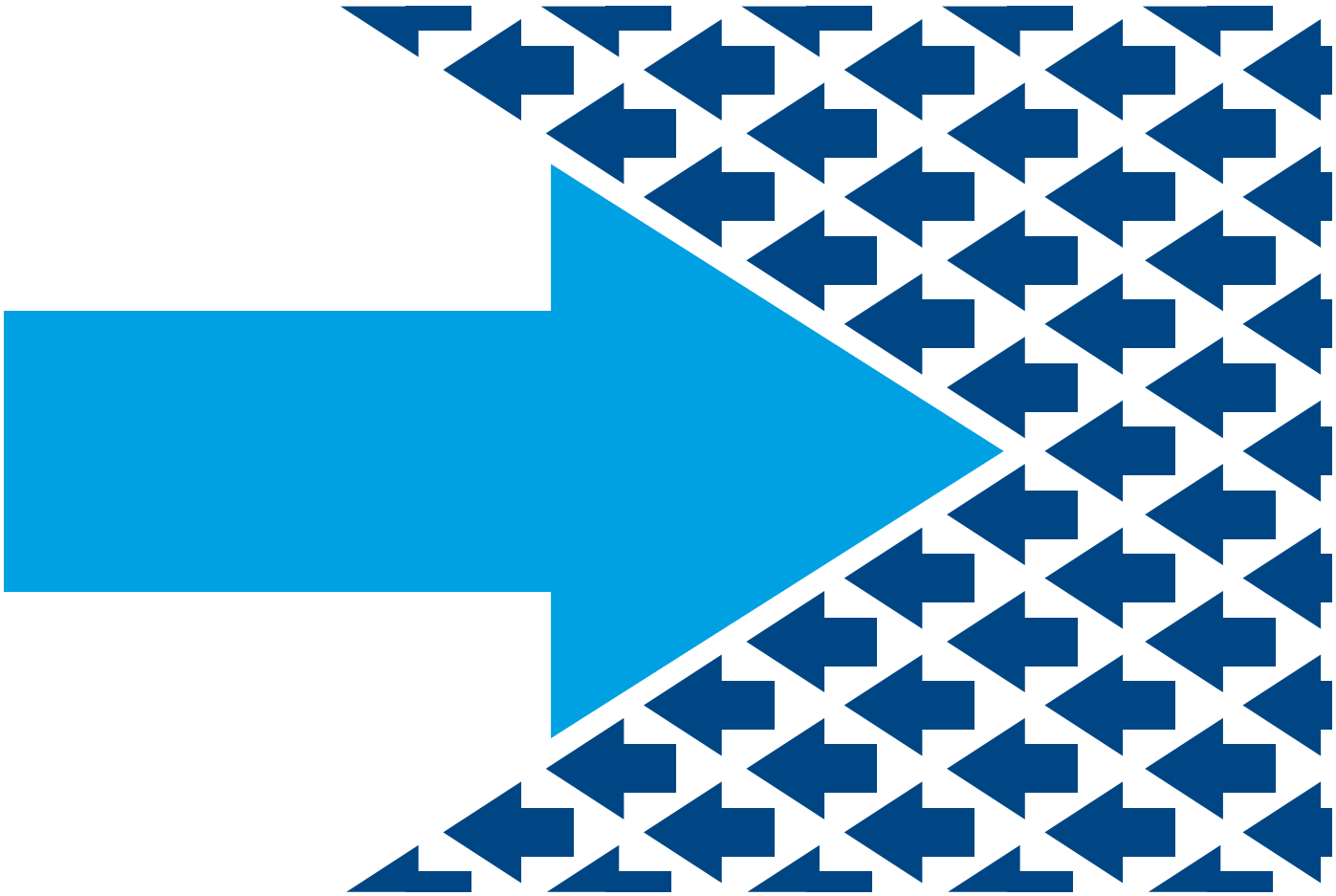
Glasgow City HSCP
Health and Social Care Partnership

NHS
Greater Glasgow and Clyde

NHSGGC Alcohol and Drug Recovery Services

Cocaine Toolkit



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Working with people at harm from cocaine use

Executive summary

Emerging data from nearly 2000 comprehensive Assessments of Injecting Risk (AIR) suggests that cocaine has become the primary drug of injection for the majority of people who prepare and inject drugs in Glasgow City.

Although we now have cocaine only injecting groups, most individuals also inject heroin. Many of these individuals are linked with services and receiving Opioid Substitute Prescribing (OST). This provides us with an opportunity to explore their cocaine use and suggest a plan to reduce harm and facilitate treatment. We must do this in order to support individuals holistically and address the real harms that they face.

Many of the harm reduction techniques and treatment options available to people using cocaine vary greatly from the traditional interventions we use when working with people using opioids. Therefore, it is vitally important that through training we develop skills and become familiar with the approaches needed to engage with individuals using cocaine.

Similarly the presentation of individuals using cocaine and stimulants can be quite different to those using depressant drugs alone. An understanding of these differences in presentation can be key to identifying the best supports for individuals. In particular cocaine has a significant impact on mental and physical health, both acutely and over a period of time. The sections on mental health, and physical health within the toolkit will give the reader a greater understanding of these risks and the skills to use to identify and address these.

This toolkit provides educational content on cocaine and its impact on the user, along with current detail of street terms used by individuals, costs and the local drug market. It also offers practical tools to use directly with individuals, such as the assessment tool, advice on crisis intervention and de-escalation, along with the motivational enhancement, developing control and developing a rewarding lifestyle worksheets.

We would encourage anyone working with individuals who use cocaine to navigate through the document in their own time and print or share resources to support individuals using cocaine, those impacted by cocaine use and also other allied services or service providers.

Foreword

The development of the Working with People at Harm from Cocaine Use Guidance is part of the work plan of the Medicated Assisted Treatment – Substitute Prescribing Management Group (MAT SPMG), NHS GG&C Alcohol and Drug Recovery Services (ADRS) Care Governance sub-group.

Members involved in the development of the guidance compromised of experts from a range of disciplines. These included representatives from ADRS medical and pharmacy independent prescribing services, psychology and psychiatry services, residential services, Injecting Equipment Provider (IEP) Services and SDF peer research and engagement services.

A key stage in the development of the guidance involved peer volunteers and people with lived or living experience to assist in identifying the particular areas to focus on. By involving individuals with peer, lived and living experience it allowed for a greater understanding of cocaine use and associated issues. This voluntary involvement was greatly appreciated and a crucial stage in the development of the guidance.

Acknowledgements

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Introduction

Individuals and services are reporting more poly drug use involving cocaine than ever before and cocaine has been implicated in more than a third of drug related deaths in Scotland in 2020. There is some data emerging from the WAND (Wound care, Assessment of Injecting, Naloxone & Dried Blood Spot Testing) initiative within Glasgow City centre that for the first time the number of people injecting cocaine may be higher than those injecting heroin. With this comes the associated risk of harm to individuals and communities.

Unlike Opioid Substitute Treatment (OST) treatment for people using heroin, there is no replacement medication available, although research is continuing to explore possible treatments. Psycho-social interventions remain the cornerstone of treatment.

Below are some basic principles which may be helpful to guide front line staff working with people at harm from cocaine use. The guidance is primarily written for staff working with individuals currently in treatment with OST for opiate dependence and using cocaine but may also be relevant to individuals presenting with primary cocaine use.

Whole family approach

Drug and Alcohol Services are underpinned by family inclusive practice. People will be given the opportunity to involve family in their care or express their wishes not to have information shared. Services have a role in supporting families and signposting them to partner organisations to access additional support where required. Staff will consider if people have caring responsibilities and aim to offer support with this. The service has an important role in protecting vulnerable others and safeguarding children's current and future wellbeing. Robust communication with other agencies involved in the care of the family is key to this.

Assessing cocaine use and impact

Guidance notes

This is an assessment tool that can be used for people with cocaine use, with a focus on injecting cocaine and smoking crack/freebase cocaine. It is not intended for use with people who use cocaine on a more occasional or recreational basis. The tool should be used to better understand an individual's cocaine use including the particular patterns of use and potential risks and harms. It is intended to help highlight areas where further exploration and support may be required and does not replace a formal physical, mental health or sexual health assessment.

The assessment does not have to be completed in any particular order and works best when completed in conversation with the service user using the questions as prompts to open up discussions rather than requiring staff to read all questions off verbatim as written. This allows focus on the relevant questions for the service user and ensures the full assessment can be completed comfortably within one appointment.

It is recognised for some service users it may not be possible to complete the assessment in its entirety or it may require to be done over more than one appointment. The more information gathered the better and where it has been necessary to complete the assessment over several appointments it is important to note that responses can change over time and it may be necessary to review previous answers with the service user.

Cocaine Assessment Tool

Interventions for harm from cocaine use

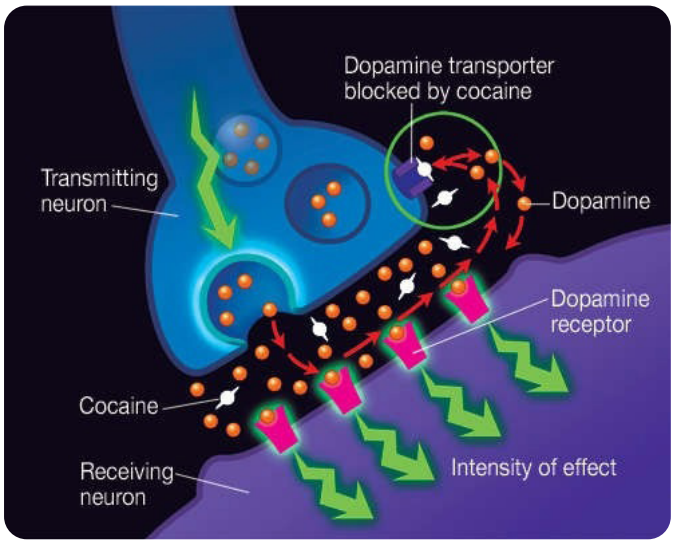
Overview of cocaine

Cocaine hydrochloride is the most common form of cocaine to be used as a psychoactive drug in the UK. It is isolated from the leaves of the Andean coca shrub using a range of chemicals. This plant can only be found in very specific regions of South America meaning all the cocaine found in the UK has been trafficked here. Of course, this also means there are multiple opportunities for it to be cut, adulterated or "bashed" throughout its journey. Common agents used to cut cocaine include glucose, creatine, caffeine and benzocaine. Analysis has also shown that on occasion cocaine has also been cut with painkillers such as phenacetin. Cocaine powder may be snorted or injected. Its form can also be changed to facilitate smoking.

Regardless of how cocaine is administered, it works by releasing a powerful surge of dopamine in the brain (one of our feel good hormones). This produces feelings of euphoria, well-being, a state of alertness and a desire for social bonding in addition to the classic cocaine effects such as increased energy, reduced appetite and reduced need for sleep.

Normally, this dopamine would be recycled back to cells for later use. However, cocaine also attaches to the dopamine transporter which blocks this return process, resulting in a build-up of active dopamine.

This mechanism creates 2 clear stages - a high, caused by large amounts of dopamine release followed by a state of dopamine depletion after use. Many of the negative psychological effects people experience relate to this state.



Common cocaine street terms

- **Gear**, **coke**, **charlie**, **chico**, **ching**, **snow** all refer to powder cocaine.
- **Gram**, **eggs** and **ham**, a **G** all refer to the most commonly sold weight of powder cocaine 1gram.
- **Line**, **patsy**, **patsy cline** all refer to a line of cocaine which is commonly snorted.
- **Bump** or **key** refer to a small mound of powder cocaine which will be snorted without a straw.
- **Rock**, **base**, **freebase**, **nugget** all refer to crack or freebase cocaine.
- **Pipe** or **crack pipe** refer to the utensil needed for smoking.
- **Snowball** refers to mixing heroin and cocaine together for injecting.

Forms of cocaine and associated cost

There are 3 main forms of cocaine used in the UK; powder, crack and freebase. Each form lends itself to different methods of administration.

Powder Cocaine (cocaine hydrochloride) is the most common form of cocaine to be sold. It is often snorted in lines through a straw or banknote. However, it is also water soluble so easy to prepare for injecting. This type of cocaine does not lend itself well to smoking due to the high melting point.

Crack Cocaine is a base form of cocaine that can be easily produced using water and sodium bicarbonate (baking soda) and then heated to form a solid rock like state for smoking. Although produced for smoking, these rocks can also be injected, if an acidifier is added to return it to a water soluble state. It is not uncommon for suppliers to add bulking agents during preparation to increase profit which will result in a poor quality product – not all crack cocaine is high purity. Cost - £10 - £20 per rock depending on weight and purity.

Freebase Cocaine is a base form of cocaine. The process of freeing the cocaine base comes from the addition of ammonia. The result is a form of cocaine that is almost 100 percent pure. In this form, it has a low melting point, which makes it easy to smoke. Freebase cocaine is not soluble in water, so an acidifier needs to be added to return it to a water soluble state - all freebase cocaine is high purity.

Cost - not commonly sold at street level. When it is, cost will always be related to weight.

The local cocaine market

Over the years the powder cocaine market has developed into a tiered model with wide ranges of purities linked to price. In Glasgow this is particularly well established with all purity levels indicated by name.

- Small bags which are aimed at those injecting £10-£15.
- Poor quality - this is often called “council” approximately £30 per gram.
- Medium quality/purity - this is often called “50-50” approximately £50 per gram.
- High quality/purity – this is often called “proper” or “prop” approximately £80 per gram.

This business model is reflective of a well-established, flexible and resilient cocaine market.

Cocaine and alcohol

The interaction between cocaine and alcohol is complex. One of the reported benefits of taking cocaine and alcohol together is the ability to consume far more alcohol without passing out or appearing very drunk. Of course the health risks caused by consuming large amounts of alcohol in a binge fashion do not disappear. This level of alcohol consumption will make peoples “come down” far worse than using cocaine on its own. When both drugs are consumed together the body produces a third chemical called coca ethylene. This is known to enhance the euphoric effect of the cocaine and increase the duration of effect. This may explain why so many people have such strong urges to use both together. As well as the risks associated with increased alcohol consumption, coca ethylene creates other risks, in particular, it is toxic to the cardiovascular system, and elevates heart rate and blood pressure more than cocaine alone would.

Cocaine compulsion and psychological dependence

The compulsive nature of cocaine is related to the powerful effect it has on the dopamine reward system. People can feel an overwhelming and sometimes unexpected urge to use, even after a significant period of abstinence. Cravings are often triggered by sights, sounds, smells or using other drugs/alcohol.

For others, daily use can become an integral part of their life and find functioning (physically, psychologically and socially) without it very difficult. Although no physical dependence occurs, even with repeated use, the psychological grip is very real and should not be underestimated. It should be noted that the symptoms of anxiety which are often present after a binge or on cessation will very much feel to the person like physical withdrawals.

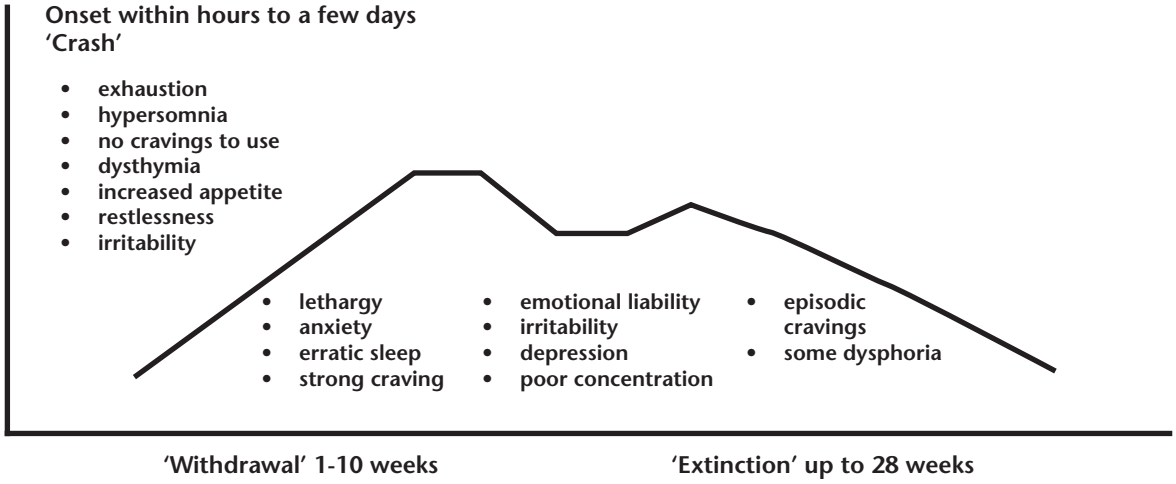
Cocaine withdrawals (sometimes called a "come down") from heavy cocaine use can be very uncomfortable, however, it is rarely life threatening.

The most commonly cited study into cocaine withdrawal was undertaken by Gawin and Kleber in 1986 and is still relevant today. Using data collected from 30 cocaine-dependent outpatients, the researchers reported three distinct phases of the withdrawal process; 'crash', 'withdrawal' and 'extinction':

Phase one, 'the crash', developed rapidly following abrupt cessation of heavy cocaine use and was characterised by acute dysphoria, irritability and anxiety, increased desire for sleep, exhaustion, increased appetite and decreased craving to use.

Phase two, 'withdrawal' was characterised by increasing craving to use, poor concentration, some irritability and some lethargy, which persisted for up to 10 weeks.

Phase three, 'extinction', comprises intermittent craving to use in the context of external cues.



Some people choose to take other drugs, such as alcohol, sleeping tablets, opiates or benzodiazepines, to help ease the first 2 phases. Of course this can contribute to further problems, including overdose and dependence to additional drugs. It may be the case that a person will continue to use cocaine even though negative consequences are evident. This is a good indicator of drug dependence, albeit psychological. Binging of cocaine is common and can quickly lead to a host of physical and mental health problems. However, social and financial problems may appear first and are often easiest to identify. Psychotic episodes are often triggered though lack of sleep, particularly if a binge progresses to days of continued use.

Cocaine harms general

Regardless how cocaine is administered, there are a number of significant and serious harms people may experience.

Cocaine overdose and stroke

It is easy to consume a life threatening amount of cocaine without realising. A large number of cocaine overdoses happen during binges. As a person doses frequently, their body cannot metabolize the drug fast enough. This causes the cocaine to build up to toxic and deadly levels within their body.

A cocaine overdose causes a person's central nervous system (CNS) to become far too stimulated. As the CNS goes into overdrive, critical life support systems speed up to the point where the body can no longer keep up. When this happens, blood pressure, breathing, heart and temperature rates all climb. This can lead to a heart attack or stroke.

Signs and symptoms of a cocaine overdose include:

- Chest pains, pain in the jaw or arm (heart attack signs)
- Rapid heart rate
- Pounding heart
- Overheating
- Dehydration
- Headache
- Delirium
- Stroke signs – drooping of the face or loss of movement in the limbs

If an overdose or stroke is suspected the person should call emergency services as soon as possible and follow the call handler's instructions.

The risk of overdose, heart attack or stroke can be reduced by:

- Taking less cocaine, by controlling the amount taken (dose), the time between doses and the duration of sitting
- Not consuming other drugs, alcohol or tobacco within the same sitting
- Accessing heart health checks as a means of identifying cardiovascular/heart problems at the earliest possible stage

Cocaine and sexual risks

Cocaine like many other drugs can lower inhibitions and make the person more likely to engage in sexual activity. This, often impulsive sex, may reduce the likelihood of condom use or other safe sex practices.

Rougher sex such as anal sex may seem more appealing, whilst prolonged sex is common due to the inability to climax. This may lead to the tearing of membranes causing the introduction of blood and therefore the potential to transmit blood borne viruses (BBVs). Men can find it difficult to get and maintain an erection.

Overall, there are considerable risk factors associated with cocaine use and sex. Unplanned pregnancies, sexually transmitted infections (STIs), BBV's and sexual assault are just some of the potential negative consequences of sex and cocaine.

Longer term cocaine use can change a woman's menstrual cycle and stop ovulation whilst damage to the fallopian tubes can result in infertility.

Cocaine use during pregnancy can cause seizures, migraines, premature birth and in some cases, the placenta can detach from the uterine wall, called placental abruption. Stillbirths and miscarriages occur at higher rates in women who use cocaine during pregnancy.

Risks associated with methods of administration

Snort risks

Septum damage is one of the most significant long-term effects of cocaine snorting. A septal perforation, or a "hole in the septum" is a condition that is commonly caused from this method of administration.

The nose has a fragile blood supply which is reduced by cocaine snorting. This process is called vasoconstriction (closing off of blood vessels). When the blood vessels constrict, the blood supply is compromised, delivering less oxygen to the tissues of the septum. With low oxygen, the septum lining begins to die. Once the lining dies, it can no longer support the cartilage underneath it and the cartilage dies. This is called a septal perforation (hole in the septum). Once the septum is perforated, the nose can collapse because the septum is the structural support of the nose. Once a septal perforation is present it will never heal on its own.

It is much easier to deal with septum damage the earlier it is identified. Therefore medical advice should be sought at the earliest opportunity if any of the following symptoms occur – constant runny nose, discharge from the nose or frequent bleeding.

Typical lines of cocaine ready for snorting

Transmission of infections including blood borne viruses

Straws, tubes or banknotes that are inserted in the nose could come into contact with hepatitis C or hepatitis B infected blood. This may then be transmitted to someone else sharing it. The risk is probably lower than previously thought, however, it does remain a risk and as such people should take it seriously. Sharing snorting items will also have a risk of transmitting other infections or viruses, including Covid.

Snort harm reduction

- Not all white powder is cocaine so a smaller line should be taken as a test dose.
- Dosage should be timed, leaving at least 30-45 minutes between lines.
- Lines should be alternated between both nostrils unless one is damaged or bleeding.
- The surface, where the line will be snorted from, should be clean and as sterile as possible. A wipe or spray with an antibacterial agent before wiping dry will help this.
- As cocaine varies in purity so too should the line size (dose). The purer the cocaine the smaller the line/dose should be.
- The powder is crushed or chopped as fine as possible to save blocking the nose.
- A straw, tube or plastic type banknote that is long enough to reach high up the nose should be chosen. This should be unused and not be shared with others.
- Old type paper bank notes are grubby by nature and difficult to clean so these should be avoided.
- If snorting with others, the tube should be taken and kept on the person (in pocket, bag etc.) until next use as this will reduce accidental mix ups.
- Blowing the nose when a build-up of mucus is felt will help clear residue.
- Dousing (sniffing up water from the palm of the hand, then blowing the nose and repeating) after the session is complete will help clear any reside.

Smoke risks

Prolonged crack/freebase smoking is likely to result in some form of lung problem. Repeated inhalations can cause or exacerbate a number of lung or respiratory conditions such as asthma, shortness of breath or COPD. Smoking crack cocaine may also cause various forms of pneumonia. All these conditions are often simplified using the term “crack lung”. Some people may experience such severe damage to the lungs that they cough up blood whilst serious cases may result in respiratory failure. Left untreated, crack induced lung damage could cause further complications in the body, including other organ damage and death.

The chemicals used during the preparation process can be inhaled directly into the lungs causing harm. This is particularly relevant to freebase rocks where the ammonia has not been properly rinsed before smoking.

Symptoms such as chest pain, extreme coughing fits, difficulty breathing are all indications that significant harm is occurring.

Pipe risks

Ideally people would smoke their crack/freebase from a purpose made pipe or glass/Pyrex tube with suitable gauze. However, if these are not easily accessible people will make their own from easy to find household items. Drinks cans, plastic bottles, glass miniature bottles and inhalers are all commonly used. A bed of cigarette ash can be used to allow the rock to melt better without clogging the holes, however the inhalation of this burning ash can create further risks. The risk with each form of pipe varies greatly. If any of these pipes are shared then there is a potential for a wide range of viruses and infections to be transmitted including Blood Borne Viruses, Tuberculosis, Covid etc.

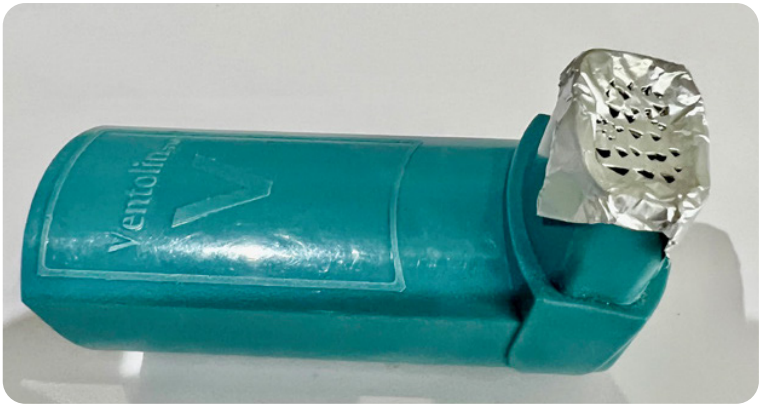
Drinks cans - holes are made and the rock is often placed on a bed of cigarette ash. Toxic fumes from the burning paint or plastic coating inside the can may be inhaled along with the drug itself. There is a risk of virus transmission and infections if shared with others.

Plastic bottles - inhalers and other plastic items. Fumes from the burning plastic can be inhaled along with the drug. Some of these pipes place the rock and flame very close to the face meaning burns are a possibility. There is a risk of virus transmission and infections if shared with others.

Glass miniature bottles - the bottom is often taken off this small bottle leaving sharp edges which may cause cuts. Risk of virus infection if shared with others.

Gauze - It is common for loose filters to be made from stainless steel scouring pads. These are chosen as a bed for the rock to sit on allowing better melting and inhalation. However, these can disintegrate and break off during heating, meaning small particles can be inhaled causing significant damage the mouth, throat or lungs.

A crack pipe provided by harm reduction services (not UK)



A makeshift crack pipe made from a salbutamol inhaler

Recycling cocaine from pipes

Once a pipe has been used numerous times, cocaine residue will gather inside. In order to free this for further use, a chemical such as acetone or nail varnish remover would be used to dissolve the cocaine. The liquid would then be poured on to a mirror and left to dry. This would then leave cocaine that could be scrapped off the mirror and re-used. Inhaling these chemicals before they have fully evaporated can cause further lung damage.

Smoke harm reduction

Personally made freebase cocaine is less likely to have impurities, when compared to street bought crack. However freebase rocks should be rinsed properly to wash off any ammonia residue. Sitting the rocks on a damp tea bag and carefully rinsing with cold water, then allowing to dry properly before smoking will help do this.

Purpose made glass or steel pipes are likely to be the safest choice. The pipe should be long enough that it is far enough away from the face to stop any burns from the flame or debris.

Pipes should not be shared with any other person to reduce the risk of virus transmission and infection.

Proper pipe gauze should be used in place of metal scouring pad type material. This should be carefully inserted in to the pipe or tube and changed frequently.

A lighter which has enough reach to melt the rock without burning the fingers should be used.

If a chef style burner is used, this will not shut off if the person collapses causing a significant fire risk. If using this type, ensure someone is with you.

Holding the crack or freebase smoke in the lungs for long periods can damage the lung tissue without increasing the effects of the cocaine.

Smoking tobacco along with cocaine increases strain on the heart and cardiovascular system.

Any burns, blisters, sores or chaps on the lips should be treated properly with appropriate ointment or cream.

Good hydration through drinking lots of fresh water may stop the lips becoming dry and chapped.

Injecting related harm

Injecting cocaine is likely to be the most harmful method of administration.

Blood borne virus risks

The direct sharing of needles and syringes carry the biggest risk for the transmission of blood borne viruses (hepatitis B, hepatitis C and HIV). Other injecting paraphernalia such as spoons, filters and water also carry a risk if shared, albeit it lesser. The indirect sharing of injecting paraphernalia is common, particularly if batches of drugs are prepared, using previously used equipment. Drawing the drug solution from a contaminated spoon, filter or water has both bacterial and BBV risks. It is also common for all the drugs to be drawn in to the one syringe, then divided equally between other people's syringes by back-loading or frontloading in to the people's syringes which again creates transmission risks.

Injecting related complications and injury

With the effect of cocaine so short lived, the compulsion to inject again frequently will occur. This can lead to a "binge injecting session". This frequent injecting can cause rapid deterioration of the veins, leading to vein collapse and circulatory problems. The anaesthetic effects of cocaine can make it difficult to 'feel' the injection properly, leading to missed hits and site damage.

Injecting in to the muscle under the skin (sometimes called skin or muscle popping) can cause significant damage to the skin, tissue and muscle. The muscle breakdown can cause toxins in the blood to cause damage to the kidneys. This is a rare condition called rhabdomyolysis.

It may be difficult for people to estimate how many times they are likely to inject in any given sitting meaning the person does not collect enough injecting equipment and needs to reuse. Even the reuse of someone's own (not shared) injecting equipment can cause bacterial infection, vein and site damage.

It is possible that the frequency of injection, often across multiple geographic locations, is a driving factor in poor general hygiene and unsterile injection practices. This has been shown to cause a number of bacterial infections such as Staphylococcus aureus and Group A Streptococci. Infections can result in serous life threating conditions such as sepsis or necrotizing fasciitis.

A public injecting site close to Glasgow City Centre and a selection of One Hit Kits

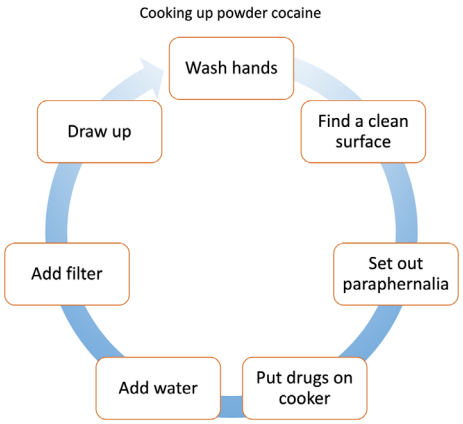
Preparing cocaine for injection

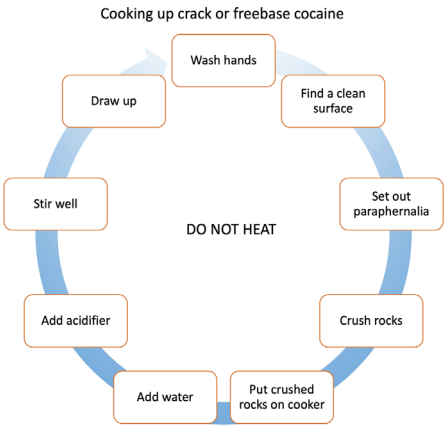
Each form of cocaine is prepared for injecting in a slightly different way.

Powder cocaine is easily water soluble without the need for an acidifier or heat. Freebase and crack do need an acidifier added to facilitate the breakdown in to a soluble state. Crack and freebase should not be heated, as this will form into an oil which may block the needle or cause damage if injected.

Snowballing (heroin and powder cocaine together in the one syringe). This would be prepared on the spoon by cooking up the heroin as normal (using an acidifier and heat). When the solution is cooling powder cocaine is added.

Snowballing with heroin and crack or freebase is a little trickier. The crack or freebase should be crushed as fine as possible before adding cold water and acidifier. When dissolved heroin should be added and the solution heated. More acidifier can be added in very small amounts if needed.





Cocaine injecting harm reduction

- Injecting equipment (needles, syringes, filters, spoons and water) should not be shared with others.
- All injecting equipment (needles, syringes, spoons, filters and water) should be new and unused.
- All injecting equipment should be considered single use and disposed of in a suitable sharps bin immediately after use.
- The drugs should be prepared and injected in as sterile an environment as possible. Ideally this environment should also be warm and well-lit with other trusted people there to help if an emergency occurs.
- Hands and target injecting sites should be washed well with warm water and soap. If this is not possible the best available method of cleaning should be used.
- Techniques for raising veins (tourniquet, gentle exercise, warm water) should be used to keep lower risk sites accessible for longer.
- The size of needle should be carefully chosen in relation to the intended injection site. The smallest possible needle should be selected where possible. Deep vein injecting however, will require a longer more robust needle.
- If batches must be prepared with others then ensure all equipment that every person uses is new and unused.
- If preparing powder cocaine for injecting then no acidifier or heat is needed. Acidifiers cause vein damage so should only be used if essential.
- Properly rotate injecting sites, ideally 5 or 6 low risk veins on the arm should be identified and kept clean in between use.
- Avoid injecting intramuscularly or subcutaneously as this carries a significant risk of skin, tissue and muscle damage.

Needle and syringe guide

Colour	Guage Size	Length	Suitability for	Drugs usually injected by needle	Available in One Hit Kit Format
Green	**21g** (0.8mm)	**1** 1/2" (38mm)	Drawing oil based steroids. Intramuscular (IM) Injection of steroids (buttocks).	Oil Based Steroids	**In Steroid Glasses Case**
Blue	**23g** (0.6mm)	**1** 1/4" (32mm)	Intramuscular (IM) injection of steroids (buttocks). Femoral (groin) injection (IV).	Steroids, Heroin, Cocaine and Amphetamine (if femoral vein accessed).	**In Blue One Hit Kit (2ml)** **In Steroid Glasses Case**
Blue	**23g** (0.6mm)	**1"** (25mm)	Intramuscular (IM) injection (buttock, thights and shoulders) of steroids. Femoral (groin) injection (IV).	Steroids, Heroin, Cocaine and Amphetamine (if femoral vein accessed).	**No-Access fixed site for Pick & Mix**
Orange	**25g** (0.5mm)	**1"** (25mm)	Femoral (groin) injection (IV). Slightly deeper veins when the needle is prone to blocking.	Steroids, Heroin, Cocaine and Amphetamine (if femoral vein accessed).	**In Orange One Hit Kit (3ml)**
Orange	**25g** (0.5mm)	5/8" (16mm)	Slightly deeper veins when the needle is prone to blocking.	Steroids, Heroin, Cocaine and Amphetamine (if femoral vein accessed).	**No-Access fixed site for Pick & Mix**
1ML Fixed (LOW DEAD SPACE)	**27g-29g**	1/2" (13mm)	Superficial veins, such as arms, hands, feet and legs (IV) Subcutaneous injection of some hormones.	Heroin, Cocaine, Amphetamine and NPS. IPEDS such as growth hormone, tanning agents and peptides.	**In Black One Hit Kit (1ml)**

Physical health monitoring and treatment interventions for individuals who are prescribed OST and are using cocaine

An update of the physical health history and regular review of all prescribed medication is particularly important for individuals using cocaine as there is greater risk of strain on the heart from medications which prolong the QT interval. There is also an increased risk with sedative medications, both prescribed and non-prescribed, that cocaine may mask the depressant impact on the respiratory system and so increase risk of overdose.

There is evidence that participation in treatment and commencement of opioid substitution therapy (OST) can be associated with reduced cocaine use in individuals with opiate dependence also using cocaine. It would therefore not be advisable to delay OST in an attempt to stabilise cocaine use first.

An ECG can give a helpful indication of strain on the heart and any prolongation of the QT interval. Where possible this is helpful at initiation of OST or during changes in dose. If this is not possible a balanced judgement is required as holding up vital treatment to await an ECG first, may increase rather than reduce risk to health.

There is reduced risk of QT interval prolongation (adding to heart strain) and reduced respiratory depression risk with buprenorphine compared to methadone. Although there is no specific recommendation in OST choice for individuals with opiate dependence who are using cocaine, this should be taken into consideration along with other individual factors.

Individuals who start to use cocaine during OST may require an update in their risk and Red/Amber/Green (RAG) assessment and more regular support from their care manager. Consideration should be given to instalment dispensing of OST.

Cocaine use should not prevent an increase in OST if this is indicated. Stabilising on an optimal dose of OST may not only make it easier for the individual to reduce and stop using non-prescribed opiates but also other drugs such as cocaine. The literature suggests that OST doses at the higher end of the treatment range are associated with reduced cocaine use.

Mental health effects and treatment interventions

Crisis intervention

A crisis is an acute, time-limited episode experienced as overwhelming emotional reactions to an event.

What is a crisis for one person may not be so for another. What becomes a crisis may not have been a crisis before or would not be a crisis in a different setting.

Crisis has been described as a system out of balance. Crises occur when balance cannot be regained, even though a person is trying very hard to correct the imbalance.

Symptoms of drug related mental health crisis

It can be difficult to differentiate between the symptoms of mental illness and temporary drug-affected behaviour, therefore it is often not possible to conduct a mental health assessment until the effects of the drugs have fully worn off. It may be necessary to provide a crisis assessment in order to ascertain if there is a need for immediate mental health intervention due to temporary incapacity, or if there is a risk to the service user or others

Common symptoms of drug related mental health crisis are:

- Extreme anxiety and / or paranoia.
- Hallucinations - auditory (hearing things), visual (seeing things), and tactile (bodily sensations such as feeling things crawling on them).
- Persecutory beliefs (believing someone is trying to harm them).
- Delusional thoughts (an unshakable belief in something untrue such as believing they are someone else or they have done something they have not).
- Self-harm.
- Suicidal ideation and or acts.
- Loss of grip on reality.
- Whilst some people report being concerned about aggression, this is usually a fear response and is unlikely to occur if the client is appropriately supported.

In the majority of cases symptoms resolve as substance(s) wear off and where the client is able to sleep.

Sometimes with severe drug toxicity, delusional behaviours and extreme agitation can occur in the presence of other serious physical health symptoms such as extreme overheating and extremely fast heart rate. Delusional behaviours may manifest as bizarre behaviours e.g. getting undressed in public or aggression and extreme fear; this condition is referred to as acute behavioural disturbance or excited delirium and is a medical emergency. In the case of stimulants, excited delirium is caused by a condition called serotonin syndrome and can be life threatening if left untreated or is placed in restraints or held down with force for prolonged periods.

Therefore if a stimulant related psychosis is suspected e.g. client presents with excited delirium symptoms, it is important to rule out a stimulant overdose. Signs you would look out for would be extreme overheating: being hot to touch and or profusely sweating, muscle rigidity, over response reflexes or involuntary muscle spasms e.g. jerking. Other signs might be seemingly insensitive to pain, displaying a high level of physical activity or energy without tiring and appearing to have excessive strength (this is due to fear if struggling with being contained or against use of restraint). If such physical symptoms are identified, urgent medical care should be sought by phoning 999.

Where there are no signs of the physical symptoms connected to excited delirium, cases can be managed as any acute mental health crisis would be with a focus on providing a safe environment, managing agitation and offering reassurance and de-escalation in the first instance.

De-escalation

For people who are experiencing an acute drug related mental health crisis, simple de-escalation techniques are often highly effective. These include:

Establish safety and trust, techniques to do this could be:

- Speak slowly and confidently with a gentle, calm tone of voice.
- Give your name and explain your role and purpose if you do not know the client.
- Use non-threatening body language.
- Avoid touching, shouting or sudden movement.
- Stay calm and provide any necessary support slowly and gently.

Offer clear and supportive communication:

- Use clear language.
- Explain and inform about any actions you need to undertake beforehand.
- Avoid intense questioning.
- Ask how you can best help them right now.
- Paraphrase their concerns.
- Do not challenge psychotic thinking or collude in delusions.
- Do not argue or threaten.
- Where someone is presenting as mentally confused avoid sarcasm, laughing or humour that may be misunderstood.
- Comply with reasonable requests e.g. making a phone call.

Establish physical safety

- Think about environment - is there somewhere quieter or where the client might feel more comfortable? Also be aware of risk management of staying in or changing environment.
- Reduce unhelpful distractions and audiences (ask others to leave etc).
- Consider if having a friend(s) to stay with them is helpful or unhelpful.
- Avoid restricting the person's movement unless unsafe.

Verbal reassurance and support

Talking through or down - depending on an individual's drug experience and levels of agitation, it may be more appropriate to simply empathetically listen to their concerns and offer reassurance where required. Where someone is very agitated or less experienced, they may prefer to be talked down where you are more directive in your support. Some useful strategies for this are:

- Normalising their experience e.g. "cocaine can cause some people to feel anxious or paranoid, you are safe here and the effects will start to wear off soon".
- Distraction and re-focusing techniques e.g. engaging them in a conversation about something else or asking them to focus on something in the room.
- Grounding techniques e.g. deep belly breathing, counting (an example techniques is described below).

Five things grounding technique

- Notice five things that you can see. Look around you and bring your attention to five things that you can see. Pick something that you do not normally notice, like a shadow or a small crack in the concrete.
- Notice four things that you can feel. Bring awareness to four things that you are currently feeling, like the texture of your trousers, the feeling of the breeze on your skin, or the smooth surface of a table you are resting your hands on.
- Notice three things you can hear. Take a moment to listen, and note three things that you hear in the background. This can be the chirp of a bird, the hum of the refrigerator, or the faint sounds of traffic from a nearby road.
- Notice two things you can smell. Bring your awareness to smells that you usually filter out, whether they're pleasant or unpleasant. Perhaps the breeze is carrying a scent of trees if you're outside, or the smell of a fast food restaurant across the street.
- Notice one thing you can taste. Focus on one thing that you can taste right now, in this moment. You can take a sip of a drink, chew a piece of chewing gum, eat something, or think of something you like the taste of.

Next steps

Once a level of safety has been established and de-escalation strategies have helped the acute phase of the crisis to pass, it is important to look at what other supports might be needed, including supporting the client to develop self-management techniques to employ should future crises occur.

It is common for clients particularly where they have underlying mental health issues to experience repeated crises. Such experiences can be utilised to provide insights in to resources and coping skills that have been effective or have yet to be tried. These discussions can help formulate action plans and form self-management techniques that can be built in to ongoing work.

Some clients may require more specialist help as part of a follow up plan, this may include a referral to community mental health or psychological therapies team (See treatment section).

The acute effects of cocaine can include a sense of inflated confidence, sexual arousal, reduced need for sleep, reduced appetite and increased agitation and paranoia. Taking cocaine when already feeling anxious can heighten sense of anxiety. Deprived sleep can exacerbate existing mental health difficulties as well as create new onset of mental health problems.

Mental health assessment

As described above, mental health symptoms usually resolve over hours or days after stopping cocaine use but they may be more persistent. Taking cocaine when already feeling anxious can heighten sense of anxiety. Deprived sleep can exacerbate existing mental health difficulties as well as create new onset of mental health problems.

Chronic use or heavy binges can lead to the development of paranoid ideation associated with anxiety and panic attacks and feeling agitated. Cocaine use can also lead to depression and suicidal thoughts. Initial anxiety and paranoia may sometimes progress onto a psychotic disorder with paranoid delusions and hallucinations (which may be auditory or tactile "cocaine bugs").

In some cases individuals can present only with delusional parasitosis (Ekbom Syndrome), the unshaken belief of skin infestation by parasites in the absence of other mental health symptoms. Characteristic is the self-damage of skin by individuals affected in an attempt to remove parasites and the presentation to primary care and unscheduled care for treatment rather than mental health services or ADRS. To prove infestation, containers with specimens or photos ('matchbox sign') may be brought to consultations. Liaison with primary care in known cocaine users who present with these symptoms is important to offer appropriate interventions. Psychological distress secondary to delusions can lead to depressed mood and may require further assessment/ or treatment.

When working with people using stimulants, it can therefore be helpful to screen for mental health problems. It is important to enquire about sleep patterns, anxiety and any fears, delusional beliefs or hallucinations. People should be asked about thoughts of self-harm and suicide. Any concerns should be appropriately escalated. A particular focus on sleep hygiene, anxiety management techniques and building a safe environment to recover from acute effects of cocaine can be helpful.

Persistent mental health symptoms beyond the acute effects of cocaine should be treated as they arise, although awareness of additional risks with interactions of prescribed medication with cocaine should be considered. Some specific considerations are that cocaine can mask depressant effects of sedative medication and patients should be aware of risks of respiratory depression and need for additional caution when using sedatives alongside cocaine. Selective serotonin re-uptake inhibitors (SSRIs) and stimulants have been known to produce toxic reactions although not commonly. The Medicines and Healthcare Products Regulatory Agency (MHRA) has reminded prescribers to note the potential increased risk of bleeding when citalopram is prescribed to patients who are taking cocaine.

Cocaine use can lead to acute psychiatric presentations which require emergency assessment and possible admission. For example should a patient present with symptoms of paranoia, hallucinations and in a state of agitation after the acute effects of cocaine have worn off, or if a patient presents with acute distress leading to suicidal ideation and not able to create a safety plan.

Some helpful contacts where further emergency assessment or admission may be required or to form part of a safety plan for a patient:

Breathing Space: ☎ **0800 83 85 87** (a free confidential service which offers telephone support to people experiencing low mood, depression and anxiety).

NHS 24 Mental Health Hub can be accessed by calling ☎ **111**. They are available 24 hours a day for patients in mental health crisis and hub staff will then support access to the Out of Hours CPN Service if specialist mental health assessment is required. This provides patients with one point of access and no call charges. Patients can also be supported to access the most appropriate response to meet their needs at the time they need it.

In addition there is direct access for GPs to the Out of Hours CPN service via the Mental Health Assessment Units based at Leverndale and Stobhill Hospitals, which can be accessed through the NHS GG&C switchboard. Addiction Services however, should refer directly to their local Community Mental Health Team (CMHT).

Where there is uncertainty around roles of alcohol and drug recovery service workers and Adult Mental Health colleagues it may be helpful to refer to the following document, the most update version of which can be found on GGC Staffnet: MHS 03 Adult Mental Health & Addictions Service Shared Guidance and Specification for Interface Working.

Psycho-social Interventions

The three common parts of effective psychosocial interventions for substance use such as crack cocaine and heroin are: enhancing motivation, developing control over impulsive behaviour and developing a rewarding lifestyle*.

Stage 1: Motivational enhancement

Motivational enhancement is an essential component of any intervention of this kind. Different strategies will be utilised depending on people's level of engagement. In the earlier stages of engagement, the first and second strategies (below) may be more useful. As the engagement deepens and strengthens, the later strategies will become more useful. However, people's engagement will fluctuate and it is important to ensure the correct strategies are being utilised at the right time. The main motivational enhancement strategies include:

1. Establishing a supportive, caring therapeutic relationship. Establishing a relationship and developing communication skills is important to enable a conversation about drug use. Effective therapeutic relationship may be strengthened by helping the individual to identify practical needs, problems and priorities. Crisis intervention and stabilisation of acute symptoms may help to strengthen the relationship.
2. Finding topics that motivate interest (motivational hooks). Find out what is important to the individual; what do they want to change in their lives. Explore their relationships and goals to find topics that motivate interest.
3. Enabling conversations which explore and discuss substance use. Why are they using? What do they like about the drug? What role does it have in their life e.g. do they think it helps them to cope with mental health difficulties. Try to remain neutral. People will be more likely to listen to information on the adverse effects of the drug, if they feel they have been listened to. Before providing this information, check their existing knowledge i.e. individuals are often aware of the risks of drug use.
4. Explore the pros and cons of behaviour change. Firstly explore the pros and cons of their current drug use, then move on to the cons and pros of making the change.
5. Strategies for supporting positive change. Look out for statements of concern or intent to change. Ask readiness to change questions. Rate the importance of each pro and con. Identify and question the positive beliefs around drug use.

Stage 2: Developing control over impulsive behaviour

Developing control over impulsive behaviour begins with investigating the behaviour itself (e.g. why someone smokes crack cocaine), in addition to what was happening before the drug use, and what the consequences of the drug use were. This process is known as Functional Analysis and it can help an individual to realise that when a trigger occurs, they can use a non-drug using behaviour, resulting in a different set of positive long-term consequences. This is one of the core principles of controlling impulsive behaviour; which involves identifying and managing triggers, coping with cravings, analysing seemingly irrelevant decisions and managing high risk situations.

Identifying and managing triggers

Individuals may not be aware of their triggers, or even that they have them. Identifying triggers enhances control in that it is the first step in learning how to manage triggers. A detailed drug diary may help to identify their triggers (as well as understanding the links between triggers, drug use and consequences, and potentially to develop a better sense of control over their drug use).

The discovering triggers worksheet can also help, as can asking the following questions:

- Before the individual used the drug, what were they thinking, feeling, doing, where were they, who were they with?
- What was the perceived coping mechanism e.g. did they believe that it improved their feelings of wellbeing or alleviated boredom?
- What were the positive and negative short and long-term consequences?

In terms of managing triggers, the individual should try to remove all of the possible environmental triggers. This will be helped by the Self-Management Plan. For those triggers that cannot be removed, develop a craving plan, using the Coping with Cravings and Urges worksheet. At some point in the future some environmental triggers may be able to return as the coping strategies strengthen. It is also important to identify thoughts and feelings which are triggers and develop a coping plan, using the Coping with Thoughts worksheet.

Coping with cravings

The following activities may help individuals to manage their cravings:

1. Distraction involves any activity that diverts their attention from the drug craving and may involve mental, physical or soothing activities. Examples include participating in sports; rediscovering interests such as art, music, film; gaming, doing crosswords, Sudoku, other puzzles, reading, TV etc.
2. In a safe setting, focus on the craving and find ways to cope with the feeling such as urge surfing, mindfulness or recovery meetings.

Again, a drug diary will be helpful in managing cravings.

Seemingly irrelevant decisions and high risk situations

Seemingly irrelevant decisions occur when a series of decisions are made that increase the risk of lapse or relapse. For example, going to the local shop and meeting an old friend may put the individual at risk of a lapse or relapse. The Seemingly Irrelevant Decisions Worksheet will help individuals gain a broader understanding of these. The individual should be supported in developing an awareness of high risk situations in terms of people, places, thoughts and feelings.

Stage 3: Developing a rewarding lifestyle

When an individual has mastered many of the skills above and has developed a strong sense of control over their substance use, it is important to support them in developing a more rewarding lifestyle, as this will help strengthen their recovery. Supporting an individual to develop new or existing skills may help improve motivation, encourage greater stability and ensure they have the commitment and energy to develop holistically. It is important to help someone develop new experiences and explore ways in which they pursue new interests. The exercises and worksheets highlighted below can help to structure the conversation and develop ideas:

1. Set priorities using the Happiness Scale and identify person-centred activities using the Recreational Survey.
2. Set goals using the Goal Setting Worksheet.
3. Monitor progress using the Highlighting Progress Graph and Calendar.

**This guidance has been taken from the NHS Education for Scotland (NES) Core Behavioural and CBT Skills for Relapse Prevention and Recovery Management Course (Laura Freeman, NES, 2011). In order to follow and implement this guidance effectively, it is recommended that workers should have attended Core Skills training. The worksheets mentioned in this guidance are covered in Core Skills training and are available from the website below:*

Links: 🌐 **https://turasdashboard.nes.nhs.scot.** Please complete the registration process (if you are not already registered) and search "core skills".

Managing complex cases

Some people will be experiencing such harm and impact from cocaine use that they are unable to undertake this work and may be struggling to engage with alcohol and drug services.

These people should be appropriately RAG and CRAFT risk assessed. They may require assertive outreach, crisis or stabilisation residential care where available, or an inpatient admission if they have mental health complexity. People experiencing harm from primary cocaine or poly drug use could be discussed in supervision and then possibly at MDT depending on the level of complexity and harm.

There are a range of residential services that support individuals at varying stages of their recovery. Resource and availability may be different in each health board area.

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Appendix

Cocaine assessment tool (Worksheet 1)

Which drugs have you taken in the last 6 months and how often do you typically take them?					
	Less than once a week	**Weekly**	**Most days**	**Daily**	**More than once a day (how many times?**
Heroin					
Methadone (street)					
Methadone (prescribed)					
Buprenorphine (espranor / subutex) and/or Buprenorphine + Naloxone (suboxone) (street)					
Buprenorphine (espranor / subutex) and/or Buprenorphine + Naloxone (suboxone) (prescribed)					
Benzodiazepine(street)					
Benzodiazepine (prescribed)					
Alcohol					
Pregabalin (prescribed)					
Pregabalin (street)					
Gabapentin (prescribed)					
Gabapentin (street)					
Cocaine powder					
Cocaine freebase / crack					
Cocaine and heroin (snowball)					
Amphetamine					
Metham-phetamine					
New psychoactive substance stimulant type (NPS)					
Steroid (IPEDS)					
Human growth hormone (IPEDS)					
Tanning agents / melanotan (IPEDS)					
Other (what?):					
Are you on any other prescribed medications? (please specify): e.g. ARV, anti-depressants etc.					

Patterns of cocaine / crack use

How would you describe your use?	
Occasional use	
Regular use	
Binge use	
Daily use	
Over the last 6 months on average how much would you typically use in a day / drug using session?	
If you binge, how many days would be a typical binge session?	
During the past 6 months, how often have you had a strong desire or urge to use cocaine / crack?	
Never / almost never	
Sometimes	
Often	
Always / almost always	
How long does a single hit last for?	
Less than 15 mins	
15-30mins	
30 mins-1 hour	
1-2 hours	
2-4 hours	
How long do you usually leave between hits?	
Less than 30 mins	
30-60mins	
1-2 hours	
2-4 hours	
4-6 hours	
6-8 hours	
Over the last 6 months on average how many hits do you get out of a gram/rock etc.?	

Dependence

Over the last 3 months: Did you ever think your use of cocaine was out of control?			
Never / almost never	Sometimes	Often	Always / nearly always
Did the prospect of missing a hit make you very anxious or worried?			
Never / almost never	Sometimes	Often	Always / nearly always
Did you worry about your use of cocaine?			
Never / almost never	Sometimes	Often	Always / nearly always
Did you wish you could stop using cocaine?			
Never / almost never	Sometimes	Often	Always / nearly always
How difficult would you find it to stop or go without?			
Not difficult	Quite difficult	Very difficult	Impossible

Side effects

How often do you experience any of the following when you use cocaine / crack?				
	Never / almost never	**Sometimes**	**Often**	**Always / nearly always**
Chest pain				
Palpitations / racing heart				
Fits / seizures				
Pain or burning at injecting site				
Coughing				
Difficulty breathing				
Burns / blisters / sores				
Disturbed sleep/insomnia				
Agitation				
Fear or panic				
Anxious				
Confused				
Paranoid				
Hear or see things				
Thinking people are trying to harm you or you are being watched / bugged etc.				
Thoughts of harming yourself or others				
Overdose				
Comedown effects, e.g. irritability, low mood				

Physical/mental health history

Any current or previous health history which may impact on your cocaine / crack use? **E.g. physical health issues or concerns / attend hospital consultants etc.? history of contact with mental health services or treatment from GP**

Poly substance use

Do you take other substances to help manage any of the side effects you experience? (tick all that apply)	
Heroin	
Benzodiazepines	
Sleeping tablets	
Alcohol	
Cannabis	
Other (what?):	

Setting

Where do you typically use? (tick all that apply)	
Own home	
Friends home	
Shelter	
Hostel	
Safe consumption facility	
Prison	
Public spaces	
Other (where?):	
Do you use alone?	
Never / almost never	
Sometimes	
Often	
Always / nearly always	

Hygiene

Do you clean your hands prior to preparing drugs?	
Never / almost never	
Sometimes	
Often	
Always / nearly always	
How do you clean them?	
Warm water and soap	
Alcohol type hand cleanser	
Cold water and soap	
Warm water no soap	
Cold water no soap	
Other (please specify):	

Sexual health and BBVs

When using cocaine / crack do you have unplanned or impulsive sex?	
Never / almost never	
Sometimes	
Often	
Always / nearly always	
When using cocaine / crack have you had sex you later regretted?	
Never / almost never	
Sometimes	
Often	
Always / nearly always	
When using cocaine / crack do you have rough sex? E.g. vigorous intercourse, fisting etc.	
Never / almost never	
Sometimes	
Often	
Always / nearly always	

When using cocaine / crack do you have unprotected sex? (worker should explore where relevant all forms of sex including oral, vaginal and sharing of sex toys)	
Never / almost never	
Sometimes	
Often	
Always / nearly always	
Are you pregnant? Is it possible you could be pregnant?	
Have you had any sexual relationships in order to get things you need e.g. money, food, alcohol or drugs, gifts or other things that are important to you?	
Have you been tested for HIV in last six months?	
Are you aware of current HIV status? ***i.e. collected results and no risk exposure since test***	
Have you been tested for HCV in last six months?	
Are you aware of current HCV status? ***i.e. collected results and no risk exposure since test***	
Have you had a sexual health check up in the last six months?	
Are you aware of current STI status? ***i.e. collected results and no risk exposure since test***	

Injecting (please only complete this section if client injects)

How do you inject?				
	Cocaine	Heroin	Amphetamine	Other (what?):
IV				
IM				
Subcutaneous				

What size needle do you generally use? (please tick)

Colour	Guage Size	Length	Suitability for	Drugs usually injected by needle	Available in One Hit Kit Format
Green	**21g** (0.8mm)	**1** 1/2" (38mm)	Drawing oil based steroids. Intramuscular (IM) Injection of steroids (buttocks).	Oil Based Steroids	**In Steroid Glasses Case**
Blue	**23g** (0.6mm)	**1** 1/4" (32mm)	Intramuscular (IM) injection of steroids (buttocks). Femoral (groin) injection (IV).	Steroids, Heroin, Cocaine and Amphetamine (if femoral vein accessed).	**In Blue One Hit Kit (2ml)** **In Steroid Glasses Case**
Blue	**23g** (0.6mm)	**1**" (25mm)	Intramuscular (IM) injection (buttock, thights and shoulders) of steroids. Femoral (groin) injection (IV).	Steroids, Heroin, Cocaine and Amphetamine (if femoral vein accessed).	**No-Access fixed site for Pick & Mix**
Orange	**25g** (0.5mm)	**1**" (25mm)	Femoral (groin) injection (IV). Slightly deeper veins when the needle is prone to blocking.	Steroids, Heroin, Cocaine and Amphetamine (if femoral vein accessed).	**In Orange One Hit Kit (3ml)**
Orange	**25g** (0.5mm)	5/8" (16mm)	Slightly deeper veins when the needle is prone to blocking.	Steroids, Heroin, Cocaine and Amphetamine (if femoral vein accessed).	**No-Access fixed site for Pick & Mix**
1ML Fixed (LOW DEAD SPACE)	**27g-29g**	1/2" (13mm)	Superficial veins, such as arms, hands, feet and legs (IV) Subcutaneous injection of some hormones.	Heroin, Cocaine, Amphetamine and NPS. IPEDS such as growth hormone, tanning agents and peptides.	**In Black One Hit Kit (1ml)**

Over the past 6 months, which of the following sites have you used for injecting?				
	Cocaine	**Heroin**	**Amphetamine**	**Other (what?):**
Arms				
Hands				
Feet				
Leg				
Groin				
Neck				
Breasts				
Penis				
Other				
How frequently do you inject?				
Less than once a week				
Weekly				
Most days				
Daily				
More than once a day (how many times)?				
Over the past 6 months have you experienced any complications which may be connected to you injecting?				
Abscesses				
Infection				
Cellulitis				
Ulcer				
DVT				
Open wound				
Blocked or collapsed veins				
Missed hits				
Other (what?):				
Do you ever flush the blood back and forth whilst the needle is still in the vein?				
Never / almost never				
Sometimes				
Often				
Always / nearly always				

Do you ever use any of the following techniques for raising a vein?				
Tourniquet				
Warm water				
Gentle exercise				
Fist clenching				
Swinging arms (windmill motion)				

Preparation for injecting

Do you clean your injecting sites prior to injecting drugs?	
Never / almost never	
Sometimes	
Often	
Always / nearly always	
How do you clean them?	
Warm water and soap	
Alcohol type hand cleanser	
Cold water and soap	
Warm water no soap	
Cold water no soap	
Other (please specify):	

Use of acidifier

Do you use an acidifier to break down your drugs for injection?	
Never / almost never	
Sometimes	
Often	
Always / nearly always	
If yes how much do you tend to use?	
Whole content of single use sachet	
2 or more single use sachets	
Only a small amount of sachet	
Other (please specify):	

Use of water

What source of water do you use to prepare your drug for injection?	
Water from injection ampules	
Water from cooled boiled kettle	
Cold tap water	
Warm or hot water from tap	
Bottled water	
Water from a cup that others have access to	
Other (please specify):	
Do you use water to flush out your syringe after injecting?	
Never/almost never	
Sometimes	
Often	
Always/nearly always	

Needle reuse and batch preparation

Do you ever share needles/syringes with anyone else?	
Never / almost never	
Sometimes	
Often	
Always / nearly always	
Do you ever share spoons, water, filter with anyone else?	
Never / almost never	
Sometimes	
Often	
Always / nearly always	
Do you ever reuse your own needle/syringe?	
Never / almost never	
Sometimes	
Often	
Always / nearly always	
Do you ever reuse your own spoons, water, filter?	
Never / almost never	
Sometimes	
Often	
Always / nearly always	

Do you ever prepare (for injecting) a larger amount of drugs to share with others?	
Never / almost never	
Sometimes	
Often	
Always / nearly always	
Do you ever have your drugs for injection prepared by others?	
Never / almost never	
Sometimes	
Often	
Always / nearly always	

Smoking (please only complete this section if client inhales)

What kind of inhalation pipes and gauzes do you use?	
Glass / Pyrex pipe	
Steel pipe	
Foil from IEP service	
Pipe made from drink can	
Pipe made from plastic bottle	
Pipe made from inhaler	
Pipe made from glass miniature bottle	
Pipe gauze	
Gauze made from metal scouring pad	
Gauze made from tin foil	
Other (please specify):	
Do you ever share inhalation pipes with others?	
Never / almost never	
Sometimes	
Often	
Always / nearly always	
How often do you change your gauze?	
Every hit / almost every hit	
Every few hits	
Occasionally	
Rarely	
Never	

When using crack/freebase do you? (tick all that apply)	
Break up the rock	
Hold the smoke in the lungs	
Scrape down residue from pipe	
Smoke with tobacco/ash	
Allow pipe to cool to touch	

Freebase cocaine

If you smoke freebase cocaine, do you typically:	
Buy as freebase	
Make your own freebase	
If you make your own freebase do you rinse off the ammonia and dry thoroughly before smoking?	
Never/almost never	
Sometimes	
Often	
Always/nearly always	

Motivational enhancement: Identifying problems (Worksheet 2)

Below are some problems that can be made worse by drug and alcohol use.

Put a check beside any that you have had.

Medical or physical:

____ Head Injury in past
____ Overdose experiences
____ Stomach problems
____ Dental / teeth problems
____ Seizures or convulsions
____ Large weight gain or loss
____ Diarrhoea or constipation
____ Nose or sinus problems
____ HIV issues
____ Hepatitis issues
____ Waking up at night with a start
____ Difficulty breathing
____ Difficulty breathing at night
____ Heart problems
____ Chronic pain
____ Specific pain problem
____ Chronic fatigue
____ Memory problems
____ Other (Specify):

Relationships:

____ Fights with partner
____ Fights with children
____ Fights with other family/friends
____ Feeling alone
____ Difficult to talk to other people
____ Difficulty solving problems
____ Loss of friends
____ Only knowing people who use
____ Problems with children/parenting
____ Loss of partner
____ Children at risk/in care
____ Problems in sex life
____ Other (Specify):

Legal:

____ Arrested – possession/dealing
____ Arrested - theft or robbery
____ Arrested - assault/other violence
____ DTTO, probation or parole
____ Divorce or separation
____ Child visitation issues ____Other (Specify):

Emotions and feelings:

____ Depression
____ General anxiety or stress
____ Panic attacks
____ Anxiety around other people
____ Anxiety when outside
____ Other specific fears/phobias
____ Sudden swings in mood
____ Problems controlling anger
____ Problems dealing with the past
____ Remembering/flashbacks to past
____ Hallucinations
____ Feeling suspicious or paranoid
____ Memory problems
____ Can't sit still – always moving
____ Can't relax
____ Can't concentrate
____ Other (Specify):

Housing, Finances, and Skills:

____ Finding a place to live/sleep
____ Furnishing/equipping your home
____ Finances and budgeting
____ Home skills (cooking, shopping)
____ Taking care of your home _____Taking care of yourself _____Other (Specify):

Daily routines:

____ Problems getting to sleep

____ Severe snoring

____ Problems waking up

____ Eating too much or too little

____ Not eating a balanced diet

____ Bored during the day

____ Lack of fun things to do

____ Loss of sports or hobbies

____ Lack of physical exercise

____ Problems finding or keeping work

____ Problems with training or school

____ Other (Specify):

Motivational enhancement: Identifying things to work on (Worksheet 3)

Now, look at this list again.

1) Check what would you like to change in your life.

2) Number those checked in order of importance.

Medical or physical:

____ Head Injury in past (#:)
____ Overdose experiences ____Stomach problems
____ Dental/teeth problems
____ Seizures or convulsions
____ Large weight gain or loss ____Diarrhoea or constipation
____ Nose or sinus problems
____ HIV issues
____ Hepatitis issues
____ Waking up at night with a start
____ Difficulty breathing
____ Difficulty breathing at night
____ Heart problems
____ Chronic pain
____ Specific pain problem
____ Chronic fatigue
____ Memory problems
____ Other (Specify):

Relationships:

____ Fights with partner
____ Fights with children
____ Fights with other family or friends
____ Feeling alone
____ Difficult to talk to other people
____ Difficulty solving problems
____ Loss of friends
____ Only knowing people who use
____ Problems with children/parenting
____ Loss of partner
____ Children at risk/in care ____Problems in sex life ____Other (Specify):

Legal:

____ Arrested – possession/dealing
____ Arrested - theft or robbery
____ Arrested - assault/other violence

____ DTTO, probation or parole
____ Divorce or separation
____ Child visitation issues ____Other (Specify):

Emotions and feelings:

____ Depression
____ General anxiety or stress
____ Panic attacks
____ Anxiety around other people
____ Anxiety when outside
____ Other specific fears/phobias
____ Sudden swings in mood
____ Problems controlling anger
____ Problems dealing with the past
____ Remembering/flashbacks to past
____ Hallucinations
____ Feeling suspicious or paranoid
____ Memory problems
____ Can't sit still – always moving
____ Can't relax
____ Can't concentrate
____ Other (Specify):

Housing, finances, and skills:

____ Finding a place to live/sleep
____ Furnishing/equipping your home
____ Finances and budgeting
____ Home skills (cooking, shopping)
____ Taking care of your home _____Taking care of yourself _____Other (Specify):

Daily routines

____ Problems getting to sleep
____ Severe snoring
____ Problems waking up
____ Eating too much or too little
____ Not eating a balanced diet
____ Bored during the day
____ Lack of fun things to do
____ Loss of sports or hobbies ____Lack of physical exercise
____ Problems finding or keeping work ____Problems with training or school ____Other (Specify):

Motivational enhancement: Daily routine worksheet (Worksheet 4)

The purpose of this worksheet is to provide participants with the opportunity to relate the content of the course with their work. The following questions can be used as a personal review of the material, as a part of a consultation with other professionals, or a structure for peer or individual supervision. Consider an individual with whom you work, either currently or in the past….

1. How do they describe their mental health in general? How do they describe their sleep? What are their beliefs about their mental health, and what do they tell themselves?

2. What time do they wake up in the morning and what do they do? What are their morning rituals?

3. What types of physical exercise do they get during the day? Do they get outside in the sunshine? What about mental exercise?

4. What do they eat and when?

5. List all the substances they use, including legal, illicit and prescribed.

6. Which parts of their living space do they use? Do they spend most of their time in one place? Do they use their bedroom for "active" activities while awake?

7. What do they do in the 2 hours before bedtime? What are their "wind down" rituals?

8. What time do they go to sleep? What do they do when if they are unable to fall asleep?

9. How do they sleep during the night? Do they describe waking up with a start? Nightmares? What do they do to cope with any sleep problems?

Motivational enhancement: Happiness scale (Worksheet 5)

The Happiness Scale is used as a part of the Community Reinforcement Approach (CRA).

For the most recent overview of CRA, see: Meyers, R. J., Roozen, H.G., and Smith, J. E. (2011). The Community Reinforcement Approach: An Update of the Evidence. Alcohol Research & Health, 33 (4), 380-387.

This scale is intended to estimate your *current* happiness with your life in each of the ten areas listed below. Ask yourself the following question as you rate each area:

How happy am I with this area of my life?

You are to circle one of the numbers (1-10) beside each area.

Numbers toward the left indicate various degrees of unhappiness, while numbers toward the right reflect various levels of happiness.

In other words, state according to the numerical scale (1-10) exactly how you feel today.

Remember: Try to exclude all feelings of yesterday and concentrate only on the feelings of today in each of the life areas. Also try not to allow one category to influence the results of the other categories.

	Completely unhappy									**Completely happy**
Drug use	1	2	3	4	5	6	7	8	9	10
Job or education progress	1	2	3	4	5	6	7	8	9	10
Money management	1	2	3	4	5	6	7	8	9	10
Social life	1	2	3	4	5	6	7	8	9	10
Personal habits	1	2	3	4	5	6	7	8	9	10
Marriage / family relationships	1	2	3	4	5	6	7	8	9	10
Legal issues	1	2	3	4	5	6	7	8	9	10
Emotional life	1	2	3	4	5	6	7	8	9	10
Communication	1	2	3	4	5	6	7	8	9	10
General happiness	1	2	3	4	5	6	7	8	9	10

Name: _____ Date: _____

Motivational enhancement: Exploring the relationships between substance use and mental health (Worksheet 6)

This worksheet is designed to explore the relationship between substance use and mental health. First, list all of the legal, illicit, and prescribed substances currently being used, either regularly or periodically. Second, list the current mental health and social problems. Then, look for ways in which the two columns interact.

Substances currently being used	Mental health and social problems

What is the perceived coping potential of the substances used (e.g substance related beliefs?)
What is the impact of the substance use on mental health?

Motivational enhancement: What I want from Treatment: William R. Miller and Janice M. Brown (Worksheet 7)

Adapted from: Center for Substance Abuse Treatment. *Enhancing Motivation for Change in Substance Abuse Treatment.* **Treatment Improvement Protocol (TIP) Series 35. DHHS Publication No. (SMA) 99-3354. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1999.**

Instructions

People have different ideas about what they want, need, and expect from treatment. This questionnaire is designed to help you explain what you would *like* to have happen in your treatment. Many possibilities are listed. For each one, please indicate how much you would like for this to be part of your treatment.

You can do this by circling one number (0, 1, 2, or 3) for each item. This is what the numbers mean:

NO means that you definitely do **NOT** want or need this from treatment.

? means that you are **UNSURE. MAYBE** you want this from treatment.

YES means that you **DO** want or need this from treatment.

YES! means that you **DEFINITELY** want or need this from treatment.

For Example:
Consider item #1, which says, "I want to receive detoxification." If you definitely do **NOT** want or need to receive detoxification, you would circle **0.** If you are UNSURE whether you want or need detoxification, you would circle **1**. If you DO want detoxification, you would circle **2.** If you **DEFINITELY** know that detoxification is an important goal for your treatment, you would circle **3**.

If you have any questions about how to use this questionnaire, ask for assistance before you begin.

What I Want From Treatment

	Do you want this from treatment	No 0	Maybe 1	Yes 2	Yes! 3
1.	I want to receive detoxification, to ease my withdrawal from alcohol or other drugs.	0	1	2	3
2.	I want to find out for sure whether I have a problem with alcohol or other drugs.	0	1	2	3
3.	I want help to stop drinking alcohol completely.	0	1	2	3
4.	I want help to decrease my drinking.	0	1	2	3
5.	I want help to stop using drugs (other than alcohol).	0	1	2	3
6.	I want to stop using tobacco.	0	1	2	3
7.	I want to decrease my use of tobacco.	0	1	2	3
8.	I want help with an eating problem.	0	1	2	3
9.	I want help with a gambling problem.	0	1	2	3
10.	I want to take Antabuse (a medication to help me stop drinking).	0	1	2	3
11.	I want to take a medication to help me stop using alcohol or heroin.	0	1	2	3
12.	I want to take methadone.	0	1	2	3

13.	I want to learn more about alcohol/drug problems.	0	1	2	3
14.	I want to learn some skills to keep from returning to alcohol or other drugs.	0	1	2	3
15	I would like to learn more about self-help groups: 0 1 2 3 12-Step programs like Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) or Smart Recovery.	0	1	2	3
16.	I would like to talk about some personal problems.	0	1	2	3
17.	I need to fulfil a requirement of the courts.	0	1	2	3
18.	I would like help with problems in my marriage or close relationship.	0	1	2	3
19.	I want help with some health problems.	0	1	2	3
20.	I want help to decrease my stress and tension.	0	1	2	3
21.	I would like to improve my health by learning more about nutrition and exercise.	0	1	2	3
22.	I want help with depression or moodiness.	0	1	2	3
23.	I want to work on my spiritual growth.	0	1	2	3
24.	I want to learn how to solve problems in my life.	0	1	2	3
25.	I want help with angry feelings and how I express them.	0	1	2	3
26.	I want to have healthier relationships.	0	1	2	3
27.	I would like to discuss sexual problems.	0	1	2	3
28.	I want to learn how to express my feelings in a more healthy way.	0	1	2	3
29.	I want to learn how to relax better.	0	1	2	3
30.	I want help in overcoming boredom.	0	1	2	3
31.	I want help with feelings of loneliness.	0	1	2	3
32.	I want to discuss having been physically abused.	0	1	2	3
33.	I want help to prevent violence at home.	0	1	2	3
34.	I want to discuss having been sexually abused.	0	1	2	3
35.	I want to work on having better self-esteem.	0	1	2	3
36.	I want help with sleep problems.	0	1	2	3
37.	I want help with legal problems.	0	1	2	3
38.	I want advice about financial problems.	0	1	2	3
39.	I would like help in finding a place to live.	0	1	2	3
40.	I could use help in finding a job.	0	1	2	3
41.	Someone close to me has died or left, and I would like to talk about it.	0	1	2	3
42.	I have thoughts about suicide, and I would like to discuss this.	0	1	2	3
43.	I want help with personal fears and anxieties.	0	1	2	3
44.	I want help to be a better parent.	0	1	2	3

45.	I feel very confused and would like help with this.	0	1	2	3
46.	I would like information about or testing for HIV/AIDS or Hepatitis C.	0	1	2	3
47.	I want someone to listen to me.	0	1	2	3
48.	I want to learn to have fun without drugs or alcohol.	0	1	2	3
49.	I want someone to tell me what to do.	0	1	2	3
50.	I want help in setting goals and priorities in my life.	0	1	2	3
51.	I would like to learn how to manage my time better.	0	1	2	3
52.	I want help to receive disability payments.	0	1	2	3
53.	I want to find enjoyable ways to spend my free time.	0	1	2	3
54.	I want help in getting my child(ren) back.	0	1	2	3
55.	I would like to talk about my past.	0	1	2	3
56.	I need help in getting motivated to change.	0	1	2	3
57.	I would like to see a female counsellor.	0	1	2	3
58.	I would like to see a male counsellor.	0	1	2	3
59.	I would like to see the counsellor I had before.	0	1	2	3
60.	I would like to see a doctor or nurse about medical problems.	0	1	2	3
61.	I want to receive medication.	0	1	2	3
62.	I would like my spouse or partner to be in treatment with me.	0	1	2	3
63.	I would like to have private, individual counselling.	0	1	2	3
64.	I would like to be in a group with people who are dealing with problems similar to my own.	0	1	2	3
65.	I need someone to care for my children while I am in treatment.	0	1	2	3
66.	I want my treatment to be short.	0	1	2	3
67.	I believe I will need to be in treatment for a long time.	0	1	2	3

Motivational enhancement: Exploring the pros and cons of using this substance (Worksheet 8)

Beside each point, write down a number between 1 (Not Important) to 10 (Extremely Important) for how much it matters to you:

The positive things about using:	The negative things about using:
Making a change: Positives	**Making a change: Negatives**
Staying the Same: Positives	**Staying the Same: Negatives**
The positive things about changing:	

Developing control: Functional analysis (Worksheet 9)

This collaborative exercise helps to identify potential skills for managing relapse and developing an alternative lifestyle. Consider the identified problem behaviour. This may be substance use (e.g. alcohol binge) or mental health (eg. self-harm). Then consider what happens before the behaviour happens. Finally, explore the short and long term consequences.

Environmental triggers	Thoughts and feelings	Behaviour	Positive consequences	Negative consequences
			Short term: Long term:	Short term: Long term:

This exercise can help a person explore the relationship between triggers, their behaviour and the consequences. It is also useful in identifying skills needed to help the person manage triggers and control impulsive behaviour. This form can also be used to explore and reinforce alternative behaviours.

Developing control: Functional analysis or recovery-orientated behaviour (Worksheet 10)

This collaborative exercise explores healthy, recovery-orientated behaviours in your life. Choose something healthy or fun that you do right now that does not involve alcohol and/or drugs. Then consider what happens before the behaviour happens. Finally, explore the short and long term consequences.

Environmental triggers (Who with? Where? When?)	**Thoughts and feelings** (What were you thinking? Feeling emotionally? Feeling physically)?	**Behaviour** (Be specific – What do you do, how long and how often?)	**Positive consequences** (Relationship? Emotions? Physical health? Legal? Job/ education? Money?)	**Negative consequences** (What are the barriers? Who, where, when? Thoughts, emotions, physical?)
			Short and long term:	**Short and long term:**

Developing control: Discovering triggers (Worksheet 11)

Adapted from: Budney, A. and Higgins, S. (1998). *A Community Reinforcement Plus Vouchers Approach: Treating Alcohol and other drugs Addiction.* **NIDA. Page 60.**

Discovering triggers of your alcohol and other drugs use

1. List the places where you are most likely to use alcohol and other drugs:

2. List the people with whom you are most likely to use alcohol and other drugs:

3. List and times or days when you are more likely to use alcohol and other drugs:

4. List any activities that make it more likely that you will use alcohol and other drugs:

5. Do you think that you use alcohol and other drugs when you are feeling certain ways? Read through the following list and mark the ones that are relevant to you. For those you have marked, list specific examples from your own experience.

a. At the end of (or during) a tense day
b. When faced with something you fear or are anxious about
c. When you've failed to accomplish something you'd planned
d. When you feel you have been taken advantage of
e. When you are bored
f. When you are in a social situation
g. When you feel bad about yourself
h. When you are depressed
i. When you want to feel energized or high
j. When you are faced with a tough problem
K. When you want to be friendly
l. When you wish your personality was different
m. others not listed here

6. List the places where you are unlikely to use alcohol and other drugs:

7. List the people with whom you are unlikely to use alcohol and other drugs:

8. List the times or days when you are unlikely to use alcohol and other drugs:

9. List the activities you engage in when you are unlikely to use alcohol and other drugs:

This form was originally adapted from Miller and Munoz 1982.

Developing control: Self-management plan (Worksheet 12)

Adapted from: Budney, A. and Higgins, S. (1998). *A Community Reinforcement Plus Vouchers Approach: Treating Cocaine Addiction.* **NIDA. Page 65.**

Self-management planning sheet

Trigger	Plans	+/- Consequences	Difficulty (1 – 10)
1.			
2.			
3.			

Developing control: Coping with cravings and urges (Worksheet 13)

Adapted from: Carroll, K. (1998). *A Cognitive-Behavioral Approach: Treating Cocaine Addiction.* **NIDA. Pages 53-54.**

Coping with cravings and urges

Reminders:

Urges are common and normal. They are not a sign of failure. Instead, try to learn from them about what your craving triggers are.

Urges are like ocean waves. They get stronger only to a point, then they start to go away.

If you don't use, your urges will weaken and eventually go away. Urges only get stronger if you give in to them.

You can try to avoid urges by avoiding or eliminating the cues that trigger them.

You can *cope* with urges by -

Distracting yourself for a few minutes.

Talking about the urge with someone supportive.

"Urge surfing" or riding out the urge.

Recalling the negative consequences of using. - Talking yourself through the urge.

Each day this week, fill out a daily record of craving and what you did to cope with craving.

Example:

Date/Time	Situation, thoughts, and feelings	Intensity of craving (1-100)	Length of craving	How I coped
Friday, 3 pm	Fight with boss, frustrated, angry	75	20 minutes	Called home, talked to Mary
Friday, 7 pm	Watching TV, bored, trouble staying awake	60	25 minutes	Rode it out and went to bed early
Saturday, 9 pm	Wanted to go out and get a drink	80	45 minutes	Played basketball instead

Developing Control: Coping with cravings and urges

Date/Time	Situation, thoughts, and feelings	Intensity of craving (1-100)	Length of craving	How I coped

This form was originally adapted from Kadden et al. 1992.

Developing control: Coping with thoughts about using (Worksheet 14)

Adapted from: Carroll, K. (1998). A Cognitive-Behavioral Approach: Treating Cocaine Addiction. NIDA. Page 64.

Coping with thoughts about using

There are several ways of coping with thoughts about using alcohol and other drugs:

- **Thinking through and remembering the end of the last time you used**
- **Challenging your thoughts**
- **Recalling the negative consequences of using**
- **Distracting yourself**
- **Talking through the thought**

Before the next session, keep track of your automatic thoughts about using when they occur, and then record a positive thought and coping skills.

Thought about using substances	The positive thought or the coping skills used

This form was originally adapted from Monti et al. 1989.

Developing control: Problem-solving worksheet (Worksheet 15

Adapted from: Budney, A. and Higgins, S. (1998). A Community Reinforcement Plus Vouchers Approach: Treating Cocaine Addiction. NIDA. Pages 79-80.

Problem-solving worksheet

Procedure:

1. *Gather information:* Recognize that a problem exists. Is there a problem? You get clues from your body, thoughts, feelings, behaviour, reactions to other people, and the ways that other people react to you. Think about the problem situation. Who is involved? When does it happen? Exactly what takes place? What effect does this have on you?
2. *Define the problem:* Describe the problem as accurately as you can. What goal would you like to achieve? Be as specific as possible. Break it down into manageable parts.
3. *Brainstorm for alternatives:* List all the things that a person in your situation could possibly do. Consider various approaches to solving the problem. Even list alternatives that seem impractical. Try taking a different point of view, try to think of solutions that worked before, and ask other people what worked for them in similar situations.
4. *Consider the consequences:* Look at each of your alternatives in turn. What things could you reasonably expect to result from taking each action? What positive consequences? What negative consequences are long-term? Which are short-term? Which do you think you could actually do?
5. *Make a decision:* Which alternative is the most likely to achieve your goal? Select the one likely to solve the problem with the least hassle. *Do it!* The best plan in the world is useless if it isn't put into action. Try it out.
6. *Evaluate its effectiveness:* Which parts worked best? Reward yourself for them. Would you do anything differently next time? After you have given the approach a fair trial, does it seem to be working out? If not, consider what you can do to strengthen the plan or give it up and try one of the other possible approaches. Remember that when you've done your best, you have done all you can do.

Developing control: Problem-solving Worksheet, Page 2

Practice exercise

Choose a problem that may arise in the near future. Describe it as accurately as you can. Brainstorm possible solutions. Evaluate the potential outcomes. Prioritise solutions.

Identify the problem situation:

_____

_____

_____

_____

Brainstorm a list of possible solutions:	**Pros:**	**Cons:**

Developing control: Seemingly irrelevant decisions (Worksheet 16)

Adapted from: Carroll, K. (1998). *A Cognitive-Behavioral Approach: Treating Cocaine Addiction.* **NIDA. Pages 76.**

Seemingly irrelevant decisions

When making any decision, whether large or small, do the following:

- Consider all the options you have.
- Think about all the consequences, both positive and negative, for each of the options.
- Select one of the options. Pick a safe decision that minimizes your risk of relapse.
- Watch for "red flag" thinking - thoughts like "I have to . . .", or "I can handle . . ." or "It really doesn't matter if . . ."

Practice monitoring decisions that you face in the course of a day, both large and small, and consider safe and risky alternatives for each.

Decision	Safe alternative	Risky alternative

This form was originally adapted from Monti et al. 1989.

Developing a rewarding lifestyle: Recreational survey (Worksheet 17)

Name: _____ **Date:** _____

Please tick the column which best describes your thoughts/feelings about each row.

Sports and games				
Activity	**Did at least 4x's last year**	**Would like to try…**	**Have tried and liked it…**	**No interest**
Football				
Tennis				
Swimming				
Golf				
Jogging / running				
Aerobics				
Gymnastics				
Bowling				
Ten-pin bowling				
Darts				
Karate				
Pilates				
Tai Chi				
Yoga				
Snooker				
Billiards/pool				
Rugby				
Badminton				
Suduko				
Crossword puzzles				
Internet based games				
Computer games				
Chess				
Dominoes				
Scrabble				
Jigsaw puzzles				
Table tennis				
Shinty:				
Other:				

Outdoor activities				
Activity	**Did at least 4x's last year**	**Would like to try…**	**Have tried and liked it…**	**No interest**
Walking				
Hillwalking				
Bike / dirt bike riding				
Fishing				
Going to the beach or shore				
Going to the park				
Ice Skating				
Sailing				
Windsurfing				
Skateboarding				
Camping				
Gardening				
Picnics				
Birdwatching				
Other:				
Art, music, dance and drama				
Drawing / painting				
Photography				
Sculpture				
Woodworking				
Jewellery making / knitting				
Sewing				
Cooking / baking				
Listening to music				
Singing karaoke				
Playing an instrument				
Dancing				
Scottish country dancing				
Line dancing				
Acting				
Other:				

Other activities				
Activity	**Did at least 4x's last year**	**Would like to try…**	**Have tried and liked it…**	**No interest**
Shopping				
Museums				
Art galleries				
Fairs				
Historical sites and events				
Sporting events				
Eating out				
Travelling				
Library				
Cinema				
Music concerts				
Theatre				
Talking with a friend				
Attending a party				
Volunteer activities				
Watching TV				
Reading				
Meditation				
Creative writing				
Supportg groups				
Other:				
Other:				
Other:				

How would you rate your satisfaction with the recreational activities in your life?

Very dissatisfied **Dissatisfied** **Satisfied** **Very satisfied**

Are there problems that make it difficult for you to develop a healthy recreational lifestyle? If yes, describe:

Developing a rewarding lifesyle: Goal setting worksheet for reinforcing recovery (with directions) (Worksheet 18a)

Consider the Summary Worksheet. Select one or two of the areas, and decide on a goal(s) for the next month or so. (1) Find a goal that is positive. Say what you want to do - not what you don't want to happen. Make the goal brief, specific and decide on how you want to measure it. Make sure the goal is realistic and builds on things that you can do already. Next, what steps will you take to reach that goal (2) and how long will the step take (3)? Finally, what will you have as a reward after each step (4). This might be something good that comes out of the step, or you might plan a specific way to reward yourself positively and celebrate.

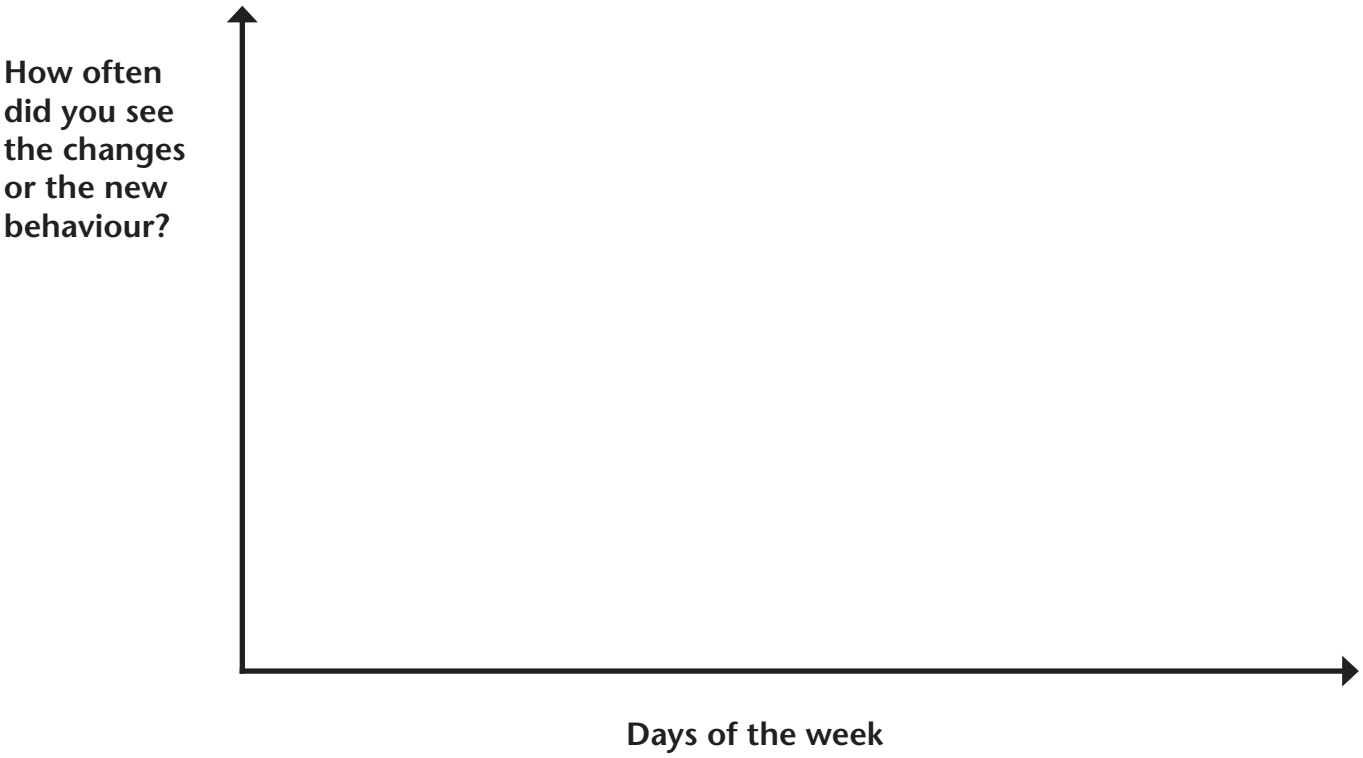
(1) **Set a goal that is positive, brief, specific, measurable and realistic.**	**(2)** **What are the steps you plan to work towards your goal?**	**(3)** **How long will you plan for each step to take?**	**(4)** **What will be the reward *or* "positive" with each step?**
Circle the area you would like to make changes in: Alcohol and other drug use Mental health Physical health Family + significant relationships Employment/training/ education Recreational/social Legal Goal for change – I would like:	Step 1: Step 2: Step 3: Step 4:	Step 1: Step 2: Step 3: Step 4:	Step 1: Step 2: Step 3: Step 4:

Developing a rewarding lifesyle: Brief goal setting worksheet for reinforcing recovery (Worksheet 18b)

(1) Set a goal that is positive, brief, specific, measurable and realistic.	(2) What are the steps you plan to work towards your goal?	(3) How long will you plan for each step to take?	(4) What will be the reward or "positive" with each step?
Circle the general area you would like to make changes in: Alcohol and other drug use Mental health Physical health Family + significant relationships Employment/training/ education Recreational/social Legal Goal for change – I would like:	Step 1: Step 2: Step 3: Step 4: Step 5:	Step 1: Step 2: Step 3: Step 4: Step 5:	Step 1: Step 2: Step 3: Step 4: Step 5:

Developing a rewarding lifesyle: Highlighting progress graph (Worksheet 19)

Highlighting the progress made as someone works towards a goal is essential. When someone is making changes in their lives, finding a visual way to see is often used to help people see the change happening. Highlighting progress can be as simple as a colour coded calendar, or as complex as graphs and charts. It is useful to create templates of charts, graphs or calendars which can be easily picked up and put to use. Here are two different examples.



Developing a rewarding lifesyle: Highlighting progress calendar (Worksheet 20)

Name: **Month:**

What do you want to see yourself doing? What's your goal?

Choose a colour and use it to mark the days when you reach your current goal.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Developing a rewarding lifestyle: Timeline exercise (Worksheet 21)

Major life events:

Birth — Current

Timeline of mental health events:

Birth — Current

Timeline of substance use:

Birth — Current

Development of beliefs and assumptions

When (or at what periods) did problematic substance use happen?