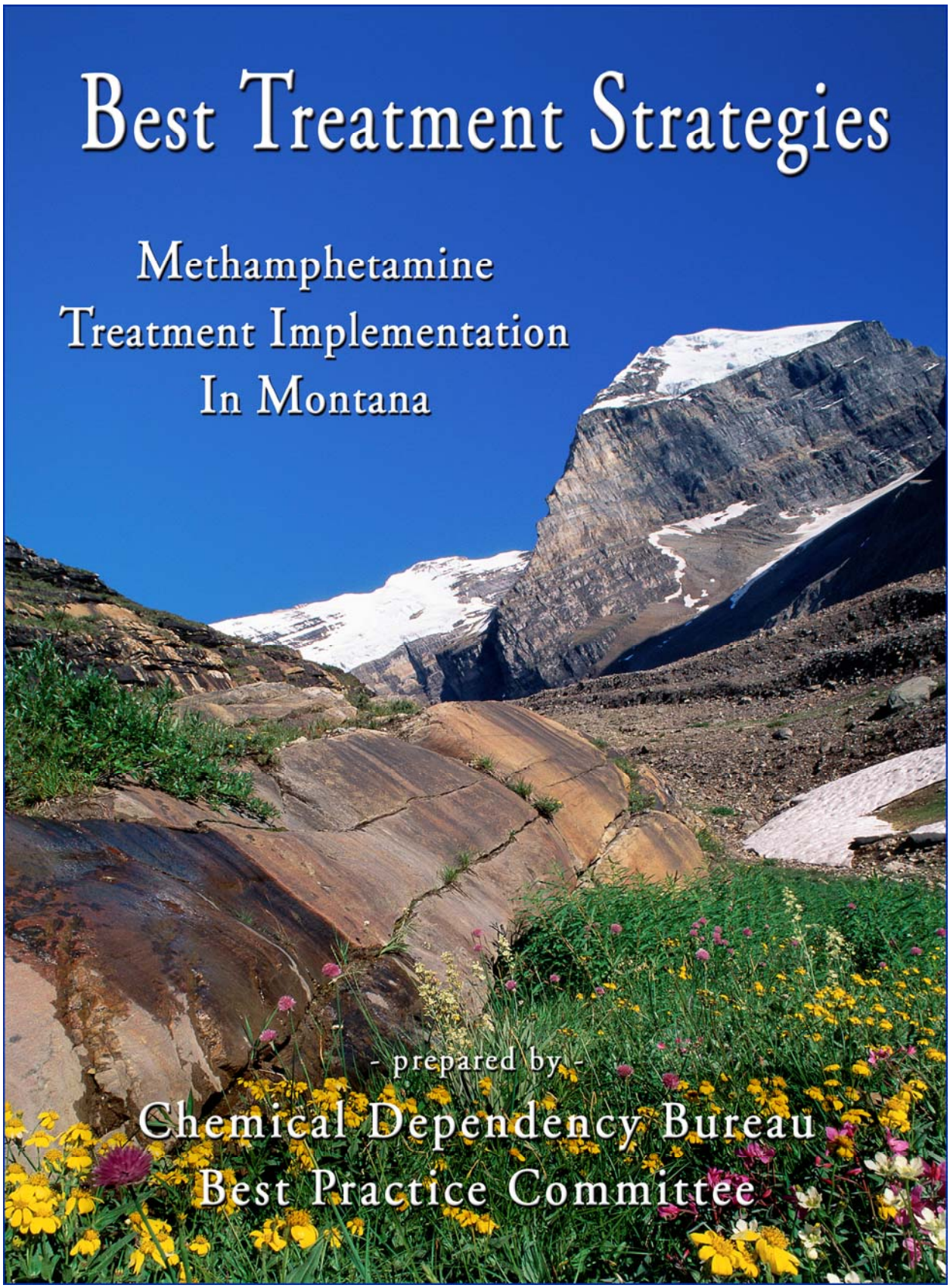
Best Treatment Strategies

Methamphetamine Treatment Implementation In Montana



- prepared by -

Chemical Dependency Bureau

Best Practice Committee

BEST TREATMENT STRATEGIES FOR METHAMPHETAMINE TREATMENT IMPLEMENTATION

In January, 2006, the Chemical Dependency Bureau, under the leadership of Joan Cassidy, Chief, appointed a Best Practice Committee of treatment providers from throughout Montana. Thus began an initiative by the Bureau to identify current best and promising practices in the treatment of Montana's methamphetamine epidemic.

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June, 2006

BEST TREATMENT STRATEGIES FOR METHAMPHETAMINE TREATMENT IMPLEMENTATION

About Methamphetamine Addiction

Our clinical experience, which is supported by national research, indicates clients who are addicted to methamphetamine and their families have some unique needs that should be acknowledged during assessment and treatment. Methamphetamine addicts can present as malnourished, medically ill, confused, paranoid, irritable, depressed and psychotic. Their initial presentation for services may be following multiple days without sleep. In addition, their ability to process information, make decisions, regulate and express emotions can be significantly compromised. During the initiation of the abstinence phase of treatment, methamphetamine addiction is typically accompanied by intense cravings, as well as emotional and physical discomfort. These issues may make retention in care a challenge and a primary goal. Some of these issues contribute to the misperception that methamphetamine addicts are unlikely to benefit from care and increase the stigma about this addiction. It should also be noted that as with any disease, there is a continuum of severity ranging from mild to severe methamphetamine dependence. Symptoms will, accordingly reflect where in the continuum the client is.

Our hope is that this document will provide direction and tools to address the subtle and unique issues of treating people who are addicted to methamphetamine. It should be noted that the following recommendations encompass multiple effective addiction treatment practices, regardless of the client's drug of choice.

Overview

These guidelines focus on how to use what is known and supported by research to implement treatment for methamphetamine addiction. A major assumption of the Best Practice Committee is that abstinence from all mood altering substances is the goal of these treatment strategies. The Committee also takes the position, based upon research that the availability of a continuum of levels of care including medical services and, at a minimum, supportive services that address legal problems, employment issues and that provide social resources are essential to the treatment of stimulant use disorders and methamphetamine in particular. Another important consideration is the need for both initial assessment of the client as well as on-going re-assessment to assure the client is placed in the level and setting of treatment that is most needed. Individuals addicted to methamphetamine, perhaps more so than any other addiction, frequently require a period of stabilization and medical intervention before they can be successfully treated in outpatient levels of care. The literature is clear about the need for biopsychosocial treatment for addiction.

Methamphetamine clients need the range of services and continuum of care represented in biopsychosocial treatment for optimum results.

There is little empirical evidence regarding the appropriate duration or frequency of treatment or session formats in delivering care. Research indicates the longer the engagement of the client in a continuum of care, the more likely the client will be to experience a positive outcome. This does not mean that all treatment is delivered in a single service or at a single level of care. It is well established that people with methamphetamine addiction have a need for very structured outpatient services of significant frequency and duration, matched to the severity of their presenting problems. Briefer sessions initially may be needed until the client is past the most severe withdrawal symptoms. The Intensive Outpatient and Partial Hospitalization levels of care can be ideal for these purposes.

The Committee, relying upon the literature, has conceptualized the ideal treatment process as consisting of Pre-treatment and Stabilization [when indicated], followed by:

1. A treatment initiation phase
2. An abstinence attainment phase
3. A maintenance phase with long-term support.

These phases correspond to the organization of traditional treatment with Phase 2 representing the primary treatment phase and Phase 3 corresponding to the aftercare/continuing care phase.

The information that follows is organized according to these phases.

TREATMENT INITIATION

Major Considerations of Patients Seeking Treatment for Methamphetamine Abuse

In, the TIP-33, Treatment for Stimulant Use Disorders, the consensus panel indicates that an understanding of the reasons stimulant users seek help is a foundation for appreciating how to engage them in the treatment process. The panel contends that rather than seeking help to alleviate withdrawal symptoms as is often the case with cocaine abusers, the meth abuser is in severe emotional turmoil; they are unable to experience pleasure, suffer from paranoia, and cycles of depression and euphoria. These conditions serve to make the abuser very ambivalent; both wanting to stop but also resistant to implementing cessation. The intense craving that accompanies methamphetamine withdrawal reinforces the notion that nothing but more of the drug could alleviate craving. While in agreement with these suppositions, the Best Practice Committee also believes that the ability of the treatment provider to intervene and alleviate some of the foregoing withdrawal symptoms, can serve to motivate the client to engage in or remain in a treatment setting.

There are several considerations that need to be addressed by treatment providers to be successful in engaging the methamphetamine abuser into a stabilization or treatment setting. While some of these issues and approaches to care may seem basic, they represent potential barriers which if not identified and resolved, will prevent methamphetamine clients from initiating or engaging in treatment.

- Accessibility: This relates to hours of services, transportation to services, finances and childcare, all of the variables that may serve as a block to immediate access.
- Use Case Managers to provide early supportive services to assure client retention.
- All initial / early services should be focused on client retention.
- Telephone Inquires: The telephone must be answered without delay. The methamphetamine abuser will hang up if they are put on hold. In 45% of initial calls, it will be family members making the first inquiry. Treatment providers should permit family members to initiate appointments. There should be no “wrong way” to establish initial contact.
- Schedule initial appointments without delay within 24 hours of the initial call even if only a partial intake can be done.
- Call and pursue any no shows. The client must be convinced that you want them to engage in services.

- Use motivational approaches in individual and group sessions for those in early stages of change who are not ready to initiate treatment.

- Provide crisis resolution—the client must experience progress and believe that immediate attention will be given to critical medical and psychological / psychiatric problems. Provide a list of community resources that can give assistance for various crises and assure the client has the means to access these services.

Staff Behaviors to Enhance Initial Engagement and the Treatment Initiation Phase

Regardless of how defiant and difficult these patients can be staff needs to realize that they are probably frightened, disoriented and cognitively impaired. Therefore, the following staff behaviors are imperative.

- Professional demeanor and respect for the patient.
- Empathic concern
- Calmness, low key in demeanor and physical movements
- Do not fight resistance. [Roll with it, as in motivational interviewing]
- Cultivate the patient's readiness to change.

I. Treatment Initiation Phase

There are three crucial functions that must be performed initially in this phase of the treatment process:

- brief assessment
- resolving barriers [transportation, childcare, shelter, etc.]
- determining the initial treatment setting.

Brief Assessment

Within the first or second face to face contact with the client, the brief assessment is initiated. A primary purpose of this assessment is to identify the safety needs of the client. Recommended tools for this assessment appear in the appendix of this report.

If the client's cognition is poor, the counselor cannot accurately assess motivation for change and should not try to do so. The use of the Mini-Mental Status Examination is one tool that can be of assistance in ascertaining a gross measure of the cognitive status of the client. In this particular tool, [See appendix] scores of 25 or less indicate significant impairment and preclude undertaking treatment. Instead, a period of stabilization should be initiated. At this early phase, clinical assessments should be tailored to the clients capacity to report and attend and may need to be a series of brief interviews. [Washton and Rawson et al. 1991]
During this assessment, a determination should be made as to when the client last used substances including methamphetamine, the frequency of use, and the route of administration.

These may be important indicators of withdrawal potential and whether or not the client may need a stabilization level of care. The quality of sleep should also be assessed to determine whether the client is potentially sleep deprived.

The duration of symptoms such as lethargy, agitation, paranoia, and dysphoria once abstinence is initiated is about 15 days. The more severe the symptoms, the more likely the patient will need a stabilization and/or residential stay to remediate withdrawal and initiate treatment.

Other safety issues include the need to assess for suicidality or homicidality, aggressiveness, paranoia etc.

Living environmental must also be assessed. Is the environment safe? Is there a supportive family member available? Is there any domestic violence? Danger in the environment may point to a need for placement in a residential setting.

Assessing Medical Problems

Another function of the brief assessment at the treatment initiation phase is to evaluate the client for chronic medical conditions that may interfere with stabilization or treatment engagement.

The following are representative of such conditions:

1. Level and severity of malnourishment
2. Evidence of systemic infections [skin, injection sites etc]
3. Dental deterioration
4. Risk or presence of Hepatitis, HIV
5. Weight loss with sweats or chills
6. Pregnancy

Any multi-systemic bio-medical complications and/or pregnancy may indicate a need for immediate medical services.

It is essential that treatment providers have access to a physician, nurse practitioner or physician assistant at this phase of treatment to either assist with the medical assessment and/or to initiate medical services. Treatment providers may need to enter into agreements with healthcare providers who have these practitioners to augment their services.
While research has not yet established optimum lengths of stay, generally, the stabilization and/or treatment initiation phase could be expected to last from 2-4 weeks for methamphetamine addiction.

The substance use history needs to be evaluated to determine all substances involved in the patients addiction. Opioid and alcohol are common substances used by methamphetamine addicts.

Assessment for **cognitive problems** that may impair ability to gain from treatment will need to be conducted to establish the client's capacity for rational thought. Assessment of the client's executive functioning (the ability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behavior) is important at this time to ascertain whether it is sufficient to assure the

patient can plan, organize and execute a treatment regimen. Is the client able to attend to and retain information sufficiently to be placed in a more intensive level of care?

Dimension five issues are also a focus of evaluation during this phase to determine placement of the client. Initial dimension five considerations should include assessing for the intensity of symptoms—either drug-related or psychiatric or both and the intensity of cravings. Determining the client's ability to maintain abstinence outside a 24 hour structured environment is also necessary.

Finally, evaluation of the **recovery environment (Dimension 6)** should be undertaken to assess financial conditions and the degree of family support and involvement in the treatment process.

Based on the assessment in this phase, [See appendix for decision tool] a decision needs to be made regarding treatment level and services. More so than any other client, individuals addicted to methamphetamine may need a stabilization setting for assistance with the crash phase of withdrawal. If the patient's cognition is significantly impaired and craving, agitation, etc., are likely to interfere with engagement, referral to a stabilization setting such as detoxification, or short-term residential care will be important.

Clients who do not exhibit significant cognitive impairment, urgent medical or withdrawal symptoms may be appropriate for less intensive motivational sessions designed to engage them in treatment

If the client evidences mild symptoms and ambivalence and is cognitively able to enter into intensive outpatient treatment, more frequent and briefer sessions may be appropriate.

In the Appendix section of this report, the reader will find a list of recommended tools that can be used to evaluate the cognitive functioning and mental status of clients who are addicted to stimulants and other substances that cause significant injury to the brain. The tools referenced can be used by Licensed Addiction Counselors.

Guidelines for Stabilization Settings

When clients evidence a need for an initial stabilization level of care, it is generally due to acute withdrawal symptoms and/or cognitive impairments. Following are some general guidelines that should govern this level of care.

Because withdrawal and stimulant-related dysphoria and depression can be particularly severe in methamphetamine abusers, the risk of suicide is intensified and careful management is essential. If there is continuing agitation and persistent inability to fall asleep during withdrawal, the use of sedating medications with low abuse potential should be considered.

An awareness of and procedures to reduce the risk of violence including staff training is essential. Staff must be prepared for the paranoia, aggression and violence that often accompany methamphetamine use. As a result, staff should:

- Keep the client in touch with reality in a low key manner by using the client's name, staff should identify themselves in any interaction and anticipate the client's concerns.

- Place the client in a quiet, subdued environment with only moderate stimuli. Make sure there is sufficient space so the client does not feel confined and have the door readily available to both staff and client assuring the client does not get between staff members and the door.

- Acknowledge agitation and potential for escalation into violence by reassuring the client that they are aware of their distress; asking clear simple questions; tolerating repetitive answers; and remaining non-confrontational.

- Foster confidence by listening carefully and remaining non-judgmental and reinforcing of the client's progress minimal as it may appear.

- Assure there are no objects in the room that can be used as weapons and make sure the client has no weapons in their possession.

- Have a backup plan and procedures in the event of violence. A simple plan is that of securing the client within the room while staff call for emergency personnel. Train staff to function as a team to manage volatile clients.

- Staff should be trained to be attentive at all times and in methods for assuring their personal safety.

Strategies for the Treatment Initiation Phase

The following strategies should be incorporated into this phase of treatment:

Contingency Management: Grounded in social learning theory, and supported as a Best Practice, the purpose of contingency management is to provide incentives and rewards for treatment and behavioral compliance. The earlier Contingency Management is initiated, the more likely the treatment provider is to engage the patient. Rewarding the client for remaining in the stabilization environment, attending motivational groups etc is a powerful tool for enhancing client motivation and retention at this phase of treatment.

- ❑ Immediately promote abstinence from all mood altering substances and employ contingency management to assist in reinforcing abstinent behavior.

- ❑ Conduct random drug screening and use contingency management to support clean drug screens.

- ❑ Assist the client in using daily schedules and planners to improve executive functioning and to begin to normalize daily routines.

II. Tasks and Modalities for Attainment of Abstinence Phase

Assessment should be on-going throughout the phases of treatment. Cognition and executive functioning in particular need re-evaluation as phases change to assure the client's ability to receive and process information. Protracted withdrawal symptoms may continue to hamper the client from 90-120 days after cessation of use. Such symptoms may pose a risk for relapse if not evaluated and managed. Initiate as appropriate, anti-craving medications and monitor the client's status to assure craving does not sabotage the early phases of treatment.

- ❑ Assess for and educate the client about **stimulant-associated compulsive sexual behavior** and directly address this issue by initiating a sexual abstinence period. Clients need to see sex as a major trigger and understand the concept of reciprocal relapse—engaging in any other compulsive behavior becomes the trigger for the initiating the primary problem.

- ❑ Program Orientation: Orientation should be kept simple and repeated over time as the client's mental status and memory improves.

- ❑ Use daily planners to minimize "down" time and boredom which are powerful relapse triggers.

- Keep group sizes small and reduce isolation. The use of a buddy system [senior peer] can be an aid in achieving this.

- Family involvement [unless contraindicated] in the treatment process is essential. There is considerable empirical evidence regarding the link between family involvement, relationship counseling and positive treatment engagement and outcomes.

- Psychoeducation sessions should include information about stimulant use disorders, symptoms, and the impact of these substances on the brain and cognition. The stages of treatment and recovery should also be part of the educational content. Early on, it is helpful to the methamphetamine client to have a mix of videos and interactive presentations and brief didactic lectures and materials that do not require considerable reading.

- Controlling and managing craving is an essential task. At the time of the publication of this clinical guide the only drug shown to be effective for methamphetamine craving is Bupropion.

- Continue to use and expand contingency management based upon the client's progress.

- Use initial and on-going action planning to deal with triggers and cues. Have concrete plans for removing drugs and paraphernalia from the home environment, and specific plans for the client to avoid high risk places, people and things. Begin developing basic refusal skills.

- Establish social support systems including the twelve step programs and the use of peer support.

- Provide family therapy. Family should be actively participating in treatment at this phase. Adjunctive family therapy and/or couples therapy are modalities that are important and which need to be available. However, timing of the initiation of these modalities is important. As is the case in all phases of treatment for the methamphetamine client, services need to be paced according to the ability of the injured brain to process and participate. Family therapy beyond crisis resolution and participation in active drug treatment needs to wait until cognitive impairments are remediated and active drug treatment is well along; if not into the continuing care phase. Behavioral Couples Therapy is a CSAT-developed modality for couples in early stages of recovery from addiction that should also be considered for inclusion in family services.

- Respond to early lapses and see them as opportunities for learning for the client. Directly and immediately address lapses and use techniques such as the behavioral chain analysis from Dialectical Behavioral Therapy [DBT] to help the client understand the process of relapse, cues and triggers. Nodelink mapping is another tool for this purpose (appendix).

- Recreation and leisure education is an important component of treatment at this phase and serves to provide healthy opportunities for leisure time. Closely related to this modality is the promotion of a balanced lifestyle with nutrition and exercise as key components.

- Address substance induced disorders, co-occurring disorders, and any symptoms that may be interfering with treatment. This also may include medication compliance.

- ❑ Address and practice management of high risk situations for the client as they surface during the treatment process.

- ❑ Teach Functional Analysis. This is an exercise aimed at helping the client understand the purpose his/her addiction serves in their life. A suggested framework for this is provided in the Appendix.

- ❑ There are predictable relapse scenarios that are well supported in the research that need to be addressed in this phase of treatment and which will be a main focus of the Maintenance of Abstinence phase of treatment. [Continuing Care]

Three particular risk factors for relapse must be countered:

Euphoric Recall
Desire to test control [return to social use]
Unanticipated Events

The counselor needs to be very aware of these risk factors and prepared to directly address them throughout this phase of treatment.

Re-assessment of the client in this phase should be aimed at dimension five issues including:

- ❑ Identification of the client's ability to assess personal relapse issues.

- ❑ Identification of personal triggers, [internal and external], and high risk situations.

- ❑ Does the client understand relapse as a process versus an event?

- ❑ Determine the client's ability to apply relapse prevention and coping skills.

- ❑ Assess the status of any substance induced disorders, co-occurring disorders and capacity for medication compliance.

- ❑ Evaluate severity of any tendency to anti-social behaviors.

- ❑ Identify patterns of self-sabotaging behaviors or any self-harm behaviors and/or defenses.

- ❑ Assess and address Axis II diagnoses or behavioral traits that may interfere with maintenance and long-term recovery.

- ❑ Present the possibility that all relapse triggers cannot be anticipated and major events can precipitate powerful cravings.

Other recovery environment considerations at this stage include vocational/educational referrals, resolution of legal problems and the status of the environment the client is living in or will return to. e.g. family support etc.

III. Maintenance of Abstinence with Long-Term Support Phase (Continuing Care Services)

Relapse prevention and other treatment methods during this phase of treatment includes a continuation of urine drug screening and contingency management and mutual self-help groups. The application of cognitive behavioral strategies such as DBT skills should continue to be reinforced during this phase as well.

Since relapse prevention skill building is the major focus of this phase, it may be necessary to correct staff myths and misconceptions about relapse:

- Relapse is not necessarily a sign of poor motivation.
- Relapse is not necessarily a sign of treatment failure.
- Relapse is predictable and avoidable.
- Relapse is not a single event, it is a process.
- Relapse does not erase the positive gains from recovery efforts and changes.
- The absence of relapse does not guarantee successful recovery.

The more interactional the relapse prevention skill building sessions are, the more effective they are likely to be. The client needs to draw from his/her own experience with triggers and cues to be able to apply the new skills being learned to high risk situations. The client and treatment staff should proactively discuss abstinence violation effects. [Marlatt]

A main function of this phase of treatment is to systematically teach the client:

1. How to cope with substance craving.
2. Refusal and assertiveness skills.
3. Decision-making skills-how seemingly incidental decisions can lead to relapse.
4. General coping and problem solving skills.
5. How to apply strategies to prevent a full-blown relapse should an episode of use occur [Marlatt and Gordon].

While traditional continuing care or aftercare services are thought of as addressing relapse, “Relapse Prevention” as a modality affords a more highly concentrated dose of skill building and practicing sessions. Some treatment providers may chose to incorporate this modality into their existing continuing care program while others may elect to offer it as a specialty program. When offered separately, it may afford more support in the early recovery period with more sessions per week.

At a minimum, treatment providers will want to plan curriculums to address the predictable relapse scenarios that are well supported in research:

1. Return to substance-using friends.
2. Sexual behavior associated with use [e.g. pornography].
3. Craving.
4. Negative affective states such as loneliness, anger, boredom, depression.
5. Alcohol or other substance use [e.g. alcohol] leading to stimulant relapse.

In the appendix of this publication are exercises and worksheets that can be used to implement relapse prevention skill building. There are more worksheets in TIP 33.

SUMMARY OF
BEST TREATMENT STRATEGIES FOR
METHAMPHETAMINE TREATMENT IMPLEMENTATION

The following issues and modalities are well supported in the literature as best practices. The committee agreed to include these modalities as representative, not exhaustive, of the most common practices that enhance treatment for methamphetamine addiction.

Relationship Counseling

Relationships can be both the foundation for support in recovery and/or a primary relapse trigger. The literature is very clear about the need to include couples, family therapies. Couples Behavioral Therapy [CBT] developed by CSAT is useful to couples in early recovery. A word of caution however, couples or Concerned Significant Other (CSO) therapy should never be undertaken if there is domestic violence occurring.

Pharmacotherapy

The efficacy of medications for co-occurring disorders, for craving, and to assist with withdrawal are all well documented. Methamphetamine abusers in particular need the benefits of these medications if they are to be successful in achieving and maintaining abstinence. This pre-supposes that treatment providers have linkages with medical personnel who can provide these services. When used for the addicted population, it is essential, to the greatest extent possible, that non-addicting or mood altering medications be used. This means the use of benzodiazepines, for example, be limited to brief detoxification or stabilization. Especially in the rural areas staff will need an understanding of basic pharmacologic strategies based on current evidence.

Length of Stay

The longer the engagement of the client in a continuum of care, the more likely the client will be to experience a positive outcome. This does not mean that all treatment is delivered in a single service or level of care. Research done on Family Drug Courts by Brenda Roche, Ph.D. indicates that a course of treatment spanning fifteen months appears to be highly associated with positive treatment outcomes for individuals involved in the justice system. Disincentives to long-term low intensity services need to be removed to assure these services for this population.

Contingency Management

The use of vouchers, points, or other structures to reward progress and positive behaviors is perhaps the single most effective tool that can be implemented in addiction treatment. To be effective, rewards must be frequent, particularly in the early phases of treatment. (See appendix for definition and examples).

Drug Screening

Random and for cause drug screening should be incorporated into each phase of the treatment process with greater frequency in the early phases. When paired with contingency management, drug screening is highly effective in promoting abstinence.
Quality urine drug screening with the availability of confirmatory testing is required.

Motivational Interviewing

This strategy aims at helping the client evaluate his/her need for services and resolve ambivalence about entering into treatment, attaining abstinence and related issues. It is the foundation for evaluating the stage of change the client is in and can be effectively used for clients in early stages of change in group sessions.

Drug Courts

Drug courts in general have a long track record of efficacy for addressing addiction in special populations. Considerable research has been conducted over a relatively long period of time that supports this as the most innovative and effective intervention in the criminal justice system. There are many different types of drug courts but all are governed by the same ten principles. Montana currently has two youth drug courts in Missoula and Great Falls and four family drug courts; Butte, Billings, Lewistown, and Miles City. Adult criminal courts at the present include two misdemeanor drug courts which also serve DUI offenders in Billings, and Kalispell. Bozeman's treatment court serves misdemeanors, felonies and has a pilot program for third offense DUI.

Case Management

Case management professionals can provide more than just ancillary or paraprofessional services within the biopsychosocial model of care. Client, strength based case management provides a full continuum of support and treatment enrichment by facilitating accountability, providing continuity of care, and bolstering client engagement. Effective case management does not exist autonomously of traditional service delivery systems; rather it integrates, expands, and valuates standardized approaches to patient wellness. Of equal value to client recovery enhancement, proactive case management can also provide the medium through which reliable and valid measurement of outcome efficiency can be demonstrated, lending credibility to programs and services by ensuring the utilization of best practices and guaranteeing responsive and accountable systems of service delivery.

Biopsychosocial Care

Montana has adopted the Patient Placement Criteria, published by the American Society of Addiction Medicine. These criteria are based upon a biopsychosocial model of care. Methamphetamine addicts are most likely to need all of the services of such a model of care due to the severity of their addiction. The challenge of implementing this model is particularly acute for rural providers where medical, addictionists and psychological resources and other professional staff are scarce.

Relapse Prevention

As used here, relapse prevention refers to a modality of care that focuses on teaching skills to clients to assist them in maintaining an abstinence-based recovery. The focus of group sessions is entirely on relapse and exercises and skills to avoid it.

Trauma Informed Therapy

This modality recognizes that most of the addicted population have experienced trauma which may have set them up for their addiction or traumatic events surrounding their involvement with substances. The importance of trauma as a trigger to relapse is the rationale for including this modality as a best practice. Pharmacotherapy combined with evidenced based psychotherapy is a key element of the management of trauma.

Cognitive Behavioral Therapy

Cognitive behavioral groups are particularly appropriate in early recovery. Cognitive processes include thoughts, beliefs and decisions. Cognitive behavioral therapy groups work to change learned behavior by changing thinking patterns, beliefs and perceptions.
It should be noted that Dialectical Behavioral Therapy (DBT) is a form of Cognitive Behavioral Therapy.

Client Retention

The treatment provider must address the concrete needs of the client and alleviate the negative impacts of unmet needs in core areas such as transportation, housing, financial assistance, childcare etc.

Exercise and Nutrition

The promotion of a healthy, balanced lifestyle that includes information on exercise and nutrition should be incorporated into each phase of the treatment process.

APPENDIX

Evaluating Severity of Symptoms for Placement

Evaluating Severity of Symptoms for Placement Purposes

We have indicated that it is essential to initially evaluate the severity of the client's symptoms to determine whether placement in a stabilization setting is indicated. The Matrix Risk Rating System from ASAM PPC-2R may be a useful tool for this purpose.

When used to evaluate symptoms initially for a stabilization setting, it will be important to assess the risk domains in Dimension I, III and IV, because these dimensions are frequently the source of greatest instability for the methamphetamine dependent client, and most likely to result in a need for a period of stabilization, before initiating treatment services.

The Matrix Rating System is:

Multi-Dimensional

- Provides benchmarks for:
    - Rating Risks
    - Determining priorities for services needed
    - Assessing intensity of services needed
- Provides individualized treatment by matching risk rating in each dimension with treatment modalities

Domains to be Evaluated Within Each Dimension

- Dangerousness/lethality
- Interference with recovery efforts
- Social functioning
    - Relationships
    - Work
    - School
- Ability for self-care
- Course of illness:
    - Frequency/intensity of symptoms
    - Chronicity

Using the Matrix

Step 1: Determine whether the patient has *immediate* needs due to imminent danger, as indicated by a Risk Rating of "4" in any of the six dimensions.

Step 2: If the patient is not in imminent danger, determine the patient's Risk Rating in each of the six dimensions. (Assess Dimensions 4, 5 and 6 separately for the mental and substance-related disorders.)

Step 3: Determine the Intensity of Service/Level of Service/ Setting by the highest Risk Rating across all the dimensions. (Consider, however, that the interaction of needs across all dimensions may require more intensive services than the highest Risk Rating alone.)

Step 4: Use the Multidimensional Risk Profile produced by this assessment to develop an initial treatment plan and placement recommendation.

Step 5: Make ongoing decisions about the patient's continued service needs and placement by repeating Steps 1 through 4. Keep in mind that movement into and through the continuum of care should be a fluid and flexible process that is driven by continuous monitoring of the patient's changing Multidimensional Risk Profile.

Recommended Cognitive Screening Instruments

The following instruments are all rated “B” which means an LAC with a four year college degree may administer, score and interpret the instrument.

Why Conduct Cognitive Screenings?

Cognitive screenings provide an estimate of an individual's neurocognitive and psychological status. These screenings are informative and work toward gaining a better understanding about how the individual's neurocognitive strengths and challenges interact with their psychological status to impact their day-to-day functioning.

- The areas that are screened in an adult include the following: intellectual ability (IQ), academic achievement, verbal and visual memory, attention, impulsivity, executive functioning (e.g., problem solving, initiation, working memory, cognitive flexibility, organization, monitoring self, etc), and mental health status.

The screenings provide valuable information regarding the adult's cognitive abilities that can drive therapeutic interventions or indicate the need for further evaluation. For instance, if an individual has significant difficulty with executive functioning and memory, those working with the individual need to realize that tasks such as keeping track of appointments, being able to make alternate plans when unexpected changes happen, problem solving, initiative, etc. are difficult for the individual. It is likely their behavior is not related to lack of motivation or non-compliance, but more related to cognitive deficits. If an individual has poor verbal memory but intact visual memory then those working with the person should make sure that information is provided visually as well as verbally. If a person has a co-occurring mental health disorder then all the professionals working with the individual need to make sure there is a plan to address the mental health issue as well as the chemical dependency issue. Also, a person with significant anxiety can look like they have Attention Deficit Disorder and can be misdiagnosed as such without a thorough evaluation to delineate what is really going on. Language disorders have also been common in the population. If a person has receptive language deficits they are not going to understand what is said to them and this can lead to many difficulties in treatment. If the providers are made aware of the language deficits they can better treat the individual. If the person has an expressive language disorder, they are going to have significant difficulty expressing themselves. This type of deficit has broad implications in treatment, and also needs to be addressed.

Once any areas of concern are identified, the providers can adjust their treatment approach and individualize the approach which is ultimately more effective. The dollars spent on a cognitive screening can save dollars in the long run because more efficient and effective treatment can be put in place earlier in the person's treatment. Another hypothesis is that, if we can identify the neurocognitive and mental health status earlier in treatment and address the issues identified, and incorporate the information into the ways we treat the individual, there will be a higher rate of treatment completion and lower drop out rate. The clients can also gain a better understanding of their strengths and challenges. Many clients think they are "crazy". Through gaining information from the cognitive screening process they can begin to understand why things have been so difficult for them in the past. Through ongoing screening and assessment, clients are able to attribute changes in their cognitive functioning to their sobriety which provides another level of affirmation for them about how substances impact their brains.

At Intake to determine if there needs to be a stabilization period before continuing with assessment:

Executive Functioning

Behavior Rating Inventory of Executive Function

The **BRIEF** consists of two rating forms: a Self-Report Form and an Informant Report Form designed to assess executive functioning. The **BRIEF** is useful in evaluating adults with a wide spectrum of developmental, systemic, neurological, and psychiatric disorders. The **BRIEF** is composed of 75 items within nine non-overlapping theoretically and empirically derived clinical scales that measure various aspects of executive functioning:

- Inhibit
- Shift
- Emotional Control
- Self-Monitor
- Initiate
- Working Memory
- Plan/Organize
- Task Monitor
- Organization of Materials

Time: 10-15 minutes to administer; 15-20 minutes to score.
Cost: Kit (manual, 25 Self-Report Forms, 25 Informant Forms, 25 Self-Report Form Scoring, Summary/ Profile Forms, and 25 Informant Forms Scoring Summary/Profile Forms) =$189.99; **BRIEF** Self-Report or Informant Forms (pkg/25) =$45.00, 2+ pkgs=$43.00 each, 5+pkgs= $42.00 each; $29.00 or 5+ pads=$28.00 each.
Purchase from: PAR
Qualification Level: B

Mini-Mental State Examination – Adults (MMSE)

The **MMSE** is a brief, quantitative measure of cognitive status in adults. It can be used to screen for cognitive impairment, to estimate the severity of cognitive impairment at a given point in time, to follow the course of cognitive changes in an individual over time, and to document an individual's response to treatment. The **MMSE** has demonstrated validity and reliability in psychiatric, neurologic, geriatric, and other medical populations. The convenient "all in one" test forms includes a detachable sheet with stimuli for Comprehension, Reading, Writing, and Drawing tasks. The form also includes alternative item substitutions for administration in special circumstances.

Time: 10-15 minutes to complete.
Cost: Kit (manual, 50 test forms) = $115.00; MMSE Test forms pkg 50 = $53.00
Purchase from: PAR
Qualification Level: B or S

Cognitive Estimation Test (CET)

This test is used to assess the ability to generate effective problem-solving strategies. There is no commercial source. The examiner provides the sheet containing the test questions and requests that the patient complete the questions with "best guesses" in the spaces provided. There is no time limit.
Scoring: Each response is compared with answers provided on the Deviation Scoring sheet. The total deviation score is computed by summing item deviation scores for all 10 CET items. Thus, higher deviation scores imply more impaired performance.

Please answer the following questions in the space provided. Although you may not know the exact answer, make a best guess. Be sure to complete all items.

1. How tall is the Empire State Building? _____ feet
2. How fast do race horse gallop? _____miles per hour
3. How long is the average necktie? _____ feet _____ inches
4. What is the average length of a man's spine? _____feet _____inches
5. How tall is the average woman? _____feet _____inches
6. How heavy is a full grown elephant? _____pounds
7. How much does on quart of milk weight? _____pound(s)
8. How fast does a commercial jet fly? _____miles per hour
9. On the average, how many TV programs are there on any one channel between the hours of 6pm and 11pm? _____
10. What is the average temperature in Anchorage, Alaska on Christmas Day? _____ degrees F.

Total Deviation Score= _____

Response	Deviation	Response	Deviation
Empire State Building		Elephant Weight	
<78	2	< 500	2
78 - 499	1	500 – 1000	1
500 – 3555	0	1001 – 4999	0
3556 – 66900	1	5000 – 20880	1
> 66900	2	> 20880	2
Race Horse		Quart of Milk Weight	
< 5	2	< 0.3	2
5 - 20	1	0.3 – 0.99	1
21 – 49	0	1.0 – 2.2	0
50 – 100	1	2.3 – 5.0	1
> 100	2	>5.0	2
Necktie Length		Speed of Commercial Jet	
< 10.5	2	< 83	2
10.5 – 18	1	83 – 250	1
19 – 47	0	251 – 787	0
48 – 70	1	788 – 6720	1
> 70	2	> 6720	2
Spine Length		Number of TV Shows	
< 12	2	< 1.3	2
12 – 24	1	1.3 – 5.0	1
25 – 42	0	5.1 – 9.9	0
43 – 64	1	10 – 88	1
> 64	2	> 88	2
Height of Woman		Temperature in Anchorage	
< 60.5	2	< -37	2
60.5 – 64.0	1	-37 - -10	1
64.1 – 65.9	0	-9 - +32	0
66.0 – 68.0	1	+33 - +59	1
> 68	2	> 59	2

Norms:

Educational Level	Mean Deviation Score	SD
≤ 12	5.9	2.3
13 – 15	4.8	2.1
16	4.2	2.4
17 – 18	3.8	1.9
≥ 19	4.2	2.0

Time: Approximately 5 minutes

Beta III (B)

Obtain a quick measure of nonverbal intellectual abilities. The Beta III provides a quick assessment of adults' (ages 16-89 years) nonverbal intellectual abilities. It is easy to administer and score and is useful for screening large numbers of people when administering comprehensive test batteries would be time consuming and costly. It is especially useful when assessing low-functioning or low-skilled individuals. Beta III can be administered to groups or individuals. Beta III is easy to use. Technicians, paraprofessionals, and others in the fields of psychology and education can administer Beta III with training and supervision. It is easily hand scored with a key.

Extensive reliability and validity studies were conducted with Beta III. The normative sample included 1,260 adults. Validation data were collected using individuals with mental retardation and more than 400 prison inmates. The standardization sample was stratified by age, gender, race/ethnicity, educational level, and geographic region according to 1997 U.S. census data. Beta III was validated using other well-known tests, including the WAIS® - III, ABLE-II, Raven's Standard Progressive Matrices, Revised Minnesota Paper Form Board Test (RMPFBT), Personal Tests for Industry-Oral Direction Test (PTI-ODT), Bennett Mechanical Comprehension Test® (BMCT®), and Revised Beta Examination, Second Edition (Beta II).

Appropriate uses for the Beta III include prison systems assessing the intellectual ability of inmates, companies evaluating the employment readiness of potential new hires, and vocational schools determining placement of students. Beta III also is appropriate for use with ESL individuals, as no reading is required. Administration instructions are available in English and Spanish. Four subtests have been retained from Beta II: Coding, Picture Completion, Clerical Checking, and Picture Absurdities. Matrix Reasoning, a measure of fluid reasoning, is new to Beta III.

Time: 30 minutes
Cost: Kit (includes Beta III Manual, 25 Response Booklets, and Scoring Key) = 199.00
Purchase from: PAR
Qualification Level: B

Shipley Institute of Living Scale

This popular measure of intellectual ability and impairment has been used with millions of individuals 14 years of age and older. The Scale is composed of two brief subtest: (1) a 40-item Vocabulary Test that requires the respondent to choose which of four listed words "means the same or nearly the same" as a specified target word; and (2) a 20-item Abstract Thinking Test, which requires the respondent to fill in numbers or letters that logically complete a given sequence.

The *Shipley* is based on clinical and research findings suggesting that intellectual impairment differentially affects various cognitive abilities-vocabulary has proven relatively resistant to change, whereas abstract thinking has been shown to be more susceptible to cognitive deterioration associated with brain dysfunction, mental disorders, or normal aging. The Shipley measures the discrepancy between vocabulary and abstract concept formation, providing a useful measure of cognitive impairment. In addition, it is widely used as a convenient intelligence measure because it is self-administering and brief (each subtest has a 10- minute time limit), and can be individually or group administered.

The Scale produces six summary scores:

- Vocabulary Score
- Abstraction Score
- Total Score
- Conceptual Quotient (an index of impairment)
- Abstraction Quotient (the Conceptual Quotient adjusted for age)
- Estimated Full Scale WAIS or WAIS-R IQ Scores

The Manual provides standard scores, updated norms (age 16 and up), a new impairment index with empirically derived corrections for age and education, age-adjusted norms for estimating WAIS and WAIS-R IQs, and a complete review of the *Shipley* literature. In addition, the WPS AutoScore™ Test Form makes administration and scoring very easy. The examinee marks his or her answers on the top sheet of this convenient carbonized form. When the top sheet is removed, correct answers and scoring instructions appear alongside the examinee's responses. Handy look-up tables are also printed on the form, so you can quickly determine the Abstraction Quotient and estimated WAIS or WAIS-R IQ. Using the *Shipley* Disk, you can administer, score, and interpret the test on your own computer. You won't have to worry about timing the subtests because the computer will do it for you. If you prefer, you can administer the paper-and-pencil format and then enter the item responses or raw scale scores obtained by hand scoring the test. The program will generate a comprehensive report that summarizes tests results and provides useful interpretive information, such as protocol validity; profile of T-scores; 68% confidence intervals for Vocabulary, Abstraction, and Total Scores; a narrative discussion of the results with associated interpretive hypotheses; and estimated Full Scale WAIS and WAIS-R IQ scores.

The *Shipley* is one of those rare instruments that has withstood the test of time, and its growing use testifies to its value as a quick yet accurate measure of general intellectual functioning.

Cost: Kit includes 100 Test Forms; 1 Manual; 1 Hand Scoring Key; 2 WPS AutoScore™ Test Forms=$126.50; **WPS AutoScore™ Form** (Used in place of Test and Scoring Key) (Pkgs. Of 25) Quantity price break available= $48.00 or 2+ pkgs = $43.95 each
Purchase from: WPS
Qualification Level: B or S

MINI MENTAL EXAMINATION

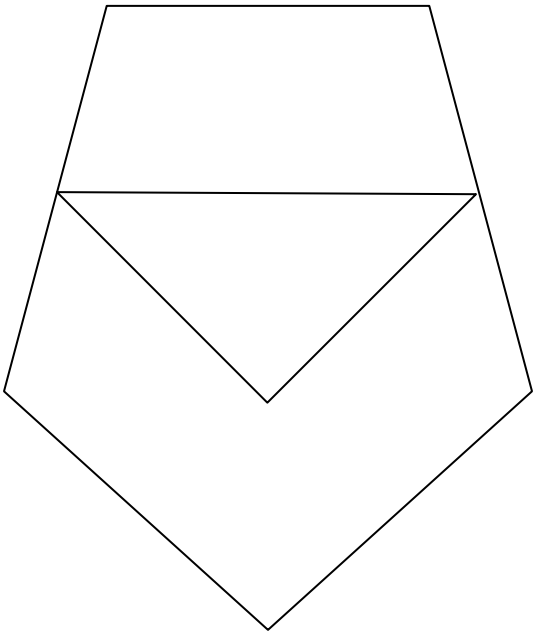
NAME _____

SCORE MAX	ACTUAL	
		1. ORIENTATION
5	( )	What is the (year) (season) (date) (day) (month)?
5	( )	Where are we: (state) (county) (town) (hospital) (floor)?
		2. REGISTRATION
3	( )	Examiner name 3 objects (1 second to say each). Ask the patient to repeat all three. Give one point for each correct answer. Repeat them until patient learns all three. Count trial and record.
		3. ATTENTION AND CALCULATION
5	( )	Serial 7's. Begin with 100 and count backward by 7, one point for each correct. Stop after 5 answers. Spell "World" backward.
		4. RECALL
3	( )	Ask for the 3 objects in #2 – to be repeated. Give on point for each correct response.
		5. LANGUAGE
6	( )	A. Show patient 2 objects – ask name of objects (ex: pencil and watch). One point for each correct answer. B. Repeat the following: "No ifs, ands or buts" (one point). C. Follow a 3 stage command (ex: "take a paper in your D. right hand, fold it in half, and put it on the floor"). 3 points

NAME _____

PATIENT WORKSHEET

SCORE MAX	ACTUAL	
3	( )	A. Read and obey the following: “CLOSE YOUR EYES”. (one point) B. Write a sentence. (one point) _____ _____ C. Copy design:



_____ Total Score Out of 30 points

Access level of consciousness along a continuum:
Alert Drowsy Stupor Coma

Recommended Screening Instruments For Common Co-Occurring Disorders

The Symptom Assessment – 45 Questionnaire

The SA-45 provides a quick, cost-effective, and comprehensive measure of psychiatric symptomatology. Using a 5-point level-of-severity scale, the SA-45 measures:

- Anxiety
- Hostility
- Obsessive-Compulsivity
- Phobic Anxiety
- Somatization
- Depression
- Interpersonal Sensitivity
- Paranoid Ideation
- Psychoticism

An index of Global Severity and a Positive Symptom total also can be obtained from SA-45. These indices are helpful in assessing overall symptomatology. Scored relative to a normative database of over 18,000 individuals, the SA-45 provides normative group-specific data for males and females, inpatients and non-patients, and adolescents and adults (ages 13 years and older). The SA-45 is a highly reliable and valid self-report measure that can be administered and scored by individuals who do not necessarily have advanced formal training in clinical psychology or psychometrics, making it especially easy to administer to large groups. In fact, it has already become a key component of the instrumentation employed in treatment outcome studies at over 100 behavioral healthcare facilities.

Time: 10 minutes
Cost: Kit (Technical Manual, 25 QuickScore™ Forms) = 86.00
Purchase from: PAR
Qualification Level: B or S

Beck Depression Inventory – II

Psych Corp
Qualification Level: C

Complete Kit: $79.00
Includes Manual and 25 Record Forms

Order Information:

Harcourt Assessment
19500 Bulverde
San Antonio, TX 78259
www.Psychocorp.com
1-800-211-8378

Beck Anxiety Inventory

Psych Corp
Qualification Level: C

Complete Kit: $77.00
Includes Manual and 25 Record Forms

Personality Assessment Screener

This self-administered objective questionnaire was developed with reference to its parent instrument, the Personality Assessment Inventory (PAI). The 22 PAS items are those items from the PAI that have been identified by extensive item analysis as the most sensitive to the broad range of contemporary clinical problems measured by the PAI. The items are organized hierarchically into 10 different "Elements" representing 10 distinct clinical problems domain:

- Negative Affect
- Psychotic Features
- Suicidal Thinking
- Anger Control
- Acting Out
- Social Withdrawals
- Alienation
- Health Problems
- Hostile Control
- Alcohol Problems

Time: (PAS) takes 5 minutes
Cost: Kit (manual and 25 Form HS Response Forms)= $85.00; PAS manual=$39; PAS Form HS Response Forms (pkg/25)=100.00
Purchase from: PAR
Qualification Level: B or S

Conners' Adult ADHD Rating Scales

Measures ADHD symptoms. Appropriate for use by a variety of health care professionals in outpatient clinic, private practice offices, and managed care settings. The CAARS contains both self-report and observer forms, providing a balanced, multimodal assessment of adult ADHD symptoms at home, at work, and in peer interaction. Both self-report and observer forms use a 4-point Likert-style format and are written at a 6th grade reading level. In addition, the CAARS contains a Long version, a Short version, and a Screening version. The long versions of the Self-Report Form (CAARS-S:L) and Observer Form (CAARS-O:L) provide comprehensive information along clinically relevant dimensions. The short versions of the Self-Report Form (CAARS-S:S) and Observer Form (CAARS-O:S) were designed to be brief and display key dimensions. The screening versions of the Self-Report Form(CAARS-S:SV) and Observer Form (CAARS-O:SV) contain the scales most relevant to clinical assessment of ADHD and require only 10 minutes for administration. Based on a large normative base of 2,000 community-bases, non-clinical adults, the CAARS provides age-and gender-based norms that you can compare to the CAARS results of respondents, aged 18 years and older. It is appropriate for use by a variety of health care professionals including psychologist, social workers, and counselors, and suitable for use in a variety of setting including outpatient clinics, private practice offices, and managed care settings.

Time: 10-15 minutes
Cost: Kit (includes CAARS Technical Manual and 25 QuickScore Forms for each of the following: CAARS-S:L, CAARS-S:S, CAARS-S:SV, CAARS-O:L, CAARS-O:S, and CAARS-O:SV= 299.00
Purchase from: PAR
Qualification Level: B

The COD Screening Tools

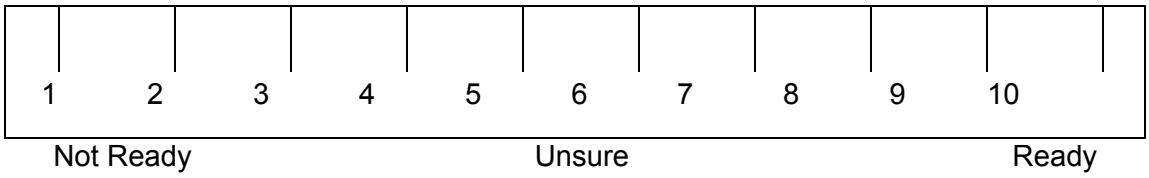
- Mental Health Screening Form III (MHSF)
  http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.section.77099

- Mini International Neuropsychiatric Interview (MINI) Screen Modified
  https://222.medical-outcomes.com/indexSSL.htm

Measuring
Readiness to Change

The TIP 35 Enhancing Motivation For Change in Substance Abuse Treatment contains the Readiness Ruler as well as the other tools listed in this Appendix

Figure 8-2
Readiness Ruler



ROLLNICK

Where are you on this scale with respect to:

- **Changing your drinking**
- **Changing your drug use**

Not Ready	**=**	**0-3**
Unsure	**=**	**4-7**
Ready to Change	**=**	**8-10**

What would it take to move from a _____ to a _____?

Where have you come from last year to now?

- **Clients can move both ways during treatment**
- **Clients cycle/spiral through change stages**
- **Use of decisional balancing can assist with ambivalence**

Readiness to Change Tools

- Alcohol and Drug Consequences Questionnaire
  http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.table.62219

- Alcohol and Illegal Drugs Decisional Balance Scale
  http://www.aa2.org/tools/stages_changes/decisionalbalance.htm

- Brief Situational Confidence Questionnaire
  http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.table.62275

- Personal Feedback Report

- Readiness to Change Questionnaire
  http://www.nzgg.org.nz/guidelines/0040/Appendix_3_change.pdf

- Situational Confidence Questionnaire
  http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.table.62296

- SOCRATES
  http://casaa.unm.edu/inst/socratesv8.pdf

- URICA
  http://www.vcu.edu/vattc/urica.html

- What I Want from Treatment
  http://casaa.unm.edu/inst/What%20I%20Want%20From%20Treatment.pdf

- What I Got from Treatment
  http://casaa.unm.edu/inst/What%20I%20Got%20From%20Treatment.pdf

- Readiness Ruler (2 versions)
  http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.61302
  http://www.motivationalinterview.org/library/readinessruler.pdf

Relapse Prevention Skill Tools

Client Worksheet 1

Daily Schedule and Planner

Date: _____

7:00 _____

8:00 _____

9:00 _____

10:00 _____

11:00 _____

12:00 _____

1:00 _____

2:00 _____

3:00 _____

4:00 _____

5:00 _____

6:00 _____

7:00 _____

8:00 _____

9:00 _____

10:00 _____

11:00 _____

- Do you have a clinic visit today? What time is the appointment?
- When will you have breakfast, lunch, and dinner?
- Are you going to work or school today? When are those commitments?
- When is your 12-Step or other self-help meeting?
- Have you scheduled time for exercise?
- Have you scheduled time for recreation and leisure activities?

Client Worksheet 2

Identifying External Cues and Triggers

Stimulant cues are those things in your life that remind you of stimulant use and can trigger drug hunger. Below are lists of people, places, events, objects, and activities. Check those items around which or whom you have frequently used stimulants. Within each list, circle the item that you think I s most strongly associated with your stimulant use.

People

☐ Drug dealers	☐ Friends	☐ Coworkers
☐ Employer	☐ Family members	☐ Spouse/ lover
☐ Dates	☐ Neighbors	☐ _____

Places

☐ Neighborhoods	☐ Friend's home	☐ Bars and clubs
☐ Hotels	☐ Worksite	☐ Concerts
☐ Certain freeway exit	☐ Bathrooms	☐ Stash storage place
☐ School	☐ Downtown	☐ _____

Events

☐ Meeting new people	☐ Group meetings	☐ Parties
☐ Payday	☐ Calls from creditors	☐ Before work
☐ During work	☐ After work	☐ Going out
☐ Before sex	☐ During sex	☐ After sex
☐ Anniversaries	☐ Holidays	☐ _____

Objects

☐ Paraphernalia	☐ Magazine	☐ Pornography
☐ Movies	☐ Television	☐ Cash
☐ Credit cards	☐ ATM machines	☐ _____

Client Worksheet 3

Identifying Internal Triggers

Stimulant cues can include certain feelings and emotions that can trigger drug hunger. Below are lists of emotions, feelings, and circumstances. Check those items that, in the past, have been associated with your use. Within each list, circle the item that you think may be the internal trigger with which you may struggle the most.

"Negative" Feelings

☐ Feeling afraid	☐ Feeling angry	☐ Feeling ashamed
☐ Feeling anxious	☐ Feeling criticized	☐ Feeling depressed
☐ Feeling guilty	☐ Feeling hateful	☐ Feeling inadequate
☐ Feeling irritated	☐ Feeling jealous	☐ Feeling left out
☐ Feeling overconfident	☐ Feeling overwhelmed	☐ _____

"Normal" Feelings

☐ Feeling bored	☐ Feeling embarrassed	☐ Feeling frustrated
☐ Feeling insecure	☐ Feeling lonely	☐ Feeling neglected
☐ Feeling nervous	☐ Feeling pressured	☐ Feeling relaxed
☐ Feeling sad	☐ Feeling tired	☐ _____

"Positive" Feelings

☐ Feel like celebrating	☐ Feeling confident
☐ Feeling excited	☐ Feeling exhausted
☐ Feeling happy	☐ Feeling "normal"
☐ Feeling passionate	☐ Feeling sexually aroused
☐ Feeling strong	☐ _____

- How do you feel immediately before using?
- Typically, how do you want to feel immediately before using?
- In the past few days, what were you feeling when you either used or wanted to use?

Client Worksheet 19

Fantasies About Controlled Use

After being in recovery for several weeks or months, you generally start feeling better. Although the healing process is just beginning, your thinking begins to be somewhat more clear, you are learning to experience and express your feelings more effectively, and you are learning problem-solving skills. A few or many of the negative consequences of your stimulant use are becoming less severe and numerous.

It is during these early recovery phases that you may have fantasies about being able to return to drug use. You may believe that if you made some changes, you could once again use drugs. You may tell yourself that if you are "careful" you could use without losing control. You may believe that you are ready to try using "one last time" to test whether you can use without losing control over use. These are called "fantasies of controlled use." They are classic warning signs of impending relapse.

If you experience fantasies of controlled use, you should immediately develop an action plan. This plan should include: (1) recognizing these as fantasies and rejecting them as options; (2) recognizing these as warning signs of impending danger; (3) immediately seeking a 12-Step sponsor, a counselor, or a recovering friend to speak with; (4) attending a 12-Step and recovery group meeting as quickly as possible; and (5) talking about these warning signs at the meetings.

- Have you ever thought about how nice it would be to use without all the adverse consequences?
- Have you ever thought about how good it would be to use but not lose control?
- Have you ever used drugs without eventually losing control, such as losing control over the amount of the drugs, the amount of money or time spent on the drugs, or on your stimulant-induced behavior?
- When you used in the past, what were some of the most troubling problems that you experienced as a result of your use?
- What is your action plan for dealing with the warning sign of fantasies of controlled use? What are the specific steps of your action plan?

Client Worksheet 28

Sample Behavioral Contract for Stimulant Abstinence

This is an agreement between _____(the client) and _____ (the clinician) to help _____ (the client) maintain abstinence from mood altering substances.

I request my counselor to establish a schedule for collecting urine specimens from me for 24 weeks. A clinical staff member of my sex will observe the urination. Samples will be assayed for a variety of drugs of abuse, among which are cocaine, amphetamines, opioid drugs, marijuana, and sedatives. Each specimen for the collection request will consist of 3 ounces of urine. If the quantity is insufficient for analysis, that shall be considered a failure to provide a scheduled sample.

If I travel out of town due to an emergency, I will inform my therapist in advance of leaving. My therapist is authorized to verify such absences with _____ [significant other, ect.]. If I require hospitalization, my therapist will arrange to collect urine samples in the hospital. It I am sick and do not require hospitalization, I will still arrange to produce scheduled urine specimens. If I have difficulties with transportation, or inclement weather makes it difficult to travel, I will arrange a way to get to the clinic for urine collection.

If for appropriate medical reasons, I am prescribed medication that is also a drug of abuse, I will provide to my therapist the name and phone number of my physician or dentist. I hereby give my therapist permission to contact my physician or dentist by phone and mail if I am given such a prescription. I agree to provide to my therapist a photocopy of the prescription or permit my therapist to see the prescription container. If the medication is appropriately prescribed, the appearance of the drug in urine tests will not be counted as relapse to drug use.

Drug-free urine samples

For each negative urine sample collected, _____ points will be earned. A voucher stating the earned points value will be presented to me following the collection of a drug-free sample. This voucher will specify the number of points earned for that day, as well as the cumulative points earned to date and their gift equivalent.

Client Worksheet 29

Components of a Functional Analysis

A functional analysis is a technique that can help you to understand your drug use so that you can engage in problem-solving solutions that will reduce the probability of future drug use. It allows you to identify the immediate causes of your drug use. A functional analysis is a method that helps you examine three aspects of your use:

- The types of circumstances, situations, thought, and feelings that increase the likelihood that you will use stimulants (triggers).
- The positive, immediate, and short-term consequences of your drug use.
- The negative and often delayed consequences of your drug use.

Triggers
In general, triggers are those circumstances, situations, people, locations, thoughts, and feelings that increase the likelihood that you will use drugs. They do not force you to use, but they increase the likelihood that you will use them.

Feelings and thoughts
When you encounter a trigger, you typically respond with certain thoughts and feelings regarding the immediate consequences of using, such as feeling better, having fun, or forgetting about troubles. You may think about the steps that you need to take to obtain and use drugs.

Behaviors
Once you are exposed to triggers, and after you start having thoughts and feelings about drugs, you engage in certain behaviors. One of those behaviors is using. However, through treatment, your use can be replaced with alternate coping behaviors.

Positive consequences
Almost immediately after using, you experience positive, strongly reinforcing consequences. Some of the positive consequences include feeling euphoric, having more energy, feeling more sexual, forgetting negative events or feelings, not feeling sadness or depression, or not feeling emotional pain. These positive consequences are generally immediate and short-term.

Negative consequences
Some of the negative consequences are experienced during or shortly after stimulant use episodes, such as spending too much money, engaging in high-risk sexual behavior, irritating or injuring others, or missing work or school. Many of the negative consequences are delayed or take a while to develop, such as damaged to family and social relations, financial health, emotional health, physical health, educational goals, vocational stability, and legal status.

Client Worksheet 30

Preparing To Conduct a Functional Analysis: Identifying Your Triggers

This worksheet should be completed before using Client Worksheet 32, *Conducting a Functional Analysis of Your Stimulant Use*, and Client Worksheet 31, *The Functional Analysis Worksheet*. This worksheet will help you to identify the circumstances, situations, people, locations, thoughts, and feelings that increase the likelihood that you will use drugs.

- List the places where you frequently used drugs:

- List the people with whom you frequently used or purchased drugs:

- List the times or days when you most frequently used drugs:

- List the kinds of activities in which you were typically engaged when you used drugs:

- List the feelings and emotions that you experienced after you were exposed to triggers:

- List the kind of things that you were thinking about after you were exposed to triggers:

Client Worksheet 32

Conducting a Functional Analysis of Your Drug Use

This worksheet is used in combination with Client Worksheet 31, *The Functional Analysis Worksheet.* It should be used only after completing Client Worksheet 30, *Preparing to Conduct a Functional Analysis: Identifying Your Triggers.*

Step 1
On the *Functional Analysis Worksheet*, in the column titled "Your behavior," briefly describe an example in which you recently used drugs.

Step 2
Think about what you were doing immediately prior to this episode of use. Can you remember who you were with, what you were doing, or the time of day? Place these in the "Trigger" column.

Step 3
Immediately prior to using stimulants during this episode, what were you thinking about? Do you remember what you were feeling? Place whatever thoughts and feelings that you can remember in the "Feelings and thoughts" column.

Step 4
What happened immediately after you used the stimulants? How did your mood change? Did you feel euphoric or powerful? Did you feel that you had more energy or power than normal? Did you feel happy or not as depressed as before? Did you stop feeling bad about something?

Step 5
What have been the long-term consequences of this and other episodes of drug use? How has it affected your relationships with friends? How has it affected your family? How has it affected your work or school situation? How has it affected your financial situation? How has it affected your emotional health? How has it affected your physical health?

Return to Step 1
Describe another example of relatively recent episode of use. Repeat all the steps as before. Repeat this until Client Worksheet 31, *The Functional Analysis Worksheet*, has been completely filled.

Client Worksheet 31

The functional Analysis Worksheet

Trigger	Feelings and Thoughts	Your Behavior	Positive Consequences	Negative Consequences

Client Worksheet 33

Functional Analysis: Important Points To Consider

You can quit
You can learn to stop using drugs. Other people with drug problems have been able to learn how to stop using.

Drug abuse is a learned behavior
It is important to begin thinking of your drug use as something you have learned to do. It is a learned behavior. Learning how to stop using does not require that you understand exactly how your problem began. Blaming other persons, events, or circumstances does not help you learn how to stop. But what is effective is learning that your drug abuse is a problem that you can do something about.

The goal is to learn to stop using and start living
One goal of t his treatment program is to help you learn how to stop using drugs. Another equally important goal is to help you learn how to live a drug-free lifestyle. You will obtain the most benefit from treatment if we can help you stop your drug use so that we can focus on helping you make other lifestyle changes that will promote long-term abstinence from drugs.

Slips are not treatment failures
Mistakes are preventable and should be prevented. But mistakes happen. If you use during treatment, you should not view it as failure. Rather, such incidents can be used to help you learn more about your stimulant use to that you can more effectively learn to stop using completely. However, it does not give you permission to use drugs.

Practice is important
You must learn to work on these new skills between treatment sessions. Learning and practicing new skills and behaviors is necessary. Talking about making changes is not sufficient to deal with high-risk situations. Rather, you learn by practice.

PROGRAM SELF ASSESSMENT FOR METHAMPHETAMINE CLINICAL PRACTICE GUIDELINES

Methamphetamine Treatment Clinical Guideline	**Policy Present (yes/no)**	**Implementation** **0-None** **1-Partial implementation** **2-Implemented**	**Evidence which supports policies and procedures are applied in service delivery (counseling and administrative staff interviews, file review, group observation, client interview)**
Early identification of clients who are seeking treatment for methamphetamine			
Biopsychosocial Model of Care			
Treatment defined in Three Phases: -Treatment Initiation -Abstinence Attainment -Maintenance Phase			
Access: initial appointments, screening and phone response times			
Engaging and Retaining clients in services			
Program Orientation			

Methamphetamine Treatment Clinical Guideline	**Policy Present (yes/no)**	**<u>Implementation</u> 0-None 1-Partial implementation 2-Implemented**	**Evidence which supports policies and procedures are applied in service delivery (counseling and administrative staff interviews, file review, group observation, client interview)**
Case Management- Assessment of need and assignment			
Referral process to a stabilization Setting			
<u>Stabilization Residential Only</u> Medical, emergency, physical setting, staffing pattern			
Cognitive Screening			
Retention in treatment including: follow-ups on no-shows, opposition to the recommended level of care.			
Assessment includes stage of change for each clinical problem			

Methamphetamine Treatment Clinical Guideline	**Policy Present (yes/no)**	**<u>Implementation</u> 0-None 1-Partial implementation 2-Implemented**	**Evidence which supports policies and procedures are applied in service delivery (counseling and administrative staff interviews, file review, group observation, client interview)**
Stage based treatment planning			
Contingency management			
Flexible length of stay, service design to facilitate long term engagement and support			
Family engagement			
Family counseling and education			
Cognitive Behavioral Therapies			

Methamphetamine Treatment Clinical Guideline	**Policy Present (yes/no)**	**Implementation** **0-None** **1-Partial implementation** **2-Implemented**	**Evidence which supports policies and procedures are applied in service delivery (counseling and administrative staff interviews, file review, group observation, client interview)**
Recreation and Leisure as part of the Service and Treatment Plan			
Motivational Interviewing			
Nutrition and exercise, assessment and referral			
Co-occurring screening, collaborative and/or integrated care			

Methamphetamine Treatment Clinical Guideline	**Policy Present (yes/no)**	**<u>Implementation</u> 0-None 1-Partial implementation 2-Implemented**	**Evidence which supports policies and procedures are applied in service delivery (counseling and administrative staff interviews, file review, group observation, client interview)**
Relapse/ abstinence violation. How is the treatment plan modified, program philosophy, ability to modify service intensity (frequency and duration).			
Urine Drug Screen-Clinical rational (non-punitive), how it is consistently communicated to the client. Positive screens, altered screens, refusal to test			
Trauma Informed Therapy			
Pharmacotherapy			
Delivery and presentation of educational material appropriate for the clients learning style and cognitive ability			

COMMENTS:_____

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Reviewed By_____ Date_____

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