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# PSYCHOSTIMULANT CHECK-UP TRAINING KIT

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## Clinician Manual

Drug and Alcohol Services South Australia



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March 2008 (Revised 2019)

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The Amphetamine Treatment Project. Funded through the South Australian Government's Response to the 2002 Drug Summit.

ISBN 978-0-9803130-7-9

This resource has been created to assist clinicians to administer a brief intervention to psycho-stimulant users.

The Psychostimulant Check-Up Training kit comprises four parts – the Clinician Manual, Response Booklet, Check-Up Summary Form and Demonstration DVD. These tools are complementary and designed to be used in conjunction rather than independently.



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## Acknowledgements

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- Mr Rinaldo Minniti (Senior Clinical Psychologist, Drug and Alcohol Services South Australia) for suggestions and recommendations on how to conduct the Psychostimulant Check-Up
- Dr Marie Longo for editing and proofreading all documents contained in the Training Kit

# Table of Contents

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Background	1
Conducting the Psychostimulant Check-Up	2
Aims	2
How the Psychostimulant Check-Up may differ from Other Assessments and Brief Interventions	3
Spirit	3
Procedure	4
General Guidelines	10
Additional Resources	10
References	11

# Background

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In the mid to late 1990s psychostimulant use increased both nationally and in South Australia. The national lifetime prevalence rate of MDMA ('ecstasy') use rose above 6% by 2001 (AIHW, 2002) and the prevalence of amphetamine use in the last 12 months in South Australia rose above 4% by 2004 (AIHW, 2005). The use of these drugs is associated with increased rates of sleep, appetite, cognitive and physical health problems, as well as psychiatric disturbances including depression, anxiety, paranoia and psychosis (Baker et al., 2004; Chen et al., 1996; Greenwell and Brecht, 2003; Nordahl et al., 2003; Verdejo-Garcia et al., 2004; Williamson et al., 1997). In response to the local increase in psychostimulant use, particularly among younger people (aged 14-24 years), the 2002 South Australian Drug Summit funded research into the development of specialist treatments for psychostimulant users. The *Psychostimulant Check-Up* was one of the products of this research program.

The Psychostimulant Check-Up is a single-session intervention that can take as little as 20 minutes to administer. It consists of a semi-structured interview schedule that prompts clients to consider the impact of their psychostimulant use across eight broad life domains, generally contrasting their functioning in these areas when using psychostimulants with their functioning when not.

Eighty clients received the Psychostimulant Check-Up, the majority of which primarily used methamphetamine. Of the 62% able to be contacted three months later, 28% were no longer using methamphetamine and 62% had been able to reduce their monthly use by at least one gram (Smout et al., 2008a). Those followed up had also made a reliable reduction in the level of harm associated with their methamphetamine use (for example: insomnia, anxiety, arrests, arguments). In fact, those who received the Psychostimulant Check-Up had made similar progress in reducing their methamphetamine use by three-month follow-up as those receiving more 'intensive' psychotherapy (on average more than four sessions) had made by the end of their treatment (Smout et al., 2008b). These results are consistent with a broader literature in drug treatment that have found that even quite brief interventions are capable of reducing drug use to a similar extent as longer treatments (Baker et al., 2005; Moyer et al., 2002; Stephens et al., 2000).

The Psychostimulant Check-Up will not be sufficient treatment for all clients or all presenting concerns. Indeed in the evaluation study, a minority increased their methamphetamine use by three month follow-up. In such cases, the Psychostimulant Check-Up can readily serve as a first step to further intervention if required.

However, for the majority of clients who do not meet criteria for substance dependence (American Psychiatric Association, 1994) and are reluctant to enter more extended courses of treatment, the Psychostimulant Check-Up may constitute a significant intervention in its own right. It provides an empirically-supported protocol for conducting a single session intervention with users of methamphetamine, MDMA or cocaine who are new to treatment and clinicians can use it for this purpose with confidence.

A single session brief intervention such as the Psychostimulant Check-Up may be more attractive as a point of entry to drug treatment than open-ended treatment services as it requires minimal initial time commitment. This is an easy treatment task to complete, which may better build clients' confidence to take steps in the direction of changing their pattern of drug use than attempting to undergo more intensive treatments with a higher risk of dropping out. Furthermore, the content of the session can be reasonably well-specified in advance to minimize any fears about what attending treatment services may be like.

# Conducting the Psychostimulant Check-Up

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## Aims

The Psychostimulant Check-Up is intended to serve several important purposes:

- 1) To help clients attend to the impact of their drug use across a broad range of areas of functioning.
- 2) To invite clients to receive information, resources or referrals to further treatment services.
- 3) To give clients a helpful, empathic experience of health or specialist drug treatment services, to increase the likelihood of them re-presenting if they experience problems in the future.

## Attention to impact of drug use

Clinicians often underestimate the potential therapeutic value of assessments, yet they serve many of the functions usually attributed to ‘therapy’. The clinician draws the client’s attention to a broader range of areas of functioning than the client is likely to be keeping track of him or herself. The process of conversation forces thought to be structured in a manner not required for idle rumination. This tends to assist clients to clarify their understanding, beliefs and bases for their decisions. The clinician, by virtue of not being within the client’s web of social relations, is not affected by the consequences of the client’s decisions and so is uniquely placed to offer an interaction of non-judgmental exploration of concerns.

Some clinicians rush through assessments in the fear that they are ‘not giving clients anything’, as if clients were already looking at all the ‘data’ on their life and bringing the clinician ‘up to date’. Humans’ capacity to simultaneously attend to multiple sources of information is very limited. The majority of human behaviour and thinking is habitual and automatic, elicited by the environment (that is, ‘mindless’). Therefore, the likelihood that clients have carefully attended to all of the consequences of their behaviour, and their thoughts about these consequences, while remaining ambivalent and attending a treatment service, is low. The opportunity and guidance to explore more fully the impact of their own behaviour is indeed a valuable service in its own right irrespective of any new advice or behavioural direction a clinician might provide.

## Invite receipt of information and referrals

There are helpful information and self-help resources available to psychostimulant users, as well as a range of other therapeutic services. Clients are often not aware of these resources, thus the challenge for the clinician is to create a context in which clients are willing to receive further information. Preferable to directives (for example: ‘I’ll give you this to take away’, ‘I think you need to see a counsellor long term’, ‘I’ll call detox services and see if they can get you in’) is the elicitation of concerns which when reflected back, leads clients to ask for the information themselves. At the very least, the clinician should ask the client’s permission to provide information or referrals. The Psychostimulant Check-Up provides clinicians with guidance in delivering summaries that include inviting the client to consider further assistance.

### Positive experience of treatment services

Many clients who are ambivalent about their drug use will have intermittent, sporadic contact with services as their motivation to change fluctuates. While this may frustrate or disappoint clinicians, it is a fairly natural course to follow when deciding to relinquish an activity that provides enjoyment or other valued functions. Rather than the length of specific episodes of treatment, what may be more important for an individual's long-term health and wellbeing is the total amount of treatment received over longer periods of time. For instance, in a ten year period, one person may participate in three sessions in his or her first episode of treatment but then have no further treatment for six years. Another person may attend only once, but then return three months later, again attend only once or twice, but then attend six months later, until over the same ten year period a greater level of involvement in treatment has accumulated. The purpose of the Check-Up is to create an experience of treatment services that will encourage re-attendance sooner rather than later.

### How the Psychostimulant Check-Up may differ from Other Assessments and Brief Interventions

- **Distinct target population:** The Check-Up is directed at young, early-stage, 'pre-contemplative' psychostimulant users. This may or may not be typical of presenting populations in other settings.
- **Single-session intervention.** Most assessments are conducted for the purpose of deciding how to provide appropriate treatment. Clients usually attend an assessment session planning to attend further sessions with a more therapeutic focus. However, in the Check-Up, *there is no assumption that clients have any intention of receiving further treatment.* This may well be the only occasion the clinician will see this person.
- **Intended outcome is clearer understanding, not necessarily behaviour change.** A Check-Up is designed to help clients clarify their understanding of the impact their psychostimulant use is having on them. *No attempts are made to persuade clients to change their pattern of use.*
- **Pragmatic, not comprehensive assessment.** Some assessment interviews are designed to gather as much detail as possible about patterns of use, social, medical and psychiatric history, current social supports, legal and financial status. The Check-Up includes some elements from each of these domains, but the focus is on obtaining the *minimum* information necessary to illustrate the impact of psychostimulant use on the individual. If a more detailed assessment is deemed necessary, a further referral should be made.
- **Focus on current, rather than historical factors.** In general, it is unlikely to be necessary to assess the drug use history of the individual. Where the client is currently using, the assessment of current use patterns will often be sufficient to indicate the contribution of psychostimulants to concerns about current functioning.

### Spirit

Miller and Rollnick (2002) advocate those conducting *Motivational Interviewing* do so within a particular spirit, and the Psychostimulant Check-Up is intended to be conducted in the same way. The spirit is characterised by:

- 1) **Collaboration:** the therapist and client explore each area of life functioning with curiosity and openness. Psychostimulant use may or may not be impacting adversely in any particular area. It

is possible individuals are experiencing no harm from their use at present. Ideally, the interview should have the feel of joint discovery (that is, ‘let’s look and see’).

- 2) **Evocation:** the therapist should begin by assuming clients have all the capability required to make changes to their drug use. Clients do not need information, or directives. The therapist’s task is to elicit the details of the client’s experience likely to influence the client’s decision about whether or not to continue with the current pattern of drug use. It is not an exercise in persuasion. The facts will speak for themselves once the client has attended to them. The clinician’s job is to help clients attend to their experience.
- 3) **Autonomy:** the therapist never forgets that it is the *client’s* life being discussed, and the client is the only person who can make decisions about it. The client is never directed. Adopting this stance requires that the therapist sit with their discomfort and evaluations of the client should he or she choose not to change, without trying to persuade the client to choose differently.

## Procedure

The interview is guided by the schedule in the response booklet. This contains space to make notes of client responses. There are suggested questions that can be adhered to rigidly or the clinician can paraphrase or substitute similar questions of their own wording. It is more important that clinicians adhere to the spirit and use reflective listening skills, than adhere to question wording and execute repeated closed questions.

## Overview

The Psychostimulant Check-Up consists of three stages:

- 1) **Assessment**
- 2) **Feedback:** summary of client concern
- 3) **Outcome:** further information or action to be taken

It is advisable to first introduce the Psychostimulant Check-Up. A brief structuring statement tailored to your clinical setting might be useful.

**Example:** *‘We have about 30 minutes here today. If it is alright with you, I’d like to spend that time finding out, in a broad sense, how your health has been recently. I’d also like to hear about what drugs you’ve been using lately and for us both to get a sense of what impact, if any, they’ve been having on you. If you decide at the end you’d like more information or perhaps to see someone again, we can arrange that. However, there’s no obligation. How does that sound?’*

## Assessment

It is recommended that this section is read with the response booklet at hand. The response booklet format for most domains of the assessment contains an open question and a box containing symptoms or behaviours to look for. It also includes a prompt box with suggested questions to ask to obtain more detail. In general, the ‘look for’ and ‘prompt box’ information is not reproduced in the sections below unless clarification or elaboration is required.



### Recent drug use

The assessment begins with a brief review of recent drug use. The clinician should not read through the entire list of drugs, rather ask an open question such as, ‘what drugs are you currently using?’, and then collect information about last use, quantity and frequency for those drugs only. Similarly, where a client reports using methamphetamine, it is worth asking ‘what does the meth you use look like?’ and then collecting pattern information only on the forms the client uses.

The definition of ‘recent use’ as the last three months is arbitrary and does not need to be strictly adhered to. For clients who are using most weeks, the past month may be a sufficient timeframe over which to gather information about use patterns. For clients whose psychostimulant use is fortnightly or less, an exploration of the last three months is necessary to obtain an accurate pattern of use.

It is important to keep in mind how many additional drugs the client is using when assessing the impact of psychostimulant use and providing feedback. Any number of drugs could cause impairments in each domain of functioning. The purpose of the Psychostimulant Check-Up is not to diagnose which drug is contributing to which functional impairment. It is sufficient to highlight functional decrements, prompt the client to consider that psychostimulants may contribute to these (either as a primary cause or exacerbating factor), and consider reducing psychostimulant use, other drug use or both.

### Wanted and unwanted effects

Clients are first asked about the effects they seek from psychostimulants, to help put them at ease and acknowledge they have rational reasons for having used these drugs in the past. Asking about the desirable effects of drug use first also makes for an easy transition to then explore the less desirable effects. Finally, knowledge of the functions served by psychostimulant use will influence the choice of summary to feed back to clients later.

Clients are then asked about the effects they dislike from psychostimulants. The length of the client’s response to this question is often a good indication of how to pace the remainder of the interview. Voluble responses suggest the remaining sections should be covered quickly (if it is important to keep to time) with fewer prompts for detail, whereas minimal responses indicates a need for more in-depth questioning within the functioning domains.

The clinician should refer back to the responses to the ‘unwanted effects’ question when exploring specific domains of functioning. For example, if in response to the question about unwanted effects the client mentions the cost, the come down and irritability, the clinician can adapt the scheduled open-ended questions when exploring mood and day-to-day functioning to reflect and build upon these responses.

**Example:** *‘You mentioned that one of the downsides to meth use is that it leaves you feeling irritable, have you noticed any other ways your mood changes once the meth wears off?’*

**Example:** *‘Earlier you said that one of the problems with meth is how much it costs, has this caused any additional difficulties, say in your relationships or your involvement in other activities?’*

### The Come Down

Clients’ experiences of the come down can vary considerably in quality and intensity and not every client will experience this. Where clients clearly report experiencing a come down it is worth asking whether the same psychostimulant or any other types of drugs are used to cope with the experience. As always, attempt to reflect the client’s level of concern about experiencing the come down, and about the use of any drugs taken to cope.

## Sleep

Often clients will respond with incredulity when asked what their sleep is like when using psychostimulants (for example: ‘you don’t sleep!’), however a minority are able to get to sleep even after taking methamphetamine (indicative of high tolerance) so it is still worth asking. Unless the client is using almost every day, the contrast in this section (on drugs versus not on drugs) will usually elicit the pattern of sleep interference or a missed night of sleep followed by oversleeping or tiredness for the following couple of days. This pattern may or may not be of concern to clients but can usually be found to interfere with daytime role functioning, which is worth exploring in more detail. If the client is using almost daily, it may be more useful to contrast a much earlier period in the client’s life when he or she was not using psychostimulants with their current functioning.

As always, it is important to consider what other drugs the client may be using. Cannabis, alcohol, and benzodiazepines in particular are commonly used to assist sleep onset following use of psychostimulants. These drugs may also contribute to daytime lethargy and tiredness, either via hangover intoxication effects during the day or rebound autonomic arousal during the sleep period if they wear off while the client attempts to sleep. If the client regularly uses any of these sedating drugs, it is worth asking whether psychostimulants are ever used to counter their effects to enable the client to get motivated or get active after a period of lethargy.

## Appetite

Psychostimulants usually, but not always, suppress appetite during intoxication, so a lack of difference in appetite between times on and off psychostimulants probably indicates the client has developed high tolerance. The anorexic quality of methamphetamine promotes weight loss, and is often highly valued by female clients. Conversely, weight loss is usually a health concern for male clients, so the motivational influence of the effects of psychostimulants on appetite can vary enormously. It is worth reflecting back any values contained in the client’s replies to these questions, as doing so demonstrates understanding, which improves the therapist’s credibility and builds rapport.

### **Example:**

*T: ‘What is your appetite like on meth?’*

*C (female): ‘I can go for days without eating.’*

*T: ‘What about when you’re off meth?’*

*C: ‘I do have to eat eventually.’*

*T: ‘Sounds like you see not eating as a good thing’*

*C: ‘People don’t know it, but I’m actually naturally a big girl. I would never be able to fit into these clothes if I didn’t use the gear’*

*T: ‘So the fact you’re not hungry on meth doesn’t concern you. The fact you might be hungrier off meth is more of a concern to you’*

It is also worth asking whether psychostimulants affect the type of food eaten. This may exacerbate fluctuations in energy levels and sustain lethargy. Such a question often elicits a response that diet gravitates toward high fat, high sugar, high carbohydrate foods which may offset weight loss. Reflecting the impact of psychostimulants on diet quality may counteract the incentive value of weight loss in decisions to maintain current psychostimulant use patterns, freeing clients to contemplate reducing their drug intake.

## Thinking

Although the response booklet does not contain sections to contrast cognitive functioning on and off psychostimulants, the clinician can continue to explore these differences. This section more so than others may require the clinician to provide a variety of questions from the prompt box, as people tend to be less practiced in analysing and describing their cognitive abilities. Clients may have difficulty focusing or switching attention, remembering, making decisions or plans. Memory problems are one of the most consistent concerns among clients so exploration of this domain often yields responses with motivational significance.

Concentration is sometimes reported to be improved when using methamphetamine, especially among clients who report a childhood history of attention deficit hyperactivity disorder (ADHD). The clinician should not dispute this, but it is worth examining the consequences of this more closely. The clinician can offer reflections such as 'you make more progress on tasks when you use meth', 'you're able to complete tasks without getting distracted', or 'you concentrate for longer periods of time'. These will either elicit agreement and the therapist will have a more precise understanding of the functional benefit, or elicit a modified statement of the benefit, such as, 'well, I think I'll get more done but I usually end up jumping from task to task without finishing anything'.

Paranoia and other psychotic perceptual and cognitive symptoms are worth investigating in detail, particularly when methamphetamine is injected or smoked, and used in large quantities (0.5g or more per occasion of use) or regularly (almost daily). Occasionally clients may experience auditory or visual hallucinations (sounds or images in the absence of external stimulation) or more commonly illusions (misperception of external stimulation), for example mistaking common 'creaks' in the home as signs that someone is breaking in. Clients may experience ideas of reference, where unrelated world events are perceived by clients to be associated with them. Thoughts of being watched, followed or persecuted are the most commonly experienced by methamphetamine and cocaine users and in severe cases these thoughts will be of delusional conviction. If clients report thoughts that others are monitoring or planning to harm them it is worth asking how strongly they believe this is happening right now (for example: on a scale of 0-10, where 0 is not at all and 10 is 100% convinced). The client might also be asked how strongly he or she believes these thoughts when they occur during methamphetamine intoxication. Moderate to high conviction in persecutory ideas when not intoxicated warrants referral to a medical officer or psychiatrist for assessment and possibly symptomatic medication. Psychotic experiences are the consequences of methamphetamine and cocaine use likely to be of greatest concern to clients, so recognition is likely to motivate readiness to change patterns of use.

## Mood

Depressed mood and anxiety symptoms are relatively prevalent in the general community, but almost universal among regular psychostimulant users. Furthermore, depressed mood associated with psychostimulant withdrawal tends to persist for several weeks following last use. Both factors make it difficult for clients who have used psychostimulants regularly over a period of months to experience that mood is improved without psychostimulants and worsened when taking them. If the client experiences depressed mood during the come down, this is likely to provide the most persuasive evidence of any detrimental effect of psychostimulant use on mood.

Irritability and mood lability (sensitivity and instability) are particularly apt to intensify with continued psychostimulant use. A contrast between recent mood and an earlier time in life before commencement of psychostimulant use or when use was much less frequent may be most useful to illustrate the impact. Where irritability is reported, it is worth asking whether this has had any effect on relationships with family, friends and co-workers.

### Day to Day Functioning

Depending on the depth of response to the suggested opening question ‘on a day to day basis what is life like for you?’ it may be useful to follow-up with other open-ended questions, such as:

- ‘What are your relationships with your friends and family like when using psychostimulants? When not?’
- ‘What is work/school/parenting like when using psychostimulants? When not?’
- How do you spend your time (what activities do you most often do) when using psychostimulants? When not?’

### Enjoyment

While the information that can be elicited in this section could also have been elicited elsewhere, asking about enjoyment specifically helps convey interest in the client’s quality of life, rather than just an interest in detecting problems. Furthermore, the lack of alternative sources of reinforcement contributes substantially to patterns of dependent psychostimulant use.

### Physical health

If the client provides several health problems in response to the open question it may be unnecessary to ask prompt box questions. Conversely if the client provides little information in response to the open question, it is worth asking about several specific problems. The most commonly encountered are skin problems, dental problems, problems from route of administration (if regular long-term use) and susceptibility to colds and illness. For any health problems mentioned by the client, it is worth asking if the problem occurred before onset or more frequent psychostimulant use, and where the problem did pre-exist whether its severity has changed since onset or increase in psychostimulant use.

### Risk behaviours

For occasional (weekly or less frequent) users, the relevant contrast may be between times of psychostimulant intoxication and without. For regular (two or more times per week) users, the relevant contrast might be between the current period of regular use and a period prior to psychostimulant use or of less frequent use. Risk behaviours refer equally to actions taken while intoxicated, as well as actions taken to obtain psychostimulants.

### **Feedback**

At the completion of the session, summarise the information the client has given you to provide a ‘picture’ of the impact of the client’s psychostimulant use in an objective, non-judgmental manner. It is important not to attribute any undesired consequences to psychostimulant use with any certainty. It is unnecessary for clients to have definitive statements that their psychostimulant use causes functional impairments in order for them to contemplate changing their use. It is sufficient to raise the suspicion that psychostimulants contribute. Strong statements by the clinician that psychostimulant use is responsible for adverse functioning can quickly invite resistance (especially argument) from the client.

The response booklet contains clear suggestions for how to word summary feedback. The main task for the clinician is to judge how ambivalent clients appear to be about whether their psychostimulant use is problematic. This is not a great risk however, as the summary is offered tentatively, to enable a corrective response from the client. If in doubt, understate the client’s level of concern, which is likely to elicit a corrective statement from the client expressing greater concern if appropriate.

**Example:**

*T: 'It appears you don't seem to be experiencing any serious problems with your methamphetamine use at the moment...'*

*C: 'I wouldn't say that. I mean I've missed 8 days of work this month and it's all from too much gear on the weekends'*

*T: 'OK, so while you haven't noticed any effect on your relationships or your physical health, you have been a little concerned that you may be missing too much work because of the meth'*

*C: 'It is too much'*

*T: 'Time off work'*

*C: 'Yeah...and too much gear'*

*T: 'So let me check I've heard you correctly. While you really enjoy the feeling you get from meth, and the way you can stay awake longer on it, lately you've been starting to think maybe you've been using a little more than you intended...maybe it's time to reign it in a bit. Is that right?'*

*C: 'Yeah'*

**Outcome**

The Psychostimulant Check-Up should end with the client and clinician having a clear idea of the next step the client wishes to take. If the client is not concerned about his or her psychostimulant use at present, the next step may simply be to leave with an open invitation to return later down the track if things change. If the client remains unsure what to do, the next step may be to return to the clinician or to see another clinician to think through the drug use decision, or for the client to take some action to resolve this indecision. Whatever the nature of the step, both the clinician and client should be clear what it is and that step should be acceptable to the client.

**Resources and referrals**

The clinician should maintain a steady supply of written resources on psychostimulant use usually available via phone order from their state's drug and alcohol information service. A list of those recommended written resources as well as contact details for South Australian treatment services is included in the response booklet. It is important that clients not be given any information or referrals without first asking the client's permission to do so. The clinician should make it clear to clients that (with the exception of a presentation where a client is acutely suicidal or psychotic) it is up to them whether they wish to receive information or referrals. Wherever a client is willing to take it, complete the Check-Up Summary form and give it to the client so there is an individualised list of concerns to reflect upon.

## General Guidelines

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- **Maintain empathic, non-judgmental style:** More important than any other guideline, the clinician should remain non-judgmental, and empathic in reflecting client's concerns. Clients should leave with the impression that they have been heard accurately, that the clinician respected their right to make their own decisions, that the clinician cared about their safety and wellbeing and that they would feel comfortable in talking about their concerns with that clinician again in the future.
- **Keep the intervention brief.** It is important that you try to complete the Check-Up within 30 minutes. The Check-Up has been designed to be 30 minutes rather than a more 'traditional' 60-minute assessment session. The client group for which the Check-Up is intended may be unable or unwilling to tolerate longer sessions for a number of reasons (for example: extreme ambivalence about treatment, problems with attention, irritability, loss of interest).
- **Personally-tailor intervention:** Although there are time constraints it is important that you do not limit the session to an impersonal question/answer information gathering exercise (for example: rushing through each topic in a regimented fashion). Try to make the interview as interactive as possible. Remember, you do not have to follow the Check-Up exactly in the order that it has been laid out, or necessarily cover all the topics, rather use your clinical skills to flow with the client's answers.
- **Keep clients on-track.** Clients may be very talkative or go off on tangents. It is up to the clinician to guide them back to exploring their methamphetamine use.
- **Cope with greater needs by referral.** You may feel that the client has brought up issues that could be explored in more depth. There will not be time in the Check-Up interview to cover these adequately. Clients have the opportunity to seek further professional help to explore issues if they choose to, and the clinician can facilitate this by making an appropriate referral.
- **Avoid repeating questions.** Regular psychostimulant users may be especially likely to be irritable and repetitive questioning is likely to provoke irritable reactions and impair rapport. Remember that specific details may be less important in a Check-Up than in some assessment settings; the main objective is to elicit the minimum information necessary to assess the impact of psychostimulant use on the client.
- **Ensure definitions of slang terms.** Awareness of slang names for particular drugs is useful when obtaining drug information, however confirm with clients to which drug they are referring.

## Additional Resources

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Smout, M.F. & Krasnikow, S. (2008). *Psychostimulant Check-Up Training Kit: Demonstration DVD*. Adelaide, South Australia: Drug and Alcohol Services South Australia.

Smout, M.F., Krasnikow, S. & Minniti, R. (2008). *Psychostimulant Check-Up Training Kit: Response Booklet*. Adelaide, South Australia: Drug and Alcohol Services South Australia.

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