Pacific Southwest (HHS Region 9)
ATTC
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Treatment for Individuals who Use Stimulants

TRUST

A Protocol Using Empirically-Supported Behavioral Treatments for People with Stimulant Use Disorders

THERAPIST MANUAL

SAMHSA
Substance Abuse and Mental Health Services Administration

NOTE ON TREATMENT FOR INDIVIDUALS WITH STIMULANT USE DISORDER

As of 2023, contingency management is the only evidence-based treatment for helping people reduce or discontinue their cocaine/methamphetamine use. No medications have been approved by the Food and Drug Administration (FDA), and other behavioral treatments do not have robust evidence to support their use. For this reason, we strongly recommend that contingency management, with research supported incentive amounts (substantially more than $75 per patient per year) be used as a first line treatment for cocaine/methamphetamine use disorder. Period.

However, as of 2023, in many parts of the US, it is not possible to use contingency management due to the unavailability of funds. For this reason, we have produced this manual as a resource for treating patients who are using cocaine/methamphetamine. The materials are based on a collection of behavioral approaches (CBT, CRA, MI, physical exercise) that have some evidence of usefulness with this population. We hope these materials can be helpful for patients in reducing or discontinuing their stimulant use.

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Introduction

Over the past 30 years, there has been extensive research done on the development of treatments for individuals with Stimulant Use Disorder (StimUD). Considerable evidence has been compiled about what "works" and what does not. Currently, there are no medications approved by the FDA for StimUD treatment. However, there are several behavioral strategies that do have evidence of efficacy in assisting individuals to reduce and/or discontinue their stimulant use. These approaches include contingency management, cognitive behavioral therapy, community reinforcement approach, motivational interviewing, and physical exercise.

Without question, contingency management (CM) has the most robust evidence and support for the treatment of StimUD. **CM using adequate incentive levels and appropriate fraud prevention "guardrails" should be used as the foundational treatment approach for individuals with StimUD.**

However, there are jurisdictions where there are obstacles to implementing CM with adequate incentive levels. At present (August 2023), SAMHSA places a $75 maximum value per patient per year limit on the amount that can be used for incentives in substance use disorder treatment. Some states, counties, and programs have wanted to develop more effective treatment for people with StimUD trying to use this $75 incentive.

Research evidence does <u>not</u> support the use of $75 as an adequate amount for an effective CM protocol. Given that the demand for improved treatments for people with StimUD is urgent, some groups have decided to try to use the $75 incentive, within a package of other evidence-supported behavioral therapies. The rationale is that if behavioral treatment programs can be developed using evidence-based practices (EBPs), together with a $75 incentive, this might provide a step toward improved treatment for people with StimUD. <u>This is the rationale for the TRUST protocol.</u>

In the future, there is an expectation that SAMHSA will lift the $75 cap on incentives and it will be possible to implement CM with adequate, research-supported incentive levels. In addition, some states (e.g., California, Washington, and Montana, have amended their 1115 Medicaid waivers to

allow use of Medicaid money for incentives at higher levels. And presently, some states are considering using Opioid Settlement Funds to support CM at research-supported incentive levels. As soon as any of these approaches provide funding for CM in your state, we recommend implementing contingency management with adequate incentives. WITHOUT QUESTION, WHENEVER IT IS POSSIBLE TO USE CM WITH ADEQUATE INCENTIVE LEVELS, IT IS AN ESSENTIAL TREATMENT.

Purpose of this Manual

The authors of this manual have been involved in StimUD-related research, treatment, and training efforts for over 30 years. Over this period, the research on StimUD and its treatment has vastly increased and there is a great interest in better understanding StimUD and providing effective treatment for people who use cocaine and methamphetamine.

We have produced this manual to promote the use of research-supported strategies for StimUD treatment. The manual attempts to combine a number of strategies into a framework that is appropriate for use by clinicians in settings where people with StimUD receive treatment. This manual is not intended to be a cookbook and the materials used and the framework for their use are not intended to be an inflexible, one-size-fits-all prescription. At the end of the manual, we list a variety of treatment materials (see Appendix) that can be added or substituted for the ones we are recommending. We provide the contents of this manual and the framework for combining these treatment materials as one example for how research-supported strategies can be combined into a structured treatment experience.

The manual was developed at a time when CM with adequate incentives was considered impossible in the U.S. Hence, this manual was produced to offer a possible, albeit a non-evidence-based and certainly less effective alternative to CM.

As evidence-based CM protocols using adequate incentives are increasingly being developed and implemented in the U.S., there is interest in having CM delivered within a framework of other evidence-based behavioral support. The use of the materials in the TRUST Manual to augment CM treatment is another possible use of the manual, either in the form of a 12-week framework, or as ad hoc behavioral support materials.

The audience for the manual includes healthcare professionals who provide treatment services for individuals with StimUD. One category of these professionals who we particularly hope will benefit are therapists and other behavioral health clinicians who work in substance use disorder specialty care treatment programs. The manual has been written with this group in mind.

The manual intends to:

1. Provide new information about the use and effects of cocaine and methamphetamine.
2. Present several key clinical challenges that clinicians face when treating this population.
3. Review the evidence-based treatment strategies for StimUD treatment.
4. Discuss how motivational interviewing (MI) is central to the effective engagement of individuals in treatment and to assisting them with behavior change during treatment.
5. Present how elements of community reinforcement approach (CRA) and cognitive behavioral therapy (CBT) can be used to assist individuals with StimUD to reduce/discontinue their drug use and prevent relapse.
6. Describe a procedure for incorporating positive incentives into the treatment milieu and/or support the use of CM for the treatment of StimUD.
7. Provide information and guidance for how physical exercise can benefit individuals who are attempting to reduce/discontinue their use of methamphetamine and cocaine.
8. Describe a plan for providing continuing care to assist individuals to sustain the progress they have made in a structured treatment program.
9. List an array of manuals and training resources for other research-supported substance use disorder treatment approaches.

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The materials in this manual include content and worksheets from the Matrix Model Therapist Manual (SAMHSA, 2006); from the Community Reinforcement Approach, plus Vouchers Manual (NIDA, 2020).

Person-First Language

Throughout this document, we make a concerted effort to use person-first and gender-neutral language. Person-first language refers to individuals who use drugs/alcohol and/or are in treatment for a substance use disorder (e.g., “Individuals who use cocaine or methamphetamine”), rather than using more stigmatizing terms (e.g., “addict” or “cocaine/methamphetamine users”).

We also try to use inclusive, gender-neutral language and choose to use “they” instead of he or she as a singular pronoun.

Because old habits are difficult to change, we may have inadvertently used the older and more stigmatizing terminology at some points in the document. We apologize for these oversights and encourage those using this manual to join us in the effort to use person-first and gender-neutral adaptations to their language, as well.

Chapter 1: Background

Introduction

The group of drugs classified as psychomotor stimulants: methamphetamine, cocaine, and prescription stimulants, including methylphenidate (Ritalin®, Concerta®), and amphetamines (Adderall®, Vyvanse®) are widely used in the U.S. with considerable geographic variation in which of the stimulant drugs are used in which part of the U.S. Methamphetamine and cocaine are currently the most widely available stimulants and are the focus of this manual. However, there are reports about increasing misuse of prescription stimulants in some geographical areas. The content of this document may be useful in addressing the needs of individuals who are misusing prescription stimulants.

The increase in stimulant use and dependence beginning in the middle of the 2010-2020 decade and continuing, is being referred to by some federal officials as “the fourth wave” of the opioid epidemic. Increasing amounts of the cocaine and methamphetamine produced by drug cartels and transported into the U.S., now contain varying amounts of the very potent opioid, fentanyl. Price for these drugs has gone down and availability, purity and potency has gone up in much of the US, to the point where in most parts of the US, some form of psychomotor stimulant is widely available and much of the stimulant product sold on the street includes fentanyl. In large part, the addition of fentanyl to cocaine and methamphetamine supplies has resulted in dramatically increased rates of overdose and overdose deaths associated with cocaine and methamphetamine use.

Acute and Chronic Health Effects of Stimulant Use and Dependence

The acute effects of stimulant use include euphoria, increased talkativeness, hyperactivity, erratic changes in mood, increased blood pressure, elevated body temperature, and rapid heart and breathing rates. Other acute symptoms include reduced fatigue, reduced hunger, increased energy, increased sexual drive, and increased self-confidence. Heavy and long-term chronic stimulant use is associated with psychosis, paranoia, symptoms of anxiety and depression, social withdrawal, emotional volatility, and violence.

Medical Consequences of Stimulant Use

Cocaine and methamphetamine use is known to be associated with acute and chronic medical conditions affecting multiple organ systems. The most common symptoms among patients presenting in medical settings are acute stimulant intoxication, psychosis, stroke, agitation, suicidality, cardiovascular abnormalities, dermatologic issues, dental disease, and non-responsiveness due to tonic-clonic seizure activity. Use of stimulants by pregnant women can result in dangers to the woman, to the fetus and contribute to child development problems.

Overdose Risk

Acute stimulant toxicity has also been associated with fatalities resulting from drug-induced seizures, hyperthermia, hypoxic stress, and cardiovascular complications. A large amount of the methamphetamine and cocaine that is trafficked into the United States and sold on the streets in 2023 contains unpredictable levels of fentanyl. The use of these combination stimulant-fentanyl products creates a very high risk for overdose/overdose death, since fentanyl is a very potent opioid that suppresses respiration, and the individual has no way of knowing how much fentanyl is in the street drug product sold as methamphetamine or cocaine. Many individuals who use cocaine and methamphetamine do not have high tolerance for opioids, and they may not be aware of the overdose risk posed by fentanyl.

During initial contacts with treatment-seeking individuals who use stimulants, it is important to assess their awareness of the dangers from fentanyl and educate them about these risks. Individuals who use by injection are at greatest risk for overdose and overdose death. Individuals who use by injection and have experienced overdose are good candidates to be given naloxone (Narcan) overdose reversal tools and instructions on their use. Having staff who are knowledgeable and conversant in the dangers of meth/fentanyl overdose and able to fully inform patients about risks and use of naloxone for overdose is critical.

Cardiovascular Effects

Cardiopulmonary consequences are common among individuals who use stimulants. Chest pain, hypertension, shortness of breath, and tachycardia are common in ER cases. Also seen in ERs is acute coronary syndrome (ACS), which has been documented in 25% of cases in individuals who misuse methamphetamine admitted for chest pain, resulting from myocardial ischemia (reduced blood flow to the heart), with increased risk of arrhythmias and cardiogenic shock (inability of the heart to pump sufficient blood, usually after a severe heart attack). Cardiomyopathy related to stimulant use may be reversible with cessation of drug use. Pulmonary edema (fluid in the lungs) was found in over 70% of methamphetamine-related deaths, as well as pulmonary hypertension.

Effects on Teeth and Skin

Dental disease ("meth mouth") and other oral complications are common among individuals who use methamphetamine chronically. Oral health problems most often seen include rampant cavities, tooth fracture, and periodontal disease (e.g., gingivitis, periodontitis). In addition to cavities and gingivitis, individuals who use methamphetamine often present with tooth wear and temporomandibular joint (TMJ) syndrome related to bruxism (teeth grinding), which may be a reaction to anxiety and restlessness, especially during early abstinence. Skin excoriations (sores caused from picking) or cutaneous ulcers are common among individuals who use stimulants, arising in response to reported sensation of bugs crawling below the skin. In addition, cellulitis and abscesses resulting from injection of stimulants are also frequently reported.

Pulmonary Problems

Many individuals who use cocaine and meth "smoke" their drugs (commonly referred to as "crack" or "ice/crystal" for cocaine and methamphetamine, respectively) and consequently their use has profound impact on their lungs. Problems include pulmonary edema, dyspnea (difficult or painful breathing), bronchitis, pulmonary hypertension, hemoptysis (coughing up blood), chest pain, asthma exacerbation, and pulmonary granuloma (inflammation or nodules form due to infections). High concentrations of methamphetamine in the lungs have been found, with 30% greater concentrations in African

American than in white individuals who use methamphetamine. Tuberculosis is common among individuals who use methamphetamine.

Neurologic/Psychiatric Problems

Neurologic problems include strokes, seizures, chronic headache, cerebral swelling and hemorrhage, involuntary movements, and tics. All routes of administration have been associated with strokes and seizures, producing long-term neuronal damage. Many individuals who use stimulants suffer from neurocognitive impairments and psychiatric co-morbidity, including severe psychosis, depression, and suicidal ideation. As a result of the disruption to cognitive functioning and other neurologic symptoms, individuals who have been using stimulants chronically are said to have an altered brain state consistent with degenerative central nervous system diseases.

Acute Clinical Presentation and Management of Stimulant Use Disorder

Intoxication and Overdose

Ingestion of cocaine and methamphetamine causes a surge in catecholamines in the central nervous system. A potent release of dopamine and norepinephrine leads to euphoria, hyperexcitability, hypersexuality, increased locomotor activity, agitation, and psychotic symptoms, including paranoia and hallucinations. Acute agitation from cocaine/methamphetamine intoxication is most often the condition that leads individuals who use stimulants to seek medical attention. “Talking down” the patient in a calm environment is the first course of action. Toxicity from injection or smoked routes of administration may necessitate the use of charcoal and medications such as ammonium chloride to hasten clearance from the gastrointestinal tract and the circulatory system.

Those individuals who exhibit severe symptoms of intoxication may require medication, including short-term benzodiazepine use. Benzodiazepines may be effective in acute management of agitation and distress and may reduce seizure potential in patients, particularly with cocaine toxicity. Due to cocaine’s shorter duration of action, cocaine intoxication generally resolves more rapidly (2-4 hours) than methamphetamine intoxication, which can last up to 12 hours

or longer.

Overdose from cocaine and methamphetamine can be fatal. As of 2022, the primary cause of overdose death from stimulant use is from the fentanyl which is widely found in the stimulant supply (and increasingly the presence of xylaxine). However, even without these other drugs, fatal stimulant overdose is possible and not uncommon. The primary dangers are heart attack, stroke, and very high body temperatures (105º and above). For high temperatures, it is imperative to reduce the temperature rapidly with ice packs and ice blankets. No medications are available to reverse methamphetamine overdose. However, as discussed above, patients exhibiting opioid overdose symptoms from fentanyl (or heroin) mixed with methamphetamine or cocaine, should be monitored closely for problems with breathing and naloxone should be available. Emergency services should be called if an overdose is suspected (either stimulant or opioid or both).

Acute Stimulant-Induced Psychosis

Cocaine and methamphetamine-induced psychoses are similar; although more common among individuals who use methamphetamine, and the severity and duration are often greater with methamphetamine use. With individuals who use stimulants chronically, psychosis can be triggered with even small doses of cocaine or methamphetamine. The psychotic symptoms frequently include auditory hallucinations (most common) and visual phenomena (flashing lights, seeing threatening strangers/police). In addition, powerful paranoia and persecutory delusions are extremely common. Individuals in a stimulant-induced psychotic condition have an increased potential for violence, and caution should be used in interacting with these patients.

Stimulant-induced psychosis is generally transient, and management of patients with psychosis may require use of either a benzodiazepine or an antipsychotic, both of which should be discontinued when acute symptoms have resolved. Agents such as risperidone and olanzapine are less likely to cause extrapyramidal symptoms compared to first generation agents, and their sedative properties may ameliorate psychomotor agitation. It is, however, important to monitor for hyperthermia and dehydration when antipsychotics are used in patients with acute stimulant intoxication.

Chronic Stimulant-Induced Psychosis

Persistent symptoms of psychosis are rarely reported among individuals who use cocaine, in the absence of other co-morbid psychiatric disorders. However, symptoms of persistent or chronic methamphetamine psychosis are often so similar to those of schizophrenia that some clinicians may regard them as clinically equivalent conditions, although it has been argued that methamphetamine *produces* a persistent psychosis that resembles schizophrenia. Regardless of the causal direction or association, the symptoms of schizophrenia and of persistent methamphetamine psychosis are not readily distinguishable, and the treatment for these conditions is basically the same.

Stimulant Withdrawal

Stimulant withdrawal symptoms consist of severe fatigue, cognitive impairment, feelings of depression and anxiety, anergia, confusion, and paranoia. For most patients experiencing acute withdrawal/early-phase abstinence, most symptoms resolve within 2 to 10 days. Rest, mild/moderate exercise, and a healthy diet may be the best management approach for most people in withdrawal. Those with heightened agitation and sleep disturbance may respond to benzodiazepines for a brief period, but acute depression and anhedonia associated with early abstinence generally resolve without intervention. Again, clinicians should be aware of possible dehydration and hyperthermia.

Challenges in Treating Individuals with Stimulant Use Disorder

Stimulant use disorder, like other substance use disorders, is marked by loss of control over stimulant use despite consequences caused by use. Per the *Diagnostic and Statistic Manual of Mental Disorders, Fifth Edition (DSM-5)* (American Psychiatric Association, 2013), substance use disorders are diagnosed using 11 criteria including:

1) Difficulty cutting down or stopping use,
2) Excess time spent obtaining, using, or recovering from use,
3) Use in excess of what was intended,
4) Cravings,

5) Tolerance,
6) Withdrawal,
7) Failed role obligations,
8) Recurrent use in physically hazardous situations,
9) Activities given up because of use,
10) Use despite social or interpersonal problems, and
11) Use despite psychological or medical consequences

The severity of use disorder is characterized by the number of criteria met over the previous 12 months: mild (2–3), moderate (4–5), or severe (6 or more).

Common Clinical Challenges when Treating Individuals Who Use Stimulants

Anhedonia

Anhedonia (the inability to feel pleasure) has been recognized as a component of the withdrawal syndrome for many drugs/alcohol. However, this symptom is particularly robust and clinically challenging for many individuals as they attempt to reduce or abstain from stimulant use. For many individuals who use stimulants in their early months of abstinence from cocaine/methamphetamine, anhedonia, together with symptoms of anxiety and depression are important factors in relapse. There is some evidence that exercise may reduce some of the severity of these symptoms.

Pavlovian Cues and Craving

Although not unique to stimulants, individuals who use cocaine and methamphetamine develop a powerful Pavlovian craving response that is "triggered" when they come into contact with cues previously associated with stimulant use (cue-induced craving). These cues or "triggers" can include objects (e.g., cash), people (e.g., friends who use drugs), other substances (e.g., alcohol), places (e.g., areas where stimulants are sold or used), time periods (e.g., weekends, after work) and emotional states (e.g., depression, boredom). This powerful craving response frequently plays a key role in return

to drug use. It is important to educate individuals in treatment about the powerful impact of cue-induced craving and strategies for avoiding situations in which “triggers” are experienced, and to develop skills to manage cravings when triggered.

Stimulants and Violence

There is a dose related relationship between the amount of methamphetamine used and incidents of violence. While those individuals who became psychotic had higher rates of violence, even without psychosis, those who use higher doses of meth had more involvement with violence during the period of their meth use. Co- occurring alcohol use also increased the association between meth use and violence. Clinicians working with individuals who use methamphetamine need to be aware of the relationship between meth use and violence and be cognizant of the consequences of violence on individuals who use methamphetamine and their families.

Hypersexuality and Sexual Dysfunction

A related aspect of this Pavlovian response concerns the relationship between stimulant use and sexual behavior. Previous research has demonstrated that individuals who use cocaine and methamphetamine frequently combine their drug use with sexual activity. During treatment, hypersexuality may continue and can be associated with a return to drug use and for some, in the early months of reduced use/abstinence, sexual functioning may be impaired, causing psychological distress. Educating patients about the possibility of changes in sexual function during early recovery can help reduce their anxiety if these symptoms are experienced.

Cognitive Deficits

Extensive research has been conducted on the impact of stimulants (especially methamphetamine) on cognition. A variety of cognitive deficits, including attention and memory problems, have been documented during early weeks and months of abstinence and can be severe enough to interfere with functioning. These cognitive difficulties can make treatment approaches that involve learning and remembering new information somewhat challenging. Clinical efforts should inform individuals in treatment about these cognitive

deficits and in delivering treatment, use strategies that provide some repetition of information and do not depend on optimal memory.

Poor Engagement and Retention in Treatment

Poor engagement and retention of individuals who use stimulants in treatment is a frequent challenge. This retention problem is a major challenge to a positive treatment outcome as there is a well-established relationship between retention in treatment with individuals who use stimulants and positive outcomes. Selecting treatment strategies that promote retention in treatment is essential to have positive impact from stimulant treatment efforts.

Methamphetamine Populations with Unique Clinical Concerns

Several groups present some unique challenges in treatment settings.

People Who Inject and People Who are Heavy Daily Users

Injecting stimulants and heavy daily use appear to lead to a more difficult clinical disorder. Individuals who inject stimulants tend to report far more severe cravings during their recovery and higher rates of depression and other psychological symptoms before, during, and after treatment. Individuals who inject stimulants and who are heavy daily users also have higher dropout rates and exhibit higher rates of stimulant use during treatment. In a sample of individuals who are dependent on methamphetamine who entered treatment in the Midwest, Hawaii, or California, the rate of hepatitis C infection was 15%. Of the individuals who inject methamphetamine, over 45% were positive for hepatitis C. Clearly, preventive efforts that address behaviors that expose individuals to hepatitis C infection (blood-to-blood transfers or sharing drug paraphernalia) should be incorporated into treatment protocols.

Men Who have Sex with Men (MSM)

Use of stimulants (particularly methamphetamine) by MSM is a significant public health problem. Elevated rates of methamphetamine use and associated high-risk sexual behavior have been reported in many MSM communities throughout the United States. Rates of HIV seroprevalence have been reported to be threefold higher among MSM who use methamphetamine- than among MSMs who do not use methamphetamine. A report by the U.S.

Centers for Disease Control and Prevention on the connection between methamphetamine use, high-risk sexual behavior, and HIV transmission in MSM communities suggests that this combination of factors poses a major threat of high rates of HIV infection among MSM.

Women

Women use stimulants at rates approaching those of men. Women are more likely than men to be attracted to methamphetamine for weight loss and to control symptoms of depression. Over 70% of methamphetamine-dependent women report histories of physical and sexual abuse, and women are more likely than men to present for treatment with greater psychological distress. Many women with children do not seek treatment or they drop out early for fear of losing custody of their children, if reported to authorities for child abuse or neglect.

Children and Perinatal Issues

The effects of stimulant use by pregnant women include growth retardation, premature birth and, possibly, neurological disorders among their children. Children of methamphetamine-using parents also are at high risk of negligence and abuse because of the parents' drug preoccupation, erratic behavior, and psychiatric instability.

Adolescents

In communities where stimulant-use levels are high, adolescents who use methamphetamine have been seen in treatment centers in significant numbers. Of note is the extremely high rate of methamphetamine use among teen girls admitted for substance use disorder treatment. One study found that 63.7% of adolescent females seeking treatment reported methamphetamine as their primary drug of choice. Methamphetamine use among adolescents has been shown to be associated with higher levels of emotional, psychiatric, and delinquency problems, compared with adolescents with other drug use diagnoses.

Treatment Approaches for Individuals with Stimulant Use Disorder

Medication Treatments

After 30 years of intensive effort, there are no FDA approved medications for treating individuals with stimulant use disorders. The use of any pharmacotherapy to target stimulant use disorders is considered off-label at this time. Limitations of many of the existing clinical trials include limited power, methodological deficiencies, poor medication compliance, and high attrition rates.

Recently published studies provided some promising results in support of mirtazepine and bupropion plus extended-release naltrexone for the treatment of methamphetamine use disorder. Additionally, some evidence exists for bupropion and naltrexone alone, as well as topiramate and sustained release methylphenidate for methamphetamine use disorder. For cocaine use disorder, topiramate, bupropion, modafinil, sustained release mixed amphetamine salts, disulfiram, and naltrexone/buprenorphine have supportive research.

Behavioral Approaches

Behavioral interventions are the mainstay of stimulant use disorder treatment. Several studies have examined the same research trials, clinical applications, protocols, and measures with individuals who use cocaine and methamphetamine. In all these studies, treatment response of individuals who use cocaine and methamphetamine has been comparable. For this reason, unlike the previous review of medications, we will review the evidence for the following behavioral strategies with the assumption that results from individuals who use cocaine will generalize to the population of individuals who use methamphetamine and vice versa. The approaches with the most substantial evidence will be reviewed in some detail, followed by those with less, but some supportive evidence.

Behavioral Approaches with Robust Empirical Support

Contingency Management (CM)

During the past decade, there have been a number of systematic reviews of treatments for stimulant use disorders, including two Cochrane Reviews, a review by the World Health Organization (WHO) for their Mental Health Guidelines document (MH-GAP, WHO), a meta-analysis by De Crescenzo et al. (2018) and two systematic reviews (AshRani et al., 2020, Bentzley et al, 2021). In all these analyses, contingency management is recognized as having the strongest evidence of support. For example, in the Knapp et al. (2007) review, the following conclusion is reached from the analysis: “The comparisons between different types of behavioral interventions showed results in favor of treatments with some form of contingency management in respect to both reducing dropouts and lowering cocaine use.” Further, the De Crescenzo, et al, 2018 meta-analysis also concludes that contingency management (together with the community reinforcement approach) produces the best evidence of effectiveness for generating a variety of positive outcomes.

Contingency management (also known as motivational incentives) applies the principles of positive reinforcement for performance of desired “target” behaviors consistent with abstinence from cocaine or methamphetamine. CM involves the contingent delivery of an incentive for behaviors such as attendance at treatment sessions, a drug-negative urine specimen, or documented completion of a homework assignment. Incentives include privileges or desired items, such as vouchers. A variety of ways exist to structure and individualize CM, and a variable schedule of reinforcement can be applied, using the “fishbowl approach,” which uses low-cost incentives. As the target behaviors are performed consistently over time, the value of the reward escalates. Failure to perform the target behavior can result in a “reset” of the reward value to a lower amount. This relatively simple, positive reinforcement procedure has been shown to produce and sustain substantial and clinically meaningful reductions in stimulant use.

Some of the specific research findings supporting contingency management for StimUD treatment include the landmark paper by Higgins et al. (1991) that documented highly significant reductions in cocaine use and very large and significant increases in extended periods of cocaine abstinence using

CM. Roll et al., 2006, extended these findings to individuals who use methamphetamine and reported that CM produced significantly greater retention in treatment and significantly more methamphetamine-negative urine samples. Rawson et al. (2002) found that with individuals in methadone treatment who also used cocaine, CM produced significantly more cocaine-free UAs when compared to no treatment (other than methadone) or cognitive behavioral therapy (CBT). Further, the addition of CBT did not produce additional benefits over and above CM alone.

Despite the strong empirical support for CM, its application in real world treatment settings has been limited, even though NIDA and SAMHSA have joined to produce a set of "Blending" manuals and materials to support the use of CM (https://www.drugabuse.gov/blending-initiative/motivational-incentives-package). Roll et al. (2009) described some of the obstacles that interfere with broad scale application of CM in community treatments. One effort that has shown promise is a large implementation trial promoting the use of CM as a routine treatment approach within United States Department of Veterans Affairs (VA). The effectiveness of this implementation project has been documented by DePhilippis et al., 2018, who reported that CM is being successfully implemented across a large number of VA sites and that patient outcomes were significantly improved by the addition of CM within these treatment settings.

As cocaine and especially methamphetamine use and overdose rates have risen over the past 5 years, there has been great interest in using CM. However, there were some significant obstacles in addition to those mentioned in Roll, et al 2009. These included:

> OIG Restrictions. Until Dec 2020, there were concerns that the SAMHSA Office of Inspector General (OIG) would not allow for the use of incentives given to people using Medicaid and Medicare. There were concerns that giving people incentives would be viewed as "kickbacks" and would risk legal penalties. For this reason, until 2021, there was virtually no use of CM outside of the VA. In Dec 2020, the OIG published a "Final Rule" that clarified its position on use of incentives and made it clear, that incentives could be used, with no financial cap, as long as robust fraud prevention plans are in place to prevent fraud and misuse of funds.

$75 per person per year cap. In 2020, SAMHSA announced that money awarded in their grants could be used for CM. However, they imposed a $75 per patient per year cap on the amount that could be used for the CM incentives. In the research literature, $75 is well below the amounts used in CM for StimUD studies. The maximum amounts that can be earned for perfect performance in the research literature range from about $150-$300 per month over 3-4 months. Therefore, protocols where patients can earn $1000-$1200 for perfect performance are most common.

In 2022, several states including California, Montana, and Washington applied for federal waivers to use Medicaid money to finance CM at evidence-based levels. In addition, SAMHSA has indicated that higher amounts will be allowed in future grants, although as of Sept 2022, a specific date has not been announced.

Contingency Management: The Bottom Line. The research evidence is crystal clear that CM is the treatment of choice for people with StimUD. Regulatory issues have been clarified. CM can be done within a Medicaid environment as long as the CM protocol being used is based on research evidence, there are policies and procedures to ensure compliance with the protocol and there are very clear procedures to ensure the accounting for how incentives are delivered and accounted for. These regulatory "guardrails" are of paramount importance to ensuring that CM does not become a source of waste and fraud in the Medicaid system.

CM financing is progressing by different mechanisms, hopefully SAMHSA policies will change and the $75 per patient cap will be lifted. But regardless, there are many efforts, including the use of funds awarded in opioid lawsuits that will move forward the use of CM.

As soon as it becomes possible to use CM at adequate incentive levels, it should be the treatment of choice for treating people with StimUD. All of the treatments reviewed below may be effectively used to support CM, but CM should be the foundational, essential element in protocols to treat people for StimUD.

Community Reinforcement Approach (CRA)

The Community Reinforcement Approach (CRA) is a combination of behavioral strategies that address the role of environmental contingencies in encouraging or discouraging drug use and attempts to rearrange these contingencies so that a non- drug using lifestyle is more rewarding than a using one. CRA components include behavioral skills training, social and recreational counseling, marital therapy, motivational enhancement, job counseling, and relapse prevention. In a number of CRA trials for cocaine use disorder, a voucher-based CM reinforcement program was added. Higgins et al. (1991) established the efficacy of CRA and vouchers (CM) for cocaine dependence treatment. To isolate the effects of CRA, Higgins et al. (2003) replicated this study, comparing CRA with vouchers versus vouchers only. Study results demonstrated that while both conditions produced significant reductions in cocaine use, participants in the CRA-plus-vouchers condition were better retained in treatment and had fewer days of cocaine or alcohol use. Further, those treated with CRA plus vouchers had more employed days, fewer hospital admissions and legal problems, and reduced symptoms of depression. A systematic review of CRA concludes that CRA has evidence of support for reducing cocaine use, and CRA together with CM produced higher rates of abstinence than CRA alone. To promote the dissemination of CRA plus CM, NIDA has produced a manual describing the approach in detail.

Cognitive Behavioral Therapy (CBT)

Cognitive behavior therapy (CBT) is a form of “talk therapy” based on principles of social learning theory that is used to teach, encourage, and support individuals in reducing or stopping their harmful drug use. CBT provides training and practice in skills that are valuable in assisting people to gain initial abstinence from drugs (or in reducing their drug use) and provides skills to help people sustain abstinence.

CBT addresses negative thought patterns and teaches individuals how to cope with distress to prevent a return to drug use. A systematic review highlighting randomized control trials using CBT as an intervention for individuals who use methamphetamine reported that CBT was associated with reduced stimulant use and facilitated improvements in mood and other areas of functioning (ref), and a review of CBT for a variety of substance use disorders concludes that it is an effective approach (ref). Carroll and colleagues have conducted studies establishing the efficacy of cognitive behavioral therapy (CBT) for cocaine use disorder treatment. These studies

demonstrated that the use of their CBT manual reduced cocaine use over a 1-year period. In fact, their report suggests that CBT produces especially efficacious results at follow-up points. In a meta-analysis of behavioral treatments for cocaine and methamphetamine use disorders, studies evaluating efficacy of CBT consistently reflect positive findings. However, data in this meta-analysis indicated that in numerous comparative trials in which CBT is compared to CM, CM strategies consistently result in greater reductions in stimulant use.

Recently, CBT has become more accessible through computerized delivery. In a randomized trial for cocaine-using individuals in methadone maintenance treatment, results showed that participants receiving computer-based training for cognitive-behavioral training ("CBT4CBT") were significantly more likely to have 3 or more consecutive weeks of abstinence from cocaine compared to controls.

Behavioral Approaches with Supportive Evidence

The following behavioral strategies have been the subject of at least one randomized clinical trial demonstrating superior outcomes when compared to control procedures.

Exercise Therapy

Exercise is a simple and effective intervention for substance use disorders. By increasing endogenous opioid release, exercise helps potentiate dopamine efflux, improves mood and cognition, and can help prevent a return to drug use. A recent 8-week trial (ref) showed that participants who use methamphetamine randomized to a supervised, progressive endurance and resistance training three times per week demonstrated improved dopamine receptor binding compared to individuals receiving health education only. In addition, the participants who received the exercise intervention had lower anxiety and depression scores over the study period, and individuals with lower severity methamphetamine use at baseline had significantly lower return to drug use rates after discharge from residential care.

A large, randomized control trial funded by the National Institute on Drug Abuse also explored the relationship between stimulant use and exercise in residential programs. This study found a modestly significant higher percentage of days abstinent for participants receiving exercise who were

adherent to their regimens, compared to those only receiving health education

Mindfulness

Mindfulness is a practice derived from Buddhist teachings that centers on a conscious presence in the here and now with focused attention and nonjudgmental monitoring. Positive effects with regard to stress and cue reactivity in individuals with alcohol and/or cocaine use disorders receiving mindfulness compared to CBT have been reported. A systematic review of the literature (Garland & Howard, 2018) recently concluded that mindfulness behavioral interventions could reduce consumption of cocaine and amphetamines to a greater extent than controls. Recently, a small pilot trial of a 10-week mindfulness therapy found that abstinence rates in participants who use cocaine who received mindfulness were greater than those of historical comparison groups.

Transcranial Magnetic Stimulation (TMS)

Transcranial magnetic stimulation is FDA approved for treatment resistant depression and has demonstrated preliminary evidence of potential efficacy for stimulant use disorder. A pilot trial that randomized participants with cocaine use disorder to receive repetitive TMS (rTMS) on the left dorsolateral prefrontal cortex (DLPFC) found a significant reduction in craving and cocaine positive urine tests in the rTMS group compared to the control. Similarly, it was shown that five sessions of rTMS on the left DLPFC significantly reduced cravings in patients with methamphetamine use disorder, while improving cognitive function. A subsequent study confirmed that cue-induced cravings for methamphetamine were diminished by rTMS of the dorsolateral prefrontal cortex, irrespective of side or frequency. This non-invasive treatment modality has limited side effects and may represent a unique way to target disordered stimulant use going forward.

Matrix Model

The Matrix Model of Intensive Outpatient Treatment is a combination of therapeutic strategies, including CBT, motivational interviewing, family involvement, and psychoeducation combined in a manner to produce an integrated outpatient treatment experience. In a large, multisite randomized trial comparing the Matrix Model to treatment as usual, individuals who use

methamphetamine were retained in treatment longer, provided more methamphetamine negative urines, and had longer periods of abstinence than controls.

Motivational Interviewing (MI)

Motivational interviewing is a technique that aims to help individuals resolve their ambivalence about affecting positive change. In a recent randomized clinical trial, motivational interviewing demonstrated positive benefit with decreased methamphetamine use and lower cravings in participants receiving MI, regardless of intensity. Of note, intensive MI lasting 9 weeks was found to be especially impactful for women with methamphetamine use disorder and comorbid alcohol use. Another randomized trial examining MI for cocaine use found those individuals who used cocaine on 15 or more of the 30 days prior to baseline had a significantly higher mean reduction in days of cocaine use following MI.

Twelve-Step Facilitation

Twelve-step facilitation is a therapy that is founded on the principles of Alcoholics Anonymous and traditionally comprises non-directed participation in meetings, fellowship, and attainment of a sponsor for guidance in recovery from substance use. A large multisite randomized trial sponsored by the National Institute on Drug Abuse demonstrated evidence that participation in 12-step therapy resulted in significant decreases in reported stimulant use and cravings and led to prosocial service engagement. Additionally, a secondary analysis suggested that having a sponsor was associated with a higher likelihood of sustained abstinence from stimulants at follow-up.

Chapter 2: Therapist Orientation

As treatment organizations attempt to apply evidence-based practices (EBPs) to address the treatment needs of their patients with StimUD, it can be challenging to decide if one of these EBPs should be provided alone or together with other EBPs. This manual presents a framework and content for how these EBPs can be combined into a 12-week protocol, followed by an ongoing continuing care support program.

The manual is intended to provide clinicians with suggestions for how these techniques can be integrated to address the needs of individuals with StimUD. An appendix at the end of the manual includes a list of other manuals and materials with a varied amount of empirical support which may be of value in treating this patient population. For treatment organizations that use the TRUST protocol as a core for an intensive outpatient level of care (ASAM level 2.1 and above), we recommend that materials from the appendix be considered as additional treatment materials.

The Components of the TRUST Protocol

Harm Reduction as a Foundational Philosophy

The drugs on the street in 2023 are incredibly lethal. With fentanyl currently mixed into the drug supply, anyone using these drugs is at high risk for overdose death. The lethality of the drug supply requires some therapists to rethink their priorities in working with individuals who are currently using drugs.

For many years, for many therapists/counselors who worked in SUD treatment settings, there was a single goal in treatment…helping people become abstinent from all drugs and alcohol and enter “sobriety”. This was a non-negotiable, inflexible goal. Anything short of this goal was viewed as failure. Any reduction in use, short of total abstinence or cessation of certain drugs, but not all drugs/alcohol, was considered treatment failure. “My way or the highway”, “if you don’t accept abstinence as a goal, don’t waste my time…come back when you are ready”.

In 2023, this approach is unacceptable. In 2023, the lethality of the drug supply requires that SUD services prioritize keeping the individual alive as the first and most important goal. Dead people don’t recover. A related concept is:

“Kicking people out of treatment dramatically raises their risk of death and is unacceptable”.

In the 2022 US National Drug Control Plan, harm reduction is defined as: an approach that emphasizes working directly with people who use drugs (PWUD) to prevent overdose and infectious disease transmission, improve the physical, mental, and social wellbeing of those served, and offer low-threshold options for accessing substance use disorder (SUD) treatment and other health care services.

The Office of National Drug Control Policy (ONDCP) currently defines harm reduction as a public health approach designed to advance policies and programs for PWUD, based on the principles of Care-Support-Connect-Respect.

In the context of the TRUST approach, we recognize that people enter treatment at different points in their drug use journey. We hope we can help people reduce and optimally discontinue their harmful drug use. The message in TRUST is that we hope to provide you with information and strategies that will assist you in developing a positive recovery from drug use.

However, we recognize that not everyone who enters treatment with TRUST is committed to abstinence from all drugs, or even some drugs, or even reducing their drug use. They are at an early stage of recognition of their problem with drugs and may still be enjoying many aspects of their drug use. In the “old days” some treatment programs might have told them they weren’t “ready” for treatment and should come back when they “hit bottom”.

In 2023, whatever reason individuals have for entering treatment or whatever attitude they have toward their drug use and the idea of reducing/stopping their drug use, if they have made the effort to show up for treatment and participate in some aspect of treatment, this is an opportunity to reduce their risk of death.

In the last section of this chapter, we define “retention” as the priority of treatment in TRUST. As the old saying in AA says: “Keep coming back”. It can be challenging to work with people who aren’t committed to sobriety. Often the materials of TRUST may not be relevant to them. However, if you can keep them coming back, you can reduce their risk of death.

When working with an individual who is actively using, but willing to meet with you, you may need to move away from the TRUST sessions and work with

them in individual sessions that focus on reducing risky drug use, learning about naloxone and other suggestions for reducing overdose risk. However, your non-judgmental and compassionate approach will give them a message of treatment as a place of assistance and not of judgement and criticism. If/when they decide to act toward reducing their use, you will be viewed as a trusted source of help.

The Incentive Program

As reviewed in Chapter 1, contingency management (CM) is the technique with the greatest evidence of effectiveness for StimUD treatment. In the research trials that have shown CM to be effective, the amount of possible reinforcement that can be earned by study participants has ranged from $400-$1,200 over a 12- or 16-week period. Average amounts earned in research studies are in the range of $500 over 12 weeks. stimulant abstinence. This escalating schedule of incentive values with the reset is a component in all CM research.

As discussed in the introduction to the TRUST manual, the TRUST materials can be used in support of CM treatment protocols that use adequate incentives (REAL CM). And this use of the TRUST materials (i.e., together with REAL CM) is the current most encouraged approach for treatment of StimUD.

As of August 2023, there are jurisdictions that are not able to use adequate incentive amounts and are attempting to provide effective treatment for people with StimUD using the $75 incentive amount. For these situations, the following incentive program is described below. **However, it should be emphasized that when $75 is used as the maximum incentive, this practice does not represent the use of CM.**

The $75 incentive program used is not “REAL CM”. TRUST uses a modest $75 incentive program, which in combination with other research-supported interventions MAY provide effective treatment for individuals with StimUD.

We believe the use of positive reinforcement (incentives) for positive behavior change can promote treatment goals and is a useful component of this manualized treatment protocol. For this reason, we will refer to the systematic delivery of rewards for target behaviors as the “Incentive Program” component.

Incentive Program

The incentive program recommended for use in the TRUST manual is developed to be simple and to be used in circumstances in which $75 is the maximum amount that can be used for incentives.

We recommend that at the orientation session, candidates for the TRUST program should be given a $15 gift card to compensate them for their time and demonstrate to that incentives are part of the TRUST program. We want patients to know that we understand that it is hard to always find the motivation to make positive progress and the incentives are an extra way we support their effort.

The specific incentive program employs Incentives for reduced stimulant use. At each weekly session where a urine sample is collected, if the result is negative for stimulants, a $15 gift card is earned and given to the patient (up to a total maximum of $75). Described in more detail in Chapter 5.

Motivational Interviewing

As described in Chapter 3, a number of specific MI skills are particularly useful in promoting engagement with patients and helping to address some aspects of patient ambivalence and reluctance to make behavior change. To an even greater extent, we see the spirit of MI, especially compassion and non-judgmental acceptance, as fundamental to the success of treatment using the TRUST (or for any) approach for StimUD treatment. We hope that an overarching message in the TRUST protocol is that individuals with StimUD must be treated with compassion and dignity and without judgement throughout their treatment experience.

Cognitive Behavioral Therapy and Community Reinforcement Approach

CBT and CRA are both “talk therapies” that teach, encourage, and reinforce patients to have a better understanding of their own behavior and to develop some active techniques to make behavior change.

One of the major foci of the CBT exercises in this protocol is helping patients learn about the conditioned cues that often set off their craving for stimulants. These “triggers” established via Pavlovian conditioning are extremely powerful events that can often derail a patient’s progress. It can be helpful for them to understand this “triggering” process, avoid triggers if possible, and cope with them when they occur. In addition, there is an emphasis on helping patients manage their time and find drug-free environments and people to help support

their recovery efforts.

The major contribution of the CRA exercises is to educate and encourage patients to develop new non-drug related, reinforcing behaviors that help sustain progress in recovery. When a person has StimUD, methamphetamine and cocaine become the dominant source of reward in their lives. When they attempt to reduce/stop their use of stimulants, their lives are often devoid of reinforcement and can seem joyless and empty. Part of the anhedonia that patients experience is often expressed in terms of “there is nothing positive in my life.” CRA strategies educate and assist people in initiating and sustaining new behaviors that support recovery and provide new sources of enjoyment and reward in life.

Physical Exercise

There is a vast amount of research that supports the benefits of exercise on many aspects of health (e.g., cardiovascular health). More recently a robust set of evidence has been collected to document the benefits that exercise has on mental health symptoms, particularly anxiety and depression. In the past decade, there is a newly developing collection of research that shows that physical exercise can be useful to individuals in recovery from StimUD.

Several NIDA-funded studies have reported that for individuals with StimUD, exercise can produce brain changes that help people address the commonly experienced anhedonia, anxiety, and depression in the early months of recovery. Further, return to methamphetamine use was reduced if a residential treatment program was augmented with a program of regular exercise. For this reason, exercise is integrated into the TRUST protocol.

Continuing Care

Obviously 12 weeks is merely the beginning of the process to reduce/discontinue cocaine and methamphetamine use. It is essential for individuals with StimUD to have a support system to help them progress and build their life in recovery. The continuing care component is a very modest framework to provide support.

Clearly a successful sustained recovery requires long term behavioral change and the development of many new activities and attitudes. Continued participation in exercise and learning CRA and CBT concepts and other

strategies to promote physical and mental benefits are essential for sustained benefits. 12-Step and other self-help activities can be valuable and available support systems. Additional participation in treatment activities and approaches listed in the appendix can also be useful.

Retention in Treatment-An Overarching Priority

As we have come to recognize substance use disorders as chronic health problems, our treatments have necessarily become increasingly focused on retaining patients in treatment and recovery services for extended periods of time. As was recognized by the founders of Alcoholics Anonymous (AA) and supported by decades of research, the longer a person remains involved in treatment and/or recovery activities, the less drugs/alcohol they use, the less they are involved in criminal justice activities, and the better they function within their families and communities. An even more direct measure of the importance of patient retention in treatment can be seen in overdose death statistics. People with SUD who currently are in treatment or recovery activities have far lower rates of overdose deaths than those with SUD who are not involved in treatment or recovery activities. In short, retaining patients in treatment reduces overdose death rates.

Retaining people with StimUD in treatment is a major challenge. Medications like buprenorphine or methadone that support retaining patients in treatment are not currently approved by the FDA. With the tools currently available, two of the most powerful factors in promoting treatment retention are the use of incentives and a positive therapeutic relationship between the therapist and the patient. In this manual, we include an incentive component to promote early retention, and we strongly recommend the use of motivational interviewing as a way of encouraging a strong positive relationship between patients and treatment staff. For many patients, the relationship with their therapist is the glue that holds patients in treatment. In the next chapter, we describe some of the essential MI skills that are of greatest importance in retaining people in treatment.

There are other factors that can reduce treatment drop out/promote treatment retention. First, it is important that patients have transportation to get to and from the treatment site. For those with transportation challenges, it may be possible to do some of the treatment activity over a telemedicine platform. It is also important that the treatment sessions are scheduled on days/times that

are compatible with patient schedules (i.e., working patients may need evening treatment sessions).

Childcare can be a challenge for some patients. In some treatment programs, childcare is provided on site, which can be a major benefit to many patients who have childcare responsibilities. Finally, many patients in outpatient treatment live in unstable/active drug use situations. For these patients, consideration should be given, in line with ASAM Criteria, to include drug-free housing as part of their treatment plan.

Often patients miss treatment sessions, and when this occurs, it is important for staff to reach out by phone/text (following proper patient privacy/security protocols) to encourage patients to come for a replacement session and/or to attend their next scheduled session. Patients who have recently stopped methamphetamine or cocaine have very chaotic and disorganized lives and are cognitively impaired. Attending scheduled sessions on time can be a major challenge. Therefore, it is important for staff to maintain a positive and supportive attitude that recognizes the difficulty of treatment participation for patients.

Attendance should be praised/reinforced, and those who have attendance problems should be given continuing support and encouragement to attend.

Treatment practices that promote retention

- ✓ Positive, supportive, safe environment
- ✓ Use a non-judgmental, MI interaction style with patients
- ✓ Use positive incentives (whenever possible, contingency management)
- ✓ When possible, make snacks and drinks available
- ✓ Support with transportation
- ✓ Childcare on-site
- ✓ Flexible service hours (evenings, weekends)
- ✓ Telephone/text outreach and encouragement when patients miss sessions
- ✓ Coordinating care with primary care and mental health professionals (*or even better, fully integrates StimUD care with primary and mental health care*)

Chapter 3: Motivational Interviewing

This chapter on Motivational Interviewing (MI) is not meant to be an exhaustive tutorial, but rather an overview of the components of MI, and a review of basic MI skills that are of great importance in working with patients with StimUD. These tools are meant to help therapists work with the ambivalence of patients and promote positive attitude and behavior change. MI is a set of skills that must be learned and used in your treatment activities**.** Practice**,** practice, practice.

Motivational Interviewing, developed by Miller and Rollnick (1991), is a way to interact with individuals to strengthen their personal motivation towards achieving a specific goal. Building on the humanistic concepts of Carl Rogers, MI recognizes and validates an individual's right to make their own choices. Additionally, research shows there is a protective factor, in the form of reducing burnout for therapists consistently engaging in MI-adherent interactions.

A wide range of on-line training courses on MI are available. These include single and multi-day courses. Additional details are available at: https://attcnetwork.org/centers/northwest-attc/motivational-interviewing-mi.

The "Spirit" of Motivational Interviewing

The underlying **Spirit of MI** includes *Compassion, Partnership, Acceptance and Evocation.* Developing a helping relationship requires each of these components to be able to thrive. A patient must feel accepted and not judged, feel empathy and not pity, be a valued-equal team member, to be able to talk openly about their deepest darkest secrets which may not have ever been shared with another person. The shame, guilt and embarrassment that accompany behaviors that frequently occur to obtain drugs or while under-the-influence of drugs can overwhelm the desire to be open and honest. MI provides a set of skills that helps the therapist communicate to a patient that they are safe to share personal information without being judged or criticized.

What would take it for you to be able to share your innermost thoughts and feelings with another person? What characteristics or qualities would that person need to have for you to let your guard down?

The spirit of MI is a requisite to set the tone for a productive relationship. This spirit and the skills to express empathy, compassion and acceptance are essential throughout all the activities in the TRUST protocol.

Principles of Motivational Interviewing

The five principles of Motivational Interviewing are as follows:

- Express Empathy
- Develop discrepancy between the individual's goals and current situation
- Avoid confrontation
- Recognize and adjust to resistance to promote change talk
- Promote self-efficacy

Expressing Empathy

MI emphasizes "meeting an individual where they are" and accepting that the patient may be very early in the process of recognizing the negative consequences of their drug use. Before MI was used in substance use disorder treatment, patients who were less than fully compliant were viewed as "in denial" and often sent away from treatment and told to "come back when you are ready to change." This toxic, judgmental attitude, and approach toward people with StimUD is neither ethical nor acceptable. Patients turned away or kicked out of treatment are at very high risk of overdose and death.

MI recognizes ambivalence as a "normal" part of making difficult behavioral changes. Instead of judging the individual as being "not ready," or "in denial," use of MI helps the therapist to communicate understanding and acceptance of the patient's condition and their right to make their own decisions. Early in an individual's struggle with StimUD, it is often difficult to envision the need for change. Through the use of MI, the therapist can express to the patient that the decision to change their life and begin a program of recovery is a decision that can only be made by the individual. Through the expression of empathy, the therapist accepts the patient's feelings and beliefs and communicates them in a respectful, non-judgmental manner in the form of a *Reflection*, one of the four MI Micro-skills.

It is important for the therapist to communicate to the patient that they recognize the patient-therapist relationship as a partnership. The individual with StimUD brings to the treatment milieu a set of life experiences, skills, strengths, challenges, and resources. The therapist also brings to the relationship a set of life experiences, skills, strengths, challenges, and resources. From the interwoven, collective experience of these individuals, a platform of opportunity for change can be constructed to support the patient. The therapist serves at the behest of the patient and is there to listen, provide acceptance and support, while offering information and guidance if desired by the patient.

Developing Discrepancy

The Cambridge Dictionary defines “discrepancy” as: “a difference between two things that should be the same.”

With MI we try to help patients develop a discrepancy between 1. where they currently are in relation to their stated goal(s), and 2. where they would ultimately like to be or like to achieve.

Patients are encouraged to share how they could change their lives to better achieve their goals. It can be helpful to encourage patients to think about how they might go about making changes: “change talk.” In this discussion it is helpful for patients to talk about: the not-so-good things about making those changes as well as the good things about making the stated changes. Engaging in this exercise helps to create a vision for the direction the change process can take, serve as a roadmap for change and can become the foundation in developing a sense of accountability, and ultimately self-efficacy.

A useful tool in the effort to develop discrepancy between the individual’s current situation or life circumstances and personal goals, is to look to the future. Often when a person who uses substances reflects upon their past, they feel a sense of loss, shame, guilt, self-doubt, trauma, and disappointment. Looking ahead provides an opportunity for hope and a reason to make change. Listening for “Change Talk” as the patient describes the urgency and importance that cutting back or ceasing drug use provides the therapist insight as to what is important to the patient, and potentially specific steps they are willing to take.

Avoiding Confrontation and Adjusting to Discord

Individuals with StimUD typically come into treatment with a great deal of ambivalence about whether or not they have a problem with drugs and with considerable ambivalence towards change. This is the rule, not the exception. Frequently they express strong opinions about why they don't need treatment. Being able to listen to patients give their opinions, without disagreeing with what they are saying and/or arguing with them does take considerable patience and discipline.

Understanding and acceptance of the patient's perspective is foremost to establishing rapport. Acceptance of the individual is not the same as approval of the patient's behaviors. Lecturing, arguing, criticizing, making sarcastic comments, and scolding are inconsistent with the spirit of MI and tend to produce discord and friction in the patient-therapist relationship. Active listening to understand the patient's perspective about their drug use and its role in their life is an important step in relationship building.

Promote Self-Efficacy

Recognizing incremental change in our patients is an invaluable tool towards facilitating "self-efficacy." The use of affirmations to highlight their positive actions can help to bolster confidence and enhance motivation while reinforcing the exact behaviors most likely to lead to a successful recovery.

Genuine affirmations increase change talk while decreasing sustain talk Catch your patients doing something positive and acknowledge their efforts. When a patient shows up late to their appointment, the therapist who scolds the patient for tardiness fails to acknowledge that the patient has indeed made the effort to attend their appointment. Change is difficult, and so is managing the expectations of our patients.

Change-Talk

Expressions of *Desire* ("I want to …", "I would like to …"), *Ability* ("I think I can do that!", "I've done that before!") *Reasons* ("If I don't make these changes I think my partner is going to leave me!") and *Need* ("I got so sick the other day, I have to stop drinking!") are considered preparatory change talk statements. These statements can be viewed as an invitation to the therapist to provide an open-ended question, affirmation, or reflective statement as a way to learn

more, reinforce, or check for clarity on the statement made.

Motivational Interviewing Core Skills

Expressions of *Commitment*, *Activation, or Taking Steps* are considered "Mobilizing Change-Talk" with an individual preparing to act, move into action, or having already taken steps to elevate their condition. Again, utilizing the MI Micro-skills of:

Open-ended Questions, **A**ffirmations, **R**eflections and **S**ummaries.

(OARS) can serve the therapist in reinforcing statements of change (Change-talk) thereby increasing the likelihood of change occurring.

Curiosity is an incredibly powerful resource at the disposal of the therapist, which will go a long way to establish rapport and build trust. Being curious about your patients indicates that you are interested in them. Be curious. "Where did you go to high school"? "Were you involved in sports?" "How many brothers and sisters do you have and where do they live?" Understanding the perceived value that stimulant use has provided the patient, and conversely, the challenges that stimulant use has presented for the patient and their family, will allow the therapist to more fully comprehend the impact stimulant use has had on the individual.

This process may ultimately highlight the central theme(s) towards developing discrepancies.

Open-ended questions such as: "How would you like for things to be different?" "What would it take to achieve those goals you just described?" will provide patients an opportunity to articulate where they would ultimately like to be, and what they would like to accomplish during the time you are working together. Gaining this insight can be invaluable, both in terms of learning to understand what is important to your patient and towards developing a meaningful, individualized treatment plan.

An individual who uses stimulants may want to regain custody of their children or may want to get their probation officer off their back. As they consider these challenges, they often do not view their drug use as a problem, rather, they view the problem as the child protective services or the probation officer.

Many therapists would consider these individuals to be in "denial" and confront them by saying "You know, your meth use is why you lost your

children and if you stopped using meth you might have a chance to get them back." or "If you stopped using and went to meetings, your probation officer might see you as being serious about your recovery."

In each of these cases, the patient has indicated what their desires are, "to get their children back" or to "get in the good graces of their probation officer." A simple reflection, such as, "Your children are important to you!", or an open-ended question, "What would it take to get your PO off your back?" provide an opportunity for the patient to express their own course of action(s) for change and avoids discord in the form of an argument or confrontation around the need to stop using substances.

As we began this section on Motivational Interviewing, we will end this section by emphasizing that Motivational Interviewing is a set of skills that must be learned and used in your treatment activities. **Practice, practice, practice.**

Chapter 4: Patient Orientation Session

When individuals are admitted into treatment for StimUD, they complete a variety of medical and psychosocial evaluations and frequently treatment placement assessments using the ASAM Criteria. After the individual has completed the evaluation and placement process and if they are appropriate for treatment in the outpatient protocol described in the TRUST manual, they can be oriented for treatment. It may be that this orientation is provided at the same time as the medical/psychosocial assessment or in a subsequent appointment. To promote engagement, the time period between the assessment and the orientation (treatment initiation) should be as short as possible. Do not require patients to wait to enter treatment as part of a group cohort. Immediate admission is a priority.

Important Considerations and Skills in Orienting Patients to the TRUST Protocol

It is important to orient patients to the elements of the TRUST protocol. It is useful to begin the orientation by asking the patient to provide an overview of their drug use history, with detailed information about recent stimulant use (amount, frequency, route of administration and time since last use). If there has been very recent use (past 24 hours) or very heavy use over the past 30 days (particularly via injection), the patient's attention span is likely to be limited, and the orientation should emphasize immediate priorities and expectations. For those who are less acutely impaired, the provider may take more time to explain the rationale for the program, the elements of the program, and find out more about the patient and their life in an effort to build a positive rapport.

It is important to give the patient an opportunity to talk about what they want from treatment. For many patients, this will be straightforward. The patient will describe how stimulant use has damaged their life and why they are in treatment to become abstinent from stimulants. Other patients will have goals that are less clear. They may say they hope to reduce, but not discontinue use of stimulants, or they may say they feel that they don't have a problem with stimulants, but they have been forced into treatment by family or legal pressure. Motivational interviewing skills will be extremely valuable in working with these patients (see previous chapter).

It is important to keep in mind that if individuals who use stimulants are

attending treatment, their risk of overdose death is reduced. Getting them into treatment and retaining them in treatment are priorities. Not everyone enters treatment saying "the right things." However, individuals who express ambivalence about abstinence as a treatment goal and/or who express outright skepticism about treatment can benefit from information they receive in treatment and certainly, over time, they may modify their views of treatment and/or the benefits of discontinuing stimulant use. It is important to remember that this treatment is intended to meet the needs and treatment goals of the patient, which may or may not be the same as those of the majority of patients (and therapists).

Regardless of a patient's motives for treatment or treatment expectations, the priority is to get them "connected" to a therapist and to keep them coming back.

For ambivalent/skeptical individuals who are very vocal and dogmatic in their views, it may be necessary to conduct all their treatment sessions as individual sessions, rather than have them attend group. The same treatment content that is scheduled for group sessions can be delivered and discussed in individual sessions. Having an individual in a treatment group who has treatment goals that are very different than the other group members can be disruptive to the group and distract from the purpose of the group for all of the patients including the individual.

Patients should be oriented to the fact that the typical service schedule is for two visits per week for 12 weeks, followed by at least another 3 months of continuing care/recovery services. The therapist can discuss with the patient when the two sessions would be most convenient and plan a treatment schedule, with one individual and one group session. If possible, the same therapist should deliver all services to an individual patient as a way of maximizing rapport building and development of strong positive relationship.

It is helpful to explain to the patient that the treatment services will include group sessions and one individual session and one urine test per week, collected and tested immediately in a point of care test cup. In addition, treatment involves the development of an exercise program and an incentive program in which the patient will be able to earn some incentives in the form of gift cards.

In fact, when the patient attends the orientation session, they will receive their first gift card worth $15. Following this first session patients can earn up to an additional $60 worth of gift cards for stimulant-negative UAs.

It should be explained to patients that an unusual aspect of the TRUST protocol is that physical exercise is a formal component of the treatment experience. We encourage exercise because there is research to support the fact that for individuals with StimUD, a program of regular exercise can reduce symptoms of anxiety and depression, reduce drug craving, promote recovery in the brain's dopamine system and reduce the likelihood of a return to stimulant use following a period of abstinence.

It is useful in establishing rapport for the therapist to listen to any patient concerns and answer any questions the patient may have about the treatment. It is important to clarify that the individual and group sessions are designed to provide patients with new information and useful information for addressing their use of stimulants. Patients will be encouraged to take part in discussions, but it is their choice when and how much they want to talk.

It is important for therapists to keep in mind that when individuals who use cocaine and/or methamphetamine enter treatment, they are often disoriented, emotional, sleep deprived, and ashamed. For individuals with StimUD to "connect" with a therapist, it is important for the therapist to maintain a nonjudgmental and compassionate perspective. It is important for therapists to express encouragement, optimism, and genuine empathy. The point of most frequent treatment drop out is in the first 3 sessions. Therapists' ability to express genuine acceptance and compassion is essential.

Calendar and Dots

One of the treatment activities that is conducted at each treatment session (individual and group) is a simple visual tracking exercise using a calendar page and colored stickers or "dots". Patients are encouraged to put a colored "dot" on each day that they have abstained from stimulant use. This calendar provides a visual record of their success at developing days abstinent from stimulants.

Patients are encouraged to do this exercise based upon their self-report of stimulant use. This small simple exercise can develop symbolic importance to patients, and frequently they will look forward with great enthusiasm to applying the dots to their calendar. On days when stimulant use occurs, no dot is applied. Over time for the majority of patients, the calendar pages become filled with dots and are a source of pride.

At the end of the orientation session, calendar and dots are introduced to patients. For those who have some non-use days, they can apply dots to their pretreatment stimulant abstinent dates. For many, they may have used within hours and do not have any days to mark with a dot. When they come in for each session, they are encouraged as a first activity to apply these dots throughout the 12-week treatment experience.

Orientation Checklist

In the orientation session it is useful to:

Review drug history and recent events that have brought the individual to treatment.

1. Determine goals in treatment and discuss and agree on a treatment session schedule.
2. Describe the group and individual session format and content.
3. Provide a brief explanation of the incentive and exercise treatment components.
4. Begin “calendar and stickers” routine.
5. Make a specific plan for the first treatment session, and help the patient schedule their time from when they leave your office until their next appointment.

Orientation Summary: We are glad you have come to treatment, and we hope you fully benefit by attending all the scheduled sessions. “Come to Treatment, Stay in Treatment”

It can be helpful to give patients the metaphor that treatment groups and individual sessions are like doses of medicine. The more consistent they are in attending, the more “medicine” they receive and the more they benefit. If they have some challenges in attending treatment, we hope that they will let the therapist know so they can get some help with finding a way to “attend”.

It is good to remind patients that if they are going to miss an appointment, let the therapist know and see how an alternative can be created to allow the patient to participate in the session.

Let the patient know that if they unexpectedly miss an appointment, you will call/text/email them to connect and reschedule.

In addition, it is good to let the patient know that if they are going to be late for a session, they should come anyway. Attending twice per week provides a valuable structure to their recovery and a brief visit is far better than no visit. If patients encounter problems between appointments (for example, craving, emotional difficulty, drug use), they should contact the therapist by phone or text.

COVID-19 Considerations and/or Transportation Considerations

During the current COVID-19 pandemic, it may not be practical for patients to attend twice weekly in person sessions. It may be necessary to use telemedicine/zoom/skype etc. for some patients for some sessions. There is no research currently available to guide how this can be done optimally. Some experienced treatment practitioners currently in this struggle have observed that they feel that for many patients, individual sessions can be done with good participation and effect over a video platform. Group sessions are more challenging to do on a video platform, but possible. The one observation made by numerous experienced clinicians is that it is not optimal to move the entire treatment to a remote platform. Some amount of in-person attendance is considered important. According to these clinicians, a mixture of in-person and remote video sessions may be optimal.

Of course, in the case of patients with high-risk profiles and high concern about infection it may be necessary to deliver all sessions by video or even telephone (or a “chat” service?). Similarly, some patients start treatment with an ability to travel to the clinic, but at some point, lose their transportation. For these patients a remote video platform may be the only viable alternative.

Chapter 5: Incentive Program

Contingency Management (CM)

Contingency management (CM), also known as motivational incentives, applies the principles of positive reinforcement for performance of desired behaviors consistent with abstinence from cocaine or MA. CM involves the contingent delivery of an incentive for “target behaviors” such as attendance at treatment sessions, drug-negative urine specimens, or other behaviors that promote reduction/cessation of stimulant use. Incentives include desired items or privileges, such as vouchers or gift cards or “prizes”.

The goal of contingency management is to use robust incentives to help individuals struggling with stimulant use disorder to discontinue or reduce their cocaine and/or methamphetamine use. There have been multiple systematic reviews and meta- analyses that clearly document that of all behavioral strategies (and there are no approved effective medications), contingency management/incentives has by far the best evidence of effectiveness for the reduction of stimulant use by individuals with StimUD (e.g., De Crescenzo, et al., 2018; Farrell et al., 2019). Currently, CM is the primary approach for treatment stimulant use in the VA system DePhilippis et al., (2018).

The TRUST materials can be used as a support program for REAL CM. Without question, REAL CM will provide be best treatment response for patients with StimUD. In our opinion, use of the TRUST materials with REAL CM is the best use of these materials.

As discussed in Chapter 1, in 2023 in many places, the amount of money that can be used for incentives is $75. A $75 incentive program is not REAL CM. When it becomes possible to use higher incentive amounts, these amounts should be organized into a CM protocol as described in the research literature. Whenever possible, REAL CM should be the foundation of treatment of individuals who use stimulants.

The $75 Incentive Program in TRUST

The TRUST protocol employs an incentive program that provides up to $75 in incentives (gift cards) to patients to promote reduction in stimulant use. In Chapter 4, the Patient Orientation Session chapter, the concept of incentives is explained to the patient. In fact, we recommend that individuals who are entering treatment are automatically given $15 in gift cards for attending the initial Patient Orientation session. This $15 in gift cards provides a small

incentive to promote treatment initiation and lets patients experience the reality that they can earn incentives as part of treatment in the TRUST protocol. As always when incentives are provided the gift card should be presented with praise and enthusiasm.

Note: **Cash is never used as an incentive**. For people with StimUD, cash can be a trigger and can result in triggering use of stimulants.

Recommended Use of Incentives within the TRUST Protocol

Provide an automatic $15 gift card for attending the patient orientation session.

1. Incentives to promote reduction in stimulant use. Provide a $15 gift card for each stimulant-negative urine specimen. If this model is used, it is essential to have point of care urine testing, so the incentive can be delivered immediately after the sample is provided and tested. In addition, specimens should be temperature monitored to ensure validity. If a patient provided all stimulant-negative UAs from the start of treatment, they would earn the $75 maximum incentive total in week 7. In this $75 incentive program, we recommend providing $15 at each time an incentive is given. If possible, we recommend purchasing $15 gift card for the TRUST program. However, for many commercial outlets, it is not possible to get gift cards in $15 amounts. In that case, we recommend purchasing $5 gift cards and each time an incentive is earned, 3, $5 gift cards are provided.
2. In some pilot trials with TRUST, smaller incentive amounts ($5 and $10) were used. Feedback from the staff using these amounts was that their patients did not appear to find these amounts to be meaningful or useful in promoting engagement/retention.
3. It is clear that $75 is not an adequate amount to conduct REAL CM. It is our hope that the use of $15 gift cards in the early weeks of treatment may be useful in reducing the problem of early (first 30 day) drop out. The use of the incentives as recommended in this TRUST protocol is to specifically help engage patients in treatment and help them establish some reduced drug use in the first month and complete this period of high risk for drop out.

We have purposely structured the incentive program in a way that it will help patients stop their stimulant use in the early weeks of treatment. It is our hope that all patients earn the maximum $75 in incentives as quickly as possible. We hope this schedule will focus the incentive benefit on the early weeks in treatment when patients are most vulnerable to drop out and have the most difficulty in stopping their stimulant use.

Fraud Prevention Guardrails on Use of Incentives in TRUST

Maintain security and a record of incentive delivery. Use of incentives involves having incentives in the clinic that are of considerable value. For example, if a program is going to treat 40 patients with TRUST and they plan to use gift cards incentives, they will have 40 x $75 worth of gift cards. In this case, $3,000 worth of gift cards will be used over the course of the program. It is extremely important to have a robust security and recordkeeping plan for the gift cards. In situations where a large supply of gift cards is kept in clinics, they can be great sources of temptation for patients and staff if not carefully monitored and secured. Theft of gift cards by patients and/or staff is a very demoralizing event, and good security and recordkeeping are needed to avoid this situation.

Tracking and distribution system. A very well-organized tracking sheet showing all incentives delivered to patients according to the protocol is critical.

Incentive coordinator. One person (and a trained back up) who manages the incentive program for all patients is needed. The CM security and distribution system needs active supervision by a senior person in the organization who regularly (weekly?) audits the security and distribution of incentives. Access to the computer used to calculate the incentive values and record CM distribution should be password protected and password information limited to the incentive coordinator and supervisor.

Supervisor audits. The supervisor should conduct regular (weekly? biweekly?) audits of the gift card supply and the distribution sheet, to ensure incentives are distributed per the protocol.

a. If gift cards are used, have a variety of cards for stores where they can be redeemed. Some patients prefer gasoline cards, others Walmart or Target, others grocery store cards. It is important that the cards can be redeemed for items that are desired by the patient. To the extent possible, if gift cards can be used that do not allow for purchase of alcohol, this is an excellent option.

b. If, during the COVID pandemic, in person contact is reduced but treatment is still being delivered via telemedicine/zoom/skype, it is possible to provide electronic gift card delivery. Hopefully when COVID adaptations are made to treatment programming, efforts to sustain the incentive program will be made.

Chapter 6: Exercise for Stimulant Use Disorder

Excellent evidence exists that physical exercise has many medical and psychological benefits. A growing body of literature supports the notion that exercise can have substantial benefits for individuals in recovery from drugs and alcohol use disorder. One of the recent studies by the authors has shown exercise to be particularly useful for individuals who use methamphetamine. One study does not provide sufficient evidence to establish exercise as an evidence-based intervention, but we think the research support is very promising. We think the inclusion of exercise can be of great help to individuals in early recovery (and later recovery) from StimUD.

Although we think the evidence supports promoting exercise with our patients in StimUD recovery, we cannot claim to know the best types of exercise, nor, and importantly, the best way to get individuals in treatment to develop exercise as part of their lives. This will be your challenge. We offer some suggestions, but at the present time, these are "best guesses" and we hope clinicians using this manual will use their clinical creativity to help patients develop exercise as a short term treatment strategy as well as a lifetime habit.

Exercise is Effective for Medical Conditions and Symptoms

The U.S. Department of Health and Human Services' updated *Physical Activity Guidelines for Americans* (USDHHS, 2018) provides a comprehensive review of the literature and documents strong evidence for the general health benefits of physical activity. For adults, improvements ensuing from regular exercise at moderate levels include lower risk of early death, heart disease, stroke, diabetes, high blood pressure, adverse blood lipid profile, metabolic syndrome, and colon and breast cancers. Exercise is helpful for the prevention of weight gain and weight loss, particularly when combined with a lower caloric diet and is also associated with improved cardio-respiratory and muscular fitness, and better sleep and cognitive function.

Exercise is Effective for Psychiatric Conditions and Symptoms

Aerobic and resistance exercise interventions are useful for a wide range of psychiatric conditions, including anxiety and depression (Saeed, Cunningham, & Bloch, 2019; Zschucke, Gaudlitz, & Ströhle, 2013). The

majority of studies have demonstrated efficacy of exercise in reducing symptoms of depression in both inpatient (Martinsen, Medhus, & Sandvik, 1985) and outpatient (e.g., McNeil, LeBlanc, & Joyner, 1991) settings; favorable results have been highlighted in several review articles (e.g., Barbour, Edenfield, & Blumenthal, 2007; Martinsen, 2008) and meta-analyses (Craft & Landers, 1998; North, McCullagh, & Tran, 1990).

Exercise and Substance Use Disorders

Exercise may hasten or improve recovery from SUDs by modifying underlying neurobiological processes, such as dopamine activity (Robertson et al., 2016). Cognitive deficits have been observed in individuals who use substances chronically as evidenced by poor performance on memory, attention tasks, and learning deficits (Ramey & Regier 2018). Substance use disorders are also associated with poor impulse control and selective processing (Lundvquist, 2005). These deficits are positively affected by exercise. In addition, exercise has been shown to ameliorate negative mood states that may contribute to a resumption of substance use.

Study of Exercise as an Intervention for Methamphetamine Use Disorder

From 2010-2015, a UCLA research team conducted a NIDA-funded evaluation of exercise as a therapeutic intervention for individuals who use methamphetamine in early abstinence. The study examined the utility and efficacy of an 8-week, evidence-based aerobic and resistance exercise intervention to promote improved treatment outcomes for a sample of 150 individuals in residential treatment for methamphetamine use disorder. The study examined medical, psychiatric, neurocognitive, and behavioral benefits that may accrue during participation in the 8-week exercise intervention, as well as possible sustained beneficial impacts on drug use following completion of the exercise protocol and discharge from the residential treatment program. The project also included a brain imaging component to collect data leading to an improved understanding of the mechanisms that may underlie observed effects on treatment outcomes and symptom remediation associated with the exercise intervention.

DSM-IV-diagnosed methamphetamine dependent individuals were screened to determine eligibility, and those randomized to the exercise intervention participated in supervised progressive endurance and resistance training 3

times per week for 8 weeks (24 sessions), consistent with current guidelines for comprehensive exercise programs (American College of Sports Medicine [ACSM], 2000). Each session consisted of a 5-minute warm-up, 30 minutes of aerobic activity on a treadmill, 15 minutes of resistance training, and a 5-minute cool-down with stretching and light calisthenics. Participants randomized to the control condition participated in a health and wellness education session 3 times a week for 45 minutes.

Results from the Exercise Study

Over the course of the 8-week trial, individuals who used methamphetamine were able to safely engage in exercise and derived significant health benefits over a short period. Study results demonstrated that in comparison to the control condition:

- ✓ Exercise improved aerobic fitness, body composition, and muscle strength.
- ✓ Exercise improved striatal dopamine receptor binding.
- ✓ Exercise increased heart rate variability.
- ✓ Exercise group participants with less severe baseline methamphetamine use provided more stimulant-free UAs at multiple time points discharge.
- ✓ Exercise reduced depression and anxiety symptom severity.
- ✓ Exercise reduced craving for methamphetamine.

Implementation of Exercise in TRUST

At the present time, there is virtually no research to guide how to engage patients in an exercise program. The TRUST workbook provides some patient worksheets that discuss some strategies for encouraging exercise participation.

Some “common sense’ recommendations include. Exercise should be:

- Convenient. The exercise has to be easy to fit into your schedule. Avoid complicated arrangements (i.e., going to a gym before or after work when you have kids at home, etc.). Comfortable- The exercise should not be intimidating. Walking into an unfamiliar gym or class can be uncomfortable. Promote activities that are familiar and/or have

friend go with you.

- Affordable. Gym memberships are expensive, but there are low-cost alternatives (YMCAs; College gyms).
- Consistency is important. Better that you do something on a regular basis than less frequent big workouts. Arnold says. “A short workout is better than no workout.”

Because there are no well-established methods to promote exercise in this patient population, we encourage clinicians to be innovative in trying multiple strategies to promote exercise initiation and ongoing participation.

Conclusion

Exercise is a useful approach to aiding individuals with SUDs in their efforts to avoid drug use after they have achieved abstinence via treatment. Exercise facilitates abstinence by enhancing positive mood states and reduces craving. In addition, the new activity and routines (and frequently new friends) associated with developing an exercise program also helps people develop some new positive behaviors to support recovery.

Chapter 7: Drug Cessation Group (DCG)

The drug cessation group (DCG) is the initial group treatment experience for patients consisting of four, 60-minute groups. Often patients enter this group only a few days from their last use of stimulants or even with drugs still in their bloodstream. Therefore, frequently patients enter this group in a very emotionally unsteady or even volatile condition. Some may be very hyperactive, talkative, and unfocussed, while others may be very withdrawn, subdued, and reluctant to talk.

The most important thing is that they have shown up for the group. Because this is the most important fact for all patients, patients deserve praise and a genuine and enthusiastic welcome to the group.

DCG Format and Content

Because being in a group is a new experience for many individuals, it is important for group leaders to be sensitive to how patients are functioning and to make sure they are not severely intoxicated or upset. If there are individuals who are too intoxicated or emotionally volatile, they should be taken aside and seen by another staff member who can assess their status and schedule them for the next available DC group. Patient safety considerations should be assessed, and a plan for their safe transportation to their housing arranged.

Each group session is initiated by asking each individual if they are OK and ready to begin. To begin each session, it is useful for the group leader to provide:

a. A short introductory description of the purpose of the group (to help patients learn some information and skills that are important to stopping drug use).
b. The group's duration (60 minutes).
c. The format of the group (a topic and worksheet for discussion, plus time to learn about the patient).
d. Permission for patients to talk or not to talk depending on their preference.
e. A review of the group rules.
f. Reminder of confidentiality of the group.

Because the group members are early in treatment and new to treatment, it's important for the leader to make the group a "safe" place. The group leader is the person in charge of the group, and it's important for the patients to

know that the group leader will guide the discussions. Criticism or attacks by one patient on another is not allowed, and that the group agenda is fully under the control the group leader. This is NOT a “what’s on your mind” group.

At the beginning of each group, it is useful to allow each patient to introduce themselves and give a bit of background about how they happen to be in treatment, how long they have been in treatment, and what they hope to get from treatment. (Of course, if a patient is not comfortable talking, that is ok, and the group leader will suggest that they will come back to the patient at a later time to see if they feel comfortable talking).

The topic will be introduced, and the first 30 minutes of the group will be spent discussing the topic. Worksheets are passed around with a clipboard and pen/pencil. The group leader, or one of the group members who volunteers, reads through the worksheet out loud, then the members are given 5 minutes to write in some responses.

Using the worksheets as a focal point for discussion, the group leader asks patients for a sample of their responses and if this topic sounds like something they have experienced. Some patients will have a great deal to contribute, others will be quiet. It’s important for the group leader to allow the time to be shared among all the group members. Surely the session will not be equally divided among members (some will not want to talk at all), but it’s important that all members be given an opportunity and encouragement to speak and that no group member, including the therapist or group leader, monopolize the group.

The primary conversations in the group are between the group leader and each patient. In some ways, the group is almost a series of 1:1 sessions, while others are observing. At this early stage of group involvement, it is important for the group leader to manage the group quite assertively, linking patients’ comments to a central theme. While patients may be asked to make observations about other patients’ comments or challenges, spontaneous inter-patient dialogue generally is kept to a minimum (especially if there are patients being critical or confrontational).

From 30-45 minutes into the group, patients are given an opportunity to talk about their challenges, accomplishments and ask questions. During the last 15 minutes, the scheduling handout is reviewed. For individuals who are in

their first group, the group leader will introduce the concept to the new patient(s) and help them develop a very rudimentary schedule, building upon the scheduling process first introduced during the Orientation. During this time, the other group members can be working on their schedules. In the final 5 minutes, the schedule of each patient (DC worksheet A) is reviewed in group and the group leader can praise good decisions and/or suggest alternative plans if appropriate.

Drug Cessation Session Group Descriptions and Handouts

DCG A: Scheduling

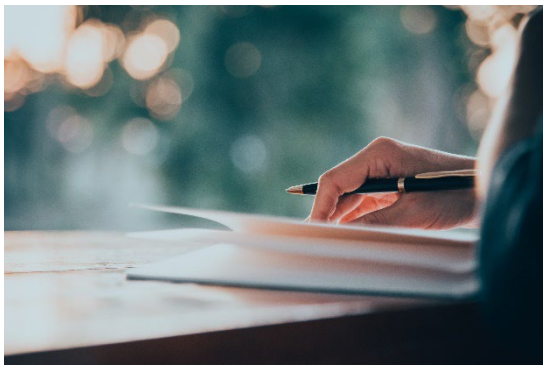
Helping patients create a plan for each day for staying away from stimulants is a central component to using behavioral treatment to stop using stimulants. Every session ends with every patient making a rough, hourly plan for the next 3-4 days. On a patient's first session, they are given a brief introduction to the task. Often the group leader works with new patients during their first session to help them understand the task. Once everyone has completed a schedule, they briefly discuss them and talk about any anticipated challenges and activities they may be looking forward to completing.

DCG A: Scheduling Handout: What is Scheduling?

What is scheduling?

A schedule is a plan you make for yourself. Your clinic visits for medication should be the basic framework of your schedule. It is also important to schedule recreation and rest as well as work and appointments. Scheduling will leave less room for impulsive, possibly high risk, behavior which may result in your using drugs.

Why should I schedule?



It is important to build a structure around yourself that helps you to avoid drugs and risky situations. Moving from addiction is like getting out of a mine field. You need to be very careful where you are going and where you are stepping.

At the Clinic. For many people the waiting room, parking lot, or other areas near the

clinic can be dangerous (for example, people who are high, dealing, or drug using friends).

It may be necessary to change your visit times or your usual route to and from the clinic. Is this the case for you? If so, what can you do?

_____

_____

Are there other times or places where you often “run into drugs”? If yes, is there a way to plan your time to avoid these? Briefly describe.

_____

_____

Do I need to write it down?

Absolutely. Schedules that are not written down are too easily revised.

Daily/Hourly Schedule

Date		Date		Date	
7:00		7:00		7:00	
8:00		8:00		8:00	
9:00		9:00		9:00	
10:00		10:00		10:00	
11:00		11:00		11:00	
12:00		12:00		12:00	
1:00		1:00		1:00	
2:00		2:00		2:00	
3:00		3:00		3:00	
4:00		4:00		4:00	
5:00		5:00		5:00	
6:00		6:00		6:00	
7:00		7:00		7:00	
8:00		8:00		8:00	
9:00		9:00		9:00	
10:00		10:00		10:00	
11:00		11:00		11:00	
12:00		12:00		12:00	

Notes/reminders:

_____

_____

DCG 1: Drugs-Drug Paraphernalia - Drug-using Friends

One of the most important things to do when deciding to abstain from drug use is to throw away any remaining drugs and paraphernalia. This session helps patients take an inventory of their house, car, and other places where drug paraphernalia is located. Drug using friends and acquaintances also present extreme risk. Patients should determine who they need to avoid and have a prepared strategy for successfully avoiding these people, while developing drug refusal skills when they are unable to avoid them.

DCG 1 Handout: Drugs - Drug Paraphernalia

It is critical to throw away any drugs you still have. Your home, your car, and the places you go need to be as safe as you can make them.

1. Which rooms have stashes of drugs/paraphernalia?

_____

_____

2. Where specifically would you likely find drugs/alcohol/paraphernalia in your house?

_____

_____

3. How safe is your car?

_____

_____

4. Are there places in or around the clinic that you need to avoid? If so, how can you best do this?

_____

_____

Drug Paraphernalia

Paraphernalia are items used for, or related to, your drug use. Paraphernalia can trigger intense cravings. It is important to separate yourself from all paraphernalia as completely as possible.

Use the following checklist to remind yourself of items to get rid of.

___Vials
___Pipes
___Straws
___Lighters/Torches
___Spoons
___Syringes
___Phone numbers
___Other

DCG – 1 Drug-Using Friends

Friends, family, and acquaintances who use drugs present an extreme risk as they can be "triggers" for your use.

- If you can avoid these people do so.
- If you run into them, you need to be clear and direct. "I'm not using anymore." "Nothing personal, but we cannot be around one another. It's not that I don't trust you, I don't trust me." Then immediately LEAVE.
- If someone unexpectedly shows up at your place, be clear and direct and do not invite them inside.
- When you make a clinic visit there are sometimes people you used with or bought drugs from.
- Sometime people at the clinic will want to talk about drugs or where they can be purchased.

Who are people you need to avoid? (first name, or initials)

_____

What will you say to these people?

_____

If someone at the clinic tries to engage you in a discussion about drugs, how will you respond?

_____

DCG 2: Common Challenges in Stopping Drug Use

A a number of issues that are commonly experienced by individuals who use stimulants as they attempt to stop using cocaine or methamphetamine. This worksheet includes some of those issues and gives patients an opportunity to learn about the importance of these issues and to consider how they might address them going forward. Drug using friends, drugs or alcohol at home, anger/irritability, boredom/loneliness, and special occasions present problems that may trigger craving and lead to drug use.

DCG 2 Handout: Common Challenges in Stopping Drug Use

Everyone who attempts to stop using stimulants runs into situations that make it difficult to maintain abstinence. Listed below are four of the most common situations that are encountered during the first few weeks of treatment. Next to these problems are some suggested alternatives for handling these situations.

Challenges	New Approaches
1. Anger, irritability: Small events can create feelings of anger that seem to preoccupy your thoughts and can lead to craving.	• Remind yourself that you are experiencing a healing of the brain and strong unpredictable emotions are a natural part of recovery. • Exercise. • Talk to a therapist or supportive friend.
2. Boredom, loneliness: Stopping stimulant use often requires a change in activities.	• Put new activities on your schedule. • Go back to activities you enjoyed before your drug use took over. • Try to find new friends at community support meetings.

3. Special Occasions: Parties, dinners, holidays, and celebrations.

- Have a plan for answering questions about drug or alcohol use (or not using).
- Start your own drug-free celebrations and traditions.
- Have your own transportation to and from events.
- Attend these special occasions with a friend or family member supportive of your recovery.
- Leave if you get uncomfortable or start feeling deprived.

4. Encountering using friends at the clinic.

- Attend the clinic when there are fewer patients.
- Develop effective ways of avoiding conversations at the clinic.
- Directly let people know that you don't want to discuss drugs.

Which of these issues are likely to be a problem for you in the next few weeks?

_____

_____

_____

How will you handle them?

_____

_____

_____

DCG 3: Triggers/Thought-Stopping

The Thought-Stopping handout is very useful to give patients some help in addressing drug cravings. Thought-stopping is a skill that patients can use to block drug thoughts and thereby regain control of their thinking process. Cravings do not have to overwhelm them. They can prevent cravings from occurring by blocking the thoughts that develop into craving. Another way to stop a craving is to engage in an activity to interrupt the process. This can be meditating, exercising, talking to someone, walking, or eating. They need to use this process quickly before the physiology of the craving gets started. Talk about how the craving cycle occurs and explore ways that will work to interrupt the cycle.

DCG 3 Handout: Triggers/Thought-Stopping

The Losing Argument

- Even though you've decided to reduce/stop meth/cocaine use, you will often find yourself thinking of using. Your brain tries to give you permission to use through a process we call "drug use justification."
- As you think about drug use, your brain will often start an internal argument where part of you wants to use and part of you doesn't want to use. The argument inside you can be part of a series of events leading to drug use.

The "Automatic" Process

During addiction, triggers, thoughts, cravings and use all seem to run together. However, the usual sequence goes like this:

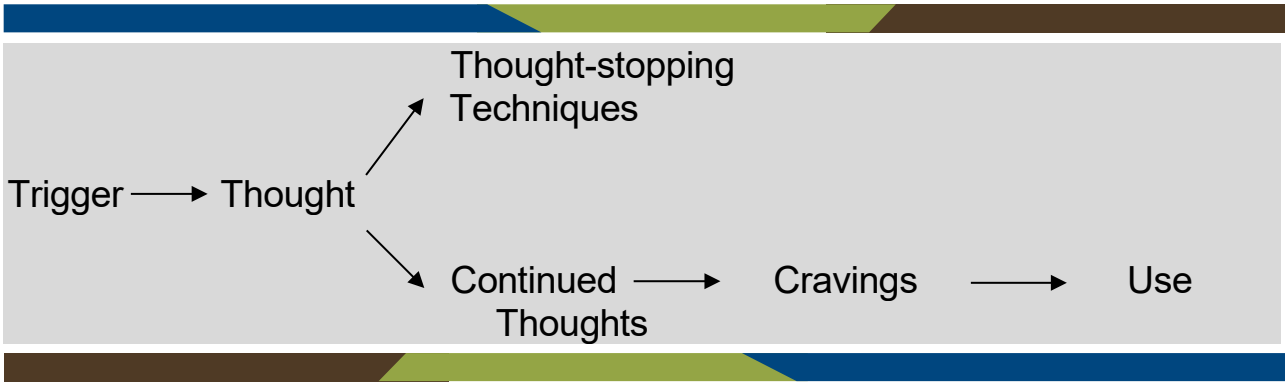
TRIGGER → THOUGHT → CRAVING → USE

Thought-Stopping

- The key to success is to recognize and stop the thought before it becomes a craving.
- It is important to respond to the thought as soon as you recognize it occurring.
- Allowing yourself to think about drug use, buying drugs, old drug experiences, etc., is taking a step toward drug use.
- The quicker you can stop the thought the more successful you will be in not using.

A New Sequence

In order to get recovery started it is necessary to change the trigger - use sequence. Thought-stopping provides a tool for breaking the process. The choice is:



You make a choice. It is not automatic.

Techniques for Thought-Stopping

Try the techniques described and use those that work best for you.

VISUALIZATION – There are many ways to use your imagination to substitute a new thought in place of the drug thought. Some include:

- ✓ Picture a switch or a lever in your mind. Imagine yourself actually moving it from ON to OFF to stop the drug thoughts.
- ✓ Focus on a positive memory/scene from your life that is something you enjoy thinking about. The face of your child, grandchild, or a parent. Any thought that has a strong positive effect.

SNAPPING – Wear a rubber band on your wrist loosely. Each time you become aware of drug thoughts snap the band and say "NO!" to the thoughts as you make yourself think about another subject. Have a subject ready that is something meaningful and interesting to you.

RELAXATION/MEDITATION/PRAYER – Thoughts can be avoided or replaced by taking a deep breath and then focusing on your normal breathing. Prayer can also be a productive way to take your mind off drugs.

EXERCISE – Exercise is a great way to get your brain to think about more positive things.

CALL A SOBER FRIEND OR SPONSOR – Talking with a positive person can be very helpful.

Can you imagine yourself using any of these activities? If yes, which ones?

DCG 4: Your Brain and Recovery

An understanding of the Pavlovian conditioning that underlies the craving and drug use cycle demystifies the seemingly self-destructive pattern of obsessive drug use for both the patient and family. This session is an opportunity to provide a brief explanation of the powerful conditioned cravings that persist despite intentions to stop drug use. The automatic nature of these cravings requires that real behavior change takes place. This topic is the underlying premise for many subsequent topics such as scheduling, triggers, and thought-stopping. It can be helpful to describe Pavlov's conditioning experiment and parallel the bell and salivary response with stimulants triggers and the craving response.

Cocaine and methamphetamine change the brain. It takes time for the brain to "recover" after stimulant use ends. It can be 4-6 months or more before the brain returns to something close to "normal" functioning. Over the course of this period, it is common for a person to experience fluctuations in mood, thinking, and energy. A common mistake is to conclude that rough periods in the recovery are related to sobriety when in fact they are likely the aftereffects of the past drug use.

Depression, sleep disturbances, ebullience, irritability, high or low energy, and drug cravings may all occur at different times over months. Understanding that this is a normal occurrence and is reflective of a healing process can prevent catastrophizing and succumbing to relapse.

DCG 4 Handout: Your Brain and Recovery

In understanding and dealing with addiction it is important to think about your brain regarding two very powerful and different parts:

1. The higher, rational brain. This is the decision-making part of your brain.

2. The lower, emotional centers in the brain. This is your pleasure center.

Decisions to use drugs or alcohol start in the higher brain. You weigh the positives and negatives associated with using, and when you use, the pleasurable experiences happen in the lower brain.

After a time, as the negative consequences of use mount, you have probably decided at times to stop using but you are not able to stop. You decide in your higher brain, but the decision to stop is overpowered by your lower brain.

What happens?

Most people describe cravings that overpower the rational decision to stop using.

Why does this happen?

1. After a period of regular substance use, the people, places, and circumstances that have been associated with the drug use have the power to trigger a response in the lower, "addicted," brain.
2. When this happens, you feel a craving and your thinking changes making it seem OK to use, "one more time," or "just a little bit," etc.

Why is this important?

1. The triggered reaction in the lower brain cannot be directly controlled. This automatic reaction is like a reflex.
2. No amount of good intentions, promises, or commitments will reduce the strength of the cravings.
3. If you are around people, in places, or in situations where you have used in the past, the chances are great that you will use again even if you have a sincere desire to stop using.
4. If you understand substance dependence you can begin to effectively deal with it.

What can you do about this?

1. Change your behavior so that you avoid the things that will trigger cravings.
2. Start doing new, healthy, alternative behaviors.
3. Reassume higher brain control of what you do by planning your day and scheduling you time.

Understanding the brain and addiction makes sense out of your behavior up until now and provides the key to beginning your first steps in recovery.

1. Have you tried to stop in the past and failed? What happened?

_____

_____

2. What could you have done differently in light of what you know now about the brain?

_____

_____

Brain Changes by Drug Use.

The brain has neurons that release and receive dopamine. Dopamine is a brain chemical that allows us to feel pleasure, happiness, and positive emotions. As people use meth and cocaine, the brain becomes addicted, one of the major parts of the biology of addiction is the result

of how methamphetamine and cocaine change the dopamine system. The good news is that the brain recovers with time and no stimulant use. In a sense the brain “heals.” Understanding this aspect of addiction is important for people to understand so they can see hope for the future when stimulant use is stopped.

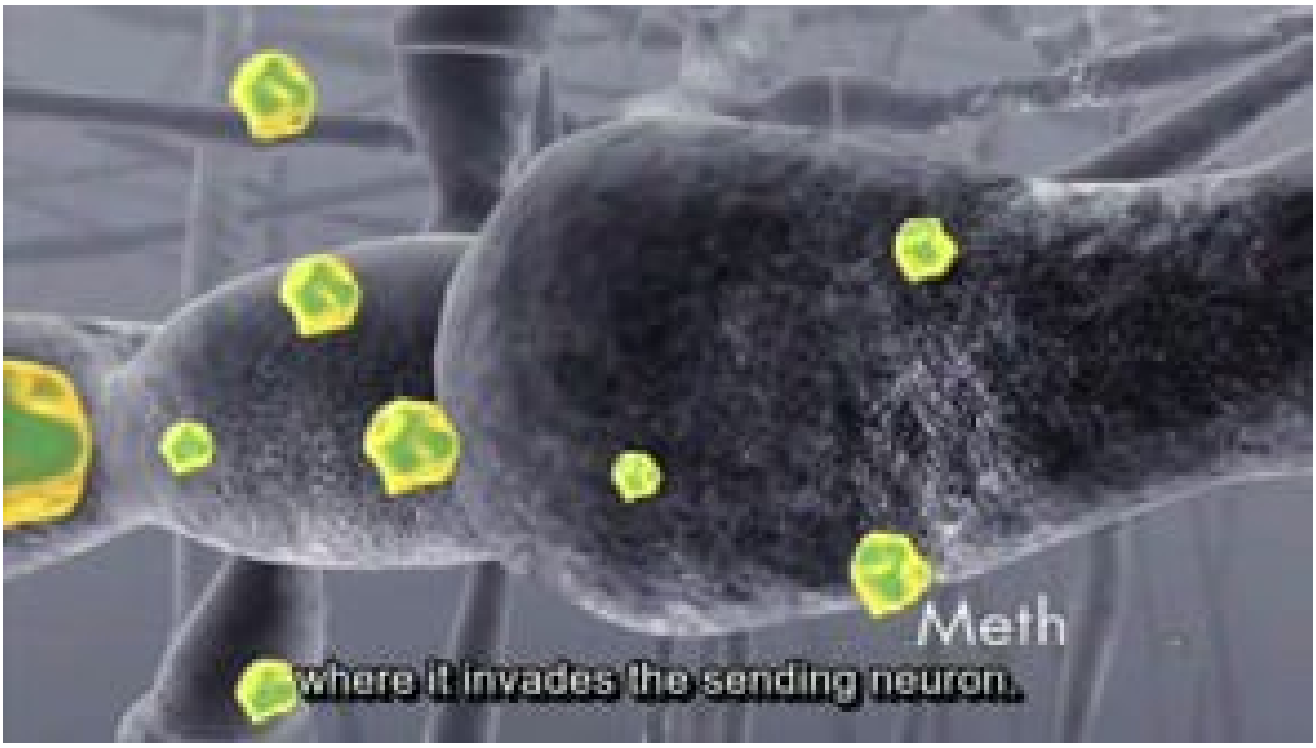
Video Clip 1.Normal dopamine function

Press play below, or access the video online here:
https://vimeo.com/418131516

Video Clip 2.Dopamine system changes from the use of methamphetamine

Press play below, or access the video online here:

https://vimeo.com/418132723



Video Clip 3: Dopamine recovery with abstinence from methamphetamine.

Press play below, or access the video online here:
https://vimeo.com/433507468

Chapter 8: Recovery Skills Group (RSG)

The 12 weekly, 90 minute sessions of the Recovery Skills Group (RSG) provide information, promote new skills, provide strategies for addressing challenging situations and encourage patients to make valuable behavior change. The topics and materials included in these 12 sessions are adapted from the NIDA Community Reinforcement Approach (CRA) manual (NIDA, 1998) and the cognitive behavior therapy materials included in the Matrix Manual (SAMHSA, 2006). The group setting provides an opportunity for patients to learn from other patients and to develop a peer group and receive support and encouragement.

RSG Format and Content

The session format and counseling approach used in the RSG are similar to the methods used in the DCG (Chapter 5). Patients are given the opportunity to apply dots to their calendars. Each group meeting begins with new members introducing themselves and giving a brief description of their substance use history, and success in the recovery process.

Following the introductions and during the first 15 minutes of the session, the therapist orients group members to the session topic in a casual, didactic manner, emphasizing why this topic is important. It can be useful to have a patient- volunteer read through the worksheet (some people are uncomfortable reading aloud and should not be pressured to complete this task).

The therapist then addresses specific parts of the topic, and/or specific input given by patients to written responses on the worksheet. Each patient should have the opportunity to discuss the topic and how it does/does not apply to their situation. Over the first hour of the meeting, the therapist ensures that all the important aspects of the topic are covered and that premature digressions from the main topic are avoided. The therapist wraps up the discussion period with a reiteration of the session topic and the important issues relevant to it.

During the last 30 minutes of each group session, the therapist asks patients whether they have had any recent problems or whether they wish to bring up any matters. Individual patients, particularly those who have been having problems or those who have not participated in the group session, should be encouraged to participate. General questions that usually evoke a response include the following:

What new developments have occurred with the problem you brought up last time? Describe any cravings and talk about how you handled them. What are your plans for not using stimulants this week?

The therapist summarizes the discussion and acknowledges any unresolved issues. Discussion of these issues can be carried over to the next meeting. The therapist can ask patients who during the session mentioned cravings or who appear troubled, angry, or depressed to stay afterward to talk briefly and to schedule them for individual sessions as soon as possible. All sessions should end with a brief review of their scheduling exercise, a reminder that groups are confidential and a commitment by each patient to do their best to not use, and to attend the next RSG meeting.

Special Challenges

At times, the therapist may need to intervene assertively in response to specific types of patient behavior in the group. This intervention may consist of quieting a patient, limiting a patient's involvement in the group, or removing a patient from the group. Below are some strategies for handling troublesome behaviors.

Behavior: Occupying too much session time with an issue that has been addressed. Intervention: Politely suggest that it is time to allow others to discuss their issues and move on.

Behavior: Arguing in favor of behavior that is counter to recovery (e.g., using, dropping out of group, using self-control instead of avoiding triggers) after receiving repeated feedback. Intervention: Use MI skills to have patient review the not-so-good things and the good things (a decisional balance) related to courses of action.

Behavior: Making threatening, insulting, or personally directed remarks; behaving in a manner obviously indicative of intoxication. Intervention: Politely request the patient come out of the group with you and ask another therapist to safely get the patient home and address any immediate crises. Be sure that the patient has calmed down before leaving them. Arrange for transportation home if the patient cannot drive or get home safely.

Behavior: Having a general lack of commitment to treatment, as evidenced by poor attendance, resistance to treatment intervention, disruptive behavior, or repeated drug use. Intervention: Using MI skills, in individual session explore with patient if they can discuss their feelings about treatment and the various components of treatment. Ask if the patient would like to make changes in the

treatment schedule or type of sessions. Adjust the treatment plan to better meet the needs of the patient

Adapting Patient Worksheets

Worksheets are written in simpler language than the session descriptions for therapists. The patient materials should be understandable for someone with an eighth-grade reading level. Difficult words (e.g., abstinence, justification) are occasionally used. Therapists should be prepared to help patients who struggle with the material. Therapists should be aware that handouts will need to be adapted for patients with reading difficulties.

Recovery Skills Group Descriptions and Handouts

RSG 1: Building a Recovery Support Program: Mooring Lines ---- Avoiding Recovery Drift

Mooring lines – Ropes or cables that hold a boat from drifting away from its dock/pier.

This group is designed to guide patients in building a set of recovery behaviors and maintain them to avoid drug use. Also, it can help to highlight how recovery has been helped by avoiding certain risky situations. Remember, patients very early in sobriety or those who are still using will not have many mooring lines, if any, in place yet. A review of mooring lines is scheduled twice during the 12-week initial treatment and should be reviewed regularly in continuing care.

RSG 1 Handout: Building a Recovery Support Program: Mooring Lines ----- Avoiding Recovery Drift

Mooring line – Ropes or cables that hold a boat from drifting away from its dock/pier.

Recovery from stimulants doesn't "just happen". You build the recovery with your behavior. You add new behaviors to your life. These might include: Attendance at treatment sessions, 12 Step meetings, exercise, scheduling your time, meditation, ending time with drug-free friends, yard work, etc.

These recovery behaviors become your "mooring lines". These activities keep you from moving toward drug use.

How It Happens

- Drug use does not suddenly occur. It does not happen without warning and it does not happen quickly.
- The slow movement away from sobriety can be compared to a ship gradually drifting away from where it was moored. The drifting movement can be so slow that you don't even notice it.

Interrupting the Process

- During recovery, each person does specific things that work to keep them sober.
- These "mooring lines" need to be clearly stated and listed in a very specific way so they are clear and measurable.
- These are the ropes that hold the recovery in place and prevent drift back to drug use from happening without being noticed.

Maintaining a Recovery

Use the Mooring Lines Recovery Chart to list and track the things that are holding your recovery in place. Follow these guidelines when filling out the form:

1. Identify 4 or 5 specific things that are now helping you stay sober. (e.g., working-out for 20 min., 3 times per week).

2. Include items such as exercise, therapist and group appointments, scheduling, 12-Step meetings, eating patterns, etc.

3. Do not list attitudes. They are not as easy to measure as behaviors.

4. Note specific people or places that are known triggers and need to be avoided during the recovery.

The checklist should be completed regularly (probably weekly). When two or more items cannot be checked, it means that recovery drift is happening. Sometimes things weaken your mooring lines. Vacation, illnesses and holidays sometimes cannot be controlled. The mooring lines loosen up. Many people return to drugs during these times. Use the chart to recognize when you are more likely to use and decide what to do to keep this from happening.

RSG 1a – Mooring Lines; Recovery Chart

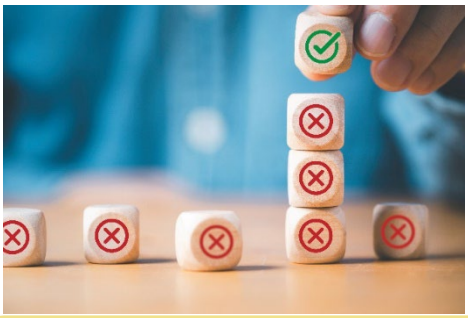
Use the chart below to list those activities that are very important to your continuing recovery. If there are specific people or things you need to avoid, list those. Look back at your list regularly to check yourself and make sure you are continuing to stay moored in your recovery.

Mooring Line Behaviors	Date (✓)	Date (✓)	Date (✓)	Date (✓)	Date (✓)
1.					
2.					
3.					
4.					
5.					
I am Avoiding	Date (✓)	Date (✓)	Date (✓)	Date (✓)	Date (✓)
1.					
2.					
3.					
4.					
5.					

RSG 2-3: Internal/External Trigger Questionnaire/Trigger Chart

This session gives the patient a sense that their stimulant use will not be set off by random events. By asking what situations may be triggering them to use stimulants, they become more aware of when they are more likely to use. When they change these triggering behaviors or stay away from the triggering situations, the chance of using can be reduced. The exercises in this session should help give the patient a feeling of greater understanding about what sets off the use episodes and how to avoid using. The reflexive nature of the craving process covered in the DC group "Your Brain and Recovery" should be emphasized to stress the importance of identifying and avoiding triggers.

RSG 2 Handout: Internal Trigger Questionnaire



There are often certain feelings or emotions that trigger the brain to think about using drugs. Read the following list of emotions and place a check mark **(x)** next to the feelings that trigger (or used to trigger) thoughts of using stimulants. Place a zero **(0)** next to the emotions that don't trigger you to use stimulants.

_____ Afraid	_____ Frustrated	_____ Neglected
_____ Angry	_____ Guilty	_____ Nervous
_____ Confident	_____ Happy	_____ Sexy
_____ Criticized	_____ Inadequate	_____ Pressured
_____ Depressed	_____ Insecure	_____ Relaxed
_____ Embarrassed	_____ Irritated	_____ Sad
_____ Excited	_____ Jealous	_____ Bored
_____ Exhausted	_____ Lonely	_____ Tired

1. Which of the emotions above are the most often triggering for you?

_____

2. Are there any times in the recent past in which you were attempting to not use and a specific change in your mood clearly resulted in your using? (For example, You got in an argument with someone and used in response to getting angry.) Yes ___ No ___

If yes, describe: _____

RSG 3 Handout: External Trigger Questionnaire

1. Place a check mark next to activities or situations in which you frequently use or buy meth/cocaine. Place a **zero (0)** next to activities or situations are not associated with meth/cocaine use or purchase.

__Home alone	__Before a date	__After payday
__At home with friends	__During a date	__Calling friends who use
__At a friend's home	__Before sex	__Before work
__At a party	__During sex	__At a lunch break
__At the clinic	__After sex	__In some neighborhoods
__At bars/clubs	__Before work	__After work
__At night to stay awake	__When carrying money	__Driving in some areas
__When going to the clinic	__Near a dealer's place	__Texting certain people
__When I gain weight	__With drug using friends	__After medication dose

2. List any other settings or activities where you use meth/cocaine.

_____

_____

3. List activities or situations in which you would not use.

_____

_____

4. List people you could be with and not use meth/cocaine.

_____

_____

RSG 2a-3a: Trigger Chart Handout

Name:_____

Date:_____

Instructions: List some of the internal and external triggers for meth/cocaine use (people, places, objects, situations, and emotions) and some situations, people and emotions that are not associated with meth/cocaine use.

Chance of Using

Chance of Using

Never Use	Almost Never Use	Almost Always Use	Always Use
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
These are "safe" situations.	These are low risk, but caution is needed.	These situations are high risk. Staying in these is dangerous.	Involvement in these situations is deciding to stay involved with drug use. Avoid totally.

RSG 4: Taking Care of Yourself

Doing things to take care of yourself is a way of showing respect for yourself. Emphasize that as a person in recovery, it is important to recognize personal value. Part of recovery is taking action to improve health and reflect a change in lifestyle. Some areas where action might be taken include dental, vision, grooming, diet, and healthy habits. Looking better and feeling better move a person farther away from the old ways.

RSG 4 Handout: Taking Care of Yourself

During periods of drug use people often do not take care of themselves. There is often not enough time or energy to attend to health and grooming when you are using. How you look becomes unimportant. Health is secondary to drug use.

- Not caring for yourself is a major factor in losing self-esteem.
- This is a time to recognize your own value. In recovery, your own health and appearance become more important as you care more for yourself.
- It is part of starting to like and respect yourself.

Attending to the following will strengthen your image of yourself as a healthy, drug-free, person.

1. Have you seen a doctor for a thorough check-up?

_____
_____

2. When is the last time you went to the dentist?

_____
_____

3. Have you considered getting a "new look" next time you cut your hair?

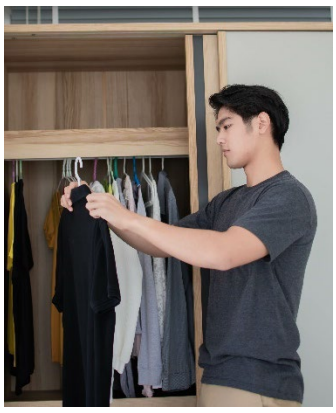
_____

What kind of changes might you like to try?

_____
_____

4. Are you paying attention to what you are eating? Is it too much, too little or of adequate nutritional value? How many meals a day do you eat?

_____
_____
_____



5. Do you still wear the same clothes you wore during your using episodes?

_____
_____

6. Do you need to have your vision or hearing checked?

_____
_____
_____

7. What exercise do you do regularly?

_____
_____
_____

8. Is your caffeine or nicotine intake out of control?

_____
_____
_____

- If doing all these things at once is too overwhelming, work on one or two items each week.
- Decide which are the most important and do those first.
- You will begin to see a person you like and respect.

The first thing I need to do to take care of myself is:

_____

_____

_____

_____

RSG 5: Be Smart. Not Strong

Many times, people in recovery try to test the strength in their recovery process and put themselves into high-risk situations: Trying to be strong is not being smart. An exercise is included in the session to make patients more aware of how smart they are being in their recovery. Trying to tough your way out of drug use is not smart.

RSG 5 Handout: Be Smart. Not Strong

"I can be around meth/cocaine. I am certain I don't want to use and once I make up my mind, I'm very strong."

"I have been doing well and I know I can be around friends who are using meth/cocaine, and not use. It's just a matter of willpower."

Staying off stimulants takes more than just strength or will power. The key to not using is to keep far away from drug use situations. The closer you get, the more likely you are to use. If meth/cocaine appears unexpectedly and/or you are around friends who are using, your chances of using are much greater than if you weren't in that situation. Be smart and avoid triggers as much as possible.

How smart are you being? Rate how well you are doing in avoiding using cocaine and meth:

	Poor	Fair	Good	Excellent
1. Practicing Thought-Stopping	1	2	3	4
2. Scheduling	1	2	3	4
3. Keeping Appointments	1	2	3	4
4. Avoiding Triggers	1	2	3	4
5. Not Using Alcohol	1	2	3	4
6. Not Using Drugs	1	2	3	4
7. Avoiding Individuals who use Drugs/Alcohol	1	2	3	4
8. Avoiding Drug/Alcohol Places	1	2	3	4
9. Exercising	1	2	3	4
10. Being Truthful	1	2	3	4

Which area(s) do you want to improve?

_____

_____

_____

_____

How do you plan to do that?

_____

_____

_____

_____

RSG 6: Drug Use Justification

The thinking, which is characteristic of a person moving toward drug use, is examined in this session. The point should be stressed that one may be less susceptible to these drug use justifications if they are identified and evaluated ahead of time. Ask patients to pick out particular drug use justifications to which they may have been susceptible in the past.

RSG 6 Handout: Drug Use Justification

Once a person decides not to use drugs anymore, how does it happen again? Is there some way of avoiding the return to drug use?

Drug use justification is a process that happens in people's brains. The addicted part of the brain invents excuses that move the person close enough to drug use situations so that “accidents” can and do happen. You may remember times when you were planning to stay drug free and the mental justification process happened before you used again.

Use the questions below to help you identify justifications your addicted brain might use and interrupt the process with thought-stopping.

Accidentally or Other People

Does your addicted brain ever try to convince you that you have no choice when an unexpected situation catches you off-guard? Have you ever said any of the following to yourself?

1. It was offered to me. What could I do?
2. An old friend called, and we decided to get together.
3. I was cleaning my house and found drugs I'd forgotten about.
4. I was in a bar and someone offered me a beer.
5. Other_____.

Catastrophic Events

Is there one unlikely, major event that is the only reason you would use? What might such an event be for you? How would using drugs improve the situation?

1. My spouse left me. There's no reason to stay drug free.
2. I just got injured. It's ruined all of my plans. I might as well use.
3. I just lost my job. Why not?
4. Other_____.

For a Specific Purpose

Has your addicted brain ever suggested that using a certain drug or alcohol is the only way to accomplish something?

1. I'm gaining weight and need stimulants to control my weight.
2. I'm out of energy. I'll function better.
3. I need drugs to meet people more easily.
4. I can't enjoy sex without using.
5. Other_____.

Depression, Anger, Loneliness, and Fear

Does feeling depressed, angry, lonely or afraid make using seem like the answer? Is it really? What might you do when your addicted brain says the following to you?

1. I'm depressed. What difference does it make if I use or not?
2. When I get mad enough I can't control what I do.
3. They think I've used, I might as well use.
4. Other_____

My Addiction is Cured

Everyone struggles with the fact that addiction and recovery are on-going processes. Does your addicted brain ever try to convince you that you can use just once or just a little?

1. I'm back in control. I'll be able to stop when I want to.

2. I've learned … I'll only use once in a while.

3. This drug (or alcohol) was not my problem – the other one was. So I can use this and not use the other.

Testing Yourself

Would your brain like to prove you can be stronger than drugs/alcohol? It's very easy to forget that being smart is the key to staying sober; not being strong. Have you ever thought?

1. I'm strong enough to be around it now.

2. I want to see if I can say "no" to drinking/using.

3. I want to see if I can be around my old friends.

4. I want to see how stimulants feel now that I've stopped.

RSG 7: Building a Recovery Support Program: Mooring Lines ---- Avoiding Recovery Drift

This group is designed to highlight the specific components of the recovery process that have already been started and must be continued. Also, it can help to highlight how recovery has been helped by avoiding certain risky situations. Remember patients in very early sobriety or those who are still using will not have many mooring lines, if any, in place yet. A review of mooring lines is scheduled twice during the 12-week initial treatment and should be reviewed regularly in continuing care.

RSG 7 Handout: Building a Recovery Support Program: Mooring Lines ----- Avoiding Recovery Drift

Mooring line – Ropes or cables that hold a boat from drifting away from its dock/pier.

Recovery from stimulants doesn't "just happen". You build the recovery with your behavior. You add new behaviors to your life. These might include: Attendance at treatment sessions, 12 Step meetings, exercise, scheduling your time, meditation, spending time with drug-free friends, yard work, etc.

These recovery behaviors become your "mooring lines". These activities keep you from moving toward drug use.

How It Happens

- Drug use does not suddenly occur. It does not happen without warning and it does not happen quickly.
- The slow movement away from sobriety can be compared to a ship gradually drifting away from where it was moored. The drifting movement can be so slow that you don't even notice it.

Interrupting the Process

- During recovery, each person does specific things that work to keep them sober.

- These "mooring lines" need to be clearly stated and listed in a very specific way so they are clear and measurable.
- These are the ropes that hold the recovery in place and prevent drift back to drug use from happening without being noticed.

Maintaining a Recovery

Use the Mooring Lines Recovery Chart to list and track the things that are holding your recovery in place. Follow these guidelines when filling out the form:

1. Identify 4 or 5 specific things that are now helping you stay sober. (e.g., working-out for 20 min., 3 times per week).
2. Include items such as exercise, therapist and group appointments, scheduling, 12-Step meetings, eating patterns, etc.
3. Do not list attitudes. They are not as easy to measure as behaviors.
4. Note specific people or places that are known triggers and need to be avoided during the recovery.

The checklist should be completed regularly (probably weekly). When two or more items cannot be checked, it means that recovery drift is happening. Sometimes things weaken your mooring lines. Vacation, illnesses, and holidays sometimes cannot be controlled. The mooring lines loosen up. Many people return to drugs during these times. Use the chart to recognize when you are more likely to use and decide what to do to keep this from happening.

RSG 7: Mooring Lines; Recovery Chart

- In becoming sober you have had to learn to do certain new behaviors - behaviors that work for you in keeping you sober.
- Charting the new behaviors and checking occasionally to make sure the lines are secure can be very useful.

Use the chart below to list those activities that are very important to your continuing recovery. If there are specific people or things you need to avoid, list those. Look back at your list regularly to check yourself and make sure you are continuing to stay moored in your recovery.

Mooring Line Behaviors	**Date (✓)**	**Date (✓)**	**Date (✓)**	**Date (✓)**	**Date (✓)**
1.					
2.					
3.					
4.					
5.					
I am Avoiding	**Date (✓)**	**Date (✓)**	**Date (✓)**	**Date (✓)**	**Date (✓)**
1.					
2.					
3.					
4.					
5.					

RSG 8: Addictive Behavior

Ask patients to identify which behaviors were characteristic of their addiction. Emphasize that the re-emergence of these behaviors is an important signal of impending drug use. This is a good opportunity to point out necessary behavioral change and how these changes can lead the way to long-term sobriety.

RSG 8 Handout: Addictive Behavior

As stimulant use increases, eventually the use affects almost all areas of life. Stopping stimulant use requires you to leave all the drug behaviors behind.

However, they can creep back into life and often are signals that a return to drug use is going to happen. Learning to recognize when one or more of these begin happening will help you know when to start fighting extra hard to move away from using drugs.

Which of these behaviors do you think are related to your stimulant use?

_____ Lying
_____ Stealing
_____ Being irresponsible (not meeting family/work commitments)
_____ Being unreliable (late for appointments, breaking promises, etc.)
_____ Being careless about health and grooming (wearing "using" clothes, stopping exercise, poor diet, messy appearance)
_____ Taking medication not according to directions
_____ Behaving impulsively (without thinking)
_____ Behaving compulsively (too much eating, working, sex, etc.)
_____ Changing work habits
_____ Losing interest in things (recreational activities, family life, etc.)
_____ Isolating (staying by yourself much of the time)
_____ Missing clinic appointments
_____ Other _____

RSG 9: Brain Tips

The brain is affected in many ways as a result of stimulant use. In fact, chronic use of cocaine and methamphetamine “injure” the brain. It’s important to understand the ways in which the brain is injured and how this may affect thoughts, emotions, and behaviors.

In early recovery many of our interactions with the world and with how we think and feel are changed and impaired. It is important to understand recovery from stimulant dependence involves a true “healing” of the brain.

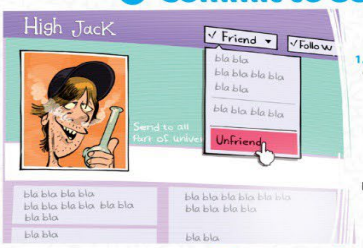
Discussion of the topics in these sheets can help patients understand the reality of StimUD and recovery as involving the brain functioning in many ways.

RSG 9a: Brain Tips Poster

RSG 9b: Brain Tips Poster

10 "Do's" to Foster Brain Recovery Starting at Initial Abstinence

1 Commit to abstinence from intoxicants



1. **Avoid** places where you used/drank. Any drug-related cue can activate processes in your brain that are harmful for its health.

2. **Break** relationships with all using partners. Your brain needs new healthy friends to be able to recover.

3. **Affirm** commitment to "total abstinence" from any drug, including alcohol, legal or illegal. Your brain is very vulnerable to any intoxicant during recovery. Take care of it responsibly.

2 Be patient and hopeful

1. **Treat** your brain as you would any other injured part of your body that needs extended rest and healing for a period of time to experience recovery

2. **Rely** upon the example of other injuries healing over time, accept that you will achieve your brain health gradually

3. **Gather** with and call upon people in successful recovery to benefit from their experience, strength, and hope

3 Be calm and relaxed

1. **Not unlike** other bodily injuries, your brain needs sufficient time to become peaceful and calm to experience healing

2. **Stress** is your brain's worst enemy and exposure to heightened stress hampers the recovery process

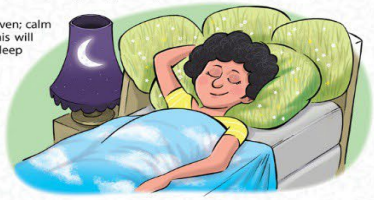
3. **Avoid** when possible, people, places, events and other things that tend to raise your stress level. You can start to gradually and slowly expose yourself to the normal life stressors after first few months of recovery under supervision of your counsellors and therapists.

4 Be a healthy sleeper

1. **Your brain** needs sufficient (but not too much) sleep at night and periods of daytime rest to recharge

2. **Turn** your bedroom in to a sleep haven; calm and dark with proper temperature. This will help your brain to take advantage of sleep as much as possible for its recovery.

3. **Commit** to and maintain a regular, healthy and helpful sleep schedule. Fixed daily schedule for sleep will help your brain to be rested and accessible when you need it.

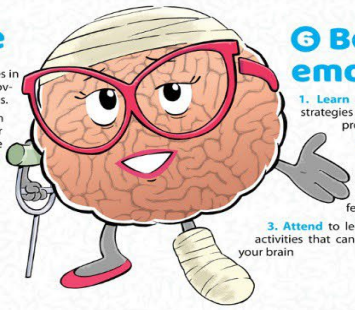


5 Be a healthy foodie

1. **Include** more fruit (especially berries) and dark green leafy vegetables in your diet. Their natural antioxidants and vitamins will help your brain to recover injured and inflamed areas.

2. **Eats lots** of oily fish (salmon and tuna) and eggs. Their micronutrients will provide your brain with materials to restore its disturbed structures.

3. **Reduce** salt intake and make intentional efforts to lower Cholesterol



6 Be in tune with your emotions

1. **Learn and practice** problem-solving strategies in order to deal with daily life problems

2. **Gain** skills to practice emotional awareness in order to identify and separate various emotional states and feelings

3. **Attend** to leisure and recreation activities that can soothe and restore your brain

7 Be more socially active

1. **Get involved** with other people who are living in recovery successfully

2. **Be committed** to engage in 12 step or other mutual support groups regularly

3. **Be willing** to focus your relationships with people, including family members, who encourage and support your abstinence and recovery

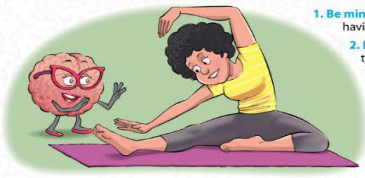
8 Be more physically active

1. **Try** to make time for regular exercise and other physical activities. Your brain and body generate chemicals during rigorous physical activity, including workouts that promote your brain recovery

2. **Engage** in aerobic exercises, as recommended for someone of your age, medical condition, build, and gender to promote holistic health but, avoid too much or too intensive exercise

3. **Try** exercising in group-settings for support, encouragement and meet the social needs of your healing brain

9 Be a healthy friend to yourself



1. **Be mindful** of your emotions, thoughts and behaviors as often and intentionally as possible

2. **Be willing** to practice yoga or attend any type of meditation classes. Practice meditation exercise as part of a daily program to help your brain progress in recovery

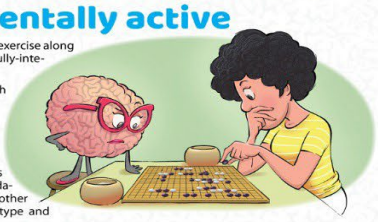
3. **Be willing** to practice mindfulness exercises in daily tasks, such as eating, walking, and cleaning house/yard work, etc. Experiencing normal pleasures from normally pleasurable tasks is a staple of recovery

10 Be more mentally active

1. **Honor** the fact that your brain needs exercise along with your body to be able to regain its fully-integrated functions

2. **Be willing** to do brain exercises which are systematically designed for improvement of brain functions (see our next poster)

3. **Progress gradually** into difficult and challenging levels of brain exercise, much like you might increase the weights in gym exercises. Follow the recommendations of a counselor, recovery coach or other helping professional in regard to the type and level of mental exercises you practice



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In Summary

Your brain during early abstinence is like a broken hand. It needs your active support to be able to recover properly. After the initial weeks of abstinence, your brain will need active rehabilitation exercise to start to recover its own abilities over the time. The brain healing takes time but it is guaranteed if you pay enough time and attention to it. You can have more details about the brain exercises in our next poster or in our book "Brain-Healing First Aid: How to Recover My Brain's Abilities during Addiction Treatment"

Authors: Hamed Ekhtiari, Tara Rezapour, Brad Collins, Martin Paulus; Illustrator: Naeem Tadayon; Graphist: Mohsen Farhadi

Scan the QR code above with your smartphone to get a free PDF version of the book.

RSG 9c: Brain Tips Poster

10 Series of Daily Brain Exercises for Brain Recovery During Abstinence

1 Attention

1. Do Word Exercises: Practice reverse spelling during daily conversation and spell the words you hear backward in your mind. Ex: Apple could be elppa in your "Brain language"

2. Be Your "Present-Moment" Attention Coach: You can practice controlling your attention and lessen your brain's tendency to wander during important tasks. Intentional, gentle and internal messages such as "focus on the task at hand" or "come back to the present moment" can become a habit to bring you back into focus.

3. Train Your Brain to be Flexible: Try to shift between two or more brain tasks as a daily exercise. Ex: Practice a Sudoku puzzle for 10 min and then shift to solving a crossword for 10 min and then return to the Sudoku again.

2 Memory

1. Journal in Your Brain Book: Document important events that influenced your day every night. You can visualize and observe the events of your day as if watching a play.

2. Play "Memory Games": Prepare a list of information such as a grocery list or word list every day and try to memorize it throughout the day. Commit a snapshot of the list to memory for ready-access, so new words will be available when you need them.

3. Reduce "Brain Clutter": Try to reduce the load of information taking up brain-space by economizing strands into smaller, associated "chunks". Ex: Instead of remembering 140593251, simplify to 140-593-251. Any other innovative ways to organize and chunk information will help your memory.

3 Decisions & Control

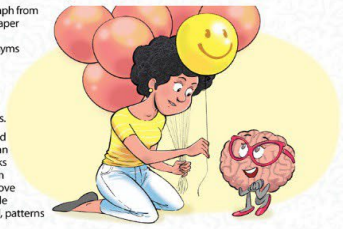
1. Set Daily Goals: Set at least one goal every day and strive to achieve it by the end of that day. Small goals such as saving ... walking 1/2 a mile, to start are worthwhile. You can gradually set 7 goals for each week and achieve them.

2. Track Your Money: Try to monitor your daily money spending, even when it is very low, with writing and calculating on paper. Being a good personal money manager will help you to take over control in other aspects of your life.

3. Practice Patience: Whenever you feel overwhelmed by impulses and emotions to make a decision or take an action: stop, take a deep breath, and close your eyes. Then starting from 10, count up to 20 slowly.

4 Movement & Speech

1. Practice Paraphrasing: Select a paragraph from recovery literature, a magazine or a newspaper and read it mindfully. Then rewrite the paragraph in your own words, using synonyms and alternative descriptions.

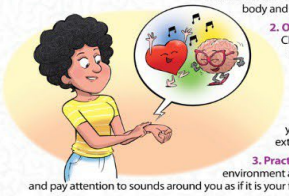


2. Enjoy the "Artist in You": Grab a coloring book and allow yourself to get colorfully creative! Try to color without going outside the confines of the patterns.

3. Improve Dexterity: Don Henley, famed drummer for the Eagles, said he first began drumming by tapping on his school books and desk. Sit and intentionally strike drum beats, varied and different paced to improve and stimulate manual dexterity. Enjoy little competitions with yourself around speed, patterns and precision.

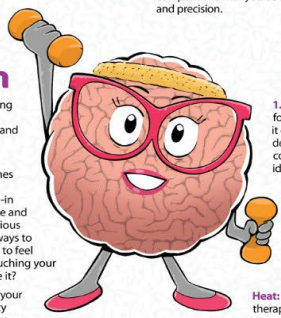
5 Brain-Body Connection

1. Practice Body-Presence: Focus on your body while you are exercising, practicing yoga, sitting in meditation, etc. instead of listening to the music. Experience the communication created between your brain and body and feelings associated with it.



2. Observe Your Heart Rate: Check your pulse several times during different activities throughout the day. Tune-in to the message your pulse and heart rate will offer at various conditions. Try different ways to check your pulse. Even try to feel your heart beat without touching your external body? Can you sense it?

3. Practice Mindfulness: Observe your environment and your body with curiosity and pay attention to sounds around you as if it is your first time to experience them.



6 Arousal and Sleep

1. Create a Sleep Haven: Prepare your bedroom for a relaxing and soothing sleep by making it dark and quiet. Turn your electronic devices to silent and offer yourself comforting supports, such as an ideal pillow.

2. Pamper Yourself Occasionally: Utilize spa activities such as massage, sauna, hot tub, manicure, pedicure, etc. whenever possible. You can even use your home bathtub as your personal spa.

3. Enjoy the Benefits of Warmth/ Heat: Take a warm shower to ease tension in your muscles. Set your home water on a therapeutic temperature to relax your joints and muscles.

7 Feeling Bad

1. Use Positive Language: Replace negative words with positive ones. Use positive affirmations such as: "Look how far I have come" as opposed to: "I am not progressing fast enough."

2. Live in Gratitude: Consistently acknowledge things for which you are grateful. To your recovery friends, to your family, to yourself and to your spiritual life. Make a list of areas and things in your life for which you are grateful.

3. Volunteer for Charity Work and Express Your Spiritual Generosity: Help other people even if it seems small. Volunteering or charity work is a great opportunity to be of service to others.

8 Feeling Good

1. Be a Member of the Happiness Club: Try to laugh and share humor with other people. Spend your leisure time watching comedy shows with your family and offer some funny stories and tell some jokes. Turn on your sense of humor and enjoy your life.

2. Be a "Hobbiest": Choose joyful hobbies that help you relax and feel joyful. Ex: Swimming, arts/crafts, cooking, golf or gardening could enhance your recovery and brain healing.

3. Detox Your Brain from Negative Memories by Making New Positive Ones: Try new fun experiences and form happy memories. You can visit new places or learn new exercises associated with joy and pleasure without using alcohol or any other drugs.

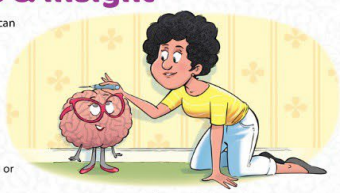
9 Social Cognition

1. Use Compassion and Understanding: In every meeting, place yourself in other people shoes, try to view the world from their perspective and consider their circumstances.

2. Allow Yourself to be Transparent: Express your thoughts, fears, and emotions to your recovery friends or family members, when safe to do so whenever you feel out-of-sorts or tense. Use a journal or a notebook to write about emotions you experienced that day.

3. Be a Voice Analyzer: Listen to your partner's expressions and tone of voice deeply during conversations and try to understand by writing about his/her emotions from voice inflections and body language.

10 Awareness & Insight



1. Observe Your Brain Processes: You can monitor what is happening inside your brain and ask yourself such questions as""What type of process is my brain engaged in right now?""What brain processes encourage me to feel certain emotions such as glad, sad, or mad?"

2. Attend to Your Posture: Use your brain power to monitor your posture moment by moment especially when you are in the middle of walking, typing or watching TV.

3. Live Weight-Conscious: If your body weight has been a health risk for you, find out what your ideal BMI is. Find brain processes that help you reach your food intake and body weight goals.

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In Summary

Much like your body, your brain needs exercise on a regular and progressively more challenging basis. Our brain needs exercise to stay sharp and encourage resiliency to handle the day-to-day rigors of life. A healing, addicted brain needs even more attention, nurturing and care. In this third educational poster, we introduce some of the exercises which can be done easily, almost everywhere, anytime without any special equipment. So, please enjoy the offerings of our poster series and our book "Brain-Healing First Aid...": and their recommendations for healing.

Authors: Hamed Ekhtiari, Tara Rezapour, Brad Collins, Martin Paulus; Illustrator: Naeem Tadayon; Graphist: Mohsen Farhadi

Scan the QR code above with your smartphone to get a free PDF version of the book.

RSG 10: Onward and Upward: Career/School/Parenting

One of the major factors in developing and maintaining a recovery is for an individual to feel positive and productive in their lives. Being a productive person who is employed in a job they are proud of, or are in school to build a career, or are responsible for the care of their children, are among the biggest sources of reinforcement in life. A major contributor to positive self-esteem is the feeling that one is responsible for their own life and in many cases for support for their families. Very often career initiation and advancement is an essential part of a successful recovery.

Explanation:

It is important to individualize this discussion. For someone who has been unemployed and out of the workforce, this exercise has to focus on small steps toward identifying a potential career pathway with school or steps toward a starter job. For those who are in a job and hope to advance or move to a more rewarding job, this requires a different conversation. For individuals who are focusing on their role as parent, the exercise may focus on how they understand the importance of their parenting activity and steps they might take to make this activity more fulfilling.

Review of form:

Discuss with the patient their goals and aspirations and some possible steps they can take for advancement. Provide encouragement and praise for their willingness to work on improving this aspect of their lives.

RSG 10 Handout: Onward and Upward: Career/School/Parenting

The focus of recovery changes and expands over time. The early goals may be:

- Not using stimulants for a day, a weekend, a week, a month, etc.
- Working on healthy eating and exercising.
- Attending all of your treatment appointments.
- Shedding relationships with people who use drugs and establishing a new group of sober friends.

When you make changes in your life that establish a break from drug use, you reach a new starting point in recovery. Goals need to be more focused on personal growth and a new lifestyle beyond just being drug-free.
These goals may be:

- Returning to school or a training program (for example, the trades, computers, or a high school or college degree).
- Applying for jobs and returning to work.
- Contributing financially to your household and family.
- Being a full-time parent and being responsible for children.

These goals are not only a way to move farther away from the drug use life but bring a feeling of self-esteem. It puts you in a world where you are more than simply drug-free, but a new and positive place where you can experience the satisfaction of being a contributing member of society.

What are some things you could do to achieve these “bigger picture” goals?

Goal_____ When _____

Initial steps _____

Goal_____ When _____

Initial steps _____

Goal_____ When _____

Initial steps _____

RSG 11: Signs of Stress

Stress is a major cause of a return to drug use. The two informational sheets provide some of the ways that stress can become part of drug use and can be a challenge in recovery. Patients can use the two information sheets to identify possible areas of stress.

The worksheet can help patients recognize their own signs of stress. They may be showing obvious signs of stress but not seeing these signs as being stress related. The leader and fellow group members may be able to help bring the signs to the patient's attention. Once signs of stress are recognized it is important to be able to alter behavior to reduce the level. As they become familiar with various stress reduction techniques, they should be encouraged to incorporate them into their daily living to prevent and reduce stress.

RSG 11 Handout: Signs of Stress

Stress is what a person experiences as the result of difficult or upsetting events, particularly those which continue for a period of time. Stress can be a big trigger for meth/cocaine use.

Sometimes we are unaware that we are stressed until we recognize the physical symptoms. **Check off any of the following problems you have experienced in the past 30 days:**

___ 1. Sleep problems
   a. Difficulty falling asleep
   b. Waking up off and on during the night
   c. Nightmares
   d. Waking up early and being unable to fall back to sleep

___ 2. Headaches
___ 3. Stomach problems
___ 4. Chronic Illness
___ 5. Fatigue
___ 6. Moodiness
___ 7. Irritability
___ 8. Difficulty concentrating
___ 9. General dissatisfaction with life
___ 10. Feeling overwhelmed
___ 11. Other
_____

By becoming more aware of stress and learning ways to cope, you can further ensure your continuing recovery and improve your physical and mental health. Stress, like cravings can often be managed by using specific grounding techniques, such as deep breathing, meditation, and exercise.

You can practice grounding exercises with your therapist to help you reduce the impact that stress has on your body and behaviors.

What are some ways that you have managed stress in the past?

_____

_____

_____

RSG 12: Drug Use Prevention

Drug use does not just happen. There are warning signs in behavior and thinking that patients can be taught to monitor. Also, there is frequently an emotional building prior to a return to use following a period of abstinence. This is a subtle and difficult concept. People with substance use disorders need to learn the indicators of stress and anxiety such as insomnia, nervousness, or headaches, and to view these as signals of possible drug use. Learning from previous experience is critical.

RSG 12 Handout: Drug use Prevention

Why is drug use prevention important?

Recovery is more than not using drugs/alcohol. The first step in treatment is stopping drug/alcohol use. The next step is not starting again. This is very important and the process for doing it is called DRUG USE PREVENTION.

What is relapse?

Relapse is going back to drug/alcohol use and to all the behaviors and patterns that go with that. Often the behaviors and patterns return before the actual drug/alcohol use. Learning to recognize movement towards drug use can help the recovering person stop the process before actual drug/alcohol use begins.

What is substance use behavior?

The things people do as part of using drugs or alcohol are called “using behaviors.” Often these are things the individual does to get drugs or alcohol, to cover-up drinking/using or as part of the use. Lying, stealing, being unreliable, and acting compulsively are types of these behaviors. **Describe yours:**

What is emotional building?

Feelings that don't seem to go away and just keep getting stronger cause emotional building. Sometimes the feelings seem unbearable. The kinds of feelings that can build are boredom, anxiety, sexual frustration, irritability, and depression. Are any of these familiar to you now or in the past?

_____

_____

_____

What is drug use justification?

In AA these kinds of thoughts are called "stinking thinking." They are thoughts that make using or drinking seem O.K. Some examples are, "I can handle just one drink", "If they think I'm using, I might as well", or "I have worked hard. I need a break." What might your brain say to you?

_____

_____

_____

The important step is to TAKE ACTION as soon as you recognize the danger signs. Which actions might work for you?

____ Call your therapist
____ Call a sober friend
____ Go to a support meeting
____ Exercise
____ Do something you enjoy
____ Talk to a family member
____ Talk to your spouse
____ Read the Bible/Prayer

What other actions might work for you?

_____

_____

Individual Coaching Session (ICS) Worksheets

Chapter 9: Individual Coaching Sessions (ICS)

The individual coaching session (ICS) component of the TRUST protocol provides patients with an opportunity to establish an individualized relationship with a therapist and receive some of the TRUST protocol information that is optimally discussed in a 1:1 setting. The 1:1 setting allows the patient to discuss some issues they may not be comfortable discussing in a group setting. In this setting they can receive the nonjudgmental guidance and support of the therapist. Use of motivational interviewing skills in this context is strongly encouraged. The topics of the ICS include materials from CBT and CRA and are delivered with a motivational interviewing style.

Individual Coaching Session Rationale and Content

The ICS provides an opportunity for patients to develop their own recovery plan with the guidance and "coaching" of a therapist. In some programs, the incentive component may be delivered in these sessions and many of the other behavior change treatment components are discussed in these sessions.

Physical exercise. The ICS also provides the opportunity to help patients develop a program of physical exercise. Exercise is included in the TRUST protocol because there have been several studies that have shown it to be useful in stimulant recovery. Over the course of the 12-week program, we recommend the therapist ask about exercise frequently and help problem solve difficulties patients have in starting and sustaining exercise. Developing an exercise program is surely not a "one size fits all" concept. Therapists should be supportive of small steps and encouraging of patients to "keep trying".

Session Format and Content

One weekly, 45-minute session, provides an important opportunity for therapists to address the individual needs of patients. As described below, there are session topics and worksheets that cover some specific content areas of importance in stimulant treatment. However, these 12 individual coaching sessions need to have a balance of the planned worksheet topic coverage and time for therapists to ask questions and learn about details of the patients' background and current life and future aspirations and at the same time build rapport with patients and provide them with positive reinforcement for their recovery efforts. In general, the topic can be covered in 20-25 minutes. The balance of the session can be used to discuss issues of current concern to the patient as well as review ongoing recovery activities (e.g., scheduling, exercise, etc.)

If possible, ICS should be scheduled on a day of the week that is not contiguous with the group sessions. For example, if the DCG and RSG are held early in the week (Monday/ Tuesday), it is preferable that the ICS be scheduled toward the end of the week (Thursday/ Friday) or vice versa. ICS scheduling should accommodate the patients' work/childcare/transportation/etc. situation to the extent possible. It is really important that patients who are working can attend treatment sessions during times that do not conflict with work hours (e.g., evenings). If a patient must choose between going to work or going to treatment, this almost always leads to premature treatment termination. Similarly, patients with transportation challenges need special accommodation (e.g., travel support or sessions via a secure website platform (e.g., Zoom, etc.)).

Individual Coaching Session Descriptions

ICS A: Drug Use Analysis and Chart

This session is not routinely scheduled, but it is useful when someone has resumed drug use. If the patient enters the session and reports drug use, it is useful to do at the start of the session to try and reframe the use, not as a failure, but as a signal that a change in the recovery plan is needed. Using this form can help reduce the embarrassment and upset that the patient feels about their drug use. A resumption of drug use does not occur suddenly and unpredictably. However, it often feels like it happens that way to the patient. The drug use analysis chart can be helpful in understanding the factors and signals that led to the resumption of drug use.

ICS A Handout: Drug Use Analysis and Chart

When does a return to drug use begin?

If drug use happens, it is important to analyze the events surrounding it. By doing this, you can make necessary changes to avoid future drug use.

Prior to the actual substance use there are usually signs and changes in your behavior days or even weeks ahead of the drug use.

Use the drug use analysis chart to help zero in on the causes of drug use in the past, more recently, or potentially in the future.

Look at the events over the 1 – 4-week period preceding drug use. Note any change or stressor even if it might not seem relevant. Areas to look at are:

1. **Work** – significant events or a change in status relative to a job.

2. **Personal** – events or a change in the status of relationships with family/friends as well as other situations unrelated to any other category.

3. **Treatment** – events or a change in status of the regular treatment plans as well as transition from one phase of treatment to another.

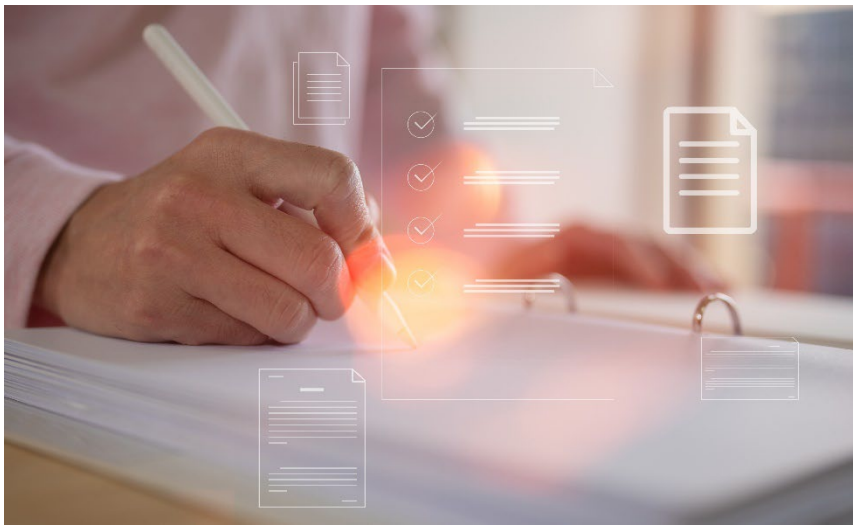
4. **Drug/Alcohol Related Behaviors** – behaviors directly related to drug and alcohol consumption (e.g., drinking, going to bars, visiting a dealer or seeing someone who uses)

5. **Behavior Patterns** – new or resumed behaviors that are part of addiction (e.g., lying, stealing, behaving compulsively, isolating, etc.)

6. **Drug use Cognitions** - thoughts that seem to justify drug use, even if they were brief and seemed minor. Being aware at any point that a return to drug use might be in progress. Fantasies about using or the behaviors above that go with using. Dreams about drugs and drug use.

7. **Health Habits Status** - events or a change in status or routine of normal eating, sleeping, exercise, or grooming behaviors. Illness or injuries are particularly pertinent.

It is not likely that there will be significant events in every single category. It is important to get a picture of overall vulnerability before the actual drug use occurred.



Drug Use Analysis Chart

Name: _____

Date of Drug Use: _____

An episode of drug use does not begin when drug ingestion occurs. Frequently there are pre-use events that occur, which are indicative of a return to drug use. Identifying your individual pre-use patterns will allow you to interrupt the process of a return to drug use. Using the chart below, note events occurring during the week immediately preceding the drug use being analyzed.

WORK EVENTS	PERSONAL EVENTS	TREATMENT	DRUG/ RELATED BEHAVIOR	BEHAVIORAL PATTERNS	DRUG USE THOUGHTS	HEALTH HABITS STATUS

THOUGHTS OR FEELINGS RELATIVE TO ABOVE EVENTS

ICS 1: Functional Analysis

A functional analysis is an essential "starting point" to give the therapist a picture of the way in which stimulant use has become integrated into each patient's life. Listening to the individual describe the details of their drug use provides a valuable array of information that will be critically important in helping the patient develop a plan of recovery. It is important for the therapist to express genuine interest in and curiosity about the details of the when, where, why, with whom and what happens of an individual's stimulant use. Ask questions, be curious, try to understand how stimulants have become a part of each individual's life.

ICS 1: Functional Analysis: The Five Ws

- Your meth/cocaine use isn't random. It doesn't happen accidentally.
- If you have been using stimulants on a regular basis, then there are probably some patterns to your use (e.g., places, times of day, with certain people).
- If you understand how methamphetamine/cocaine are entangled in your life, then you can work on reducing or eliminating your use.

To gain an understanding of how drug use has become involved in your life, it is useful to do understand "The five Ws."

The Five Ws

- **When**: The time periods <u>when</u> you use stimulants
- **Where**: The places <u>where</u> you use and buy stimulants

- **Why**: The external cues and internal emotional states that trigger craving and use of stimulants (why)
- **Who**: The people who you use drugs with or the people who you buy drugs from.
- **What**: What effects do you experience (good and bad) when you use stimulants (what happened)

When are the days of the week/ times of day that you most often use cocaine or methamphetamine:

_____

_____

Where are the places you most often use and buy meth/cocaine:

_____

_____

Why does use happen? What are the events or things around you or the emotional feelings (triggers) that you have that often occur right before you buy and use meth/cocaine:

_____

_____

Who are the people you frequently use stimulants with, or buy stimulants from?

_____

_____

What happens when you use methamphetamine/cocaine? Good and Bad.

_____

_____

_____

ICS 2: Exercise and Recovery

Exercise is an intervention that can make a major difference in helping people with the challenging emotional symptoms that often are part of the early months of stimulant recovery. We know that chronic stimulant use damages the dopamine system and that individuals in the first 12-16 weeks (or longer) of stimulant recovery have very challenging symptoms of anhedonia, depression, and anxiety.

Often patients will say: “If this is how it is going to feel to be sober for the rest of my life, I can’t live this way”. Obviously, this emotional context can be a justification for use of stimulants. “I just needed to do this once, to feel normal”, etc.

Exercise helps speed the recovery of the brain. Brain imaging studies have shown that exercise helps the dopamine system recover more quickly and that people who engage in 20-30 minutes of exercise, 3 times per week, have fewer negative emotional symptoms and fewer cravings. There have also been studies to show that exercise can help with concentration. Therefore, exercise has many of the benefits that we would find valuable in a medication to help individuals who use stimulants in recovery.

There are added benefits to exercise. Exercise is often a new (or long forgotten) set of behaviors that patients can use to build their non-drug using schedules. The exercise can be as simple as taking brisk walks with sober friends. Using exercise to build a new set of friends and ways to spend time can be an important building block in recovery.

Although exercise is introduced in this session, it is important for therapists to come back to the topic of exercise regularly though out the 12-week protocol and in continuing care.

The topic of exercise is similar to the scheduling concept. Exercise activity needs to be inquired about, verbally reinforced and encouraged and problem-solving support from therapists can be really helpful to patients in finding the time and methods for exercise.

ICS 2 Handout: Exercise and Recovery

- People who exercise on a regular basis in stimulant treatment do better than those who don't.
- Research has been done that shows exercise can reduce anxiety, depression, weight gain and help reduce craving.
- Any exercise that increases heart rate (aerobic) and can be done for 20 minutes, 3 times per week can make a huge benefit on the health and mental health of people recovering from stimulant dependence.
- Exercise provides a new set of behaviors to use your time in a non-drug related activity.

Making a plan for exercise, one day at a time, is a really valuable way to increase your chances of success in stimulant recovery.

You can do simple things alone without expense or equipment (e.g., jogging, sit-ups, etc.) or there are group activities that can provide you with support and new non-drug-using friends (yoga, joining a gym, aerobics classes). In addition, there are also many apps for smart phones, tablets, and computers that you can use to support and track your exercise efforts.

1. What are some exercises that you are willing to add to your recovery plan?

_____

_____

2. List any medical or physical problems that you should speak with your physician about that could be obstacles to exercise?

_____

_____

3. Do you exercise now? ____ Have you exercised in the past? ____

   Describe your exercise experiences:

_____

_____

4. What exercise plan would work for you? Think about:
   - Is there someone you could exercise with?
   - Do you have any equipment (e.g., a bike, hand weights, basketball)?
   - When could you block out a half hour for exercise? 3 x week?
   - What exercise program has worked for you in the past?
   - What kinds of things do you like to do physically?

_____

_____

Start slowly, don't overdo it, some is better than none.

Be consistent-do a little but do it consistently.

ICS 3: Drug Refusal Skills

As many as one-third of individuals who enter treatment for a substance use disorder, resume drug use as a direct result of social pressure from friends who use. Most individuals who use drugs who are trying to quit continue to have some contact, either planned or inadvertent, with friends or acquaintances who are still using. Turning down methamphetamine or cocaine or opportunities to go places where they are available will be much more difficult than most patients anticipate. When initiating drug-refusal training, therapists begin by explaining why this will be important.

For example, “drug refusal training can be very important in helping you achieve an initial period of abstinence and for maintaining that abstinence. We are going to practice ways to refuse drugs or to refuse to go to places where drugs are available. The ability to effectively say “no” in these situations will help you feel in control when faced with situations that are tempting and to which you may previously have said “yes” automatically. If you do not prepare yourself to deal with these situations, good intentions may not lead to effective refusal. An important component of this training is for you to be creative in anticipating many of the situations that may come up in the following months. We have developed some examples that we feel are typical of what many individuals who use stimulants face, but each person has a unique set of circumstances. This training will benefit you most if you include situations relevant to your life so that we can rehearse how to handle them.”

Part of this session includes role-playing. The therapist should play the role of the person offering drugs and the patient should play themself. Remind the patient of the important components of effective refusal which are provided on the session handout.

ICS 3 Handout: Drug Refusal Skills

Refusing Methamphetamine and Cocaine
Some Important Things to Know:

- People who offer you meth/cocaine are not thinking of your best interests. Once you have decided to reduce or stop use of meth/cocaine, anyone (friend or not) who offers you drugs is a danger to you. Offers to use have to be refused - politely, if possible, but firmly.

- **Saying "NO" is the first and most important part of your refusal response.** There are different ways of saying "NO" for different situations. It is important to feel comfortable with how to say "NO!" You have to develop your own style.

- Think of a time you had difficulty refusing meth/cocaine? Choose a specific situation, specific people, time of day, place, and the activity.

_____

_____

COMPONENTS OF AN EFFECTIVE REFUSAL

- *"No"* should be the first thing you say.
- Tell the person to stop asking if you want to use drugs.
- Use appropriate body language.
- Make good eye contact; look directly at the person when you answer.
- Your expression and tone should clearly indicate that you are serious.

- Discuss how you might say "NO" to a similar offer in the future.

_____

_____

ICS 4: Social Skills/Assertiveness Training

Many people in treatment for drug and alcohol problems have difficulty with interpersonal relations. Poor interpersonal skills can give rise to emotional states such as anger, frustration, resentment, depression, or anxiety and decrease the quality of life and increase the risk of a return to drug use.

Social-skills training is provided to help patients to:

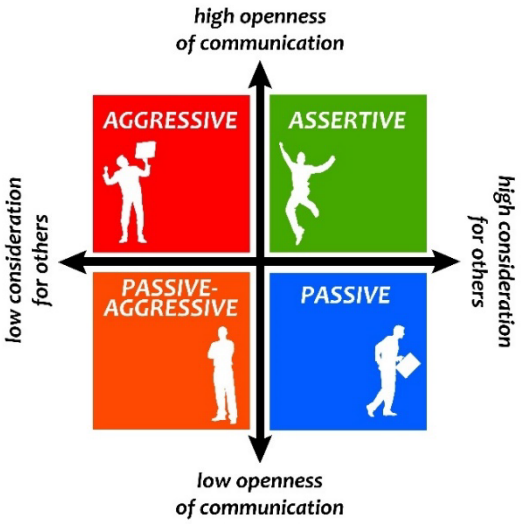
- Meet nondrug-using peers.
- Interact more effectively with coworkers, family members, or roommates.
- Attend social activities that have normally been avoided.
- Express their feelings or assert themselves in an appropriate way.

The goal: to better handle interpersonal situations; to experience more positive reinforcement and fewer negative, aversive effects. Assertiveness training is particularly appropriate for patients who tend to be either too passive or too aggressive in social situations. Assertiveness training is one method for increasing positive experiences and decreasing negative experiences in social settings.

Explain to the patient: Learning how to be assertive will enable you to act in your own best interest, to stand up for yourself without experiencing excessive anxiety, to express your feelings honestly and comfortably, and to exercise your personal rights without denying the rights of others. Review the “Tips” and discuss each one.

Role play: Ask the patient to act out situations they identify as being non-assertive and provide feedback. It may help to role play first to make the patient more comfortable with the exercise.

ICS 4 Handout: Assertiveness



What is assertiveness?

Assertiveness means to behave in a confident, forceful, yet respectful way. Being assertive helps you to stand up for yourself and stick to your beliefs. Being effectively assertive is important if you tend to be either too passive or too aggressive in social situations.

What is assertive behavior?

- Assertive behavior enables you to express your feelings honestly.
- Assertive behavior allows you to achieve your personal goals.
- Assertive behavior respects the feelings of others.

What is passive behavior?

Do you deny yourself or your rights?	___Yes ___No___ Sometimes
Do you avoid expressing feelings?	___Yes ___No___ Sometimes
Do you feel hurt and anxious?	___Yes ___No___ Sometimes
Do you allow others to choose for you? _	___Yes ___No___ Sometimes
Do you fail to achieve your goals?	___Yes ___No___ Sometimes

What is aggressive behavior?

Do you accomplish goals without concern of bad feelings and resentment in others?	___Yes ___No ___Sometimes
Do you express feelings and promote yourself, but usually hurt others in the process?	___Yes ___No ___Sometimes
Do you minimize others' worth and put them down?	___Yes ___No ___Sometimes
Do you make choices for others, and deny them their rights?	___Yes ___No ___Sometimes

- ***Passive***: You are hurt by not getting what you want.
- ***Aggressive***: The other person is hurt and may seek revenge.
- ***Assertive***: Neither person is hurt, and both get what they want.

Some tips on how to be assertive. Rate yourself on each item from 0 to 10: 0 meaning "I need to work on this" 10 meaning "I'm as good as I can be with this."

- I clearly express my needs (what you want). Rating: _____

- I use "I" statements when expressing my feelings or needs. (For example, you could say "I am angry because I feel like nobody cares about my feelings," instead of "You make me feel awful.")Rating: _____

- I speak clearly and firmly (Your message should be said with authority but not hostility. You want to convey that you mean business but are respectful). Rating: _____

- I make good eye contact when speaking. I look at the other person when I speak and when I listen. (Again, this promotes the impression that you are serious about your message). Rating: _____

- My body gestures and facial expressions are consistent with my message. (For example, don't smile if you are angry.) Rating: _____

ICS 5: Recovery Checklist

This session provides a worksheet for patients to see what proactive things they are doing in their treatment and what aspects of their treatment they need to work on.
This is an opportunity for the group members to receive and provide input on dealing with items on the checklist.

ISC 5 Handout: Recovery Checklist

Reducing your use of meth/cocaine requires a lot of hard work and a great deal of commitment. It is necessary to change old behaviors and replace them with new behaviors.

Check all the things that you do (or have done) since entering treatment:

_____ Schedule on a daily basis

_____ Avoid triggers (when possible)

_____ Use thought-stopping for cravings

_____ Eliminate all paraphernalia

_____ Avoid individuals who use meth and cocaine

_____ Attend the clinic for your scheduled medication visits

_____ If receiving take-home medication, take as prescribed.

_____ Attend 12-Step/other support meetings

_____ Avoid bars and clubs

_____ Stop using alcohol

_____ Reduce or discontinue tobacco use (ask your therapist for help)

_____ Exercise every day

_____ Pay financial obligations promptly

_____ Discuss your thoughts, feelings, and behaviors openly with your therapist

_____ Avoid triggering websites

_____ Delete triggering contacts from your phone/computer

Which of the above is easiest for you to do?

_____

_____

Which of the above takes the most effort for you to do?

_____

_____

Which have you not done yet? What is keeping you from doing this?

_____

_____

ICS 6: Motivation for Recovery

Sometimes the reasons for entering drug treatment do not make a difference in the long-term outcome of treatment. Almost always the motives for starting treatment have to do with ending or escaping a bad situation (at home, at work, bad health, depression, etc.). With some period of abstinence these reasons resolve, and the question becomes “why stay sober now?” Motivation shifts to experiencing the benefits of a drug-free life. In this session, discuss this issue and pose questions at the end of the session to each patient to increase their awareness of why they want sobriety now. For newer patients, the motivations typically will not have changed much since beginning treatment.

ICS 6 Handout: Motivation for Recovery

Ask any group of people just starting into recovery WHY they want to stop using right now and you will get many different answers:

- "I was arrested and it's either this or jail."
- "My wife says if I don't stop, we are finished."
- "Last time I used I thought I was going to die; I know I will if I use again."
- "They are going to take the children from us unless we stop."
- "I've been using for 20 years now; it's time to change."

The reasons people stop using have little bearing on whether they will be able to successfully lead a drug-free life.

What does make a difference is whether they can stay drug-free long enough to appreciate the benefits of a different lifestyle. Life becomes less complicated and more enjoyable. When debts are not overwhelming, when relationships are rewarding, when work is going well, and health is good, the recovering person WANTS to stay drug free.

FEAR WILL GET SOMEONE INTO TREATMENT BUT

FEAR ALONE IS NOT ENOUGH TO KEEP THEM IN RECOVERY.

1. List some of the specific reasons you first entered treatment. (e.g., medical problems, family pressure, job problems, depression, etc.):

_____

_____

2. List some of the specific reasons you are continuing to work on the recovery process today:

_____

_____

3. Do you feel that your reasons for stopping drug use initially are the same as your reasons for staying off drugs today? Explain why or why not.

_____

ICS 7: Managing Anger

Anger is repeatedly defined as an overwhelming negative emotional trigger. The purpose of this session is to provide patients with alternative ways of dealing with anger, to avoid feeling overpowered, and to avoid the strong possibility of drug use.

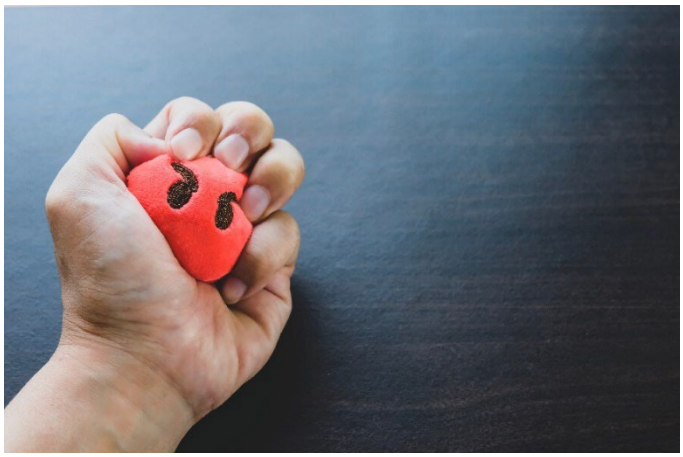
For many people, substance use is a way to cope with feelings that are uncomfortable. When faced with a troubling emotion, such as anger, people often choose not to cope with it and turn to substance use instead. Patients in recovery no longer can turn to drugs and alcohol for a temporary escape from difficult emotions.

The following steps may help patients better understand and manage their anger:

- Be honest with yourself. Admit when you are experiencing anger.
- Be aware of how your anger shows itself. Physical sensations and patterns of behavior can help you recognize when you are angry.
- Think about how anger affects others. Being aware of anger's effects on those you care about might motivate you to minimize its effects in your life.
- Identify and implement coping strategies. Keep using strategies that have always worked and find new ones that may be useful.

ICS 7 Handout: Managing Anger

Anger often leads people to use meth/cocaine.



Frequently, anger slowly builds on itself as you may constantly think about the people and events that make you angry. Sometimes it seems like the issues causing the anger are the only important things in life. Often, a sense of victimization accompanies the anger.

Do you ever think these things?

- "Why do I get all the bad breaks?"
- "How come they don't understand my needs?"
- "Why won't they just do what I want them to do?"

1. Does any of this seem familiar to you?_____ Explain.

_____

_____

2. How do you recognize when you are angry? Does your behavior change? For example, pacing, clenching your jaw, feeling restless? How or where do you feel or notice it?

_____

_____

3. How do you express anger?

- Do you hold it in and eventually explode?

_____

_____

- Do you become sarcastic or passive-aggressive?

_____

_____

Consider these methods that focus on positive ways to deal with anger:

- Talk to the person with whom you are angry (unless this is dangerous or might make the situation worse).
- Talk to a therapist, a Twelve Step sponsor, or another trusted, rational person who can give you guidance.
- Talk about the anger in a Twelve Step or community support group meeting.
- Don't lose sight of where you are in your recovery.
- Write about your feelings of anger.
- Take a break to change your frame of mind.
- Exercise.
- Other (Remember things that might have worked for you in the past):

_____

_____

Which of these would you try?

_____

_____

ICS 8: Social/Recreational Behavior

This session focuses on developing interest and participation in recreational and social activities that are pleasurable and do not involve drug use. The goal is to increase participation in social activities that may serve as alternatives to drug use.

Therapists should provide a rationale for working on lifestyle changes in social and recreational areas. Many times, when drugs become a regular part of someone's life, they either stop doing many of the nondrug activities they used to enjoy, or they never start or develop any regular recreational activities. Social and recreational activities are important in most people's lives. They provide a source of enjoyment that can be looked forward to after a stressful day, a way to decrease boredom, a way to feel physically healthy, an outlet for developing a skill that makes you feel good about yourself, and a chance to be with people with whom you would like to develop friendships.

The first step in social/recreational counseling is to develop a list of potentially reinforcing activities that the patient is interested in pursuing. Therapists could also use the ***Leisure Interests Checklist*** handout to help. Once possible activities are identified, therapist and patient should attempt to categorize activities by amount of interest, cost, others' involvement, time commitment, likelihood of engaging in the activity, and whether it is physical or sedentary.

The next step is to create a list of people who might participate in activities with the patient. This can be difficult, because patients will often report that they don't know anyone who abstains from using drugs or alcohol; this is rarely true. With gentle prompting about extended family and old acquaintances, patients can usually name at least one safe person to target as a contact.

If patients are unable to identify anyone, move on and come back to this issue later. Finding safe people has high priority, since establishing a social network of non- using friends or family members can play a substantial role in the achievement and maintenance of abstinence.

ICS 8 Handout: Social/Recreational Behavior

This session focuses on developing interest and participation in recreational and social activities that are pleasurable and do not involve drug use.

Why this is important?

Social and recreational activities provide a source of enjoyment that can be looked forward to after a stressful day. They are a way to decrease boredom and to feel physically healthy. They are a way to develop a skill that makes you feel good about yourself, and an opportunity to be with new people and to develop friendships.

These activities can play a very important part in becoming and staying drug free.

List Activities and People

The first step is to develop a list of activities that you are interested in pursuing.

- What are some current activities you enjoy that do not involve drugs?

  _____

  _____

- What are some non-drug related activities you've enjoyed in the past?

  _____

  _____

- What are some activities you have always wanted to do, but have never done?

_____

_____

- Of these activities which are the most realistic with regard to: your amount of interest, cost, others' involvement, time commitment, your likelihood of engaging in the activity?

_____

_____

- List some non-drug-using people who might participate in these activities with you?

_____

_____

Set Goals

- What activities could you take part in over the next week?

_____

_____

- Who could take part in these activities with you?

_____

_____

ICS 9: Stimulants and Sex – A Natural Connection

This session opens the door to a sensitive and important topic. It gives the patient an opportunity to discuss sexual issues in a safe environment. This topic can sometimes be uncomfortable unless the topic is presented as a natural part of the addiction/recovery process. It is important to maintain a serious tone in this group. Explicit detailing of sexual experiences is not important. The relationship between sex and resumption of drug use should be discussed.

ICS 9 Handout: Stimulants and Sex-A Natural Connection

Meth/cocaine use affects the same part of the brain that controls both sexual behavior and sexual pleasure. Were any of these true for you?

In the Beginning

Stimulants increased sexual pleasure	____yes ____no
Stimulants helped sex last longer	____yes ____no
Stimulants allowed me to do things I might not otherwise do	____yes ____no
Stimulants helped me meet people	____yes ____no
Stimulants made me less anxious in new sexual encounters	____yes ____no
Stimulants added excitement to relationships	____yes ____no

It is not unusual for people to experience some of the above effects from stimulant use in the beginning. As the addiction gets worse, less pleasant things often begin to happen. Did you experience any of the following?

Near the End

Continued ability to prolong sexual activity with decrease in pleasure from the experience	____yes ____no
Increased, more unusual sex (looking for pleasure)	____yes ____no
Thinking about sex and drugs became more exciting than the real thing	____yes ____no
Difficulty achieving erection (males) or orgasm (females)	____yes ____no
Using stimulants replaced sex	____yes ____no

Thinking/fantasizing about sex is a trigger for drug use.

Are you getting triggered from any of the following?

Porn: Looking at porn internet sites or cruising through areas of prostitution can result in arousal and then cravings. It is difficult to fight this 1-2 punch from your addicted brain.

Bars/Clubs: Many people miss the social scene that goes along with using and try to return to the same places where stimulants and sex were used together. A menu for drug use.

Extra-relationship Sex: Forbidden sex can be a trigger during recovery. One of the reasons for this is that such activity may involve lying, cheating, etc. All of these are addictive behaviors.

Dysfunction: It takes a while after stopping drug or alcohol use to experience pleasurable, normal sex again. It is not unusual to lose all interest in sex. For some people it's difficult not to get anxious about this.

Over time, with abstinence, normal sexual functioning will return. Some people may be faced with drug-free sex for the first time since adolescence – or ever! It's important not to rush back to sex. The triggering will occur less often and with less power over time. Let your triggers (or the lack of them) be your guide for your return to sexuality.

In what ways does your sexual functioning interact with your meth/cocaine use?

_____

ICS 10: Recovery Checklist

This session provides a worksheet for patients to see what proactive things they are doing in their treatment and what aspects of their treatment they need to work on. This is an opportunity for the group members to receive and provide input on dealing with items on the checklist. This is a repeat of this topic to allow the therapist and patient to see improvements or regression in recovery. Repeated review is akin to checking the recovery vital signs.

ISC 10 Handout: Recovery Checklist

Reducing your use of meth/cocaine requires a lot of hard work and a great deal of commitment. It is necessary to change old behaviors and replace them with new behaviors.

Check all the things that you do (or have done) since entering treatment:

_____ Schedule on a daily basis

_____ Avoid triggers (when possible)

_____ Use thought-stopping for cravings

_____ Eliminate all paraphernalia

_____ Avoid individuals who use meth and cocaine

_____ Attend the clinic for your scheduled medication visits

_____ Attend 12-Step/other support meetings

_____ Avoid bars and clubs

_____ Stop using alcohol

_____ Reduce or discontinue tobacco use (ask your therapist for help)

_____ Exercise every day

_____ Pay financial obligations promptly

_____ Discuss your thoughts, feelings, and behaviors openly with your therapist

_____ Avoid triggering websites

_____ Delete triggering contacts from your phone/computer

Which of the above is easiest for you to do?

_____

_____

Which of the above takes the most effort for you to do?

_____

_____

Which have you not done yet? What is keeping you from doing this?

_____

_____

ICS 11: Relationship Scale

This scale is intended to estimate your current feelings about your relationship in each of the 10 areas listed below. Ask yourself the following question as you rate each area:

How satisfied am I with my partner today in this area? Then circle the number that applies.

Numbers toward the left indicate some degree of dissatisfaction: numbers toward the right reflect some degree of satisfaction. By using the proper number, you can show just how you feel with each relationship area.

Remember: You are indicating your feelings for today. Also do not let your feelings in one area influence your rating in another area.

Completely dissatisfied **Completely satisfied**

Household Responsibilities	1	2	3	4	5	6	7	8	9	10
Rearing of Children	1	2	3	4	5	6	7	8	9	10
Social Activities	1	2	3	4	5	6	7	8	9	10
Money	1	2	3	4	5	6	7	8	9	10
Communication	1	2	3	4	5	6	7	8	9	10
Sex and Affection	1	2	3	4	5	6	7	8	9	10
Academic/Occupational Progress	1	2	3	4	5	6	7	8	9	10
Personal Independence	1	2	3	4	5	6	7	8	9	10
Partner's Independence	1	2	3	4	5	6	7	8	9	10
General Happiness	1	2	3	4	5	6	7	8	9	10

ICS 11a: Examples of Relationship-Related Activities

Social Activities

- Going together to:
- the movies
- out to dinner
- Visiting friends, going for walks
- Participating in or watching sports

Rearing of Children

- Preparing their meals
- Bathing/dressing the children
- Disciplining the children
- Watching the children
- Playing with the children
- Helping with homework

Money

- Paying bills
- Budgeting money
- Buying/receiving presents
- Saving too much or too little
- Buying clothes or necessities

Communication

- Planned discussion periods
- Frequent discussion periods'
- Frequent arguments
- Using tactful statements
- Misinterpreting things said
- Solving problems through discussion

Academic/Occupational Progress

- Spends too much or too little time on it
- Too much procrastination
- Constant complaining about job
- Poor job location

Personal Independence

- Has day or night off alone
- Allowed to drive by myself
- Allowed to learn to drive
- Attends social events alone
- Feels free to ask partner's advice
- Can make decisions w/o asking

Partner's Independence

- Partner relies on you to make household decisions
- Partner goes out without you
- Partner will not go out without you
- Partner is too possessive
- Partner is not possessive enough
- Partner lacks friends
- Partner has no personal interests
- Partner does not drive

ICS 12: Continuing Care Plan

Patients should be oriented to viewing the treatment after the initial 12 weeks as a non-optional extension of the intensive treatment period. Attendance in the weekly continuing care group is critical to sustaining the progress achieved. In this session the therapist should review the ***Mooring Lines and Recovery Checklist*** handouts to reinforce continued positives and discuss areas which need more attention. In addition to attendance in the program's continuing care meeting other offsite recovery activities should be identified and planned. Some of these are community support meetings (12-Step, SMART recovery, etc.), regular exercise activities, spiritual activities, counseling, volunteer work, and others. If possible, the therapist should meet the patient at the first continuing care meeting to introduce the patient to the group and reinforce the attendance. If the patient fails to show for the meeting the therapist should call, text, or email the patient to draw them back in.

ICS 12 Handout: Continuing Care Plan

Chronic health problems require ongoing attention. The Continuing Care group provides a weekly opportunity to help maintain the progress you've made. It is important to begin the Continuing Care group right away. Taking a "vacation" from treatment often results in the end of care.

What to expect from the group:

- It is a drug use prevention group. Every group of recovering people is a drug use prevention group. The group fortifies your new, healthy lifestyle and can help get you back on track if you stray from your plan.
- It is a support group. People who are in recovery for stimulant use have an invaluable understanding and empathy for each other. The people in the group provide support for progress and help during rough times.
- It is a place to review the status of your continuing care plan. The Mooring Lines handout will be reviewed regularly with attention to changes in behavior that may reflect some slippage.

Other plans:

- Are you attending or planning to attend 12-Step or other community support groups? If so, which ones, where, and when?

_____

_____

_____

- Are you attending or planning to attend counseling for personal or relationship issues? If so, where and when?

_____

_____

_____

- What are your regular social/recreational healthy activities? How often do you take part in these?

_____

_____

_____

Chapter 10: Continuing Care Group

The 12-week TRUST program is one way in which evidence-based strategies can be combined into a protocol to organize treatment materials. However, 12-weeks represents an introduction and initial skill building period that can help develop a long-term recovery program. As we have come to recognize substance use disorders as a chronic brain disorder that requires long term guidance and support, it is a mistake to think that completing a 12-week treatment episode is sufficient for meaningful engagement in recovery.

We present the following brief section to help you consider what kinds of ongoing support and treatment materials can be useful to your patients. At minimum, continuing attendance at a weekly session for an extended period is highly recommended if the progress made in the first 12 weeks is going to be maintained. However, the content of the sessions needs to be developed to meet the needs of the individuals in your treatment facility and you may need a menu of ongoing services.

We recommend as a minimum, a weekly continuing care group that patients who have completed the 12-week TRUST protocol can advance to for as long as they benefit. It is important to present this group as continuing care, not "aftercare" which implies the treatment is over and this group is optional. Recovery from StimUD takes longer than 12 weeks. Frequently if a treatment service presents an intensive treatment phase followed by "aftercare," patients get the message that "aftercare" is not important, and they discontinue involvement. The continuing care group provides a safe and intimate therapeutic setting where the norms of the groups have previously been established and patients join already familiar others group members. As a result of the cohesiveness of the group, some patients will come to view it as their "home group."

This groups serves several purposes:

1. It is a support group of peers.
2. It helps prevent a return to drug use.
3. It helps patients stay on the course established in the initial 12-weeks of treatment.
4. It provides accountability of the things in place which are key to recovery (e.g., a review of the mooring lines).

5. It provides accountability for experimenting with new goals and behavioral changes.
6. If there is repeated drug use or a deterioration in the behaviors which had supported abstinence, the group may be instrumental in getting a person into a higher level of care.

If possible, to answer questions and reduce patient anxiety about entering a new group, it is useful for the therapist to meet the patient immediately before the first continuing care meeting to welcome the patient, explain the group and how it is different from earlier group sessions in the TRUST protocol. If the patient fails to show for the meeting the therapist should reach out to the patient (call, text, or email) to reinforce the invitation and show interest in the patient's continuing to receive support.

Start the group with the agenda and expectations followed by introduction of new members who are asked to give a brief account of the challenges and accomplishments over the initial 12 weeks of treatment. Have patients provide a brief check-in covering triggers, cravings, and successes. Time can be limited to 3 or 5 minutes per patient depending on the size of the group. It is a good idea to inform patients in the agenda how much time they will have for the check-in.

It is useful to have a topic to provide a focus for the session, these topics should be tailored to address issues of importance to be members of the group. There are numerous manuals and websites and training documents listed in the Appendix that provide materials for consideration. The TRUST program organizers can provide suggestions and guidance if requested.

The last quarter of the group can be an open discussion of any relevant problems. By this time, patients should be able to share their support by giving examples of how they have handled similar problems. Remember to remind patients not to give advice unless it is asked for. Telling people what to do generally shuts down the process of individual sharing and problem-solving.

Attendance in the program's continuing care meeting is frequently done in combination with community support meetings (12-Step, SMART recovery, etc.), regular exercise activities, spiritual activities, counseling, volunteer work, and others. The following are some sample topics and worksheets that can be useful for continuing care sessions.

Attending Events with a Sober Objective

Sober Objective- It is important to have a sober objective before attending a potentially triggering event. A sober objective is your reason for attending an event other than using drugs or alcohol. The sober objective should include the specific reason I am attending an event and the things I plan to do there.

If I don't have a sober objective, I should not attend the event.

My Plan B- What I will do instead of attending the event if I recognize that the event will be too triggering for me. This way, I will have a pre-planned alternative way to spend that time. It's never too late to choose to use your Plan B (even if you're in the parking lot, ready to walk into the event).

Sober Objective Event Guide

Fill this out with any events between now and our next meeting. Use the example on the next page as a guide.

Event	Sober Objective	Possible Risks	Exit Strategy	Plan B

Example:

Event	**Sober Objective**	**Possible Risks**	**Exit Strategy**	**Plan B**
The wedding of a friend (I will only stay for the ceremony)	To support the newlyweds, tell them how beautiful they look and compliment the parents on a lovely ceremony.	Alcohol or drugs will be available.	Have my own transportation and leave if the risk occurs.	Go on a hike and picnic with sober friends

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The TRUST Materials include content and worksheets from the Matrix Model Therapist Manual (SAMHSA, 2006), and the Community Reinforcement Approach, plus Vouchers Manual (NIDA, 2020).

Appendix: Other Evidence-Based Practice Resources, Manuals, and Websites

Contingency Management/Motivational Incentives

The CM Manual; A Guide to Instituting Low-Cost Motivational Incentives. Designed by Christine Higgins, Dissemination Specialist, Mid-Atlantic Node of the National Institute on Drug Abuse, Clinical Trials Network

Contingency Management for Healthcare Settings Online Training
https://attcnetwork.org/centers/northwest-attc/cm

Promoting Awareness of Motivational Incentives
https://attcnetwork.org/centers/global-attc/product/promoting-awareness-motivational-incentives-pami

Community Reinforcement Approach

Community Reinforcement; Community Reinforcement and Family Training Support and Prevention (CRAFT-SP). Steven M. Scruggs, Robert Meyer and Rebecca Kayo Published by the Department of Veterans Affairs, South Central Mental Illness Research, Education, and Clinical Center (MIRECC), 2001. Last updated 12/15/2014.
https://www.mirecc.va.gov/visn16/docs/CRAFT-SP_Final.pdf

The Community Reinforcement Approach: A Guideline developed for the Behavioral Health Recovery Management Project. Robert J. Meyers and Daniel D. Squires, University of New Mexico Center on Alcoholism, Substance Abuse and Addictions, Albuquerque, New Mexico. The Behavioral Health Recovery Management project is an initiative of Fayette Companies, Peoria, Il; Chestnut Health Systems, Bloomington, Il; and the University of Chicago Center for Psychiatric Rehabilitation. This project was funded by the Illinois Department of Human Services', Office of Alcoholism and Substance Abuse.

Cognitive Behavioral Therapy

Therapist's Treatment Manual: Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders. Center for Substance Abuse Treatment. HHS Publication No. (SMA) 13-4152. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006. https://store.samhsa.gov/product/Matrix-Intensive-Outpatient-Treatment-for-People-With-Stimulant-Use-Disorders-Counselor-s-Treatment-Manual/SMA13-4152

Anger Management for Substance Use Disorder and Mental Health Clients. A Cognitive-Behavioral Therapy Manual
https://store.samhsa.gov/sites/default/files/d7/priv/anger_management_manual_508_compliant.pdf

Getting Off: A Behavioral Treatment Intervention for Gay and Bisexual Male Methamphetamine Users, A Training Manual for Therapists
www.friendscommunitycenter.org/resources

Motivational Interviewing

Enhancing Motivation for Change in Substance Abuse Treatment (TIP 35) (Substance Abuse and Mental Health Services Administration (SAMHSA) This guide helps clinicians influence the change process in their patients by incorporating motivational interventions into substance use disorder treatment programs.

Motivational Interviewing Network of Trainers (MINT) International non-profit organization of trainers in MI that aims to promote good practice in the use, research, and training of MI. Website includes information on upcoming events/trainings and a "Library" of MI publications, coding and assessment tools, practice tools, and more.

Motivational Interviewing Training and Technical Assistance

Northwest ATTC Motivational Interviewing Resources:
https://attcnetwork.org/centers/northwest-attc/motivational-interviewing-mi

UNM Center on Alcohol, Substance Use, and Addictions MI and Therapist Manuals: https://casaa.unm.edu/mimanuals.html

Tour of Motivational Interviewing (HealtheKnowledge/ATTC)
4-hour self-paced online training that takes the learner on a tour of the essential skills used to strengthen an individual's motivation for behavior change. ***4 hours of CE available!***

Motivational Interviewing CME/CE and Patient Simulations (NIDA-SAMHSA Blending Initiative) Includes: *Talking to Patients about Health Risk Behaviors with MI Patient Simulation* and *Engaging Adolescent Patients About Marijuana Use*

MIA:STEP – Motivational Interviewing Assessment:
Supervisory Tools for Enhancing Proficiency

Other Resources

Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57. HHS Publication No. (SMA) 13- 4801. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014. https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816

Substance Abuse and Mental Health Services Administration. SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014. https://ncsacw.acf.hhs.gov/userfiles/files/SAMHSA_Trauma.pdf

HIV Rapid Testing
https://www.drugabuse.gov/blending-initiative/hiv-rapid-testing

Buprenorphine
NIDA/SAMHSA Blending Initiative, Buprenorphine Suite:
https://archives.nida.nih.gov/nidasamhsa-blending-initiative

Twelve-step Facilitation
https://pubs.niaaa.nih.gov/publications/projectmatch/match01.pdf

Treatment Planning
Treatment Planning M.A.T.R.S.: Utilizing the Addiction Severity Index (ASI) to Make Required Data Collection Useful:
https://nida.nih.gov/nidamed-medical-health-professionals/ctn-dissemination-initiative/treatment-planning-matrs-utilizing-addiction-severity-index-asi-to-make-required-data-collection

Texas Christian University, Institute of Behavioral Research
Brief interventions, including:

- Getting Motivated to Change
- Straight Ahead: Transition Skills for Recovery
- Understanding and Reducing Angry Feelings
- Disease Risk Reduction WaySafe Intervention
- Mapping the Journey: A Treatment Guidebook
- Treatment Readiness and Induction Program

National Institute on Drug Abuse: Principles of Effective Treatment
https://nida.nih.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/preface

Center of Excellence for Integrated Health Solutions. Funded by Substance Abuse and Mental Health Services Administration Operated by the National Council for Mental Wellbeing
https://www.thenationalcouncil.org/integrated-health-coe/

National Institute on Drug Abuse & Substance Abuse and Mental Health Services Administration Blending Initiative
https://www.drugabuse.gov/nidasamhsa-blending-initiative

Assertive Community Treatment: Getting Started with EBPs. DHHS Pub. No. SMA-08-4344, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2008.

The California Evidence-Based Clearinghouse for Child Welfare; Information and Resources for Child Welfare Professionals
https://www.cebc4cw.org/program/community-reinforcement-approach/detailed

TIP 33: Treatment for Stimulant Use Disorders: Treatment Improvement Protocol (TIP) Series 33. HHS Publication No. (SMA) 09-4209. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
https://store.samhsa.gov/product/treatment-for-stimulant-use-disorders/PEP21-02-01-004

Substance Abuse and Mental Health Services Administration. A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department. HHS Publication No. SMA18-4357ENG. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Revised 2018.
https://store.samhsa.gov/product/A-Guide-for-Taking-Care-of-Your-Family-Member-After-Treatment-in-the-Emergency-Department/sma18-4357eng

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