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Amanda Baker [1,2], Nick Heather [3], Anna Stallard [4], Katy O'Neill [2,5] and Alex Wodak[6]

1. Discipline of Psychiatry,
   Faculty of Medicine,
   University of Newcastle,
   CALLAGHAN NSW 2308
   AUSTRALIA

2. National Drug and Alcohol Research Centre,
   University of New South Wales,
   SYDNEY NSW 2052
   AUSTRALIA

3. Centre for Alcohol & Drug Studies,
   Northern Regional Drug and Alcohol Service,
   Newcastle City Health NHS Trust,
   Plummer Court, Carliol Place,
   Newcastle Upon Tyne, NE16UR
   UNITED KINGDOM

4. Department of Psychological Medicine,
   University of Glasgow,
   Gartnavel Royal Hospital,
   Great Western Road,
   GLASGOW, G12
   UNITED KINGDOM

5. Drug and Alcohol Services,
   Ryde Hospital,
   37 Fourth Avenue,
   EASTWOOD NSW 2122
   AUSTRALIA

6. Alcohol and Drug Service,
   St. Vincent's Hospital,
   Victoria Street,
   DARLINGHURST NSW 2010

AUSTRALIA

For copies of this monograph, please write to:

The National Drug and Alcohol Research Centre,
University of New South Wales,
SYDNEY NSW 2052
AUSTRALIA

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INTRODUCTION

This manual describes a cognitive-behavioural program for reducing the HIV risk-taking behaviour of injecting drug users (IDUs). In two studies (both randomised controlled trials) this program was shown to successfully reduce injecting risk-taking behaviours without necessarily reducing drug use. It did not, however, have any impact on the sexual risk-taking behaviours of IDUs.

CAVEATS

The techniques described in this manual are based on psychological research. Health workers who do not have a background in psychology may find it helpful to arrange for supervision or consultation with a psychologist while learning to apply the techniques.

While the techniques may be adapted for different situations (for example, group work) it must be borne in mind that the effectiveness of the program was established using the techniques exactly as described in this manual.

ORGANISATION OF THIS MANUAL

The program contained six sessions of cognitive-behavioural techniques conducted on a one-to-one basis. This manual first describes some of the theoretical background to the program. A chapter is then devoted to each session of the program.

BACKGROUND

IDUs risk HIV transmission by sharing injecting equipment and by unprotected sex. Factors associated with HIV risk-taking behaviour remain poorly understood.

HARM REDUCTION

Heather, Wodak, Nadelmann and O'Hare (1993) argue that the harm reduction approach does not necessarily require any reduction in drug use. Instead, its emphasis is to decrease problems associated with drug use rather than drug use itself.

Stimson (1990) has outlined five key ideas underlying a harm reduction, "public health" approach with IDUs. These key ideas are that:

(i) the most important problem with drug use is the injection of drugs;

(ii) drug users are rational, capable of feeling concern for their health and able to take responsibility for reducing their risk of acquiring HIV infection;

(iii) interventions should target needle sharing and unsafe sexual practices because they transmit blood-borne viruses such as HIV, Hepatitis B and C (HBV and HBC);

(iv) workers in outreach, community, clinic and needle exchange settings should be skilled in physical aspects of HIV infection, counselling and community action; and

(v) treatment and other services should be accessible, non-judgmental and responsive to consumer needs.

The harm reduction approach requires that single intervention goals are replaced by a hierarchy of goals, ranging from the most safe to the least safe alternatives.

Mattick and Hall (1993) listed the injecting hierarchy range:

(i) abstinence from drugs;
(ii) using drugs but not injecting;
(iii) using only new equipment;
(iv) re-using and/or sharing but sterilising equipment; and
(v) sharing injection equipment but injecting less frequently.

McCusker et al. (1992) have listed the sexual risk-taking behaviour hierarchy range:

(i) abstinence (no sex at all);
(ii) monogamous (exclusive) relationship with only one partner who is seronegative and does not share injecting equipment;
(iii) use of condoms with regular and casual sexual partners;
(iv) use of condoms with casual and commercial partners but not regular sexual partners; and
(v) no use of condoms but reduction in the number of sexual partners.

(Reviews of the effectiveness of various harm reduction measures include those conducted by Brettle (1991), Darke (1992), Des Jarlais, Friedman and Casriel (1990), Des Jarlais, Friedman and Ward (1993), Friedman and Des Jarlais (1991) Longshore (1992) and Wodak and Des Jarlais (1993).)

CONTINUED HIV RISK-TAKING AMONG IDUs

While harm reduction strategies all appear to have had at least some success, further risk reduction is needed among IDUs. Two commonly reported obstacles to further HIV risk reduction include relapse to riskier levels of behaviour and lack of success in reducing sexual risk-taking behaviour.

Needle sharing among IDUs continues (although at substantially reduced rates) despite needle exchange schemes (Baker, Kochan, Dixon, Wodak & Heather, 1994), despite educational interventions (Calsyn, Saxon, Freeman & Whittaker, 1992) and despite methadone maintenance treatment (Darke, Baker, Dixon, Wodak & Heather, 1992).

Knowledge of HIV transmission does not prevent HIV risk-taking (Morlet, Darke, Guinan, Wolk & Gold, 1990). In some studies, initial risk reduction has not been maintained (Des Jarlais, Abdul-Quader & Tross, 1991; Longshore, Anglin, Annon, & Hsieh, 1993).

This program was therefore developed with the aim of further reducing HIV risk-taking behaviour and to maintain safer injecting and sexual behaviour in IDUs who were still engaging in HIV risk-taking behaviour.

RECENT DEVELOPMENTS IN THE TREATMENT OF ADDICTION

Three major developments in the treatment of addiction have occurred in the last decade. These are:

(i) the stages of change model (Prochaska & DiClemente, 1986);

(ii) relapse prevention (Marlatt & Gordon, 1985); and

(iii) motivational interviewing (Miller & Rollnick, 1991).

There is evidence for the usefulness of all three of these developments in the treatment of addiction, although more research is required. These developments have shown sufficient promise in the alcohol and smoking fields to justify testing their usefulness in reducing injecting and sexual risk-taking behaviour.

MARLATT & GORDON'S (1985) RELAPSE PREVENTION PROGRAM

The relapse prevention approach has been described in numerous publications (e.g., Larimer & Marlatt, 1990; Marlatt & George, 1984; Marlatt & Gordon, 1985).

Relapse prevention programs start by training the person to identify and anticipate their own particular high risk situations. The person is then encouraged to keep a diary (self-monitoring) of the problem behaviour and of relapse triggers. Once high risk situations have been identified, the program focuses on teaching the person ways of coping with the high risk situations. Behavioural strategies such as a) keeping away from the high risk situation, b) assertiveness, c) stress management, d) relaxation training and e) communication skills can be taught if the person needs them. Cognitive (or mental) skills such as a) reminding oneself of goals and b) using self-talk to overcome urges to engage in the problem behaviour can also be taught.

Relapse prevention programs also involve teaching problem-solving skills (D'Zurilla & Goldfried, 1971). Once a person has learned problem-solving skills they can adapt those skills to any high risk situation.

Sometimes it is not possible to practise new coping skills in real life situations and so coping skills are rehearsed as in a play. This involves instructing the person to imagine that they are in a high risk situation and thinking about coping with the situation. Realistically, learning new coping skills takes some effort and so it is important to imagine coping with difficulty rather than to imagine coping with ease (which may not happen in real life).

Relapse prevention programs also encourage people to improve their lifestyles in order for them to cope with stress. A balance between daily responsibilities (duties) and pleasant activities (pleasures) is encouraged. The development of `positive addictions' (e.g., aerobic exercise, relaxation) is emphasised.

Urge control procedures are taught. One of the most basic is to remove as many triggers to the high risk situation as possible. Coping with urges or cravings is also discussed. The client is informed that craving is natural and to be expected, that

cravings are triggered by internal and/or external cues, and that they peak and then fade. The client is encouraged to `ride out' urges like surfers ride out waves.

Clients are taught to see whenever they are "setting themselves up." This involves learning to recognise SIDS (Seemingly Irrelevant Decisions), which may place them closer to a lapse. The client is taught to acknowledge such decisions and to see them as representing urges and thus also as early warning signals of a lapse.

Finally, coping strategies for use in the case of a lapse are planned. The aim is to prevent the lapse from becoming a fully blown relapse. Using self-talk after a lapse is discussed. The lapse is to be seen as a learning experience rather than a failure. It is to be seen as an opportunity to learn how to avoid similar situations in the future and how to cope more effectively. In this way, feelings of hopelessness (the counterproductive effects of the AVE (Abstinence or Rule Violation Effect) will be avoided. A small reminder card with instructions to read in the event of a lapse is carried in the person's wallet.

THE STAGES OF CHANGE MODEL

This model has evolved over several years and has come to consist of five stages (DiClemente et al., 1991). These stages are:

(i) "precontemplation";
(ii) "contemplation";
(iii) "preparation";
(iv) "action"; and
(v) "maintenance..

Each stage reflects the person's readiness to change problem behaviours. People respond differently according to which stage of change they have reached.

At the "precontemplation" stage the person is not thinking about changing their behaviour, that is, they have not yet contemplated changing his/her behaviour. The person could be unaware of any problems associated with the behaviour or they may just have no desire to change.

At the "contemplation" stage, the person is in two minds about changing a behaviour, that is they are ambivalent about change. They recognise reasons for change but continue to engage in the behaviour.

The "preparation" or "determination" stage describes readiness for action, with the person seriously considering change and making plans to do so.

The next stage, the "action" stage, is where the person takes action to change the problem behaviour. Traditionally, clients have been assumed to have reached the "action" stage when they present at treatment agencies. However, this is not always the case (see the section on motivational interviewing below).

Once action has been taken, the challenge for the individual is to maintain changes that have been made. The "maintenance" stage involves preventing relapse to problem behaviours (Marlatt & Gordon, 1985) and may require different strategies to those employed at the "action" stage (Miller & Rollnick, 1991).

Should "relapse" occur, the challenge for the person is to return to the "contemplation" stage and to go through all the stages to eventually reach the "maintenance" stage once again. Miller and Rollnick (1991) point out that it is considered normal for people to go through the stages of change several times before maintaining change. In other words, relapse is a normal event.

MOTIVATIONAL INTERVIEWING

Motivational interviewing encourages people in the "precontemplation" stage to explore thoughts and feelings and perhaps move toward the "contemplation" stage and similarly encourages people in the "contemplation. stage to move towards the "action" stage. Motivational interviewing was developed by W. R. Miller (1983) and is described by Miller & Rollnick (1991). Miller and Rollnick suggest specific counselling tasks according to the stage of change of the client. These tasks are outlined in the table below (reproduced from Miller & Rollnick, 1991, p.18).

Stages of Change and Therapist Tasks

Client stage	Therapist's motivational tasks
Precontemplation	Raise doubt - increase the client's perception of risks and problems with current behaviour.
Contemplation	Tip the balance - evoke reasons to change, risks of not changing; strengthen the client's self-efficacy for change of current behaviour.
Determination	Help the client to determine the best course of action to take in seeking change.
Action	Help the client take steps toward change.
Maintenance	Help the client to identify and use strategies to prevent relapse.
Relapse	Help the client to renew the processes of contemplation, determination, and action, without becoming stuck or demoralised because of relapse.

Miller and Rollnick (1991) outline five general principles underlying motivational interviewing:

(i) therapist expression of empathy through reflective listening;
(ii) development of incompatibility in the client's mind between current behaviour and important personal goals;
(iii) avoiding arguments and direct confrontation;

(iv) use of client resistance to generate momentum toward change rather than argument; and
(v) encouraging hope, that is, belief that the client can change.

Miller and Rollnick (1991) also outline five strategies that may be employed early in a motivational interview to assist clients explore their conflict or ambivalence about change and to state their own reasons for change. These strategies are:

(i) asking open-ended questions to encourage the client to do most of the talking;
(ii) skilful reflective listening to encourage the client to further explore ambivalence;
(iii) providing affirmation and support;
(iv) using summary statements to link together material, to reinforce what has been expressed, to demonstrate that the therapist is interested and listening and to prepare the individual to move forward; and
(v) eliciting self-motivational statements from the client.

While the first four motivational interviewing strategies are derived from client-centred counselling, the fifth strategy is unique to motivational interviewing. Its purpose is to help the client resolve his/her ambivalence and to `nudge' him or her toward a more advanced stage of change.

This strategy, eliciting self-motivational statements, aims to have *the client* express: recognition of a problem; concern about the problem; intention to change; and optimism regarding change.

Key skills employed to elicit these statements include:

< asking open-ended questions to explore the client's perceptions;
< discussion of the positive and negative points regarding their problem behaviour;
< asking for elaboration;
< questioning about the extremes of the client's concerns;
< discussion of how things were for the client before the problem began;
< imagining a changed future;
< exploring the individual's most important goals; and, finally,
< employing paradox by appearing to need convincing that the client does, in fact, have reason for concern.

Miller and Rollnick (1991) outline further strategies for use once the client shows signs of readiness to change. They state that the aim of the interview changes from building motivation to strengthening commitment to change the problem behaviour. The therapist can begin this transition by summarising the client's current situation. Open-ended key questions regarding "the next step" are employed to encourage the client to think about changing their behaviour. Information and advice can be given, preferably when the client asks for it. Suggestions should be qualified and tailored to suit the individual's circumstances. A cluster of options for change should be offered to the client, rather than any prescribed action. A plan for change is developed by setting goals of the client's choosing, discussion of possible methods for achieving change and decisions about which methods are to be employed.

Commitment to the plan can be elicited by checking that the client approves of the plan, involving significant others in the session and by starting initial steps immediately.

In summary, motivational interviewing draws on client centred therapy and has developed unique strategies to help motivate clients from earlier to later stages of change. Its main aim is to prepare clients for behaviour change.

RESEARCH ON THE EFFECTIVENESS OF THIS PROGRAM

RESEARCH ON THE PROGRAM DESCRIBED IN THIS MANUAL

The first study was carried out by Baker, Heather, Wodak, Dixon, and Holt (1993). They compared the program as described in this manual with a motivational interview alone. In their study, IDUs who were enrolled in methadone maintenance treatment programs were randomly allocated to (i) the six sessions as described in this manual or (ii) a one session motivational interview or (iii) methadone maintenance treatment alone (the control group). At six-month follow-up, neither the program nor the motivational interview had reduced injecting or sexual risk-taking behaviour in the month before the follow-up interview. Subjects in the six session group, however, reported significantly lower injecting risk-taking behaviour (despite similar levels of drug use) during "binges" or periods of elevated drug use. This finding showed that the program reduced HIV risk-taking during high risk periods.

The second study, also using the program described in this manual was carried out by O'Neill, Baker, Cooke, Collins, Heather and Wodak (1996). In this study, (also a randomised controlled trial), pregnant IDUs who went through the program reduced their injecting risk-taking behaviour, while those who did not go through the program did not reduce their injecting risk-taking behaviour. This new behaviour was maintained at a nine-month follow-up. The injecting risk-taking behaviour was reduced during periods of typical drug use as well as during periods of elevated drug use (binge episodes). No change in drug use *per se* was observed. Women who went through the program reduced the frequency of using a needle after another person, accepted less shared injection equipment, passed on a used needle to fewer people and increased the frequency of bleach decontamination of used injection equipment. The program reduced the risks associated with injection rather than the frequency of injection itself.

Both studies found no effect of the program on sexual risk-taking behaviour or the frequency of injecting or in drug use *per se*. Both studies found the program reduced injecting risk-taking behaviour during periods of heavy drug use (binge episodes).

The relapse prevention component of the program encourages IDUs to implement safer injecting practices during binge or heavy periods of use.

The finding that improvement can continue long after the program is over may turn out to be a promising feature of relapse prevention interventions.

ASSESSMENT

Participants in both studies were asked to fill out the HRBS (HIV Risk-taking Behaviour Scale) (Darke, Hall, Heather, Ward & Wodak, 1991) (a subscale of the Opiate Treatment Index (OTI) (Darke, Hall, Wodak, Heather, & Ward, 1992). The HRBS consists of 11 items covering both injecting and sexual behaviour in the month prior to interview. In addition to total risk-taking score, the HRBS provides separate scores for injecting and sexual risk-taking behaviour.

The Drug Use subscale of the OTI (Darke, Heather, Hall, Ward, & Wodak, 1991) was also administered to all participants. This scale assesses the subject's use of 11 classes of drug in the month prior to the day of interview and provides an estimate of the number of episodes

of use per day. All of these scales have been shown to have satisfactory psychometric properties.

In order to assess risk-taking behaviour during binge periods the Highest HIV Risk-taking Behaviour Scale (HHRBS) was used. This scale is adapted from the HRBS. Clients are asked to nominate which month in the last six months they injected most frequently (the highest HIV risk-taking period). They then answer the same questions as in the HRBS for this particular month.

The assessment is used in the first session of the intervention to offer personalised feedback about the client's particular areas of HIV risk.

The HHRBS is reprinted in Appendix C.

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THE PROGRAM

SESSION STRUCTURE

Each session was conducted individually with the client. Sessions typically lasted 60 to 90 minutes and were placed about a week apart. During the session the therapist and the client worked through the relevant section of the client handouts (see Appendices A and B). The client was encouraged to complete the section of the client handouts between sessions.

Session Notes

From the initial session with a client to the last session, it is extremely helpful clinically to record a summary of each session. Clinically useful information such as high-risk situations or important impending personal events should be recorded and then reviewed as appropriate. Relying on memory can lead to mistakes and this can effect rapport with the client. A session plan should be drawn up for the client after recording the previous session's content.

No names or any information which could incriminate a client should be recorded. If necessary, code information. Session notes should be dated and kept in point form.

At the end of each session, the client is to be asked how he/she has found that particular session and should be encouraged to offer comments about the program. More often than not, the client will probably not make any particular comments. However, if he/she does make a comment, either positive or negative, enter this in a separate file, the client comments file. If the client makes a comment at other times, record this as well. It could be useful to review this file and modify the program content accordingly if appropriate.

Session Format

Each session is structured in the same way:

(a) Set agenda with the client;

(b) Review the previous session;

(c) Review homework;

(d) Introduce new material;

(e) Summarise the session;

(f) Agree on practice tasks (homework);

(g) Discussion of the client's questions.

Emphasis on Review

The session structure above helps to keep the sessions focused and allows for full review and preparation for work between sessions (homework). Homework is very

important in cognitive-behavioural treatment approaches. Its aim is to have the client practice the skills taught in the treatment sessions in real life. Practice in real life is of crucial importance in behaviour change. Unless the client can use cognitive and behavioural skills in real life without the therapist, and with at least some success, there is little chance of long term behaviour change. As the program progresses, more time in each session is spent reviewing the previous session's homework practice. Successes are to be fully encouraged. Difficulties are to be fully discussed in a way that does not `blame' the client. Factors contributing to difficulties should be identified and decisions taken within the session regarding relevant action.

Counsellor Style

The way the counsellor relates to the client is very important. Obviously, a counsellor who appears uninterested in the client's progress or who advises without a full assessment of the client's problem is unlikely to obtain the same results as a counsellor who demonstrates the skills listed below.

Marlatt and Gordon (1985) point out that the client's self-efficacy is likely to be enhanced by the following techniques:

(i) the counsellor relates to the client as a mutual colleague instead of an expert/patient relationship;

(ii) the counsellor instructs the client that the process of changing one's habits involves a skill acquisition procedure instead of a battle of the will, with willpower as the only weapon against sharing/injecting;

(iii) changing a bad habit is described to the client as a gradual process over time, a voyage or journey that has several stages. The client is encouraged to take small steps toward a goal partly so that any problem in achieving a particular step is seen as a small and temporary problem rather than a total failure;

(iv) the client should be given positive feedback about performance on any new task even if only distantly related to the immediate steps or goals.

Miller (1989) has described a number of different tools or approaches that the counsellor can use in seeking to encourage motivation for change:

(i) Feedback: personal, individual feedback of the harm a substance is causing the individual can have a strong motivational effect.

(ii) Goal Setting: a perceived discrepancy between one's goal and one's present state can strongly motivate change. Throughout treatment and especially during problem solving, the client will be helped to clarify his/her goals and to compare these with the present state of affairs.

(iii) Helping Attitude:

(a) an empathic counsellor is very important in motivating and treating people who use drugs. An empathic counsellor is characterised as warm, supportive, sympathetic and attentive. Listening to and reflecting the client's statements and feelings throughout treatment is extremely important.

(b) an optimistic counsellor is also important in influencing client motivation. Expectations of good prognosis and wanting to help the client are predictive of good outcomes.

(c) an active role in the client's counselling can increase compliance. For example, if he/she loses the client handout, replace it as soon as you can either with another or a photocopy. This may also mean posting it so the client does not miss monitoring etc for another week.

Client Handouts (Appendix A and B)

The intervention includes written material for the client. The client handouts are designed to help the client apply the skills taught in each session in his/her real life. The client should be encouraged to view work done outside the session as an integral and important part of counselling.

Client handouts have been written for those clients who wish to reduce sharing injection equipment (Appendix B) (but not to reduce their injecting) and for those who wish to reduce both sharing and injecting (Appendix A).

Assertive Reminders

The counsellor should be active in encouraging attendance. For many reasons, clients may need assistance keeping appointments. This should be fully discussed with the client and if he/she is agreeable, decisions should be made about reminder calls and/or letters and contact after a missed session. If this is discussed with the client before he/she misses an appointment, a feeling of coercion can be avoided on both sides. If the client does not want to be contacted either by telephone or in writing, this wish must be obeyed by the counsellor.

At the very least, a letter should be sent following a missed appointment, offering another appointment time.

Client Goals

Each client is asked to nominate their own goal from the hierarchy of harm reduction. The program works well with whatever goal the client chooses, e.g. to reduce injecting frequency or simply to reduce sharing of injection equipment. This manual will therefore refer to sharing/injecting.

A:\MANUAL1.WP6

A:\MANUAL2.WP6

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Session 1
MOTIVATIONAL INTERVIEWING

GOAL

To increase client motivation for change; that is, to increase the likelihood that the client will initiate and maintain behavioural changes needed to reduce the risk of HIV infection. A major objective is to have the client express in his or her own words concerns about sharing (i.e., borrowing, lending, re-using injection equipment) /injecting and unprotected sex and their effects, to recognise and state that sharing/injecting and unprotected sex are concerns, and to express a need for and willingness to change (Miller, 1989).

MATERIALS

(i) Notes from assessment measures relevant to the client's high risk situations and behaviours for sharing/injecting and unsafe sex.

(ii) Client handout.

(iii) Writing pad and pen (to illustrate journey).

(iv) Client suggestions file.

BACKGROUND

Miller's motivational interviewing approach is useful in this session as: clients tend to be more committed to a plan that they perceive as their own; and clients tend to resist counsellor assertions like "You have a serious problem and you should deal with it" (Miller, 1989).

EXAMPLE

One of the most useful open-ended questions in terms of eliciting self-motivational statements is to ask: What are the good things about sharing/injecting/unprotected sex? And what are the less good things? The aim of this question is to have the client

think of and state good reasons to change sharing/injecting and sexual behaviour. The counsellor should not be challenging or judgmental. The counsellor should prompt the client to give very specific reasons for change rather than vague ones. Here is an example of this style. The counsellor is prompting the client to examine possible problem areas without `putting words into his or her mouth'.

T: What are the less good things about using heroin?

C: Well, its done my head in.

T: Can you tell me more about that?

C: I can't do without it now. Its like I have to have it to be normal. There's something missing without it.

T: In what way is that a concern for you?

C: Well before, if, say, I wanted to go out at night, I'd just go and that'd be it. Now I don't feel right if I haven't taken anything.

T: So you find it difficult to manage socially when you're not using.

C: Yes. It's hard.

T: What exactly is hard about it?

C: I feel really tense and stupid - nothing to say to anybody.

T: So could we write down that one of the less good things you get from heroin is that you feel tense in social situations when you haven't taken anything?

C: OK

T: Can you think of any other less good things?

C: No. That's about it.

T: Well, you've mentioned the example of feeling tense in so cial situations. Some people say they have hassles with their family too. Is that a hassle for you?

C: Yes, my Mum's really cracking up. I don't see my parents much anymore.

T: How much does that concern you?

C: Heaps.

T: So we could put down something about that too. What do you think we should put down?

In this way, the counsellor can assist the client to think about different problem areas. It is possible to work through major areas (legal, social, financial, family, sexual relationships, psychological). The counsellor should avoid being confrontational, as in this example:

T: Can you think of any other bad things about using?

C: No.

T: Well, you do have other problems you know. What about this list of convictions? You have to admit that being in gaol twice is a problem.

The counsellor may have communicated more effectively by saying something like this:

T: During our assessment, you mentioned that you had some convictions and two gaol sentences related to your drug use. Is that a concern for you at the moment?

Confronting the client often causes him or her to resist your assertions. The client's sharing/injecting/unprotected sex is best aired in a way that gives the client a chance to weigh up the costs of risk-taking behav iour. Clients' reasons for changing their behaviour vary. For example, one may be bothered about his or her health, while another may be more concerned about his or her family. If clients continue to resist the notion that there may be reasons for concern regarding sharing/injecting/ -unprotected sex in their lives, it is usually best not to confront them or insist that they list them in the client handout.

Sometimes clients hold faulty information and beliefs which need to be corrected in an objective and neutral way.

INTRODUCING THE SESSION TO THE CLIENT

"Last time we spoke you said you might be interested in receiving some help with your sharing/injecting and unprotected sex so as to help prevent you catching/spreading HIV. I'd like to talk to you today about these things and about some of your assessment results. Then we can decide together whether you think you might be helped by the counselling I can offer you. How does that sound?"

Feedback results in terms of risk associated with borrowing, lending, re-using and

unprotected sex and risk to partner/s and foetus. This should be done in a non-judgemental, objective way. It is useful to ask the client about their reaction to this feedback e.g., "What do you make of this information?"

POSSIBLE MOTIVATIONAL EXERCISES

Exercises will vary from client to client. Some appropriate strategies are exemplified below. Most of the useful strategies are detailed in Miller & Rollnick's (1991) book and can be adapted to this client population.

Exercise 1: Good Things/Less Good Things About Sharing/Injecting

The following introduction regarding the stages of change may be useful in some, though not all, cases.

"First, let's talk about stopping sharing/injecting. There are four stages in stopping sharing/injecting:

a) Thinking about stopping.

b) Deciding to stop.

c) Actually stopping.

d) Staying off.

Which do you think would be most difficult? Step four, staying off, is the hardest. Lots of people have managed to stop but then go back to sharing/injecting again. That's what this programme is all about - staying off".

"At this stage it may help to make a list of the good things you get out of using as well as the less good things".

List in client handout.

Encourage the client to note some of the good things from drugs (such as relief from anxiety, relief from withdrawals, escape from problems, a `rush', fun, social esteem), as well as the less good things.

As well as asking directly "What are the less good things about using?", it may be useful to prompt for less good things by asking : "Have you had any warnings that your body isn't coping well with the drug?" If the client responds with some ideas, you may try asking whether he/she thinks that warning sign may be due to something else. Typically, this will serve to strengthen the client's conviction that it really is the drug's effect. The danger though, is that the client may in fact respond in the opposite way to the question, finding some other reason for the problem.

Exercise 2: Health Risks from Sharing/Injecting

"The most risky part of drug use is injecting, especially sharing fits. That is why these sessions are concerned with stopping/staying off sharing as well as injecting. Can you tell me some reasons why injecting drugs may be a health risk?"

List in client handout.

This exercise is more educational. Therefore, the counsellor can be a little more directive, informing the client of the dangers. The following should be included:

Dangers of taking drugs by mouth: Overdose and/or poisoning; accidents whilst intoxicated; damage to body organs, e.g., hypoxia and the brain.

Dangers of injecting: as by mouth but also abscesses; less control over dose so more chance of an OD; adulterants; other infections.

Dangers of sharing: as for injecting but also Hep B; Hep C; HIV.

When the client has come up with some answers for the dangers of drugs by mouth, injecting and sharing, ask the client something like: "What do you expect your longevity to be?" or "What do you see for yourself in the future?".

The client may be asked to complete this risk exercise for homework.

Exercise 3: Self versus User/Sharer

The counsellor asks the client "What are your best attributes?"

and then asks "What about you as a sharer/user?"

and finally "How do these fit together?"

Exercise 4: Bad Things About Stopping

"What is the longest length of time you've gone without sharing/injecting?"

"What are the bad things about stopping sharing/injecting?"

Exercise 5: Main Reasons to Stop

"We've talked about the good things and less good things about using and the risks of sharing/injecting. What are the main reasons for stopping sharing/injecting? Even if you have already stopped, it may help to remember the reasons why you gave up".

Write reasons in client handout.

Exercise 6: Good Things and Less Good Things About Unprotected Sex

"We've talked about the risks of sharing/injecting, and one of the main risks was catching the AIDS virus. As you recognised during assessment, unprotected sex (i.e., sex without using a condom) can spread the virus too. What are the good things about unprotected sex and what are the less good things?"

List in the client handout.

Encourage frank and open discussion. Prompts to open up discussion may be useful (e.g., "One of my clients was initially put off condoms because she thought her partners would think she was too easy. Have you ever had unprotected sex because you were worried about what your lover might think? ... Can we say then that a good thing about unsafe sex is that it saves embarrassment?"

Good things
Possible good things about not using condoms that may be suggested by clients include:

(i) saves embarrassment
(ii) saves awkwardness
(iii) shows that you trust your partner
(iv) prevents the chance of rejection
(v) stops you looking prepared for sex and therefore `easy'
(vi) doesn't interfere with spontaneity or intimacy
(vii) prevents a reduction in sensitivity

(viii) saves having to hear that the man doesn't like to wear them
(ix) saves having to put them on

Less good things
Possible less good things about not using condoms that may be suggested by clients include:

(i) may catch/spread the AIDS virus
(ii) may catch/spread Hep B, or Hep C,
(iii) may catch other STDs: the wart virus; chlamydia; gonorrhoea; syphilis
(iv) neither partner accepts responsibility for the other
(v) indicates you don't care for your partner or their health
(vi) may get pregnant
(vii) contrary to open communication about sex, intimacy, etc.

Exercise 7: Main Reasons to Stop Unprotected Sex

"What are the main reasons you have for stopping unsafe sex?"

List in client handout.

Exercise 8: Questioning Strategies to Motivate Thinking About Condom Use

These questioning strategies are for individuals who are "precontemplators" as far as using condoms with their regular partner and are unlikely to have identified any less good things about not using condoms with their regular partner in the previous two exercises. The aim with these lines of questioning is simply to get the client thinking rather than necessarily persuading them to change. Since these questions deal with fundamental issues such as fidelity and trust in a relationship a sensitive approach is essential.

Some of these strategies will be more acceptable to some clients than others. Which strategy will probably depend on the client. The client's response to the question "Are there any circumstances in which you would consider using a condom with your regular partner?" may guide the choice of questioning strategy.

<u>Strategy 1: He/She might share</u>

The aim of this strategy is to dissociate the use of condoms or clean fits from issues of trust and bring in issues of compassion for an IDU partner slipping up during drug withdrawal.

How does it feel when you hang out? (Elicit physical, emotional, mental feelings).
How does your partner feel when he / she is hanging out?
Have you ever done anything you wouldn't normally do when you were hanging out, such as sharing a needle?
How would you feel about your partner if he / she shared because he / she was hanging out? Could you understand him / her?
Could he / she tell you about it if he / she shared?
How would you react?
Would he / she tell you about it if he / she shared?
Would you consider using condoms then?
Would you consider not sharing needles then?
How does all this tie in with your decision not to use condoms or to share fits with each other?

Strategy 2: Contraception

The aim of this strategy allows the couple to dissociate the use of condoms from the issue of trust and relate condom use to health concerns with contraception if such concerns are relevant.

Are you planning to get pregnant?
What contraception have you used in the past?
What do you think of your method?
Have you had any side effects?
What contraception have you thought about using?
What are your concerns about it?
If the woman smokes and is not considering quitting: Can I give you some information about smoking and the pill? (Give information about the risk of clots, strokes etc. for women who smoke while on the pill).
If the woman is using heroin: Can I give you some information about heroin and pregnancy? Dispute the myth that heroin reduces the likelihood of conceiving - heroin reduces the frequency of menstruation and therefore pregnancy may be relatively advanced before detected.
Have you discussed contraception with your partner?
Have you told your partner about your concerns or preferences?

Strategy 3: Statistics

The aim of these questions is to allow the client to consider whether statistics about sex with IDU are relevant. This line of questioning obviously requires sensitivity.

Can I tell you some statistics about women and HIV?

As of 30th September 1995:

- most new diagnoses of HIV infection among women were due to unprotected sex. About one in five of these cases was caused by having unprotected sex with a male IDU;

- of new diagnoses of heterosexually acquired HIV infection among men, about one in ten cases was caused by having unprotected sex with a female IDU.

What do you make of these figures? (Females are more likely to contract HIV infection from men than vice versa.)

(The figures above are from Kaldor, J. (Ed.). (1996) Australian HIV Surveillance Report, 12, (1). Sydney: National Centre in HIV Epidemiology and Clinical Research.)

Can I tell you a statistic from America about women and AIDS?

As of June 1993, two thirds of women who contracted AIDS through heterosexual sex contracted it through sex with a male IDU. These were women who were not injecting drugs themselves. Perhaps their partner shared or was unfaithful.

(This figure is from Centres for Disease Control and Prevention. (1993). HIV/AIDS Surveillance Report. USDHHS, Public Health Service, CDC. June.

How do you feel about this information?
Do you believe it?
Does it concern you?
How does this concern tie in with your decision not to use condoms with your partner?

Strategy 4: Communication

The aim is to allow the couple to consider whether infidelity would necessarily be the end of the relationship and that discussing how they would cope (e.g. safe sex) can be a sign of love rather than mistrust.

How did you meet?
What attracted you to each other?
Have the two of you ever talked about how you would feel if the other was unfaithful?
What did you say to each other?
How did it feel (would it feel) to talk about it?
Would you tell each other if you were unfaithful?
How would you react?
Would you want to know or would you rather not know if your partner was unfaithful?
Would you want to tell your partner if you were unfaithful? Do you think your partner

would rather not know if you were unfaithful?
How do your decisions (to tell each other, not to tell each other etc.) tie in with your decision not to use condoms with each other?

Strategy 5: Hepatitis B or C

The aim of this strategy is to consider the risks of unsafe sex if one or other partner has Hepatitis. Note that much is still unknown about the transmission of Hep B and Hep C.

How did you find out one of you had Hep B or Hep C?
How did you feel when you found out?
How has it affected you?

What have doctors told you about the transmission of Hep B or C?
How does this influence your decision not to use condoms with each other?

Strategy 6: Colombo Technique

The aim of this strategy is to get the client thinking about the arguments for condom use between regular partners. The following request for advice from the client may be helpful:

It can be really difficult to get people to think about condoms. Especially with their regular partners.

People say things like "It's like having a shower with a raincoat on."
Everyone thinks they can trust their partner.

It can be important because safe sex is a really important way of preventing the spread of HIV.

What sort of things do you think would help convince people?

FEEDBACK:
Summary of motivational interview

"From what you have said today, it sounds like you think you might be at risk for catching/spreading the AIDS virus. Although there are good things you get from sharing/injecting and unprotected sex, it seems like you are saying there are quite a few less good things and risks to your (and others') health as well...(Elaborate on these less good things and risks)..

Next step

"I wonder, what's the next step?" or "Where do we go to from here?"

Menu of options

.There are a number of ways you could be helped with these risky behaviours".

RATIONALE FOR RELAPSE PREVENTION (Marlatt & Gordon, 1985)

"This programme contains a lot of different sorts of things people have found helpful in stopping sharing/injecting and unprotected sex. It would be up to you to try these things with my help and you could choose which of these were the most helpful for you".

The text below should be used by the counsellor as a guide to the explanation given to the client of the relapse prevention approach. The journey metaphor should be fully discussed with the client, and the points highlighted should all be covered at some point. It is usually helpful to illustrate some of the points made on paper (or a whiteboard if available). The client handout contains illustrations pertaining to the metaphor of an outing to the beach. You may also use other metaphors that seem more relevant to a particular client. For example, training to become a competitive boxer and trying to retain a title, has been one metaphor suggested by a client during the first session.

Journey Metaphor

"By making a decision to stop sharing/injecting, and to participate in this programme, you have taken the first step in a journey that leads to increased freedom, greater self-esteem, and a longer, healthier life. The most important part of any journey is setting the goal, making the commitment to embark on the trip. But by itself, your will and commitment to change cannot transport you instantly to your journey's ultimate

destination. You must actually take the journey of change yourself. The programme that you have chosen to undertake is designed to help people make the journey; it is a programme that is like a guide whom you have hired to assist you by providing maps and navigational assistance and by pointing out dangers and pitfalls along the way."

Willpower Not Enough

"The purpose of the programme is to provide you with a means of attaining your goal; you have the will (by making the commitment to stop sharing/injecting), the programme offers the way to reach your goal. Many people who set out on this journey of quitting make the mistake of thinking that their will is all they need to reach their goal - that they will overcome all obstacles on the path through their sheer strength of their willpower. This makes about as much sense as the naive explorer who sets out across unknown territory without the aid of a compass, map, or other essential gear. In most cases, these inexperienced travellers become lost along the way or find themselves unable to get more than a few steps from base camp before turning back. Usually, the first time they encounter signs of trouble on the trail, they find that their will is not enough to get them through successfully (e.g., meeting a crocodile and trying to "stare it down" in a battle of wills). The first trouble spot often escalates into a total failure, as the naive explorer gives up and heads back to familiar territory..

Setting Out

"Quitting sharing/injecting is a journey in its own right and it can be a difficult one. After living with sharing/injecting for many years, you finally make the decision to leave behind the years of sharing/injecting.

Although you have many mixed feelings about leaving your friends who share/inject (after all, you went through a lot of hard times together), you feel an increasing need for independence and freedom, to strike out on your own. What are you leaving behind, after all? The sharing/injections with which you lived for so long are becoming an increasingly heavy burden. Although they appear to promise friendship and relaxation, you become increasingly aware that the sharing/injections are stealing things like your strength, your time, your money, often your friends, and eventually they may demand your life. Although it sometimes seems as though you have the people you regularly share/use with under your control, you realise more and more that you have fallen under their control - you feel like a prisoner, you have become `hooked', unable to move about freely on your own without the constant presence and `protection' of your sharing/injecting friends. It is time to escape".

Prepare; Tools; Skills, Attitude (illustrate ups and downs of journey)

"As you make your escape plans, you discover that the only vehicle you can obtain for your journey is a bicycle; to make matters worse, it has been a long time since you last rode a bike. The territory ahead seems unknown and fraught with dangers. Doubts loom in your mind: "Will I make it? What if I get lost or fail? I don't think I can make it on my own", and so on. These doubts are natural before any important journey, but they

can be reduced to the extent that you are prepared in advance for the journey - that you have the right tools (e.g., maps, bicycle maintenance tools, proper clothing, and supplies); that you have mastered the appropriate skills (learning to ride the bike, use the tools, etc.), and that you have the right attitude about the trip (knowing that it really is a journey with ups and downs and adventures along the way - and that it will take some time to reach your destination). The programme is designed to equip you for the journey (by providing the necessary tools and skills) and to help guide you through the early stages of the trip. Unlike other treatment programmes this programme does not just drop you at the outskirts of your destination and leave you to your own resources; we will accompany you through the first difficult stages after you have left sharing/injecting completely behind. Our experience as guides comes from working with many people who have attempted to make the trip before. We have learned much from both the successful survivors and from those who have experienced difficulties".

"Specifically, the programme consists of the following components designed to help you on your journey:

Coping

1. It teaches you coping strategies (constructive ways of thinking and behaving) to deal with the immediate problems that arise in the early stages of the trip, namely, coping with the urges and craving to use (which may lead not only to injecting but to sharing as well).

Maps

2. It provides you with maps showing the location of various temptation situations, pitfalls, and danger spots along the way that can throw you off course with the lure of temptation. The programme will give you information on detours to avoid temptation situations where possible and to help you to acquire the skills to cope with them successfully without giving in or giving up.

Early warning signals

3. It helps guide you through the tricks our minds sometimes play on us when we have doubts along the way. We will teach you to recognise the early warning signals that alert us to the danger of relapse. We will show how our minds often play tricks on us that increase our danger of relapse and how we can learn to cope with these inner temptations.

Lifestyle

4. It will help you make important changes to your everyday lifestyle, so that the good

feelings you have obtained from sharing/injecting are replaced with other non-destructive and ultimately more satisfying activities. Sharing/injecting drugs mostly becomes a dependency because people use it as a means of coping with life's continual ups and downs: people share/inject drugs when they're feeling tense, but they also share/inject to increase their enjoyment when they're feeling good or celebrating. It becomes difficult to just let things be, without a hit. When people stop sharing/injecting they begin to learn that they can trust their inner feelings and experiences, without trying to hide them.

Anticipate slips

5. Finally, the programme will help you to anticipate slips and be prepared for possible problems or relapses along the route. Many people begin their journey with very high expectations and demands for themselves. They frequently expect themselves to act perfectly without a single error, so that if they have any difficulty they think this proves they do not `have what it takes'. Remember when you first learned a new skill such as riding a bicycle? Were you able to get your balance perfectly the first time? Most of us had to take a painful spill or two before getting the hang of it - but these were mistakes we learned from. The same applies to the journey you are going on. Although most people hope to stop sharing/injecting without many serious problems, an unrealistic expectation of perfection may set them up for failure; we may be tempted to give up altogether the first time we have a problem or slip along the way. If we find that our bike gets a flat tyre on the road, should we give up and start hitching back? Or, to take a more realistic approach, shall we learn to anticipate and cope with the road conditions that might otherwise cause a blowout (e.g., by taking an alternative route)? And, if all precautions fail, shall we find out how to patch up a flat tyre, learn from experience, and continue on the path ahead? This programme favours this approach. Just as fire drills and lifeboat drills are used as a means of teaching people what to do to save themselves in case of emergency, so this programme offers relapse drills to teach you what to do in case you slip up and share/inject".

   "Instead of reacting to problems with a sense of self blame and failure, this programme treats these so-called setbacks as mistakes that we can learn from to improve your eventual chances of success. The goal is to help you refrain from sharing/injecting".

Time

6. "How long does it take to complete the journey to stay off sharing/injecting? People differ tremendously in how long it takes them to get there. Each step you take on the journey will increase your confidence, the feeling you can cope without sharing/injecting. Setbacks along the way need not lead to impossible dead-ends or impassable cliffs; alternative route planning is always possible. Each time you try,

you learn a little more about how to do it".

CONTRACT

Ask the client:

"What do you think about this sort of programme?
What sorts of things will help you?"

The programme runs for six sessions, once a week.

Each session will last about an hour or an hour and a half.

The sessions will follow the same sort of format every week:

(a) set agenda together;
(b) review the last session;
(c) review the `homework' - its helpful for your progress if you practice what we cover each session at home. We'll call this your homework. Its important that we assess how things work out outside the session so we can discuss problems and work out what's best for you;
(d) cover new material;
(e) review each session and discuss it;
(f) set homework;
(g) discuss any questions you have".

Give the client your contact number to phone if they have to cancel. Instruct them it is important to attend every session and to be on time. Ask if it is OK to telephone them about missed appointments. Ask if they want reminder calls.

REVIEW OF SESSION
1. Summarise the session by reviewing: (i) the client's list of good things/less good things about sharing/injecting; (ii) the client's list of risks of sharing/injecting; (iii) the client's main reasons for stopping sharing/injecting;

(iv) the client's list of good things/less good things about unprotected sex;
(v) the client's main reasons for stopping unprotected sex;
(vi) personal risk for HIV;
(vii) the rationale for a relapse prevention approach, using the journey metaphor.

2. Ask the client for his/her opinion of the session:
e.g., "How did you find the session today?"

Discuss the client.s comments.

SET HOMEWORK

Ask the client to:

Read the relevant section of the handout;

Complete (i), (ii), (iii), (iv) and (v) above.

QUESTIONS

Ask if the client has any remaining questions.

Make an appointment with the client and write it down for him/her.

Remind the client to bring the client handout each session, even if he/she has not written much in it.

. . . . . .

MAJOR REFERENCES USED IN COMPILING THIS SESSION AND USEFUL READING

Marlatt, G. A., & George, W. H. (1984). Relapse prevention: Introduction and overview of the model. British Journal of Addiction, 79, 261-273.

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Miller, W. R. (1989). Increasing motivation for change. In R. K. Hester & W. R. Miller (Eds.), Handbook of alcoholism treatment approaches (pp. 67-80). New York: Pergamon Press.

Miller, W.R., & Rollnick, S. (1991). Motivational interviewing: Preparing people for change. New York: Guilford Press.

Session 2
IDENTIFYING HIGH RISK SITUATIONS AND PROBLEM SOLVING

GOALS

(i) Improve awareness of high risk situations for sharing/injecting.

(ii) Improve awareness of high risk situations for unsafe sex.

(iii) Improve problem solving.

MATERIALS

(i) Notes from assessment sessions and session 1 relevant to the client's high risk situations and behaviours for sharing/injecting and unprotected sex.

(ii) Writing pad and pens.

(iii) Client suggestions file.

(iv) Client handout.

SET AGENDA

Set an agenda with the client for this session. This should include:

(i) Summary and review of the previous session;

(ii) Review of the homework;

(iii) New material to be covered in this session;

- high risk situations for sharing/injecting
- high risk situations for unsafe sex
- problem solving

(iv) Discussion of the session;

(v) Homework setting;

(vi) Questions;

(vii) Additional items the client should state now, at the beginning of the session, so that enough time is left to discuss them.

SUMMARY OF SESSION 1

Summarise the content of session 1 briefly. State the topics that were covered last time:

- pros and cons of injecting
- dangers of sharing/injecting
- main reasons for stopping sharing/injecting
- pros and cons of unsafe sex
- main reasons for stopping unsafe sex
- the rationale for a relapse prevention approach.

Ask if the client has any questions about the previous session and discuss them.

REVIEW OF HOMEWORK

Ask whether the client thought about/completed the exercises listed above. Discuss each exercise briefly. If the client did not add anything further, discuss why this was the case, pointing out that the problems the client has with doing the homework help to identify real life problems with staying off sharing/injecting. In other words, the client should begin to feel that problems can be discussed openly and that the emphasis is on identifying risk factors and doing something about them, not passive compliance with the treatment. Problems in carrying out homework would be excellent examples to work through in the problem solving section of this session.

PART ONE: IDENTIFYING OWN HIGH RISK SITUATIONS FOR SHARING /INJECTING

GOAL

To teach the client to recognise risk factors and high risk situations (situations in which a number of different risk factors are present).

BACKGROUND

Careful questioning in this session will enable the client to identify many high risk situations. The client can then learn different ways of responding in these situations. A first step in this approach is to help the client to recognise that high risk situations are best seen as signals that behaviour in that situation needs to be changed, in the same way that road signs signal the need for alternative action. Viewed like this, these

situations can be seen as choice points rather than as inevitable and uncontrollable challenges that must be endured. In this view, the choice to either simply avoid or to take a detour around risky situations becomes more available to the client.

RATIONALE

"This programme is about staying off sharing/injecting and unsafe sex so that you don't get/spread the AIDS virus. You have decided to stop, but sticking to that decision can be difficult. Just as any journey has its road signs along the way to signal possible danger, staying off sharing/injecting has its trouble spots. These trouble spots are called risk factors. They are very similar to road signs in that they signal to you that you need to change your behaviour in order to avoid an accident. For example, if you did not take any notice of a red light you may well crash into oncoming traffic, harming yourself and people in other cars. A red light signals to you to change your driving behaviour - to slow down and stop. You choose to stop, the red light doesn't force you to do so. It's the same with risk factors for sharing/injecting drugs. If you are in a situation where you feel you would like to share/inject, it is a it is a signal to change your behaviour (what you are doing) in some way. These signals are choice points for you to decide whether to change your behaviour and therefore prevent yourself from sharing/injecting."

Discuss this notion with the client.

Exercise 1: Risk Factors for Sharing/Injecting

"What kinds of things do you think would be risky for you?"

List the client's ideas in the client handout. If the client has difficulty identifying personal risk factors, refer to information obtained during the assessment sessions as some risk factors may have been identified then.

Try to elicit specific risk factors. For example, a client may say it would be risky at a party with all his/her friends. Would this be due to social anxiety, social pressure, availability of drugs, exposure to drug related cues or other reasons?

The following risk factors might be identified (and the client should be briefly asked about them if he/she has not already identified them):

Negative emotions

(i) Difficulty with negative emotional states, such as frustration, anger, boredom or depression.

E.g., "Sometimes people get really uptight and anxious (or bored and depressed). They might have a hit (and end up sharing) to relax or to cheer themselves up or they may feel like nothing matters so they share equipment. Does anything like that apply to you?"

Physical discomfort

(ii) Difficulty with physical discomfort or pain, discomfort which may or may not be independent of drug use.

E.g., "Sometimes people feel very uncomfortable without drugs. This is not just during withdrawal, but can happen later when they are reminded in some way about drugs. Has this ever happened to you?"

Positive emotions

(iii) Wanting to enhance a positive emotional state.

E.g., "Sometimes people are feeling great or want to celebrate something, and inject drugs (and end up sharing) because they think it would make it even better. Do you think that would happen to you?"

Personal control

(iv) Testing personal control.

E.g., "Do you ever feel tempted just to try injecting (and end up sharing) once just to prove you are not addicted? Do you feel that might be a danger to you?"

Drug related cues

(v) Giving in to temptations which are triggered by drug related cues. These include the substance and injection equipment as well as other items less directly associated with sharing/injecting.

E.g., "Sometimes people feel a strong craving to inject drugs when they see fits and they end up sharing. Do you feel that may be a danger for you?"

E.g., "Also, sometimes people feel a strong craving to inject which seems to come out of the blue, but is in fact triggered by seeing things that used to be associated with hitting up (e.g., neck ties). Do you feel that might be a danger for you - that you might end up sharing/injecting?"

Interpersonal conflict

(vi) Coping with anger or other emotional problems because of interpersonal conflict.

E.g., "Some people feel like injecting drugs when they are angry or upset with someone. Is this a possible danger for you - that you might end up sharing/injecting?"

Social pressure

(vii) Being under pressure to share/inject from other people, or watching other people sharing/injecting.

E.g., "If you see other people sharing/injecting, or they offer you a hit, it can be very difficult to stick with your original decision to stop sharing/injecting. Do you think you might decide to share/inject drugs because everyone else was doing it or because someone offered you a hit?"

Social situation

(viii) Being in a good social situation, such as a party, where drugs are being used to enhance the good feeling of being there.

E.g., "Sometimes people are having a good time with their friends and really feel like injecting so that they enjoy themselves even more. Do you think this may be a danger for you - that you might end up sharing/injecting?"

Others

These may include: availability; inability to think of an alternative to drug use; etc.

SET HOMEWORK
Ask the client to add any more risk factors they can think of to the list in his/her handout before next session.

Exercise 2: Discussing High Risk Situations for Sharing/Injecting

This exercise involves having the client assess risk levels in different situations (high or low risk). Ensure that the client considers the person in the example and not him or herself. The examples focus on either high risk for using or high risk for sharing. Some clients will have chosen to maintain levels of drug use and focus only on HIV risk- these examples are labelled "sharers only".

Note that this exercise involves examining the issue of `willpower' which might require some discussion.

"Situations with a number of risk factors in them are called high risk situations. Because there are more risk factors involved in these situations, people may be more likely to slip up in them. I'll read you some examples and see if you can tell me whether the person in them is in a high risk or a low risk situation".

(i) "Jim has just had his appeal for a social security grant turned down. He goes into his back pocket and his hands touch the $50 he had to pay rent with. On his way home he passes a pub where he knows he could buy some heroin (or the drug the client injects most frequently)". Sharers only: "He has no fit."

"Is this a high or a low risk situation?"

"Can you find any risk factors?"

(ii) "Mary is taking her ten year old son to the pictures for the afternoon and then going to her evening job in a pub." Sharers only: "She has no fit."

"Is this a high or low risk situation?"

(iii) "John goes to stay with his grandmother in Gundagai". Sharers only: "He has no fit".

"Is this a high risk situation?"

(iv) "Bill has been bored all afternoon and is glad to see his friends calling round for him even though they are all stoned." Sharers only "He has no fit".

"Is this a high risk situation?"

Skillpower

The point that taking specific action (skillpower) in a high risk situation is far more effective than relying on the vague concept of `willpower' should be made clear and discussed. This might be discussed as follows:

"Jim and Bill are both in high risk situations. They did not want to start sharing/injecting

drugs again. This is what they did to try to prevent sharing/injecting:

Jim knew he was in a high risk situation so he avoided the pub and went round to his mum's house to ask her to look after the $50.

Sharers only: Jim knew he was in a high risk situation so he avoided the pub until he'd been to the needle exchange.

Bill knew he was in a high risk situation so he decided to use his willpower to resist temptation if any of his friends offered him anything.

Who is more likely to succeed?"

"Why?"

"Jim is more likely to succeed because he took definite action instead of just relying on willpower. Even if Jim `lost' his willpower, he has arranged it so that he would still stay off sharing/injecting. Bill has nothing to protect him if he suddenly loses confidence and finds his willpower slipping away. You can't tell how strong your willpower will be. That's why some people slip up even though they felt certain they would never share/inject again."

Exercise 3: Personal Example

In the final part of this section, the client is asked to describe a high risk situation: one in which a number of different risk factors are present. The client might be prompted as follows: Personal example "You have already described some risk factors such as _____, _____,_____. Can you think of a situation with a number of these present?" Record this in the diary in the client handout.

Ways of coping

The client is also asked to suggest ways of coping with the situation. Encourage any response which involves active coping rather than relying on willpower, without spending much time on this issue in this session.

Record this in the client handout.

Self-monitoring

This sometimes has the effect of altering the client's behaviour and also provides useful information. The client should be encouraged to complete the diary every day. You should make a separate note of diary entries in the client's progress notes and give clients feedback each week on how their diary-keeping is going, noting problem areas especially those which crop up consistently, and ensuring that the information is specific and precise.

If the client forgets the diary or has failed to complete it, have some loose sheet copies prepared. It would usually be possible for the client to recall level of desire to share/inject retrospectively for the last week.

The client should be discouraged from recording illegal activities in the diary. For example, injecting could be recorded by using a prearranged code. People's names and specific places should be avoided.

Rationale for diary

A rationale should be given to the client:

"It is often very helpful for people to keep a diary of their sharing/injecting. It provides a record of your progress, a record of your sharing/drug use and drug craving so that you can identify risk factors, and a record of methods to stay off which work for you. I'd like you to consider yourself as a co-counsellor in keeping your diary - to have a `scientific' attitude when writing in it and reviewing it. What's of interest to us is your tempting and problem situations. It will be most helpful if you try to distance yourself from your use when you fill in the diary and try to keep a scientific eye on things."

Work through an example with the client.

"You should write in the diary at least once each day even if you don't feel like sharing/injecting drugs."

"Bring your diary with you each week so that we can review your progress."

PART TWO:
RISK FACTORS FOR UNSAFE SEX

Exercise 1: Risk Factors for Unprotected Sex

"Just as there are risk factors for sharing/injecting, there are risk factors for unsafe sex (i.e., not using condoms)".

"What kinds of things do you think would be risky for you?"

List in client handout. Continue until the client has grasped the concept and complete the list for homework.

If the client has difficulty identifying personal risk factors, refer to his or her assessment data as some risk factors may have been identified on it.

If the client says they are not sexually active or that they are not at risk, continue with the exercise, either discussing possible risks in the future or risk situations in the past.

Try to elicit specific risk factors. For example, a client may say it would be risky after a party with someone he/she doesn't know very well. Would the client's failure to use a condom be due to prior use of alcohol (and/or other substances), embarrassment, pressure from the partner not to use one, inexperience with use of a condom or unavailability?

The following risk factors might be identified:

Check each of them with the client in the same way as you did sharing/injecting risk factors last session. E.g., "Sometimes people do risky things like not using a condom when they've been drinking. Is this a possible danger for you?"

In this exercise, a range of different risky behaviours occurring in a range of different situations should be identified. For example, number of partners, use of a condom, and type of activity may vary across situations etc.

(i) **Difficulty with negative emotional states**, such as boredom, depression, anxiety.

(ii) **Interpersonal factors** may include old lovers with whom the client has a history of unprotected sex, any partner who exerts pressure to do unsafe activities, difficulty asserting one's desire to have safe sex, fear of rejection or abandonment, concern that safe sex interferes with intimacy and spontaneity.

(iii) **Physical factors** may include urges, fantasy, sexual arousal and drug use.

(iv) **Cognitive factors** include low self-esteem, low self efficacy, motivational conflict, and an identity that may have been largely based on lifestyle and sex.

(v) **Lifestyle** balance factors include poor stress management skills and a limited repertoire of nonsexual/nondrug ways of achieving stimulation, satisfaction, and pleasure.

(vi) **Environmental `hot spots'** include bars, adult book shops etc and for gays, parks, baths etc.

Exercise 2: High Risk Situations for Unsafe Sex

This exercise involves having the client assess risk levels in different situations (high or low risk). Ensure that the client considers the person in the example and not him or herself.

As in the high risk situation exercise last section, this exercise involves examining the issue of `willpower' which may again require some discussion.

"You might remember that situations with a number of risk factors in them are called high risk situations. Because there are more risk factors involved in these situations, people may be more likely to do risky things in them. I'll read you some examples and see if you can tell me whether the person in them is in a high risk or a low risk situation."

(i) "Barry is on his way to a party and hopes to see Sue, the woman he met today, there. Sue's a user too. Barry leaves his place without putting any condoms in his wallet as he's got none left".

"Is this a high or low risk situation?"

"Can you find any risk factors?"

(ii) "Sandra has been drinking all night at the pub with friends. An old lover offers to take her home. She doesn't especially want to be with him".

"Is this a high or low risk situation?"

(iii) "David's been to the pictures with Liz. It's the first time they've gone out together. Liz invites him back to her place. Although David has some condoms in his wallet, he says `No thanks but see you next week?'"

"Is this a high or low risk situation?"

Skillpower

The point that taking specific action (skillpower) in the high risk situation is far more effective than relying on the vague concept of `willpower' should be made clear and discussed. This might be discussed as follows:

"Barry and Sandra are both in high risk situations. They did not want to do risky things. This is what they did to try to prevent risky sex:

Barry knew he was in a high risk situation so he decided he'd be strong on willpower if Sue asked him home.

Sandra knew she was in a high risk situation and thought before the pub she'd better put some condoms in her purse just in case.

Who is more likely to have risky sex?"

"Why?"

"Barry is more likely to have risky sex because he is relying on willpower and he has nothing to protect himself if he finds his willpower slipping away. You can't tell how strong your willpower will be, especially after drinking or taking other drugs. That's why some people slip up even though they felt certain they would not have risky sex".

Exercise 3: Personal Example

In the final part of this section, the client is asked to describe a high risk situation: one in which a number of different risk factors are present. The client might be prompted as follows:

"You have already described some risk factors such as _____, _____, _____. Can you think of a situation with a number of these present?"

Record these in the client handout.

Ways of coping

The client is also asked to suggest ways of coping with the situation. Encourage any

response which involves active coping rather than relying on willpower, without spending much time on this issue in this session. The availability and the use of condoms at all times should be encouraged.

Record this in the client handout.

DIARY

"Just as it is often helpful for people to keep a diary of their sharing/injecting, it is also often helpful to keep a diary of sexual activity. It provides a record of your progress, a record of your risky sex, and a record of ways to prevent having risky sex which work for you".

"So as well as your sharing/injecting diary, I'd like you to keep a diary about your sexual activity for the next week including safe sex activities".

If the client is not currently sexually active or says he/she is not currently engaging in unprotected sex, ask him/her to record some examples in his/her diary of past or possible future risk factors as well as their current safe practices.

Work through an example with the client.

"Bring the diary with you next time so we can talk about how you're doing".

Ask if the client has any remaining questions before moving on to the next section.

PART THREE:
PROBLEM SOLVING

BACKGROUND

Problem solving is a method of coping with problems in a systematic and objective way. It involves breaking down, defining and working on problems in such a way that they cease to be overwhelming. There are five reasons why this is a useful way of dealing with problem areas:

(i) It helps the client distance him/herself from the problem;

(ii) The problem is broken down from a seemingly overwhelming burden to manageable components;

(iii) The technique aims to increase the quantity and hence the quality of solutions reached by the client;

(iv) It gives the client the sense that he or she has reached a decision about specific actionrather than being dictated to by the counsellor;

(v) Since problem solving can be applied to all kinds of problems, coping skills generated by this method can be produced by the client outside the treatment programme.

The following steps should be followed:

These should be generally outlined to the client, then a specific problem should be chosen to work through. The client should identify the problem with as little prompting from the counsellor as possible. If the client does have difficulty, assessment data may help to identify problems.

Step 1: Choosing a Problem

The client should be encouraged to identify a problem related to stopping injecting.

Step 2: Defining the Problem

A well defined problem almost solves itself! The reverse is true: a vaguely defined, or over-general problem is almost impossible to solve because it does not lend itself to specific action. For example, the problem might be: "I can't cope with being bored". The counsellor might try these questions to break the problem down:

"When is it worst?"

"In what circumstances do you get bored?"

"What times of day?"
"Which places?"

"With which people?"

"On which days- weekends, weekdays?"

"How long have you had this problem?"

"What did you do when you were not bored?"

"How about mornings, is it worse when you get up or later on?"

You should expect to end up with several more specific sub-problems. For example:

"I can't cope with afternoons- the mornings are O.K. because I do some housework but by the afternoon I've got nothing to do. I used to spend that time out scoring. Before then I had a job."

"Evenings are difficult. I would like to go out with my friends but I don't know anybody who doesn't use drugs and I haven't got any money. When I was working I had a busy social life and played football two evenings each week but that's all finished with now."

You could identify other sub-problems from these statements, such as not having work or not having money. Being bored in the afternoons seems to be related to finding a useful occupation while boredom in the evenings seems more related to finding new friends. The client will need to decide which of these two types of boredom to work on.

Step 3: Thinking of Solutions (Brain-storming)

The aim here is to write down as many solutions as possible without attempting to evaluate them. Quantity breeds quality and freedom to list solutions without evaluation allows freedom to explore what at first seemed like unpromising avenues.

Several sorts of prompts should be helpful and these should be given to the client and answers written in his/her handout:

(i) What have I done about this problem in the past?

(ii) What have I seen others do?

(iii) Who can I ask for advice?

(iv) What did they suggest?

(v) What other ideas do I have?

The counsellor should throw in a few wild suggestions as well as sensible ones so

that the client does not feel inhibited when suggesting ideas. Keep emphasising that at this brainstorming stage any sort of discussion (except to clarify) or evaluation of suggestions is not allowed.

Step 4: Choosing a Solution

At this point, evaluation of the solutions generated in step two takes place. Start by completely scoring out impossible solutions. Then evaluate the remaining ones, choosing the best, along with some `back-up' ideas. Although problem solving is aimed at producing a `self-sufficient' client, in the early stages the counsellor is likely to be more skilled in choosing effective solutions, and should guide the client's choice accordingly.

Step 5: Action

This stage provides an opportunity to use skills training techniques. A solution is unlikely to be suitable immediately - the client may have to practice in the counselling setting. The solution may need to be broken down into steps so that the client is able to work up to it in easy stages. For example, you may have both decided that the problem mentioned earlier, finding new friends, is a problem that should be worked on. One solution, looking up some old football friends, whom the client has not seen for some time, may need to be broken down into achievable steps. These steps may involve practice phone calls, role plays of conversations and decisions about how much the client should disclose about his or her drug using past. He or she may start off with a brief meeting and work up to more extended periods. Each step should be planned so that you and the client are fairly sure (75% sure) that he or she will succeed. Each step should be an achievable challenge for the client, and self confidence should be increased as the client progresses from one step to another. Steps chosen to work on should not be too small as the client may feel insulted or that such trivial steps indicate low counsellor expectations.

Finally, make out a timetable with the client for practice of each step:

Example Timetable:

Sunday	Phone footballing friend
Monday or Tuesday evening	Visit footballing friend to arrange a game later in the week
Thursday or	Game. Remember to arrange the

Friday	next match.

Step 6: Evaluation of Outcome (Did it work?)

Each session you should review with the client how each particular solution worked. If it was not successful, further work may be needed on necessary skills. Alternatively, another solution may be more appropriate or easier for the client at this stage - he or she may return to an unsuccessful solution when self confidence is greater. Since this is a time limited programme, the client should choose another solution to that problem and begin work on another problem as well.

SET HOMEWORK

Carry out the action part of the problem solving as it was planned in the session.

OTHER ITEMS

Discuss any other items the client may have wanted placed on the agenda at the beginning of the session.

REVIEW OF SESSION

1. Summarise the session by reviewing:

   (i) the client's high risk situations for sharing/injecting;
   (ii) the client's high risk situations for unprotected sex;
   (iii) the six problem solving steps.

2. Ask the client for his/her opinion of the session:

   E.g., "How did you find the session today?"

   Discuss the client's comments.

   Record the client's comments in his/her client notes and in the suggestions file.

SET HOMEWORK

Ask the client to:

(i) Complete any exercises from last session if appropriate;

(ii) Keep a diary of high risk sharing/injecting situations;

(iii) Keep a diary of sexual activity;

(iv) Carry out the `action' part of the problem solving.

QUESTIONS
Ask if the client has any remaining questions. Make an appointment for the client and write it down for him/her. Remind the client to bring the client handout each session, even if he/she has not written much in it.

. . . . .

MAJOR REFERENCES USED IN COMPILING THIS SESSION AND USEFUL READING

D'Zurilla, T. J., & Goldfried, M. R. (1971) Problem solving and behaviour modification. Journal of Abnormal Psychology, 78, 107-126.

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Marlatt, G. A., & Gordon, J. R. (1989) Relapse prevention: future directions. In M. Gossop (Ed.), Relapse and addictive behaviour (pp. 278-292). London: Tavistock/Routledge.

Stallard, A. (unpublished). Stop HIV. Stop Injecting. A guide for drug users.

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Session 3

COPING WITH CRAVINGS

GOALS

(i) Reinforce awareness of high risk situations for sharing/injecting.

(ii) Reinforce awareness of high risk situations for unprotected sex.

(iii) Reinforce use of problem solving.

(iv) Improve coping with craving.

MATERIALS

(i) Notes from sessions 1 and 2 relevant to the client's high risk situations and behaviours for sharing/injecting and unsafe sex, and problem solving.

(ii) Writing pad and pens.

(iii) Client suggestion file.

(iv) Client handout .

(iv) Drug related cues.

(v) Cloth to cover drug related cues.

(vi) Rating cards:

- Strength of desire for a hit (1-100)
- Difficulty resisting a hit (1-100)

SET AGENDA

Set an agenda with the client for this session. This should include:

(i) Summary and review of the previous session;

(ii) Review of the homework;

(iii) New material to be covered this session:

< coping with craving;

(iv) Discussion of the session;

(v) Homeworksetting;

(vi) Questions;
(vii) Additional items the client should state now, at the beginning of the session, so that enough time is left to discuss them.

SUMMARY OF SESSION 2

Summarise the content of session 2 briefly. State the topics that were covered last time:

< high risk situations for sharing/injecting;
< high risk situations for unprotected sex;
< problem solving.

REVIEW OF HOMEWORK

Discuss the following exercises with the client:

< diary of high risk sharing/injecting situations

Read these out aloud. Discuss common risk factors and situations. If an appropriate high risk situation is identified, suggest that the client apply the problem solving steps to this situation for homework, writing these in the client handout.

< diary of sexual activity

Read these out aloud. Discuss common risk factors and situations. If an appropriate high risk situation is identified, suggest that the client apply the problem solving steps to this situation for homework, writing them in the client handout.

Encourage behaviour change if the client suggests it at this stage (e.g., use of condoms, avoiding using drugs before sex).

< problem solving action

Review this using step 6 of problem solving guidelines in the client handout:

Did it work?

Yes - remember that for next time!

No - don't give up!

Did the action stage go wrong (step 5 of problem solving)? How could you improve it?

Can you choose another solution (step 4 of problem solving)?

Have you run out of solutions (step 3 of problem solving)? Can you think of any more?

If any of the homework is incomplete, discuss this with the client and use problem solving if appropriate to help solve difficulties in doing any of the exercises. Work through some examples with the client from their past experience.

SET HOMEWORK
Ask the client to:
(i) Complete any exercises from last session if appropriate;
(ii) Keep a diary of high risk sharing/injecting situations;
(iii) Keep a diary of sexual activity;
(iv) Problem solve one sharing/injecting and one risky sex problem.

COPING WITH CRAVING

GOAL

To teach the client to cope with the craving experience.

BACKGROUND (Marlatt & George, 1984; Marlatt & Gordon, 1985)

Marlatt and George (1984) point out that, even after many changes have been made in lifestyle, occasional craving may still surface from time to time. Various procedures to

control or cope with craving are therefore recommended. Sometimes cravings are directly triggered by external cues, like the sight of a needle and syringe or meeting an old friend who is a regular user. The frequency of these externally triggered cravings can be substantially reduced by employing simple stimulus control techniques aimed at minimising exposure to these cues. Sometimes, avoidance is the most effective way of reducing the frequency of externally triggered cravings. Certain events or situations like parties where there are users may just have to be avoided temporarily while the individual develops more coping skills. In general, avoidance strategies can often come in handy for dealing with unexpected high-risk situations that crop up. A selection of viable avoidance strategies can enhance the client's sense of choice when confronted with high risk situations.

Avoidance should be discussed fully with the client when reviewing his/her diaries of sharing/injecting and sexual activity and as a possible solution to various problems.

However, not all situations or cues that elicit craving can be avoided and it may be inappropriate to do so. The individual must learn to cope with craving without resorting to sharing/injecting.

In teaching clients to cope with craving, it is important to emphasise that the discomfort associated with these internal events is natural. Users who are craving often have a tendency to think the discomfort will continue to increase until they can no longer possibly resist the craving. It should be stressed to clients that cravings are triggered by external or internal cues - that they do not come out of the blue. Cravings rise in intensity, reach a peak, and then subside. In this respect, craving can be likened to the waves on the sea: they rise, crest and fall. Using this analogy, the client should be encouraged to wait out the craving, to look forward to the down side, and to endure that period of time when the urge is peaking.

In this session, the aim is to demonstrate to the client the usefulness of waiting or riding out an episode of craving. In order to demonstrate this, craving must be experienced by the client within the session. If the client experiences a mild to medium level of craving within the session, and copes (rides it out) successfully, he/she will feel more confident to try the same technique outside of the session.

Obviously, the craving will in most instances have to be artificially induced within the session, unless the client reports he/she is already craving. The technique used to induce craving is called cue exposure. Although it is being used artificially within the session, cue exposure occurs naturally in the client's everyday life. Clients are frequently exposed to high risk situations and consequently experience episodes of craving. Therefore, employing cue exposure within the session is not really any different to what happens when the client is not in the clinic. An important point about cue exposure is that cues that elicit craving vary enormously from person to person. It is therefore very important that clients be very actively involved in the selection of cues to which they

will be exposed in this session.

It is important to keep in mind that until the client has learned some coping techniques, it is wise for him/her not to be exposed artificially or in his/her natural environment to cues which may elicit strong or very strong craving. As discussed above, the client should be encouraged to avoid such cues where possible, until he/she has developed confidence in coping with strong craving.

Combined with homework practice (exposing him/herself to a graded hierarchy of cues), cue exposure aims to gradually desensitise the client to external and internal drug related cues. The hierarchy should consist of a list of cues from those which the client thinks would elicit no craving whatsoever (0) to those cues that he/she would find almost impossible to resist (100). With the counsellor's help, the client should draw up a hierarchy of drug related cues at estimated craving levels of 10, 30, 50, 70 and 90. This hierarchy should be copied (one copy for the client and one for the counsellor) as the hierarchy will be used during the following weeks.

During this session, clients should experience a craving level of about 30. The counsellor induces low to moderate craving by exposing the client to his/her suggested cue. There are two reasons why cue exposure might be effective. Firstly, drug related cues are thought to elicit conditioned craving and also conditioned withdrawal responses. These sorts of responses have been found to occur in both humans and animals. The technique may work by extinguishing such conditioned withdrawal symptoms and craving. Secondly, it may work by altering the client's expectations and beliefs about the experience of craving and withdrawal. The procedure may challenge the client's beliefs about craving by demonstrating that the feelings lessen over time, and that he/she can exercise control over them.

It is on this basis that cue exposure is employed in this program - teaching skills of relaxation and self-talk - to allow the client to experience a reduction in craving severity over time.

RATIONALE

Personal examples

"Have you ever wanted to share/inject so much that it seemed impossible to resist? Can you describe a situation like that?"

Discuss.

"Have you noticed when these feelings are worst? Can you list some of the situations which cause really bad craving?"

Discuss.

Triggered by cues

"It may seem like cravings are always caused by physical withdrawal symptoms and therefore arise from bodily sources that cannot be controlled. However, although physical withdrawal may cause some cravings when drug use is initially stopped, most cravings are triggered by external factors such as exposure to drug cues and involvement in high risk stress situations. Often the bad feelings that people get in high risk stress situations are misinterpreted as symptoms of physical withdrawal. What is really happening is that the person craves for the drug as a means of attempting to cope with stress".

Natural, not failure

"So, craving is actually brought on by drug cues in the environment or by unpleasant feelings. Some people think that craving is a sign of treatment failure or a sign of imminent relapse. Have you ever thought these things?

"Craving is not a sign of failure or weakness nor does it necessarily signal relapse. It is completely natural and should be expected. Cravings are a natural product of stopping sharing/injecting - if you have regularly shared/injected in certain places, situations, times or with certain people, for example, when you encounter these situations again, you will almost certainly experience cravings. These situations used to signal sharing/injecting so your thoughts and feelings almost automatically focus on sharing/injecting."

Signal for coping

"If these cravings are not strengthened by you sharing/injecting in that situation, the cravings will eventually fade away. So instead of seeing craving as a sign of failure and a signal for relapse, it can be seen as a signal for you to come up with an effective way

of coping. In other words, cravings can give you important feedback cues that something is `wrong' and needs attending to. Instead of trying to block out these stress signals by sharing/injecting, you can use the craving as a signal for positive coping - craving then becomes a signal for active coping instead of passive yielding."

Bearable

"You might have thought up till now that these feelings are unbearable but you can learn to bear them. If you stick it out, they will become much weaker or even go away in just a few minutes. So today we are going to practice this and look at coping with these unpleasant feelings".

Personal craving

"What is craving like for you?" List the client's symptoms in the client handout according to physical feelings or thoughts. Prompt the client to list at least a few physical and cognitive (mental) symptoms. Ask about ways of coping: "How do you think you could cope with these feelings without sharing/injecting?".

Discuss.

Physical

"To learn to cope with the feelings of craving, I'm going to try to get you to have mild craving here in this room. In the handout we listed two parts to your craving. One was the physical part - you mentioned ... (client's symptoms).

Relaxation

"To cope with these feelings you can learn to relax".

"The second part to the craving was the thinking part - you mentioned .....

Thinking

"To cope with the thinking part of the craving you can learn to think differently in situations where you get craving. This all takes practice, so it will be very helpful if you can try these things during the week and we can talk about how you get along with them each session".

Ride out craving

"People have found that the best way to deal with craving is to simply allow it to happen. Because it is a natural and automatic response for some time after stopping

sharing/injecting that cannot be suppressed, it is pointless to try to suppress it through the exercise of willpower. Because craving is automatic, it does not mean that sharing/injecting automatically follows craving. You can learn to experience craving without giving in to it. The best strategy is to simply notice the craving when it occurs, don't worry that its occurring, and just let it be. Remember that it is the experience of craving without sharing/injecting that will eventually lead to the absence of craving. So, in a way, craving is a positive thing to be experiencing - each time you ride one out, you are weakening the strength of craving itself and decreasing its occurrence in the long run".

Ocean wave

"Its helpful to imagine the craving as an ocean wave that grows in strength, peaks, and then subsides. There is no point trying to stop a wave - the best thing to do is to recognise it and let it be or ride it out. Also, behind each ocean wave, there is another, sooner or later. Waves are natural, to be expected. Its the same with craving; after one episode there will be another and another. The best strategy is to just let them be."

"When people first try to stop sharing/injecting, they sometimes experience a lot of craving. This is like a storm, with big waves at first. These big waves eventually subside until the ocean is calm again. Its the same with craving - you can ride out each wave and in time you will only experience little `ripples'."

CUE EXPOSURE

"In this session, mild craving should be experienced. If there was a scale from `0', `no craving', to `100', the most severe craving you've ever felt, mild craving would rank about `30'. You've already said today what situations seem worst for craving. What things might lead to mild craving?"

In vivo stimuli

Try to elicit drug-related stimuli from the client. If he/she does not mention it spontaneously, ask about the following stimuli:

- glossy paper
- lemon juice/squeeze
- neck tie
- spoon
- cotton wool
- cigarette filters
- foil
- pineapple juice
- half a coke can
- ascorbic acid

If the client rates one or more of these as able to elicit mild craving, these materials can

then be used in the session.

Clients with the goal of stopping sharing may find the stimuli able to elicit craving, but this craving will have to be paired with imaginal exposure to sharing.

If none of these stimuli are rated by the client as able to induce mild craving, or if they are rated as able to induce severe craving, imaginal exposure can be used instead.

Imaginal stimuli

Ask the client what recent situations have elicited mild craving. Have them describe the situation to you in detail and take notes that you can refer to during the exposure. Ask the client where they were, who they were with, when it was, what time of day, what drugs were around and so on to increase the realism of the situation and the likelihood of the client being able to experience some craving.

PROCEDURE

The procedure involves periods of relaxation and periods of exposure to the stimuli (either real or imagined).

The first period (lasting 5 minutes) involves relaxation. The second to fifth period lasts until the craving is less than 10. These periods involve exposure to a triggering stimuli (either in vivo or in the imagination) while the person relaxes and uses self-talk to reduce the craving. Finally the person relaxes again.
The following table outlines the periods of exposure and relaxation:

Period	Minutes	Content
1	0 - 5	Relaxation.
2	6 - 9	Looking at or imagining stimuli and relax and self-talk.
3	10 - 12	Repeat relaxation + self-talk if craving from period 2 remains > 10.
4	13 - 14	Handling stimuli or imagining stimuli and relax and self-talk.
5	15 -20	Repeat relaxation and self-talk if craving still > 10. Relaxation.

MEASURES

Two subjective measures are taken:

(i) desire for a hit (0 - 100)
(ii) difficulty resisting a hit if one was available (0 - 100)

A score of zero would represent no desire or difficulty while a score of 100 would be the greatest desire or difficulty. The measures are taken every few seconds after presentation in vivo or in imagination.

INSTRUCT CLIENT

"I'm going to measure your reactions to see how strong your craving is, and to make sure it does not become too strong. First of all, I'll ask you how strong is your desire for a hit (sharers only: and to share if you were offered someone elses's fit) right now?"

Client replies....

"Let's put a number on it. On a scale of 0 - 100, if `0' is no desire and `100' is the strongest desire you ever had, how strong would you say your desire for a hit (and to share) is right now?"

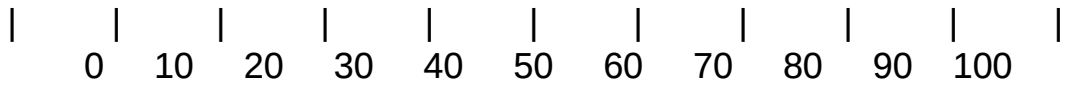
Place Card 1 on the table.

Client replies....

"Now I'm going to ask you how hard it would be to resist a (shared) hit right now if one was available? On a scale of 0 - 100, if `0' is no difficulty and `100' is as difficult as you ever found it, how difficult would it be to resist a (shared) hit right now if one was available?"

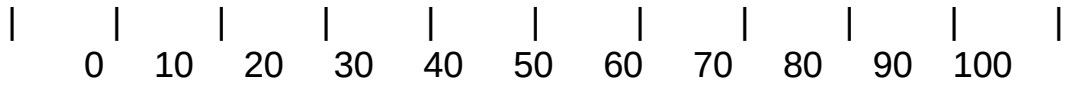
Client replies....

Card 1:
Desire for a hit.



No strong desire | Moderate desire | Very desire

Card 2:
Difficulty resisting a hit if one was available.



No difficulty | Moderate difficulty | Almost impossible

Place Card 2 on the table.

Client replies....

Practice until the client can give an instant answer on minimal prompting. For example:

T "Desire?"

C "20"

T "Difficulty?"

C "10"

Leave the cards on the table throughout the procedure.

"During some parts of the session you will be relaxed and should not speak, but if you find desire or difficulty reaches `30' or more, be sure to tell me".

RELAXATION

The method used here is brief and simple and is based on six steps:

(i) Body check - sitting in a relaxed pose;
(ii) Breathing control;
(iii) Arms;
(iv) Head and neck;
(v) Torso;
(vi) Legs.

You should speak slowly, giving the client time to settle into each routine.

Do not read these instructions to the client but become thoroughly familiar with them and use your own language.

The client should tense muscles for **10 seconds** and then the relaxation `patter' should follow for about a minute.

Have the client sit in a comfortable chair, with his/her head supported if possible. Then introduce the procedure as follows:

RATIONALE

"Before we see if you can experience mild craving today, I'm going to teach you a way of relaxing. This way of relaxing works by comparing relaxation with tension. Try making your fist tense. Clench your fist - tell me how it feels."

Client responds.

Tension

"Yes, its uncomfortable. Don't tense so tight so it hurts - just tense enough to feel the difference between tension and relaxation."

Relaxation

"Now let your fist relax. How does that feel? Looser? More relaxed? You might notice that the temperature of your hand changes - this is because your circulation improves when you relax. You might find that your hand feels heavy or light - this is because you are relaxing. I'd like you to concentrate on these feelings as we do the training today and I'll ask you later how you felt."

Demonstrate

Demonstrate the various muscle groups and tension production procedure for each group so that the client can more easily understand your instructions during the actual training. Instruct the client that it is OK to cough, scratch etc if they need to - the purpose is to learn how to relax, not to sit completely still!

Quiet

If possible, ask that no interruptions be made in the session e.g., phone calls.

Seating

Turn the client's chair so that you are not directly facing him/her.

Body check

"Let's start with a body check. Close your eyes. Starting with your feet, check your body to make sure you are as comfortable as possible. Feet and legs uncrossed, flat on the floor or resting on heels and turned out slightly , legs uncrossed, thighs slightly apart, buttocks and hips comfortable, weight evenly distributed, and back comfortable. Arms resting either side on your chair and hands uncurled, not absolutely straight, shoulders even and relaxed, head balanced, eyes closed."

"Keep your eyes closed. Now we've done a quick body check. This is something you can do anywhere - on the bus, in the pub, in front of the T.V. and so on."

Breathing

"Take one deep breath, deeper, hold it ..... now slowly breath out, taking your time. Allow the tension to drift away as you breath out. Concentrate on the difference between tension and relaxation. As you breath out, see if you can become even more relaxed."

Repeat this once more.

"Don't take any more deep breaths - just let it return to normal - easy breaths in and out."

"As you breathe out, think the word `relax' to yourself. If you find your thoughts wandering, just come back to the word `relax'."
Never ask the client to take more than three deep breaths as this may lead to hyperventilation, which may in turn lead to a panic attack.

Arms

"Now tense your arms - clench your fists and tighten your muscles .... hold it, concentrate on the tension. Now relax, feeling the difference in the muscles. Let the tension go, allowing the tension to drain away from your finger tips. Resting your arms comfortably, checking for any remaining tension and seeing if you can let it go. See if you can release even more tension as you breathe out and think the word relax."

Head and neck

"Now tense the muscles in your face and neck. Frowning, squinting, biting your jaw together. Point your chin downwards, preventing it from touching your chest. Now release the tension, letting it go. Allowing your forehead to become smooth. Let your jaw relax - your lips part slightly as your jaw loosens up, your tongue resting at the bottom of your mouth. Your neck resting comfortably. Thinking the word `relax' to yourself as you breathe out."

Torso

"Keeping your head and neck relaxed, now hunch up your shoulders, arch your back and tense your buttocks. Hold the tension and concentrate on it. And relax. Contrast the difference between tension and relaxation. As you relax, your shoulders will slope downwards, more and more. Allow the other muscles to loosen, and feel the chair

against you. See if you can find any remaining tension and concentrate on letting it go. Think the word `relax' to yourself each time you breathe out."

Legs

"Now I want you to tense your legs. Point your toes forward, tense your calves and thighs, tighten them, hold it, and relax. Feel the difference between tension and relaxation. As you relax, you might find your legs become warm and heavy. Concentrate on how your legs feel. Allow the full weight of your legs to rest on the chair and floor. Think the word `relax' as you breathe out."

Body check

"Now I want you to check that the muscles we have covered today are as relaxed as possible: your arms and hands relaxed, resting comfortably, you hands uncurled; your head and neck - smooth forehead, lips slightly parted, shoulders sloping downwards; your back, stomach and buttocks relaxing and loose; your legs resting against the chair and floor; and your breathing - even and relaxed. Now take a moment to concentrate on the feelings of relaxation."

EXPOSURE

The aim is to help the client cope with craving. If he or she is already experiencing craving, it is not necessary to induce it! Simply use the self-talk and relaxation procedures. Once the craving has been induced instruct the client in self-talk and relaxation procedures until subjective ratings have been reduced to below `10'. You may find that one exposure trial, either imagined or in vivo, is sufficient for the whole session. Do not introduce a new cue until the three minute exposure period is over, even if the craving is non-existent or reduced quickly.

IMAGINAL EXPOSURE

Once the client is relaxed, having completed the relaxation procedure, instruct him/her to keep his/her eyes closed and introduce the idea of self-talk as follows (using a drug related scene that the client had rated as capable of inducing mild craving):

"We'll now try to imagine a drug related scene. I want you to imagine yourself .... (continue with the client's own scene) .... (e.g., I want you to imagine yourself in a flat. It is a place you used to go to get heroin (or whatever drug the client usually shares/injects). You go in and see one of your drug using friends. One is preparing to hit up, you can see the open packet on the table and your friend is heating up the heroin on a spoon. Another friend is injecting him/herself with heroin. He has a

tourniquet on. The needle is in his/her arm - a good vein. You see him feel a rush of well-being and relief and you wish you could do it too. Sharers only: He offers you his fit). Remember to tell me when your desire reaches `30' and if it starts to rise above that."

Self talk

Any time the client alerts you that his/her desire has reached `30' or higher, stop the image and start the self talk.

"Now say to yourself: `When I relax the craving goes away. If I stick this out, I'll feel the urge going away. That's a great feeling, the feeling that the urge is going away. Now picture your friend - think of all the poison in the syringe, the dirt and the poison, and the AIDS virus. Imagine his/her cravings made stronger than ever. The next hit he/she shares with others will spread Hepatitis/AIDS virus. Each time he/she shares/hits up, his/her cravings are strengthened and he/she is more likely to share/inject again. Imagine yourself leaving the room, walking out of the building and breathing fresh, clean air. You keep walking away from the building, away from the area, into a green park, where you lie down and breathe in the clean air. You breathe evenly and think the word `relax' as you breathe out. You concentrate on your body. Do a body check - arms, head, neck, body and legs - all relaxed. I don't need a hit to relax, I can relax myself. You find the desire is going away. You can just relax and the craving subsides. As you breathe in and out, clean blood is going through your veins and you feel good. Feel how nice it is for the craving to go away and for the clean blood to go through your veins."

Repeat: "I don't need a hit to relax. I can cope with this if I relax. If I relax I will cope with this feeling. I don't need a hit to relax, I can relax without a hit."

Continue this patter for three minutes.

In vivo

Now have the client open his/her eyes and show the equipment at the other side of the table - tourniquet, cotton wool, cigarette filter, spoon, matches, lemon juice, half coke can, etc. Cover it over if desire for a hit reaches `30' or more, otherwise continue exposure for three minutes. If the client has not given a rating spontaneously, ask for `desire' and `difficulty' ratings every few seconds.

Give a coping `patter' when a rating of `30' has been made:

Self talk

"I don't need a hit, I can relax without a hit, I can cope because I'm relaxed. Feel how

nice it is for the craving to subside and for the clean blood to be flowing through your veins. Imagine yourself walking away from this building, breathing fresh air."

When the first three minute interval is over and craving has subsided or is at least no greater than `30', show the equipment on the table again, following the same procedure.

After three minutes, move on to asking the client to handle the equipment. Again, stop and cover over equipment when craving reaches `30' or more. Otherwise, continue for three minutes, having the client relax and using self-talk throughout.

Follow up with five minutes relaxation.

Difficulties

If the client becomes distressed at any stage, stop the exposure immediately and move on to relaxation. Do not attempt exposure again within the session, but discuss the client's reaction when he/she is calm again. Coping with craving outside of the session is the aim of this procedure, so exposure within the session, although probably extremely useful for some clients, may not be useful with all clients.

If the client alerts you to craving with a rating greater than `30', go straight to relaxation but continue with exposure when the rating becomes lower, in keeping with the routine described above.

Discuss any difficulties the client may have had with this exercise. Discuss the experience of craving and reinforce the client's ability to reduce craving by using relaxation and self-talk.

SET HOMEWORK

Ask the client to try these relaxation and self-talk techniques during the week and to record an attempt at least once per day. **The client should be encouraged to avoid situations which he/she thinks may elicit strong craving.** He/she should be encouraged to actively employ relaxation and self-talk in mild craving situations (up to a rating of `30') that he/she encounters in his/her everyday activities in the next week.

The client should also be encouraged to use these same procedures when he/she experiences urges to engage in unsafe sex. These should also be monitored in the client's diary.

OTHER ITEMS

Discuss any other items the client may have wanted placed on the agenda at the beginning of the session.

REVIEW OF SESSION

1. Summarise the session by reviewing:

   (i) the client's high risk sharing/injecting situations;
   (ii) the client's high risk situations for unprotected sex;
   (iii) the six problem solving steps and the client's progress in using these;
   (iv) coping with craving - that it is a natural phenomenon which can be controlled using relaxation and self-talk. These procedures can also be used to help cope with sexual urges.

2. Ask the client for his/her opinion of the session:

   E.g., "How did you find the session today?"

   Discuss the client's comments.

   Record the client's comments in his/her notes and in the suggestion file.

SET HOMEWORK

Reiterate the homework already set:

(i) Complete any exercises from last session if appropriate;

(ii) Keep a diary of high risk sharing/injecting situations;

(iii) Keep a diary of sexual activity;

(iv) Problem solve one sharing/injecting and one risky sex problem;

(v) In the diaries (ii) and (iii) above, at least one entry per day for sharing/injecting (and sex if appropriate) should record the results of attempts to cope with

craving.

QUESTIONS
Ask if the client has any remaining questions. Make an appointment with the client and write it down for him/her. Remind the client to bring the client handout each session, even if he/she has not written much in it.

. . . . .

MAJOR REFERENCES USED IN COMPILING THIS SESSION AND USEFUL READING

Marlatt, G. A., & George, W. H. (1984). Relapse prevention: introduction and overview of the model. British Journal of Addiction, 79, 261-273.

Marlatt, G. A., & Gordon, J. R. (1985). Relapse prevention: Maintenance strategies in the treatment of addictive behaviours. New York: Guilford Press. (chapter 2).

Moring, J. & Strang, J. (1989). Cue exposure as an assessment technique in the management of a heroin addict: case report. Drug and Alcohol Dependence, 24, 161-167.

Stallard, A. & Heather, N. (unpublished). A cognitive-behavioural approach to the prevention of relapse to injecting among IV drug users. Treatment Manual.

Session 4
MINI-DECISIONS and LIFESTYLE BALANCE

GOALS

(i) Reinforce awareness of high risk situations for sharing/injecting.

(ii) Reinforce awareness of high risk situations for unprotected sex.

(iii) Reinforce use of problem solving.

(iv) Reinforce coping with craving.

(v) Improve awareness of `mini-decisions' (apparently irrelevant decisions).

(vi) Improve lifestyle.

MATERIALS

(i) Notes from assessment sessions and sessions 1, 2 and 3 relevant to the client's high risk situations and behaviours for sharing/injecting and unsafe sex, problem solving, and coping with craving.

(ii) Writing pad and pens.

(iii) Client suggestion file.

SET AGENDA

Set an agenda with the client for this session. This should include:

(i) Summary and review of the previous session;

(ii) Review of the homework;

(iii) New material to be covered this session:

< making `mini-decisions';
< improving lifestyle;

(iv) Discussion of the session;

(v) Homework setting;

(vi) Questions;

(vii) Additional items the client should state now, at the beginning of the session, so that enough time is left to discuss them.

SUMMARY OF SESSION 3

Summarise the content of session 3 briefly. State the topics that were covered last time:

- high risk situations for sharing/injecting and unprotected sex;
- problem solving;
- coping with craving.

PART ONE:
MINI-DECISIONS (Marlatt & George, 1984; Marlatt & Gordon, 1985)

BACKGROUND

Most of this session will be spent reviewing homework as the client should have attempted various techniques in his/her everyday life. It is important that these attempts are given adequate attention and discussion in order for the client to feel the counsellor is genuinely interested in his/her progress and also because difficulties with these techniques are to be expected and need to be fully addressed.

It should be stressed to the client that difficulties with the techniques are normal and that you have left aside most of this session to discuss the homework because you expect you will have lots of difficulties to talk about.

If the client has forgotten his/her manual or has not completed the homework set last time, the session should be partly used to discuss barriers to homework completion. Examples from the past or anticipated situations can then be discussed.

The new material to be covered in this session regarding mini-decisions should be raised within the context of the homework.

Marlatt and George (1984) point out that cravings may not always operate at a conscious level, but may become masked by cognitive distortions. As such, cravings can still exert a potent influence by allowing for `seemingly irrelevant decisions (SIDS)': mini-decisions that inch the person closer to relapse. To counter this, the client needs to be trained to `see through' these self-deceptions by recognising their true meanings. Explicit self-talk can help in making mini-decisions seem more relevant. By acknowledging to oneself that certain mini-decisions (e.g., visiting places known for sharing/injecting), actually represent cravings, the client becomes able to use these experiences as early warning signals. An important objective in these techniques is to enable the individual to externalise cravings and to view them with detachment. Another way to achieve this detachment is to encourage the client to deliberately

label the craving as soon as he/she becomes conscious of it. Recall that cravings should be viewed as natural occurrences that happen in response to environmental and lifestyle forces rather than as signs of treatment failure and indicators of future relapse.

RATIONALE

" In today's session, we're going to spend most of the time talking about how the techniques you've been learning are going in practice. The more difficulties you have with these techniques, the better! It's true that you learn by your mistakes. So, the more you experience difficulty whilst still seeing me, the better prepared you will be later on, as we can iron them out in the sessions. Firstly let's look at your diary."

REVIEW OF HOMEWORK

(i) Diary of high risk sharing/injecting situations:

< read the diary through briefly out aloud

< return to specific entries and note the high risk situations.

Mini-decisions

< explain the notion of mini-decisions to the client:

"I wonder how you ended up in that situation?"

Client responds.

People usually find that they end up in high risk situations as a result of lots of little decisions. These decisions may seem trivial or irrelevant at the time, but combined with other decisions, they lead to high risk situations. For example, deciding to walk past a cafe that other users go to instead of avoiding it, may lead you into the cafe to join friends, the friends may ask you back to their place, you may not really want to go, but you find yourself soon afterwards in their lounge room, watching them hit up and they offer their fit to you".

Links

"Its like the first link in a chain. Individual links form the chain. Each mini-decision makes a link in the chain, until you find yourself in a high risk situation. The earlier you recognise these mini-decisions, the fewer high risk situations will you have to try to cope with".

Personal example

Select an example from the client's diary or ask him/her to select an example from the past if he/she has not filled in the diary. Trace the high risk situation

back to the mini-decisions that led to it. Reinforce the client for recognition of mini-decisions and any attempts made to lessen the likelihood of a risky sharing/injecting situation. Ask the client if, in hindsight, he/she could have recognised certain mini-decisions earlier and interpreted these as early warning signals.

Sharers: clean fits

The emphasis for sharers should be to always carry spare fits with them: one for themselves and one for someone else. Mini-decisions leading to not carrying fits should be discussed.

(ii) Diary of sexual activity

< read the diary through briefly to obtain an overall picture of that week's sexual activity.

< discuss and reinforce any safe sexual activity reported. Discuss whether this safe activity was enjoyable and whether the consequences of it (e.g., less worry about STDs and AIDS) are less anxiety provoking.

< note any high risk situations and as in the exercise above, trace back at least one of these to its mini-decisions. Reinforce recognition of these mini-decisions and discuss whether he/she could recognise them sooner in the future and act upon them as early warning signals.

Stimulus control

< discuss rearranging the environment to decrease the likelihood of risky sexual behaviour:

e.g., < avoid walking or driving past settings conducive to unprotected casual sexual behaviour or unprotected sex with a regular lover.

< drinking less or stopping other drug use which may have preceded risky sexual behaviour in the past.

< keeping condoms easily available if sexual activity might occur.

Delay

< discuss delay with the client: delaying acting on a mini-decision for a minute or two. This may give him/her time to decide to act differently.

Substitution

< discuss substitution with the client: perhaps lower risk sexual activities can be suggested to his/her partner(s): mutual masturbation, massage, nongenital sensual pleasuring.

Fantasy

< discuss the role of fantasy in high risk sexual behaviour - this may be one of the first `links in the chain' that could be broken. There is insufficient time in this programme to engage the client in fantasy retraining, but the client should be encouraged to fantasise about low risk erotic behaviour rather than about high risk behaviour.

Self talk

< self talk may be useful in deciding against early (and later mini-decisions). The client should be encouraged to generate and practice self-statements emphasising that safer practices could be developed (e.g.," I can change risky sex practices), that anxiety will be reduced by doing so ("I will feel much better tomorrow if I don't do anything risky tonight"), and that risk reduction change was praiseworthy ("I am pleased with myself that I didn't do anything risky this week).

(iii) Review problem solving of sharing/injecting situation

Review this using the client handout:

Did it work?

Yes - remember that for next time!

No - don't give up!

Did the action stage go wrong (step 5)? How could you improve it?

Can you choose another solution (step 4)?

Have you run out of solutions (step 3)? Can you think of any more?

Could you intervene any earlier in the chain?

(iv) Review problem solving of a risky sex problem

Follow the steps as above.

(v) Review attempts at coping with craving (sharing/injecting and unprotected sex)

Reiterate the main points covered last session about craving:

< craving is triggered by things in the environment and by moods and feelings.

- craving is natural, it doesn't mean you're a failure.
- you can bear it and ride it out like an ocean wave.
- relaxation and coping self-talk can help you to ride out the wave of craving.

Sharing/Injecting

What levels of craving did the client experience this week?

Was he/she able to avoid situations which may elicit severe craving? If not, what did he/she do? Emphasise that the client should not yet expect to find the coping techniques taught so far effective in situations which elicit strong craving. Emphasise that leaving the situation is a positive action to take and that craving does subside, even if it is strong.
Was he/she able to try the techniques taught last week in situations which elicited mild craving? If not, what barriers were there to attempting these techniques? Engage the client in problem solving, applying the six steps to the barriers the client can identify.

Reinforce any successful attempts at using relaxation and self-talk in situations where mild craving was experienced.

Risky sex

Was the client able to try the techniques to help avoid risky situations or to help suggest and use condoms?

Discuss.

PART TWO:
LIFESTYLE (Marlatt & George, 1984; Marlatt & Gordon, 1985)

BACKGROUND

In addition to specific intervention techniques designed to teach the individual to effectively anticipate and cope with potential relapse situations (sharing/injecting and unsafe sex), a more global lifestyle intervention is needed aimed at improving overall coping skills and promoting health and well-being (Marlatt and George, 1984). These authors suggest that pervasive stress factors may serve as antecedents to the occurrence of high risk situations. They have devised a number of treatment strategies to prevent or reduce the covert antecedents to relapse and promote mental and

physical well being.

A chronic sense of deprivation can result from an individual's perceived imbalance between shoulds (duties and obligations in life) and wants (indulgence in gratifying activities). As the sense of deprivation mounts, the desire to treat oneself to an immediately gratifying indulgence grows. For the client, sharing/injecting (or sometimes perhaps unsafe sex) has probably been thought of as a source of immediate gratification and a method for restoring balance to an unfairly lopsided equation. This desire for indulgence may translate into cravings and cognitive distortions that permit one to `unintentionally' head towards relapse.

Exercise 1: Should versus wants

Discuss the notion of a "should versus want" imbalance with the client. This should begin with a rationale similar to the following:

Rationale

"As well as risk factors, there are a few other important influences on people's sharing/injecting (and sexual behaviour). One of the most important of these is your general lifestyle. By `lifestyle' I mean the balance between the `shoulds' in your life, or the things you have to do, like cooking and cleaning, and the `wants' in your life, the indulgences like buying a new record or going to the beach. If there are too many shoulds

in your life, what do you think might happen? You'd be more likely to feel fed-up or depressed and what might happen then? You'd be more likely to share/inject. For some people, its the same with sex. They feel fed up and go with someone to feel better.

Remember we were talking about how stopping sharing/injecting is like going on a journey? Well, going without wants is like going on a long bushwalk without any rests. How would you feel then? Pretty tired and certainly not enjoying things. Its the same when you go without wants in your everyday life - you're more likely to feel bad. On a bushwalk you'd be likely to leave the trail and give up. In your real life, without wants, you'd be more likely to `unintentionally' share/inject (or have risky sex) because you feel you `deserve' to feel good because you feel `deprived'.

Ask the client if he/she thinks he/she has a good balance between shoulds and wants. What wants does he/she have regularly? These need not be expensive, they may simply be time alone in a bath, reading a book, listening to music,

catching a ferry ride, going for a swim etc.

Do not spend too much time discussing this. Explain to the client that many people are unaware of their should/want imbalance until they scrutinise it themselves.

SET HOMEWORK

Record in his/her diary a daily record of duties and obligations on one side and indulgences on the other.

OTHER ITEMS

Discuss any other items the client may have wanted placed on the agenda at the beginning of the session.

REVIEW OF THE SESSION

1. Summarise the session by reviewing:

   (i) the importance of mini-decisions in finding oneself in a high risk situation.

   (ii) the client's high risk situations for sharing/injecting and possible ways of avoiding these.

   (iii) the client's high risk situations for unprotected sex and possible ways of avoiding these.

   (iv) the six problem solving steps and the client's progress in using these.

   (v) coping with craving and the client's use of relaxation and self-talk.

   (vi) the importance of `wants' and the client's attempts to incorporate these

into his/her life.

2. Ask the client for his/her opinion of the session:

   E.g., "How did you find the session today?"

   Discuss the client's comments.

   Record the client's comments in his/her notes and in the suggestion file.

SET HOMEWORK

(i) Complete any exercises from last session if appropriate;

(ii) Keep a diary of high risk sharing/injecting situations;

(iii) Keep a diary of sexual activity;

(iv) Problem solve one sharing/injecting and one risky sex problem in the client handout;

(v) Choose one `want' each day and record it in the client handout;

(vi) In the diaries (ii) and (iii) above, at least one entry per day for sharing/injecting (and sex if appropriate) should record the results of attempts to cope with craving.

QUESTIONS

Ask if the client has any remaining questions.

Make an appointment with the client and write it down for him/her.

Remind the client to bring the client handout each session, even if he/she has not written much in it.

MAJOR REFERENCES USED IN COMPILING THIS SESSION AND USEFUL READING

Kelly, J. A., & St. Lawrence, J. S. (1989). The AIDS Health Crisis. New York: Plenum Press.

Kelly, J. A., St. Lawrence, J. S., Hood, H. V., & Brasfield, T.L. (1989). Behavioural intervention to reduce AIDS risk activities. Journal of Consulting and Clinical Psychology, 57, 60-67.

Marlatt, G. A., & George, W. H. (1984). Relapse prevention: introduction and overview of the model. British Journal of Addiction, 79, 261-273.

Marlatt, G. A., & Gordon, J. R. (1989). Relapse prevention: future directions. In M. Gossop (Ed.), Relapse and addictive behaviour (pp. 278-292). London: Tavistock/Routledge.

Quadland, M.C., & Shattls, W.D. (1987). AIDS, sexuality, and sexual control. Journal of Homosexuality, 14, 277-298.

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Session 5
COPING WITH A LAPSE

GOALS

(i) Reinforce awareness of high risk situations for sharing/injecting.

(ii) Reinforce awareness of high risk situations for unprotected sex.

(iii) Reinforce use of problem solving.

(iv) Reinforce lifestyle change.

(v) Reinforce coping with craving.

(vi) Reinforce awareness of mini-decisions.

(vii) Improve ability to cope with lapses and abstinence/rule violation effect.

MATERIALS

(i) Notes from assessment sessions and sessions 1-4 relevant to the client's high risk situations and behaviours for sharing/injecting and unprotected sex, problem solving, lifestyle, coping with craving, and mini-decisions.

(ii) Writing pad and pens.

(iii) Client suggestion file.

(iv) `Coping with a lapse' drill card.

SET AGENDA

Set an agenda with the client for this session. This should include:

(i) Summary and review of the previous session;

(ii) Review of the homework;

(iii) New material to be covered this session:

< coping with lapses;

(iv) Discussion of the session;

(v) Homework setting;

(vi) Questions;

(vii) Additional items the client should state now, at the beginning of the session, so that enough time is left to discuss them.

SUMMARY OF SESSION 4

Summarise the content of session 4 briefly. State the topics that were covered last time:

< high risk situations for sharing/injecting and unprotected sex;
< problem solving;

< lifestyle: the inclusion of wants in daily activity;
< coping with craving;
< the importance of mini-decisions.

REVIEW OF HOMEWORK

Approximately half the session should be spent discussing the homework and the latter half should be spent on the topic of coping with lapses.

(i) Diary of high risk sharing/injecting situations

< read the diary through briefly, aloud

< return to specific entries and note the high risk situations.

< discuss and reinforce the client for the recognition of mini-decisions and any attempts made to lessen the likelihood of a risky sharing/injecting situation.

(ii) Diary of sexual activity

< read the diary through briefly to obtain an overall picture of that week's sexual activity.

< discuss and reinforce any safe sexual activity reported. Discuss whether this safe activity was enjoyable and whether the consequences of it (e.g., less worry about STDs and AIDS) are less anxiety provoking.

< discuss and reinforce recognition of:

  < mini-decisions
  < stimulus control
  < delay
  < substitution
  < fantasy

< reinforce use of self-talk.

(iii) Review problem solving of sharing/injecting situation.

Review this using the client handout:

Did it work?
Yes - remember that for next time!

No - don't give up!

Did the action stage go wrong (stage 5)? How could you improve it?

Can you choose another solution (step 4)?

Have you run out of solutions (step 3)? Can you think of any more?

Could you intervene any earlier in the chain?

(iv) Review problem solving of a risky sex problem

Follow the steps as above.

(v) Review attempts at coping with craving - Sharing/Injecting or - Risky sex

What levels of craving did the client experience this week?

Was he/she able to avoid situations which may elicit severe craving? If not, what did he/she do? Emphasise that the client should not yet expect to find the coping techniques taught so far effective in situations which elicit strong craving. Emphasise that leaving the situation is a positive action to take and that craving does subside, even if it is strong.

Was he/she able to try the techniques taught last week and the week before in situations which elicited mild craving? If not, what barriers were there to attempting these techniques? Engage the client in problem solving applying the six steps to the barriers the client can identify.

Reinforce any successful attempts at using relaxation and self-talk in situations where mild craving was experienced.

Discuss the client's readiness to progress up the hierarchy and try using coping techniques (relaxation and self-talk) in slightly more difficult situations (with a rating of `40').

Was the client able to try the techniques to help avoid risky situations or to help suggest and use condoms?

Discuss.

(vi) Lifestyle

Was the client able to engage in a worthwhile indulgence every day?

Discuss successful attempts and reinforce the client's efforts. Help the client to challenge any guilty thoughts about taking time to indulge oneself. Encourage the inclusion of positive addictions.

Problem solve with the client any barriers to daily inclusion of wants.

Ask the client to choose one `want' each day and record it in the client handout.

SET HOMEWORK
(i) Complete any exercises from last session if appropriate;
(ii) Keep a diary of high risk sharing/injecting situations;
(iii) Keep a diary of sexual activity;
(iv) Problem solve one sharing/injecting and one risky sex problem in the client handout;
(v) Choose one `want' each day and record it in the client handout;
(vi) In the diaries (ii) and (iii) above, at least one entry per day for sharing/injecting (and sex if appropriate) should record the results of attempts to cope with craving.

COPING WITH LAPSES (Marlatt & George, 1985)

The aim of this section is to prevent a lapse or slip-up from escalating into a total relapse. Marlatt and Gordon (1985) point out that almost all journeys involve minor setbacks, frustrations and disappointments. The following material is adapted from Chapter 4 of their book. To return to the journey analogy, sooner or later most people

experience engine trouble or some form of car breakdown on the road. When this occurs, all movement forward grinds to a halt and one finds oneself stuck. Many people are tempted to give up at this point of the journey. Because of their unrealistic expectations of perfection - that the journey would proceed smoothly, without a hitch - they are often unprepared to cope with such setbacks; they don't expect problems and are unprepared when they arise. They often lack the knowledge of what to do and the skills that are needed to correct the problem.

Experiencing a lapse, however, can be an occasion for growth, understanding and learning. Of course a lapse is an indication of danger (of potential relapse), but it is also the opportunity for growth and the development of new coping skills. A breakdown on the road offers an opportunity to understand what went wrong and how to remedy the problem. Instead of saying, "I blew it - its all over," one can ask, "What went wrong? Did I take a wrong turn? What can I do to fix the problem? Is there a place to go for help, or is their someone who can assist me? Is there a manual and tool-kit handy - a map to help me get my bearings?" and so on. The individual can adopt an objective approach to the problem and engage in active attempts to find a solution instead of reacting subjectively to the lapse with a sense of failure and doom. The main focus of the rest of this session is on cognitive reframing or the restructuring of attributions associated with potential setbacks.

The first step in preparing a client for a lapse is to assess his/her attributions related to the abstinence (or rule) violation effect (AVE). The AVE (or RVE) refers to the personal commitment the individual has to an extended or indefinite period of not sharing/injecting. Although the focus in this exercise is on sharing/injecting, the same cognitive factors may contribute to relapse to unprotected sex. Discuss this briefly with the client at the end of the following exercise.

INTRODUCTION

Introduce the topic to the client, saying you would like to talk about a recent lapse of theirs. Firstly, ask the client about a relapse that occurred some time in the recent past, and discuss his/her causal attributions (self-talk leading up to sharing/injecting).

OR

If the client has difficulty with this exercise, present him/her with descriptions of high risk situations and ask him/her to describe the causes of a lapse that might occur in that situation.

Identify the cognitive errors (or thinking errors) that the client makes and point them out to the client, using the following list. When you have completed going through this list with given examples, go through the rest of the list with the client asking if they have

ever had similar thoughts:

COMMON COGNITIVE ERRORS

(i) Overgeneralising: this is probably the most common faulty assumption that leads to a single lapse developing into a relapse.

"If its true in one case, it applies to any case which is even slightly similar."

e.g., "I've shared/injected again.... now I'm back to square one."

(ii) Selective abstraction:

"The only events that matter are failures. I should measure myself by errors, weaknesses, etc."

e.g., "I've shared/injected now..... the treatment's a total failure."

(iii) Excessive responsibility:

"I am responsible for all bad things, failure and so on."

e.g., "I've stuffed it up now.... I've got no willpower.... I'm so weak."

... cont.d

(iv) Assuming temporal causality:

"If it has been true in the past, then its always going to be true."

e.g., "Once a junkie, always a junkie."

(v) Self-reference:

"I am the centre of everyone's attention - especially my bad performances. I am the cause of misfortunes."

e.g., "My family all know how weak I am."

COMMON COGNITIVE ERRORS

(vi) Catastrophising:

"Always think of the worst. Its most likely to happen to you."

e.g. "This is the first step to being on the streets."

(vii) Dichotomous thinking:

"Everything is either one extreme or another."

e.g., "I've relapsed .... I'll never get back to not sharing/injecting again."

(viii) Absolute willpower breakdown:

"Willpower is absolute - once willpower has failed, loss of control is inevitable."

e.g. "I've totally failed in the battle of temptation."

(ix) Body over mind:

"Once the deed is done and the drug is in my body, physiological addiction or disease processes take over that I am powerless to control."

e.g., "I've shared/injected again - I've got a lifelong overpowering physical addiction that can't be overcome."

RATIONALE

"What do you think would happen if you thought this way after a lapse?"

Client responds.

"You would be more likely to have a relapse - that is, continue sharing/using."

"To cope with lapses (slips) in the future, it will help you to think differently about them."

Explain the following strategies of reattribution to the client:

(i) Lapse = error not relapse

A lapse is similar to a mistake or error in the learning process. By defining habit change as a learning process, lapses can be reframed as mistakes or opportunities for corrective learning, instead of as an indication of total failure or irreversible relapse.

Just as the novice bike rider learns not to take curves too fast after taking a few spills, so the beginning ex-sharer/injector learns from a slip what to do next time (avoid walking past his/her dealer's place).

Slips are to be considered relatively normal experiences.

(ii) Lapse = one event

A lapse is a specific, unique event in time and space.

Encourage the client to view the lapse as a momentary episodic event, a single act that occurs in a specific time and space. Discourage the client from making generalisation errors, viewing the lapse as a sign or symptom of something "greater" - a sign of total loss of control.

(iii) Controllable factors

The lapse can be attributed to external, specific, and controllable factors.

Reattribution here calls for a careful examination of the lapse episode to evaluate the influence of such factors as:

- difficulty level of the high risk situation;
- adequacy of the coping response (if any);
- transitory loss of motivation (e.g., fatigue, excessive stress, unbalanced lifestyle, etc.);
- and the overall uniqueness of the situation.

The purpose of this reattribution is to isolate factors that are controllable: new coping responses can be learned, stress can be reduced, lifestyle habits can be changed.

(iv) Positive

A lapse can be turned into a positive learning experience instead of a relapse.

The eventual outcome of a lapse can be beneficial: the lapse can be

considered an opportunity to learn, rather than a relapse. For example, a lapse in response to relationship difficulties may signal the need for professional help that may eventually lead to an improvement in relationship satisfaction.

(v) Control exists

Abstinence or control is only a moment away.

Abstinence or control is a state that can be regained simply by not resuming sharing/injecting - a lapse does not mean that abstinence or control is forever lost.

As long as the individual is not currently engaging in the taboo behaviour (sharing/injecting) a state of abstinence exists.

In summary

The occurrence of a lapse should be taken seriously, as a time of both danger and opportunity.

COPING DRILL

Use the problem solving steps to generate a coping drill for future reference. The coping drill should then be summarised on a card so that it can be carried about by the client. The drill should include the following:

Card:
Coping with a lapse card.

1. Stop, look and listen (to what's happening).
2. Relax.
3. Self-talk: "A slip is a mistake, an opportunity to learn."
4. Leave the situation.
5. Renew your commitment.

6. Review the factors leading up to the slip.

7. Make an immediate plan for recovery.

8. Ask for help.

SEXUAL LAPSES

Briefly discuss with the client that the same coping drill can be used after doing risky sexual things.

REVIEW OF SESSION

1. Summarise the session by reviewing:

   (i) the client's high risk situations for sharing/injecting and possible ways of avoiding these.

   (ii) the client's high risk situations for unprotected sex and possible ways of avoiding these.

   (iii) the six problem solving steps and the client's progress in using these.

   (iv) coping with craving and the client's use of relaxation and self-talk.

   (v) the importance of `wants' and the client's attempts to incorporate these into his/her life.

   (vi) coping with lapses and use of the drill card.

2. Ask the client for his/her opinion of the session:

   e.g., "How did you find the session today?"

   Discuss the client's comments.

   Record the client's comments in his/her notes and in the suggestion file.

SET HOMEWORK

(i) - (vi) above.

(vii) Use the coping with lapses drill card.

QUESTIONS
Ask if the client has any remaining questions. Make an appointment with the client and write it down for him/her. Remind the client that will be the last. Remind the client to bring the client handout each session, even if he/she has not written much in it.

MAJOR REFERENCES USED IN COMPILING THIS SESSION AND USEFUL READING

Marlatt, G. A.. & Gordon, J.R. (1985). Relapse prevention: Maintenance strategies in the treatment of addictive behaviours. New York: Guilford Press. (chapter 4)

Stallard, A. & Heather, N. (unpublished). A cognitive-behavioural approach to the prevention of relapse to injecting among IV drug users. Treatment Manual.

Session 6
REVIEW

GOALS

1. Overview and summary of the program:

    (i) Reinforce awareness of high risk situations for sharing/injecting.

    (ii) Reinforce awareness of high risk situations for unsafe sex.

(iii) Reinforce use of problem solving.

(iv) Reinforce lifestyle change.

(v) Reinforce coping with craving.

(vi) Reinforce awareness of mini-decisions.

(vii) Reinforce ability to cope with lapses and abstinence/rule violation effect.

2. Encourage continued use of the above techniques.

3. Readminister appropriate assessment instruments.

MATERIALS

(i) Notes from assessment sessions and sessions 1-5 relevant to the client's high risk situations and behaviours for IDU and unprotected sex, problem solving, lifestyle, coping with craving, mini-decisions and coping with lapses.

(ii) Writing pad and pens.

(iii) Client suggestion file.

(iv) Assessment instruments.

SET AGENDA

Set an agenda with the client for this session. This should include:

(i) Summary and review of the previous sessions;

(ii) Review of the homework;

(iii) New material to be covered this session:

< continuing to employ the treatment techniques;

(iv) Discussion of this session and the overall treatment;

(v) Questions;

(vi) Additional items the client should state now, at the beginning of the session, so that enough time is left to discuss them;

(vii) Assessments.

SUMMARY OF SESSIONS

Summarise the content of previous sessions. State the topics that have been covered:

< high risk situations for sharing/injecting and unprotected sex;
< problem solving;
< lifestyle: the inclusion of wants in daily activity;
< coping with craving;
< the importance of mini-decisions;
< coping with lapses.

REVIEW OF SESSIONS AND HOMEWORK

Approximately half the session should be spent discussing the content of the previous sessions and the homework and the latter half should be spent on the posttreatment assessments.

(i) Diary of high risk sharing/injecting situations

< read the diary through briefly out aloud.

< return to specific entries and note the high risk situations.

< discuss and reinforce the client for the recognition of mini-decisions and any attempts made to lessen the likelihood of a risky sharing/injecting situation.

< discuss the future likelihood of risky sharing/injecting situations and using his/her new awareness of them to expect them and to avoid or escape from them (or carry two fits).

(ii) Diary of sexual activity.

< read the diary through briefly to obtain an overall picture of that week's sexual activity.

< discuss and reinforce any safe sexual activity reported. Discuss whether

this safe activity was enjoyable and whether the consequences of it (e.g., less worry about STDs and AIDS) are less anxiety provoking.

< discuss and reinforce recognition of:

< mini-decisions
< stimulus control
< delay
< substitution
< fantasy
< reinforce use of self-talk

< discuss the likelihood of future high risk sexual situations and to use his/her new awareness of them to avoid or escape from them. Always carrying condoms should be discussed as a way of reducing risk.

(iii) Review problem solving of sharing/injecting situation.

Review this using the client handout:

Did it work?

Yes - remember that for next time!

No - don't give up!

Did the action stage go wrong (stage 5)? How could you improve it?

Can you choose another solution (step 4)?

Have you run out of solutions (step 3)? Can you think of any more?

Could you intervene any earlier in the chain?

Encourage the client to continue using problem solving cognitively in everyday problem situations related to sharing/injecting. If he/she has much difficulty in solving a particular problem, encourage him/her to go through the six steps with paper and pencil, as in the handout and/or to discuss the problem with someone else.

(iv) Review problem solving of a risky sex problem.

Follow the steps as above.

(v) Review attempts at coping with craving

Sharing/Injecting

What levels of craving did the client experience this week?

Was he/she able to avoid situations which may elicit severe craving? If not, what did he/she do? Emphasise that the client should not yet expect to find the coping techniques taught so far, effective in situations which elicit strong craving. Emphasise that leaving the situation is a positive action to take and that craving does subside, even if it is strong.

Was he/she able to try the techniques taught last week and the week before in situations which elicited mild anxiety? If not, what barriers were there to attempting these techniques? Engage the client in problem solving applying the six steps to the barriers the client can identify.

Reinforce any successful attempts at using relaxation and self-talk in situations where mild craving was experienced.

Discuss the client's readiness to progress up the hierarchy and try using coping techniques (relaxation and self-talk) in slightly more difficult situations (with a rating of `40'-`50'). Discuss with the client his/her progression up the hierarchy in terms of very small steps and to repeat each step a number of times before moving on to a more difficult step. In the next six months to a year, the client should be encouraged not to try to test him/herself in situations that he/she predicts will elicit severe cravings.

Risky sex

Was the client able to try the techniques to help avoid risky situations or to help suggest and use condoms?

Discuss.

Discuss the avoidance of future high risk situations, the availability and use of condoms, and modification of fantasy if appropriate.

(vi) Lifestyle

Was the client able to engage in a worthwhile indulgence every day?

Discuss successful attempts and reinforce the client's efforts. Help the client to

challenge any guilty thoughts about taking time to indulge oneself.

Problem solve with the client any barriers to daily inclusion of wants.

Discuss the maintenance of lifestyle change. This may include a discussion of short term discomfort for long term gain. Encourage any plans that may help maintain the change, such as exercising regularly with a friend.

SET HOMEWORK

(i) Complete any exercises from last session if appropriate;

(ii) Encourage the client to re-read the handouts whenever he/she is finding it difficult using the techniques. If they do not experience any difficulties, ask them to read it through every few weeks anyway, to keep their skills up;

(iii) Encourage the client to carry his/her coping drill card at all times.

REVIEW OF PROGRESS AND TREATMENT

1. Summarise the client's progress:

   (i) is he/she injecting less frequently?
   (ii) sharing less?
   (iii) cleaning equipment more?
   (iv) using condoms more often?

2. Ask the client for his/her opinion about the overall treatment:

   e.g., "How have you found the sessions overall?"

   Discuss the client's comments.

   Record the client's comments in his/her notes and in the suggestion file.

QUESTIONS
Ask if the client has any remaining questions.

ASSESSMENT
Arrange posttreatment assessment.

FOLLOW-UP
Schedule a follow-up session.

APPENDIX A

RELAPSE PREVENTION CLIENT HANDOUTS:

INJECTING VERSION

APPENDIX B

RELAPSE PREVENTION CLIENT HANDOUT:

SHARING VERSION

APPENDIX C

Subject No. _____

Study No. _____

Centre No. _____

Date of Interview _____
Interviewer _____

Pre/Post/6m/12m _____

HIGHEST HIV RISK-TAKING BEHAVIOUR SCALE

INJECTING AND SEXUAL PRACTICES

These questions are about your heaviest use of drugs in the last six months. I emphasise again that any information that you give me is completely confidential.

DRUG USE

1a). In what month did you hit up the most often? _____

(If the last month is given as the answer, enter `last month' for 1a., score 1b.-6 as for the OTI and go to question 7a).

1b). How many times did you hit up (i.e. inject any drugs) in that month? (please circle)

Hasn't hit up.....0
Once a week or less.....1
More than once a week.....2
(but less than once a day)
Once a day.....3
2-3 times a day.....4
More than 3 times a day.....5

2b). How many times in that month did you use a needle after someone else had already used it? (please circle)

No times.....0
One time.....1
Two times.....2
3-5 times.....3
6-10 times.....4
More than 10 times.....5

3. How many different people used a needle before you in that month? (please circle)

None.....0
One person.....1
Two people.....2
3-5 people.....3
6-10 people.....4
More than 10 people.....5

3b). If ‚one person': was that person your regular sexual partner?

Yes 9 No 9

4. How many times in that month did someone use a needle after you used it? (please circle)

No times.....0
One time.....1
Two times.....2
3-5 times.....3
6-10 times.....4
More than 10 times.....5

5. How often, in that month, did you clean needles before re-using them ? (please circle)

Doesn't re-use.....0
Every time.....1
Often.....2
Sometimes.....3
Rarely.....4
Never.....5

6. Before using needles again, how often in that month did you use bleach to clean them? (please circle)

Doesn't re-use.....0
Every time.....1
Often.....2
Sometimes.....3
Rarely.....4
Never.....5

Drug use Sub-total .....

SEXUAL BEHAVIOUR

These questions are about your most frequent unprotected sex (i.e., having sex without using a condom) in the last six months.

7a). In what month did you have unprotected sex the most often? _____

(If the last month is given as the answer, enter `last month' for 7a., discontinue the questionnaire and score 7b. - 11 the same as the OTI).

If the client has not had sex (protected or unprotected) in the last 6-months, score `0' for 7a. and 7c., discontinue the questionnaire and score `0' for the remaining items.

If the client has had protected sex only in the last 6-months, enter `0' for 7a. and proceed with the questionnaire.

7b). In that month, did you have a sexual partner who was an injecting drug user at that time? (please circle)

No 0
Yes 1

(If YES, is this partner your regular sexual partner?

Yes 9 No 9

7c). How many people, including clients, did you have sex with in that month? (please circle)

None.....0
One.....1
Two 2
3-5 people.....3
6-10 people.....4
More than ten people 5

8. How often did you use condoms when having sex with your regular partner(s) in that month? (please circle)

No reg. partner/No penetrative sex.....0
Every time 1
Often.....2

Sometimes.....3
Rarely.....4
Never.....5

9. How often did you use condoms when you had sex with casual partners in that month? (please circle)

No cas. partners/No penetrative sex 0
Every time 1
Often 2
Sometimes 3
Rarely 4
Never 5

10. How often did you use condoms when you were paid for sex in that month? (please circle)

No paid sex/No penetrative sex 0
Every time 1
Often 2
Sometimes 3
Rarely 4
Never 5

11. How many times did you have anal sex in that month? (please circle)

No times 0
One time 1
Two times 2
3-5 times 3
6-10 times 4
More than 10 times 5

Sexual Behaviour Sub-total .....

Total Score .....
(Drug Use Sub-total + Sexual Behaviour Sub-total)

. . . . .