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A Brief Cognitive Behavioural Intervention for Alternatives to Injecting: Therapist's Treatment

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A BRIEF COGNITIVE BEHAVIOURAL INTERVENTION FOR ALTERNATIVES TO INJECTING: THERAPIST'S TREATMENT MANUAL

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BACKGROUND

Transitions

One outcome of the human immunodeficiency virus (HIV) pandemic has been a shift in the emphasis of treatment interventions aimed at drug users from substance use *per se* to the methods by which people self-administer these substances (Darke, Cohen, Ross, Hando, and Hall, 1994). Researchers have become interested in the transitions between route of administration and reasons for making changes. Transitions to and from injecting have important implications for the spread of HIV, hepatitis C virus (HCV), and other blood borne viruses (BBV).

There have been a number of studies published that have examined transitions between routes of administration (e.g. Swift, Maher & Sunjic, 1999; Perez-Jemenez & Robert, 1997; Darke *et al*, 1994; Griffiths, Gossop, Powis and Strang, 1992, 1994; Des Jarlais, Casriel, Friedman and Rosenblum, 1992). In most instances, the transition is usually from a non-injecting route of administration (NIROA) to that of injecting. However, recent interest has focused on a different shift in drug use behaviour, whereby the transition is from injecting to NIROA; described by Strang, Des Jarlais, Griffiths, and Gossop (1992) as a "reverse transitions". Griffiths *et al* (1992) found that 34% of a sample (n=75) of heroin users in either in-patient or out-patient care reported transitions from injecting to NIROA.

Harm reduction

Preventing or reducing the level of injecting has been identified as a highly desirable method for controlling the transmission of BBVs (Des Jarlais, Casriel, Friedman and Rosenblum, 1992). Des Jarlais and Friedman (1988) also suggest that such an outcome may contribute to improvements in other health, social and psychological problems that are linked to injecting. Harm reduction need not necessarily require

any reduction in drug use, rather, its emphasis is primarily to reduce the problems associated with drug use rather than drug use itself (Heather, Wodak, Nadelmann and O'Hare, 1993).

Routes of administration

The following is a list of the primary routes of administration for heroin and amphetamine:

- **Injecting** – drug is dissolved and injected intravenously;
- "**Chasing the Dragon**" or "**spotting**" – the drug is placed on aluminium foil, the user applies heat to the underside of the foil while the user follows the smoke using a straw (or rolled up currency, biro container etc) and sucks into the mouth;
- **Snorting** – the user crushes a portion of the drug as fine as possible and places it in a line which the user inhales into the nose using a straw or rolled up note;
- **Smoking** – a small amount of the drug is placed on tobacco (or marijuana) and smoked in a pipe, bong or joint;
- **Shafting** – the drug is dissolved and placed in a syringe without the needle and inserted into the rectum where it is expelled from the syringe;
- **Swallowing** – the user takes the drug via the mouth.

INTERVENTION PROTOCOL

Format of therapy

The CBT intervention outlined here has its basis in a feasibility study of a CBT intervention for changing injecting drug users' (IDUs) route of administration to a non-injecting route of administration or *alternative to injecting* (ATI). To evaluate this intervention empirically, it will be necessary to adhere reasonably closely to the guidelines laid down in this manual. However, individual therapists may have reason to deviate from these guidelines to meet individual requirements, or, indeed, to improve upon this outlined intervention.

This CBT program for changing route of administration is based upon an outpatient treatment format, with individual client therapy. Individualised treatment was regarded as superior to a group format, as it allows the intervention to be tailored to meet the specific needs of each client. As this is a new approach to harm reduction for injecting drug users, refinement of the intervention based on the current feasibility study may lend itself to group therapy in the future.

Although an individualised approach is used, the program was designed to be administered according to a highly structured format. The general basis for the CBT program is identical for each group run in the program, but a limited choice of cognitive behavioural skills is available within certain sessions for the clients of each group to select, in consultation with their therapist, according to need. This provides the most appropriate balance between the need for a systematic intervention for evaluation purposes, and the flexibility desired for meeting separate group's needs.

Instructions for the delivery of the CBT intervention are outlined for each of the five therapy sessions in this manual. These instructions are intended as general guidelines, around which a therapist will be able to contribute according to his or her own style and experience. Also included in the session-by-session guidelines are

recommendations for the time that should be allocated to each component, and a list of materials (printed worksheets or handouts) that are required for each session. Copies of these session sheets are attached at the end of this document.

Timing and length of intervention

The CBT program is designed to be performed over a total of five therapy sessions. Each structured session should be about 60minutes in length.

A single assessment session will be undertaken in the week before therapy commences in which key data are obtained from the client, and an outline of the nature and content of the therapy is given. It is expected that assessment of clients will be conducted on an individual basis, and should require about 40 minutes. Therapists may find that the assessment time can be cut down slightly with a more streamlined interview and efficient explanation of the trial to clients. Assessment data should be scored in the week before the first CBT session, to allow relevant comprehensive feedback to be provided to the client.

The timing and physical location of the therapy sessions should be as consistent as possible. That is, appointments for the same time and day should be made for each subsequent week, and the place (i.e. consulting room) should be held constant. This may help to optimise the establishment of a working rapport with the therapist and assist the client in becoming comfortable with the therapeutic arrangements.

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, and if that is not possible, the session should be carried over to the regular time the following week. Missed sessions of more than three weeks in a row compromises the effective running of the program, and clients in this position should be encouraged to consider seriously their reasons for being involved in the program.

Inclusion and Exclusion Criteria

Because this manual is developed for a research trial of the feasibility of the CBT intervention, strict inclusion and exclusion criteria must be employed. These are outlined below. While therapists using this manual should remember that the efficacy of the methods described here are based on these criteria, they should also be encouraged to make their own judgments regarding the suitability of individual clients for treatment with this intervention.

Clients will be aged 18 or over and have fluency in speaking and reading English. This is necessary for completion of research instruments and consent forms, as well as the need for a high level of communication during sessions.

Clients will be injecting drug users, primarily of heroin. While there is no requirement for clients to be dependent (e.g. DSM criteria), it is expected that most clients who apply to participate will meet DSM-IV criteria for opiate dependence. It would be preferable that clients are not currently dependent on other substances (excluding nicotine), although this may depend upon the sample that applies to participate in the program. Many prospective clients are likely to abuse alcohol, however, this should not be an automatic exclusion criterion. Instead, a cut-off score on the AUDIT (Alcohol Use Disorders Identification Test; Saunders & Aasland, 1987) of 15 will be used to exclude very heavy problem drinkers. This score is elevated from the usual cutoff of 9 for determination of problem drinking status. Hence, clients may have mild problems with alcohol, but alcohol abuse should not be so severe as to compromise their capacity to successfully follow the instructions provided in the program and maintain effective behaviour change after concluding.

Clients with major psychopathology should be excluded, although no strict criteria have been established for this issue. The main criterion is whether, in the clinical opinion of the therapist, the client is incapacitated by some form of psychopathology which may compromise success in the current program. In this way, clients with mild

levels of depression or anxiety will not be excluded, but clients suffering severe examples of these disorders would be excluded. Clients who currently qualify for a diagnosis of a DSM Axis I diagnosis may be included in the program if their symptoms are currently stable or sufficiently mild as to cause no impact on their ability to progress satisfactorily. Clients who are currently symptomatic (e.g. severe depression, psychosis) should not be included. This may be ascertained using the SCL-90.

For the purposes of the research study, it is important that clients are not currently engaged in other treatment for a substance abuse problem, so as not to contaminate the present intervention.

Detoxification

Clients will be accepted without the need for a full detoxification prior to the commencement of the CBT intervention. However, clients should be encouraged to consider undergoing a detox, as this may provide a stronger base from which to move successfully into a new route of drug administration.

Clients who are turned away from detoxification centres owing to a lack of space will be accepted into the program. In addition, clients will also be accepted from detoxification units after completing a detox or if they left prior to the intended discharge date.

Assessment procedure

For the purpose of the research on which this manual is based, a detailed assessment package will be used. A guide for appropriate assessment procedures is therefore outlined here.

The assessment for the feasibility study comprises a brief, structured interview, in which key data pertaining to demographics, drug use, family history, pattern and

history of opiate use, past treatment experiences and criminal history will be obtained. In addition, clients shall be required to complete several self-administered instruments.

The structured interview will be adapted from the Opiate Treatment Index (OTI, Darke et al., 1991). Sections to be used from this instrument will include: demographics and treatment history; drug use; injecting and sexual practices; social functioning; health; and psychological adjustment.

Psychometric instruments

The Severity of Dependence Scale (SDS, Gossop et al., 1992) for assessment of opiate dependence. This short questionnaire is a valuable clinical tool, providing information about psychological concerns regarding drug use.

The instruments which may be self-administered are:

- SCL-90-R: Symptom Checklist 90 (Revised) (Derogatis, 1994)
- BDI: Beck Depression Inventory (Beck, 1978)
- AUDIT: Alcohol Screening Questionnaire (Saunders & Aasland, 1987)

Clients will be required to sign an informed consent form, approved by the relevant local ethics committee (University of New South Wales Committee on Experimental Procedures Involving Human Subjects). A copy of the subject information sheet and consent form can be found in Appendix B.

Classification of treatment dropouts

Clients who fail to complete at least three of the five sessions will be considered to be a dropout. Nevertheless, all clients who are assessed are included in the treatment outcome analyses of the present randomised controlled trial (i.e. analyses will be

conducted on an intention to treat basis). Completion of treatment is an empirical issue that this feasibility study aims to investigate.

GUIDELINES FOR DELIVERY OF COGNITIVE BEHAVIOURAL TREATMENT PROGRAMME

The following sections outline the content of the CBT NIROA program, described on a session-by-session basis. While this manual aims to provide as comprehensive a description of the method as possible, completely verbatim instructions are impractical, as individual therapists must respond to each client's requirements differently. Thus, a guideline for delivering the intervention is provided, which allows conformity with the general principles while maintaining an individualised approach by the therapist.

SESSION 1: Setting the scene & introduction to motivational enhancement training

Planning to change

This session constitutes the first part of the treatment intervention, although the assessment completed a week earlier will mean that this is the second meeting with the client. The broad aims and outline of the treatment will have been explained briefly at intake. Therefore, a slightly more detailed depiction of the program should be provided at this point. The client may have thought of questions, or have concerns or comments which s/he would like to discuss at this point.

Ground rules & outline of treatment.

The standard therapeutic guidelines should be explained to the client at the commencement of the session. These include the "rules" of the program. The major points to explain include: the need for the client to maintain a record of prompt attendance, and a requirement of 24 hours notice to change appointments. Clients should be reminded that they are expected to attend all five sessions in order for the

intervention to have its optimal impact (although ethics approval allows for clients to drop out at will, as stipulated in the consent form). There may be some advantage in setting out the ground rules for therapy in a contract, which the therapist and client both sign at the commencement of treatment. This will ensure that both parties understand the conditions upon which the therapy is based, and record them in an unambiguous manner.

It is useful to outline the rationale of cognitive-behaviour therapy in the first session. It should be explained so that the client understands that this CBT intervention involves the learning of specific skills or techniques that will assist the client to become effective in making desired changes and maintaining those gains in the longer term. The client should be made aware that s/he will be expected to work hard to change route of administration and that effective gains are not achieved without some hard work, which will certainly be rewarded. Explain that this approach to treatment involves a collaborative relationship, which means that the therapist and client should work together for an optimal outcome. The advantage of a collaborative relationship also means that the client has an important role in deciding and influencing the content of the intervention. It is important that the client plays a role in determining the pacing of the sessions, as well as the choice of skills to be developed (Sessions 4 and 5).

It should also be indicated that the general purpose of CBT involves a simultaneous emphasis on the client's *thoughts* and *actions,* and the interrelationship between these factors. Although the present program must follow a standardised format (owing to the requirement for methodological rigour), there is ample room for individualisation, and every effort should be made to make the program as relevant to the client's needs as possible.

The therapist should outline the specific elements of the program to be covered throughout the six sessions, and indicate how these will assist the client in changing

to a NIROA. While it will not be possible to outline every component, an attempt should be made to point out the most important ones. These might include:

- Enhancement of motivation and exploration of reasons and motives for changing to NIROA.
- Urge/craving management skills
- Identification of triggers for injecting
- Learning techniques for managing automatic thoughts that accompany injecting, especially negative or irrational thinking, and expectancies of injecting behaviour.
- Techniques for managing negative moods: e.g. anxiety, stress, depression
- Relapse to injecting prevention strategies

Suggested Time: 15 min

Feedback from assessment: Profile of injecting drug use pattern.

The therapist should share with the client any or all of the important features of the assessment. The aim here is to complete a picture for the client of his or her injecting drug profile, using aspects from the assessment. This can form the basis for a discussion about the nature of injecting and the problems that are associated with this route of administration.

Level of dependence

The fact that the client probably qualifies for a diagnosis of dependence should elicit concern, although it is not likely to be a surprise. Discuss the implications of this, and consider the issues involved with physical and psychological dependence. This can be achieved by providing feedback on the client's level of dependence using the Severity of Dependence Scale. Use the guide for rating dependence on the handout and confirm whether the client considers this to be an accurate reflection.

High risk situations and triggers

Self-efficacy or situational confidence is another key construct to discuss. Discuss high risk situations for injecting with the group and compile a list of the high risk situations or "vulnerabilities" for each person. Clients should write down their personal high risk situations on a work-sheet. Elicit the client's concerns about high risk situations, and discuss the circumstances surrounding these. Introduce the concept of personal triggers, then go on to explain how triggers promote behaviours such as injecting, and often lead to increased desires or urges.

Dealing with high-risk situations can be briefly introduced at this point, and returned to later in more detail. This will allow this issue to be addressed in conjunction with more detailed strategies, such as dealing with urges, cognitive skills, etc.

Reasons for injecting: Pros and cons.

This is one of the key issues to be considered in Session 1. Discuss the client's reasons for injecting drugs, perhaps eliciting the clients' reasons for commencing injecting. Consider the positive aspects, and determine how important these still are (e.g. "cleaner"?, "more efficient"?, "less waste"? "no other alternative"?). After considering the positive aspects of injecting, turn to the negative things about injecting, and begin to make a contrast between the positive and negative effects of injecting. Establish whether the positive reasons outweigh the negative.

One approach for weighing the positive and negative factors involves completing a Pros and Cons exercise outlined on the handout sheet, to obtain a decisional balance score. If the client is highly motivated to commence their change to NIROA, it may be sensible to move on to planning strategies for making the change to NIROA. If, however, there is ambivalence or uncertainty, introduce principles of motivational interviewing.

Suggested Time: 10 min

Motivational enhancement training.

This section outlines the basic steps required for a brief motivational interview. The therapist must decide whether this component is required, as some clients may be highly motivated and are ready to commence changing to NIROA. Such clients, who would be considered to be in the action, or late contemplation, stages of change (Prochaska & DiClemente, 1986), would have no need for a motivational enhancement intervention. This section is intended to increase the motivation to change for clients who have some degree of ambivalence, or would be considered to be in the earlier levels of the contemplation stage of change.

The standard approach outlined by W.R. Miller and colleagues (e.g. Miller & Rollnick, 1991) shall be used to enhance motivation to change. Although most clients are likely to be at least at the contemplation stage, some will have a greater desire to change than others. Attempt to establish the client's position regarding attitude to changing, and structure motivational interview accordingly. The following guidelines might be adopted for a "difficult to budge" client. Others may require less work, and so time may be more fruitfully spent on other activities.

The critical conditions for promoting change (accurate empathy; non-possessive warmth and genuineness) will be gradually established during the course of the session. Suggested strategies for promoting motivation to change (according to Miller & Rollnick, 1991), include:

- ◊ **giving clear ADVICE**
- ◊ **removing BARRIERS**
- ◊ **providing CHOICE**
- ◊ **decreasing DESIRABILITY**
- ◊ **practising EMPATHY**

◊ **providing FEEDBACK**

◊ **clarifying GOALS**

◊ **active HELPING**

The therapist should attempt to construct a discussion around the goals of the client, and the client's motivations for changing to a NIROA. The client should have received clear advice in the previous section, that is, avoiding injecting is important for his or her long term health and well-being and to avoid likely problems developing or worsening in the future.

In a collaborative discussion with the client, consider the reasons that have prompted him or her to arrive at the point of commencing treatment, and help the client to see these reasons in a global sense. Help to educate the client about the advantages of NIROA. While many clients will be quite well informed about the issues of using a non-injecting route, there may nevertheless be certain things that the client has not considered, or has not appreciated fully. This is difficult to fully expound here, and therapists are encouraged to develop an understanding of each client's knowledge of NIROA to guide the discussion.

It may also be useful to dispel some of the prominent myths about NIROA. Therapists may find it useful to include some quotations from recent research that are relevant to the NIROA approach. For example:

- Many users consider injecting a "cleaner" method of using a drug. In fact, any route that utilises direct administration into the bloodstream is likely to be messy and run the risk of blood borne viruses, etc.
- Injecting is seen as more economical, or more "bang for the buck". In the longer term, however, injecting is associated with increased levels of dependence, which means heavier usage and greater costs involved.

- It is also disputed as to whether the heroin available in Sydney is suitable for chasing. While it may not always be the ideal type, its chemical composition varies widely and many users (especially Vietnamese users around the south-west of Sydney) chase regularly.
- Chasing means missing out on the rush or bolus effect. This is not true, and the fastest way of getting a drug into the brain (where it has its major effects) is via a smoking route. This takes around 7 seconds for peak effect, whereas injecting takes around 20 seconds for peak effect.
- Smoking a drug is very effective as it is absorbed via the lungs which have a huge surface area, owing to millions of tiny pockets or alveoli. These have a surface area approximately equal to a tennis court and make absorption very rapid and effective. The route from the lungs to the brain is very short and direct as well, via the pulmonary artery. In contrast, injecting involves a long route through the peripheral veins and the liver (where some of the drug is broken down) before reaching the brain in a less concentrated dose.

It may also be useful to develop a decisional balance sheet by eliciting from the client the pros of injecting and compare them with the cons. Which is the most important at this stage? This procedure can be made more vivid for the client by drawing up a list of "good things" and "less good things", or problems, associated with injecting. Each of the items on the list might be given a rating out of ten to determine how important they are personally to the client.

For example:

	CONS	**PROS**
1.	less intense rush	reduce risk of infection
2.	waste of drug	less vein damage
3.	heroin available not suitable for chasing	more control over drug use

Encountering ambivalence

If the client is in a genuine state of ambivalence, attempt to explore the reasons that may underlie this. Establish the initial reasons for the client seeking treatment, and reasons for using/wishing to change ROA. Again, guide the client through a firm and rational discussion of the issues involved. Incorporate information on health and psychological effects of continuing to inject. Establish the nature of any doubts that might exist. Help the client to construct challenges to faulty logic or irrational beliefs or thoughts about the nature of injecting. Encourage the client to get on with the job and reassure him/her that changing a long-established behaviour is never as difficult as it seems at the beginning. Positive reinforcement and encouragement will assist the client in taking the first tentative, but crucial, steps.

Suggested Time: 20-25 min

Setting goals

Consider the goals of the client by discussing reasons for injecting and reasons for wanting to change to NIROA. Although a complete change to non-injecting is the desired goal, reduced injecting may be preferred by some. It may be necessary to be prepared to compromise in order to maintain a strong working relationship with clients. Consider the degree of dependence, recent pattern of use, and previous attempts to reduce injecting, and discuss these issues with the client.

Indicate that the nominated day for changing ROA will be set for some time in the week following the next session. Confirm that this is OK, or identify the next suitable day during the following week.

Suggested Time: 5-10 min

Introduction to behavioural self monitoring

Introduce the idea of an injecting diary (e.g. by explaining that: *"These are successful with people trying to quit smoking cigarettes or to cut down on their drinking"*). Provide the client with the self-monitoring form, and explain how the form is to be filled out. Explain that keeping tabs on injecting behaviour over time has an important influence in helping to slow down the "automatic" nature of an addictive behaviour. This strategy can help clients to realise that an alternative ROA may provide an effective hit or dose for a given situation. On the self-monitoring form, the client should also keep a record of urges or cravings experienced on each day. Ask the client to record urges on a 1 - 10 scale, concurrently with amount the used, the situation, and thoughts and feelings at the time of injecting. There is also a column on this form to record the outcome of strategies employed to avoid injecting. Explain to the client that this column will be used in the next session to record the results of specific strategies discussed in following weeks.

Suggested Time: 5 min

SESSION 2: Planning to Change ROA

Review of the week and homework (self monitoring) exercise

Commence the session with a review of the previous week. Have an informal discussion about general activities (*"What's been happening, etc"*), to promote and extend rapport. Also attempt to determine whether there are any important issues that have arisen or appear to be looming.

Check that the client has completed their homework, and understood the reasons for this type of approach. If they did not complete their homework, take a few moments to fill out some of the previous week's drug use (injecting) and urge diary. Ensure that the client understands the importance of these exercises, and check whether motivation is appropriate. If any blocks exist at this point, they should be discussed briefly before commencing. Check the client's thoughts on process of change and strategies for achieving changes.

Review of personal triggers and high risk situations.

Review the urge and triggers diary, and establish whether there are any behavioural patterns surrounding use of injecting. Most injecting will occur in a reasonably stereotypical manner, e.g. in certain places, with certain people (or on their own), or at certain times of the day. Assist the client to confirm whether the personal high risk situations (HRS) identified in Session One are confirmed by the actual occurrences recorded in the diary. Are there any high risk situations that were not previously anticipated? The diary should provide a more accurate reflection of high risk situations, providing the week has been a typical drug use week. Add any new HRS to the summary list, and re-order them in terms of priority, if the evidence from the diary suggests that the original outline is inaccurate.

Also summarise specific triggers or cues for injecting. Emphasise the role that these play in eliciting urges to inject. Re-order these also, if the diary suggests that the original the summary was misleading.

Introduction to NIROA: Exploring possible alternatives

This is the session in which the main planning for making the change will occur. That is, clients will be encouraged to make the switch immediately after this session, or on a day nominated during the current week.

The session should emphasise educating the client in practical issues in NIROA. For this purpose a video will be shown to clients to help them in learning about the more specific details of chasing and snorting, etc.

This part of the session should explore and explain all of the possible alternatives to injecting. Each should be considered and the pros and cons of each should be explored with the client.

Chasing

Go through the general procedure with the client and explain how this achieved. Provide the client with a copy of the pamphlet, *Chasing and other ways to use*, (prepared specifically for this study and not for general distribution). This pamphlet provides a description of the materials needed and a step-by-step guide to chasing.

Consider also any alternatives to this general method: for example using heroin with a cigarette and smoking, and "snowcones". Explain that these are widely used in countries such as the UK and parts of Europe and Asia.

Snorting

Although most clients will be familiar with the procedure for snorting, go through the process with the client. Examine again the pros and cons of using this route.

Oral use

Oral use may involve actually swallowing the drug. While this is less efficient in terms of the amount of drug that is available for entry into the CNS, it is the safest of all and requires little if any preparation and equipment. The pros and cons should again be considered, even if the client is not initially attracted to the option. It may be kept in mind as a possible alternative route when others are unavailable.

Shafting

This involves injecting the drug solution into the rectum using only the syringe, without the needle. The lining of the large intestine has a large surface area (like the lungs) and is also very absorbent. Therefore, drugs will be rapidly absorbed into the blood stream. Some users report that there is a very distinct type of rush associated with this route. Clients should be reminded that sharing or re-using injecting equipment, even without a needle or involving direct contact with blood, may be risky.

SHOW VIDEO TO CLIENT
After the video, there should be opportunity to discuss any issues that are raised.

Exercise: Pros and cons for preferred NIROA

Draw up a list of pros and cons for the NIROA methods preferred by the client. There may not be time to go through all of the pros and cons for each NIROA. Therefore, concentrate on the client's preferred route and discuss the pros and cons of this method.

Consider some of the various issues known about NIROA:

- latency to onset
- amount of drug available for CNS activity
- potency of drug
- chemical form of drug (whether smokable)
- materials required for administration
- convenience of method
- reduction in level of dependence: (possible preparation for quitting use altogether?)
- reduction of physical damage to veins, vital organs, etc
- reduce risk of transmission of viruses: Hepatitis B Virus (HBV) & Hepatitis C Virus (HCV) + Human Immunodeficiency Virus (HIV)
- social desirability
- longer duration of action

The client may be uncertain about the method by which he or she should use: chasing, snorting or oral use. This choice may depend on a range of factors, including the client's degree of dependence. If the degree of dependence is moderate-to-severe, suggest chasing as this maximises the amount of drug that can be absorbed into the CNS. This method will also work better if the client works toward reducing overall level of use and thus level of dependence.

One approach might also involve reducing general drug-related behaviour, such as gradually delaying the time of the first use each day by 2-3 hours. Get the client to estimate the amount used and work at reducing this by about 10 per cent per week.

If the level of dependence is mild-to-moderate, the client may be suited to snorting or oral use as well as chasing. These methods may help to further reduce level of

dependence and ultimately assist with the task of switching to NIROA. Urges may be intense at first, but will rapidly diminish with each additional day of non-injecting.

If the client has used one method successfully in the past, encourage its use again now. However, if one method has been difficult or resulted in failure, suggest another method this time. Try to enhance the client's optimism in approaching the task by highlighting previous success, or, alternatively, a new approach to a difficult, but not impossible, task.

Homework

The client should be assisted with setting a specific goal for switching to NIROA. If the change is not to occur on the day of this session, then help the client to identify exactly which day the change shall take place. This decision must be made on pragmatic grounds. Help the client to ensure that this goal is adhered to.

Encourage the client to continue a diary of injecting as well as Non-injecting uses of drug. Ask the client to rate satisfaction of experience, as well as other factors, such as, convenience of use.

PREPARE RECORD SHEET

SESSION 3: Understanding thought processes that accompany drug using behaviour

Review of previous week

Commence the session by reviewing progress over the previous week. In particular, ask the client about his or her experience with using a non-injecting route. Discuss the effects of the drug, but do not make this the sole issue around changing routes. Be careful to highlight practical issues such as convenience of the method, reduction of risky behaviour, an opportunity for damage to veins to recover, etc.

Review briefly the diary from the previous week and identify with the client any trouble areas, especially surrounding the attempt to adopt a new route of administration.

Changing thoughts/ cognitive restructuring

This section is devoted to working on the cognitive aspects of drug using behaviour, especially the expectancies that drive much of the perceived effects or outcomes of drug use. The rationale is as follows and this may be used as a guide for delivery to clients:

There has been a lot of work done in the past ten years or so that have examined how peoples' thoughts affect their use of and dependence on drugs. That is, a big part of the way people become dependent on drugs is to do with how people think about the whole thing. Most people who use drugs regularly have certain thoughts that influence the way in which they use drugs, for example, the urges or cravings that they have are all to do with thinking, and so are the reasons and motives for taking drugs. In fact, the way in which drugs actually affect people has a lot to do with the way in which you want them to work, as it is to do with the actual effect of the chemical in your body. That is, if you want to feel relaxed, you are more likely to feel that effect, and if you want to feel energised, you will also feel that way.

For example: a user who takes heroin to feel more relaxed will almost certainly feel that way if he or she <u>expects</u> to get that effect. But that same person may also take heroin to get motivated to do a difficult task - something quite different from relaxation. But again, the expectations or thoughts that the user has will influence the <u>perceived</u> effect of the drug. In either case, just wanting to feel a certain way will have as much influence as the drug itself. That is, making a decision to relax and giving

yourself the best opportunity to relax will help you to relax whether or not you have used heroin (or some other drug).

This session is about looking at the role of thought process that influence the way you use drugs and we will work on certain skills that will help you to manage some of those processes. Tthis will give you better control over the way in which you use, and will help make the transition to NIROA easier and more effective in the long term.

NOTE: Try not to get engaged in argument about the role of expectancies in drug effects: try to delay longer questions until after the rationale has been explained.

The general idea is based upon what we call the ABC's of thinking, and this approach has been used very effectively to help people make changes to many sorts of psychological issues, including managing depression, anxiety and other negative moods, as well as enhancing people's performance (e.g. in sporting contests). It is also a really important part of drug use in general and helps not only to manage urges and cravings, but to understand a lot of the irrational or automatic negative thoughts that go hand in hand with habitual drug use.

The main aim of cognitive restructuring is to assist the client to determine when he or she is thinking negatively or engaging in automatic patterns of thought that lead to drug use. The techniques employed should assist the client to interrupt this style of (automatic) thinking. Finally, the client should learn to challenge negative thoughts and to replace them with more positive ones, or thoughts that help to reduce the urge for injecting, especially if this is based on ideas such as injecting is the only way to get full satisfaction.

Begin with a brief discussion on the issue of "automatic thoughts." The client should be familiar with the concept, and will probably respond readily to the notion of recurring unwanted thoughts about wanting to inject. One theme that appears common is the process of mental "justification" for injecting, despite having previously decided not to do so. Clients state that these justifying thoughts tend to be automatic and persist without any real effort being made to create them. The feeling is of the mind "playing tricks," and can be distressing owing to their persistence and capacity to undermine sincere efforts to avoid injecting or abstaining.

Also introduce the client to the notion of self-talk ("the voice inside your head"), and elicit examples of both negative and positive patterns of self-talk.

Next move on to the key concept of cognitive re-structuring: that thinking influences the way a person feels and the way they behave. In other words, **T**houghts lead to **F**eelings and **A**ctions. It is important for the client to understand that emotions and the response to those emotions (e.g. injecting a drug to overcome stress or anger) are not the direct result of some external influence. This, of course, immediately appears to be counter intuitive, as the client may want to suggest that an insulting gesture or the death of a loved one will **cause** feelings of anger or sadness.

Indicate how one's **thoughts** always come before any feelings or actions. A person's thoughts usually arise **automatically** in response to a particular event, and so therefore, we tend not to be aware of them. The thoughts we have in response to particular events are usually the same each time, and are very predictable in this sense. Automatic thoughts cause us to **interpret** events in a certain way, which may lead to negative feelings.

The diagram below (also on a handout sheet: see Appendix A) explains this process, using Ellis's "ABC" model:

A ----------> B ----------> C
Antecedent event Belief Consequences
(Action)

Provide an example of this model. For example:

Somebody insults or ----------> "I'm hopeless / stupid" ------> Depression,
criticises you tension, anger

Assist the client to generate another example.

Indicate how the usual interpretation is to exclude the "B" step, that is the belief or automatic thought. Most people assume that "A" causes "C". Explain how this is not true. There may be some resistance to this idea, and clever clients may enjoy providing examples that falsify the model. Some discussion of this issue may be important for the client to become convinced of its validity. The important point to convey is that our thoughts are what give rise to our feelings, and that most thoughts are automatically generated. **Point out that these thoughts can be changed,** and this can have the effect of helping a person to deal more effectively with adverse circumstances.

Changing automatic thoughts: Delaying action

The next step is to help the client to understand that negative thoughts can be changed by "catching" them, or becoming aware of them before they are acted upon. Encourage the client to react to a negative thought in the same way as they do with urges: STOP, SLOW DOWN and THINK ABOUT the thought. Make a decision not to act upon the thought for a short period of time, and the chance is that the thought will soon pass without any harmful consequence.

Changing automatic thoughts: Challenging and replacing negative thoughts

Negative thinking can be changed by becoming aware of the thought (see above) and directly challenging the thought. Help the client to find ways to challenge the major negative thoughts that he or she tends to experience. The basic steps to help in this process might include:

1. Examine the evidence
2. Consider what is wrong with thinking that way
3. Decide whether the thought is unhelpful (a thinking error)

4. What alternatives are there for this thought?

It will be useful, if time permits, to generate several examples of challenging negative thinking, so that the client has fully understood the basic process involved.

Application to drug use

The ideas discussed above are general, and might be more easily explained in a general sense rather than in reference to drug use. Therefore, it may be necessary to relate the model to drug use *per se*. This can be done in two ways: In general people are more able to deal with problems when they are less troubled by negative thinking. Explain the role of negative thoughts in the genesis of depression, anxiety, and other negative states. Indicate how correcting and overcoming negative thinking will help in the *overall* process of overcoming dependence on drugs.

The second suggestion is that much negative thinking is closely linked to IV drug use. That is, injecting use is often a consequence (STEP C) of a negative thought. The client should be able to start challenging negative thoughts that lead to drug use (e.g. I feel stressed, the only way to cope is to have a shot).

Discussion of the role of expectancies

This component might end with a brief introduction to the role of expectancies in drug use. Explain how much anticipation of having a shot (and the concomitant urges/desire) is due to the influence of expectancies. These may be positive (a shot will put me in a good mood and make me more sociable), or negative (injecting will get rid of my stress or boredom).

Like negative thoughts, expectancies can be challenged. Most clients would be very surprised to learn that the main effect of injecting small amounts of a drug is due to psychological expectancies, rather than the physical effect of the drug. That is not necessarily to say that injecting a placebo would induce the same effect (although

most users feel something even if the substance is inert), but that the major positive benefits of injecting are mediated by the client's expectation or anticipation of feeling a certain way, based upon past experience.

This may be met by some with incredulity. One way of approaching this skepticism might be to inquire about any time in the past when the client was thinking about injecting to overcome some negative affective state, but had no drug available. Ask the client to consider the feelings (positive expectancies) that he or she may have had at that point. Then ask them to remember how they felt when the drug suddenly became available (e.g. obtained money to score; they finally found a dealer, etc). The client will typically have experienced an improvement in mood at this time. According to the logic of most users, this change in mood state should only be achievable by actually injecting the drug, yet there is marked improvement with the knowledge that it will be available. Ask the client to consider this as an example of expectancies mediating the urge or desire to use, and in the same way, mediating the perceived positive effects of injecting.

In general, high expectancies and low confidence in resisting leads to strong urges. Encourage the client to challenge automatic expectancies, by replacing them with alternatives:

e.g. “Injecting is the only way in which I will get the full satisfying effect” replaced by “chasing will also help me to feel OK if I really allow myself to feel OK and work on relaxing myself, and I won’t feel so guilty either”,
OR
"I need to inject to relax," replaced by "injecting may relax me, but I know that giving myself permission to spend time on my own and unwind for a while will also help me to feel the same effect."

Suggested time: 40 min

SESSION 4: Working on specific non-injecting skills

This session is devoted to developing further skills that will be useful in helping clients to consolidate or continue to move toward adopting a non-injecting route of administration.

Review of previous week

Start the session with a review of the previous week and examine the client's diary of drug use. Discuss any issues that have occurred in the past week.

Specific skills

The general idea with this session is to identify certain areas that each client will benefit from and inspire enthusiasm from the client in learning new skills.

The first is managing urges, and follows logically from the cognitive restructuring exercise from the previous session. This should be approached on two broad levels: firstly to encourage clients to manage urges to inject (and so allow an opportunity to consider or adopt an alternative route); and second, to encourage clients to avoid drug use at all when this is possible or feasible for that individual. Remember that reducing drug use generally will allow a reduction in overall level of dependence and thus will mean that less of the drug is required with each administration.

Effective urge management strategies: Advice to give to the client

The proposed means for assisting the client with urges or cravings to inject is based upon cognitive behavioural techniques used in the alcohol, nicotine and opioid treatment fields. Educating the client on the genesis and time course of urges is an important aspect of helping the client to prepare for the task of coping with them. Instructing the client in practical techniques for coping with urges will foster acquisition of skills to cope more effectively with this aspect of changing to NIROA.

Understanding urges: what are they?

Begin this task with an outline of the nature of drug-related urges: elicit the client's experience of urges and focus on the fact that they are the subjective element of "drug hunger." Prompt the client to recall past experiences of the way that urges build up over time and indicate that they are reinforced by the effect of the drug on reward centres of the brain. Urges are triggered by cues for drug administration (remind the client of his or her particular salient cues or triggers). Understanding urges is an important part of the process of overcoming habitual injecting behaviour.

Explain limited time course of urges

One suggested outline for covering this issue might be as follows:

> *"Urges for using drugs (especially heroin) rarely last for very long. In fact, they almost never last for longer than about 30 minutes, providing that you have decided that you are going to abstain this time (and providing that there are no current symptoms of withdrawal). This is true for everybody, but few users ever give themselves the chance to prove it."*

Ask the client whether there have been times when s/he did not or could not have a shot when an urge was present. Find out whether the urge did pass. Most clients will invariably have had past experiences of urges passing. This is an important strategy for clients to identify, as it can greatly improve self-efficacy for overcoming or riding out urges. The main message is that urges do not have to be acted upon.

Urge surfing and non-reinforcement of urges

This is a common technique for assisting clients in developing a means of overcoming urges. The analogy used is that urges are like waves, and reach a peak before subsiding. A suggested explanation for this phenomenon is as follows:

> *"Urges usually come and go in waves. Therefore, if they are feeling intense, try to distract yourself for a little while and you will soon notice that the worst part has subsided. Imagine the wave rising up to its peak level, and then it will pass by you, leaving you feeling more*

comfortable and no longer in need of a shot. This is called urge surfing. You will feel good when the urge wave has passed and you did not have to act upon it by injecting".

Another analogy involves the reinforcement of unwanted animals - urges to inject are the same as they are continually being reinforced by actually having that shot. Resisting injecting in the presence of an urge will help to weaken urges to inject via the process of extinction.

"If you make a decision to resist feeding an unwanted animal they usually whine and howl for a while. In fact they will be at their strongest when you have decided not to reinforce their behaviour. Soon, however, they will come to realise that they are no longer being reinforced, and will gradually go away and disappear. Your decision to stick with the action you know is best for you will "undo" the problem that you unknowingly built up in the first place."

"Urges do go away, but they may be very strong for a short while immediately after stopping injecting. Knowing that they will weaken will help you to continue to resist the impulses that you will feel, especially in response to your personal triggers."

Urge coping strategies: distracting and delaying

Another useful strategy is to use distraction, or avoiding situations that contain strong triggers. Remind the client that to persist in sitting in front of the TV (if that is a trigger), with other people nearby who are using, and with other personal cues nearby, will only enhance the urge levels.

Distracting works on the principle that urges are thoughts, and thoughts can be changed (session 3). The easiest way to change thoughts is to change the behaviour or action that is occurring at the time. Hence, by engaging in some task that is unrelated to using, such as light housework, or taking a short walk, or phoning a friend, the client's thoughts will be removed from wanting to inject to the current task. This will help to pass the short time during which the urge is active.

An associated task is to use the strategy of delaying. If bothered by an urge or craving, ask the client to make a note of the present time. The next step is to make a personal commitment not to inject for at least one hour. During this time, ask the

client to engage in distraction. The key requirement of this task is to make a decision after one hour has passed, whether injecting is still necessary. In almost all cases, the client will find that injecting is no longer as important as it was earlier. An adage that the client might use in this case is to "Stop, Ask yourself, then Decide".

Encourage employing the preferred NIROA after the initial urge to inject has passed. This will gradually ensure that the urge to inject becomes less automatic and is much more manageable.

Decatastrophising

Decatastrophising refers to the tendency that most clients have of becoming overwhelmed by the presence of an urge. Remind the client that urges are not intolerable or unbearable, just temporarily uncomfortable. One suggested approach may be as follows:

> *"Also, remember that urges are just temporary feelings of discomfort. Think about the feelings that you are having and become aware of any uncomfortable sensations or feelings of tension in your body. Think about how they compare to other uncomfortable feelings, such as a bad case of sunburn or severe anxiety or grief. They are rarely as bad as they might seem to be at first. Keep in mind that while they are uncomfortable, they are never unbearable. This is called "decatastrophising" - in other words do not let them get out of proportion."*

Information and discussion of withdrawal symptoms

If the client has a high level of opioid dependence, it may be useful to spend a brief period of time discussing the management of withdrawal symptoms. Again, education about the nature of the symptoms, and instruction in techniques to manage them successfully is needed.

Nature of opioid withdrawal

Most clients will likely have experienced some degree of opioid withdrawal symptoms in the past. Therefore, they will be reasonably well informed about what to expect. It may be important not to over-emphasise the difficulty of opioid withdrawal - like other drugs, some may have little or no discomfort upon cessation. Clients will be aware that heroin produces severe physical withdrawal symptoms. Usually, however, the psychological or subjective symptoms are the most prominent. These are likely to make the physical symptoms worse, and helping the client to decatastrophise may help with the management of physical symptoms. Understanding what they are and how to deal with them should help substantially. Indicate that most withdrawal symptoms are mild to moderate. These symptoms are uncomfortable, but are not dangerous (if necessary, explain that it is not life threatening, and cannot result in any physical harm).

The main psychological symptoms of opioid withdrawal, like most drugs involve feelings of anxiety, restlessness, trouble concentrating, depression, irritability and anger, and urges to use. Most clients report a kind of nervous, restless energy. Some experience dramatic mood swings, especially toward irritability or anger, and may find themselves over-reacting to otherwise trivial situations.

Physical symptoms may include insomnia, gastrointestinal upset, sweating, aches and pains, tremors, feelings of restlessness, and loss of appetite. Some clients experience severe upset stomach, with nausea and diarrhea. Again, reassure the client that these symptoms are just temporary and will soon pass. Some over the counter medication to ease the gastrointestinal symptoms may help significantly. Remind the client that any symptoms of withdrawal are signs that their body is recovering from the long term effects of opioid injecting, so they can be viewed in a positive light. Withdrawal symptoms are unmistakable signs that they are on the path to recovery!

Examine social support systems.

One important factor in a successful attempt at overcoming a drug problem is access to effective social support. The therapist should by now have a reasonable sense of the nature of the client's social support system. The most appropriate persons from whom support can be obtained include family members or close friends who are understanding and sympathetic to the client's own goals. Research from the alcohol and tobacco treatment literature suggest that social support improves outcome significantly.

Indicate that the client will benefit from some assistance from someone close. Ask the client to nominate one or more people from whom support might be obtained. Briefly discuss what role that person can play, and when they are most likely to be of most assistance.

The client should understand the meaning of "support," especially the fact that others cannot do the task for the client. Similarly, family and friends should not attempt to control the client or force behavioural change. The client may need to educate his or her social supporters in ways that they can be most productive: encouraging and assisting within the parameters of the clients own goals, rather than coercive or domineering.

Summary

Identify with the client:

- WHO might be able to support you? Consider which people have in the past been:
  - Usually supportive
  - Usually neutral (friends or relations who don't know about your problems)
  - Usually hindering (they may become more supportive with some effort on your part)

- WHAT types of support will be most helpful?
  - Help with problem solving
  - Moral support
  - Someone to share the load
  - Information and resources
  - Emergency help

- HOW can you get the support or help you need?
  - Ask for what you need. Be specific and direct.
  - Add new supporters (people who can help you with your current problems).
  - Lend your support to others; it helps you strengthen your own skills.
  - Be an active listener when giving or receiving support.
  - Give feedback about what was or wasn't helpful; thank the person for his/her support.

CONCLUDING: Goals and Homework

Summarise goals for the coming week. Ask the client to maintain the urge diary. Give the client urge coping exercises to complete. Ask the client to approach a family member or friend for support. Plan a strategy for dealing with slips or lapses: an emergency drill. Finally, for those who require it, ask the client to rehearse drug refusal skills.

SESSION 5: Relapse prevention and consolidation

The primary reference for this session is the widely cited text by Marlatt and Gordon (1985). The purpose of Session 6 is to introduce the client to the main ideas of relapse prevention, and to prepare the client for maintaining abstinence for the future.

Review of previous week

Again, begin with a review of progress, discussion of problems, and recap on any previous techniques misunderstood or not working. Pay particular attention to the "negative thoughts" diary from the previous week. Establish whether the client has incorporated these ideas by checking the sort of challenges to negative thinking that the client has come up with. Discuss this also in a "real life" sense, so that the client can actually use this technique when it is needed.

It may be useful to spend a brief period of time going over the main points from the previous week, and tying these strategies in with any problems that the client has had during the week.

The discussion of automatic thoughts and expectancies should then lead conveniently into an introduction to seemingly irrelevant decisions. This should require about 10 min to discuss.

Seemingly Irrelevant Decisions (SIDS)

Many aspects of any drug use can become repeated so often that it becomes very automatic. Scoring and injecting heroin often seems to happen without any effort or conscious decision making especially if it has been done the same way hundreds (or even thousands) of times. In fact it often seems to be harder to avoid injecting than it is to actually go through the whole procedure involved in injecting. While

overcoming the automatic aspects of drug use seems like an impossible thing to overcome, it is not difficult if you know what to do.

Most episodes of drug use (injecting) actually begin long before the client actually loads a syringe. There are lots of small steps in the chain of events that leads to having a shot. Some of the obvious ones are: finding a dealer, buying the drug, preparing the drug for injecting, loading the syringe, finding veins, inserting the needle and so on. But there are lots of little steps that lead up even to this point. They may be things like making time to prepare for having a shot, finding the right place to use, being in the company of certain others. In many instances, the chain of events starts hours before you actually have a shot. Unconsciously and often without thinking about it, many people make seemingly irrelevant decisions that take them along a path which concludes with them ending up in a high risk situation and then injecting.

Ask the client to think about whether they have ever attempted to avoid injecting, only to find that their best intentions came undone and they wound up in a situation where it was impossible to resist. It may have been temptations from other people. On the other hand, they may have unintentionally exposed themself to internal triggers, such as boredom or stress, which set off a sequence of events that led to injecting.

Being aware of the impact of seemingly irrelevant decisions on the probability of having a shot is important. Trying to minimise temptations well before they grow into high risk situations will help the client to maintain their goals. Ask the client to list any SIDS that they know they have made in the past. Try to think up a few likely SIDS that they could imagine themself making in the future.

Give the information and homework sheet to the client and point out the main aspects of this exercise.

Relapse prevention: main ideas to be covered

Begin this component by exploring with the client his or her reasons for wanting to stop injecting, and how injecting (or drug use in general) may be causing ongoing problems that encouraged the client to consider making changes in the first place.

These reasons may involve a variety of themes. Review the reasons for wanting to change that the client gave in the first session. It can be very useful at this point to look over the pros and cons worksheet completed in Session 1. Usually, after a few weeks of non-injecting, the perceived pros of injecting no longer have any relevance (i.e. getting a more intense effect). Realising this will help the client to become even more dedicated to maintaining a NIROA for the future.

It may also be useful to spend a short time working with the client on the identification of any continuing or recurring problems, and attempting to find practical ways of resolving such issues. Spend a short time supervising the client in his or her attempt to outline a plan for action.

Dealing with slips or lapses.

Start by giving the client some indication that slips and lapses are common in the process of changing a habitual behaviour. While they are disappointing and may cause some discouragement, they do not mean failure or indicate an inability to change. Explain that slips are a natural part of the process of change. The client's challenge is to find ways to quickly overcome the slip and maintain the goals as best as possible. Every slip is a learning experience, and should help the client to strengthen his or her recovery.

It is quite common for people to make mistakes when they are trying to learn any new task or skill. Becoming free of injecting is no different to learning any other skill. And just like any other skill, people do stumble occasionally. It is important to know

that this does not mean failure, but is a temporary setback. Many people who are ultimately successful find that they have a slip along the way.

What is important in long term success is how the client handles that slip. Different ways of dealing with slips depends on the type of slip. One such type of slip is lapsing "on purpose."

Lapsing on purpose

Lapsing on purpose can happen for a couple of reasons. One may be that the client ensures him or herself that it is too much effort. They may get tired of working at their plan, and decide to take a "night off". Alternatively, the client may decide that they deserve a reward for the hard work, and injecting is naturally their favourite way of rewarding themself. These feelings certainly happen to a lot of people.

If the client has lapsed purposely for these reasons, they should think carefully about their reasons for wanting to stop injecting. Focus on the original reasons for deciding to quit injecting and encourage the client to decide how much these reasons still mean to him or her. Remind the client that each slip will lessen their chances of long term success. They will result in urges returning more strongly again, which means more hard work. It may be a case of *"buy now, pay later."* Clients inevitably kick themselves when they realise that the urge that lead to the slip would have gone away in a short time anyway.

If a client has had a slip because of exposure to high risk or tempting situations, that is, despite best intentions, help him to examine his overall quit strategies. What can be improved? Was there a SID made along the way? Is the client finding some high risk situations too hard right now? How can he deal with it more effectively? Doing some homework in this way will definitely help the client to achieve his/her goals more effectively.

Ask the client to prepare a plan to implement should a slip occur. This may involve identification of the triggers or situation in which the slip occurred, the strategies that could have been used to overcome the slip, and the consequences of having a shot, rather than NIROA. The client should also discuss it with a friend or family member, if appropriate, and make a new commitment to continuing his or her planned program of NIROA.

Remember, the best thing is to get back on track as soon as possible, and remain positive about the overall effort to be successful.

Personal rewards

Help the client to have a deserved pat on the back after achieving the goals they have set.

One approach may involve explaining the following idea:

> *"At the end of each successful week, you should give yourself a pat on the back for a job well done. Even if you have not been perfect, you should think of the good things that you have achieved and be proud of them. If there have been mistakes or problems, remain positive by examining what they are. At this point you owe it to yourself to make a list of the things that have not been successful, and summarise them. Think of strategies that you can use to help you to avoid making the same mistake again."*

Self monitoring

Encouraging the client to continue self monitoring of urges. Strategies employed to manage urges and negative thinking are also an important way to remain vigilant against relapse. Self monitoring will help clients to make sure that they are keeping track of their commitment to avoid injecting, and can assist in recognising patterns in coping that may be problematic.

The best way to do this is to continue to keep making regular entries in the self monitoring sheet. If the client has had trouble attaining the goals that have been set for the week, they can review the strategies that are being used and make appropriate changes to maintain forward progress.

Concluding therapy

At the end of this session, the usual procedure for concluding therapy should be employed. In particular, if there are any outstanding issues, consider referring the client on, or provide him or her with avenues for further support.

Follow up - important!

Also emphasise that an important part of this program, from a research point of view, is to be able to contact each client by phone after 3 months and to conduct a follow-up interview face-to-face in six months time. We are interested in seeing everyone, regardless of how well they are going. In other words, it is just as important for us to see people who did not do so well as it is to see those who were successful, so we can learn more about the effectiveness of the program.

To help us follow people up, remind the client that we will be contacting him/her in three and six months, and we will need to know how to get in touch. Ask the client to call us (the therapist) if they move or change any contact details. Also confirm who is the best person who will know where they are in six months (e.g. parent, close friend with stable residence).

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Appendix A – Handouts from treatment sessions

Session 1 - Contract

- Profile of drug use
- Pros and cons of injecting
- Diary of urges and cravings

Session 2 - "Chasing and other ways to use" pamphlet

- Pros and cons of preferred NIROA

Session 3 - Ellis' Model

Session 1

Your Profile of Drug Use

First Name: _____

Main Drug Used: _____

Number of Times Use Per Week: _____

Number of Times Use Per Day: _____

Percent of Time Injected: _____

Severity of Dependence Scale: _____

1-3	Mild
4-7	Moderate
8-12	Substantial
13-15	Severe

My Main Triggers for Injecting Are:

1. Moods:	2. Social:	3. Habitual Situations
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Main Goals I Agree to Work On:

1. Reduce or stop injecting behaviour
2. _____
3. _____
4. _____
5. _____

Session 1

Pros and Cons of Injecting

Good Things (Pros)	Less Good Things (Cons)
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____
6. _____	6. _____
7. _____	7. _____
8. _____	8. _____
9. _____	9. _____
10. _____	10. _____

CBT diary

NIROA pamphlet

Session 2

Pros and Cons of Preferred NIROA

Good Things (Pros)	Less Good Things (Cons)
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____
6. _____	6. _____
7. _____	7. _____
8. _____	8. _____
9. _____	9. _____
10. _____	10. _____

Session 3

Ellis's "ABC" model:

A ----------> B ----------> C

Antecedent event Belief Consequences

(Action)

For example:

A	**B**	**C**
Somebody insults or ----------> criticises you	*"I'm hopeless/stupid" ------>*	*Depression, tension, anger*