?

Long-term use of methamphetamine can result in a number of physical and psychological effects, which are often related to poor diet, lack of sleep, dehydration and ongoing (chronic) neurotransmitter disruption including:

- weight loss and dehydration relating to poor nutrition or malnutrition; irregular or absent menstrual periods; renal (kidney) problems caused by the lack of adequate fluid intake; chronic sleeping problems; and probable methamphetamine dependence
- extreme mood swings including depression and possibly suicidal feelings; anxiety; paranoia; and psychotic symptoms including hallucinations and delusions (see Chapter 5: *Identifying and responding to a person with mental health problems*)
- cognitive (thinking) changes including memory loss, difficulty concentrating, and impaired decision-making abilities.

What are the other risks and harms?

Users of methamphetamine are at risk for a range of other potential harms including:

- blood-borne viruses (BBV), including hepatitis B and C and human immunodeficiency virus (HIV) from sharing injection equipment
- infections and damage to veins (cellulitis)
- heart problems such as irregular heart beat, weakened heart muscle (cardiomyopathy), bacterial infections of the lining of the heart (endocarditis), and heart attack (myocardial infarction)
- burst blood vessels in the brain (stroke, ruptured aneurysm, brain haemorrhage)
- shortness of breath and dizziness in smokers of ice
- sexually transmitted diseases including HIV and syphilis linked to sexual risk taking
- poor oral health such as gum inflammation (gingivitis) and cavities caused by methamphetamine-induced dry mouth, and damaged teeth due to grinding and jaw clenching
- feelings that ‘bugs’ are crawling under the skin (tactile hallucinations)
- compulsive skin picking and scratching, particularly on the face and arms, which can increase vulnerability to skin and other infections
- family and other relationship breakdown; financial problems; loss of employment; and legal problems related to drug driving, dealing, or engaging in other crimes to support continued use.

How can the risks and harms be reduced?

A harm reduction approach should be taken with all methamphetamine users who intend to continue to use and will not consider stopping.

Users come to services with a wealth of knowledge about drug use already, so it is important for workers to ask what clients already know and what they would like to know so harm reduction advice can be tailored, appropriate and engaging.

As well as the usual safer injecting and safer sexual practices advice, which is freely available in a wide range of resources, some harm reduction strategies specifically for users of methamphetamine have been recommended (see http://www.aivl.org.au or http://www.hepatitisc.org.au) or contact the local alcohol and drug information service.

Workers should encourage clients to do the following.

Eat and drink enough

- Drink plenty of water — keep a water bottle handy and take frequent sips because people tend to forget to drink when they are intoxicated and on the go, and can easily become dehydrated.
- Eat a balanced diet including dairy products, meat and fish (or non-animal protein for vegetarians), fruit, vegetables, rice, grains, nuts, etc. Workers can help by checking a client's weight regularly.
- Drink milk, high protein drinks, shakes or fruit smoothies if solid food cannot be tolerated. (*You wouldn't run a long distance marathon without eating or drinking so you need to put some fuel into your body*.)

Rest sufficiently

- Get adequate rest. (*Going more than two nights without sleep isn't good for anyone*.) Encourage regular users to have regular non-using days each week, or plan a 'crash' period when they can rest and sleep undisturbed for several days to 'come down'.
- Get into regular patterns of eating, drinking and resting as detailed above. Even if users do not feel hungry, a little food and good hydration helps.

Understand the actions and effects of methamphetamine

- Understand how methamphetamine works (see Chapter 1 *About methamphetamine*).
- Be clear about individual signs and symptoms of psychosis. If psychotic symptoms are experienced, take a total break from using methamphetamine and seek professional help from the person's GP, local emergency department, or local mental health service (see Chapter 5, Recognising and responding to a

person with mental health problems).

- Call on friends or family who are stable supports in the person's life if he or she is feeling scared, paranoid or panicky. Support people can often help the client calm down or can call for specialist help if needed. Users could make an emergency plan and have names and numbers of support people handy.
- Be clear about signs and symptoms and overdose including advice to call an ambulance immediately if overdose occurs (see Chapter 4, *Recognising and managing overdose*).

Attend to other health and lifestyle issues

- Brush and floss teeth regularly, and chew sugar-free gum to increase saliva and to take some pressure off the enamel if teeth grinding is a problem. Dental health can suffer due to a lack of bacteria-fighting saliva in the mouth.
- Plan for the week ahead and make sure that the person does not use (or be in the middle of 'coming down') just before an important event or commitment (workers might need to assist clients to brainstorm alternatives to using). This will help to keep life a little more on track.
- Consider if the person is doing things that they would not normally do to buy methamphetamines. Sometimes a person does not realise that his or her life is out of control, and a client's own moral compass is a good indicator.
- Avoid discussing sensitive topics or making important decisions if partners are coming down together. Social or romantic relationships can suffer when people are feeling irritable, so encourage partners to be patient with each other.
- Avoid driving when intoxicated or 'coming down', particularly if alcohol has also been consumed.

What about pregnancy?

Workers in the drug and alcohol field are sometimes asked for advice about drug use during pregnancy. There is only limited evidence about the specific effects of methamphetamine on the developing foetus in humans, and most evidence comes from animal studies or is derived from studies on cocaine or 'crack' use.

The most important thing for a pregnant woman is to have regular, supportive antenatal care, which improves outcomes for both the mother and baby. The specialists in the antenatal team can assess each woman and offer individual advice and guidance throughout the pregnancy. It is not uncommon for women to be reluctant to disclose drug use, as they often fear criticism, or dread having the baby removed from their care. However, antenatal teams focus on the best interests of the mother and child, and play a crucial role in improving the likelihood of a healthy pregnancy.

Workers can assist a pregnant user by establishing strong networks and collaborating with specialist antenatal teams who see mothers at risk for complications. Antenatal teams can be contacted through the local hospital. (See Chapter 11, *Making links and creating partnerships* for advice about networking).

Workers could encourage pregnant clients to talk to other mothers who have had a good or positive experience with a local antenatal team to relieve the client's fears.

If the mother declines antenatal support and workers are concerned about the welfare of the baby or other children in the mother's care, workers should consider the role of child protective services. Workers should refer to the guidelines for mandatory reporting and seek advice from a supervisor if in doubt (see Chapter 10 *Legal issues*).

Concerns about foetal development in babies of methamphetamine users

Based on limited research, some of the concerns for pregnant methamphetamine users include the risk:

- that methamphetamine use will affect organ development during the early weeks of the pregnancy, which can cause for example, cleft pallet or heart defects
- that the foetus will not receive the oxygen and nutrients essential for normal growth and development, including brain development (eg risk of premature birth, low birth weight or subtle brain changes)
- of foetal toxicity in the third trimester (weeks 24 to birth) because it takes the developing foetus nearly twice as long as the mother to clear drugs from its system, placing the baby at significant risk for methamphetamine withdrawal after birth
- of other health-related issues linked to the mother's lifestyle such as inadequate rest, nutrition, and hydration; cigarette smoking and use of other drugs including alcohol (which puts the baby at risk for foetal alcohol syndrome[1]); increased maternal blood pressure; exposure to impurities in street methamphetamine; and being a victim of violence.

Concerns for breastfed babies of users

Methamphetamine use reduces quantity of breast milk and methamphetamine can be released into breast milk (methamphetamine has been found in the urine of babies of users). Infants breastfed by methamphetamine-using mothers may experience a range of drug-induced behavioural problems such as irritability,

1 Foetal alcohol syndrome can result in low birthweight, smaller than normal head circumference, small eyes, flattened face and heart defects. Later in life, affected children might experience low IQ, developmental delays, behavioural problems, learning difficulties and memory problems.

poor sleeping patterns, agitation and crying. New mothers who continue to use methamphetamine can often still breastfeed their infants; however, antenatal team specialists are best placed to advise mothers about the best ways to limit risks to the baby.

Advice for pregnant women

Pregnant women and new mothers who use methamphetamine should be encouraged to seek regular, effective health care during and after the pregnancy to improve maternal nutrition, reduce psychological distress and improve outcomes for newborns.

Pregnancy can be a strong motivator for change in some women, and workers can skilfully employ motivational approaches during this time.

Pregnant users should be advised to avoid other substance use; especially nicotine, cannabis and alcohol, as abstaining from these substances can also improve neonatal and early childhood outcomes.

Even if methamphetamine has been used in the earlier stages of pregnancy, there are possible benefits for reducing or ceasing use in the later stages, which should be discussed with specialists in the antenatal team.

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3
Recognising and managing intoxication

Intoxication: what to look for

Signs of methamphetamine intoxication vary according to the amount of methamphetamine (and other drugs) taken and can include the following:

- rapid or pressured speech (fast, loud and difficult-to-interrupt speech), or jumping from one topic to another
- restlessness, agitation, pacing
- repetitive movements
- impulsivity or recklessness
- clenched jaw, teeth grinding (bruxism)
- sweatiness
- suspiciousness or paranoia
- large (dilated) pupils
- anger, irritability, hostility, particularly if it is out of character

Responding to an intoxicated person

The aims of responding to a person who is intoxicated are to maintain a calm environment to reduce the chance that the person will become angry or hostile and to promote a positive, helpful interaction. **Remember that an intoxicated person has impaired judgment and will probably see the interaction differently to you.**

What you should do

✔ If other people are present, try to steer the intoxicated person to an area that is less stimulating while ensuring that the client and worker both have an easily accessible exit.

- ✔ Maintain a calm, nonjudgmental, respectful approach.
- ✔ Listen, and respond as promptly as possible, to needs or requests. (*I hear what you are saying, so let me see what I can do to help.*)
- ✔ Allow the person more personal space than usual.
- ✔ Use clear communication — short sentences, repetition, and ask for clarification if you are unsure what is said. (*I really want to help, but I'm not sure what you need. Please tell me again.*)
- ✔ Move around with the intoxicated person to continue communication if necessary.
- ✔ Have written information available for the person to take away.
- ✔ Provide opportunistic, relevant, brief interventions if you are able.

What you should not do

- ✖ Do not argue with the person and do not use 'no' messages. If you cannot provide what they are asking for, be clear about what you *can* provide.
- ✖ Do not take the person's behaviour or any criticisms personally.
- ✖ Do not ask a lot of questions — ask only what is necessary to respond to the situation, as the person will have low tolerance for frustration or questioning.
- ✖ Do not undertake a lengthy interview or try to counsel the person — if the person has presented for assessment or counselling, inform him or her that you cannot continue if he or she is intoxicated and agree to make a future appointment.

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4
Recognising and managing overdose

Methamphetamine overdose: what to look for

Methamphetamine overdose (toxicity) is a medical emergency. If untreated, overdose can lead to heart attack, stroke, breakdown of muscle tissue (rhabdomyolysis), kidney failure, and possibly death.

In addition to those listed for intoxication in the previous chapter, signs of toxicity include:

- hot, flushed or very sweaty skin, which may indicate high fever
- severe headache
- chest pain
- unsteady walking (gait)
- muscle rigidity, tremors, spasm, fierce jerking movements of the limbs, seizures
- severe agitation or panic
- difficulty breathing
- altered mental state (eg confusion, disorientation).

Symptoms of psychosis can also occur (see Chapter 5, *Recognising and responding to a person with mental health problems*).

First aid for methamphetamine overdose

✔ **CALL 000 AND REQUEST AN AMBULANCE IMMEDIATELY,** even if you are unsure if methamphetamine is the cause — ambulance officers do not routinely notify police in the event of overdose.

✔ Move the person to a quiet, safe room away from bystanders, noise, excessive light, heat and other stimulation.

- ✔ Remove constrictive or hot clothing; apply icepacks to neck, underarms and groin; or thoroughly wet a towel with cold water and place over the person's body to reduce temperature.
- ✔ If the person is unconsciousness, place him or her on the side with the upper leg bent at the knee to support the body, and tilt the chin upward slightly to maintain a clear airway and avoid any obstruction to breathing.
- ✔ If muscle spasms or seizures occur, remove anything from the immediate environment that might pose risk of injury.
- ✔ Stay with the person until the ambulance arrives and give reassurance that he or she will be attended to as soon as possible.

What not to do

- ✖ Do not attempt to transfer the person to a doctor or hospital yourself or allow others to do so.
- ✖ Do not call a doctor or hospital directly — this simply wastes precious time.
- ✖ Do not leave the person alone.

Recommended service response

It is recommended that each agency or service develop a policy or protocol for identifying and managing overdose in its particular setting. The document should include the signs and management principles listed here, and should incorporate routine staff training and review after an emergency occurs.

References Chapter 4: Recognising and managing overdose

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5
Recognising and responding to a person with mental health problems

Background

Users of methamphetamine can experience a range of mental health problems (eg depression, anxiety, psychotic symptoms). Some people experience these as a direct result of using the drug, and the problem will improve or resolve rapidly when people stop using or cut down.

Other people might experiences longer lasting psychosis (weeks to months).

Some people might have had a mental health problem before they started to use methamphetamine, for example, schizophrenia, and are likely to experience relapse of psychotic symptoms following methamphetamine use.

Many diagnostic and screening instruments are available to detect a range of mental health disorders (see http://www.adelaide.edu.au/library/guide/med/menthealth/scales.html).

This chapter describes the symptoms of psychosis, depression and anxiety. It includes tips on how to communicate with a person who is experiencing psychosis; how to respond to a client with depression or who is thinking of self-harm; and how and when to refer a client to mental health services.

What is psychosis?

The term psychosis describes a disorder in which a person's contact with reality is grossly impaired. Symptoms of psychosis include:

- Hallucinations — the person experiences sensations that have no basis in reality such as hearing 'voices' (auditory hallucinations), 'feeling' things on the skin or in the body (tactile hallucinations), or seeing things that others cannot (visual hallucinations). Other hallucinations involve taste (gustatory hallucinations) and smell (olfactory hallucinations).

- Delusions — the person holds fixed, false beliefs that do not shift even when faced with logical evidence to the contrary. For example, a person might believe that he or she is being spied upon by a secret agency, or that his or her thoughts are being controlled by external forces. Beliefs that are part of a person's religion or culture are not considered to be delusions unless those beliefs are not upheld by others in the person's same religious or cultural group.
- Thought disorder — a person's thinking becomes confused, concentration becomes difficult, thoughts may speed up or slow down, or the person will jump from one topic to another with no obvious logical connections.
- Disorganised or bizarre behaviour — a person will respond to strange thoughts or unusual sensory experiences by changing their behaviour to adapt to their beliefs or perceptions. To others, their behaviour may seem disorganised or bizarre, but to the person they make sense. For example, those who fear surveillance might pull down blinds; speak in whispers; disconnect the phone; appear generally anxious, jumpy or afraid; and may even keep a weapon for protection.

Mood swings also commonly occur when a person experiences psychosis.

Note: Mood swings, agitation and irritability *without* the presence of hallucinations or delusions does not mean that the person is psychotic. Workers should respond to these people in the usual way, such as providing a calm environment, using de-escalation techniques, and meeting the person's immediate needs.

About methamphetamine psychosis

Stimulants can bring on a psychotic episode in healthy people with no previous history of mental health problems. Many users report experiencing low-grade or 'subacute' psychotic symptoms such as visual illusions, fleeting hallucinations or odd thoughts that come and go. Other users can experience more severe episodes where they hear or see things that are not there, or they become paranoid and believe that other people are going hurt them. The rate of psychosis among regular methamphetamine users interviewed in Sydney recently was 11 *times* that seen in the general population.

Many people will recover spontaneously from psychotic symptoms within hours as the effects of the drug wear off. These people may benefit from a quiet, low-stimulus environment and will not usually need specialist treatment. On the other hand, psychosis can persist for days, weeks, months or longer in some people. In this case, it is likely that those people were already at risk for developing a psychotic disorder and methamphetamine use triggered it. These people need to have specialist mental health treatment, which usually includes medication (antipsychotic drugs).

Although hospital admissions for amphetamine psychosis have increased over the past decade, only a small percentage of people who experience psychosis actually go to hospital for treatment. When they do, it is usually through the emergency department and only when psychosis is severe. As methamphetamine psychosis is more likely in dependent users, multiple presentations to emergency departments are more common among this group.

Some regular users who have been psychotic might become psychotic again when even small quantities of methamphetamine are used. This is known as ‘reverse tolerance’ (ie even using *smaller* amounts than before can trigger psychosis). These people can also be sensitive to stressors including the use of other drugs or alcohol, which might also trigger a psychotic episode. Some people can experience fleeting psychotic symptoms or ‘flashbacks’ even after they stop using.

What is schizophrenia?

Psychosis can be fleeting and last for hours, days or a week or two. On the other hand, according to the International Classification of Diseases-10, schizophrenia is a disorder that is characterised by at least one prominent psychotic symptom (or two symptoms if not clear cut) that last for *more than a month,* and is *not related to drug intoxication or withdrawal*. A person with severe, enduring psychosis or schizophrenia also tends to lack insight into his or her symptoms, which means that the person is unable to recognise that hallucinations or delusions may not be real. People with schizophrenia can be stabilised on medication, which means that psychotic symptoms are much less severe, although some symptoms can persist. People who have a mental health problem like schizophrenia are at greater risk of experiencing psychosis than other methamphetamine users.

Methamphetamine psychosis or schizophrenia?

It is extremely difficult to distinguish between methamphetamine psychosis and schizophrenia, and only a psychiatrist can make a diagnosis, so the important thing is to respond appropriately and skilfully to every person who experiences psychotic symptoms (see *Initial response*, page 29). However, those with methamphetamine psychosis:

- have a history of methamphetamine use or have used methamphetamine recently
- have psychotic symptoms that developed during intoxication, withdrawal or shortly after withdrawal
- have psychotic symptoms that subside and resolve within hours as the methamphetamine effects wear off
- do not fit criteria for a diagnosis of schizophrenia.

Impending or 'subacute' psychosis: what to look for

Acute psychotic symptoms are usually easy to identify, although methamphetamine users may present with a range of low-grade psychotic symptoms that are more difficult to pinpoint. The following are signs of low grade or subacute psychosis:

- Suspiciousness, guardedness, hypervigilance[2] — constantly checking for threats in an exaggerated way.
- Overvalued ideas — ordinary events have special significance or are more meaningful than usual or odd.
- Illusions or misinterpreting the environment — eg a shadow might seem like a person walking into a room, or a random sound might seem like a ringing phone or a police siren; or fleeting, low-level hallucinations.
- Erratic behaviour — often related to overvalued or paranoid ideas and might include accusing others of perceived misdeeds, or arguing with bystanders for no apparent reason.

Acute psychosis: what to look for

The following are signs of acute psychosis:

- Delusions — often people feel persecuted; they may believe that others have malicious intentions or that they are under surveillance.
- Hallucinations — often auditory such as 'voices' or sounds like police car sirens, or tactile such as a feeling that 'bugs' are crawling under the skin, but these can also be visual.
- Erratic, uncontrolled or bizarre behaviour often in response to delusions or hallucinations, for example, talking or shouting in response to 'voices'; unnecessary whispering; barricading a room; checking doors; pulling down blinds; making frantic phone calls; keeping a weapon for protection from perceived threats.
- Illogical, disconnected, or incoherent speech
- Extreme or rapid mood swings that are unpredictable, irrational or erratic.

First steps in response

✔ Quickly scan the immediate vicinity and observe location of exits, bystanders, and potentially dangerous objects to judge immediate risks and decide upon the most suitable approach (leave and call for assistance or respond carefully).

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2 Due to some users' lifestyle factors, guarded or vigilant behaviour might be appropriate so enquire about this during assessment.

- ✔ If in a public place, service or treatment setting, move bystanders from the immediate environment to avoid risk of injury or escalation of the situation.
- ✔ If in a nontreatment setting or private home, stay close to the exit and remove yourself from any room that might contain dangerous implements or weapons (eg kitchen, workshop).
- ✔ Try to reduce noise, human traffic or other stimulation within the person's immediate environment.
- ✔ Try to determine if the person has recently used methamphetamine either by direct questioning or by asking companions or family.
- ✔ Observe for any physical signs of methamphetamine overdose and respond promptly (see Chapter 4, *Recognising and managing overdose*).
- ✔ If psychosis is severe, arrange transfer to an emergency department for assessment and treatment by **calling an ambulance on 000**. Give them your exact location and name of the nearest cross street; accurately describe what is happening (say exactly what the person is saying and doing); remain calm and ensure everyone's continued safety until the ambulance arrives.

Communicating with a person who is experiencing psychotic symptoms

A skilled response to a person who is experiencing psychosis will assist him or her considerably.

What the communicator should do

- ✔ Choose one worker who will communicate with the person and feels confident to do so — many communicators increase stress, confuse the person, and escalate the situation.
- ✔ The 'communicator' should place other workers on stand-by so a team approach can be undertaken. Have another staff member present to observe or step in *only if required* (the communicator could use a code word to call for assistance from the 'observer'). The observer should attempt to determine if the client has a known history of aggression or violence and, if so, extra care should be taken and the observer should be ready to call for immediate assistance if required.
- ✔ Allow the person as much personal space as possible.
- ✔ The communicator should be aware of his or her body language — arms should be by the sides with palms out and the communicator should make no sudden movements and should approach slowly from the front so the person is not startled.

- ✔ The communicator should mirror body-language signals from the person — sit with a person who is seated, walk with a person who is pacing —to show that the worker understands what the person is going through (empathy) and to ensure that the worker appears neither threatening, by standing over the person, nor vulnerable by being seated while he or she stands.
- ✔ The communicator should monitor and use appropriate eye contact — not too much (appears threatening) or too little (implies indifference or untrustworthiness).
- ✔ Use a consistently even tone of voice, even if the person's communication style becomes hostile or aggressive.
- ✔ Use the person's name if known or the communicator should introduce him- or herself by name.
- ✔ Carefully call the person's attention to their immediate environment. (*You're in the* [service] *and you're completely safe now*).
- ✔ Offer a glass of juice or water, as this can often help calm the person.
- ✔ Use careful, open-ended questioning to determine the cause of the behaviour or the person's immediate needs and communicate your willingness to help. (*I can see that you are really upset; what can I do to help you?*)
- ✔ Listen attentively and respectfully.
- ✔ Ask the person if he or she would like a minute or two to think and respond — consider stepping back to reduce the stimulus while still actively managing the situation. (*I'll give you a minute or two to think, but I'll be right here.*)
- ✔ Always appear confident — this will increase the client's confidence in the communicator's ability to manage the situation, as he or she will probably be feeling scared or anxious too.

What the communicator should not do

- ✖ Do not laugh at or argue with the person's unusual beliefs, even if they are obviously wrong or make no sense at all.
- ✖ Do not agree with or support the unusual beliefs either, as people can usually tell when workers are not being genuine. It is better to simply say:
  - ✔ *I can see that you're scared, how can I help you?*
- ✖ Do not allow the person to block the worker's exit from the room, and do not block theirs.
- ✖ Do not use 'no' language, which may prompt a hostile outburst; rather, use statements like:
  - ✔ *This is what I CAN do for you…* often encourages further communication and has a calming effect.

Note: Is the person threatening harm to him- or herself or others? If so, call the police on 000 immediately and remove all bystanders or other staff members from the location until police arrive. Workers should be aware that psychostimulant use is a risk factor for sudden death of individuals being physically restrained and if restraint is ever necessary, it should be undertaken for the *shortest possible time* (see *Responding to challenging situations: a practical guide for frontline workers*).

Longer-term management

The preferred goal of treatment for a person who has experienced methamphetamine psychosis is to stop using the drug. Motivational approaches that focus on psychosis as a consequence of methamphetamine use could be helpful in achieving this. If psychotic symptoms persist, the person must be treated by mental health specialists, preferably in conjunction with alcohol and other drugs workers, and workers should encourage the person to take psychiatric medications as prescribed (see *Referring to mental health services* later in this chapter).

It is important to encourage the person to adopt a healthy lifestyle that involves relaxation and adequate diet and sleep, due to the risk of stress-induced relapse of psychotic symptoms. For the same reason, use of other drugs or alcohol should be reduced significantly or stopped altogether.

Regardless of this advice, some people decide to keep using methamphetamine even after they have had a psychotic episode. The following advice could be helpful for such people:

- Avoid injecting or smoking methamphetamine to limit exposure to high doses of the drug.
- Avoid the use of multiple drugs.
- Take regular breaks from using and never use more than twice per week.
- Use no more than a very small amount to limit the chance of another psychotic episode.
- Understand 'reverse tolerance' and the risk of future psychotic episodes.
- Recognise the early warning signs that psychotic symptoms might be returning (eg feeling more anxious, stressed or fearful than usual, hearing things, seeing things, feeling strange or feeling that the world or people have changed in some way etc). If experiencing any of these, immediately stop drug use and seek help to reduce the risk of a severe episode.
- Inform the client that the use of methamphetamine can make prescribed medications for psychosis or schizophrenia ineffective.

Depression

Depression commonly occurs among methamphetamine users, as discussed in previous sections. Symptoms of depression (eg withdrawal from social contact; negative thoughts; feelings of sadness, guilt, pessimism; changes in appetite, libido and energy) may persist for weeks, months or even several years after quitting methamphetamine use.

Encourage clients to be aware of their symptoms and to alert a worker or seek specialist help if depression worsens, particularly if suicidal thoughts occur.

Many workers are reluctant to discuss suicide with clients, but raising the issue will not trigger suicidal ideas in a person who has no intentions. On the other hand, sensitive questioning by a worker can be a relief for clients who have been harbouring thoughts of self-harm, while providing an opportunity for the client to receive the help and support that is urgently required.

A depressed client might be at high risk for suicide if he or she:

- has a clear plan that could cause death and the means to carry it out
- has tried before in the past or recently
- continues to use alcohol and other drugs
- has psychotic symptoms
- has significant life stressors and feels hopeless and helpless to deal with them
- has few or no social supports
- has a family member who has attempted or committed suicide.

The following suggestions from the *PsyCheck* can help guide a worker's response:

Risk level	Action
Low risk: fleeting thoughts of suicide but no risk factors as described above, can guarantee own safety, has supports in place.	• Review frequently. • Identify potential supports or contacts and provide contact details. • Contract with client to seek immediate assistance if fleeting thoughts become more serious or depression deepens.
Moderate risk to high risk: suicidal thoughts present, some or many risk factors, plan has some detail or is very detailed, has means or access to means, poor or no social supports, cannot guarantee safety, feels hopeless.	• Request permission to organise a specialist mental health assessment as soon as possible, continue contract as above, and review daily. • If risk is high and the client has an immediate intention to act, contact the mental health services or emergency mental health team immediately (see *Referral* section below for details) and ensure that the client is not left alone. • Call an ambulance or police if risk is high and the client will not accept a specialist assessment. • Consult with a colleague or supervisor for guidance and support.

Anxiety

Anxiety can occur in many forms and usually involves excessive worry. Other features of anxiety can include agitation, racing heart, sweatiness, rapid breathing or a feeling of breathlessness, tightness in the chest or chest pain, fear or panic, and sleep disturbance.

It is common for methamphetamine users to experience some of these symptoms as a direct effect of the drug. In many cases, anxiety symptoms subside when methamphetamine is no longer used. However, if anxiety symptoms persist after stopping, the client must be assessed by a mental health specialist.

Anxious clients should be provided with a low-stimulus environment and encouraged to take slow, deep, calming breaths. Some useful examples of other relaxation strategies include tensing and relaxing all the large muscle groups in the body; actively imagining a peaceful, safe place of the client's own choosing; taking a warm bath; listening to music; and meditation.

Referring to emergency mental health services

Acute or emergency mental health services usually provide an intake or triage telephone line. Many are staffed on a 24 hours per-day basis in major cities, but in regional areas, emergency treatment is often provided outside of business hours through the emergency department of the local hospital. **Workers should ensure that the emergency telephone number for their most appropriate contacts are on hand at all times.**

A worker should ask the client's permission to contact mental health services. If the client refuses permission, workers can call the local mental health service or the mental health triage worker in the local emergency department and ask for advice about the situation without identifying the client in the first instance.

When contacting a mental health service, give a detailed and accurate summary of the situation and be clear about what the worker's concerns are. Workers should learn to use relevant and appropriate language and only communicate what can be observed. The mental health worker can then offer advice about what to do next.

When a worker telephones an intake officer, the officer will ask for the worker's name, the person's name and the name of the worker's service. The worker will then be asked to describe in detail his or her concerns about the person in question. A worker could state for example:

> *The person is severely agitated, appears to be responding to auditory hallucinations as he is shouting at people who are not present, and he is threatening to harm himself with a knife.*

This will have more impact and convey more information about the situation than for example, *'The guy's going off in the waiting room'*. In extremely serious situations such as this, the mental health services intake worker will probably instruct the referrer to call the police so the person can be taken to the nearest emergency department or place of safety for an immediate assessment. This is often distressing to both the client and the worker; however, this action is

dictated by the worker's duty-of-care. Workers should also enlist the support and advice of senior staff from their own service in such cases.

Another group of clients might experience serious or lingering symptoms of depression that may lead to thoughts of self-harm or suicide. Workers have a duty-of-care to ensure the safety of clients who disclose thoughts of self-harm. In this case, it is essential to gather as much information as possible before contacting mental health services so the mental health intake worker can make a rapid determination of the client's potential risk and then advise the worker of the best course of action.

Referring for nonemergency mental health assessment

Some clients might have mental health problems that do not appear to pose great risk; however, they may still complicate treatment for methamphetamine use. After gaining consent from the client, the choice of the appropriate contact for a mental health assessment will depend on the location and structure of your service and may include:

- a mental health professional in your own service
- a specialist dual diagnosis consultant
- 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.

It is important to gather as much information as possible and to use appropriate language when referring clients. Give an accurate description of the person's issues using appropriate language and terms, request an assessment, and indicate what level of involvement in the client's future treatment that you would like to maintain (ongoing contact/counselling, co-case management, etc).

If the client has an established mental health disorder as diagnosed by a psychiatrist, be sure to inform the agency. If not, simply state the client's symptoms or concerns. For example,

> *The client reports feeling anxious and tearful, and her sleeping pattern has been disturbed for several months. She has little appetite, has difficulty managing daily tasks, and although she says she can't imagine going on like this, she says she doesn't have any thoughts of self-harm.*

The assessor or intake worker will then advise the referrer of a course of action, which could include referral to a general practitioner for an assessment or an appointment for an assessment with the mental health service.

Do whatever is reasonable to help the person keep the appointment, but also be sure to maintain professional boundaries with clients. (Also see Chapter 11, *Making links and creating partnerships*).

Recommended service response

It is recommended that each agency or service develop a policy or protocol for identifying and managing mental health problems, including psychosis and suicidal ideation in its particular setting. The document should include the signs, symptoms and management principles listed here, incorporate routine staff education and support, and require prompt debriefing or review should an acute incident occur.

It is recommended that services develop close links with mental health services, ambulance, police and other key agencies so a team approach to response and treatment can be smoothly organised should it be required (see Chapter 11 *Making links and creating partnerships*).

References Chapter 5: Identifying and responding to a person with mental health problems

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6
Helping a person get through withdrawal

About methamphetamine withdrawal

Many methamphetamine users will experience what is commonly referred to as a 'crash' or a brief period of recovery when they stop using, which might last for a few days. During this time, the person is likely to experience periods of prolonged sleep, increased appetite, some irritability and a general sense of feeling flat, anxious or out of sorts (dysphoria). As neurotransmitter stores are replenished, the person improves rapidly. It is like a 'hangover' from alcohol. The crash period is not a clinical methamphetamine withdrawal so specialist intervention is usually not required.

In contrast, some dependent methamphetamine users will experience the full-blown withdrawal syndrome when they stop using, the course of which depends on the person's severity of methamphetamine dependence (see Appendix 1: *Severity of dependence scale*); how long and how often the person has used; the presence of other physical or mental heath problems; and other factors such as the setting in which withdrawal is undertaken and expectations and fears about the course of withdrawal.

Signs and symptoms of withdrawal can include:

- a range of feelings from general dysphoria through to significant, clinical depression
- mood swings
- inability to experience pleasure (anhedonia)
- decreased energy
- irritability or anger
- agitation, anxiety
- aches and pains
- sleep disturbance, lethargy, exhaustion, insomnia

- poor concentration and memory
- cravings to use methamphetamine.

Although this varies between individuals, the acute phase of withdrawal can peak around day two or three after last use and generally begins to ease after a week to 10 days. Low-grade symptoms including mood swings and agitation, cravings, and sleep disturbance can last for a further couple of weeks; however, for some individuals, depression can last from weeks to many months or even a year in severe cases.

Withdrawal is most often undertaken at home, but a specialist hospital or residential setting is more suitable for people who are at heightened risk of severe or lengthy withdrawal, have unstable housing, are exposed to methamphetamine at home, or have complicating medical or psychiatric disorders.

Supported withdrawal should be seen as the first step in a comprehensive treatment plan, including counselling and relapse prevention, rather than a treatment in itself.

Assisting a person who is withdrawing

The following strategies are recommended for helping a person who is withdrawing:

- ✔ Tell the person what to expect during withdrawal, including probable time course, common symptoms particularly agitation, irritability, anger, depression, and cravings and possible consequences such as impact on relationships, work, and other social factors.
- ✔ Determine what was and was not helpful during any previous withdrawals.
- ✔ Identify dependence on other drugs and offer appropriate interventions.
- ✔ Recommend adequate diet, rest, and fluid intake. Encourage the person to prepare by having a supply of nutritious food and drink in the house, taking leave from work, limiting visitors etc.
- ✔ Encourage the person to monitor him or herself for symptoms of depression and, if symptoms persist, become severe or thoughts of self-harm occur, advise the person to seek urgent medical attention.
- ✔ Assist with managing cravings to use, by explaining how cravings occur and by developing an early intervention and relapse prevention plan (see Baker et al 2003, *A Brief CBT Intervention for Regular Amphetamine Users*, and Lee et al (2007) for practical strategies for managing cravings).

- ✔ Identify key social supports and educate the family or carers about withdrawal and what to expect (see Chapter 9, *Assisting families, carers and significant others*).
- ✔ Provide written materials as the person may have difficulty with recall and concentration during withdrawal (eg *On Thin Ice,* http://www.ndarc.med.unsw.edu.au).
- ✔ Refer the person to a medical practitioner if the person experiences sleep disturbance or insomnia for more than a week or two, or the person has ongoing feelings of anxiety, agitation or restlessness, which is increasing the likelihood of relapse. Some people benefit from the prescription of a short course of sedative-hypnotic medications such as temazepam for sleep or diazepam for agitation and anxiety.
- ✔ Encourage the person to seek further support if symptoms such as those listed above are severe and persist beyond a week or two.
- ✔ Recommend ongoing interventions such as counselling to prevent relapse to using. Withdrawal strategies should be the *first step* in a planned, individualised treatment approach to support a client's long-term goals.

References Chapter 6: Helping a person get through withdrawal

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7
Use of other drugs and possible effects of mixing drugs

Methamphetamine users often take other drugs in an effort to improve sleep or reduce agitation or anxiety when the person is 'coming down' from methamphetamine. Other combinations provide a pleasurable experience for the user, reflect a dependence on multiple drugs, or are prescribed by a medical practitioner to treat a person's mental health disorder or physical illness.

The risks associated with continued methamphetamine use in combination with prescribed medications **should always be discussed with the prescribing doctor**. However, some clients might be reluctant to disclose methamphetamine use to their doctor for a range of reasons. Workers can assist clients by discussing the issues that are barriers to disclosure and identifying potential solutions together. Sometimes clients need to find a different doctor, with whom he or she can feel comfortable enough to discuss all issues related to their health and wellbeing, including drug use.

Risks associated with prescribed medications

Although the medications described in this section should be prescribed by a doctor, some users obtain antidepressants, antipsychotics and benzodiazepines from other sources such family or friends who have been prescribed these medications, or purchase tablets on the street.

Antidepressants including those that block reuptake of the neurotransmitter serotonin (collectively called selective serotonin reuptake inhibitors or SSRIs), monoamine oxidase inhibitors (MAOI) and tricyclic antidepressants when *used within the same two weeks as methamphetamine* can cause dangerously high blood pressure; increased blood levels of methamphetamine; and serotonin toxicity (overheating, fits, heart attack, stroke, kidney failure).

Antipsychotic medications used to treat psychotic disorders such as schizophrenia can be made ineffective. Methamphetamine can reduce blood

levels of antipsychotic medications, which reduce their effectiveness and lead to relapse of psychotic symptoms. Risk of seizures (fits) also increases.

Benzodiazepines increase the risk of benzodiazepine dependence if large or regular doses are used. Additionally, as methamphetamine use can stop the client from feeling the full effect of benzodiazepines, risk of accident and injury also increases. If clients are injecting methamphetamine, they might also be at risk for injecting benzodiazepines, which can damage veins and cause infections, which can affect the heart (see http://www.druginfo.adf.org.au/article.asp?ContentID = benzodiazepines).

It is important to note that benzodiazepines are very useful in the early stages of methamphetamine withdrawal and are prescribed frequently to reduce agitation and anxiety, and restore sleep. If a client is using benzodiazepines, workers could assist the person to regulate the dosage in the following ways:

- ✔ consider supervised dosing of benzodiazepines (or other medications); for example, a client can receive the prescribed number of tablets each day or once per week from a designated pharmacy, rather than fill a prescription for a month's supply at once
- ✔ reduce the likelihood that the person will obtain multiple prescriptions from more than one doctor (known as 'doctor shopping') by asking him or her to voluntarily complete the *Authority to release personal Pharmaceutical Benefits Scheme (PBS) claims information to a third party* form, which is used to track and monitor prescriptions
- ✔ create a contract stipulating the conditions under which the mediation will be taken (dose, frequency, etc), which the client and worker sign and date.

Blood pressure regulating medication (antihypertensives) can be made ineffective.

HIV medications can result in methamphetamine toxicity (overdose) if taken together.

As new medications are developed and brand names are often subject to change, see the MIMS online website for brand name examples of the medications described in this section http://www.mims.com.au/.

Risks associated with other drugs

Users of methamphetamine typically use a range of other drugs, which is referred to as *polydrug use*.

Alcohol combined with methamphetamine can increase blood pressure, placing greater burden on the heart. It can also stop the person from *feeling* intoxicated or drunk, but the person *is* impaired and blood alcohol levels will still be high. This increases the risk of alcohol poisoning or accidents due to a false sense of feeling sober and in control. (Some people take methamphetamine or other stimulants, because this enables them to drink more alcohol without being sick or passing out.) Use of alcohol and methamphetamine can also place a greater burden on the user's liver, which breaks down alcohol and other drugs for elimination from the body. Careful assessment of a client's use of alcohol will help to identify any problems that the worker should then target specifically (see *Guidelines for the treatment of alcohol problems*, available from http://www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/AAG07).

Cannabis use has been associated with the worsening of psychotic symptoms in some individuals, particularly those with schizophrenia. People often do not see the relationship as psychotic symptoms tend to worsen a few days after cannabis use. Methamphetamine users with a history of psychosis should be aware of the risks of smoking cannabis.

Opiates increase the risk of heroin overdose, because methamphetamine users may not feel the full effect of heroin and could use considerably more than intended.

Other psychostimulants such ecstasy and cocaine can interact with methamphetamine to increase a user's risk of heart attack, stroke and psychosis.

Tobacco is often smoked in greater quantities when a person is intoxicated with methamphetamine, increasing nicotine-related health risks (eg lung and heart disease, cancer).

Possible interactions with methamphetamine: quick reference list

Drug type	Possible interaction effects
Alcohol	Possible depressed heart and breathing functions
Antidepressants	Possible dangerous rise in blood pressure and body temperature leading to strokes, seizures or heart failure; not to be used within the same 2-week period
Antipsychotic medications	Possible reduced effectiveness of medication, increased risk of seizures
Benzodiazepines	Increased risk of accident and injury and benzodiazepine dependence if taken regularly or in large quantities
Blood pressure medications	Can reduce the effectiveness of medication and increase blood pressure
Cannabis	Linked to worsening of psychotic symptoms in people with psychotic disorders
HIV medications	Increases risk of methamphetamine toxicity (overdose)
Opiates (eg heroin)	Increased risk of opiate overdose
Psychostimulants (ecstasy, cocaine)	Increased risk of heart attack and strokes
Tobacco	Increased risk of lung and heart disease, and cancer

Advice for methamphetamine users

Continuing users of methamphetamine should be provided with the following information:

- ✔ Be aware of the potential interactions of all prescribed medications with methamphetamine, and **always discuss the risks and benefits with the prescribing doctor**.
- ✔ People should not take antidepressants in combination with methamphetamine due to the potential for serious interactions. Users must discuss the dangers with the prescribing doctor.
- ✔ Be aware of the number of benzodiazepine tablets taken as people can lose track. Only take the amount prescribed by the doctor. This will reduce the risk of benzodiazepine dependence and accidents and injuries.
- ✔ Some people can experience withdrawal symptoms if benzodiazepines are stopped abruptly after just one month. Symptoms of benzodiazepine withdrawal can be very similar to methamphetamine intoxication, toxicity or withdrawal (eg anxiety; sleep disturbances; hallucinations; headaches; and depression). The following are hallmarks of benzodiazepine withdrawal and should be attended to immediately if they occur: extreme sensitivity to loud noises, light or touch; feelings of unreality; numbness; fear of open spaces (agoraphobia), a metallic taste in the mouth; pain, stiffness and muscular spasms resulting in headaches and muscle twitching. Untreated benzodiazepine withdrawal can be life threatening because seizures (fits) can occur.
- ✔ Be aware of the amount of other drugs taken (eg heroin) to reduce the risk of overdose. If multiple drugs are taken at once, one drug might 'come one' before another, which can lead to using more of the other drug, possibly taking much more than the person is used to.
- ✔ Be aware of the amount of cannabis used and its effects in combination with methamphetamine, to limit the risk of experiencing or worsening psychotic symptoms.
- ✔ Continuing users of methamphetamine should also be told the following:
  - ✖ Never drive or operate machinery after drinking alcohol and using methamphetamine. Even if the person does not feel drunk after drinking alcohol, he or she is actually drunk, coordination and concentration will be impaired, and the blood alcohol level will reflect this.
  - ✖ Avoid using multiple types of stimulants at once.

References Chapter 7: Use of other drugs and possible effects of mixing drugs

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8
Overview of the range of treatment options

This chapter describes the principles of assessment and the range of treatment options available for methamphetamine users including brief interventions, counselling, behavioural approaches, mutual support groups, residential rehabilitation, and medications. Special considerations for Indigenous clients, youth, and those from culturally and linguistically diverse backgrounds (CALD) are highlighted.

About treatment seeking

As most people feel energetic, confident and euphoric when they use methamphetamine, it is not surprising that many users do not identify as a 'drug user' or do not actively seek treatment until the consequences are severe (eg hostility directed towards a loved one, depression or psychosis, physical health concerns).

Users also report that services are often not targeted to their needs. For example, methadone can be prescribed for heroin dependence, but there are no medications available specifically for methamphetamine use and dependence, although medication trials are currently underway in Australia and elsewhere (see *Medications* section in this chapter).

Research suggests that services generally have a poor record of attracting methamphetamine users into treatment in the first place (engagement) and then keeping them in treatment until goals are met (retention). Engagement and overall outcome are improved by establishing a firm helping relationship and by ensuring that treatment is driven by a *client's* goals rather than those of the service and is matched to the information gained from the assessment (see *Assessment* section in this chapter).

When considering appropriate treatment for methamphetamine users, workers often feel at a loss about how to respond. It is important to recognise that many

of the general approaches undertaken with clients who use other drugs are also relevant and effective for users of methamphetamine. Some useful approaches are described below.

Brief interventions

Brief interventions can be as short as a few minutes in a busy needle and syringe program, through to four one-hour counselling sessions in an outpatient treatment setting.

Brief interventions can include:

- screening and assessment
- provision of self-help materials (see *Resource Section*)
- harm reduction advice
- motivational interviewing
- education
- mood monitoring
- counselling.

Australian research has demonstrated the effectiveness of a brief cognitive behavioural intervention for regular amphetamine users to assist in reducing the quantity and frequency of amphetamine use as well as symptoms of depression. The clinical treatment manual used in the study is freely available (see *Resource Section* for download details).

Assessment

A thorough, routine assessment is undertaken for all clients in most service settings with the probable exceptions of needle syringe programs and drop in centres, for example, where only opportunistic screening or brief assessment is provided. Therefore, most workers in the drugs treatment field should be competent in undertaking a thorough assessment.

Assessments should be offered in the context of a safe, reassuring, supportive, nonjudgmental environment to enhance a client's engagement with the service, which in the early stages, is more important than specific drug treatment. Research has shown that a thorough assessment and follow-up by workers helps some users reduce or stop using amphetamines.

Workers should help clients identify their particular treatment goals (eg cut down or stop using; satisfy a court order; resume or gain employment; regain custody of children; improve a strained relationship, etc). This will help strengthen engagement and assist in the development of a treatment plan that is matched

to individual needs. The worker and client can determine collaboratively the progress of treatment against the identified goals, which can sometimes change during the course of treatment. For example, clients who try controlled use of methamphetamine at the beginning of treatment and find it difficult to maintain might choose to stop altogether.

A thorough assessment for methamphetamine treatment should include the following areas:

- current and past methamphetamine use
- other drugs use
- dependence on each drug
- physical and psychological health
- previous methamphetamine withdrawal
- social factors
- trauma history
- readiness to change.

Each of these is discussed in detail below.

Current and past methamphetamine use

History of current and past methamphetamine use should include the following:

- age at first use
- age at first regular use
- type of methamphetamine currently used (crystal, base, powder, pills)
- route of administration (*How do you usually use methamphetamine?*)
- quantity used (*How much are you using? How much do you usually spend? How many points/grams/etc would you use per day/week/fortnight?*)
- frequency of use (*How often are you using?*)
- when the client last used (*Have you used today?*)
- effects of methamphetamine use on the individual (*How does it make you feel?, Are there any effects that are causing difficulties for you?*)
- potency of methamphetamine used (*How long does it usually last*?).

Other drugs use

Using the questions mentioned above for methamphetamine use, workers should question clients about the use of other drugs. Clients might be unaware of the quantities of alcohol and other drugs that they are using, in which case workers should encourage clients to try to keep track of their use over the next week.

Dependence on each drug

Workers should obtain information about the type and severity of dependence on each drug used. The criteria for dependence on each drug should be determined according to the International Classification of Diseases (ICD-10), which state that a person is considered dependent on a drug if *three or more* of the following apply:

- The user has a strong desire or sense of compulsion to take the drug.
- The user has developed tolerance, ie needs to use more of the drug to get the same effect (*Have you found that you need to use more methamphetamine (or other drug) to get the same effect as before?*).
- The person experiences withdrawal symptoms if drug use is reduced or stopped (*Tell me about when you stop using, how do you feel?*; also see Chapter 6, Assisting a person to get through withdrawal for typical symptoms).
- The person is unable to stop using or is using in larger amounts or for longer periods than intended (*Have you ever tried to stop, but found you couldn't?, Have you ever used more than you meant to?, Have you ever used for a longer time than you meant to for example, did a plan to use for a night or two ever turn into a long binge?*).
- A great deal of time is spent acquiring, using or recovering from the drug *(How much time in your day-to-day life is spent on scoring, using or coming down?*), or important activities of life are reduced or neglected because of drug use (*Do you ever skip or miss important things like work, family, or social events due to using or coming down?*).
- The person continues using despite recognition of persistent physical or psychological harms associated with use (*Do you think that any issues that concern you are related to your drug use? Would you consider stopping because of these issues?*).

The **severity** of dependence should also be assessed (see the *Severity of Dependence Scale (SD*S), Appendix 1).

Physical health and psychological health

Workers should ask about the user's physical and psychological health (*Please tell me about your health in general. Do you have any illnesses or injuries? Do you take any prescribed medication?*).

Sometimes methamphetamine users might not be aware that they have physical problems, so workers should recommend a thorough medical checkup if the person has not seen a general practitioner for some time.

A range of screening questionnaires can be used to assess psychological health (see http://www.adelaide.edu.au/library/guide/med/menthealth/scales.html).

The following questions adapted from the *PsyCheck* package can be useful, and if the person answers yes to any question, a detailed assessment should be undertaken:

- Have you ever had emotional problems or problems with your 'nerves'/ anxiety/worries?
- Have you ever seen a GP, psychologist or psychiatrist?
- Have you ever been told that you have a mental health problem?
- Have you ever been in hospital for mental health treatment?
- Do you take medication?
- Do you feel down, sad or blue?
- Has the thought of harming yourself ever been on your mind?
- Are you more jumpy or anxious than usual?
- Do you see or hear things that other people say they can't?

Previous methamphetamine withdrawal or treatment

Workers should ask about the user's previous history of withdrawal or treatment, including its effectiveness and triggers for relapse (*Have you ever received drug treatment before? What prompted you to start using again?*).

Social factors and history of gambling

- Various social factors should be included, such as information about relationships, finances, legal issues, accommodation, social supports (*Please tell me about your life in general. What about friends and family? Are you in contact with your family? Are they supportive? Are you able to manage on the income you receive?*).
- Information about current or previous history of problematic gambling is also helpful (contact alcohol and drug information services (ADIS) for local treatment services).

Trauma history

Assessment should include information about trauma history, including childhood sexual abuse, torture, critical incidents and war experiences. (*Many people who enter drug treatment have suffered traumatic events in their past. May I ask if that is true for you?*)

If a client discloses a history of trauma and is willing, help him or her access help from a specialist because relapse to drug use is high when trauma-related issues are ignored. Be sure to follow-up the client after the assessment if he or she discloses trauma, particularly if it is the first time (contact ADIS for local treatment services).

Readiness to change

Treatment for methamphetamine use should be matched to the client's stage of readiness to change, which can be categorised as follows:

- precontemplation, where the person is not considering change
- contemplation, where the person has not yet cut down or quit, but is considering change
- preparation stage, where the person has made a firm commitment to quit or cut down
- action stage, where the person has recently cut down or quit
- maintenance stage, where the person has cut down or quit for some time
- relapse, where the person has started to use again.

Harm reduction and brief advice are suitable approaches for those not considering change. Those considering change can benefit from motivational enhancement, education, counselling. Those in the preparation or action stage can benefit from structured counselling, and those in relapse can benefit from motivational approaches and skills building.

Counselling

Formal or structured counselling is usually undertaken after withdrawal symptoms subside and should be provided only by workers who have been trained in the approaches described below (see *Making links and creating partnerships* for advice on referral).

Cognitive behavioural approaches

Cognitive behavioural approaches are the most extensively evaluated of the counselling styles and are effective in helping people address problems with meth/amphetamine use. Several clinical treatment manuals are available to guide clinicians in the use of this approach (see *Resources* section for download details).

Cognitive behavioural approaches are short-term, focused, talking therapies that aim to identify and address common errors in thinking and subsequent behaviours that lead to, and maintain, problematic drug use. These approaches include cognitive behaviour therapy (CBT), mindfulness-based cognitive therapy (MBCT), acceptance and commitment therapy (ACT), relapse prevention (RP), and motivational interviewing (MI).

CBT is also very effective for addressing mental health problems such as depression and anxiety.

The Australian Association for Cognitive and Behaviour Therapy can provide details of CBT practitioners in each area (see http://www.aacbt.org/).

Other counselling approaches

Other counselling approaches include:

- narrative therapy, which emphasises the importance of personal life stories and helps clients determine how their stories shape their thoughts and behaviours (see http://www.dulwichcentre.com.au/NC.Australia.htm for a list of therapists)
- solution-focused therapy, which applies a client's strengths to develop solutions to the problems identified(see http://www.goodtherapy.com.au/find_a_therapist.php for a list of therapists).

Randomised controlled trials of these approaches with methamphetamine users have yet to be undertaken, so their effectiveness is not yet known.

Cost of counselling

Medicare will pay for up to 12 counselling sessions by a registered psychologist endorsed by Medicare if the client is referred by a general practitioner. Some private health funds will cover some of the cost of counselling.

Online counselling for drug and alcohol problems can be accessed free of charge from *Counselling Online* 24 hours a day, 7 days a week, across Australia (see http://www.counsellingonline.org.au)

Community Health Centres also often have counsellors available who can be seen free of charge (see local White Pages or call ADIS for contact details).

The rate for counselling from private psychologists vary, but the Australian Psychosocial Society (APS) recommends fees from $100 for a 30-minute session, through to $360 for a session up to 2 hours (see http://www.psychology.org.au/).

Behavioural approaches

Behavioural approaches help clients alter their behaviours and lifestyles to reduce the risk of using drugs. Behavioural approaches can be used alone or in conjunction with CBT. Behavioural approaches include:

- Avoidance of situations, places or people that have been associated with methamphetamine use in the past.
- Adopting new, healthy lifestyle choices, for example, starting a regular exercise program or engaging in activities like dancing, surfing, diving, skiing, golfing; practicing meditation or yoga.

- Use of distraction techniques to deal with cravings to use (eg going for a walk or run, listening to music, taking a shower, calling a friend, gardening).
- Using contingency management (CM), which is based on the theory that behaviour can be shaped by reinforcement, and both positive reinforcement (reward) and negative reinforcement (punishment) will lead to repetition of desirable behaviours.

Contingency management

American studies have examined programs that provide clients with a voucher that can be swapped for goods (eg food), services (eg accommodation) or cash when they provide a urine drug screen that is free from illicit drugs, or engage in other negotiated and contracted desirable behaviours. The approach appears to be useful in the short term to help people stop using, and it is sometimes used in conjunction with CBT to help people maintain abstinence (see *Reference section* for more information on CM).

Even though this type of CM is undertaken rarely in Australia, workers can apply the principles by providing positive feedback about a client's progress and encouraging involved family members to do the same. Workers can help clients identify improvements in his or her overall quality of life. On the other hand, the risk of relapse is high if the client feels that no improvements have been made. In this case, workers can focus on detailed relapse prevention strategies and help clients identify achievable, short-term goals that can signal progress and strengthen retention in treatment.

Residential rehabilitation

Studies have shown that residential treatment is effective for some users.

Residential rehabilitation (RR) is based on the principle that a structured, longer-term, residential setting provides an appropriate environment in which to address the underlying causes of problematic drug use.

The people who are most appropriate for RR are those who have unstable or no accommodation; have poor or absent social supports; have had repeated failed attempts to cease methamphetamine use in the community; and are dependent on multiple drugs.

RR programs usually emphasise abstinence from all drugs as a treatment goal, and some programs exclude prescribed medications as well. RR programs may involve individual and group counselling sessions; and many are based on a 12-step approach (see next section).

Other RR models integrate various treatment approaches and permit the continued use of prescribed medications for mental health symptoms. This

may be important given that many long-term methamphetamine users also have concurrent mental health problems, and this approach may help address the high initial dropout rates. Workers should understand a RR facility's model for treatment and refer clients to the particular program that will best meet their needs.

Self-help or mutual support groups

Most self-help or mutual support groups are based on the 12-step approach of alcoholics anonymous (AA) or narcotics anonymous (NA), which promotes a disease concept that implies recovery from, rather than a cure for, substance dependence.

This approach is based on the '12 steps' to recovery and includes making a personal inventory of the user's life, making restitution to those injured, and assisting and supporting others through disclosure of personal stories at meetings and personal sponsorship of other users in recovery. It also emphasises a spiritual component or 'higher power'.

A specific group exists for users of methamphetamine known as *Crystal Meth Anonymous*, which is running in some areas of Australia such as Sydney (http://www.sydcma.com/index.htm). Methamphetamine users can attend NA meetings in other areas (see http://www.naoz.org.au/community/index.php for meeting details).

Research demonstrates that some people do well with the 12-step approach although dropout rates are high. Outcomes specifically for methamphetamine users have not yet been determined.

An alternative model, recently introduced to Australia, is SMART recovery (Self Management And Recovery Training), which integrates the self-help, mutual support model with elements of CBT.

The four key elements of SMART Recovery include motivational enhancement, coping with cravings to use, problem solving, and developing a balanced lifestyle. SMART recovery does not have a spiritual foundation and emphasises an evidence-based approach to self-help.

Currently, most groups are run in NSW, although new groups are launched regularly throughout Australia, so check the website for details (http://www.smartrecoveryaustralia.com.au/).

Medications (pharmacotherapies)

Three broad categories of medications are relevant to methamphetamine treatment. These are prescribed to:

- ease the symptoms of withdrawal
- help clients stay off methamphetamine (maintenance therapy or drug substitution therapy)
- treat other disorders such as mental or physical health problems.

Research into the effectiveness of a wide range of medications (referred to as pharmacotherapies) to treat methamphetamine withdrawal and to prevent relapse has not yet demonstrated the superiority of one drug over another because the medications may cause uncomfortable side effects, increased cravings, or lack of improvement in general.

Drug substitution therapy aims to replace an illegal, injectable or smokable drug with a legal drug that can be taken by mouth and to provide an opportunity to stabilise a person's lifestyle enough to allow him or her to receive structured counselling. Substitution with dexamphetamine (a central nervous system stimulant) has been available for some time in the United Kingdom and is similar in principle to prescribing methadone for heroin dependence. Substitution therapy is generally reserved for methamphetamine users who experience the most harm from use.

Medication trials of both dexamphetamine and modafinil, which promotes wakefulness and is used to treat the sleep disorder narcolepsy, are currently underway in Australia.

Evidence suggests that appropriate medications are effective and should be prescribed for diagnosed mental health conditions such as enduring depression, anxiety, and psychotic disorders.

Stimulant treatment programs

Several specific stimulant treatment programs are currently being evaluated in NSW. Treatment comprises assessment and counselling, education, support and specialised treatment for clients who also have mental health issues. Call the local ADIS for details of specific services in other areas.

Other supports

Although evidence is lacking on alternatives to those discussed above, users have expressed interest in complementary therapies and other supports

to improve their general physical and mental health. The following general principles apply to most users:

- A good diet is essential for recovery and long-term health.
- Regular exercise alleviates some symptoms of depression, regulates sleep, and boosts the immune system.
- Meditation reduces stress and improves concentration.
- Massage promotes relaxation.

Special considerations for young methamphetamine users

There is some evidence to suggest that drug use at an early age can increase a person's chances of developing dependence later in life, which is thought to be at least partly due to drug exposure before the brain has fully developed.

Methamphetamine use from a young age has been linked to structural and functional changes in the brains of long-term, regular users later in life.

Rates of amphetamine use among those involved with juvenile justice are higher than that of the general population.

Guidance for working with young stimulant users

Evidence regarding effective approaches for young stimulant users is sparse, although the following can be used as a guide:

- Assessment should include domains described in the *Assessment* section plus exploration of leisure and social functioning, family relationships, peer interactions, hobbies and educational history.
- As with adult users, the intensity of treatment should be matched to the severity of problematic methamphetamine use and associated problems, from the least to the most intensive interventions. For example, a recreational methamphetamine user could benefit from harm reduction advice and education about the short- and long-term effects to reduce risk of regular use or of moving on to injecting. A regular ice smoker with a history of psychosis would need more intensive interventions including monitoring for withdrawal and relapse of psychosis. Treatment matching is known as a 'stepped-care' approach.
- Treatment should be 'youth friendly' and include:
    - follow-up for missed appointments
    - ease of access
    - prompt screening and assessment

  - drop-in capability
  - strong links to other relevant agencies to ensure holistic treatment
  - an environment that is able to provide some basic assistance before the young person enters more formal or structured treatment.
- Family therapy is considered essential in the management of adolescent users.
- Mental health disorders should be assessed and treated appropriately, and a co-ordinated approach should be taken by all workers involved in the young person's care (see Chapter 11, *Making links and creating partnerships*).
- Hospital-based detoxification is rarely required for by young people because of a shorter exposure to the drug and because of a young person's capacity to recover rapidly.
- The Australian Government Department of Education Science and Training has produced a resource *Keeping in Touch: The Kit*. *Working with Alcohol and Other Drug Use. A resource for Primary and Secondary Schools*, which is useful for those whose work involves schools or school-aged children (see http://www.dest.gov.au/).

Special considerations for Indigenous methamphetamine users

The problems associated with the use of methamphetamine can be even more severe in Aboriginal communities where significant social and health problems already exist. Ideally, both Indigenous and non-Indigenous workers would be available so clients can choose the worker with whom they feel most comfortable. If an Indigenous worker is not available, non-Indigenous workers could seek advice, secondary consultation or other support from Indigenous workers from external agencies, in addition to undertaking training in cultural awareness.

In responding to the needs of Indigenous clients, workers should consider the following issues:

- Culturally appropriate assessment for drug use is required when working with Indigenous clients, and assessment can be enhanced by gaining information from a range of sources including the client, family and other service providers.
- Workers should liaise with other services to establish a strong network that can provide support and follow-up for Indigenous clients (see Chapter 11, *Making links and creating partnerships*).

- Indigenous clients should be informed of how to access additional information (*If you want to know more about (*subject*), this is how you can find it*).
- Careful information gathering is also required to determine the presence and content of delusions and hallucinations. When unusual beliefs or sounds (eg spirits) are described by Indigenous people, workers should not make an assumption that such thoughts are part of the person's cultural beliefs and therefore not a cause for concern. The content of the unusual thoughts should be carefully checked with the person's family or significant others to determine if the beliefs are shared by the person's family or tribe. If the beliefs are *not shared* then they could be psychotic in nature. A declining level of functioning in the person's day-to-day life is also a good indicator that the person is experiencing psychosis.
- Indigenous users may have a higher risk of diseases associated with injecting, including hepatitis B and C. Some evidence suggests that needle sharing is more common among Indigenous Australians than non-Indigenous Australians. This could be due to the culture of sharing among close friends and family, lack of access to clean equipment, or lack of awareness of how to obtain clean injecting equipment. Risks of sharing needles and how to access a supply of clean needle and syringes should be discussed with clients who do not intend to stop using methamphetamine. Workers should encourage the client to consider screening and vaccination.
- Some Indigenous clients may have a low level of literacy, and written materials should be appropriate to the reading age of the client. Other media that are culturally appropriate should be used to deliver harm reduction advice or other information (see http://www.adac.org.au for the comic, *Don't mess with meth*).
- The impact of the person's drug use on his or her family including parenting and child protection issues should be considered. Indigenous families require strong support to understand and navigate the range of agencies that might be involved in their care.
- Methamphetamine use may impose a financial burden, particularly on families that are already struggling.
- Methamphetamine use may alienate the person from family life and cultural activities, and this may affect the client's mental, emotional and spiritual health.

Special considerations for methamphetamine users from culturally and linguistically diverse backgrounds (CALD)

- Research into methamphetamine use in CALD communities is sparse, although drug use is less likely in people from CALD backgrounds than in the wider community.
- People from CALD backgrounds often experience difficulties in accessing culturally appropriate information and treatment services because most services have been developed primarily for non-CALD populations.
- The style of individualised counselling that is provided in mainstream alcohol and other drug treatment agencies may be unfamiliar, and the client and family may lack confidence in treatment outcomes. Workers should carefully explain the aims of treatment and encourage the client and family to recognise even small gains made over time.
- In many cases, cultural appropriateness requires workers to include a client's family in treatment planning, although this will vary from client to client.
- Outreach services and case management approaches are often used by specialist services to respond to the needs of clients from a CALD background.
- An interpreter may be required to ensure an accurate assessment and appropriate management strategy. The use of skilled interpreters with the appropriate dialect and of the client's preferred gender is crucial. Even when families are involved in the client's treatment, it is inappropriate to use family members as interpreters.
- Workers should establish what knowledge the client has about methamphetamine use to begin with and use that as a starting point to provide relevant information and enhance the client's engagement with the service.
- As with Indigenous clients, care should be taken when assessing the nature of possible psychotic symptoms to ensure that unusual beliefs or experiences are not related to the person's culture.
- Workers should explore support needs for any resettlement issues clients from CALD backgrounds might have (eg housing, financial, employment, language, social issues) and help the person access help needed to overcome these additional stressors, which could be a barrier to treatment progress.

General tips for agency responses to methamphetamine users

The following tips will help in responding to the needs of methamphetamine users:

- respond promptly and acknowledge the client's effort to ask for assistance
- be open and nonjudgmental
- provide written resources and advise of the availability of treatment options
- consider the appointment of a case manager and follow up missed appointments
- refer when needed
- provide adequate staff training and supervision.

Each of these is explained in more detail below.

Respond promptly and acknowledge the client's effort

- Develop a culture of prompt response, including telephone response. Be sure to schedule initial appointments, without delay, within 24 hours of the call, even if only an intake or assessment can be undertaken.
- Acknowledge the enormous effort the person has made to ask for assistance — methamphetamine users have often reached a crisis point, and feel low and extremely vulnerable at this time. Workers could say something like 'It must have taken a lot of courage and determination to come here and ask for help'. This recognition can help the person engage with the service and establish a helping relationship between the worker and the client.

Be open and nonjudgmental

- Adopt an open, nonjudgmental, nonconfrontational approach. Accept the client as an individual and do not allow any personal beliefs or feelings about methamphetamine use to cloud the helping relationship. Be willing to work with the client's goals for treatment even if they do not match those of the worker.

Provide written resources and advise of the availability of treatment options

- Ensure that a range of written resources are readily available for clients to take away.
- When amphetamine-specific treatment is available (eg CBT), place signs in prominent positions indicating that treatment is available in the service.

Appoint a case manager and follow up on missed appointments

- Appointment of a case manager can strengthen a client's engagement with the service and help maintain the person in treatment. Case managers also help people access a range of important services from other agencies.
- Follow-up for missed appointments (eg telephoning the client) also increases the likelihood that the client will continue to access the service.

Refer when needed

- Referral information should be readily at hand. However, a client in crisis often does not have the resources necessary to access other agencies, and workers should attempt to address as many of the person's needs as possible in the one setting. If this is not possible, workers should actively help the person access other agencies rather than simply providing 'passive' referrals (see Chapter 11, *Making links and creating partnerships* for referral tips).

Provide adequate staff training and supervision

- Workers should receive regular, relevant training from either more experienced workers within the service or specific training organisations. For example, *From go to whoa* is an amphetamine-specific training package that has been developed for frontline workers. Contact Turning Point Alcohol and Drug Centre in Melbourne for details (http://www.turningpoint.org.au).
- Workers should receive regular clinical supervision in addition to that routinely undertaken by line managers. Supervision provides an opportunity for reflective practice; enhancement of clinical skills; debriefing; maintaining professional boundaries; and attention to the management of stress and burnout. It is also useful for workers to clarify complex issues such as mandatory reporting and mental health interventions. A supervision resource kit can be downloaded from the National Centre for Education and Training on Addiction (NCETA) website (http://www.nceta.flinders.edu.au/csrk/).
- Consider involving peer organisations or individual peer support workers or educators in the service's overall response to methamphetamine users.
- The range of skills and knowledge required by workers to respond appropriately to methamphetamine users include:
  - sound communication
  - engagement and retention strategies
  - screening and assessment for methamphetamine use *and* mental health problems
  - brief interventions
  - risk reduction principles
  - motivational interviewing

  - relapse prevention
  - knowledge of treatment options
  - knowledge of appropriate agencies for referral and strong client advocacy skills
  - CBT or an alternative counselling style if structured clinical counselling is to be offered by the worker.
- Awareness and maintenance of professional boundaries that define the relationship between the worker and client. This can include careful consideration as to what, if any, personal information to share with clients, declining to provide personal phone numbers or addresses, and acting within the parameters of a helpful or therapeutic relationship that is in the best interests of the client.

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9
Assisting families, carers and significant others

Families are often a great source of support and encouragement for methamphetamine users and can be a strong foundation for positive change in their lives. However, family dynamics can also be complex and, in some families, drug use or even violence can be a part of the family system. Workers should explore the family dynamics thoroughly with the client and, if the family situation is unhelpful, it is in the best interests of the client to get support from elsewhere such as friends, peers, and treatment or welfare agencies.

Families should also understand that sometimes users are motivated to protect them from the consequences of their drug use by avoiding their family when they are using, withdrawing or receiving treatment.

In considering these issues, a worker might assist a client who has experienced family breakdown or help supportive families strengthen their relationship with a family member who is using methamphetamine. In some cases, the family or carer *is* the client and the drug user might not be seen by the worker at all. Families of methamphetamine users have needs in their own right, and some services now have a family therapist available.

Tips for helping families, carers and significant others

Regular users of methamphetamine can experience mood swings, anxiety, depression, irritability, anger and hostility. Such adverse effects can have a profoundly negative impact on relationships with family and others. It is often difficult for carers to understand why their family member continues to use methamphetamine in the face of often significant problems related to poor mental health, dependence, finances or the law.

Families, carers and significant others need education, support and practical assistance to help them understand the issues and to improve their own

wellbeing as they maintain a relationship or try to repair a relationship with their family member.

The following suggestions might be helpful:

- ✔ Listen to their concerns, help them clarify the major issues and assure them that a range of feelings such as distress, helplessness, embarrassment, fear and anger are shared by other families and are normal feelings in this situation.
- ✔ Explain the different ways in which people use drugs — experimental or recreational use of methamphetamine does not mean that the user is dependent (see Chapter 1, *About methamphetamine*).
- ✔ Briefly and plainly, describe how this drug works in the body and the range of possible effects. Include information about the 'crash' period and withdrawal symptoms and how regular methamphetamine use can adversely affect a person's mood, concentration and decision-making abilities (see Chapter 1, *About methamphetamine*).
- ✔ Explain the concept of 'readiness to change' to promote an understanding of relapse and how some individuals can be in two minds (ambivalent) about changing methamphetamine use; describe suitable approaches for each stage (see Chapter 8, *Overview of the range of treatment options*).
- ✔ Describe symptoms of psychosis and early warning signs, and recommend an effective approach if the user experiences symptoms. Emphasise that an expression of anger or irritability does not mean that a person is psychotic, but can simply be a sign to back off to allow space for everyone to calm down (see Chapter 5, *Recognising and responding to a person with mental health problems).*
- ✔ Help families develop a crisis plan should the user express thoughts of suicide, develop psychosis or become hostile. The crisis plan should include a safety plan; emergency contact numbers; when and how to enlist the help of specialist mental health services; and how to communicate with the user until help is gained (see Appendix 2 for an example).
- ✔ Explain the range of treatment options available and the role of harm reduction for users not considering change.
- ✔ Explain that there are many ways that a person's methamphetamine use can affect a family. Workers can help families recognise even subtle changes and should encourage the family to develop helpful strategies to deal with undesired changes.
- ✔ Determine what strategies have been successful and not so successful; encourage families to change their approach if it is not resulting in the outcomes they seek.

- ✔ Encourage the family members to be clear about what they will and will not tolerate, to maintain their limits and to communicate this calmly and clearly to the user.
- ✔ Remind family members to look after themselves and not to put their own lives on hold. Stress management, adequate diet, rest and exercise, and continuing to enjoy their usual activities will help family members cope and better enable them continue to care for their family member.
- ✔ Provide information about local support services and encourage families to meet or speak to other families in similar situations (see *Supports for families* later in this chapter). Feelings of isolation and stigma or fears of being judged as a poor parent are common and are often involved in a family's reluctance to seek help.
- ✔ If the methamphetamine user is the worker's primary client, provide as much information as possible to the family without breaching client confidentiality or obtain client consent to provide relevant information to the family.

Dependent children of adult methamphetamine users

Family relationships can become even more complex or troubled when young children are involved. Grandparents and other relatives can be caught between trying to repair relationships with their own adult child or sibling and feeling concern for the children's welfare. Grandparents and other relatives might have difficulty seeing the children if the relationship with their own adult child or sibling is strained. In some cases, grandparents, aunts or uncles find themselves being the primary care giver for the children of methamphetamine users.

In addition to the above, the following suggestions might be useful:

- ✔ Encourage family members to talk to each other about their concerns.
- ✔ If access to children is limited or denied, explore other avenues of maintaining a relationship with the children such as through letters, email or phone calls if possible.
- ✔ Grandparents and other relatives should be clear about what their concerns are in regard to the welfare of the children and, if safe to do so, calmly and clearly discuss this with the children's parents.
- ✔ If the concern for the child's welfare is significant, then the grandparent or other relatives can telephone the state child protection agency and either ask for general advice about the situation before making a decision about how to proceed, or formally report their concerns. Families must be reminded that removal of children from parents is the last resort for these departments — methamphetamine users still love their children and can continue to be good parents.
- ✔ Family members caring for children might be entitled to financial assistance, so contact *Centrelink* for advice.

Young carers

Children and young people are sometimes required to care for or support a family member who has a drug, alcohol or mental health problem. The role that the young person plays will vary from family to family, but can include cooking and cleaning, caring for younger siblings, paying bills, shopping, generally supporting the parent and even intervening during a crisis.

The impact of such a great responsibility can significantly affect the young person's school and social life. The young person might feel isolated, embarrassed, fearful, angry, anxious, and a range of other emotions.

Like older carers, young people need to continue to live their own lives and reduce their stress levels. For example, they could draw, write, listen to music, dance, sleep, read, surf the internet, spend time with friends, or do something physical like playing sport, surfing or riding.

Young carers should also be encouraged to develop a crisis plan should an emergency situation arise. This should include making sure there is at least one trusted person they can contact or stay with in an emergency (see Appendix 3, *Example of a young carer's emergency plan*).

They should also be encouraged to talk about their feelings with a trusted relative, teacher or school counsellor. Some schools now have *Young Carer* support workers and programs available.

Alternatively, they can call Kids Help Line, which is an Australia-wide, free, confidential counselling and support service available to children and young people aged 5 to 25 years. Email or web-based counselling is also available. Telephone toll free: 1800 55 1800. Website: http://www.kidshelp.com.au.

There are several other sites for young carers that have useful links, chat rooms, and practical information available for download: http://www.youngcarersnsw.asn.au; http://www.youngcarers.net.au; http://www.reachout.com.au; http://www.headroom.net.au.

Supports for families

Resources

A Guide to Coping. Support for families faced with problematic drug use. This publication contains personal stories and information about a range of drugs, and offers practical advice to assist families of drug users. The book can be purchased from Family Drug Support. http://www.fds.org.au/

Parent Drug Information Service Information and Support Pack for Parents and Families: For those faced with problem drug or alcohol use of a child or family

member, by the Drug and Alcohol Office Western Australia. This publication can be downloaded from the following site: http://www.dao.health.wa.gov.au/

What parents should know about ice. Victorian Government Health Information website. Brochure can be downloaded in pdf format from the following site: http://www.health.vic.gov.au/drugservices/pubs/ice.htm

Contact numbers and websites

Australia-wide

Family Drug Support is a national, nongovernment support and information service with a chapter in each state that provides family assistance 24 hours a day. http://www.fds.org.au/. Helpline: 1300 368 186.

There is an Alcohol and Drug Information Service (ADIS) in each state, which offers confidential telephone information 24 hours, 7 days a week, advice and counselling services for people with problems related to drugs and alcohol. Each ADIS keeps a complete database of treatment agencies in its state. See contact numbers for ADIS in each state below.

Carers Australia website has many useful links and tips for families http://www.carersaustralia.com.au.

Each state has Al-anon, Nar-anon and Families Anonymous groups. Call your ADIS for local information.

ACT

ADIS: (02) 6205 4545, toll free nonmetropolitan: 1800 422 599.

ParentLink provides confidential telephone information, advice, guidance and referral service: (02) 6205 8800 or http://www.parentlink.act.gov.au/.

NSW

ADIS: (02) 9361 8000, toll-free nonmetropolitan: 1800 422 599.

Family and Carers Support Group, Ted Noffs Foundation: 02 9310 0133 or http://www.noffs.org.au/ (Sydney, Wollongong, Canberra, Coffs Harbour and Dubbo). Programs for parents or carers concerned about their child's drug use.

Parent Line, available 9 am to 4.30 pm AEST Monday–Saturday: 13 20 55.

Northern Territory

ADIS Darwin: (08) 8922 8399, Alice Springs: (08) 8951 7580, toll-free nonmetropolitan: 1800 131 350.

Parentline, a confidential telephone counselling service providing professional counselling and support for parents and care givers, available 8 am to 10 pm, seven days a week: 1300 30 1300 (http://www.parentline.com.au).

Queensland

ADIS: (07) 3236 2414, toll-free nonmetropolitan: 1800 177 833.

Family Drug Support: (07) 3252 1735.

Parent, Child and Family Support Program: (07) 3620 8111.

Queensland Injectors Health Network (QuIHN) http://www.quihn.org.

Parentline, a confidential telephone counselling service providing professional counselling and support for parents and care-givers, available 8 am to 10 pm, seven days a week: 1300 30 1300 (http://www.parentline.com.au).

South Australia

ADIS: (08) 8363 8618, toll-free nonmetropolitan: 1300 13 13 40.

Family Drug Support: (08) 8384 4314.

Tasmania

ADIS Hobart: (03) 6222 7511, toll-free nonmetropolitan: 1800 811 994.

Parenting Line Tasmania: 1300 808 178.

Victoria

ADIS: (03) 9278 8100, toll-free nonmetropolitan: 1800 888 236.

Family Drug Help provides support and information to families and friends of drug users by assisting families and agencies to develop self-help and mutual support groups in their local community: (03) 9572 2855.

Western Australia

ADIS: (08) 9442 5000, toll-free nonmetropolitan: 1800 198 024.

The Parent Drug Information Service (PDIS) is a confidential telephone support service that provides support, counselling, information and referral service 24 hours a day to parents and families in Western Australia: (08) 9442 5050, country toll-free: 1800 653 203.

Grand Care is operated by Wanslea Family Services and is designed to support grandparents who care for their grandchildren. The program offers group and individual support, limited individual consultation and an information line staffed by volunteers during business hours: 1800 008 323. http://www.wanslea.asn.au/services/servicesGC.html.

References Chapter 9: Assisting families, carers and significant others

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10
Legal issues

There is a range of legal issues related to methamphetamine use, and key areas are briefly considered here.

Clients who are forced into treatment (coerced clients)

There are times when a person might feel pressured to enter treatment. This is known as *coercion*.

Coercion can be both *formal* and *informal*.

- *Formal coercion* involves treatment that is legally mandated or required to fulfil a court order. The client will be supervised by community corrections, drug courts, diversion programs or similar programs. Clients may also enter treatment to meet requirements of child custody or access rights.
- *Informal coercion* includes pressure to enter treatment from a spouse, parent, carer, other family member, or any significant person in the client's life, and is not bound by legal obligations.

Workers sometimes feel a sense of pessimism about treatment outcomes for coerced clients, particularly those mandated by the courts. However, evidence suggests that treatment is *just as effective for users who are pressured to enter treatment as for those who seek help voluntarily*. Workers must take into consideration that, although the person was coerced to enter treatment, he or she ultimately made the decision to attend.

Careful attention to building rapport, developing an alliance, and enhancing engagement and motivation are important aspects in treatment of the coerced client. Workers should employ a nonjudgmental approach and emphasise that the worker is there to help the client and will respond to his or her needs, and that workers have no role in pressuring or punishing the client in any way.

In responding to the needs of coerced clients, it is important to determine whether the coercion is formal or informal and to target assistance or treatment accordingly. For example, if the coercion is *informal*, client consent is required before any information about his or her progress can be shared with a spouse, family member, significant other or any other party. The extent to which others are involved in a client's care is entirely up to the client even if he or she feels pressured to attend sessions.

If coercion is *formal*, establish a firm working relationship at the outset. Workers should clearly state under what circumstances and to which agencies they are legally obliged to disclose information regarding the client's progress even without client consent (eg diversion programs, community corrections, family services). If workers are unaware of their legal obligations, they should make every effort to find out before the first session is undertaken.

It is also important to note that a longer time in treatment is associated with more positive outcomes for methamphetamine users mandated to treatment; therefore, engaging the coerced client is essential for improving long-term outcomes.

Mandatory reporting

Mandatory reporting relates to legislation specifying who is required by law to report suspected cases of child abuse and neglect.

Every Australian state and territory now has mandatory reporting legislation in place. The information to be reported and the categories of people required by law to report vary across states and territories, so workers have a duty to familiarise themselves with the legislation in their own state or territory. Workplaces should provide an opportunity for workers to understand their responsibilities under this legislation. If ever in doubt about their responsibilities, workers should seek assistance from a supervisor.

Generally speaking, workers are required to report to the relevant state body (eg department of family services, child protection office, department of child safety) if they suspect or confirm that a child or young person is suffering, has suffered or is likely to suffer abuse, neglect or harm. In some states, harm also includes exposure to domestic violence.

Many reports throughout Australia have involved parents who use drugs.

In some states reports can be made before a child is born or shortly after delivery.

For details of specific mandatory reporting legislation, see the Australian Government Institute of Family Studies website for an overview of Australia-wide legislation and for links to each state and territory at http://www.aifs.gov.au.

Crime

A recent survey of Sydney users revealed that many could afford to pay for methamphetamine with a legitimate income, although regular or dependent users were more likely to turn to criminal activity such as drug dealing or stealing to fund continuing methamphetamine use.

There is widespread public perception that all users of methamphetamine are violently out of control. Although methamphetamine users have higher rates of violent offending than the general population, violent crime tends to be limited to a relatively small group of methamphetamine users who are likely to be polydrug users (particularly alcohol and heroin), and who are already inclined toward criminal activity. A single dose of methamphetamine does not inevitably cause a person to become violent.

Violence, when it does occur, is often linked with fear and paranoia associated with regular or dependent methamphetamine use and is frequently triggered in response to a perceived threat, or when a person is paranoid or psychotic. Therefore, hostility and violence are often time limited and tend to occur only when symptoms are acute.

Readers are referred to *Responding to Challenging Situations Related to the Use of Psychostimulants: A Practical Guide for Frontline Workers* at http://www.nationaldrugstrategy.gov.au.

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11 Making links and creating partnerships

This chapter provides guidance on developing links and partnerships with a range of agencies and service providers including general practitioners (GPs), mental health services, antenatal teams, police and ambulance services. The different types of referral and tips on improving referral practices are also offered.

Why create partnerships?

Users of methamphetamine are faced with a range of general and mental health concerns, as well as other day-to-day needs. GPs, specialist mental health services (MHS), ambulance services, housing services, employment services, legal aid, and a range of other welfare or support agencies can provide the care and specialist assistance that alcohol and drug treatment services often cannot. The aim of collaboration is to help facilitate timely, appropriate and targeted responses to clients' needs, minimise access barriers for clients, and ultimately improve client outcomes.

Barriers to effective partnerships

Any of the following factors can act as a barrier to developing an effective partnership:

- fear of breaching client confidentiality
- reluctance of some services or agencies to accept or treat known methamphetamine users
- unfamiliarity with the role and function of other service providers or roles in client treatment
- use of different language or jargon

- breakdown of communication or referral pathways, which discourages ongoing collaboration
- workers' lack of awareness of referral pathways and specific roles *within* an organisation.

Tips for developing partnerships

Collaboration can be seen as a continuum, with simple advice or referral at one end to coordinated shared care at the other. Each service should decide the level of collaboration it is hoping to achieve and actively take steps to realise that outcome.

In many cases, collaboration occurs naturally as a consequence of a personal relationship between individual staff members from different services. However, cooperation may stop or change when staff members leave organisations, so formal links are much more likely to last.

Local agencies

The following is a suggested sequence for identifying appropriate local agencies and developing partnerships with them.

1. Identify local agencies

Workers should determine which local agencies could improve their service's response to users of methamphetamine — it is important to find out what potential partners actually offer to make sure the partnership is workable or useful, and that the worker's clients fit the target agency's access criteria before negotiations begin.

2. Meet with the target agency

Workers should approach the target agency with a request for collaboration or cooperation and determine ahead of time how their service could support the partner agency. Workers need to be prepared to outline how their service, the target agency and clients could benefit from a recognised or formal collaboration. Workers might need to challenge some myths that could arise about methamphetamine users (eg all users are violently out of control) and use persuasive client advocacy skills at this stage.

3. Decide on the nature of the collaboration

If the agency is receptive, workers from both services should collaboratively decide on an appropriate level of cooperation, agree on roles, function and outcomes. These might include fast-tracked assessment or access to the other service; reciprocal telephone or face-to-face support or advice; taking turns to provide a regular service to clients in each of the service settings; offers to provide in-service training; sharing of relevant information; co-case management.

4. Consider a joint memorandum of understanding

Consider developing a joint memorandum of understanding (MoU, see Appendix 4 for an example); formal referral pathways; policy and procedures for collaboration including confidentiality and information sharing issues; and timelines for review of effectiveness of collaboration according to the level of cooperation chosen.

The following points relate to developing links with specific services.

Mental health services

The structure of mental health services (MHS) varies across states and territories. Services are provided mainly in the community, and there is now a greater emphasis on collaboration with alcohol and other drug (AOD) services as the overlap between mental health problems and drug use has become increasingly more evident.

Acute MHS undertake assessments of people who are considered a risk to themselves or others. If the risk is high, these people tend to be stabilised in a hospital or acute care setting, whereas those considered less at risk are cared for in the community.

AOD treatment agencies will from time to time contact acute or crisis MHS if workers are concerned about the safety and mental health of a client who is experiencing psychosis or expressing thoughts of self-harm. Similarly, workers will collaborate with community MHS practitioners' if clients with mental health problems receive services from both agencies.

The following steps provide a starting point and an opportunity to develop more formal links.

1. Initiate contact with the MHS

Workers could start by contacting the local MHS with an offer to provide an in-service training session for both community and acute MHS staff members on the topic of methamphetamine use and related problems.

Workers should make contact with the local MHS team that is responsible for assessments (eg crisis team, acute care service, admissions office, etc) and ask for information about their intake procedures, criteria for admission, geographical intake boundaries (usually limited to clients residing in certain suburbs or districts), and office hours, etc so the worker's service can refer clients appropriately.

2. Describe the service offered

Workers could take the opportunity to inform both community and acute MHS staff members of what their service provides; the intake and assessment process; office hours etc, so an understanding of each other's service can be fostered.

3. Develop links with the MHS

If clients with a pre-existing mental health disorder have an MHS case manager, workers should develop cooperative links with the case manager so a collaborative treatment plan can be developed.

In all steps, workers are advised to use appropriate language when referring clients to MHS (see the section *Referring to mental health services* in Chapter 5).

General practitioners

Here are some strategies for establishing links with GPs.

- Start by looking at recent referrals to find which GPs are already accessing the service and who may be willing to become involved in collaboration or shared care.
- Identify whether there is a GP liaison or support person in the local area, because he or she will be working with GPs who are interested in AOD issues. The liaison person might be willing to approach potentially interested GPs on behalf of the service.
- Consider liaising with the local division of general practice to determine if a drug and alcohol or mental health interest group exists and offer to provide an information session on methamphetamine. This is an effective way to make personal contact with GPs to begin a dialogue about cooperation. The publication, *Management of Patients with Psychostimulant Use Problems: guidelines for general practitioners* could be a useful tool (see *Resources* section for download details).

Police and ambulance

The police and ambulance service may be called to provide assistance to workers, so it is helpful to establish a good working relationship with these professionals before a serious situation arises.

- Start by initiating a meeting with representatives from the local ambulance service (some services have paramedics who specialise in drug overdose). This will allow workers to learn about the service; share information; and increase collaboration should an emergency arise.
- If the ambulance workers are not already familiar with resources, introduce them to the publication *Management of Patients with Psychostimulant Toxicity: Guidelines for Ambulance Services*, and offer to provide extra information or support if required (see *Resources* section for download details).
- Contact the community liaison officer of the local police and initiate a meeting to discuss their service, desire for support and prompt response

when required. Offer to provide in-service training or information sessions on methamphetamine or other drugs as required. The publication *Psychostimulants — Management of Acute Behavioural Disturbances, Guidelines for Police Services*, could be helpful as a starting point. (see *Resources* section).

- Consider developing a visiting policy for police to indicate when and where it is acceptable to visit to ensure client confidentiality and continued access of the service. The details could be included in a MoU.

Antenatal teams

- Start by locating antenatal teams by telephoning local hospitals.
- Introduce the workers and the service offered and ask to meet with one or more members of the 'high-risk' team to create a personal link. Inform the antenatal team about what the service offers, and find out what service the antenatal team provides; this information is helpful for both workers and clients.
- Explore the possibility of a shared care role, or at least collaboration, to improve outcomes for pregnant clients.
- Offer to fast-track referrals from the antenatal team to the worker's service for drug counselling/support of pregnant users.
- Offer to provide training for the antenatal teams in methamphetamine or other drug use issues.

Maintaining and improving established links

Workers should establish regular liaison with the target agencies through telephone contact, general practice visits, and informal or formal meetings. This can also include a designated liaison worker if the interaction between agencies is regular.

Offer to provide in-service education to the other agency on topics related to methamphetamine and other drug use, or other topics as required.

Respond promptly to referrals and requests for information or assistance made by the collaborating agency or GP to ensure that communication remains two-way and that collaboration continues uninterrupted and strengthens over time.

Workers should evaluate and revise the partnership if necessary. Evaluation might include the following questions:

- How many clients have been referred to the worker's service by the partner agency? How many clients have actually been seen? Has this number increased or decreased?

- How many clients has the worker's service referred to the partner agency? How many clients have actually been seen? Has this number increased or decreased?
- Have clients of the worker's service experienced reduced waiting time to access the partner agency or otherwise benefited from improved services? Have clients of the partner agency experienced reduced waiting time to access the worker's service?
- Are staff members in both services satisfied with the partnership? Why or why not? Do they have recommendations for improvement?
- Are clients satisfied with the partnership? Why or why not? Do they have recommendations for improvement?

Types of referral

Three different referral practices are outlined below:

- Passive referral — the client is given the name and number of the other agency to make his or her own appointment. This is only suitable for clients who are motivated to ask for help, are not depressed or 'flat', and have the resources to make and keep the appointment.
- Facilitated referral — the worker telephones the other agency, provides basic information, and makes an appointment on behalf of the client. This is probably most suitable for the same group of clients who can receive passive referral.
- Active referral — the worker telephones the other agency in the presence of the client, uses appropriate language to provide detailed information so the client does not have to repeat it at the next appointment, and makes the appointment for the client. This is most suitable for clients who are depressed and or who lack the resources necessary to make an appointment or advocate on their own behalf. Agencies could also facilitate transport to the other service if the resources are available.

Strategies for effective referral

Use of the following strategies can enhance the effectiveness of referrals:

1. Workers address the client's pressing needs first before suggesting referral to another agency for assistance with less important matters.
2. Workers understand the needs of the client, including financial resources; access to transport; requirement for child care; cultural and social issues; level of ability to advocate for self; literacy level; and mental health concerns before making any referral.
3. Workers are aware of agencies that might be of assistance to clients, including location, hours of opening, cost, who is eligible for assistance, and waiting times for access.
4. Workers offer the client a choice of referral points if more than one agency is available to respond to his or her needs.
5. Workers ensure that the type of referral undertaken is the most appropriate for the client, and consent for level of referral is given. The different ways of referring were discussed in *Different referral practices* in Chapter 5.
6. Services involve Indigenous and culturally and linguistically diverse communities in the development of referral practices and pathways.
7. With client consent, workers actively follow up referrals made, to determine if the client kept the appointment and if the agency was able to provide the assistance required. Additional referrals or actions can then be initiated if required.
8. Strong links and partnerships, as described in this section, underpin effective referral processes.

Reference Chapter 11: Making links and creating partnerships

Furler J, Patterson S, Clark C, King T and Roeg S (2000). *Shared Care: Specialist Alcohol and Drug Services and GPs Working Together*. Turning Point Alcohol and Drug Centre Inc, Fitzroy.

Glossary

Abstinence: no longer using a specific drug

Agoraphobia: fear of open spaces

Aneurysm: ballooning of the wall of a blood vessel leading to weakening

Anhedonia: inability to experience pleasure

Auditory: related to hearing (see *Hallucinations*)

Base methamphetamine: 'base' is the street name for methamphetamine that has a damp, oily or paste like appearance

Binge: irregular, on-again, off-again pattern of moderate to heavy drug use

Brain haemorrhage: also known as cerebral haemorrhage, the rupturing of a blood vessel, usually an artery, in the brain (a cause of cerebral vascular accident (CVA), also known as stroke

Bruxism: teeth grinding

Cerebral haemorrhage: the rupturing of a blood vessel, usually an artery, in the brain (a cause of cerebral vascular accident (CVA) — also known as stroke

Coercion: formal (court ordered) or informal (family, spouse, peer, etc) pressure to enter treatment

Cognitive: pertaining to thoughts or thinking processes

Cognitive behaviour therapy: a talking therapy that seeks to modify dysfunctional or distorted thoughts and beliefs

Crystalline methamphetamine: methamphetamine that has a crystalline appearance, which is typically high in purity — street names include ice, crystal and shabu

Depression: a mood disorder or state that meets diagnostic criteria characterised by blunted affect (facial appearance), psychomotor retardation (slowed physical movements and thinking), dysphoria (flat mood) and anhedonia (inability to experience pleasure)

Delusions: fixed, false beliefs that are not amenable to logical challenge

Dependence: characterised by three or more of the following: a strong desire to take the drug, using more than intended, a desire to cut down or quit, using despite harms, increased tolerance, withdrawal

Detoxification: the planned cessation of drug use in someone who is drug dependent

Dexamphetamine: amphetamine that is available on prescription

Dilated: enlarged (eg pupils)

Dopamine: a brain chemical messenger (neurotransmitter) involved in the control of movement, thinking, motivation and perception of reward or pleasure (ie 'reward pathway')

Dysphoria, dysphoric mood: emotional state characterised by discontent, depression, anxiety and malaise

Endocarditis: a bacterial infection of the lining of the heart

Engagement: to attract a person into a service setting; to make a connection with a potential client that will facilitate him or her to actively participate in treatment or the service provided

Euphoria: a strong feeling of wellbeing or elation

Gingivitis: inflammation of the gums

Hallucinations: sensory impression having no basis in external stimulation, can be auditory (hearing), tactile (feeling), olfactory (smelling) or visual (seeing)

Harm minimisation/harm reduction: refers to a range of strategies that aim to reduce harms associated with continued drug use

Hypervigilance: exaggerated preoccupation with external events or people, usually associated with fear of harm

Ice: see *Crystalline methamphetamine*

Illusions: mental impression derived from misinterpretation of an actual sensory event (eg a shadow in a room is perceived as a person)

Insomnia: inability to fall or remain asleep

Intoxication: being affected by a drug

Intranasal: method of administering drugs by sniffing through the nose (snorting)

Lethargy: weariness, lack of energy or stupor

Libido: sex drive

Mandatory reporting: relates to the legislation, which specifies who is required by law to report suspected cases of child abuse and neglect

Methamphetamine, methylamphetamine: amphetamine with the addition of a methyl group on the molecular chain, which gives a potent effect

Motivational interviewing: a non-confrontational cognitive behavioural style of interviewing used to assist clients to recognise and address their health concerns leading to behaviour change

Myocardial infarction: medical term for a 'heart attack', which involves damage to the heart muscle generally through lack of blood supply

Neurotoxicity: injury to the nervous system, death of brain cells

Neurotransmitters: the chemicals that are involved in the transmission of signals from one brain cell (neuron) to the next across a short distance (synapse)

Noradrenaline: a neurotransmitter secreted by the adrenal glands promoting energy and alertness

Over-valued ideas: ordinary events have special significance or are more meaningful than usual

Palpitations: a heartbeat that is unusually rapid, strong or irregular enough to make a person aware of it

Paranoia: mental disorder characterised by delusions of persecution

Pharmacological: relating to the properties or actions of drugs (medications)

Polydrug use: use of multiple drugs

Potency: relating to the level of effect from a specific dose of the drug

Pressured speech: fast, loud and difficult-to-interrupt speech

Psychosis: a mental health disorder characterised by a separation from reality, may include symptoms such as delusions, hallucinations, disorientation and confusion

Psychostimulants: a group of central nervous system stimulants that act to increase the activity of the neurotransmitters dopamine, noradrenaline and serotonin

Recreational use: irregular drug use in a social setting

Regular use: recurring, routine pattern of drug use

Relapse: recurrence of an illness, or return to drug use after a period of abstinence

Residential rehabilitation: medium to long-term treatment option offered in a home-like setting

Respiratory: pertaining to breathing (respirations)

Retention: in this guide retention refers to the maintenance of client engagement with a service, or client participation until identified service or treatment goals are met

Reuptake: reabsorption

Rhabdomyolysis: disintegration of muscle tissue due to very high body temperatures

Route of administration: path into the body by which drugs are used or administered

Seizure: in this guide, a seizure refers to a sudden alteration in motor function, characterised by severe muscle jerking or spasm, and usually involves an alteration in level of consciousness (lay term 'fit')

Serotonin: neurotransmitter involved in complex behaviours such as mood, appetite, sleep, cognition, perception, motor activity, temperature regulation, pain control, sexual behaviour and hormone secretion

Shabu: see *Crystalline methamphetamine*

Sign: behaviour or event that can be seen by an observer

Stepped care: matching the intensity of treatment to the severity of problematic methamphetamine use and associated problems, from the least to the most intensive intervention

Stroke: lay term for cerebrovascular accident involving a blockage of a blood vessel in the brain, which leads to varying degrees of brain damage and possibly death

Subacute: a condition that is not a severe acute condition, and has not progressed to a chronic, long-term state

Substitution therapy: prescription of a drug, which is similar in effects to the illegal drug, which aims to reduce the harms associated with illegal drug use

Suicidal ideation: thoughts or preoccupation with suicide

Symptom: an experience or sensation that is described by the sufferer and often cannot be seen by an observer (contrast with *sign*)

Tactile hallucinations: a hallucination that involves the sensation of touch

Tolerance: a condition in which higher doses of a drug are required to produce the same effect as that experienced when the drug was first used

Toxic: poisonous

Toxicity: the capacity of a substance to produce toxic or poisonous effects

Tremors: shakes, usually of hands, or limbs, can be mild (fine) or severe (coarse)

Urine drug screen: analysis of a specimen of urine to detect the presence of drug metabolites

Withdrawal: the progress and time-course of detoxification

Resources

A wide range of resources about methamphetamine and other psychostimulants are available; the following titles are just a sample:

For workers

Written materials

Australian General Practice Network (2007). *Management of Patients with Psychostimulant Use Problems: Guidelines for General Practitioners.* Australian Government Department of Health and Ageing, Canberra.
http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/psychostimulant-gp

Baker A, Kay-Lambkin F, Lee NK, Claire A and Jenner L (2003). *A Brief Cognitive Behavioural Intervention for Regular Amphetamine Users: A Treatment Guide*. Australian Government Department of Health and Ageing.
http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-publicat-document-cognitive_intervention-cnt.htm (note this website is under review)

Baker A, Lee NK and Jenner L (eds) (2004). *Models of Intervention and Care for Psychostimulant Users — Monograph Series No 51.* Australian Government Department of Health and Ageing, Canberra.
http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-publicat-document-mono51-cnt.htm

Beneath the Ice. A CD ROM for workers, teachers, parents. Purchase details:
http://www.adf.org.au/store/article.asp?ContentID = Beneaththeice725

Lee NK, Johns L, Jenkinson R, Johnston J, Connolly K, Hall K and Cash R (2007). *Clinical Treatment Guidelines for Alcohol and Drug Clinicians. No 14: Methamphetamine Dependence and Treatment*, Turning Point Alcohol and Drug Centre Inc, Fitzroy.
http://www.turningpoint.org.au/library/lib_ctgs.html#14

Jenner L, Baker A, Whyte I and Carr V (2004). *Psychostimulants — Management of Acute Behavioural Disturbances: Guidelines for Police Services.* Australian Government Department of Health and Ageing, Canberra.
http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/psychostimulant-police

Jenner L, Spain D, Whyte I, Baker A, Carr VJ and Crilly J (2006). *Management of Patients with Psychostimulant Toxicity: Guidelines for Ambulance Services.* Australian Government Department of Health and Ageing, Canberra.
http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/publications-psychostimulant-ambulance

McIver C, Flynn J, Baigent M, Vial R, Newcombe D, White J and Ali R (2005). *Management of Methamphetamine Psychosis, Stage 2: Acute Care Interventions for the Treatment of Methamphetamine Psychosis and Assertive Community Care for the Post-discharge Treatment of Methamphetamine Psychosis*, Drug and Alcohol Services South Australia, South Australia.http://www.dassa.sa.gov.au/webdata/resources/files/Monograph_21.pdf

Websites and useful contacts

Australian Drug Information Network: a government-funded, Australia-wide information, referral, and resource site for workers, clients, families and other interested parties.
http://www.adin.com.au

Australian Government Department of Health and Aging: has a wide range of resources available for download by frontline workers.
http://www.health.gov.au

Department of Human Service, Tasmania Alcohol and Drug Service has on-line facts sheets available as well as information on services throughout Tasmania.
http://www.dhhs.tas.gov.au/services/view.php?id = 354

Drug and Alcohol Services South Australia (DASSA) has on-line resources available for frontline workers as well as details of services in SA and relevant training.
http://www.dassa.sa.gov.au/site/page.cfm

Drug and Alcohol Office (DAO) has on-line resources available for frontline workers as well as details of services in Western Australia and relevant training.
http://www.dao.health.wa.gov.au/

National Centre for Education and Training on Addiction (NCETA) has on-line resources available for frontline workers as well as details of relevant training.
http://www.nceta.flinders.edu.au/

National Drug & Alcohol Research Centre (NDARC) has on-line resources available for frontline workers as well as details of relevant training.
http://ndarc.med.unsw.edu.au/

National Drug Research Institute (NDRI) has a range of publications as well as details of training available in Western Australia.
http://www.ndri.curtin.edu.au/

Next Step Drug & Alcohol Services has on-line resources available for frontline workers as well as details of services in WA and relevant training.
http://www.dao.health.wa.gov.au/AboutDAO/DrugAlcoholServices/tabid/60/Default.aspx

Northern Territory Government Alcohol and Other Drugs Program has information available for workers.
http://www.nt.gov.au/health/healthdev/aodp/aodp.shtml.

NSW Government, NSW Health Druginfo has details of relevant services in NSW
http://www.druginfo.nsw.gov.au/treatment

Queensland Alcohol and Drug Research and Education Centre (QADREC) has on-line resources available for frontline workers as well as details of relevant training.
http://www.uq.edu.au/qadrec/

Turning Point Alcohol and Drug Centre has on-line resources available for frontline workers as well as details of relevant training.
http://www.turningpoint.org.au/

For users

Written materials

A user's guide to speed. National Drug and Alcohol Research Centre
Can be ordered from http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/page/Resources

Crystal meth: reducing and quitting. AIDS Council of NSW (ACON)
http://www.acon.org.au/assets/file_library/other/ACON_CRYSTAL.pdf

Crystal Meth — Effects. Health. Sex. Help. AIDS Council of NSW (ACON). An information booklet for the gay, lesbian, bisexual and transgender community.
http://www.acon.org.au/assets/file_library/brochures/Crystal%20Booklet%20Web%2020051213.pdf

Fast facts on ice. National Drug and Alcohol Research Centre
http://ndarc.med.unsw.edu.au/

Ice: crystal methamphetamine fact sheet. Alcohol and Drug Foundation.
http://www.druginfo.adf.org.au/article.asp?ContentID=ice_crystal_methamphetamine_hy

Ice fact sheet. National Drug and Alcohol Research Centre.
http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/resources/NDARCFact_Drugs7/$file/ICE+FACT+SHEET+2.pdf

On thin ice: a user's guide. National Drug and Alcohol Research Centre
http://ndarc.med.unsw.edu.au/

Websites and telephone contacts

Beyondblue: an organisation that helps people to address problems associated with depression.
1300 224 636
http://www.beyondblue.org.au

Counselling online: is a service where people can communicate with a professional counsellor about an alcohol or drug related concern, using text-interaction. This service is free for anyone seeking help with their own drug use or the drug use of a family member, relative or friend. Counselling Online is available 24 hours a day, 7 days a week, across Australia.
http://www.counsellingonline.org.au

Family Drug Support
1300 368 186
http://www.fds.org.au

Headspace: a government funded youth mental health information site.
http://www.headspace.org.au

Kids Help Line: a free, confidential and anonymous, telephone and online counselling service specifically for young people aged between 5 and 25.
1800 551 800
http://www.kidshelp.com.au

Lifeline: free, confidential telephone counselling service available 24 hours per day, anywhere in Australia
13 11 14

Narcotics Anonymous Australia: information on NA groups and help lines in each state.
http://www.naoz.org.au/community/index.php

Reach Out!: a web-based service that aims to improve young people's mental health and wellbeing by providing support information and referrals in a format that appeals to young people.
http://www.reachout.com.au

SANE Australia: promotes understanding of mental illness through a range of education products and services for those affected, their family and friends, health professionals and the general community.
SANE Helpline: 1800 187 263
http://www.sane.org

SMART Recovery Australia: information on the S.M.A.R.T. recovery approach and location of mutual support groups.
http://www.smartrecoveryaustralia.com.au/

Appendix 1
Severity of dependence scale

(Gossop et al 1995)

1. Have you ever thought your [speed] use is out of control?

Never (0)	Sometimes (1)	Often (2)	Always (3)

2. Has the thought of not being able to get any [speed] really stressed you at all?

Never (0)	Sometimes (1)	Often (2)	Always (3)

3. Have you worried about your [speed] use?

Never (0)	Sometimes (1)	Often (2)	Always (3)

4. Have you wished that you could stop?

Never (0)	Sometimes (1)	Often (2)	Always (3)

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

Not difficult (0)	Quite difficult (1)	Very difficult (2)	Impossible (3)

Total Score:_________

Note: A cutoff score of greater than 4 indicates severe amphetamine dependence (Topp & Mattick 1997)

Appendix 2
Example family emergency plan

Emergency contact names and telephone numbers

Suicidal thoughts	Psychotic symptoms
High risk if: depressed, discloses a plan that is lethal and has the means or access to the means to carry it out; has tried before; feels hopeless; can't guarantee own safety.	Sees things or hears things others can't; is suspicious or paranoid; has odd or unusual beliefs; behaves in strange or bizarre ways; speech might be disconnected or illogical; might also be anxious, panicky or disoriented.
✔ **DO** be calm, listen without judging, acknowledge feelings, express a desire to help, and determine level of risk. ✖ **DON'T** argue, nag, lecture, or tell them how to 'fix it'. Don't assume that he or she will just get over it or that help isn't required. **If risk is not high but thoughts are present**, encourage the family member to see a counsellor or GP, or telephone a dedicated suicide help-line for support if available. **If risk is high**, do not leave the person alone, do not agree to keep his or her plan a secret, contact the emergency mental health team or call an ambulance on 000.	✔ **DO** be calm, talk slowly, reassure and comfort, acknowledge fears, reduce noise and distractions in the room, call attention to familiar surroundings. ✖ **DON'T** argue, threaten, shout, lecture or laugh. Don't play along with unusual beliefs or ideas. Don't attempt restraint, don't block exits. **Settles?** Continue to reassure, watch carefully and call the mental health service for advice. If psychosis persists call the mental health crisis team or take the person to the local emergency department for assessment (call an ambulance if safety is at risk). **Becomes violent?** Call the police on 000 and enact safety plan.

Safety Plan

Person/service to call first if you feel threatened or in danger:

Place that you (and other family members) will go if you need to leave the house in a hurry (eg *neighbour, friend who lives close by, other relative*):

Location of extra keys to your house and car:

Other actions:

Appendix 3
Example young carer's emergency plan

Name of young carer:

Phone number(s):

Name of parent or family member:

Name and age of other siblings:

Address:

Emergency contact numbers [insert others here eg kids help line, relative]

000 Ambulance or police

What to say to ambulance officers in case of an emergency:

Other things to do in case of an emergency:

First person to contact if your relative goes to hospital or somewhere away from home:

Name and contact details of person you will stay with:

When staying with someone else, things you should take from home (eg clothes, school uniform, toothbrush, schoolbooks, pocket money)**:**

Other things you need when staying with someone else (eg details of sports practice, a letter to your teacher, transport to school)**:**

Things the person should know about you (eg medications? allergies? doctor's appointments? special food?)**:**

Person to look after your pet:

Person to check on the house while you're away:

When staying at home, the details of help you need to manage:

Person/people to give you this help:

Name and phone number of your local doctor:

Medicare number:

Name and contact number of school:

Support person at school:

Adapted from Young Carers Care Plan, http://www.youngcarers.net.au/

Appendix 4
Example Memorandum of Understanding

MEMORANDUM OF UNDERSTANDING

between

(Insert Agency 1 name here)

AND

(Insert Agency 2 name here)

Purpose or statement of intent

This Memorandum of Understanding (MoU) establishes an arrangement between *(first agency name and description of service)* and *(second agency name and description of service)*.

This arrangement establishes a collaborative relationship between the parties. Each agency recognises that the aims and purposes of the MoU are to *(insert purpose here)*.

Both parties have agreed to enter into this MoU on the terms and conditions contained herein.

Objectives of the MoU

List what the MoU is intended to achieve.

In the operation of the partnership, the parties agree to:

Specify the conditions of the MoU here.

1.

2.

3.

Term of MoU

Insert the duration of the MoU, date of expiry, when and how the MoU will be reviewed, and how it can be terminated before the expiration date if necessary.

Contact persons for MoU

Insert title and contact details for both parties.

Signatories

Signed on this *(insert date)* day of *(insert month)* 20XX.

signed_______________________________________

Name and position of authorised person, agency 1

signed_______________________________________

Name and position of authorised person, agency 2

A brief cognitive behavioural intervention for regular amphetamine users

A treatment guide

© University of Newcastle 2003

ISBN 1-74186-503-4

Online ISBN 1-74186-504-2

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Publication approval number 3013

This guide is based on an intervention developed by Baker, A., Kay-Lambkin, F., Lee, N.K. & Claire, M., and was adapted from the sources cited in the 'Sources and Acknowledgements' Section of this guide.

This project was funded by the Illicit Drugs Section, Drug Strategy Branch, Population Health Division, Australian Government Department of Health and Ageing.

This guide was prepared by Linda Jenner and Frances Kay-Lambkin on behalf of the study group.

Suggested Citation: Baker, A., Kay-Lambkin, F., Lee, N.K., Claire, M. & Jenner, L. (2003). A Brief Cognitive Behavioural Intervention for Regular Amphetamine Users. Australian Government Department of Health and Ageing.

The opinions expressed in this document are those of the authors and are not necessarily those of the Australian Government.

Publications Production Unit
Australian Government Department of Health and Ageing

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Background

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

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

This manual is divided into five sections:

Section 1. Context

- Key points from the *National Drug Strategy Monograph No 51. Models of Intervention and Care for Psychostimulant Users* are included to present the evidence supporting this type of intervention for regular amphetamine users.
- A flow-chart to place the intervention in a treatment context.

Section 2. Brief background to the study and summary of results of evaluation

- A brief description of how the study was developed, undertaken and evaluated.
- A brief description of the evaluation outcome data (detailed results will be published separately).

Section 3. The intervention

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

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

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

Section 5. Other available resources

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

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

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

Section 1. Context

Section 1. Context

Key Points in the Provision of Interventions for Psychostimulant Users[1]

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

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

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

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

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

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

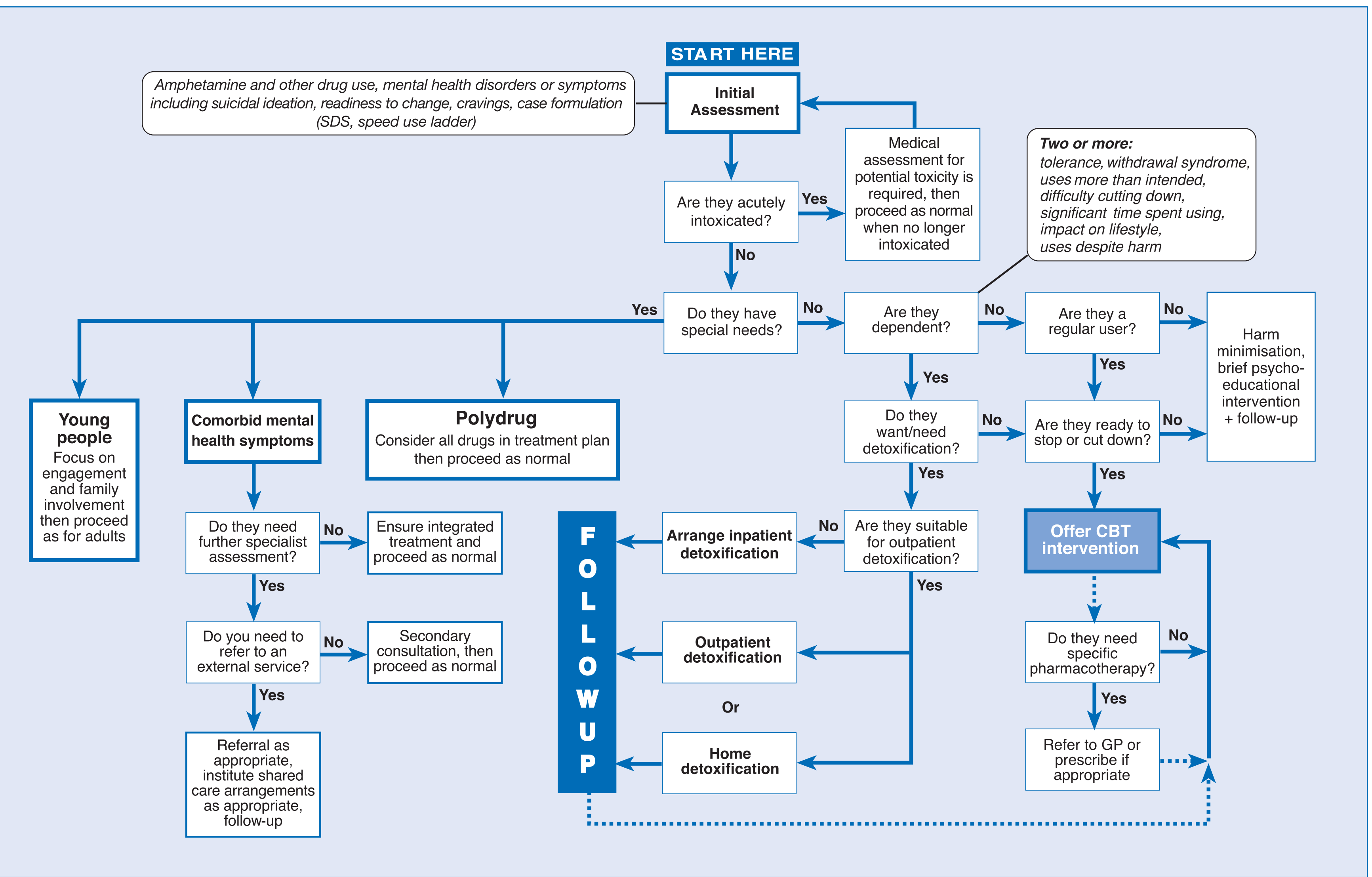
Amphetamine users report a reluctance to seek treatment and a level of dissatisfaction with services currently provided (Kamieniecki, Vincent, Allsop, Lintzeris, 1998). Adverse consequences of amphetamine use such as symptoms of dependence, aggression, depression, hallucinations and panic attacks have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

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

A flow-chart[2] that visually depicts the context in which the current CBT intervention could be offered is presented in Figure 1. For further detail please refer to the National Drug Strategy Monograph Models of Intervention and Care for Psychostimulant Users.

[2] Adapted from Chapter 12, Clinical Recommendations in Baker, Lee & Jenner (eds), Models of Intervention and Care for Psychostimulant Users, National Drug Strategy Monograph Series No 51.

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



Section 2. Brief background to the study and summary of results of evaluation

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Introduction

The present study replicates and extends a pilot study conducted by Baker, Bloggs and Lewin (2001) which showed that conducting and evaluating brief cognitive behaviour therapy (CBT) in a randomised controlled trial among regular amphetamine users was feasible.

Participants and procedure

A total of 282 people were screened for the study between October 2001 and September 2002. Of these, 214 regular (at least weekly) users of amphetamines were enrolled in the study from the Newcastle region of New South Wales (n=98) and from the Greater Brisbane region, Queensland (n=116).

Measures

Data were collected on demographic characteristics, past and present alcohol and other drug use and mental health, treatment history, amphetamine related harm and severity of amphetamine dependence (see Section 3 for recommended instruments). A random sample of urine screens was obtained at 6-month follow-up.

Design

Participants were randomly assigned to either an active intervention (two or four sessions of CBT in addition to a self-help booklet) or control condition (self-help booklet alone). The self-help booklet was developed by the National Drug and Alcohol Research Centre (NDARC, 2001). Assessments were scheduled at pre-intervention, post-intervention (five weeks following pre-intervention assessment) and six months following the post-intervention assessment. Assessments were conducted by interviewers who were blind to participants' intervention allocation.

Cognitive behaviour therapy conditions

This treatment guide, revised and expanded from that used in the pilot study (Baker et al., 2001), and a self-help booklet (NDARC, 2001) guided intervention sessions that focused on developing skills to reduce amphetamine use. Four sessions were conducted individually and lasted 45-60 minutes. In the two-session CBT condition, the procedure and content of the first two sessions was the same as that for the four-session intervention.

Control group

Subjects allocated to the control condition were assessed at pre-intervention, post-intervention and 6 month follow-up and were given the same self-help booklet as the intervention conditions at pre-intervention (NDARC, 2001).

Therapists

Therapists were University graduates (three psychologists and one social worker). A week-long training session was held at the commencement of the project. This covered research procedures and role-plays of assessment instrument administration and intervention sessions. Videotaped feedback was used to enhance training. Session checklists were employed to guide weekly supervision provided by the chief investigators (AB, NKL).

Summary of main results

Detailed results of the study will be reported separately.

At pre-intervention, the current sample comprised a group of regular amphetamine users with long histories of amphetamine use who had high levels of dependence on amphetamines, injecting risk-taking behaviour, polydrug use, depression, psychiatric illness and poor quality of life. Although only 35% of the initial sample were at an action stage for reducing amphetamine use, 71.5% (153/214) were retained at 6 month follow-up. Almost three-quarters (72.14%, 101/140) of participants assigned to intervention conditions attended all sessions. Thus, regular users of amphetamines, many of whom are ambivalent about change, can be recruited, treated and retained for follow-up evaluation.

The results of the present study indicated that overall there was a marked reduction in amphetamine use among this sample over time and this was not differentiated by intervention group. This reduction was likely to be related to commitment to being in the project and to the assessment process.

However, being in the intervention group was significantly associated with abstinence, which implies active therapy gave subjects an added incentive for abstinence. Approximately one-quarter (13/48, 27.1%) of the participants in the control condition were abstinent from amphetamines at the 6 month follow-up, compared to 49.4% (42/85) of those who participated in two or more intervention sessions. Adjusting for the effects of duration of regular amphetamine use, this represents a significant increase in the likelihood of abstinence among those receiving two or more intervention sessions [Adjusted Odds Ratio (AOR) = 3.00, $p < .01$, 99% Confidence Interval: 1.06 to 8.44]. Self-report data was confirmed by urinalyses among a random sample of participants.

In addition, being in the intervention group had a significant short-term beneficial effect on depression. There were no intervention effects on any other variables (HIV risk-taking, crime, social functioning and health).

Section 3. The intervention

Section 3. The intervention

Rationale and principles of intervention

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

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

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

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

Goals of intervention

The main goal of intervention is to reduce the level of drug use and harm, e.g., mental and physical health, financial, social, occupational, associated with regular amphetamine use. The client will be assisted to identify specific goals. If the client has a concurrent mental health problem, such as depression or a psychotic illness, then an important goal is to enhance the client's understanding of possible interactions between their use of amphetamines and other other prescribed or illicit drugs, current psychiatric symptomatology and potential for relapse.

Format of therapy

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

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

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

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

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

Initial assessment

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

1. A thorough alcohol and other drug use history that includes use of amphetamines and other drug classes, quantity, frequency, route of administration and associated risks, duration of current use, age of initiation, severity of dependence, experience of previous intervention, and history of withdrawal symptoms.
2. A thorough mental health assessment including past mental health history and assessment of current symptoms (presence and severity) with an emphasis on psychosis, depression and suicidal ideation (see Figure 3 for suggested questions for assessing suicidal ideation). The reader is referred to the recently published Review of diagnostic screening instruments for alcohol and other drug use and other psychiatric disorders (Dawe, Loxton, Hides et al., 2002) for a review of relevant screening and assessment instruments.
3. Client's readiness to change amphetamine and other drug use (see Figure 4, Client self-assessment tool on speed use below).

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

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

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

Figure 2. Severity of Dependence Scale

1. Have you ever thought your speed use is out of control?
   Never (0) Sometimes (1) Often (2) Always (3)
2. Has the thought of not being able to get any speed really stressed you at all?
   Never (0) Sometimes (1) Often (2) Always (3)
3. Have you worried about your speed use?
   Never (0) Sometimes (1) Often (2) Always (3)
4. Have you wished that you could stop?
   Never (0) Sometimes (1) Often (2) Always (3)
5. How difficult would you find it to stop or go without?
   Never (0) Sometimes (1) Often (2) Always (3)

Total Score: ____________________

Gossop, Darke, Griffiths et al. (1995).

Note: A cut-off score of greater than four corresponds to a diagnosis of severe amphetamine dependence (Topp & Mattick, 1997)

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

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

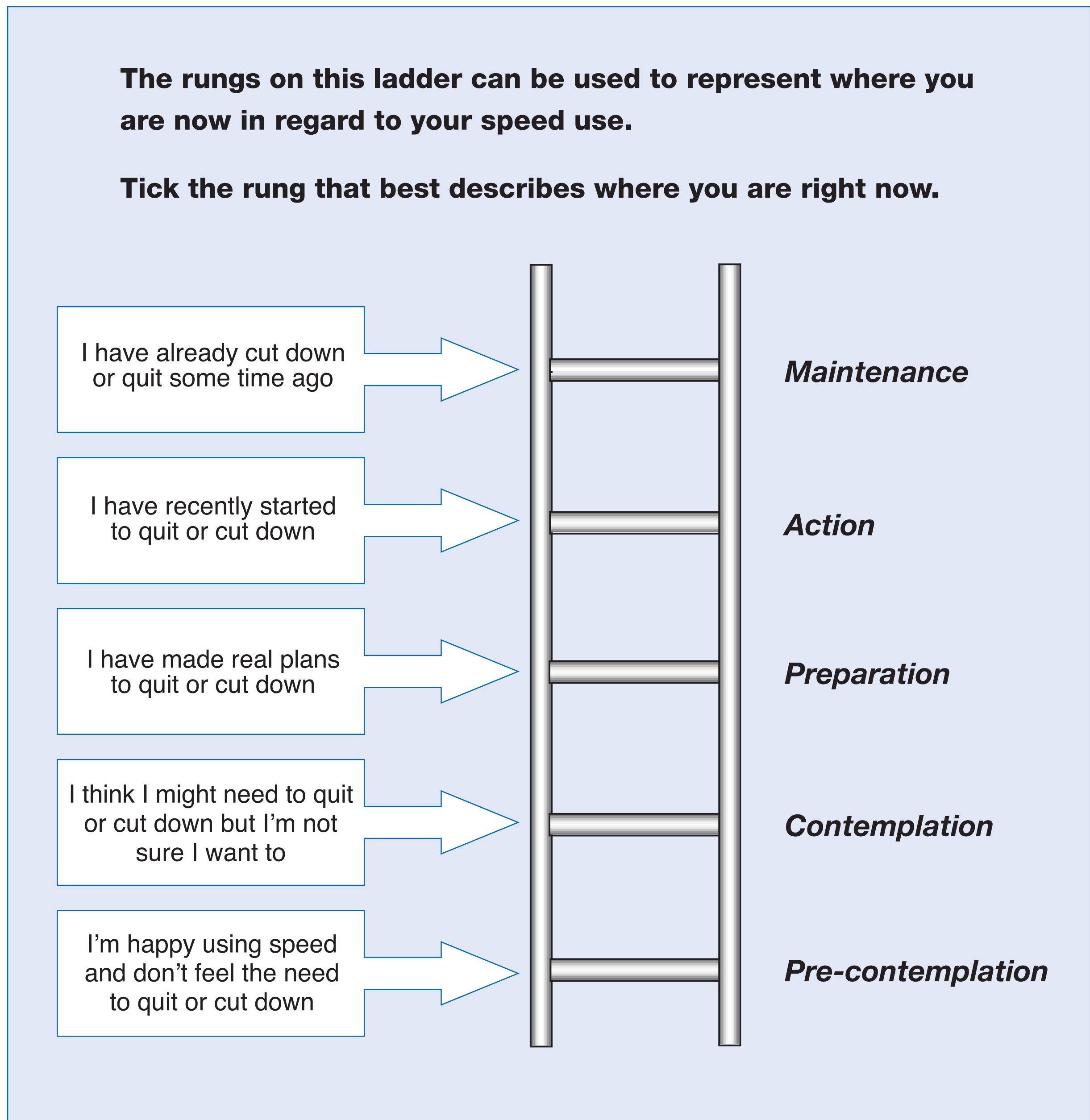
Figure 3. Questions for assessing suicidal ideation

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

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

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

Figure 4. Client self-assessment tool on speed use



Adapted from Biener and Abrams (1991).
See footnote 6 for an explanation of the readiness to change model.

Session 1: Motivational Interviewing

THERAPIST SUMMARY SHEET

Aims

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

Materials needed for Session 1

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

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

PHASE 1: Building motivation to change

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

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

PHASE 2: Strengthening commitment

Use the following strategies:

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

PHASE 3: Behavioural self-monitoring

Use the following strategies:

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

PHASE 4: Case formulation

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

PHASE 5: Session termination

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

DETAILED INTERVENTION

Engagement and building motivation for change in amphetamine use

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

PHASE 1: Building motivation to change

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

(i) maintain rapport;

(ii) accept small shifts in attitude as a worthy beginning;

(iii) promote some concern about risk (e.g. for health, legal problems);

(iv) avoid increasing resistance;

(v) promote self-efficacy and responsibility; and

(vi) view lifestyle holistically (each aspect usually affects the other).

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

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

Presenting the rationale for intervention

The following is an example of what you might say:

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

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

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

A typical day

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

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

(later)

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

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

> *"What happened then?"*

Review and summarise, and if required ask:

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

Personal feedback from assessment

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

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

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

"How do you feel about this?"

"Does it surprise you?"

Impact on lifestyle

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

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

If appropriate…

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

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

Explore the pros and cons of using speed

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

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

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

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

   "Tell me about your speed use. What do you like about it? What's positive about using for you?"

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

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

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

   "And what's the other side? What are your concerns about your speed use?"

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

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

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

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

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

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

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

If you pick up on this, use the following techniques in response (Miller, Zweben, DiClemente and Rychtarik, 1995, pg 24):

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

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

Explore concerns

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

"What other concerns do you have about speed?"

"I wonder how you feel about using speed … What can you imagine happening to you?"

"How much does that outcome concern you?"

Explore health risks

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

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

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

"How does your use of speed affect your mental health?"

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

If appropriate, ask the client for permission to provide them with some information about the health risks associated with using speed. You may like to photocopy the "Information about speed" handout on page 28 for the client to review.

Financial costs of using

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

"Do you have any idea just how much you think you would save if you didn't use speed?"

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

Looking back

"What were things like before you started using?"

Looking forward

"How would you like things to be different in future?"

"What's stopping you from doing what you like now?"

"How does using affect your life at the moment?"

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

Self vs self as a user

This step helps to develop discrepancy.

"What would your best friend/mum say were your best qualities?"

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

"And how would you describe you as a speed user?"

"How do these two things fit together?"

Information about speed

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

Information taken from these publications:

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

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

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

A primer of drug action. By Robert Julien

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

Summarise Briefly summarise all of the information gained from Phase 1.

PHASE 2: Strengthening commitment

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

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

"I wonder where this leaves you now?"

"Where do we go from here?"

"What does this mean about your speed use?"

"How would your life be different if…"

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

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

Address fears

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

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

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

Provide information and advice

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

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

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

"Does that surprise/make sense to you?"

Setting goals

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

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

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

Commend abstinence and offer the following points in all cases:

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

If the assessment information indicates the need to advise a goal of abstinence and they are not considering this (ie. previous episode of amphetamine-induced psychosis, current mental health disorder etc):

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

PHASE 3: Behavioural self-monitoring

Introduce rationale for behavioural self-monitoring

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

Elicit concerns about high-risk situations and triggers for using

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

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

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

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

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

Use urge diary

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

Exercise 2: The urge diary

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

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

"Do I have it right?"

"What have I missed?"

Record any additional information that is offered.

PHASE 4: Case formulation

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

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

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

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

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

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

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

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

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

Explain rationale for formulation

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

Agree on the elements of the formulation

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

Make a joint treatment plan

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

Exercise 3: The case formulation

- Presenting problem/s:

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

- Main problem of concern:

- How did these problems develop (predisposing factors)?

- What are the identified triggers (precipitating factors)?

- What factors maintain drug use?

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

- Treatment plan:

PHASE 5: Session termination

Summarise

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

Shoring up commitment

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

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

Establishing a contract

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

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

Setting homework

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

Session 1 homework:

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

Session 2: Coping with cravings and lapses

THERAPIST SUMMARY SHEET

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

Materials needed for Session 2
- Blank paper and a pen
- Photocopied craving plan or alternative
- Photocopied urge diary or alternative for next week

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

PHASE 1: Session introduction
- ☐ review week
- ☐ review homework tasks
- ☐ set agenda for the session

PHASE 2: Introduction to coping with cravings
- ☐ complete exercise 1: describing a craving or urge

PHASE 3: Information about cravings

Provide information about cravings and urges to use:
- ☐ provide information from 'Some facts about craving' section

PHASE 4: Strategies to cope with cravings

Discuss the following strategies to cope with cravings:
- ☐ behavioural (3Ds)
- ☐ cognitive (self-talk)
- ☐ relaxation and imagery

PHASE 5: Developing a craving plan
- ☐ complete exercise 2: devising a craving plan

PHASE 6: Dealing with a lapse

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

PHASE 7: Session termination
- ☐ set homework, including:
  - ☐ implement craving plan
  - ☐ continue cutting down
  - ☐ complete urge diary for the week
  - ☐ utilise craving plan strategies as required

DETAILED INTERVENTION

PHASE 1: Session introduction

Review of the week, homework exercise, set agenda

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

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

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

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

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

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

PHASE 2: Introduction to coping with cravings

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

Exercise 1: Describing a craving/urge[8]

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

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

BEHAVIOURS + PHYSICAL + THOUGHTS = CRAVING

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

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

PHASE 3: Information about cravings

Provide the following information about cravings and urges to use

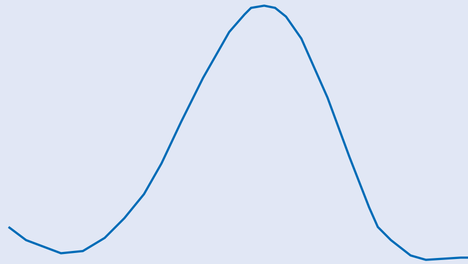
Speed cravings and urges are the sense of wishing to have a hit of speed, or experiencing an impulse to seek out and use it. Urges and cravings tend to increase during withdrawal or in the absence of using. Therefore if your client is trying to abstain from speed, he/she will experience more intense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

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

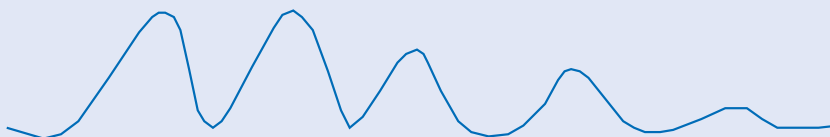
[8] Adapted from Monti, Abram, Kadden & Cooney, 1989

Some facts about cravings (Marlatt & Gordon, 1985)

1. Cravings/urges to use are a natural part of modifying speed use. This means that **you** are no more likely to have any more difficulty in altering your speed use than anybody else does. Understanding cravings helps people to overcome them.
2. Cravings are the result of long-term speed use and can continue long after quitting. So, people with a 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. Explain a craving in terms of a wave at the beach. Every wave/craving starts off small, and builds up to its highest point, and then it will break and flow away. Each individual craving rarely lasts beyond a few minutes.



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



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

PHASE 4: Strategies to cope with cravings

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

(a) Behavioural

Discuss the "3Ds" of coping with cravings:

1. **D**elay – encourage the client to avoid situational triggers, particularly during the early phase of modifying their use; however this will not stop cravings from coming altogether. When a craving does hit, delay the decision to use for a minute at a time or longer if the client can manage. During this time, ask the client to say to themselves: "I will not act on this craving right away. I'll DELAY my decision to act on this craving for…minutes". This will help the client to break the habit of immediately reaching for speed when a craving hits. Refer back to assessment (precipitation factors/triggers) to discuss real-life examples with your client.
2. **D**istract – once the decision to use is delayed, the client needs to distract themselves from thoughts about using. Generate some ideas for strategies to use as a distraction technique such as going for a brisk walk, calling a support person, listening to music etc. Write these down for the client and ask him/her to keep this list handy and accessible for ease of reference when the craving begins. Explain to the client that once they are interested in, or actively doing, something else, they will find the urges will reduce in intensity until they have gone altogether.
3. **D**ecide – after the craving has passed, revisit all the reasons why the client wanted to stop using speed in the first place. Decide then and there not to use again and ask the client to congratulate himself or herself on not giving in to something that is, after all, only a THOUGHT or a FEELING.

(b) Cognitive

Positive talk – by asking the client to remind themselves about the short-term nature of cravings (e.g. *"this feeling will pass"*, *"I can cope with this"*, *"I don't have to act on this because it will go away on its own"*), the urges themselves will be easier to deal with. It is important to "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 practise in the session.

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

Mastery (imagine not using in the given situation).

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

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

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

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

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

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

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

PHASE 5: Developing a craving plan

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

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

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

Exercise 2: My craving plan

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

PHASE 6: Dealing with a lapse

Coping with a lapse: the abstinence/rule violation effect

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

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

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

> *"The **'breaking the rule effect'** could happen if you have a slip and 'break your rules'. By this I mean your goal or rule about staying off speed completely (or cutting down to a lesser level if reduction is your client's goal). The **'breaking the rule effect'** happens when you have a slip and break your rules, and then think something like "oh stuff it, I've had a hit – broken my rule, I might as well keep going…".*
>
> *But, there are other ways of looking at the situation. Slips will happen – everybody makes mistakes, and it doesn't mean that you have failed completely. You can stop at one hit, and go again from there – you can start with a clean slate. A slip doesn't mean you are getting worse, or headed for a relapse, rather that you are experiencing what everybody does – a simple slip. But, if you have a slip, it is more likely to turn into a relapse if you give into the **'breaking the rule effect'**."*

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

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

Unhelpful thought:

“I’ve blown it”.

Helpful thought:

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

Unhelpful thought:

“I knew I wouldn’t be able to stop”.

Helpful thought:

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

Unhelpful thought:

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

Helpful thought:

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

Discuss these alternative thoughts with your client during the session.

PHASE 7: Session termination

Homework

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

Session 3: Controlling thoughts about using speed

THERAPIST SUMMARY SHEET

Aims

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

Materials needed for Session 3

- Photocopy of the "Self-monitoring record" (this now replaces the urge diary from Sessions 1 and 2).
- Photocopy of the "Activities list".
- Photocopy of "The activity record".
- Photocopy of "Seemingly irrelevant decisions" sheet.
- Blank pieces of paper and a pen.

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

PHASE 1: Session introduction

- ☐ review week
- ☐ review homework tasks
- ☐ set agenda

PHASE 2: Link between thoughts and behaviour

Use the following strategies:

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

PHASE 3: Triggers

Use the following strategies:

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

PHASE 4: Seemingly irrelevant decisions

Use the following strategies:

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

PHASE 5: Pleasant event and activity scheduling

Use the following strategies:

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

PHASE 6: Homework

- ☐ Set homework, including:
  - ☐ complete self-monitoring record
  - ☐ practise identifying seemingly irrelevant decisions as they occur
  - ☐ implement activity record
  - ☐ continue cutting down

DETAILED INTERVENTION

PHASE 1: Session introduction

Review of the week, homework exercise and set agenda

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

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

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

Review their urge diary. Address any important aspects.

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

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

PHASE 2: The link between thoughts and behaviours[9]

Rationale for the exercise

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

Use the following rationale with your client:

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

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

Link between thoughts, feelings and behaviour

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

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

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

Exercise 1: Demonstrating the link between thoughts and behaviour

- Take one of the situations from the homework task in which the client experienced strong urges/cravings to use speed or did use speed.
- Help the client to identify the A's, B's and C's surrounding that event/situation. Include any unhelpful self-talk/thoughts the client experienced, such as *"I can't cope without speed"*.
- Explain to the client that an important part in managing those situations that trigger cravings to use speed is to become aware of their unhelpful thinking patterns associated with these situations. The client can then better recognise the patterns associated with a relapse, and develop alternative thoughts or interpretations for those situations.
- Explain to your client that the thoughts that usually lead to cravings and urges to use characteristically fall into one of five *unhelpful patterns of thinking*:

    1. **Black and white thinking**: this pattern of thinking is characterised by the interpretation that things are either all good or all bad – with nothing in between, no balance, no shades of grey. For example, because something has gone wrong once, black and white thinking dictates it will always go wrong. Does your client have strict rules about themselves and their lives? Are they rigid in their need to stick perfectly to their goals? If so, black and white thinking might be an unhelpful thought pattern that your client is using. Examples of black and white thinking include: *"If I fail partly, it is as bad as being a complete failure"*, or *"I never get what I want so it's foolish to want anything"*. In particular, *"even if I use once this week, I'm a failure, so why bother"* or *"I can't change, so it's pointless trying at all"*.
    2. **Jumping to negative conclusions**: does your client automatically draw a negative conclusion about an issue more times than not? People who 'jump to negative conclusions' sometimes act like 'mind readers'. They think they can tell what another person is **really** thinking, often without checking it out or testing the conclusion. Other times, people who 'jump to negative conclusions' may engage in 'fortune telling'. They believe that things will turn out badly, and are certain that this will always be the case. For example, they might think: *"Things just won't work out the way I want them to"*, or *"I never get what I want so it's stupid to want anything"*, or *"There's no use in really trying to get something I want because I probably won't get it"*. In relation to their speed use, people with this pattern of thinking may believe *"I'll never be able to change my drug using, it'll never be any different"*.

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

3. **Catastrophising**: people with this pattern of unhelpful thinking tend to give too much meaning to situations. They convince themselves that if something goes wrong, the result will be totally unbearable and intolerable. For example, *"If I get a craving, it will be unbearable and I will be unable to resist it"*. If 'catastrophisers' have a disagreement with someone, they may think that *"the person hates me, doesn't trust me, and things will never change"*. Or, *"if I don't have a hit, I'll never be able to cope with this."*

4. **Personalising**: 'personalisers' will blame themselves for anything unpleasant that happens. They take a lot of responsibility for other people's feelings and behaviour, and often confuse facts with feelings. For example, *"My brother has come home in a bad mood, it must be something that I have done"* or *"I feel stupid, so I am stupid"*. People with this pattern of thinking often put themselves down, and think too little of themselves, particularly in response to making a mistake. They may think things like *"I'm weak and stupid, there's no way I'll be able to resist my craving"*. In response to a slip, personalisers will often say to themselves: *"see, I knew I'd never be strong enough to resist, I'm such a terrible person."*

5. **Shoulds/oughts**: people with this pattern of thinking use 'should', 'ought' and 'must' when they think about situations. This often results in feelings of guilt. Shoulds and oughts quite often set a person up to be disappointed, particularly if these thoughts are unreasonable. For example, *"I must not get angry"*, *"He should always be on time"*, and especially, *"I should be strong enough to never even experience a craving – I should just be able to stop."* 'Should' statements can cause a person to experience anger and frustration when that person directs these statements at others.

- In helping your client to better cope in these craving situations, it is important for them to identify the unhelpful thought patterns they are likely to engage in, and then learn ways to deal with these thoughts directly, without using speed.

- Help the client to identify from their urge diary, which unhelpful thinking patterns they are likely to use.

PHASE 3: Triggers

Challenges to unhelpful thinking patterns

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

Exercise 2: Recognising unhelpful patterns of thinking

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

Exercise 3: Monitoring thoughts about triggers

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

Self-monitoring record

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

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

PHASE 4: Seemingly irrelevant decisions[10]

Rationale behind seemingly irrelevant decisions

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

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

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

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

Exercise 4: Seemingly irrelevant decisions

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

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

Exercise 4: Seemingly irrelevant decisions (continued)

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

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

Practise Exercise

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

What situations led up to the lapse?____

____

____

____

What decisions led up to the lapse?____

____

____

____

What stopped me from recognising these signs?______________________________

____

____

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

____

____

____

____

Plan to manage high-risk situations: ____________________________________

____

____

____

PHASE 5: Pleasant event and activity scheduling

Rationale behind activity scheduling

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

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

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

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

Active scheduling of pleasurable and achievement activities

Exercise 5: Identifying pleasurable and achievement activities

- Refer to the "Activities list" sheet on page 58.
- Ask the client to list activities they like and enjoy doing that do not involve using speed. For example, going for a walk, taking time for themselves, visiting friends, going to the beach, shopping, reading, having a cup of coffee etc. Make sure these activities are broken down into concrete components. For example, 'time to myself' needs to be broken down into the actual activities that constitute time to oneself. These could include listening to the radio, practising relaxation etc.
- List these activities in the "Pleasurable activities" column.
- Next, ask the client to list the things he/she needs to do. This could include attending intervention sessions, taking medication.

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

- List these tasks in the "Achievement activities" column.

The activity record

Exercise 6: The activity record

- Refer to the sheet titled "The activity record" on page 59.
- Using the list of pleasurable and achievement activities developed during the last exercise, complete with the client a schedule for the following day. Be sure to include both pleasurable and mastery activities for that day.
- In the "Evening" section of the record, schedule in time to complete the activity record for the following day, along with any other daily homework you have set for the client to complete over the following week. Mark these activities as "Achievement activities".
- Ask the client to sit down at the end of each day during the following week and complete the activity record for the next day. Whilst in the session, schedule in your next appointment with the client, and enter this into the activity record. If the client is aware of any appointments they must keep throughout the following week, add those to the activity record during the session.
- Make sure the client understands the importance of including a balance of both pleasurable and achievement activities into each day. For example, each achievement activity should be followed by a pleasurable activity to help enhance and maintain motivation.

PHASE 6: Homework

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

Activities list

Pleasurable activities (Things I like to do)	**Achievement activities** (Things I have to do)

The activity record

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

Session 4: Relapse prevention

THERAPIST SUMMARY SHEET

Aims

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

Materials needed for Session 4

- Photocopy the "Refusal skills" reminder sheet and give to client.
- Photocopy "Preparing for high-risk situations" sheet and give to client.

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

PHASE 1: Session introduction

- [ ] review week
- [ ] review homework tasks
- [ ] set agenda

PHASE 2: Speed refusal skills

Use the following strategies:

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

PHASE 3: Relapse prevention

Use the following strategies:

- [ ] Identify high-risk situations by –
  - [ ] discussing a rationale for relapse prevention
  - [ ] identifying high-risk situations from self-monitoring
  - [ ] completing exercise 2: identify/ anticipate high-risk situations
- [ ] Prepare for high-risk situations by –
  - [ ] identifying people and means of maintaining skills
  - [ ] completing exercise 3: preparing for high-risk situations
- [ ] Regulate consequences by –
  - [ ] discussing behavioural self-rewards for abstinence or maintaining goals
  - [ ] completing exercise 4: regulate consequences
- [ ] Devise a relapse prevention plan by –
  - [ ] discussing a written relapse prevention plan
  - [ ] discussing when and where to use the plan
  - [ ] discussing need to monitor early warning signs
  - [ ] discussing refining and updating the plan as necessary

PHASE 4: Session termination

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

DETAILED INTERVENTION

PHASE 1: Session introduction

Review the week, homework tasks and set agenda

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

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

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

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

PHASE 2: Speed refusal skills

Rationale for learning speed refusal skills

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

Non-verbal measures for refusing speed (Monti et al., 1989)

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

Verbal measures for refusing speed (Monti et al., 1989)

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

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

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

Photocopy the "Refusal skills reminder sheet"[11] on page 63 and give to the client. Go through the refusal skills at the top of the page to help summarise the previous exercise.

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

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

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

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

[11] NIDA, 1998

Refusal skills reminder sheet

Tips for responding to offers of speed:

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

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

PHASE 3: Relapse prevention

Rationale for relapse prevention

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

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

Identification of high-risk situations from self-monitoring

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

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

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

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

Preparation for high-risk situations

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

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

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

- Look at the list made in the previous activity that will detail the client's anticipated high-risk situations.
- Ask the client to think back about all the different skills they have learned during the therapy sessions, and nominate which ones are appropriate to use in each of the high-risk situations. Examples may include: speed refusal, coping with cravings, challenging unhelpful thoughts, relaxation etc.
- Write these coping behaviours down on the space provided on the "Relapse prevention plan" handout on page 67.
- Explain to the client that not all situations can be anticipated in advance. Therefore it is useful to think about some generic coping strategies that the client can employ regardless of the situation. Write these down in the space provided on the handout ("General coping strategies for any situation").
- Also ask the client whether there are any additional skills they think they may need to assist them in future situations. Record these on the form ("Additional skills required") and discuss options for referral with the client to ensure he/she receives the necessary treatment.

Regulate the consequences of thoughts and behaviours

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

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

Exercise 4: Regulate consequences (Wilson, 1992).

- Refer back to the "Relapse prevention plan" handout on page 67.
- Ask the client the following questions: "How will you know that you are successfully maintaining your behaviours? How can you reward yourself for a job well done?"
- Write these 'rewards' down on the "Relapse prevention plan" handout.

Identify support people and additional means of maintaining skills

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

"Who can help you to maintain these skills you have learned?"

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

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

Using the relapse prevention plan

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

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

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

PHASE 4: Session termination

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

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

Relapse prevention plan

Anticipated high-risk situations	Coping strategies	Reward

General coping strategies for any situation:

Additional skills required:

My early warning signs of relapse are:

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

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

Support people I can call on are:

Support person / agency	Contact number
1. ______________________	______________
2. ______________________	______________
3. ______________________	______________
4. ______________________	______________

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

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

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

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

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

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

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

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

The essential elements of a brief intervention are included in the FRAMES model first developed by Miller and Sanchez (Hulse, G. 2003).

Feedback: involves feedback to clients of findings from your assessment

Responsibility: patient is responsible for acting on the feedback given

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

Menu: offer the patient a menu of options for change

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

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

Regular users and dependent users who are not considering change

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

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

Section 5. Other available resources and useful websites

Section 5. Other available resources and useful websites

1. A user's guide to speed. National Drug and Alcohol Research Centre (NDARC) ndarc.med.unsw.edu.au/ndarcweb.nsf/page/respurces#speed (to order a copy).
2. Alcohol and Other Drugs: A Handbook for Health Professionals. Australian Government Department of Health and Ageing, 2003.
3. Australian Drug Foundation: www.adf.org.au
4. Australian Drug Information Network (ADIN) www.adin.com.au
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8. Centre for General Practice Integration Studies, University of NSW http://notes.med.unsw.edu.au/CPHCEweb.nsf/page/CGPIS
9. Clinical skills training series: effective approaches to alcohol and other drug problems, modules 1-5. University of Newcastle: Training, Health and Educational Media, 1998. (National Teaching Grant held by Amanda Baker and National Centre for Education and Training on Addiction).

   Module 1: Motivational interviewing: how to encourage motivation for change.

   Module 2: Relapse prevention.

   Module 3: Raising the issue and assessment: triggers to learning.

   Module 4: Brief intervention: triggers to learning.

   Module 5: Brief intervention strategies among Aboriginal and Torres Strait Islander people.

   Each module consists of 1-3 videotapes and a booklet including summation of the script, training questions and exercises, and student assessment and evaluation forms.
10. Clinical Treatment Guidelines Series, Turning Point Alcohol and Drug Centre, www.turningpoint.org.au/library/catalogue.web.nsf

11. Davies, J. (2000). A Manual of Mental Health Care in General Practice. Commonwealth Department of Health and Aged Care. Canberra.

12. Hulse, G. et al. (2003). Alcohol and other drug clinical presentations and management – a case series exercise and record book. Oxford University Press.

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16. Treatment Approaches for Alcohol and Drug Dependence: An Introductory Guide. ndarc.med.unsw.edu.au/ndarc.nsf/website/Publications.resources (to order a copy).

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Appendix 1. Sources and acknowledgements

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

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- Graham, H.L. (2000). Cognitive-behavioural integrated treatment (C-BIT): An approach for working with your clients who have severe mental health problems and use drugs/alcohol problematically. Northern Birmingham Mental Health (NHS) Trust, Birmingham.
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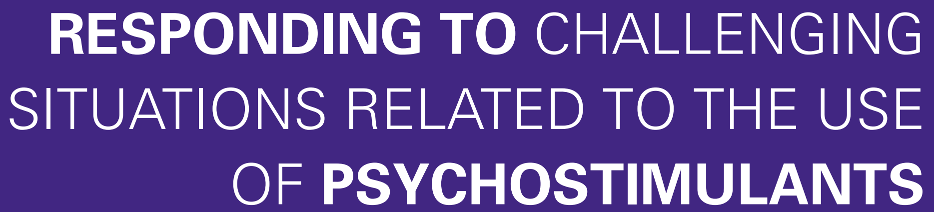
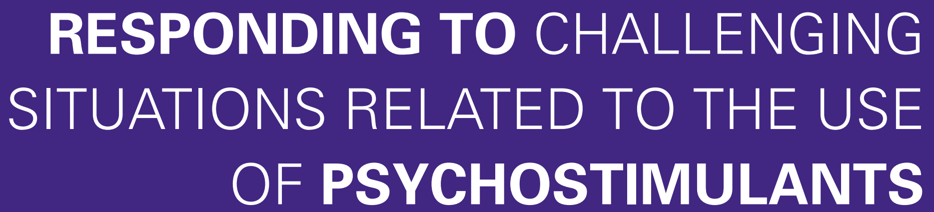
Notes



RESPONDING TO CHALLENGING SITUATIONS RELATED TO THE USE OF **PSYCHOSTIMULANTS**

a practical guide for frontline workers



RESPONDING TO CHALLENGING SITUATIONS RELATED TO THE USE OF **PSYCHOSTIMULANTS**

a practical guide for frontline workers

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ISBN: 1-74186-634-0
Online ISBN: 1-74186-635-9
Publications Approval Number: P3-3918

Suggested citation:
Jenner L and Lee N (2008). *Responding to Challenging Situations Related to the use of Psychostimulants: A Practical Guide for Frontline Workers*. Australian Government Department of Health and Ageing, Canberra.

Acknowledgments

This publication was made possible by the input of many people who willingly gave of their valuable time, expertise, and experience to offer suggestions and critical commentary. The project team would especially like to thank the members of the Steering Committee:

Steve Allsop
Amanda Baker
Adrian Dunlop
Linda Gowing
Rebecca McKetin
Annie Madden
Katherine-Walsh Southwell

We would also like to thank the workers from the following organisations for their valuable participation in focus groups that were undertaken in various locations throughout Australia:

139 Club Inc., Brisbane

Addiction Help Agency, Cairns

BHP Billiton, Port Hedland

Cairns Alcohol Tobacco and Other Drug Services (ATODS)

Canberra Alliance for Harm Minimisation and Advocacy (CAHMA)

Department of Child Protection, Port Hedland

Drug and Alcohol Withdrawal Network (DAWN)

Families SA, Port Lincoln

Melbourne City Mission

Neighbourhood Renewal, Melbourne

Next Step Drug and Alcohol Services, Perth

Open Family, Melbourne

OzCare, Brisbane

Palmerston Assoc Inc, Perth

Pilbara Community Drug Service Team

Prince Charles Hospital Health Service District, Harm Reduction Centre, Brisbane

St Bartholomew's House, Perth

St John of God Community Drug Service Team, Bunbury

St Vincent's de Paul Society, Port Lincoln

Saltwater Clinic Mobile Support Team, Melbourne

Sydney South West Area Health Service, Drug Health Service, Bankstown, Bowral, Redfern, and Royal Prince Alfred Hospital

Tasmanian Alcohol and Drug Service, Launceston, Ulverstone

Upper Hume Community Health Service

Well Women's Centre, Port Hedland

Western Australia Substance Users Association (WASUA)

West Coast Youth Services, Port Lincoln

Yirra Residential Rehabilitation Service, Mission Australia, Perth

Youth Involvement Council, Port Hedland

Youth Substance Misuse Service, Cairns

Youth Substance Abuse Services, Melbourne

Youth Link, Cairns

We also wish to thank the user representatives from CAHMA for their generosity in sharing personal stories, which contributed to the development of the content of this guide; and the Western Australian Network of Alcohol and Other Drug Agencies (WANADA), and Drug and Alcohol Office Western Australia (DAO), for assisting with the organisation of focus groups in WA.

Finally, we wish to thank Jeremy Williams and Linda Rigby from the Australian Government Department of Health and Ageing for their assistance with the project.

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Introduction

Psychostimulants have been used by some people in Australia for many years. Psychostimulants include cocaine ('coke'), amphetamine ('speed'), methamphetamine (also known as 'speed', 'crystal', 'ice', 'crystal meth', 'base', 'louie') and dexamphetamine (a medically prescribed stimulant).

People who interact with psychostimulant users include frontline workers, including counsellors, case managers, support workers, administration officers, volunteers from alcohol and other drug services, and workers from a variety of other health, welfare and service settings. These people are sometimes required to respond to challenging situations.

Challenging situations can include situations involving hostility, threats of violence and actual violence, and incidents involving people with psychostimulant-related psychosis. The vast majority of people who access health services, including users of psychostimulants, are not aggressive or violent. Rather, research suggests that a small proportion of service users can be involved in a large number of incidents. This may lead to an unsafe workplace.

This guide for frontline workers is based on the best and most recent information available. The research literature on challenging situations was reviewed, using databases such as PubMed and PsychInfo, to find relevant studies. However, most research on challenging situations focuses on those involving violence and aggression. Also, there is little research evidence specifically addressing the role of psychostimulants in challenging situations. Where evidence is lacking, information has been drawn from national and international guidelines, and expert opinion.

Challenging situations may be caused by stressful situations, including financial, interpersonal and health problems. Feelings that have been shown to trigger violence or aggression include anger, anxiety and fear. Features of the physical environment and the effects of psychostimulants are additional factors that may increase the likelihood of challenging situations. Challenging situations sometimes escalate quickly, but if hostility or violence occurs, it is usually

preceded by a progression from relative calm through increasing levels of agitation. This guide outlines early signs that a person is becoming hostile or aggressive. It also suggests de-escalation techniques that involve calming the person and managing the physical environment to reduce the risk of harm to him or herself and others. Although few studies have been conducted on de-escalation techniques, they are recommended consistently by national and international guidelines, and expert opinion.

Success stories from the literature demonstrate that effective policy responses to challenging situations include strong organisational awareness and support for risk reduction. All workers (including both front-line workers and managers) have a role in reducing the likelihood of a challenging situation. Challenging situations are often underreported in the health workplace, and incident reporting is an important part of establishing a workplace culture that promotes a safe workplace for all.

This guide is intended to be useful to a range of frontline workers, particularly those without a professional or clinical background. It offers practical tips for reducing the likelihood of challenging situations, responding during a crisis, and reviewing the management of a challenging situation. The guide also includes considerations for specific service settings such as needle syringe programs; outreach services; withdrawal programs; community health centres; and residential rehabilitation settings.

The guide is not intended to replace existing policy and procedures. Rather, it can be used to guide a review or modification of existing practices for responding to challenging situations related to the use of psychostimulants. This guide should be read in conjunction with *Treatment Approaches for Methamphetamine Users: A Practical Guide for Frontline Workers,* which can be accessed via the Australian Government Department of Health and Ageing website and clicking on the ‘publications’ link (http://www.health.gov.au).

1
About challenging situations

How can psychostimulants increase the risk that users will become angry, hostile or aggressive?

Psychostimulants include cocaine ('coke'), amphetamine ('speed'), methamphetamine (also known as 'speed', 'crystal', 'ice', 'crystal meth', 'base', 'louie') and dexamphetamine (a medically prescribed stimulant). All of these drugs stimulate the central nervous system. The rate of a user's normal bodily processes increases so that the person feels alert and energetic, and usually will have an intense feeling of wellbeing.

A person who has recently used psychostimulants can:

- have fast, loud and difficult-to-interrupt speech
- appear agitated (eg pace or can't sit still)
- engage in impulsive or reckless behaviour
- appear sweaty
- clench the jaw or grind the teeth
- have large pupils.

Following a high dose of psychostimulants, users can experience:

- tremors, anxiety, sweating, racing heart (palpitations), and dizziness
- tension, irritability, and confusion
- intense fear, paranoia and panic states
- sleeplessness
- seeing or hearing things that other people cannot (illusions or hallucinations)
- loss of behavioural control and aggression.

Withdrawal from psychostimulants can lead to:

- agitation
- irritability
- mood swings
- disrupted sleep patterns
- poor concentration.

(see *Treatment Approaches for Methamphetamine Users: A Practical Guide for Frontline Workers* for more information).

Although psychostimulants can increase the risk of aggression, not all psychostimulant users will become aggressive. Similarly, not all people who become aggressive have used psychostimulants.

What can trigger a challenging situation?

A challenging situation can be triggered by:

- the specific effects of intoxication or withdrawal from psychostimulants, as described above
- an exaggerated response to a real event in the person's life or a trigger in the immediate environment
- fear or paranoia
- psychostimulant-related psychosis (a person's contact with reality is grossly impaired)
- lack of staff training in recognising and responding to escalating hostile behaviour
- a seeming or actual long wait for service, or lack of communication that leads to frustration or anger
- a range of other environmental stressors.

Which service users are most at risk of involvement in challenging situations?

People who are most at risk of being involved in a challenging situation include those who:

- have been aggressive or violent in the past
- are using multiple drugs with psychostimulants (eg alcohol, heroin, benzodiazepines, cannabis, or more than one type of psychostimulant at once)

- are intoxicated with psychostimulants or another drug
- are withdrawing or 'coming down' from psychostimulants
- have multiple difficulties in their life (eg financial, legal, health, housing, relationships, etc)
- also have a serious mental illness such as schizophrenia (see page 12, *What if a person is experiencing psychosis*?).

Young men are more likely to be involved in challenging situations than other users.

How should workers respond to challenging situations?

Workers are often well equipped with the skills and knowledge necessary to respond challenging situations. Even when psychostimulant use is involved, workers should rely on their experience and feel confident in their ability to respond appropriately.

Challenging situations should be managed in the same ways that other hazards in the workplace are managed, and workers have a responsibility to familiarise themselves with their agency's existing policy and procedures. Frontline workers and managers alike have key roles to play in reducing the likelihood of challenging situations and in responding skilfully if they do occur; *teamwork and a consistent approach are essential*.

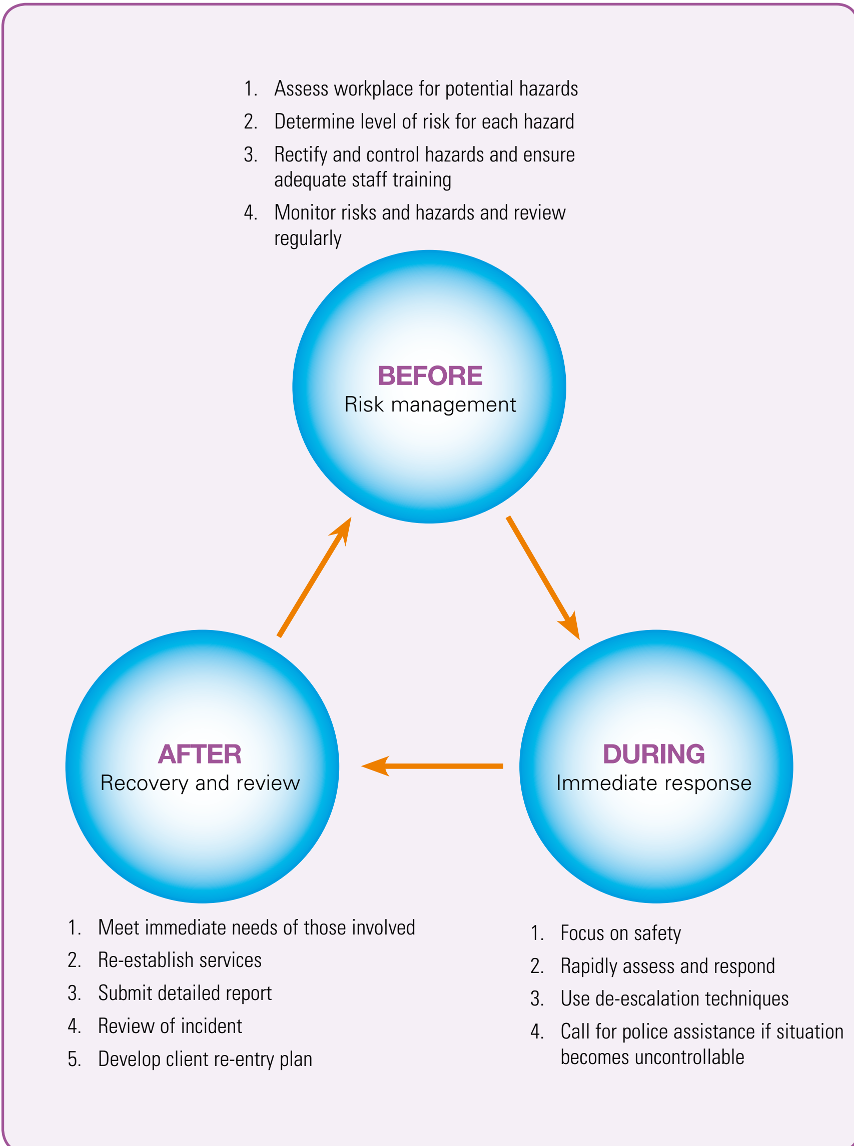
An effective response to challenging situations involves a linked, three-phased approach as described by the National Health and Medical Research Council (NHMRC).

1. **Before**: planning and initiation of risk management strategies.
2. **During**: direct and immediate response to challenging behaviours.
3. **After**: recovery and review.

Although service managers are largely responsible for ensuring that the 'before' component of the model is undertaken, frontline workers have a key role to play in informing the regular revision of relevant documents and plans, and ensuring that such plans are applied consistently. Both managers and frontline workers have important roles in both the 'during' and 'after' phases.

All workers have an obligation to themselves, their colleagues and their clients to ensure that attention to hazards and risks in the workplace are identified promptly and assessed, and that action or management plans are applied consistently.

The model is designed to improve the service response and is depicted in the following figure on the next page. Each phase of the model is described in detail in subsequent chapters.



Adapted from National Health and Medical Research Council (NHMRC) (2002). *When it's Right in Front of You: Assisting Health Care Workers to Manage the Effects of Violence in Rural and Remote Australia*. NHMRC. Commonwealth of Australia, Canberra.

2
BEFORE — preventing and reducing the likelihood of a challenging situation

The occurrence of challenging situations in which hostility, aggression or violence occur will never be completely eliminated in the workplace, so appropriate and active steps should be taken to reduce and manage risk before it occurs.

Consistent with NHMRC guidelines services should aim to:

1. Assess the workplace for potential dangers before they arise **(hazard identification)**.
2. Determine the level of risk associated with each hazard **(risk assessment).**
3. Take steps to rectify those hazards that pose the most risk **(risk prevention and control)**.
4. Monitor hazards and risks and undertake regular reviews so lessons can be learned and workplace procedures adapted accordingly **(monitoring and review)**.

Hazard identification

Hazards are anything that places workers, service users, bystanders or visitors at risk. Hazards can be identified in the physical environment and in the delivery of services. A thorough and careful exploration of each workplace should be undertaken to identify potential hazards. All members of staff, including frontline workers and management should actively participate in this process.

It is also useful to recall past situations as well as possible future situations in an effort to identify hazards that place workers at risk. Workers should discuss in detail what the possible outcomes would be if a challenging situation should occur in the workplace.

Potential workplace hazards are specific to individual services settings and can include:

Hazards relating to staff training and communication

- lack of a clear plan for responding to challenging situations
- staff untrained in recognising and responding appropriately to challenging situations
- poor communication or lack of communication between workers and service users.

Hazards relating to work practices

- work practices involving after hours services with limited numbers of staff members
- lengthy waiting times for service.

Hazards relating to environmental and security factors

- risk factors related to the building layout or design, including lack of telephone access, poor lighting, areas with unsecured access, awkward or limited number of exits, lack of duress alarms, isolated interview rooms
- physical environments where service users are crowded or are required to congregate for extended periods
- too much noise or stimulation in waiting areas (eg noisy televisions, radios, mobile phones)
- furniture or fittings that can be easily moved or thrown
- unknown effectiveness of existing security measures.

Risk assessment

Each workplace will vary in the number and type of hazards identified, so the next step in reducing and preventing the likelihood of a challenging situation is *risk assessment.*

Risk assessment involves identifying *which hazards pose the greatest safety risks to workers and service users*. The hazards should then be prioritised from the most urgent to the least urgent, taking into consideration the service's budget constraints. The priority list will then guide the next step in the process, which is *risk prevention and control.*

Workers should also ensure that an assessment of the mental state of service users who are known to have a psychotic illness is undertaken by a

trained clinician so that an individualised plan for preventing and responding to a challenging situation can be developed (see page 12, *What if a person is experiencing psychosis*?).

Risk prevention and control

These measures relate to the previous steps. A range of actions could be suitable to tackle the identified hazards and could include the following.

Staff education and training

- Make sure that workers are familiar with existing policies and procedures regarding challenging situations, or creating policies and procedures or detailed action plans if none currently exist.
- Educate workers about psychostimulants. This can include the effects of psychostimulant intoxication and withdrawal, including accelerated bodily functions and high level of arousal; short attention span; potential for paranoia or psychosis; irritability; mood swings; sleeplessness.
- Train workers to respond to challenging situations including recognising when a service user is becoming hostile or aggressive, and how to calm a person using verbal and non-verbal communication skills (known as 'de-escalation techniques'). Role plays of specific scenarios are useful in helping workers practice their skills. Workers should be encouraged to respond to challenging situations according to their personal ability and level of confidence.
- Provide regular staff training regarding incident reporting and action plans for challenging situations, with an emphasis on the importance of consistently applying the action plan.

Attention to service users

- Make a visibly clear statement of service users' rights and responsibilities that incorporates clear processes of communication, complaints and advocacy.
- Provide sensitive and timely information to waiting service users.
- Adopt measures to decrease waiting time if possible.
- Aim for a smooth flow of service user movement through the agency if practical or possible.
- Provide flexibility in service delivery to meet the individual needs of psychostimulant users.

Safety issues

- Provide free access to exits, telephones, and duress alarms.
- Minimise hazards relating to staff members who work alone, particularly at night or when assistance is unavailable.
- Establish links with mental health services to ensure a prompt assessment or secondary consultation should a challenging situation occur (see *Treatment Approaches for Methamphetamine Users: A Practical Guide for Frontline Workers* for tips on creating links and partnerships).
- Require every worker to report all threats, hostility or incidents of violence to a supervisor or manager, and every worker to keep detailed records and reports of such incidents.
- Establish a liaison with local police to ensure a prompt response should a serious incident occur.

The process for regular monitoring and review

The processes of hazard identification, risk assessment and management should be undertaken regularly as workers and workplaces change and evolve over time. Regular review of the risk prevention and control activities is crucial to monitoring their effectiveness and determining whether other actions are necessary to reduce workplace risks.

Monitoring and review also provide an opportunity for reflective practice. Services can learn valuable lessons by reviewing in detail their responses to challenging situations (see page 20, *Review: After the event*).

3
DURING — responding to challenging situations

General principles

1. **SAFETY IS PARAMOUNT.**
2. Workers need to recognise that reasons for a service user's anger or frustration are often valid so workers should listen and respond sensitively to concerns as they arise.
3. Workers need to understand that, in a crisis, they are responsible for managing the situation and avoiding provocation — it is often not realistic to expect an agitated, angry, or intoxicated person to calm down just because he or she is asked to do so.
1. Workers should recognise the point at which de-escalation techniques have failed to calm a situation sufficiently, at which time police assistance should be sought urgently.

Aims of the response

When faced with a real or potentially challenging situation, workers should:

1. Recognise the signs of impending aggression or violence.
2. Intervene early to reduce the chance that a challenging situation will lead to aggression or violence (see page 14, *De-escalation techniques*).
3. Maintain the safety of everyone involved.
4. Call for assistance when de-escalation strategies are not effective (see page 16, *When the person does not respond to de-escalation techniques*).

The signs of hostility and de-escalation techniques detailed in this section appear in the *Quick Reference Chart* at the end of this guide. The chart is designed to be an easily photocopied, visual reminder of the main points for frontline workers.

What are the signs that a person is becoming hostile or aggressive?

Signs that a person is becoming hostile or aggressive often include but are not limited to:

- increased content and volume of speech that can be demanding or argumentative and may involve shouting
- agitation, restlessness, erratic movements, inability or unwillingness to sit or stand still
- behaviours such as pacing, clenching fists, drumming fingers, repeatedly running hands through hair, tapping or banging on walls or furniture
- tense, frustrated or angry facial expressions
- extended eye contact that appears challenging, or overt glaring
- rapidly shifting mood
- appearance of intoxicatation with psychostimulants and or other drugs, particularly alcohol; the signs of psychostimulant intoxication include rapid speech, sweatiness, large pupils, restlessness and agitation
- rapid breathing, muscle twitching, wide-eyed expression
- lack of recognition of staff by a regular service user
- disclosure of feelings of great fear, anger, or loss of control
- blocking of escape routes or attempts to back you into a corner
- vague or clear verbal threats or gestures.

What if a person is experiencing psychosis?

The term psychosis describes a disorder in which a person's contact with reality is grossly impaired. People who are experiencing psychosis are not usually aggressive or violent. However, sometimes symptoms such as hallucinations or delusions can cause people to become aggressive.

Symptoms of psychosis include:

- Hallucinations — the person experiences sensations that have no basis in reality such as hearing voices (auditory hallucinations) or seeing things (visual hallucinations) that others cannot. Other hallucinations involve touch, taste and smell.
- Delusions — the person holds fixed, false beliefs that do not shift even when faced with logical evidence to the contrary. For example, a person might believe that he or she is being spied upon by a secret agency, or that his or her

thoughts are being controlled by external forces, or that complete strangers intend to harm the person in some way. Beliefs that are shared by others in a person's religion or culture are not considered to be delusions.

- Thought disorder — a person’s thinking becomes confused, concentration becomes difficult, thoughts may speed up or slow down, or the person will jump form one topic to another with no obvious logical connections.
- Disorganised or bizarre behaviour — a person will respond to strange thoughts, mood swings or unusual sensory experiences by adjusting his or her behaviours to adapt to these beliefs or perceptions. To others, such behaviour seems disorganised or bizarre, but to the person it makes sense. For example, those who fear surveillance might pull blinds, speak in whispers, disconnect the phone, appear generally anxious, jumpy and afraid, or keep a weapon for protection.

Because of these symptoms, a service user might feel anxious or scared, and may swing rapidly and unpredictably between different mood states. He or she might also act upon commands given by auditory hallucinations or ‘voices’ (eg the ‘voice’ could say something like *'get him before he gets you'*), or lash out to protect himself or herself from perceived threats linked to the frightening delusions (eg a belief that workers or bystanders intend to injure or apprehend the service user).

A mental health clinician can often determine the content of a person’s hallucinations and delusions during an assessment. This information can then be used by frontline workers to develop a service or action plan that is specific to the needs of the individual service user. If the service user already has a mental health case manager, a collaborative approach is recommended (see *Treatment Approaches for Methamphetamine Users: A Practical Guide for Frontline Workers* for referral and collaboration tips).

Response strategies

DO NOT APPROACH IF:

- the worker does not feel confident or capable of managing the situation; **if in any doubt, do not approach** and call for the immediate assistance of a senior staff member or supervisor
- the person is enclosed in a small space with no exit
- the person is already too hostile, unstable, fearful or intoxicated to respond
- the person is threatening harm to workers or bystanders
- the person has a weapon.

In these situations, the worker should **call for immediate assistance** (senior worker or supervisor; police; security personnel, etc); clear the room of other workers, service users or bystanders; and wait for assistance to arrive.

De-escalation techniques

Strategies designed to prevent an aggressive or violent incident are known as *de-escalation techniques*. De-escalation techniques involve taking steps to calm the person and manage the physical environment. Calming communication strategies and steps to reduce risk to the safety of workers, bystanders, visitors and the service user are important components of de-escalation techniques.

If a worker is interviewing or counselling a service user when signs of hostility or aggression occur, immediately stop counselling/interviewing, consider activating a duress alarm if available and attempt to de-escalate the situation as described below.

Initial approach

- ✔ Quickly scan the immediate vicinity and observe the location of duress alarms, exits, bystanders, and potentially dangerous objects to judge immediate risks and decide upon the most suitable approach (leave and call for assistance, or respond skilfully).
- ✔ One person only should take control of the situation and undertake all communication with the service user (ensure the 'communicator' feels confident, calm and able to do so).
- ✔ The communicator should place other workers on stand-by so a team approach can be undertaken. Have another staff member present to observe or step in *only if required* (the communicator could use a code word to call for assistance from the 'observer'). The observer should attempt to determine if the service user has a known history of aggression or violence and, if so, extra care should be taken; the observer should be ready to call for immediate assistance if required.
- ✔ Usher bystanders from the immediate environment, stop others entering and create some physical space.
- ✔ Consider removing potential, personal hazards such as necklaces, eyeglasses, pens, and keys.
- ✔ Adopt an open body posture (ie arms by sides, palms forward, move slowly).
- ✔ The communicator should always approach the person from the front or the side so that he or she can be seen so the service user is not startled or scared.

- ✔ Monitor eye contact — not too much (appears threatening) or too little (implies indifference or untrustworthiness).
- ✔ Ensure that a safe distance is maintained (ie the person will need a larger area of personal space than usual).
- ✔ Sit with a person who is seated, walk with a person who is pacing — mirroring body language signals shows that you understand what the person is going through (empathy) and ensures that you appear neither threatening by standing over the person nor vulnerable by being seated while he or she stands.

Communication strategies

The communicator should:

- ✔ Use an even, calm tone of voice, even if the person's voice becomes loud or aggressive.
- ✔ Speak to the person by name if known, or attempt to establish a rapport if unknown — the communicator can introduce him or herself by name, or remind the person of his or her identity.
- ✔ Acknowledge the grievance and communicate a willingness to help — ask open-ended questions about the cause of the person's current anger or distress without delving into past grievances, for example *'Tell me what happened* today*', 'What can I do to help you right* now*'?*
- ✔ Show concern and attentiveness through non-verbal (eg nodding head) and verbal responses *'I understand how you feel…'* or *'Tell me about that…'*
- ✔ Ask the person if he or she would like some time to think before responding — consider stepping back to reduce the stimulus while still actively managing the situation *'I'll give you a minute or two to think about this, but I'll be right here'*.
- ✔ Negotiate realistic options to resolve the situation and be clear about what the communicator is trying to achieve *'I want to help, and we need to talk this through but I can't understand you when you're shouting…'*.
- ✔ Take the person to a dedicated, 'quiet room' or 'safe room' if available — such a room promotes calm and allows service users to feel that their immediate needs are being met.
- ✔ Try to establish if the person has used psychostimulants. If so — and without being patronising or dismissive — reassure the person that the uncomfortable feelings will pass by gentlyly reminding him or her that the feelings are probably related to stimulant use and will subside with rest and time.
- ✔ Always appear confident even if the communicator does not feel it.

The communicator should avoid:

- ✖ use of 'no' language, which may prompt a hostile outburst, rather focus on what can be done for the person:
  - ✔ statements like *'What I CAN do to help is …'* often encourages negotiation and may have a calming effect
- ✖ arguments
- ✖ threats
- ✖ being blocked from the exit (stand near the exit if possible), and do not block the service user's exit
- ✖ promises that cannot be kept
- ✖ an assumption that the person will inevitably become violent as this might lead the worker to unintentionally adopt a defensive posture, which can itself trigger an aggressive response.

When the person does not respond to de-escalation techniques

The communicator should signal the observer to **TELEPHONE THE POLICE**. Because of the strong arousing effects of psychostimulants, severity of psychotic symptoms, or a combination of individual and environmental factors, some people might not respond to de-escalation techniques, and the safety of workers, bystanders and the service user may become threatened. In this case, follow the agency's existing policy and procedures for calling for police assistance and state:

1. your exact location (including the name of your organisation and the nearest cross street)
2. the exact nature of the situation including number of bystanders, if and what threats have been made, presence of weapons, and any other relevant information.

After removing non-involved workers, other service users and bystanders from the immediate environment, the communicator and observer should leave and not re-enter until police arrive. If the person is known to be involved with another agency such as mental health services, workers should promptly inform the person's case manager and provide relevant details of the event.

Note: Be aware that if the person is afraid or paranoid, the sight of a police uniform may escalate the situation even further, so prepare everyone concerned for this possibility. Workers should also be aware that psychostimulant use is a risk factor for sudden death of individuals being physically restrained and, if restraint is ever necessary, it should be undertaken for the *shortest possible time*.

When the person does respond to de-escalation techniques

A service user can be embarrassed or remorseful when the incident has blown over so acknowledge the person's effort in calming him or herself. Negotiate a plan with the person to implement any actions that were agreed upon during the de-escalation process. Reinforce the service user's rights, responsibilities and processes for communication, grievances and advocacy.

When the person has left the agency, complete an incident report and ensure all workers are aware of the situation. Include the person's individual signs of impending hostility or triggers to the challenging situation if any were identified by the communicator or observer. Identify any strategies that can be put in place to limit reoccurrence of a challenging situation involving the particular service user. See Chapter 4, *After — recovery and review.*

4
AFTER — Recovery and review

Recovery: Immediately following the situation

Immediately following an incident, the physical, emotional and psychological needs of staff members, other service users or bystanders should be attended to in a supportive safe environment, particularly if any were victims of aggression or violence. Immediate responses to any worker(s) who was involved, injured or traumatised during the incident include:

- medical care if required
- the offer of counselling if required (eg employee assistance program or on-site counselling if available)
- an opportunity to seek legal advice if required.

When the situation is under control, the previously developed recovery plan should be implemented as quickly as possible and should include:

- re-establishment of services to service users as soon as possible
- provision of clear information about the incident to workers and others directly concerned
- provision of a verbal report to the appropriate supervisor or manager
- completion and submission of a detailed written or electronic incident or situation report that includes date, time, location of incident, details of people present, nature of the incident, and outcome (check existing policy and procedures for reporting guidelines).

Review: After the event

Services should undertake a dedicated and timely review to examine the responses to the incident. The review process should be undertaken in the spirit of open enquiry with the aim of improving future responses rather than an attempt to assign blame. The following points should be considered:

1. Identify the specific situation that occurred, including triggers if identified (use the completed incident report as a starting point).
2. Identify the steps taken that were effective.
3. Identify any steps taken that were ineffective.
4. Determine if the action plan for response was carried out as intended. If not, determine why not. Identify the barriers to implementing the plan. Brainstorm solutions to overcoming the identified barriers. Determine if the plan was realistic or useful, or if it was lacking in some way.
5. Determine what hazards led up to the situation. Determine if the hazards were previously identified. If additional hazards were identified following the situation, determine how the risk of future challenging situations can be reduced.
6. Determine if the workers involved recognised the signs of an impending challenging situation and whether they intervened appropriately.
7. Identify any additional training for workers that might be required. Determine who can best provide the training and schedule it accordingly. Determine how the effectiveness of the training will be evaluated.
8. Determine if existing security measures were or were not useful.
9. Determine if additional support for workers is required and how the support can be introduced (if several additional supports are required, identify the priorities). Determine the time frame for introducing the new supports.
10. Identify how the overall service's responses could be improved to deal with a future challenging situation should one arise.

Following the review, the action plan should be updated accordingly, and all staff should be made aware of any alterations to the planned response to challenging situations.

On-going support

Workers who are affected by hostile or violent incidents should have clear information about what continuing support services are available. The option of time out from duties and an appropriate return to work plan should also be available if required.

Workers should also be offered an opportunity for psychological counselling during which personal feelings about the incident can be explored. Uncomfortable feelings related to challenging situations can include anger, guilt, frustration, disbelief, blame, fear and anxiety, all of which can impact negatively on the worker on a personal and professional level. However, the usefulness of debriefing (particularly compulsory debriefing) is not clear, and sessions should be offered on an individual and voluntary basis.

In some states and territories, WorkCover will refer injured or traumatised workers to a psychologist and will pay the cost for a specified period of time. Workers should contact their relevant agency for advice.

Preparing for the service user's return to the service

Individuals who have been involved in a challenging situation can be unknown to the agency, do not return and pose few ongoing management difficulties for workers. However others will be long-term service users or will require ongoing support or services. Therefore, it is essential to develop a plan for re-entry or re-engagement of the person into the service and **every worker should ensure that the plan is applied consistently** to reduce the risk of challenging situations reoccurring (workers should refer to their individual agency's service user re-entry guidelines).

The service user re-entry plan will be based on the circumstances surrounding the challenging situation and should be developed in conjunction with the service user following the review. For example, if the situation was triggered by a service user who was intoxicated, then verbal or written warnings might be suitable. On the other hand, if the situation was triggered by a service user with a history of aggression or violence who is regularly involved in such situations or repeatedly threatens workers or other service users, a formal management plan or conditional service agreement could be a more suitable option.

Service users who have an established mental health disorder such as schizophrenia will often have a relapse of symptoms following methamphetamine use, so the person's mental state should be reviewed before re-entry with the agency. Individual signs of acute psychosis can then be highlighted in the person's treatment or service plan so workers can intervene early if they observe these signs again.

A range of possible re-entry options from least to most intensive include:

- *all staff to be alerted* to the service user's role in the challenging situation
- *all staff to be alerted* to a service user's identified triggers for hostility or aggression with clear directions for response
- *face-to-face meeting* with the service user and a senior worker to discuss the incident and negotiate a plan to minimise risk of future challenging situations (particularly appropriate for young people)
- the service user can be offered *referral to a counsellor* to work through any personal issues that might prompt episodes of hostility or aggression
- *verbal warnings* to the service user to refrain from any further unacceptable or threatening behaviours and clear written explanation of service users' rights and responsibilities, advocacy and complaints process
- *written warnings* to the service user (consistent with the person's literacy level) to refrain from any further unacceptable or threatening behaviours, the consequences of breaking the contract and a clear written explanation of the service user's rights and responsibilities, advocacy and complaints process
- *written contract* (consistent with the person's literacy level) to be developed in conjunction with the service user and signed by both service user and senior worker/manager indicating clearly that the person will refrain from any further unacceptable or threatening behaviours and the consequences of breaking the contract
- *formal management plan* (eg where and when the service will be offered and by whom; how to respond if the person becomes hostile or aggressive; what to do if the person appears to be experiencing psychosis, etc) that is to be communicated clearly to the service user and all staff must **adhere consistently to the plan**
- *conditional service agreement*, which details the conditions under which the service will be provided (eg when the service user is not intoxicated; at a specific time of day; in a specific room or open environment; by certain members of staff; when the service user is not accompanied by others who are known to be disruptive to services); the agreement is to be communicated clearly to the service user in writing (consistent with the person's literacy level), and all staff must **adhere consistently to the plan.**

Note: If the agency expects to have contact with the service user soon after the event (eg in a needle syringe program) an interim plan should be created immediately.

When a service user cannot re-enter the service

Because of the severity of the challenging situation, repeated incidents, for other reasons that are specific to the incident, or for reasons related to the resources or policies of an individual agency, the decision might be taken to disengage a service user from the service. In this case the following options could be appropriate:

- *Initiate alternate service arrangements*. The person should receive services from a different agency that is better resourced to deal with the service user's tendency for hostility, aggression or violence. Management or a senior worker should negotiate the referral with the person, and the referral agency should also be informed of the reason for referral.
- *Obtain an apprehended violence order (AVO).* The order is legally binding and can be obtained to protect staff and other service users. Each state has its own procedure for obtaining an AVO, so check with local police for advice.

If the service user is mandated to attend the service (eg by a court order) then the appropriate agent such as a community corrections officer, drug courts officer or diversion program case manager must be contacted about the outcome of the service user's review so alternative service arrangements can be made.

5
Special considerations for specific service settings

The general principles described in this guide apply to all service settings. This chapter highlights special considerations for a variety of settings.[1]

Needle syringe programs

Needle syringe programs can be a unique challenge because service users are not usually known by name, which can make it more difficult to identify them, especially those with a history of violence or aggression. The following points serve as a guide:

Meeting service users

- One staff member should be visible to service users at all times if possible.
- Respond to service users as quickly and helpfully as possible. If the worker is delayed, at least acknowledge the presence of the service user and indicate that you will attend to him or her as soon as possible.
- If a service user appears to be intoxicated with stimulants or other substances, refrain from extended engagement and limit unnecessary questioning.
- Ensure that all staff members are aware of service users who have been involved in challenging situations in the past and develop an action plan in case a challenging incident re-occurs. Because service users are usually not known by name, try to use an accurate description to assist other workers to be alert to users who have been previously involved in challenging situations. Some service users have specific signs or behaviours that might indicate an impending episode of hostility or violence, and these should be highlighted in the action plan.

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1. As there may be some overlap of considerations across settings, workers are encouraged to review all points in the first instance and adopt whichever are appropriate.

Ensuring safety

- Be alert to changes in the presentation of known service users and initiate de-escalation techniques as appropriate using the helping relationship (rapport) that already exists.
- Be alert for signs of impending anger or hostility in unknown service users and respond quickly and appropriately.
- Consider designating one room a 'quiet room' that is created specifically as a safe place where agitated service users can be attended to in a calming, low-stimulus environment.
- Orient all workers to the floor plans of the building and ensure that they are aware of emergency exits and duress alarms if present.

Community health centres

Community health centres sometimes offer services from multiple disciplines or to a range of service users. The following points relate to the provision of services in the context of community health centres.

Meeting service users

- Ensure that administration or front office staff members are trained in identifying impending hostility and aggression, and are instructed to call for immediate assistance if a service user becomes unusually agitated (consult with an alcohol and other drug counsellor in the health centre if one is available).
- If service providers from multiple disciplines (eg dentistry, women's health, drug and alcohol) are on-site, it might appear to a psychostimulant user that others are being seen out of turn, so ensure that waiting service users are acknowledged promptly and made aware of the procedure for intake and assessment to the various services.
- Alcohol and other drug workers should ensure that a client who is known to be using psychostimulants is not kept waiting in the general waiting area beyond the time of the scheduled appointment and that the person's needs are responded to promptly. If the delay is unavoidable, at least acknowledge the presence of the client and indicate that he or she will be attended to as soon as possible.

Ensuring safety

- Workers should position themselves closest to the exit in an interview room.
- All workers should be oriented to the floor plans of the building and be aware of emergency exits.
- When conducting a detailed hazard assessment, pay particular attention to unsecured furniture or fittings (eg loose chairs, indoor plant containers, magazine racks); objects or procedures that might increase environmental stress (eg noisy televisions in the waiting area, which should be fixed and have appropriate programming and sound level), or crowded conditions (eg children and adults in the one area).
- Duress alarms should be available, and all workers should be trained to respond immediately.
- Ensure that all workers report every incident of hostility or aggression to a supervisor, no matter how minor, and complete incidents reports according to existing policy and procedural guidelines.

Residential withdrawal (detoxification) settings

- As far as possible, limit environmental stressors such as noisy televisions or radios.
- Newly abstinent service users can be impulsive, irritable and experience extreme mood swings, so workers should take extra care in the early stage of withdrawal to reduce the risk of a challenging incident.
- Newly abstinent service users should be provided with adequate physical space to move around freely.
- Newly abstinent service users should be offered access to activities that help them manage uncomfortable feelings, such as relaxation sessions, physical activities or other distractions.
- In some geographical locations, particularly rural and regional towns, residential service users are likely to be familiar with each other, so be alert for signs of interpersonal conflict and defuse this rapidly.
- Ensure the safety of other service users if an incident does occur.

Community/outpatient alcohol and other drug counselling settings

This section assumes that community alcohol and other drugs workers will see service users within an agency setting. If workers are required to offer outreach services, please refer to the next section, *Outreach/home based services*.

Meeting service users

- If a service user has been involved in a challenging situation in the past, it is essential that all workers are aware of the risk so a service-wide plan for risk reduction and response can be devised and implemented if necessary.
- Ensure administration or front office staff members are trained in the identification of hostility and aggression, and are instructed to call for immediate assistance if a client becomes unusually agitated.
- Ideally, the intake or assessment interview room should be closest to the front entrance of the building.
- Workers should ensure that a client who is known to be using psychostimulants is not kept waiting in the general waiting area beyond the time of the scheduled appointment and that the client's needs are responded to promptly.

Ensuring safety

- The worker should position him or herself closest to the exit without blocking the service user's exit.
- Windows could be placed in a door so passing workers are able to observe interview rooms for safety purposes.
- Consider designating one room near the entrance or exit a 'quiet room', created specifically as a safe space where agitated service users can be attended to in a calming, low-stimulus environment.
- When conducting a detailed hazard assessment, pay particular attention to unsecured furniture or fittings (eg loose chairs, indoor plant containers, magazine racks); objects or procedures that might increase environmental stress (eg noisy televisions in the waiting area, which should be fixed and have appropriate programming and sound); or crowded conditions (eg children and adults in the one area).
- Duress alarms should be available, and all staff members should be trained to respond immediately.
- Where no duress alarms are available, workers could nominate a special code word or phrase that can be used to alert other workers to a need for assistance. For example, to avoid inflaming a potentially hostile situation, a worker who feels uncomfortable or threatened could telephone a colleague and use a benign code phrase such as *'Please bring the red book'* to call for help.

- All workers should be oriented to the floor plans of the building and be aware of emergency exits.

Outreach/home based services

A range of safety strategies for outreach services are available in most agencies, and workers should refer to existing policies and procedures for advice. The following points serve as a guide.

Meeting service users

- Meet new service users within the agency setting so an assessment of the potential for risk and hazards during home or site visits can be undertaken (eg establish if other people live in the house such as boyfriends, partners, friends; presence of dogs).
- Try to anticipate hazards ahead of time. If the outreach service does not have an appropriate venue for the initial assessment, a neutral public space or a borrowed office in another agency could be used.

Establishing a work plan

- Establish a daily work plan for mobile workers including a designated contact person who can follow up if a worker does not report in as expected. Include the address of the visit, nearest cross street, estimated time of return, car number plate, service user to be visited, and worker's mobile phone number.

Ensuring safety

- Two staff members should undertake at least the first home or site visit, and they should exercise extra care in unfamiliar homes and environments.
- Workers should park the car in the street facing the direction they intend to leave so a hasty exit can be made if necessary (never park in a driveway or face into a cul de sac).
- Always carry a mobile phone and pre-program the phone with emergency contact numbers and carry the car keys in hand.
- Scan the environment upon arrival for signs of potential hazards.
- When the service user opens the door, try to assess the person's presentation and do not enter if workers feel uncomfortable.
- At all times workers should position themselves where the service user can see them, and workers should not move suddenly.

- Workers should tell the service user exactly what they are doing and why, and ask permission if they want to go to another area of the person's dwelling.
- Workers should not let a service users get between them and an exit.
- Leave the premises immediately if a risky or challenging situation occurs. One approach is to agree on a special 'password' ahead of time that can be used by either worker to communicate to the other a feeling of unease or discomfort. If either worker uses the password, both workers should leave the premises immediately without further discussion.
- If it is established that the personal safety of workers is threatened in a particular environment, the setting should be avoided and alternatives for care of the service user should be pursued.
- If mobile workers visit another agency that is unfamiliar to them (eg homeless shelter), workers should familiarise themselves with both the agency's policies and procedures for managing challenging situations and the layout of the building, including exits, upon arrival.

Residential rehabilitation

A challenging situation can affect the disturbed resident, other residents and workers. Use of the following points can help to decrease risk to all concerned while promoting resolution of the situation.

When an incident occurs

Should a challenging situation occur, all other residents should be moved away from the disturbed resident until the situation is under control.

One worker only should undertake communication with the disturbed resident and take control of the situation. The worker is referred to the de-escalation techniques described in this guide.

After an incident

When the situation is resolved, a reviewing session for anyone involved could be helpful in assisting staff members and other residents to come to terms with the incident.

If the resident is required to leave the service, workers should alert a relevant agency, such as a homelessness response team, if the person has no accommodation to return to.

If a previously settled resident becomes hostile or aggressive and no obvious environmental stressors or triggers can be identified, it is possible that

psychostimulants have been secreted into the facility so a check for the presence of illicit drugs is advisable.

Individualised attention

In some geographical locations, particularly rural and regional towns, residential service users are likely to be familiar with each other so be alert for signs of interpersonal conflict and defuse rapidly.

Engagement and retention of stimulant users in residential rehabilitation could be enhanced by an individually tailored, flexible rehabilitation plan that takes into account a newly abstinent user's potential for impulsivity, irritability, paranoia, intense cravings, and memory impairment. For example, an emphasis on brief individual counselling sessions and motivational approaches could be useful over the more challenging group therapy in early stages and reduce the risk of a challenging situation occurring.

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1: About challenging situations

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Responding to challenging situations: Quick Reference Chart

Signs of escalating hostility or aggression

- Increased content and volume of speech that can be demanding or argumentative and may involve shouting
- Agitation, restlessness, erratic movements, inability or unwillingness to sit or stand still
- Pacing, clenching fists, drumming fingers, repeatedly running hands through hair, tapping or banging on walls or furniture
- Tense, frustrated or angry facial expressions
- Extended eye contact that appears challenging, or overt glaring
- Rapidly shifting mood
- Appearance of intoxication with psychostimulants and or other drugs (eg rapid or loud speech, sweatiness, restlessness, agitation, clenched jaw, large pupils)
- Rapid breathing, muscle twitching, wide-eyed expression
- Disclosure of feelings of great fear, anger, or loss of control
- Vague or clear verbal threats or gestures
- Blocking escape routes or attempting to back you into a corner

Communication strategies

✔ Use an even, calm tone of voice.
✔ Speak to the person by name or introduce yourself by name.
✔ Acknowledge the grievance and communicate your willingness to help *'Tell me what's happened today'?, 'What can I do to help you'?*
✔ Show concern and attentiveness through non-verbal (eg nodding head) and verbal responses *'I understand how you feel...'*, or *'Tell me about....'*
✔ Allow the person time to think and respond — *'I'll give you a minute or two to think, but I'll be right here'*, and step away while still actively managing the situation.
✔ Negotiate realistic options to resolve the situation and be clear about what you are trying to achieve *'I want to help, and we need to be able to talk this through, but I can't understand you when you're shouting…'*
✔ If a dedicated, low-stimulus room is available, ask the client to accompany you there to reduce excessive environmental stimulation.
✔ Always appear confident even if you don't feel it.
✖ Do not use 'no' language, instead try:
  ✔ *'What I CAN do to help is …'.*
✖ Do not argue with the person.
✖ Do not threaten the person.
✖ Do not allow the person to block your exit from the room (stand near the exit if possible), and do not block the person's exit either.
✖ Avoid making promises you cannot, or do not intend to keep

Emergency contact names and telephone numbers

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DO NOT APPROACH IF:

- The worker does not feel confident or capable of managing the situation — if in any doubt do not approach — call for the immediate assistance of a senior staff member or supervisor
- The person is threatening harm to workers or bystanders
- The person is already too hostile, unstable, fearful or intoxicated to respond
- The person is enclosed in a small space with no exit
- The person has a weapon
- Call for immediate assistance (senior worker or supervisor; police; security personnel, etc), clear the room of other workers, clients or bystanders and wait for assistance to arrive.

De-escalation techniques: initial approach

- ✔ Quickly scan the immediate vicinity and observe the location of duress alarms, exits, bystanders, and potentially dangerous objects to judge immediate risks and decide upon the most suitable approach.
- ✔ One person only should take control of the situation and undertake all communication with the person.
- ✔ The communicator should place other workers on stand-by. Have another staff member present to observe or step in; use a code word to call for assistance from the observer.
- ✔ Usher bystanders from the immediate environment, stop others entering and create some physical space.
- ✔ Consider removing potential, personal hazards such as necklaces, eyeglasses, pens and keys.
- ✔ Adopt an open body posture (ie arms by sides, palms forward, move slowly).
- ✔ Always approach the person from the front or the side so that you can be seen.
- ✔ Be aware of your eye contact — not too much (appears threatening) or too little (implies indifference or untrustworthiness)
- ✔ Ensure that a safe distance is maintained as the person will need a larger area of personal space than usual.
- ✔ Sit if the person sits, stand if the person stands, and walk if the person walks.

No response? Continues to be aggressive?

- Is the safety of workers, bystanders or the person at risk? If yes,
  TELEPHONE THE POLICE on 000 and state:
  1. your name, name of your organisation and exact location
  2. the exact nature of the situation including the number of bystanders, if and what threats have been made, presence of weapons, and any other relevant information
  3. clear the location of workers and bystanders and await police arrival.

- Immediate assistance to workers or others, incident report, formal review, service user re-entry plan.