Amphetamine-Type Stimulant (ATS) Use

Treatment Protocol: An intervention developed for the use of staff and clinicians working with ATS clients in Therapeutic Communities

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WHAT IS THE AMPHETAMINE TYPE STIMULANTS (ATS) GRANTS PROGRAM?

- $22.9 million committed in Australian Federal budget to enhance capacity of NGOs to respond to rising demand of users of ATS.
- Reduce harms caused by ATS to individuals, their families and the Australian community.
- Intended to be one off funding to allow NGO’s to:
  - Cater for and treat
  - Attract ATS users and/or
  - Increase referrals of ATS users in treatment
WHAT IS THE AMPHETAMINE TYPE STIMULANTS (ATS) GRANTS PROGRAM?

Achieved by provision of targeted grants to:

- Existing AOD NGO treatment services to meet the increasing demand for users dependent on ATS; and

- NGOs who wish to expand or establish new treatment services to address growing need for treatment programs targeted specifically to users dependent on ATS.
KEY PRINCIPLES

Treatment interventions should:

1. Reduce and treat the use of illicit drugs.
2. Be informed by evidence and use models of good practice.
3. Reduce the risk of infectious disease.
4. Improve physiological and psychological health.
5. Reduce criminal behaviour and
6. Improve social functioning.
WHAT IS THE PROJECT?

To develop a treatment protocol specific to therapeutic communities for people who are adversely affected due to their use of ATS.

Phase 1 –

- A literature review including:
  - Prevalence rates of ATS use, current available treatment interventions and TC programs, including context, populations and outcomes;
  - Evidence-based treatment approaches in Australia and abroad, current Australian research
- Consultation with members of the National Drug and Alcohol Research Centre and other research institutes and clinicians with expertise on ATS.
- Consultation with members of the ATCA through forums in Queensland, New South Wales, Victoria, Western Australia, South Australia and the Australian Capital Territory; and with New Zealand.
WHAT IS THE PROJECT?

Phase 2 –
- Development and trial of the draft treatment protocol in two selected TCs that have populations with high rates of ATS use.
- Trial included youth, family and adult populations in selected TCs in Western Australia, which has been identified as having highest prevalence in Australia, and Queensland, which has high rates of ATS among young people.

Phase 3 –
- Development and roll out of the final Treatment Protocol for use by staff & clinicians working with ATS clients of Therapeutic Communities, following trial period.
EXPECTED OUTCOMES

- A treatment protocol specific to the TC environment.
- A product which has both national and international implications.
- The overall project will enhance the efficacy of the TC in working with this complex client group.
- Products are a manual and CD-Rom for use by TC clinicians and workers.
7.7% of males (0.7 million) and 4.9% of females (0.4 million) over 14 years of age have tried meth/amphetamine.

3% of males and 1.6% of females aged 14 years and over had used meth/amphetamine for non-medical purposes in the 12 months prior to the survey.

A total of 6.3% of the general population has used meth/amphetamine.

These figures translate to approximately 1.1 million Australians having used meth/amphetamine in their lifetime.
AUSTRALIAN USE OF ATS

- Just 2.3% of the population have used meth/amphetamine in the past 12 months.

- Lifetime use of ecstasy is higher than meth/amphetamine use, at 8.9% of the population, and recent use is 3.5%.

- Therefore, approximately 1.5 million Australians have used ecstasy at some time in their life, and approximately 0.6 million have used ecstasy in the past 12 months.

Proportion of IDU reporting recent use of crystalline methamphetamine, by Australian jurisdiction, 2000-2005
ATS USE IN NEW ZEALAND

- 2007 Illicit Drug Monitoring System (IDMS) interviewed 324 frequent drug users, including 110 frequent methamphetamine users, 105 frequent ecstasy (MDMA) users and 109 frequent injecting drug users in Auckland, Wellington and Christchurch.

- Use patterns were:
  - Methamphetamine (97%),
  - Cannabis (87%),
  - Tobacco (84%),
  - Alcohol (79%),
  - Crystal methamphetamine (66%),
  - Ecstasy (MDMA) (52%),
  - BZP party pills (43%), and
  - LSD (34%).
Frequent drug users by gender, 2007: New Zealand

- Meth: 74% Female, 26% Male
- Ecstasy: 69% Female, 31% Male
- IDU: 64% Female, 36% Male
- All: 69% Female, 31% Male
ISSUES FOR SERVICE PROVISION

- ATS users are poorly connected with services and retention rates are therefore low.
- Many of the treatments used for other drug related problems have relevance for people affected by ATS use -
- However, there are gaps in knowledge about ATS specific withdrawal and treatment strategies; and
- The infrastructure to support effective responses to ATS related problems is limited in some areas. This includes the lack of coordination of response among services, including law enforcement, AOD specialists and other health (including mental health) networks.
Methamphetamine Treatment Evaluation Study (MATES)

- 1st Australian longitudinal study.
- Included 5 TCs in Queensland – Fairhaven, Goldbridge, Logan House, Mirikai and Moonyah Detoxification Unit.
- Methamphetamine was the primary or secondary drug of choice; no inpatient meth/amphetamine treatment in the month prior.
- 44% Major Depression and further 45% reported Substance-Induced Major Depression.
- 31% Social Phobia.
- 22% had Substance-Induced Social Phobia.
- 31% met the criteria for Panic Disorder.
- 58% Agoraphobia.
- 10% Substance-Induced Panic Disorder.
Methamphetamine Treatment Evaluation Study (MATES)

- TC sample showed greater impairment, 91% scoring below 40 on the SF-12.

- TC participants more likely to be unemployed, with 92% of the TC sample compared with 74% of the Other sample & 86% of the Total sample (p<0.05 cf. other treatment agencies).

- TC participants more likely to have exhibited clinically significant symptoms of psychosis in the month prior to treatment.

- Significantly greater number of TC participants met the DSM-IV criteria for panic disorder (31% Total sample, compared to 14% Others and 40% TC).
Methamphetamine Treatment Evaluation Study (MATES): Outcomes

- Treatment outcomes showed marked reductions in all measures of methamphetamine use at both three and 12 month follow up.

- 61% abstinent from methamphetamine use at both three and 12 month follow-up (compared with 2% at baseline).

- Major Depression was, however, the same at 12 month follow-up as it was at baseline (44%).

- Significant decrease in Substance-Induced Major Depression.
Effects of ATS use on psychopathology, aggression and cognitive function among clients within TCs

- 20% of people receiving treatment for ATS use from 2005-2007 were treated in a TC (National Minimum Data Set).

- Recent study of 104 participants (67 males and 37 females, with ages ranging from 19 to 60 years) from Karralika (Australian Capital Territory), Odyssey House (New South Wales), Mirikai (Queensland), and Goldbridge (Queensland).

- Study investigated differences in executive function and the prevalence of co-occurring mental health problems—psychopathology and aggression—among participants who identified as being ATS users compared with non-ATS users (Gunn & Rickwood, 2009).
STUDY RESULTS

- ATS users in TCs showed markedly greater level of impairment in overall global executive function and subcomponents of behavioural regulation and metacognitive abilities to manage attention and solve problems.
- Impairment most evident in impulse control;
- Ability to move freely from one situation, problem or activity to another as the situation demands;
- Capacity to monitor social behaviour;
- Ability to hold information in the mind in order to complete a task;
- Capacity to initiate a task and independently generate ideas; and
- Being able to organise personal effects.
Aspects of executive functioning shown to be affected relate to:

- Reflective functioning, which involves self-monitoring and self-evaluation of performance,
- Impaired functioning in these areas is likely to inhibit reflecting on behaviour,
- Ability to make objective decisions,
- Learn to control impulses, and to
- Learn from past mistakes.

Need to consider process for ATS users for learning and reflecting, decision-making and impulse control in order to gain benefits of treatment, and most importantly, to *remain* in treatment.
SUMMARY OF TC CONSULTATIONS

- With few exceptions, ATS was identified as the principal illicit drug of concern by TCs.
- 3 main drugs of concern were most usually identified as alcohol, ATS and cannabis; although heroin was nominated as the second illicit drug of concern after ATS at Odyssey House (NSW).
SUMMARY OF TC CONSULTATIONS

- Assessment process more complex, need to collect more information, especially relating to MH history.
- Pre-admission extended to gather information, and to ensure the person has been stabilised, often on medications.
- Development of early intervention programs, active case management in consultation with other services.
- Assessment and earlier phases of treatment have had to change in order to cope with this population group.
- TCs have introduced new programs including waiting list support, early intervention and day programs, and detoxification to assist the transition into treatment.
- Provide an opportunity for a stepped-care approach, which is particularly valuable where a person experiences an episode requiring intensive support or a period away from the wider TC community.
SUMMARY OF TC CONSULTATIONS

- Increased concerns in relation to violence, threats of violence and aggression amongst this client group.
- Need for tolerance and latitude, conversely there was a view that TCs needed to be clear about their expectations of behaviour, especially in relation to violence or threats of violence.
- The need for boundary setting was emphasised, while at the same time appreciating that impulse control as part of executive functioning, was often a considerable issue of concern for this client group.
- Woolshed in SA - Use of contingency management, modelled on the ‘star chart’ and training of senior residents as mediators - receive a ‘mediator licence’.
- Rewards for successful mediation and resolution of concerns.
SUMMARY OF TC CONSULTATIONS

- Increased incidence of comorbidity.
- Need for more individualised work, which in turn places greater stress on other aspects of the program.
- Prescribed anti-psychotic medications.
- High prevalence of depression & anxiety, also increased diagnoses: schizophrenia, bipolar disorder & others.

Mirikai:
Primary diagnoses 2007-2008
Residents also have Secondary diagnoses, adding to complexity.
SUMMARY OF TC CONSULTATIONS

- Lack of sexual boundaries has sometimes been a part of a person’s behaviour prior to entering treatment.
- Issues relating to sexual assault, including PTSD and significant issues relating to shame, guilt and grief.
- First stage of treatment vital – need for more activity-based interventions, fewer cognitively-based education interventions and didactic teaching.
- Use of contingency management.
- Development of peer support and mediation skills amongst residents, leading to greater self-management and internal locus of control, rather than external systems.
- As TCs have modified to include more psychoeducation, tendency to reduce the amount of time residents spend in traditional work programs.
Consultations with TCs overwhelmingly supported the need for an intervention that concentrated on the pre-treatment and early treatment stages of the TC program.

The use of interventions incorporating Cognitive Behavioural Therapy (CBT), Motivational Interviewing (MI), Acceptance Commitment Therapy (ACT), and Mindfulness-Based Cognitive Therapy (MBCT) were strongly endorsed.

There was strong recognition of the TC as providing a stepped-care approach, together with workskills programs, which were found to be efficacious in working with this client group.

There was strong support for a flexible model which included Tip Sheets, Clinical information for Assessment and Withdrawal, Treatment Intervention and Worksheets.
The development of the *Treatment Protocol: An intervention developed for the use of staff & clinicians working with ATS clients of Therapeutic Communities* has utilised the information from all consultations with TCs in Australia and New Zealand, and has incorporated materials from:


The Treatment Protocol has been enhanced through attendance at three valuable experiential workshops, from which information has been sourced and utilised with permission of the authors:

- Liana Taylor, Mindfulness-Based Cognitive Therapy, experiential intensive course and professional development, Canberra, 12 – 15 February, 2009.

- Dr Chris Wagner, Adapting Motivational Interviewing to a Group Counselling Setting, Sydney, 9-10 March, 2009.

The treatment package has been divided into four sections:

- **Section 1: Clinical Assessment**
  - Comprehensive assessment, Assessing readiness for change, Mental Health assessment, Screening for depression & Anxiety, Information on the PsyCheck Screening Tool, Psychosis Screening Tool

- **Section 2: Tip Sheets**
  - 12 Tip Sheets covering clinical information, withdrawal, motivation for change, coping with cravings, recovery metaphors, managing feelings, coping with anxiety & relapse dangers.
Learning to deal with Cravings through Urge Surfing – Understanding that you have the power over feelings provides a sense of Control.

1. Cravings/urges to use are a natural part of modifying drug use. This means that you are no more likely to have any more difficulty in altering your drug use than anybody else does. Understanding cravings helps people to overcome them.

2. Cravings are the result of long-term use and can continue long after quitting. So people with a history of heavier use will experience stronger urges.

3. Cravings can be triggered by people, places, things, feelings, situations or anything else that has been associated with using in the past.

4. Think of a craving in terms of a wave at the beach. Every wave/craving starts off small, and builds up to its highest point, and then it will break and flow away. Each individual craving rarely lasts beyond a few minutes.

5. Cravings will only lose their power if they are NOT strengthened (reinforced) by using.

6. Using occasionally will only serve to keep cravings alive. That is, cravings are like a stray cat – if you keep feeding it, it will keep coming back.

7. Each time a person does something other than use in response to a craving, the craving will lose its power. The peak of the craving wave will become smaller, and the waves will be further apart. This process is known as extinction.

8. Abstinence is the best way to ensure the most rapid and complete extinction of cravings.

9. Cravings are most intense in the early parts of quitting/cutting down, but people may continue to experience cravings for the first few months and sometimes even years after quitting.

10. Each craving will not always be less intense than the previous one. Be aware that sometimes, particularly in response to stress and certain triggers, the peak can return to the maximum strength but will decline when the stress subsides.

Taking this a bit further. Think of riding the waves as Urge surfing – going through the experience of craving without ‘fighting’ the experience.

Focusing attention on the feelings and sensations and recording the intensity of cravings before and after the peak will help in gaining a sense of control over the experience.
Tip Sheet 5: Drug treatment metaphor
(Adapted from Hermann Meyer, 2007)

People get into drug use for all kinds of reasons. You can compare it to getting into boating. At first you are given free rides and you like it. Then you get your own boat and you enjoy your trips. But soon you find yourself adrift at sea attacked by pirates. You have to seek shelter in a shark infested archipelago, full of reefs, sandbanks, rocks and dangerous currents and things get really unpleasant and very scary.

The sensible thing to do now is to throw in your anchor (which is a good metaphor for seeking help). You might do this to start off by going onto a pharmacotherapy program, doing some counselling, going into detox or doing some meetings. These are all good starts, and although you might still be in the same territory, for now you have steadied the boat and you are safe from running aground, drowning and being eaten by sharks.

Remember, at this point there is nothing wrong with that sea anchor. You might want to pull it up and go on your way, but getting stabilised first is a good thing. You are not making any progress by setting yourself adrift again in those dangerous waters. In this situation the anchor is not your problem, it is your salvation.

But over time you will want to move on. Maybe it’s getting too hard bobbing on the ocean, not really moving in any direction. So you think about where to go from here, looking for a safe direction and a worthwhile goal.

Once you have made up your mind where you want to go, you plot a course out of the treacherous waters. Lifting the anchor free to move towards the goals you have chosen according to your deeply held values.

Maybe it’s time to start to look at some of the reasons for your drug use? Maybe some of the other things that have been going on in your life could do with some attention?

Makes sense?
TREATMENT PROTOCOL

- Section 3: Treatment Modules – 7 modules:
  - Module 1: Building motivation for change
  - Module 2: Understanding and coping with cravings
  - Acceptance & Commitment Therapy
  - Module 3: Understanding how thoughts influence behaviour
  - Module 4: Understanding feelings and making the Mind/Body connection
  - Module 5: Learning to deal with anxious thoughts and feelings
  - Module 6: Understanding and acknowledging core beliefs and values
  - Module 7: Relapse Prevention
Section 4: Worksheets

The treatment intervention includes 21 different worksheets covering:

- Timeline follow-back and stages of change ladder;
- Psychosis screener;
- Lifestyle issues causing problems; Decisional balance;
- Vitality & Suffering Diary; Unhelpful thinking patterns; Self-monitoring record; Understanding how we experience feelings; Feelings of Anger, Loss, Shame and Guilt; Pleasant thoughts calendar; Anxious thoughts questionnaire;
- Values worksheets, including Personal Values Card Sort;
- Positive Affirmations; Relapse dangers and Goal Setting.
Building motivation for change first step in change process

Worksheet 2: Stages of Change Ladder

The rungs on this ladder can be used to represent where you are now in regard to your ATS use. Tick the rung that best describes where you are right now.

- Maintenance
- Action
- Preparation
- Contemplation
- Precontemplation

I have recently been to detox. I'm ready to come into the TC
I'm ready to go to detox, and then I want to come into the TC
I have made real plans to quit or cut down and that includes detoxing
I think I might need to quit or cut down, but I'm not sure I want to or that I’m ready for it
I'm happy using and don't feel the need to quit or cut down

Adopted from Lee, et. al. (2007), and from original work of Diener & Abrams (1991)
WORKSHEETS

ACT Exercise:
Think about the main thoughts and feelings you struggle with – the ones that get you down, interfere with your life, or set you up for a struggle with yourself & others.

BODY – write down the urges, cravings, sensations you feel in your body.

MIND – write down your thoughts, memories you struggle with.
WORKSHEETS

Now you have a choice. VITALITY is what we are aiming for: a sense of wellbeing. Write down all the positive things you have done when these difficult thoughts & feelings have shown up. SUFFERING is what we are aiming to reduce. What are the strategies you’ve used in the past that have actually made things worse?
TRIAL OF TREATMENT PROTOCOL

- The initial trial of the Treatment Protocol was conducted within selected TCs that are geographically located in areas with high ATS prevalence and are working with ATS clients.
- Cyrenian House (Perth) working with adults & women with children and Mirikai (Gold Coast) working with young people.
- The initial short trial (1 – 2 months) sought information from participants and clinicians on their response to the intervention, use of Tip and Worksheets and flow of sessions.
- This was largely a qualitative study.
- Some adjustments were then made to the Treatment Protocol, prior to its release at the ATCA Conference in Canberra in September 2009.
INTERVENTION FOR AMPHETAMINE-TYPE STIMULANT (ATS) USE IN THE THERAPEUTIC COMMUNITY

- The Treatment Protocol will now be tested through a 3 year PhD study with the University of NSW to assess the effectiveness of the specialist ATS intervention in a therapeutic community setting.
- This will be a quasi-experiment comparing process and outcomes of treatment for clients with ATS as a principal or secondary drug of concern in the TC setting receiving the ATS intervention compared with treatment as usual in other TC settings.
- 125 participants will be recruited in each of the groups (intervention in 5 TCs, compared with treatment as usual in another 5 TCs).
- Participants will be interviewed at treatment entry, discharge data (records/interview if planned), 3 months and 12 months post entry.
INTERNATIONAL APPLICABILITY

- Expected the Treatment protocol will translate well into European & American TCs.
- Information from 1st Global Methamphetamine Conference in Prague in 2008 confirmed findings of Australasian consultations.
- Issues are similar, therefore it is likely the solutions will also be similar.

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