The Centre for Mental Health Studies is currently looking at the characteristics of people who use amphetamines. As part of this we are carrying out a research project looking at whether counselling can help users of amphetamines to reduce their use of the drug. To start with, we would like you to fill in some questionnaires and answer some questions about your lifestyle and use of amphetamines, and we will reimburse you for your time. We would like to repeat this process in one-month and 6 months time.

Interested participants will be randomly assigned to receive usual treatment, two sessions of counselling or four sessions of counselling at one-week intervals. The counselling aims to teach users how to cope with their desire to use amphetamines, to recognise and avoid high risk situations and how to plan alternative ways of coping with situations in which they normally use.

A member of our research staff will work with you throughout the study period, usually in a clinic setting but other locations, including your home may be possible. You will be asked to discuss your background, information on how to contact you over the next 6 months, previous and current alcohol and other drug use, amphetamine related problems, and previous alcohol/drug treatment experiences. Your consent will be sought for follow-up interviews and we will ask you to provide the name, address and telephone number of someone we can call if you move. Also, some participants will be asked to provide a urine sample at the 6-month follow-up assessment. This is for research purposes only, to show the amount of general agreement between self-report and an objective measure of amphetamine use.
Risks and Discomforts
Reducing amphetamine use can be associated with withdrawal discomfort and we will monitor this and advise you about how to cope with any discomfort.

Involvement in the study
By participating in this study you may help us to determine the usefulness of interventions for amphetamine use and you may reduce your consumption of amphetamines. You will also receive $20 reimbursement for attendance at pre-treatment, 4 weeks and 6 month follow-up interviews. Your treatment in this study will be free.

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or except as required by law. Only the person interviewing you and the person coordinating the study will have access to this information. The results of the study may be published or discussed, but no individual participating in the study will be identified in any way.

Termination of Involvement in the Study
Whether you take part in the study or not will not affect your relationship with the University of Newcastle or Hunter Area Health Service. If you decide to take part in this study, you can stop any time you like. Should you decide to discontinue your participation in the study at any time, you may do so by notifying a member of the research staff. If you do pull out of the study, it will not affect your future relationship with this University.

We cannot and do not promise that you will receive any benefits from this study.

If you have any questions at any time, Dr Amanda Baker (02 49246610) will be happy to answer them. You will be given a copy of this form to keep.

If you have any complaints about the manner in which this research is conducted you may contact the researchers in person or if an independent person is preferred, the University’s Human Research Ethics Officer, Research Branch, The Chancellery, University of Newcastle, Callaghan, NSW, 2308, telephone (02) 49216333 of the Professional Officer, HAREC, C/-HAHS, Locked bag No. 1, New Lambton, telephone (02) 49214950.

Dr Amanda Baker
Counselling for Amphetamine Users

CONSENT FORM

I, ____________________________________________________________,
agree to participate as a subject in the study described above;

I understand that this is a study of the effectiveness of counselling among regular users of amphetamines;

I understand that all the information that I give in this study is completely confidential and will not be passed on to any other person, except as required by law;

I acknowledge that I have read the above statement, which explains the nature and aims of the study, and the statement has been explained to my satisfaction. Before signing this document I have been given the opportunity to ask any questions relating to any emotional harm that I may suffer as a result of my participation and have received satisfactory answers. I am aware that I will not necessarily personally benefit from participation in this study. I understand that I can withdraw from this study at any time without notice and do not have to give my reasons for withdrawing and this will not affect wither my current or future treatment. I agree that research data gathered during the course of this study may be published providing that then name or identifying information is not used.

CONSENT BY PARTICIPANT
I hereby certify that I have read and understood all the information provided that I have been allowed to ask questions. I agree to take part in the counselling for amphetamine use study described in this consent form.

Date: ________________ Signature by Participant: ______________________________

CONSENT BY RESEARCHER
I hereby certify that I have disclosed the relevant information and risks that may be involved, in terms readily understood by the patient.

Date: ________________ Signature by Researcher: ______________________________
WE NEED YOUR HELP!

This check-up is part of a research project looking to help people regularly using amphetamines to reduce their use.

You can help by giving us information about your own personal lifestyle.

In return, you will be reimbursed for your time and receive personal feedback about the results of your check-up.

Individual follow-up will be available to those interested.

If you would like a free check-up, please phone Frances on 49246616 for an appointment.

WE HOPE TO HEAR FROM YOU SOON
Appendix B

STUDY 2

B.1 INFORMATION SHEET AND CONSENT FORM FOR STUDY 2

Centre for Mental Health Studies

Health Sketch

Information Sheet

The Centre for Mental Health Studies is currently looking at helping people who experience severe mental health problems and also use alcohol and/or drugs. As part of this we are carrying out a research project looking at whether a particular treatment that looks at mental health and alcohol/drug use at the same time is helpful. To start with, we would like you to fill in some questionnaires and answer some questions about your lifestyle, and we will reimburse you for your time. We would like to repeat this process 3 months, 6 months and 12 months. If you were an inpatient during the last 2 months and you completed the Repeatable Battery for the Assessment of Neuropsychological Status (RBANS), we would like you to give permission to access that information.

Interested participants will be randomly assigned to receive ten individual sessions of counselling, either in their home or in a clinic. The counselling covers the relationship between drinking/using and mental illness and aims to teach you to cope with your desire to drink/use, how to recognise and avoid high risk situations for drinking/using, and how to plan alternative ways of coping with those situations where you usually drink/use. We hope to learn whether this new treatment is able to assist people experiencing mental illness to reduce their drinking and/or using.

A member of our research staff will work with you throughout the study period. You will be asked to discuss your background, information on how to contact you over the next 12 months, previous and current alcohol and other drug use, alcohol/drug related problems, and previous alcohol/drug treatment experiences. Your consent will be sought for follow-up interviews and we will ask you to provide the name, address and telephone number of

LOCATION:
Officers Quarters Complex
James Fletcher Hospital
Newcomen Street, Newcastle
Phone: 02 4924 6610  Fax: 02 4924 6608

SCHOOL OF MEDICALPRACTICE & POPULATION HEALTH
Faculty of Health

Correspondence:
Dr Amanda Baker, Senior Clinical Psychologist/Senior Lecturer
Discipline of Psychiatry
E-mail: amanda.baker@newcastle.edu.au

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someone we can call if you move and who will be able to tell us how you are going with your alcohol/drug use.

**Risks and Discomforts**
In an effort to avoid an exacerbation of your symptoms of mental illness, we will monitor your mental health during the study. We would also like to inform your case manager and general practitioner of your participation in Health Sketch and the results of your initial assessment.

**Termination of involvement in the study**
By participating in this study you may help us to determine the usefulness of interventions for drinking/using above recommended levels among people with a mental illness and may help to reduce your consumption of these. You will also receive $20 reimbursement for attendance at pretreatment, posttreatment and 6 and 12 month follow-up interviews. Your treatment in this study will be free.

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or except as required by law. The person interviewing you, the person coordinating the study, a clinical psychology master’s student associated with this project and a research team at the Centre for Mental Health Studies will have access to this information. The results of the study may be published or discussed, but no individual participating in the study will be identified in any way. Parental consent will be necessary for participants under the age of 18.

Whether you take part in the study or not will not affect your relationship with the University of Newcastle or Hunter Area Health Service. If you decide to take part in this study, you can stop any time you like. Should you decide to discontinue your participation in the study at any time, you may do so by notifying a member of the research staff. If you do pull out of the study, it will not affect your future relationship with this University.

We cannot and do not promise that you will receive any benefits from this study.

If you have any questions at any time, Dr. Amanda Baker (0249246605) will be happy to answer them. You will be given a copy of this form to keep. If you have any complaints about the manner in which this research is conducted you may contact the researchers in person or if an independent person is preferred, the University’s Human Research Ethics Officer, Research Branch, The Chancellery, University of Newcastle, Callaghan, NSW, 2308, telephone (02) 49216333 of the Professional Officer, HAREC, C/-HAHS, Locked bag No. 1, New Lambton, telephone (02) 49214950.

Dr. Amanda Baker
CONSENT FORM

I, ____________________________________________, agree to participate as a subject in the Health Sketch study (counselling for alcohol and/or other drug problems among people with a major mental illness) described above;

I understand that this is a study of the effectiveness of counselling for alcohol and/or other drug use above recommended levels among people with a mental illness;

I understand that all the information that I give in this study is completely confidential and will not be passed on to any other person, except as required by law;

I acknowledge that I have read the above statement, which explains the nature and aims of the study, and the statement has been explained to my satisfaction. Before signing this document I have been given the opportunity to ask any questions relating to any emotional harm that I may suffer as a result of my participation and have received satisfactory answers. I am aware that I will not necessarily personally benefit from participation in this study. I understand that I can withdraw from this study at any time without notice and do not have to give my reasons for withdrawing and this will not affect wither my current or future treatment. I agree that research data gathered during the course of this study may be published providing that then name or identifying information is not used;

I understand that a clinical psychology master’s student will have access to the information I provide.

I understand that a research team at the Centre for Mental Health Studies will have access to the information I provide.

CONSENT BY PARTICIPANT
I hereby certify that I have read and understood all the information provided that I have been allowed to ask questions. I agree to take part in the counseling for drinking/smoking/using study described in this consent form.
Date: ________________________ Signature by Participant: _________________________

Date: ________________________ Signature by Parent: ____________________________

I hereby certify that I have disclosed the relevant information and risks that may be involved, in terms of readily understood by the patient.

Date: ________________________ Signature by Investigator: _________________________
WE NEED YOUR HELP!

The Health Sketch project is a research project for people who have a psychotic illness, and who also currently drink alcohol or use other sorts of drugs to help them cope.

You can help by giving us information about your own personal lifestyle.

In return, you will be reimbursed for your time and receive personal feedback about the results of your health sketch.

Individual follow-up will be available to those interested.

If you would like a free check-up, please phone Frances or Sandra on 49246616 for an appointment.

WE HOPE TO HEAR FROM YOU SOON
Appendix C

Study 3

C.1 Study 3 Data Analysis

C.1.1 Alcohol/Other Drug Use Outcomes

Changes in self-reported use of alcohol were an average of 2-3 standard drinks per day across the assessment occasions. This was with the exception of those in the comorbid depression group who were allocated to receive four sessions of psychological treatment for their amphetamine use, and whose mean level of alcohol use peaked at almost six drinks per day at the six-month follow-up assessment (see Table C.1).

Table C.1 Mean levels of alcohol use in the month prior to survey according to depression and intervention status for participants completing all follow-up assessments in a treatment trial for regular amphetamine users.

<table>
<thead>
<tr>
<th>Assessment Occasion</th>
<th>Initial Mean</th>
<th>Initial S.D.</th>
<th>5-week follow-up Mean</th>
<th>5-week follow-up S.D.</th>
<th>6-month follow-up Mean</th>
<th>6-month follow-up S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comorbid Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>2.02</td>
<td>4.26</td>
<td>0.39</td>
<td>0.72</td>
<td>0.75</td>
<td>1.86</td>
</tr>
<tr>
<td>2-session Intervention</td>
<td>0.56</td>
<td>1.04</td>
<td>1.15</td>
<td>3.20</td>
<td>1.10</td>
<td>1.48</td>
</tr>
<tr>
<td>4-session Intervention</td>
<td>3.86</td>
<td>6.10</td>
<td>3.69</td>
<td>9.15</td>
<td>5.70</td>
<td>12.89</td>
</tr>
<tr>
<td>No Comorbid Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>1.18</td>
<td>1.66</td>
<td>1.81</td>
<td>2.80</td>
<td>1.06</td>
<td>1.30</td>
</tr>
<tr>
<td>2-session Intervention</td>
<td>1.44</td>
<td>3.60</td>
<td>1.51</td>
<td>2.77</td>
<td>2.46</td>
<td>4.68</td>
</tr>
<tr>
<td>4-session Intervention</td>
<td>4.80</td>
<td>5.94</td>
<td>6.44</td>
<td>8.57</td>
<td>1.34</td>
<td>1.61</td>
</tr>
</tbody>
</table>

The pattern of alcohol use at each assessment timepoint, as indicated in Table C.1 above, did not vary according to intervention status ($F(4,64)=0.160$, $p=0.958$), initial depression status ($F(2,64)=0.114$, $p=0.892$) or over time ($F(2,64)=0.191$, $p=0.826$). In addition, the interaction between these variables was not statistically significant ($F(4,64)=0.522$, $p=0.720$).
Levels of cannabis use across the follow-up assessments did not vary according to time (\(F(2,64)=0.346, p=0.708\)), treatment allocation (\(F(4,64)=0.374, p=0.827\)) or initial depression status (\(F(2,64)=1.503, p=0.226\)), nor was the interaction between these factors statistically significant (\(F(4,64)=0.235, p=0.918\)). Table C.2 displays the mean cannabis use scores for participants across each assessment according to initial depression status.

### Table C.2
Mean cannabis use as a function of depression and intervention status for participants completing all follow-up assessments in a treatment trial for regular amphetamine users.

<table>
<thead>
<tr>
<th></th>
<th>Assessment Occasion</th>
<th>Initial</th>
<th>5-week follow-up</th>
<th>6-month follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
</tr>
<tr>
<td><strong>Comorbid Depression</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td></td>
<td>9.06</td>
<td>10.64</td>
<td>14.42</td>
</tr>
<tr>
<td>2-session Intervention</td>
<td></td>
<td>3.91</td>
<td>4.11</td>
<td>3.22</td>
</tr>
<tr>
<td>4-session Intervention</td>
<td></td>
<td>1.16</td>
<td>1.82</td>
<td>2.44</td>
</tr>
<tr>
<td><strong>No Comorbid Depression</strong></td>
<td></td>
<td>1.54</td>
<td>3.34</td>
<td>0.83</td>
</tr>
<tr>
<td>Control</td>
<td></td>
<td>3.68</td>
<td>6.80</td>
<td>4.34</td>
</tr>
<tr>
<td>2-session Intervention</td>
<td></td>
<td>8.75</td>
<td>8.84</td>
<td>9.65</td>
</tr>
</tbody>
</table>

Figure C.1 displays the rates at which the sample met a threshold warranting intervention for alcohol and cannabis at the five-week and six-month follow-up assessments. This threshold was different for alcohol and cannabis. People exceeding the recommended guidelines for safe alcohol consumption or those smoking cannabis in excess of once weekly were regarded as above a threshold for treatment for these behaviours.
As indicated in Figure C.1, a higher proportion of people without comorbid depression were consuming alcohol at the five-week follow-up at a level above recommended safe drinking guidelines (30% versus 17%), however this difference was not significant ($\chi^2_{1}=0.746$, $p=0.388$). This tendency was reversed for alcohol use at the six-month follow-up assessment, however again the difference between groups was not significant (25% versus 20%, $\chi^2_{1}=0.019$, $p=0.890$). Rates of cannabis use above a once-weekly threshold were identical for people with and without depression at both the five-week and six-month follow-up assessments.)
Tobacco use was also examined across follow-up assessment points for participants with and without depression and according to treatment allocation. The results of this analysis are displayed in Table C.3.

Table C.3  Mean use of tobacco at follow-up assessment according to depression and intervention status for participants completing all follow-up assessments in a treatment trial for regular amphetamine users.

<table>
<thead>
<tr>
<th>Assessment Occasion</th>
<th>Initial</th>
<th>5-week follow-up</th>
<th>6-month follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
</tr>
<tr>
<td>*<em>Comorbid Depression</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>13.93</td>
<td>9.99</td>
<td>16.46</td>
</tr>
<tr>
<td>2-session Intervention</td>
<td>19.94</td>
<td>14.50</td>
<td>18.28</td>
</tr>
<tr>
<td>4-session Intervention</td>
<td>20.19</td>
<td>8.54</td>
<td>16.43</td>
</tr>
<tr>
<td>*<em>No Comorbid Depression</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>10.58</td>
<td>8.06</td>
<td>7.67</td>
</tr>
<tr>
<td>2-session Intervention</td>
<td>17.03</td>
<td>11.69</td>
<td>14.80</td>
</tr>
<tr>
<td>4-session Intervention</td>
<td>6.25</td>
<td>8.84</td>
<td>25.00</td>
</tr>
</tbody>
</table>

* A score of 1 indicates 1 cigarette was smoked each day in the month prior to survey. A score of 2 indicates 2 cigarettes smoked daily, etc.

Tobacco use remained relatively stable across follow-up occasions, with the exception of those in the four-session intervention without comorbid depression. Table 4.7 displays the mean and standard deviation values for tobacco use across time and according to depression and intervention status. Generally, people with comorbid depression reported higher levels of tobacco use at each follow-up assessment relative to their non-depressed counterparts.

Repeated measures ANOVA revealed no significant relationships between changes in tobacco use and time ($F(2,64)=1.853$, $p=0.161$), depression status ($F(2,64)=1.889$, $p=0.155$) and intervention status ($F(4,64)=1.954$, $p=0.106$). However, the interaction between time, depression status, intervention status and changes in tobacco use was statistically significant.
(F(4,64)=3.403, p=0.011), although Scheffè follow-up tests did not identify particular associations between these factors that were significant at p=0.01.

C.1.2 Mental Health Outcomes

Table C.4 displays the mean global severity scores and standard deviations for participants with and without comorbid depression, across each follow-up assessment timepoint.

Table C.4 Mean global severity subscale scores (BSI, Derogatis & Melisaratos, 1983) across each assessment timepoint according to depression and intervention status for participants completing all follow-up assessments in a treatment trial for regular amphetamine users.

<table>
<thead>
<tr>
<th>Assessment Occasion</th>
<th>Initial Mean</th>
<th>Initial S.D.</th>
<th>5-week follow-up Mean</th>
<th>5-week S.D.</th>
<th>6-month follow-up Mean</th>
<th>6-month S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comorbid Depression</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>1.86</td>
<td>0.82</td>
<td>1.81</td>
<td>1.04</td>
<td>1.43</td>
<td>0.92</td>
</tr>
<tr>
<td>2-session Intervention</td>
<td>1.61</td>
<td>0.67</td>
<td>1.43</td>
<td>0.76</td>
<td>1.27</td>
<td>0.58</td>
</tr>
<tr>
<td>4-session Intervention</td>
<td>1.76</td>
<td>0.76</td>
<td>1.20</td>
<td>0.80</td>
<td>1.11</td>
<td>0.83</td>
</tr>
<tr>
<td><strong>No Comorbid Depression</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>0.64</td>
<td>0.33</td>
<td>0.76</td>
<td>0.36</td>
<td>0.41</td>
<td>0.40</td>
</tr>
<tr>
<td>2-session Intervention</td>
<td>0.73</td>
<td>0.32</td>
<td>0.62</td>
<td>0.44</td>
<td>0.76</td>
<td>0.58</td>
</tr>
<tr>
<td>4-session Intervention</td>
<td>0.58</td>
<td>0.33</td>
<td>0.50</td>
<td>0.23</td>
<td>0.35</td>
<td>0.23</td>
</tr>
</tbody>
</table>

Global severity indices decreased over time for people in the comorbid depression group, irrespective of treatment allocation. At six-month follow-up, those in the comorbidly depressed group who had received four-sessions of therapy also reported reduced scores on the global severity index relative to the other treatment groups. However, repeated measures ANOVA revealed no significant differences in these global outcomes across the main effect of time (F(2,63)=3.293, p=0.040), nor for the time by intervention status (F(4,63)=0.861, p=0.489) or time by initial depression status (F(2,63)=1.110, p=0.333) interactions. In
addition, the interaction between time, depression status and intervention status was not statistically significant \((F(4,63)=0.252, p=0.908)\).

### C.1.3 Other Outcomes

Table C.5 displays the mean quality of life scores for participants across each assessment timepoint, as a function of their initial depression status and treatment allocation. Increasing scores on each subscale indicate increasing satisfaction with that particular quality of life experience.

People with comorbid depression reported consistently lower levels of satisfaction with their physical health, social relationships, psychological health and environment at each assessment timepoint relative to their non-depressed counterparts. However, these differences were not statistically significant. Repeated measures ANOVA revealed that changes in physical health scores for participants were not related to the interaction between time and intervention status \((F(4,63)=1.540, p=0.195)\) or time and initial depression status \((F(2,63)=0.261, p=0.770)\). In addition, the interaction between depression status, intervention status, time and physical health scores was not statistically significant \((F(4,63)=0.514, p=0.726)\). A trend emerged for changes in physical health scores over time \((F(2,63)=4.357, p=0.015)\), however this was not statistically significant.
Table C.5  Mean quality of life subscale scores across each assessment timepoint according to depression and intervention status for participants completing all follow-up assessments in a treatment trial for regular amphetamine users.

<table>
<thead>
<tr>
<th>Assessment Occasion</th>
<th>Initial</th>
<th>5-week follow-up</th>
<th>6-month follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
</tr>
<tr>
<td>Comorbid Depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>53.57</td>
<td>16.50</td>
<td>49.73</td>
</tr>
<tr>
<td>2-session intervention</td>
<td>46.03</td>
<td>14.54</td>
<td>50.99</td>
</tr>
<tr>
<td>4-session intervention</td>
<td>39.50</td>
<td>18.96</td>
<td>55.25</td>
</tr>
<tr>
<td>No Comorbid Depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>67.26</td>
<td>12.66</td>
<td>63.10</td>
</tr>
<tr>
<td>2-session intervention</td>
<td>63.81</td>
<td>19.23</td>
<td>66.67</td>
</tr>
<tr>
<td>4-session intervention</td>
<td>57.14</td>
<td>10.10</td>
<td>69.64</td>
</tr>
<tr>
<td>Comorbid Depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>45.51</td>
<td>26.27</td>
<td>42.31</td>
</tr>
<tr>
<td>2-session intervention</td>
<td>36.11</td>
<td>27.12</td>
<td>44.41</td>
</tr>
<tr>
<td>4-session intervention</td>
<td>24.51</td>
<td>22.34</td>
<td>48.53</td>
</tr>
<tr>
<td>No Comorbid Depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>62.50</td>
<td>26.22</td>
<td>61.11</td>
</tr>
<tr>
<td>2-session intervention</td>
<td>63.89</td>
<td>27.03</td>
<td>62.22</td>
</tr>
<tr>
<td>4-session intervention</td>
<td>58.33</td>
<td>23.57</td>
<td>58.33</td>
</tr>
<tr>
<td>Comorbid Depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>39.42</td>
<td>17.73</td>
<td>40.06</td>
</tr>
<tr>
<td>2-session intervention</td>
<td>36.34</td>
<td>16.16</td>
<td>47.45</td>
</tr>
<tr>
<td>4-session intervention</td>
<td>30.39</td>
<td>17.29</td>
<td>48.28</td>
</tr>
<tr>
<td>No Comorbid Depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>60.42</td>
<td>13.63</td>
<td>61.81</td>
</tr>
<tr>
<td>2-session intervention</td>
<td>70.28</td>
<td>20.40</td>
<td>65.56</td>
</tr>
<tr>
<td>4-session intervention</td>
<td>60.42</td>
<td>14.73</td>
<td>68.75</td>
</tr>
<tr>
<td>Comorbid Depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>48.08</td>
<td>25.88</td>
<td>50.48</td>
</tr>
<tr>
<td>2-session intervention</td>
<td>52.26</td>
<td>18.65</td>
<td>55.38</td>
</tr>
<tr>
<td>4-session intervention</td>
<td>48.71</td>
<td>13.71</td>
<td>62.50</td>
</tr>
<tr>
<td>No Comorbid Depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>63.54</td>
<td>22.24</td>
<td>63.02</td>
</tr>
<tr>
<td>2-session intervention</td>
<td>71.25</td>
<td>16.54</td>
<td>58.96</td>
</tr>
<tr>
<td>4-session intervention</td>
<td>62.50</td>
<td>13.26</td>
<td>65.63</td>
</tr>
</tbody>
</table>

Similar patterns were observed for the dimension of social relationships, with repeated measures ANOVA revealing no significant main effect of time ($F(2,63)=0.710$, $p=0.494$),
time by intervention status ($F(4,63)=0.428, p=0.789$) or time by depression status
($F(2,63)=0.874, p=0.420$) or the interaction between these factors and scores on the social
relationships subscale ($F(4,63)=1.333, p=0.261$). Participant ratings of their quality of their
environment across assessment timepoints was not statistically significant ($F(2,63)=0.398,$
$p=0.672$), nor was the effect of time by intervention status ($F(4,63)=1.047, p=0.386$) or time
by depression status ($F(2,63)=2.443, p=0.091$) on these scores. In addition, the interaction
between these factors and environmental health ratings provided by participants was not
significant ($F(4,63)=1.074, p=0.372$).

A non-significant trend emerged for a main effect of time on psychological health subscale
scores ($F(2,63)=3.958, p=0.022$), perhaps indicating a tendency for satisfaction with this
aspect of life to increase over the assessment timepoints. However, Scheffé follow-up tests
failed to reach significance. In addition, psychological health scores did not change as a
function of time by intervention status ($F(4,63)=0.957, p=0.434$), or time by depression
status ($F(2,63)=1.172, p=0.313$), nor was the interaction between depression status,
intervention status or assessment timepoint and psychological health subscale scores
significant ($F(4,63)=0.508, p=0.730$).

Table C.6 displays the mean risk taking behaviours reported by participants at each
assessment timepoint, according to their treatment allocation and initial depression status.
Table C.6  Mean risk taking behaviour index as reported by participants completing all follow-up assessments in a treatment trial for regular amphetamine users, according to treatment allocation and initial depression status.

<table>
<thead>
<tr>
<th>Assessment Occasion</th>
<th>Initial</th>
<th>5-week follow-up</th>
<th>6-month follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
</tr>
<tr>
<td>Comorbid Depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>11.36</td>
<td>6.51</td>
<td>9.64</td>
</tr>
<tr>
<td>2-session Intervention</td>
<td>8.56</td>
<td>7.64</td>
<td>7.17</td>
</tr>
<tr>
<td>4-session Intervention</td>
<td>10.88</td>
<td>5.84</td>
<td>8.18</td>
</tr>
<tr>
<td>No Comorbid Depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>11.00</td>
<td>4.00</td>
<td>8.33</td>
</tr>
<tr>
<td>2-session Intervention</td>
<td>8.07</td>
<td>7.59</td>
<td>8.40</td>
</tr>
<tr>
<td>4-session Intervention</td>
<td>4.50</td>
<td>3.53</td>
<td>6.50</td>
</tr>
</tbody>
</table>

Risk taking behaviours were relatively similar across intervention status and comorbid depression status at the initial assessment. Repeated measures ANOVA confirmed this, with no significant differences found for the main effect of time and risk taking behaviours ($F(2,64)=1.743$, $p=0.179$), nor for time by intervention status ($F(4,64)=0.263$, $p=0.901$) and time by depression status ($F(2,64)=0.092$, $p=0.912$). In addition, the interaction between time, intervention status, depression status and risk taking behaviours was not statistically significant ($F(4,64)=0.229$, $p=0.921$).

An index of criminal activity was also calculated from the OTI questions (Darke, Ward, Hall, Heather, & Wodak, 1991). Mean criminal activity in the month prior to assessment according to depression status and treatment allocation is displayed in Table C.7.
As indicated in Table C.7, there was a tendency for people with comorbid depression to report higher frequencies of criminal activity than their counterparts without depression, with the exception of people in the two-session intervention group. In general, the frequency of self-reported involvement in criminal behaviours reduced from the initial to follow-up assessments, however repeated measures ANOVAs indicated there was no significant effect of time on criminal activity (F(2,64)=1.999, p=0.140). In addition, the time by intervention status interaction was not significant for criminal activity (F(4,64)=0.142, p=0.996), nor was time by depression status (F(2,64)=1.222, p=0.298). The interaction between time, intervention and depression was also not statistically significant (F(4,64)=0.104, p=0.981).
Appendix D

STUDY 4

D.1 STUDY 4 DATA ANALYSIS

D.1.1 Alcohol/Other Drug Use Outcomes

The percentage of people reporting abstinence from alcohol at each follow-up assessment is displayed in Figure D.1 below.

Figure D.1 Rates of abstinence from alcohol, according to treatment allocation and depression status, among people with a psychotic disorder, participating in a study of treatment for problematic alcohol/other drug use who completed all phases of assessment (n=78).
Continuity-corrected chi-squared analysis indicated that, at the three-month follow-up assessment, rates of abstinence among the treatment group did not significantly differ according to depression status ($\chi^2 = 0.013$, $p = 0.568$). Similar results were found for the six-month (continuity-corrected $\chi^2 = 0.000$, $p = 1.000$) and 12-month follow-up assessments (continuity-corrected $\chi^2 = 0.000$, $p = 1.000$), with no differences in the rates of abstinence reported by people with and without comorbid depression within the treatment group.

Within the control group participants at the three-month follow-up, a non-significant trend did emerge, indicating an increased likelihood of abstinence among the control group for people without comorbid depression, relative to those with depression allocated to this condition (continuity-corrected $\chi^2 = 5.374$, $p = 0.020$). This trend had disappeared by the six-month follow-up (continuity-corrected $\chi^2 = 0.106$, $p = 0.745$) and was not detected at the 12-month follow-up assessment (continuity-corrected $\chi^2 = 1.41$, $p = 0.285$).

In the six months between the initial and six-month follow-up assessments, one person (7%) met SCID diagnostic criteria for alcohol abuse, while a further seven people (48%) met criteria for alcohol dependence. Among people without comorbid depression over the same period of time, two people (9%) met criteria for alcohol abuse, and seven people (32%) met SCID diagnostic criteria for alcohol dependence. Pearson chi-squared analysis revealed that the rates of abuse and dependence on alcohol over this time period did not differ according to the presence of depression ($\chi^2 = 2.684$, $p = 0.443$).

Two people with comorbid depression (13%) met criteria for alcohol abuse, and a further six (40%) met criteria for alcohol dependence according to the SCID. Rates of abuse among
people without depression for the same six-month period were 18% (n=4) for alcohol abuse, and 27% (n=6) for alcohol dependence. Pearson chi-squared analysis indicated that these rates were not significantly different over this time period for people with and without comorbid depression ($\chi^2_{3}=0.843$, $p=0.839$).

To examine changes readiness to change for alcohol use, an aggregate score of was calculated, with increasing scores indicating increasing propensities towards the action stage of change. Figure D.2 displays the readiness to change aggregate scores for people with and without depression across the assessment occasions, according to treatment allocation.

Figure D.2 Variations in readiness to change alcohol use, according to treatment allocation and depression status, among people with a psychotic disorder. Data presented for people who met criteria for harmful use of alcohol at the initial assessment and completed all phases of assessment (n=37).
Repeated measures ANOVA indicated that readiness to change aggregate scores did not significantly change over time ($F(3,29)=1.958, p=0.126$), or according to treatment allocation ($F(3,29)=0.594, p=0.620$) or depression status ($F(3,29)=1.318, p=0.274$) across the follow-up period. In addition, the interaction between time, depression status, treatment allocation and readiness to change scores was also not significant ($F(3,29)=2.567, p=0.060$).

In addition to aggregate stage of change score for alcohol use, readiness to change was also examined as a categorical variable. Table D.1 displays the frequency with which people meeting criteria for hazardous use of alcohol at the initial assessment report being in the pre-contemplation, contemplation and action stages of change throughout the follow-up period.

<table>
<thead>
<tr>
<th>Follow-up Assessment Occasion</th>
<th>3-months</th>
<th>6-months</th>
<th>12-months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Comorbid Depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Precontemplation</td>
<td>4</td>
<td>28.6</td>
<td>5</td>
</tr>
<tr>
<td>Contemplation</td>
<td>5</td>
<td>35.7</td>
<td>3</td>
</tr>
<tr>
<td>Action</td>
<td>5</td>
<td>35.7</td>
<td>5</td>
</tr>
<tr>
<td>No Comorbid Depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Precontemplation</td>
<td>10</td>
<td>45.5</td>
<td>11</td>
</tr>
<tr>
<td>Contemplation</td>
<td>6</td>
<td>27.3</td>
<td>3</td>
</tr>
<tr>
<td>Action</td>
<td>6</td>
<td>27.3</td>
<td>8</td>
</tr>
</tbody>
</table>

At the three-month follow-up assessment, people with comorbid depression were reasonably evenly distributed across the stage of change categories. Many people without comorbid
depression reported being in the pre-contemplation stage of change at the three-month assessment, with just over one-quarter of this sub-group indicating a contemplation or action stage of change. Pearson chi-squared analysis indicated that those with and without comorbid depression were not statistically significantly different ($\chi^2 = 1.026$, $p = 0.599$).

At the six-month follow-up, the majority of people with depression were in either the pre-contemplation or action stage of change for their alcohol use. This pattern was similar to that reported by those without comorbid depression, as indicated in Table D.2. Pearson chi-squared analysis indicated that no significant differences existed in stage of change for alcohol use, according to comorbid depression status ($\chi^2 = 0.672$, $p = 0.714$).

Almost 60% of the people with comorbid depression reported being in the contemplation stage of change for their alcohol use by the 12-month follow-up assessment. This was in contrast to those without depression, 50% of whom were still in the pre-contemplation stage of change for alcohol use, and around one-third reported being in the action stage of change. Pearson chi-squared analysis indicated that these differences were not statistically significant ($\chi^2 = 5.721$, $p = 0.057$).

### D.1.1.2 Cannabis Use Outcomes

As for alcohol, rates of self-reported abstinence from cannabis among the sample as a whole were calculated at each follow-up assessment timepoint. These rates are displayed as percentages in Figure D.3.
Figure D.3  Rates of abstinence from cannabis, according to treatment allocation and depression status, among people with a psychotic disorder, participating in a study of treatment for problematic alcohol/other drug use. Data represents those participants who completed all phases of assessment (n=78).

Among the treatment group, continuity corrected chi-squared analysis indicated there were no significant differences in cannabis abstinence rates according to the presence of comorbid depression at entry to the study ($\chi^2_1=0.073$, $p=0.788$). This was also the case at the six-month (continuity-corrected $\chi^2_1=0.127$, $p=0.722$) and 12-month follow-up assessments (continuity-corrected $\chi^2_1=0.212$, $p=0.645$).

Similarly, rates of abstinence from cannabis among the control group did not significantly differ according to comorbid depression status at the three-month (continuity-corrected
\( \chi^2_1 = 0.890, \ p = 0.346 \), six-month (continuity-corrected \( \chi^2_1 = 0.000, \ p = 0.988 \)), and 12-month follow-up assessment (continuity-corrected \( \chi^2_1 = 0.000, \ p = 1.000 \)).

Forty-four people (56%) met criteria for hazardous use of cannabis (i.e. at least weekly use) at entry to the study. These people formed the sample on which remaining analyses in this section were conducted. Mean cannabis usage over time is displayed in Table D.2 as a function of these variables.

Table D.2 Mean daily cannabis use* in the month prior to assessment for people participating in a study of substance use treatment for coexisting psychosis and substance use disorders, according to treatment allocation and depression status. Note that these data represent only those people who met criteria for harmful use of cannabis at entry to the study (n=44).

<table>
<thead>
<tr>
<th>Assessment Occasion</th>
<th>Initial Mean</th>
<th>3-months Mean</th>
<th>6-months Mean</th>
<th>12-months Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>S.D.</td>
<td>S.D.</td>
<td>S.D.</td>
<td>S.D.</td>
</tr>
<tr>
<td>Comorbid Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment</td>
<td>5.99</td>
<td>6.29</td>
<td>4.25</td>
<td>5.99</td>
</tr>
<tr>
<td>Control</td>
<td>8.01</td>
<td>7.93</td>
<td>3.47</td>
<td>5.09</td>
</tr>
<tr>
<td>No Comorbid Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment</td>
<td>10.07</td>
<td>9.32</td>
<td>5.53</td>
<td>7.58</td>
</tr>
<tr>
<td>Control</td>
<td>3.80</td>
<td>3.91</td>
<td>5.44</td>
<td>10.36</td>
</tr>
</tbody>
</table>

* A score of 1 equates to once daily use over the month prior to survey. A score of 2 equates to two occasions of use per day, 3 to three use occasions per day, etc.

Level of cannabis use among the sample was variable over the follow-up time period. Repeated measures ANOVA revealed however, that this variation was not related to time \( (F(3,40) = 0.699, \ p = 0.555) \), comorbid depression status over time \( (F(3,40) = 0.850, \ p = 0.469) \), or treatment allocation \( (F(3,40) = 2.025, \ p = 0.114) \). In addition, the interaction between changes in cannabis use levels and time, depression status and treatment allocation was also
not significant for this sub-group of participants ($F(3,40)=1.682$, $p=0.174$). The data contained in Table D.2 are also displayed graphically in Figure D.4, below.

Figure D.4  Mean daily cannabis use over the previous month, according to treatment allocation and depression status, among people with a psychotic disorder, participating in a study of treatment for problematic alcohol/other drug use. Data includes people who completed all phases of assessment and who met criteria for harmful use of cannabis at the initial assessment ($n=44$).

At the three-month follow-up, seven people (36.8%) with comorbid depression were abstinent from cannabis, two (10.5%) were using below a hazardous level (less than once weekly), while over half ($n=10$) were using above a once weekly (hazardous) threshold. Among those people without comorbid depression, 72% ($n=18$) continued to use at a hazardous threshold at the three-month follow-up, two (8%) were using below this threshold, and one-fifth ($n=5$) were abstinent. Pearson chi-squared analysis indicated that the cannabis
status did not significantly differ across people with and without comorbid depression ($\chi^2 = 1.835, p=0.400$).

At the six-month follow-up assessment, most people without depression (n=14, 56%) were continuing to use cannabis above a once weekly, hazardous threshold. Similarly, 58% of people with depression were using at this threshold (n=11), while one person from each of the depressed groups was using cannabis below a hazardous threshold. Around 40% (n=10) of people without depression reported abstinence at the six-month follow-up, compared with seven (37%) people with depression. Pearson chi-squared analysis indicated that the cannabis status across depression groups was not significantly different at alpha=0.01 ($\chi^2 = 0.073, p=0.964$).

Similarly, at the 12-month follow-up assessment, no significant differences existed between those with and without comorbid depression in terms of their cannabis use status (Pearson $\chi^2 = 3.351, p=0.187$). Specifically, around one-third of people with and without depression (n=7 and n=8, respectively) were abstinent from cannabis at 12-months and four people without depression (16%) reported use below a hazardous threshold (n=0 among those people with depression). Use of cannabis above a hazardous threshold was most common among the sample, with almost two-thirds of people with comorbid depression (n=12) using above this level, compared with 13 people (52%) without depression.

Rates of cannabis abuse and dependence were calculated at six- and 12-month follow-up assessments, using the SCID DSM-IV diagnostic criteria. At the six-month follow-up, using
the six-month period between the initial and six-month assessment, one person (5%) with comorbid depression met criteria for cannabis abuse, while a further ten people (53%) with comorbid depression met diagnostic criteria for cannabis dependence. Among people without comorbid depression at the six-month follow-up, three met diagnostic criteria for cannabis abuse (12%), and nine (36%) met criteria for cannabis dependence. Pearson chi-squared analysis indicated that these rates of abuse and dependence were not significantly different according to depression status ($\chi^2_{3}=3.024$, $p=0.388$).

When the six-month period between the six- and 12-month follow-up was considered, no people with comorbid depression met criteria for cannabis abuse, however thirteen (68%) reported cannabis dependence. In addition, two people from the no-depression group were abusing cannabis (8%), while a further ten (40%) met criteria for cannabis dependence. Despite the apparent difference in rates of cannabis abuse and dependence, Pearson chi-squared analysis revealed no significant differences existed between depressed and non-depressed groups according to this outcome variable ($\chi^2_{3}=4.841$, $p=0.184$).

**D.1.1.3 Other AOD Use Outcomes**

Tobacco use among the sample was generally high across the assessment occasions, as can be seen in Table D.3. Tobacco use did not vary in a consistent way according to treatment allocation or initial depression status. Indeed, repeated measures ANOVA revealed no significant changes in tobacco use were reported by the sample over time ($F(3,74)=0.727$, $p=0.537$), or treatment ($F(3,74)=0.448$, $p=0.719$) nor depression status ($F(3,74)=0.843$, $p=0.472$) result in significant changes in tobacco use over the course of the study. In
addition, the interaction between time, depression status, treatment allocation and changes in

tobacco use was not statistically significant ($F(3,74)=1.808, p=0.147$).

Table D.3  Mean daily tobacco use* in the month prior to assessment for people
participating in a study of substance use treatment for coexisting psychosis and
substance use disorders, according to treatment allocation and depression status.

<table>
<thead>
<tr>
<th>Assessment Occasion</th>
<th>Initial</th>
<th>3-months</th>
<th>6-months</th>
<th>12-months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
<td>S.D.</td>
</tr>
<tr>
<td>Comorbid Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment</td>
<td>17.78</td>
<td>11.79</td>
<td>21.82</td>
<td>9.98</td>
</tr>
<tr>
<td>Control</td>
<td>16.40</td>
<td>12.11</td>
<td>13.77</td>
<td>12.11</td>
</tr>
<tr>
<td>No Comorbid Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment</td>
<td>14.04</td>
<td>7.43</td>
<td>17.07</td>
<td>8.62</td>
</tr>
<tr>
<td>Control</td>
<td>16.55</td>
<td>9.57</td>
<td>19.64</td>
<td>18.44</td>
</tr>
</tbody>
</table>

* A score of 1 equates to one cigarette, on average, per day over the month prior to survey. A
score of 2 equates to two cigarettes per day, 3 to three cigarettes per day, etc.

D.1.2 Mental Health Outcomes

Figure D.5 displays the changes in psychiatric symptomatology, as measured by the BPRS,
over the assessment timepoints. Psychiatric symptomatology remained fairly constant
throughout the study period, and people with comorbid depression reported higher BPRS
total scores than did their counterparts without depression.
Figure D.5  Changes in mean levels of psychiatric symptomatology over time, according to treatment allocation and depression status, among people with a psychotic disorder, participating in a study of treatment for problematic alcohol/other drug use who completed all phases of assessment (n=78).

Repeated measures ANOVA revealed no significant main effects for time ($F(3,74)=1.259$, $p=0.289$), nor for time by treatment allocation ($F(3,74)=0.300$, $p=0.825$), time by comorbid depression ($F(3,74)=1.236$, $p=0.297$), or the interaction between time, treatment allocation, comorbid depression and changes in BPRS scores ($F(3,74)=0.451$, $p=0.717$). Table D.4 displays the means and standard deviations for these analyses.
Table D.4  Mean psychiatric symptomatology (BPRS total scores, Ventura, Green, Shaner, & Liberman, 1993) as reported by participants who completed all follow-up assessments in a trial of substance use treatment among people with co-existing psychotic and alcohol/other drug use problems, according to treatment allocation and initial depression status.

<table>
<thead>
<tr>
<th>Assessment Occasion</th>
<th>Initial</th>
<th>3-months</th>
<th>6-months</th>
<th>12-months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
<td>S.D.</td>
</tr>
<tr>
<td>Comorbid Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment</td>
<td>44.50</td>
<td>20.91</td>
<td>40.00</td>
<td>10.41</td>
</tr>
<tr>
<td>Control</td>
<td>39.46</td>
<td>14.22</td>
<td>36.54</td>
<td>4.58</td>
</tr>
<tr>
<td>No Comorbid Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment</td>
<td>30.43</td>
<td>4.72</td>
<td>31.07</td>
<td>4.84</td>
</tr>
<tr>
<td>Control</td>
<td>35.06</td>
<td>10.09</td>
<td>34.09</td>
<td>11.30</td>
</tr>
</tbody>
</table>

D.1.3  Other Outcomes

Table D.5 displays the mean (and standard deviations) GAF scores of the sample over the assessment timepoints.

Table D.5  Mean general functioning scores (GAF, APA, 1994) as reported by participants who completed all follow-up assessments in a trial of substance use treatment among people with co-existing psychotic and alcohol/other drug use problems, according to treatment allocation and initial depression status*.

<table>
<thead>
<tr>
<th>Assessment Occasion</th>
<th>Initial</th>
<th>3-months</th>
<th>6-months</th>
<th>12-months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
<td>S.D.</td>
</tr>
<tr>
<td>Comorbid Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment</td>
<td>64.17</td>
<td>13.02</td>
<td>60.56</td>
<td>14.23</td>
</tr>
<tr>
<td>Control</td>
<td>66.00</td>
<td>16.36</td>
<td>63.15</td>
<td>9.81</td>
</tr>
<tr>
<td>No Comorbid Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment</td>
<td>72.29</td>
<td>8.78</td>
<td>72.93</td>
<td>6.57</td>
</tr>
<tr>
<td>Control</td>
<td>73.67</td>
<td>9.79</td>
<td>68.27</td>
<td>11.86</td>
</tr>
</tbody>
</table>

*Higher GAF scores indicate higher functioning
As can be seen in Table D.5, and in Figure D.6, which displays this information graphically, GAF scores did not appear to fluctuate over the follow-up assessment period, regardless of treatment allocation or the presence of comorbid depression.

Figure D.6  Changes in global functioning over time, according to treatment allocation and depression status, among people with a psychotic disorder, participating in a study of treatment for problematic alcohol/other drug use who completed all phases of assessment (n=78).

Repeated measures ANOVA confirmed this observation, indicating no significant main effects of time ($F(3,74)=1.639, p=0.181$) on GAF scores, and no significant interactions between GAF scores and time/treatment allocation ($F(3,74)=0.428, p=0.733$), time/comorbid depression ($F(3,74)=1.344, p=0.261$), and time/comorbid depression/treatment allocation ($F(3,74)=0.585, p=0.625$).
In addition, quality of life was measured using several scales from the Lancashire Quality of Life Scale (LQoL, Oliver, 1991-1992). Figure D.7 displays the mean scores on the LQoL scale for the person’s “life as a whole” over time for people with and without comorbid depression and according to treatment allocation.

![Mean overall quality of life scores, according to treatment allocation and depression status, among people with a psychotic disorder, participating in a study of treatment for problematic alcohol/other drug use who completed all phases of assessment (n=78).](image)

Participants with comorbid depression consistently rated their “life as a whole” lower than did their counterparts across the initial assessment and follow-up occasions. Repeated measures ANOVA, failed to show any significant effects of comorbid depression over time on LQoL “life as a whole” scores ($F(3,73)=1.913, p=0.128$). Further, LQoL scores did not significantly vary as a function of time ($F(3,73)=1.497, p=0.216$), the interaction between time and treatment allocation ($F(3,73)=1.438, p=0.233$), or the combined effects of time,
comorbid depression and treatment allocation ($F(3,73)=0.578$, $p=0.630$). The mean “life as a whole” scores for participants across the assessment timepoints can be seen in Table D.6.

**Table D.6** Mean satisfaction with “life as a whole” (Lancashire Quality of Life Profile, Oliver, 1991-1992) as reported by participants who completed all follow-up assessments in a trial of substance use treatment among people with co-existing psychotic and alcohol/other drug use problems, according to treatment allocation and initial depression status.

<table>
<thead>
<tr>
<th>Assessment Occasion</th>
<th>Initial Mean (S.D.)</th>
<th>3-months Mean (S.D.)</th>
<th>6-months Mean (S.D.)</th>
<th>12-months Mean (S.D.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comorbid Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment</td>
<td>2.94 (0.87)</td>
<td>3.56 (1.42)</td>
<td>3.83 (1.58)</td>
<td>3.78 (1.31)</td>
</tr>
<tr>
<td>Control</td>
<td>3.84 (1.01)</td>
<td>4.46 (1.01)</td>
<td>4.38 (1.12)</td>
<td>3.84 (1.41)</td>
</tr>
<tr>
<td>No Comorbid Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment</td>
<td>5.29 (1.07)</td>
<td>4.86 (1.29)</td>
<td>5.29 (1.07)</td>
<td>5.14 (1.10)</td>
</tr>
<tr>
<td>Control</td>
<td>5.00 (1.50)</td>
<td>5.19 (1.38)</td>
<td>5.00 (1.22)</td>
<td>4.91 (1.44)</td>
</tr>
</tbody>
</table>

Participants were also asked to rate their current global well being, according to a ten-rung ladder, by ranking themselves between the upper and lower limits of the best and worst life they could imagine. Table D.7 displays the means and standard deviations of the ratings given by participants on this measure over the initial and follow-up assessments. At each assessment timepoint, people with comorbid depression at entry to the study consistently rated their global well being one-two points lower on a ten-rung ladder than did those without comorbid depression. Repeated measures ANOVA revealed that, despite this apparent trend, global well being ratings as per the ten-rung ladder did not significantly change over time ($F(3,73)=1.599$, $p=0.191$) or according to the interactions between time and comorbid depression ($F(3,73)=1.358$, $p=0.256$), time and treatment allocation ($F(3,73)=0.347$, $p=0.791$), or the combined effects of time, treatment allocation and
comorbid depression status ($F(3,73)=0.078, \ p=0.972$). These data are depicted graphically in Figure D.8.

**Table D.7**  Mean ratings on the global well being ladder (Lancashire Quality of Life Profile, Oliver, 1991-1992) as a function of treatment allocation and initial depression status for participants completing all follow-up phases in a study of substance use treatment for people with coexisting psychotic and substance use disorders.

<table>
<thead>
<tr>
<th>Assessment Occasion</th>
<th>Initial</th>
<th>3-months</th>
<th>6-months</th>
<th>12-months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
<td>S.D.</td>
</tr>
<tr>
<td>Comorbid Depression</td>
<td>Treatment</td>
<td>3.78</td>
<td>1.26</td>
<td>4.56</td>
</tr>
<tr>
<td></td>
<td>Control</td>
<td>4.38</td>
<td>1.39</td>
<td>5.23</td>
</tr>
<tr>
<td>No Comorbid Depression</td>
<td>Treatment</td>
<td>6.18</td>
<td>1.44</td>
<td>5.86</td>
</tr>
<tr>
<td></td>
<td>Control</td>
<td>6.22</td>
<td>1.93</td>
<td>6.31</td>
</tr>
</tbody>
</table>

**Figure D.8**  Changes in mean ratings of global well being, according to treatment allocation and depression status, among people with a psychotic disorder, participating in a study of treatment for problematic alcohol/other drug use who completed all phases of assessment (n=78).
Appendix E

STUDY 5

E.1 INFORMATION SHEETS AND CONSENT FORMS

E.1.1 Adult participants

Centre for Mental Health Studies

THE SHADE PROJECT
(Self-Help for Alcohol/other drugs and Depression)

Information Sheet

The Shade Project is a project run by the Centre for Mental Health Studies that is looking to help people who experience depression and also use alcohol or other drugs. We are carrying out a research project assessing whether a treatment that addresses depression and alcohol/drug use at the same time is helpful. To start with, we would like you to fill in some questionnaires and answer some questions about your lifestyle, and we will reimburse you for your expenses up to $20. We would like to repeat this process in 3 months, 6 months and 12 months.

If you agree to take part, you will be randomly assigned to either treatment as usual in the community plus a self-help booklet, ten individual sessions of counselling with a therapist, or ten individual sessions of counselling via CD-ROM. The counselling covers the relationship between depression and drinking/using and aims to teach you to cope with your depressive symptoms, or your desire to drink/use. These counselling sessions are between 45 minutes and 1 hour in duration. We hope to learn whether this new treatment is able to assist people experiencing depression to reduce their drinking and/or using and to improve their quality of life.

A member of our research staff will work with you throughout the study period. You will be asked to discuss your background, information on how to contact you over the next 12 months, history of depression, previous and current alcohol and other drug use, alcohol/drug related problems, and previous alcohol/drug treatment experiences. Your consent will be sought for follow-up interviews and we will ask you to provide the name, address and telephone number of someone we can call if you move and who you agree will be able to tell us your new contact details.

Audiotaping Treatment Sessions

LOCATION:
Officers Quarters Complex
James Fletcher Hospital
Newcomen Street, Newcastle
Phone: 02 4924 6610 Fax: 02 4924 6608

SCHOOL OF MEDICAL PRACTICE
& POPULATION HEALTH
Faculty of Health

Correspondence:
Dr Amanda Baker, Senior Clinical Psychologist/Senior Lecturer
Discipline of Psychiatry
E-mail: amanda.baker@newcastle.edu.au
We would like to ask for your permission to audiotape the treatment sessions you are involved in as part of this project. Given we are testing the effectiveness of treatment for depression and alcohol/other drug use problems, we need to make sure that each therapist in the study is delivering the same treatment to each participant.

Audiotapes will be marked with your participant identification number only, the initials of the therapist giving you treatment, and the date and number of treatment session. No personal details about you will be associated with the labelling of these audiotapes.

All audiotapes will be stored in a locked storage cabinet that is only accessible by the research team. Tapes will be kept until the conclusion of the treatment period of the study (approximately June 2003). At this time, a member of the research team will randomly select a proportion of the audiotapes for analysis. The analysis will include whether the therapist delivered the set program planned for that particular session (treatment adherence), and how well the therapist interacts with the participant (therapeutic alliance/relationship). No analysis will be carried out on the issues you raise during the session. After this analysis is complete, all therapy audiotapes will be erased by person conducting the analysis. It is anticipated that this will take place in March 2004.

Please note that you are under no obligation to consent to the audiotaping of your treatment sessions. You may participate in the study without having your treatment sessions audiotaped.

Please take note of item 8 on the Consent Form attached to this information sheet, which asks you to specifically consent to the audiotaping of your treatment sessions. You can do this by ticking either “Yes” or “No” at item 8.

If you do agree to have your sessions audiotaped, the therapist involved in your treatment will give you the opportunity at each treatment session to revise this decision. In addition, at the conclusion of each treatment session, you will be given the opportunity to review the audiotape, and make any deletions you feel are necessary. At this time, you are also able to withdraw your consent for audiotaping, either entirely or just for that particular session.

**Risks and Discomforts**

In an effort to avoid an increase of your symptoms of depression, we will monitor your mental health during the study. We would also like to inform your case manager and general practitioner of your participation in the Shade Project and with your permission, the results of your initial assessment should they ask for it.

Should you be assigned to receive treatment via the computer program, a member of our research staff will assist you at every session. At the conclusion of each session, you will meet briefly with this person who will assess how your symptoms of depression are affecting you.

**Termination of involvement in the study**

By participating in this study you will help us to determine the usefulness of interventions for drinking/using above recommended levels among people with depression and may help to reduce your consumption of these and improve your quality of life. You will also receive up to $20 at each assessment point, to reimburse your expenses associated with travelling to our offices for assessment. Your treatment in this study will be free.
Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or except as required by law. The person interviewing you, the person coordinating the study, a PhD student associated with this project and a research team at the Centre for Mental Health Studies will have access to this information. The results of the study may be published or discussed, but no individual participating in the study will be identified in any way.

Whether or not you take part in the study your relationship with the University of Newcastle or Hunter Area Health Service will not be affected. If you decide to take part in this study, you can stop any time you like. Should you decide to discontinue your participation in the study at any time, you may do so by notifying a member of the research staff. If you do pull out of the study, it will not affect your future relationship with this University.

We cannot and do not promise that you will receive any benefits from this study.

If you have any questions at any time, Dr. Amanda Baker (0249246605) the researcher responsible for the project will be happy to answer them. You will be given a copy of this form to keep.

**Complaints**

If you have any complaints about the manner in which this research is conducted you may contact the researchers in person. If an independent person is preferred, please contact the University’s Human Research Ethics Officer, Research Branch, The Chancellery, University of Newcastle, Callaghan, NSW, 2308, telephone (02) 49216333 or the Professional Officer, Hunter Area Research Ethics Committee, C/- Hunter Area Health Service, Locked bag No. 1, New Lambton, telephone (02) 49214950.

Dr. Amanda Baker
CONSENT FORM

I, __________________________________________, agree to participate in the Shade study described above.

I understand that this is a study of the effectiveness of counselling for alcohol and/or other drug use above recommended levels among people with depression, and that one form of treatment will be delivered by computer program.

I understand that all the information that I give in this study is completely confidential and will not be passed on to any other person, except as required by law.

I acknowledge that I have read the above statement, explaining the nature and aims of the study, and the statement has been explained to my satisfaction. Before signing this document I have been given the opportunity to ask any questions relating to any emotional harm that I may suffer as a result of my participation and have received satisfactory answers. I am aware that I will not necessarily personally benefit from participation in this study. I understand that I can withdraw from this study at any time, I do not have to give my reasons for withdrawing and this will not affect either my current or future treatment. I agree that data gathered during the course of this study may be published providing that names or identifying information is not used.

I understand that in addition to the research team at the Centre for Mental Health Studies having access to the information I provide, a PhD student will also access de-identified information from the project.

I give permission for the research team to contact the alternative contact person I have nominated should I change my current address. I agree that this person can provide current contact information for me so that I can be contacted about completing follow-up assessments.

☐ Yes  ☐ No

I give permission for my treatment sessions to be audiotaped. I understand that this is only for the purpose of checking that the therapists are delivering the same treatment to every participant, and that the content of my sessions will not be analysed in any other way. I understand that audiotapes will not contain my name or any other identifying information that links the audiotape to me.

☐ Yes  ☐ No

I would like a copy of the study’s results sent to me when available.
☐ Yes ☐ No

CONSENT BY PARTICIPANT: I hereby certify that I have read and understood all the information provided, and that I have been allowed to ask questions. I agree to take part in the Shade study described in this consent form.

Date: _________________________ Signature by Participant: _______________________________________

I hereby certify that I have disclosed the relevant information and risks that may be involved, in terms understood by the person.

Date: _________________________ Signature by Investigator: _______________________________________
E.1.2 Participants under the age of 18 years

THE SHADE PROJECT
(Self-Help for Alcohol/other drugs and Depression)

Information Sheet

The Shade Project is a project run by the Centre for Mental Health Studies that is looking to help people who experience depression and also use alcohol or other drugs. We are carrying out a research project assessing whether a treatment that addresses depression and alcohol/drug use at the same time is helpful. To start with, we would like you to fill in some questionnaires and answer some questions about your lifestyle, and we will reimburse you for your expenses up to $20. We would like to repeat this process in 3 months, 6 months and 12 months.

If you agree to take part, you will be randomly assigned to either treatment as usual in the community plus a self-help booklet, ten individual sessions of counselling with a therapist, or ten individual sessions of counselling via CD-ROM. The counselling covers the relationship between depression and drinking/using and aims to teach you to cope with your depressive symptoms, or your desire to drink/use. These counselling sessions are between 45 minutes and 1 hour in duration. We hope to learn whether this new treatment is able to assist people experiencing depression to reduce their drinking and/or using and to improve their quality of life.

A member of our research staff will work with you throughout the study period. You will be asked to discuss your background, information on how to contact you over the next 12 months, history of depression, previous and current alcohol and other drug use, alcohol/drug related problems, and previous alcohol/drug treatment experiences. Your consent will be sought for follow-up interviews and we will ask you to provide the name, address and telephone number of someone we can call if you move, and who you agree will be able to tell us your new contact details.

Audiotaping Treatment Sessions
We would like to ask for your permission to audiotape the treatment sessions you are involved in as part of this project. Given we are testing the effectiveness of treatment for depression and alcohol/other drug use problems, we need to make sure that each therapist in the study is delivering the same treatment to each participant.

Audiotapes will be marked with your participant identification number only, the initials of the therapist giving you treatment, and the date and number of treatment session. No personal details about you will be associated with the labelling of these audiotapes.
All audiotapes will be stored in a locked storage cabinet that is only accessible by the research team. Tapes will be kept until the conclusion of the treatment period of the study (approximately June 2003). At this time, a member of the research team will randomly select a proportion of the audiotapes for analysis. The analysis will include whether the therapist delivered the set program planned for that particular session (treatment adherence), and how well the therapist interacts with the participant (therapeutic alliance/relationship). No analysis will be carried out on the issues you raise during the session. After this analysis is complete, all therapy audiotapes will be erased by person conducting the analysis. It is anticipated that this will take place in March 2004.

Please note that you are under no obligation to consent to the audiotaping of your treatment sessions. You may participate in the study without having your treatment sessions audiotaped.

Please take note of item 8 on the Consent Form attached to this information sheet, which asks you to specifically consent to the audiotaping of your treatment sessions. You can do this by ticking either “Yes” or “No” at item 8.

If you do agree to have your sessions audiotaped, the therapist involved in your treatment will give you the opportunity at each treatment session to revise this decision. In addition, at the conclusion of each treatment session, you will be given the opportunity to review the audiotape, and make any deletions you feel are necessary. At this time, you are also able to withdraw your consent for audiotaping, either entirely or just for that particular session.

**Risks and Discomforts**

In an effort to avoid an increase of your symptoms of depression, we will monitor your mental health during the study. We would also like to inform your case manager and general practitioner of your participation in the Shade Project and with your permission, the results of your initial assessment should they ask for it.

Should you be assigned to receive treatment via the computer program, a member of our research staff will assist you at every session. At the conclusion of each session, you will meet briefly with this person who will assess how your symptoms of depression are affecting you.

**Termination of involvement in the study**

By participating in this study you will help us to determine the usefulness of interventions for drinking/using above recommended levels among people with depression and may help to reduce your consumption of these and improve your quality of life. You will also receive up to $20 at each assessment point, to reimburse your expenses associated with travelling to our offices for assessment. Your treatment in this study will be free.

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or except as required by law. The person interviewing you, the person coordinating the study, a PhD student associated with this project and a research team at the Centre for Mental Health Studies will have access to this information. The results of the study may be published or discussed, but no individual participating in the study will be identified in any way.

Because you are under the age of 18 years, it is necessary to gain the signed consent of your parent or guardian to participate in this research. Please be aware that no information relating to your assessments or treatment in this project will be released to this parent or guardian without your permission.
Whether or not you take part in the study your relationship with the University of Newcastle or Hunter Area Health Service will not be affected. If you decide to take part in this study, you can stop any time you like. Should you decide to discontinue your participation in the study at any time, you may do so by notifying a member of the research staff. If you do pull out of the study, it will not affect your future relationship with this University.

We cannot and do not promise that you will receive any benefits from this study.

If you have any questions at any time, Dr. Amanda Baker (0249246605) the researcher responsible for the project will be happy to answer them. You will be given a copy of this form to keep.

Complaints
If you have any complaints about the manner in which this research is conducted you may contact the researchers in person. If an independent person is preferred, please contact the University’s Human Research Ethics Officer, Research Branch, The Chancellery, University of Newcastle, Callaghan, NSW, 2308, telephone (02) 49216333 or the Professional Officer, Hunter Area Research Ethics Committee, C/- Hunter Area Health Service, Locked bag No. 1, New Lambton, telephone (02) 49214950.

Dr. Amanda Baker
THE SHADE PROJECT
(Self-Help for Alcohol/other drugs and Depression)

Consent Form

I, ______________________________________, agree to participate in the Shade study.

I understand that this is a study of the effectiveness of counselling for alcohol/other drug use above recommended levels among people with depression, and that one form of treatment will be delivered by computer program.

I understand that all the information that I give in this study is completely confidential and will not be passed on to any other person, including my parent or guardian, except as required by law or with my permission.

I acknowledge that I have read the above statement, explaining the nature and aims of the study, and the statement has been explained to my satisfaction. Before signing this document I have been given the opportunity to ask any questions relating to any emotional harm that I may suffer as a result of my participation and have received satisfactory answers. I am aware that I will not necessarily personally benefit from participation in this study. I understand that I can withdraw from this study at any time, I do not have to give my reasons for withdrawing and this will not affect either my current or future treatment. I agree that data gathered during the course of this study may be published providing that names or identifying information is not used.

I understand that in addition to the research team at the Centre for Mental Health Studies having access to the information I provide, a PhD student will also access de-identified information from the project.

I give permission for the research team to contact the alternative contact person I have nominated should I change my current address. I agree that this person can provide current contact information for me so that I can be contacted about completing follow-up assessments.

I give permission for my treatment sessions to be audiotaped. I understand that this is only for the purpose of checking that the therapists are delivering the same treatment to every participant, and that the content of my sessions will not be analysed in any other way. I understand that audiotapes will not contain my name or any other identifying information that links the audiotape to me.

☐ Yes ☐ No

I would like a copy of the study’s results sent to me when available
☐ Yes ☐ No

CONSENT BY PARTICIPANT: I hereby certify that I have read and understood all the information provided, and that I have been allowed to ask questions. I agree to take part in the Shade study described in this consent form.
I hereby certify that I have disclosed the relevant information and risks that may be involved, in terms understood by the person.

Date: ______________________________ Signature by Investigator: ________________________________
The Shade Project is a project run by the Centre for Mental Health Studies that is looking to help people who experience depression and also use alcohol or other drugs. We are carrying out a research project assessing whether a treatment that addresses depression and alcohol/drug use at the same time is helpful. To start with, we would like your son/daughter/ward to fill in some questionnaires and answer some questions about their lifestyle, and we will reimburse them for their expenses up to $20. We would like to repeat this process in 3 months, 6 months and 12 months.

If you agree to allow your child/ward to take part, they will be randomly assigned to either treatment as usual in the community plus a self-help booklet, ten individual sessions of counselling with a therapist, or ten individual sessions of counselling via CD-ROM. The counselling covers the relationship between depression and drinking/using and aims to teach them to cope with their depressive symptoms, or their desire to drink/use. These counselling sessions are between 45 minutes and 1 hour in duration. We hope to learn whether this new treatment is able to assist people experiencing depression to reduce their drinking and/or using and to improve their quality of life.

A member of our research staff will work with your child/ward throughout the study period. He/she will be asked to discuss their background, information on how to be contacted over the next 12 months, history of depression, previous and current alcohol and other drug use, alcohol/drug related problems, and previous alcohol/drug treatment experiences. Their consent will be sought for follow-up interviews and we will ask them to provide the name, address and telephone number of someone we can call if they move and who they agree will be able to tell us their new contact details.

Audiotaping Treatment Sessions
We would like to ask for your permission to audiotape the treatment sessions in which your son/daughter/ward is involved in as part of this project. Given we are testing the effectiveness of treatment for depression and alcohol/other drug use problems, we need to make sure that each therapist in the study is delivering the same treatment to each participant.

Audiotapes will be marked with your child/ward’s participant identification number only, the initials of the therapist providing treatment, and the date and number of treatment session. No personal details about your child/ward will be associated with the labelling of these audiotapes.
All audiotapes will be stored in a locked storage cabinet that is only accessible by the research team. Tapes will be kept until the conclusion of the treatment period of the study (approximately June 2003). At this time, a member of the research team will randomly select a proportion of the audiotapes for analysis. The analysis will include whether the therapist delivered the set program planned for that particular session (treatment adherence), and how well the therapist interacts with the participant (therapeutic alliance/relationship). No analysis will be carried out on the issues you raise during the session. After this analysis is complete, all therapy audiotapes will be erased by person conducting the analysis. It is anticipated that this will take place in March 2004.

Please note that you are under no obligation to consent to the audiotaping of your child/ward’s treatment sessions. They may participate in the study without having your treatment sessions audiotaped.

Please take note of item 8 on the Consent Form attached to this information sheet, which asks you to specifically consent to the audiotaping of your child/ward’s treatment sessions. You can do this by ticking either “Yes” or “No” at item 8.

If you do agree to have your child/ward’s sessions audiotaped, the therapist involved in your treatment will give them the opportunity at each treatment session to revise this decision. In addition, at the conclusion of each treatment session, they will be given the opportunity to review the audiotape, and make any deletions they feel are necessary. At this time, they are also able to withdraw their consent for audiotaping, either entirely or just for that particular session.

**Risks and Discomforts**

In an effort to avoid an increase in symptoms of depression, we will monitor your child’s/ward’s mental health during the study. We would also like to inform their case manager and general practitioner of their participation in the Shade project and with your permission, the results of your initial assessment should they ask for it. Should your child/ward be assigned to receive treatment via the computer program, a member of our research staff will assist them at every session. At the conclusion of each session, they will meet briefly with this person who will assess how their symptoms of depression are affecting them.

**Termination of involvement in the study**

By participating in this study your child/ward will help us to determine the usefulness of interventions for drinking/using above recommended levels among people with depression and may help to reduce their own consumption of these and improve their quality of life. They will also receive up to $20 at each assessment point, to reimburse expenses associated with travelling to our offices for assessment. Their treatment in this study will be free.

Any information that is obtained in connection with this study and that can be identified with your child/ward will remain confidential and will be disclosed only with their permission or except as required by law. The person interviewing your child/ward, the person coordinating the study, a PhD student associated with this project and a research team at the Centre for Mental Health Studies will have access to this information. The results of the study may be published or discussed, but no individual participating in the study will be identified in any way.

Because your child/ward is under the age of 18 years, it is necessary to gain your consent as their parent or guardian for them to participate in this research. Please be aware that no information relating to their assessments or treatment in this project will be released to you without their permission. Whether your child/ward decides to take part in the study or not will not affect their
relationship with the University of Newcastle or Hunter Area Health Service. If they decide to take part in this study, they can stop at any time. Should your child/ward decide to discontinue participation in the study at any time, they may do so by notifying a member of the research staff. If they do pull out of the study, it will not affect their future relationship with this University.

We cannot and do not promise that your child/ward will receive any benefits from this study.

If you have any questions at any time, Dr. Amanda Baker (0249246605) the researcher responsible for the project will be happy to answer them. You will be given a copy of this form to keep.

Complaints
If you have any complaints about the manner in which this research is conducted you may contact the researchers in person. If an independent person is preferred, please contact the University’s Human Research Ethics Officer, Research Branch, The Chancellery, University of Newcastle, Callaghan, NSW, 2308, telephone (02) 49216333 or the Professional Officer, Hunter Area Research Ethics Committee, C/- Hunter Area Health Service, Locked bag No. 1, New Lambton, telephone (02) 49214950.

Dr. Amanda Baker
THE SHADE PROJECT
(Self-Help for Alcohol/other drugs and Depression)

Consent Form

I,_____________________________________, agree to allow my child/ward __________________________
to participate in the Shade study.

I understand that this is a study of the effectiveness of counselling for alcohol/other drug use above
recommended levels among people with depression, and that one form of treatment will be delivered by
computer program.

I understand that all the information that my child/ward provides in this study is completely confidential and
will not be passed on to any other person, including myself, except as required by law or with their permission.

I acknowledge that I have read the above statement, explaining the nature and aims of the study, and the
statement has been explained to my satisfaction. Before signing this document I have been given the
opportunity to ask any questions relating to any emotional harm that my child/ward may suffer as a result of
participating and have received satisfactory answers. I am aware that my child/ward will not necessarily
personally benefit from participation in this study. I understand that my child/ward can withdraw from this
study at any time, without giving reasons for withdrawing and this will not affect either their current or future
treatment. I agree that data gathered during the course of this study may be published providing that names or
identifying information is not used.

I understand that in addition to the research team at the Centre for Mental Health Studies having access to the
information I provide, a PhD student will also access de-identified information from the project.

☐ Yes  ☐ No

I give permission for my child/ward’s treatment sessions to be audiotaped. I understand that this is only for
the purpose of checking that the therapists are delivering the same treatment to every participant, and that the
content of the sessions will not be analysed in any other way. I understand that audiotapes will not contain my
name or any other identifying information that links the audiotape to my child/ward.

☐ Yes  ☐ No

I would like a copy of the study’s results sent to me when available
☐ Yes  ☐ No

CONSENT BY PARTICIPANT: I hereby certify that I have read and understood all the information provided,
and that I have been allowed to ask questions. I agree for my child/ward to take part in the Shade study
described in this consent form.
I hereby certify that I have disclosed the relevant information and risks that may be involved, in terms understood by the parent/guardian.

Date: ___________________________ Signature by Investigator: ____________________________
COUNSELLING FOR YOUR MENTAL HEALTH WORRIES

The Centre for Mental Health Studies is looking to help people with worries about their mental health who also use alcohol and other drugs.

You can help by giving us information about your lifestyle.

In return, you will be reimbursed for your expenses. Individual follow-up assessments are provided over a 12-month period.

If you would like to assist with this project, please phone Frances on 49246616 or return this slip to: SHADE Project, Centre for Mental Health Studies, Newcomen Street, Newcastle 2300.

WE HOPE TO HEAR FROM YOU SOON

I give permission for my contact details listed below to be passed onto the research team responsible for the above project. I understand that this does not automatically mean that I have agreed to take part in the study, only that I have agreed to discuss this possibility.

Name of Referrer (if different from yourself): …………………………………………

Relationship to Participant: ………………………………………………………………

Participant Name:……………………………………Phone No:………………………

Address:……………………………………………………………………………………..

If no phone, can we visit you at home – Yes/No

Participant Signature: …………………………………………Date:………………………
WE NEED YOUR HELP!

The SHADE Project is being run by the University of Newcastle. If you are experiencing symptoms of depression, and also drink alcohol or use other drugs, then we’d really like your help.

You can help by giving us information about your own personal lifestyle.

In return, you will be reimbursed for your expenses. Individual follow-up assessments will be provided over a 12-month period.

If you would like to participate in this project, please phone Frances on 49246613 for an appointment.

<table>
<thead>
<tr>
<th>PH</th>
<th>Frances</th>
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<td>4924</td>
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IMPORTANT COMMUNITY ANNOUNCEMENT

The Editor,
«Name»
«Address»
«Suburb» «Postcode»

Could the following item please be read/printed as a Community Announcement as it contains useful educational information for your readers/listeners/viewers? More details can be provided upon request.

Thank you.
Frances Kay-Lambkin
Ph: 4924 6616

DRUG AND ALCOHOL RESEARCH

The University of Newcastle’s Centre for Mental Health Studies is conducting research into the use of alcohol, tobacco and other drugs among people with depression or psychotic illnesses. The Centre is looking for people over the age of 16 years, who fit these criteria, to participate in the programs. Reimbursement of travel costs and expenses will be available. For more information please call Frances on 4924 6616
E.3 SHADE TREATMENT MANUAL – THERAPIST DELIVERED TREATMENT

Treatment Manual© for
The SHADE Project
Self-help for Alcohol/other drug use and Depression
November 2002
Frances Kay-Lambkin (Chief Investigator/PhD Student)
Amanda Baker (Chief Investigator)
Sandra Bucci (Project Officer)
Centre for Mental Health Studies, University of Newcastle

Please do not quote, cite, circulate or reproduce without permission of the authors.

The authors would like to acknowledge the contribution made by Dr David Kavanagh in reviewing the content of this treatment manual.

© Centre for Mental Health Studies, The University of Newcastle
This manual has been written for the SHADE project: Self-help for Alcohol/other drug use and Depression. The randomised controlled trial for which this manual was developed included therapy conducted face-to-face with a therapist trained in the following manual, and therapy conducted via a computer program. Funding from the Australian Brewer’s Foundation and the School of Medical Practice and Population Health, Faculty of Health, The University of Newcastle supported he development of the computer program. The following manual was used for the therapist-delivered section of the project, and is identical to the computer-based version of therapy also developed for this research.

Neither the manual, nor the computer program is intended to stand-alone. Rather, it is to be accompanied by extensive reading of the research and clinical literature, training in the approaches used and ongoing supervision.

The SHADE manual was adapted by Frances Kay-Lambkin, Dr Amanda Baker & Sandra Bucci from the following sources:


The following videos demonstrate the use of motivational interviewing and cognitive-behaviour therapy with a person who is hospitalised with an amphetamine induced psychosis:


**Rationale and principles of treatment**

This treatment adopts the assumption of the Motivational Enhancement Therapy (MET) approach that the responsibility for change lies within the client. The therapist's task is to create a set of conditions that will enhance the client's own motivation and commitment for change. The therapist does this by following the five basic motivational principles: express empathy; develop discrepancy; avoid argumentation; roll with resistance; support self-efficacy. These five conditions are aimed at enhancing changes in substance use in particular. Following the development of the client’s commitment to change, the therapist assists the client in learning skills that will help him/her achieve change (Miller, Zweben, DiClemente & Rychtarik, 1995).

**Goals of treatment**

The main goal of treatment is prevention of relapse to an acute episode of depression. If the client has a concurrent alcohol/other drug problem then there are two further goals of treatment. The first goal is to enhance the client's understanding of possible interactions between their use of alcohol and/or other drugs and their mental illness (symptomatology and treatment compliance). The second goal is to reduce the harm (e.g., mental and physical
health, financial, social, occupational) associated with problem alcohol and other drug use and psychiatric symptomatology. The client will identify more specific goals to work towards in therapy.

Many clients with concurrent mental health and alcohol/other drug problems will become motivated to reduce their use. However, some may not wish to work on their alcohol/other drug problems directly. This manual can be used flexibly to work on symptom relief or relapse prevention by either directly addressing alcohol/other drug use as a risk factor for relapse or symptom exacerbation, or by focussing on other factors associated with relapse.

**Timing and length of intervention**

The treatment is delivered individually over a total of ten therapy sessions. Each session should last around an hour. Although weekly sessions are preferable, there will be occasions when clients cannot attend or forget their appointment. In this case, an attempt should be made to reschedule for the same week. If this is not possible, the session should be carried over to the regular time the following week. Missed sessions of more than three weeks in a row are serious compromises to the effective running of the program, and clients in this position should be encouraged to consider seriously their reasons for being involved in the program. Ideally, the timing and physical location of the therapy sessions should be as consistent as possible. That is, appointments for the same time and day should be made for each subsequent week, and the place should be held constant. This may help optimise the establishment of a working rapport with the therapist and assist the client in becoming comfortable with the therapeutic arrangements. Many clients will be ambivalent about change, therefore participation in the project may be enhanced by conducting home visits.

One or two assessment sessions are undertaken in the week prior to therapy commencing in which key data are obtained from the client, and an outline of the nature and content of the therapy is given. Questionnaire data may be scored in the week prior to the first session to allow relevant comprehensive feedback to be provided to the client.

**Assessment Procedure**

For the purpose of the research on which this manual is based, a detailed assessment package was developed. All assessment instruments were widely used in the mental health and/or AOD research and included the following measures: demographics, hospital admissions, Structured Clinical Interview for DSM-IV (SCID – Depression Scale), stages of change measures (drug use & depressive illness), mental health measures (International Personality Disorder Examination, Beck Depression Inventory II, Global Assessment of Functioning (GAF), WHO Quality of Life Instrument, Beck Hopelessness Scale, Dysfunctional Attitude Scale, State-Trait Anxiety Inventory), and AOD use measures (AOD scale (SCID-R), Opiate Treatment Index (OTI), Drug Attitudes Inventory, AUDIT for Alcohol use). The research team asked participants to disclose information about an illegal activity (i.e. illicit drug use), and provided the following assurances:

“I’m now going to ask you about your use of alcohol and other drugs in the past, and at the moment. I just want to remind you that you are under no obligation to answer these questions. Of course, the more questions you answer honestly, the more useful the
information is to me and to the project, but you do not have to answer them all. The information you give me is completely confidential, except as required by law.”

If pressed to explain “required by law”: “Up until now, I haven’t been asked to pass on any information collected from participants in the research programs I have been a part of. And I think it is pretty unlikely that the courts would be aware that you are involved in this project and therefore likely to request this information. The only circumstances I could imagine this happening would be something like…you going out during our time together and committing a crime for which you are charged, then somehow the police or courts finding out you are involved in this project, them thinking the information you have given me is somehow relevant and then requesting the information through the court system. I think it is very unlikely.”

It should be noted that this assessment would normally not be necessary for the purposes of most practicing therapists. All clients are required to sign an informed consent form, approved by the relevant ethics committee, before assessment can commence.

Format of therapy
Guidelines for the delivery of the treatment sessions are given for each of the ten sessions in this manual. These guidelines are general, around which a therapist will be able to add his or her own style and experience. Each session is structured in a similar way, commencing with a review of the previous week (5-10 minutes), setting the agenda for the current session, and reviewing homework activities, learning/developing new skills, assigning homework and conclusion. All activities featured in each session are general cognitive and behavioural skills that can be applied to several different situations and conditions simultaneously (e.g. depressive symptoms and alcohol/other drug use problems). This was clearly explained to clients in an effort to increase generalisation of skills to many areas of their lives.

Brief Check-in
At the conclusion of each treatment session, regardless of treatment allocation (therapist, computer, usual treatment), all therapists completed a “brief check-in” with participants. This included a review of the homework activities set for completion in between treatment sessions, with clients asked to describe each homework activity in their own words to the therapist. Therapists and participants then worked together to formulate a plan to carry out the homework activities through the week, including perceived obstacles/problems and possible solutions. The “check-in” additionally included a brief suicide and mood assessment, which included the Beck Depression Inventory – fast screen, and the suicide risk assessment contained on pages 14-16. These “check-in” interactions were tape-recorded and therapists asked to estimate the amount of time spent on each “check-in” agenda item.

Session handouts
A number of exercise and activities are performed during the treatment session discussed in this manual. The following is a summary of handouts you may give to your client throughout treatment:
Session 1
Case Formulation and Treatment Plan
Information about Depression/AOD
Pros and Cons Balance Sheet
Mood Monitor
Client + Therapist Alliance questionnaires
Self-help material as required
Summary Sheet – Session 1

Session 2
Copy of completed Handout: Pros & Cons
Balance Sheet from Session 1
Mood Monitor
Activity Log
Mindful Walking
Summary Sheet – Session 2

Session 3
Interpreting Situations
Thought Monitoring
Activities List
Activity Log
Summary Sheet – Session 3

Session 4
Activity Log
Thought Monitoring
Change Plan Worksheet
Facts about Cravings
Coping with Cravings
Summary Sheet – Session 4

Session 5
Activity Log
Unhelpful Automatic Thought Patterns
Steps in Managing Unhelpful Thought Patterns
Managing Thoughts
Mindful Breathing
Client and Therapist Alliance Questionnaires
Summary Sheet – Session 5

Session 6
Activity Log
Managing Thoughts
3-minute Breathing Space
Six Steps to Problem-Solving
Problem-Solving
Summary Sheet – Session 6

Session 7
Activity Log
Managing Thoughts
Schema Form
Schema Continuum
“Alternative View” worksheet
Summary Sheet – Session 7

Session 8
Activity Log
Managing Thoughts
“Alternative View” worksheet
Allowing/Letting Be
Refusal Skills
Emergency Plan
Summary Sheet – Session 8

Session 9
Activity Log
Managing Thoughts
“Alternative View” worksheet
Seemingly Irrelevant Decisions
“Breaking the Rule” Effect
“Looking After Yourself”
Summary Sheet – Session 9

Session 10
Relapse Management Plan
Client and Therapist Alliance Questionnaires
Any other handouts the client requests
Missed appointments

If an appointment is missed, respond immediately and adopt the following procedures (MET manual). If you cannot reach the person by phone, write a letter offering another appointment and affirming the client. This should be done within 2 days of the missed appointment to maximize the likelihood of the client’s return. Place a copy of this note in the clinical file.

Telephone the client and clarify the reasons for the missed appointment;
Affirm the client - reinforce him/her for having previously attended;
Express your eagerness to see the client again;
Briefly mention serious concerns that emerged and your appreciation (as appropriate) that the client is exploring these;
Express your optimism about the prospects for change and reschedule.

If a reasonable explanation for the missed appointment is not offered, explore this with the client and determine whether the missed appointment is reflective of any of the following: uncertainty about whether or not treatment is necessary; ambivalence about making a change; frustration/anger for participating in treatment. These issues should be handled in a manner consistent with the MET approach, and this interaction documented in the clinical notes for that client.

Treatment Fidelity

To ensure treatment fidelity, all interactions between a Psychologist and participant in the SHADE project were audiotaped. This included treatment sessions and the brief check-in sessions for therapist, computer and brief intervention participants. A random sample of each “type” of session was selected for each Psychologist involved in the treatment phase of the project, and rated by an independent assessor for adherence to the manual and therapeutic alliance.

The following information was marked on each audiotaped interaction and then stored in a secure location accessible only to the SHADE research team: participant project ID number, psychologist initials, date of session, session type (treatment session, case formulation session, brief check-in), and session number (1-10).

The following rationale was provided to all clients about the audiotaping of sessions: “As you already know, this is a research project, and we have a couple of different therapists working with us to deliver the SHADE treatment. Before we can say whether any of this treatment is useful to people with depression, we need to make sure that each therapist is giving people the same treatment as other therapists on the project. The only way we can do this is to audiotape each session and then get someone else to listen to them as a check. So, I’d like to ask your permission to audiotape each of our sessions together.

Before you say ‘yes’ or ‘no’, I need to tell you a few things about what will happen to these tapes. The first thing to know is that the only thing written on this audiotape that relates to you is your participant ID number. The rest of the information includes my initials, the date of the session, and the number of the session (1-10). No other information that identifies you as you is kept with or written on this tape. Also, all the audiotapes are kept
in a locked filing cabinet, and only the research team for the SHADE project has a key. The person who will rate the tapes a bit down the track will be one of the members of our research team who hasn’t been a therapist on the project, and doesn’t know any of the participants. When this person comes to rate the tapes, all they will see is your participant number written on the tape – nothing else will identify you, and that person will not know which participant number goes with each participant. All the rater is interested in is what the therapist does and says during the session – they won’t be focussing on what you say, or the things you discuss. As far as confidentiality goes, the same rules apply to these audiotapes as to the assessment information you gave me during our first few sessions together. The tapes are confidential unless required by law. Do you have any questions?”

Clients were asked to indicate on the consent form whether or not they agreed to have their sessions audiotaped.

Letters: after Session 1 and to clinicians
Therapists on the SHADE project sent a follow-up note to all clients after session 1. This was to improve rapport between client and therapist, and to encourage commitment to seeing the treatment program through until its completion (use p53 MET manual as a guide):

[Letterhead]
Dear Mr. Bloggs
This is just a note to say that I’m glad you were able to spend time talking with me today. I appreciate how openly you discussed your lifestyle and health concerns. I look forward to seeing you again on [day, date, time].
Regards
[Name of therapist]

Following the initial assessment and first session with SHADE clients, letters were sent to the client’s GP, Case Manager and treating Psychiatrist (with the client’s consent) advising them of their client’s participation in the project. A copy of all correspondence was retained in the client’s clinical records.

Location of intervention and therapist safety
In line with assertive outreach programs, sessions conducted in the SHADE project may occur in the client’s home. The safety of the therapist is of prime importance. Safety should be enhanced by a referral process, which involves each client’s case manager or a key worker (is it appropriate to visit the person at this time?). All home visits are to be conducted by two therapists. Always trust your judgment and terminate an interview if you have any doubts about your safety. Carry a mobile phone and record your whereabouts on the office whiteboard.

SHADE Project Security Protocol: On the day of each assessment or treatment intervention, the appropriate research assistant will telephone the participant and assess their level of functioning, the likelihood of other people being present in the house for the visit etc. and the appointment will be rescheduled if necessary. Research assistants will
visit the participants in pairs and will have access to the Discipline’s mobile telephone to
take with them in case of emergency. Research assistants will inform the Department
Secretary about the details of any home visits on each day. Research assistants will ring
the Secretary at an agreed time after the visits are completed. If this telephone call does not
occur, the Secretary will attempt to contact the research assistant on the Department mobile
phone, failing this, the police will be sent to the last known appointment location. We
recommend a similar protocol (if conducting home visits) be incorporated in your therapy
regime.

**Treatment Phases**

Graham et al. (2000) outlines four treatment phases: engagement and building motivation
for change; negotiating behaviour change; early relapse prevention and relapse
prevention/management. As clients will move between the different stages of change
(Prochaska & DiClemente, 1992, described in Miller and Rollnick) within and between
sessions, the therapist will need to use strategies appropriate to each phase flexibly, rather
than in a linear sequence.

In addition, it is recommended that cognitive behaviour therapy focus in the initial stages
on behavioural strategies, then move into cognitive techniques as the sessions progress, and
the client’s mood lifts (Beck et al., 1979; Persons et al., 2001). This is the premise
underlying the organisation of sessions 1-10 of SHADE, however the therapist should
additionally use his/her judgement in relation to the receptiveness and appropriateness of
certain techniques to the client.

**Recruitment Criteria for SHADE**

Recruitment sources included people discharged from hospital, community mental health
centres, rehabilitation centres, drug and alcohol services, community adolescent teams,
private psychiatrists and newspaper/other media advertisements.

The initial approach varied in each instance but involved: being pleasant, acknowledging
the person and asking if you could talk with them for a few minutes, handing out a flyer
about the study; mentioning they would be reimbursed and that information disclosed is
confidential. In cases where the person was engaged with another health professional, this
service provider was also involved in the recruitment process.

The SHADE project focussed on people diagnosed with a Major Depressive Disorder (non-
psychotic features) and who consumed alcohol above recommended levels (four drinks a
day for men, two for women) or used cannabis or amphetamines at least weekly in the
month prior to interview.

**Classification of treatment dropouts**

Clients who do not attend three consecutive appointments were considered treatment
dropouts.

Therapists should decide for themselves whether it is worthwhile pursuing individual
clients.
Nevertheless, all clients assessed were followed up at the appropriate follow-up time intervals and were included in the SHADE treatment outcome analyses.

**Suicide: Risk Assessment**

If you identify throughout your assessment/sessions with the client that he/she is at risk of suicide, use the following questions to assess the level of risk (Casey, 2000):

1. What has happened that makes life not worth living? (nature of problems, duration, recent changes).
2. When you feel this way, have you ever had thoughts of killing yourself?
3. When do you have these thoughts?
4. How often do you have these thoughts?
5. How long do these thoughts last?
6. Have you ever acted on these thoughts? How? Did you plan it?
7. When was the last time you had these thoughts?
8. What effect have these most recent thoughts had on your daily activities?
9. Have your thoughts ever included harming someone else as well as yourself?
10. Have any of your family or friends attempted or completed suicide?
11. Recently, what specifically have you thought about doing to yourself?
12. Have you taken any steps toward doing this?
13. Have you thought about when and where you would do this?
14. Have you made any plans for your possessions or left any instructions for people for after your death, such as a note or a will?
15. Are your family and friends supportive in helping with your problems?
16. Have you thought about the effect your death would have upon your family and friends?
17. What has stopped you from acting on your thoughts so far?
18. What are your thoughts about staying alive?
19. What help could make it easier for you to cope with your problems at the moment?
20. How does talking about this make you feel?

The following table should be used as a guide when assessing a client’s level of suicide risk. Your clinical judgement will guide the use of this form.

If you feel that a client fits in the “**high-risk**” suicide category, follow the suicide policy in place at your workplace. For the SHADE study, all clients involved with a case manager used this person as the first point of contact, and research staff should liaise with this person to determine the role of the researcher, if any, in managing the client. If no other health professional is involved in the person’s care, and a decision is made to manage a high-risk suicidal client, the client should be given written information about how to seek further help. This includes a 24-hour telephone contact number and written details outlining treatment plans, including who to contact for information or clarification in your area. Research staff should also follow the NSW Health Suicide policy, shown in Table 2, in determining their course of action (NSW Health, 98).
<table>
<thead>
<tr>
<th>SUICIDE RISK CHECKLIST (Casey, 2000)</th>
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<tbody>
<tr>
<td><strong>Availability of Means</strong></td>
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<tr>
<td>Time</td>
</tr>
<tr>
<td><strong>Lethality of Method</strong></td>
</tr>
<tr>
<td>Pills, slash wrists</td>
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<tr>
<td><strong>Chance of Intervention</strong></td>
</tr>
<tr>
<td><strong>Previous Suicide Attempts</strong></td>
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<tr>
<td><strong>Symptoms: Coping Behaviour</strong></td>
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<tr>
<td>Stress</td>
</tr>
<tr>
<td><strong>Depression</strong></td>
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<tr>
<td><strong>Resources</strong></td>
</tr>
<tr>
<td><strong>Communication Aspects</strong></td>
</tr>
<tr>
<td><strong>Lifestyle</strong></td>
</tr>
<tr>
<td><strong>Medical Status</strong></td>
</tr>
</tbody>
</table>
Flow Chart for Community Mental Health Services

Patient presents or phones with suicidal behaviour/deliberate self harm/suicidal ideation or with other indications of risk

- Suicide attempt
  - Cal ambulance
    - Admit
    - Risk continues
      - Continue to monitor and assess
        - Admit to hospital
        - Continue to follow-up
          - Patients attend early appointment
          - Risk diminishes
            - Continue to monitor and assess
              - Staff arrange follow-up information and make an early appointment with the person's primary clinician or case manager to occur within 24 hrs. Staff must provide appropriate contact numbers to patients.

Patient who has attempted suicide and/or is considered an ongoing risk does not attend early appointment.

- Assess risk
  - Consult with appropriate services as necessary
    - Risk diminishes
      - Continue to monitor and assess
        - Outreach contact and assessment urgently mobilised.
Session 1: Case Formulation

Aims:
- Form a collaborative relationship between client /therapist.
- Discuss and create a case formulation for the client’s current state using information collected during assessment and provided by client.
- Feedback information from assessment, and commence motivational interviewing around alcohol/other drug use, introduce client to the concepts of mood monitoring.

Materials needed for Session 1
- Handout: Case Formulation and Treatment Plan
- Handout: Information about Depression
- Handout: Information about Cannabis
- Handout: Information about Speed
- Handout: Information about Alcohol
- Handout: Pros and Cons Balance Sheet
- Handout: Mood Monitor
- Randomisation Envelope (SHADE project only)
- Self-help material as required (“Taming the Black Dog”, AOD self-help booklets)
- Questionnaires: Client and Therapist Questionnaires
- Handout: Summary Session 1

Areas to be covered within session 1 include:
1.1 Case Formulation and Rapport Building
1.1.1 Identifying Information
1.1.2 Problem List
1.1.3 Diagnosis
1.1.4 Raise the Issue of Drinking/Using
1.1.5 Working Hypothesis
1.1.5.1 Schema
1.1.5.2 Precipitating and Activating Situations
1.1.5.3 Expectancies for Drinking/Using
   Exercise: Decisional Balance
1.1.5.4 Origins
1.1.5.5 Working Hypothesis
1.1.6 Strengths and Assets
1.1.7 Randomisation
1.1.8 Treatment Plan
1.2 Conclusion
1.3 Brief Check-in
1.3.1 Homework set for Session 1
1.3.1.1 The Mood Monitor
1.3.2 Plan for Completing Homework
1.3.3 Suicide Risk Assessment
1.3.4 Therapeutic Alliance Measure
1.3.5 Confirm next appointment
Sessions 1: Case Formulation and Feedback from Assessment

Case formulation (Persons et al., 2001; Persons, 1989)
The first session of treatment will focus on developing rapport and formulating an idea about how the person came to be in their current situation. It is important that you allow plenty of time for the subject of alcohol and other drug use to emerge. Focussing too soon on substance use will most likely elicit resistance from the client and interfere with rapport building. Remember that critical conditions for promoting change are: accurate empathy, non-possessive warmth and genuineness.

The case formulation is a theory that explains a person’s current symptoms and problems and hypothesises how they developed. It includes information gathered from assessment, therapist observations and client reflections. Although the treatment protocol for the SHADE project is standardised, it is based on a general formulation at the level of the syndrome or problems associated with depressive illnesses and co-occurring alcohol/other drug problems. In carrying out the protocol, it is important to individually construct a formulation specific to the person who presents for therapy, to gain a better understanding of their presenting problems and to anticipate potential barriers to treatment.

The case formulation detailed below is adapted from Persons et al. (2001), and is a systematic way of synthesising results from assessment with individual information from the client. The aim is to develop a “working hypothesis” of how the person’s problems developed, how they formed a negative view of themselves, the world and the future (cognitive triad), and how particular behaviours (e.g. use of alcohol/other drugs) are related and maintained. You will also use the case formulation as a starting point for motivational enhancement training for your client later in this session.

The case formulation model conceptualises psychological problems as occurring at two levels, overt symptoms (cognitions, behaviour, mood) and underlying mechanisms (schema). It is difficult in the space of one session to adequately assess a person’s problematic schema, which may well have developed during childhood. However, using Beck’s (1983) theory about “typical types of depression”, it is possible make some initial hypotheses about the schema underlying the overt symptoms that are picked up by the assessment.

Beck (1983) proposed two “types” of depressive schema common to people experiencing depressive symptoms: dependent type (“I must be loved by others or I’m worthless”) and the autonomous type (I must be independent, or accomplish significant achievements or else I am worthless”). Beck (1983) hypothesised that each “type” of depressive schema produces a pattern of depressive symptoms: dependent types are vulnerable to sadness, feelings of unattractiveness and crying, and the autonomous type tends to experience feelings of failure, self-blame, guilt, loss of interest in others and hopelessness. However, these hypothesised patterns of symptoms associated with each type have received only equivocal support from research; so be wary of limiting the formulation to them.

Although you develop some of the case formulation in between sessions with the client, it is important to seek their input into its development. As Persons et al. (2001) explain, a
formulation shared by both the therapist and the client can strengthen the therapeutic alliance and enhance motivation to comply with treatment. If the formulation is helpful for the therapist, it is likely that this will also be useful for the client. Present your initial formulation to the client during the first session, and complete the remaining sections during this session with the client’s input.

The case formulation has six parts: (1) identifying information; (2) the problem list; (3) diagnosis; (4) working hypothesis; (5) strengths and assets; and (6) the treatment plan. These points have been modified slightly to suit the language of the client. Motivational interviewing techniques will also be incorporated into each of these sections as appropriate.

Use the handout at the end of this section to complete as much of your case formulation as you feel able, prior to your first session with the client. The following case formulation activity was taken from Persons et al. (2001). You may like to explain the following to the client (MET Manual, pg50):

"Before we begin, let me just explain a little about how we will be working together. You have already spent time completing the assessment, and I appreciate the effort you put into that process. We'll make good use of that information from those (questionnaires) today. This first session will be spent taking a closer look at your situation, what is working for you, what you are having trouble with, and so on. I hope that you'll find it helpful."

**Identifying Information**
List the person’s name, age, marital status, ethnicity, gender, occupational status and living situation. It may also be useful here to list the source of referral. You can do this prior to the first session.

**Problem List**
Generate a comprehensive problem list describing any problems the person is having psychologically (mood, behaviour, cognitive symptoms), and at the interpersonal, occupational, medical, legal, financial, social levels. Include information gathered from your assessment (e.g. scores on the Beck Depression Inventory, symptom scores, alcohol/other drug scores), evidence of suicidality, therapy-interfering behaviours (e.g. noncompliance with treatment), and behaviours that interfere with quality of life (e.g. alcohol/other drug use) that may prevent the person from solving any other problem.

When reporting on scales/self-report questionnaires, elaborate on what a person’s score on each of these measures indicates. Make the feedback meaningful to the person by anchoring it to “norms” and/or an interpretation of a particular score. For example, explain to them what a score of 20 means on the Beck Depression Inventory (i.e. the symptoms they are experiencing are considered to be of moderate level).

Graham et al. (2000) suggest the following questions are useful in developing the problem list with the client:

*What things are causing you the most distress at the moment?*
*What do you consider are your main problems at present?*
It is useful to specify the problems in terms of mood, behavioural and cognitive components where possible as often this will lead directly into the cognitive behavioural skills planned for treatment. Make sure you are concrete in describing these problems, and behavioural descriptions also make it easier to translate problems into measurable goals. Be as inclusive as you can, even though therapy may only focus on some of these problems.

**Diagnosis**

Although not strictly a component of case formulation, it is often useful to include the psychiatric diagnosis you have arrived at following your assessment. Include current levels of depression symptoms, including a diagnosis, and presence of alcohol/other drug abuse or dependence.

Importantly, provide brief advice on what the person’s level of alcohol, cannabis, and/or speed use means in relation to “accepted” safe using guidelines and population standards:

For alcohol, explain: “Last week, you mentioned you were drinking at XXX level. Just as a guideline, health research suggests that problems associated with drinking are minimised when people drink within the “safe drinking guidelines” of... (2-4 standard drinks daily for men, 1-2 standard drinks daily for women, at least 2 alcohol-free days, no more than 6 drinks on any one occasion).”

For cannabis, explain: “Last week, you mentioned you were using pot at XXX level. Although there are no known safe limits for using pot, research suggests that the negative effects are minimised if a person keeps their pot use at a level of once a week or less.”

For speed, explain: “Last week, you mentioned you were using speed at XXX level. Although there are no known safe limits for using speed, research suggests that the negative effects are minimised if a person keeps their speed use at a level of once a week or less.”

Ask for feedback from the person on what these diagnoses mean to them.

Provide the person with feedback on the sequelae of their depression and alcohol/other drug problems – explain which problem is primary, and which is secondary (if known), and what this might mean in terms of recovery. For example, depression that is secondary to alcohol/other drug use problems will most likely remit after a period of abstinence.

**Raise the issue of drinking/using** (Rollnick et al., 1999)

Use the previous discussion as an introduction to raising the issue of drinking/using with the client. It is likely that, in the discussion about the person’s problem list and in responding to feedback from assessment, that their use of alcohol/other drugs will be mentioned. Use this opportunity to lead into a more detailed discussion of the role alcohol/other drugs play in the person’s life and in the management/control of their symptoms.
In this section, the client will be asked to question their current levels of use in the context of other things happening in their lives, including their depressive symptomatology. As Miller and Rollnick (1991) explain, one of the biggest obstacles to a useful discussion is raising the issue of a person’s drinking/using in a way that minimises resistance, and opens the door to constructive conversation. Miller and Rollnick (1991) suggest that a good general approach is to ask open-ended questions, to listen reflectively, affirm the person and summarise as you go along.

Begin by asking generally about the client’s lifestyle, using the preceding discussion as a guide:

“The information we have talked about in this session has given me a bit of an idea about what is going on in your life at the moment. But, I really don’t know a lot about you and the kind of life you lead. Perhaps we can spend a few minutes with you telling me about a typical day in your life, so that I can understand in more detail what happens? Tell me a bit more about the things you struggled with and how you felt at the time. Can you think of a typical recent day from beginning to end... You got up...”

Allow the person to continue with as little interruption as possible. If necessary prompt with open-ended questions: “What happened then?” Review and summarise. If necessary, ask: “Is there anything else at all about this picture you have painted that you would like to tell me?”

If the person does not volunteer information about drinking or using, ask the following: “Can you tell me where your drinking/using fits in?”

You could ask the following to explore the person’s beliefs about their drinking or using:

“How does your use of cannabis/alcohol/speed affect your depression/mood?”

Choose an appropriate moment during this discussion to provide the person with some additional information about depression, alcohol use, cannabis use and speed using the handouts contained in this section (Information about Depression, Information about Alcohol, Information about Cannabis and/or Information about Speed). Ask the person’s permission prior to giving out this information.

Your aim is to elicit self-motivational statements from the client about the arguments for change (Miller & Rollnick, 1991). Self-motivational statements fall into categories (Miller & Rollnick, 1991):

- Problem recognition: “I guess there is more of a problem then I thought”, “I never realised it was as serious as this”;
- Expression of concern: “I’m worried about this”, or nonverbal cues such as tears, gestures etc.;
- Intention to change: “This isn’t how I want to be”, “Maybe it’s time to think about changing”; and
- Optimism about change: “I think I can do it”.

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In this session you will focus on strategies to elicit statements from the client in the first two categories.

Depending on the person’s response to this discussion, it may be appropriate to lead into the decisional balance activity described in Expectancies for Drinking/Using at this point, rather than in the context of developing the working hypothesis. For example, if, in the person’s description of their “typical day”, they make statements about their alcohol/other drug use expectancies, it may be appropriate to probe more specifically about whether their expectations are met. This may then naturally lead into a discussion about the pros/cons of their drinking/using.

**Working Hypothesis**
This section has several components: schema, precipitants, activating situations, origins and summary of the working hypothesis. Here is where you could summarise the information discussed in the previous section, including the relationship between a person’s alcohol/other drug use and depression. Try to link the beliefs a person holds about their alcohol/other drug use with their depressive symptomatology. You can continue with motivational interviewing techniques in this section.

**Schema**
Schemas are the core beliefs that a person uses to interpret their experiences. Beck (1983) suggests that people with depression tend to hold one of both of the following types of schema – “I must be loved by others or I’m worthless” (dependent type) and “I must be independent, or accomplish significant achievements or else I am worthless” (autonomous type). Incorporate the information gained from the self-report Dysfunctional Attitude Scale (DAS) contained in the SHADE assessment battery into your hypotheses about the person’s problematic schema.

The client’s answers to the following questions may also be useful (Graham et al., 2000):
What beliefs are held about their AOD use and/or depression?
What core beliefs does the client hold about himself or herself?

Whether a person reports that they use alcohol/other drugs in times of high mood or low mood, help them to make an informal assessment about what they expect will happen when they have a drink or use drugs. If the client identifies they use alcohol/other drugs to alter their mood or feelings, ask the following:

“What do you expect to happen when you have a drink/use cannabis or speed?”

The client may describe any of the following: make problems go away, take the edge off, just go numb etc. Take some time to assess in detail the client’s beliefs.

**Precipitants and Activating Situations**
Beck (1976) suggests that external events can activate problematic schema that then give rise to depressive symptoms and alcohol/other drug use. Precipitants are large-scale events that appear to have caused an episode of depression or a lapse to drinking/using.
The SHADE assessment will have briefly covered the onset of the person’s depression and initiation of alcohol/other drug use, but it is useful to discuss this in more detail.

Sometimes, in the case of people with chronic, long-term depression, it is difficult for them to recall the precipitants of their symptoms, however they will usually be able to report what caused them to seek treatment.

Activating situations are small-scale events that trigger negative mood or AOD use, such as negative automatic thoughts. These situations can trigger the same schema activated by the precipitating event. Careful analysis of the types of events and situations that lead to problems often gives you information about the person’s problematic schema and will help you form your working hypothesis. Both precipitants and activating situations are all potential entries in the “situation” column of the thought record to be introduced in later sessions of this program. These additional questions may also assist you (Graham et al., 2000):

- What factors (e.g. situations, mood, symptoms) trigger AOD use and/or depression?
- What factors maintain AOD use/depressive symptoms in a problematic pattern (i.e. reasons for using; effects/problems associated with their use; what proportion of their social network uses drugs)?
- What are the positive/negative influences in the social network towards AOD use?

Information gathered from the SHADE assessment (e.g. reasons for AOD use) will also provide additional useful insight here.

**Expectancies for Drinking/Using**

Once you and the client have identified some of their expectancies from AOD use, ask the following:

“How much do you believe (from 0% to 100%) that drinking alcohol or using cannabis or speed will do these things? Does drinking, smoking cannabis or using speed actually do these things?”

It is likely that the client will not be 100% confident in the beliefs about the benefits of their AOD use. If you are able to elicit such statements from the client, highlight this discrepancy and summarise the person’s comments. For example, you might say:

“So on the one hand, when you are feeling really low you drink to make yourself feel better, to make yourself go numb, and your problems go away. But on the other hand you are not entirely convinced that drinking is able to do these things, and you have had some experience that suggests that the problems don’t always go away.”

Look for motivational statements elicited by the client in response to this summary. Continue to listen reflectively as they provide more detail about their drinking/using related beliefs. You may be able to continue with:

“While there are good things you are able to see in drinking/using, you are also finding that in some cases it doesn’t live up to your expectations.”
Continue with this discussion until you feel it is appropriate to commence a more formal assessment of the pros and cons of the client’s AOD use. When this occurs, use the following exercise.

**Exercise: Decisional Balance** (Miller & Rollnick, 1991)

- Use the “Pros and Cons Balance Sheet” for this exercise
- Try to elicit self-motivational statements from the client. Start with the statement: “So, perhaps there are some good things and some not so good things about your AOD use. Can we look at this a little more closely?”
- Ask the client to write down all the positives they associate with drinking alcohol and/or using other drugs in the relevant quadrant of the grid. Use the following questions as a prompt: “Tell me about your drinking/smoking cannabis/using speed. What do you like about it? What's positive about drinking/using for you? And what's the other side? What are your concerns about drinking?” If necessary, prompt further: “I wonder how you feel about smoking cannabis/using speed? What can you imagine happening to you?” And: “Some people find that changing drinking/using can improve their depression. What do you think? “How does your use of cannabis/alcohol/speed affect your mental health?” Avoid the use of terms such as “problem”, “abuse” etc. as these can elicit resistance from the client at this early stage.
- Ask the client to rate the importance of each of these positive aspects using the following questions as a guide: “How IMPORTANT is this to you personally? If ‘0’ was ‘not important’ and ‘10’ was ‘very important’ what number would you give this aspect of your drinking/using?” Write the client’s importance rating next to the relevant aspect.
- Repeat this exercise with the negatives of drinking/using and assess how important (0-10) these are to the client.
- Ask the client to list the positives and negatives associated with modifying drinking/using habits and record in the relevant quadrant. For each issue raised, discuss the importance to the client.

**Origins**
Information about how the person might have developed or learned their problematic schema is useful in forming your schema hypotheses. Include here relevant details about the person’s early learning experiences that may have contributed not only to the formation of their schema, but also to the use of maladaptive behaviours (e.g. AOD use, negative styles of thinking). The following questions might also be raised (Graham et al., 2000)
What might have contributed to the client using substances initially?
What key early experiences might have shaped the clients view of themselves/world/other people?

**The Working Hypothesis**
Here is where the therapist “tells the story” that describes how the person learned the schema that are now being activated by the external events to cause the depressive symptoms,
substance use and other problems listed on the person’s problem list. Consider the following questions, and cover these with the client if appropriate (Graham et al., 2000):

- What is the relationship between their substance use and depression?
- What are the links in the beliefs the person holds about their drug use and depression?
- How does the person explain their current difficulties with work, relationships, the law … other life areas”

Here is an example of a working hypothesis generated by Beck et al. (1979):

\[ X \text{ was subjected to } \ldots \text{ in childhood and came to the belief that she was inadequate and unlovable. These core beliefs have been carried into adulthood where } XX \text{ experiences } \ldots \text{ (e.g. discomfort in social situations). } XX \text{ took to using } \ldots \text{ in the belief that it would make her feel } \ldots \text{ Unfortunately this compensatory strategy has led to compulsive use of } \ldots \text{ leading to the following further problems (e.g. frequent conflict with family, finances, other relationships). These life problems feed back into } XX \text{'s life cycle of } \ldots \text{ (depression, sadness and low self-worth) and renewed her belief that the only way to be accepted is to } \ldots \text{ through use of } \ldots \text{ As a result, finances, drugs, marital problems have gotten worse and her sense of helplessness and hopelessness has increased.} \]

**Strengths and Assets**

This section of the formulation is intended to draw on the person’s strengths and assets that may be useful in implementing the treatment that will follow. Examples include good social skills, ability to work collaboratively, a sense of humour, good job, good support network, intelligence, stable lifestyle etc. Include your impressions, as well as those identified by the client. Be sure to include any of the motivational statements you were able to elicit from the client during the “decisional balance” activity and at other times in this session.

**Conduct Randomisation** (SHADE Project only)

At the conclusion of session 1, participants in the SHADE project are randomly assigned to one of three conditions: Therapist, Computer, or Usual Treatment.

Participants allocated to the “therapist” condition will receive a further 9 sessions of motivational interviewing and cognitive behaviour therapy conducted face-to-face with a SHADE therapist. The remainder of this manual details these 9 sessions, which ideally would be conducted one-week apart.

The “computer” condition also provides participants with 9 further sessions of motivational interviewing and cognitive behaviour therapy, however the sessions are conducted via a computer program (“SHADE”). The content of therapy is identical to the SHADE manual, with sessions conducted one-week apart.

The final condition – “usual treatment” – involves no further contact with a SHADE therapist or computer program after session 1. Participants are offered self-help material on depression, alcohol use, cannabis use and/or amphetamine use to take home with them and review. They can also be referred onto other treatment groups or services in the community, but will not be contacted again until the 3-month follow-up assessment occasion.
Participants in the SHADE project are allocated a participant number, which is linked with their treatment allocation by a system of central and external randomisation. Please give the appropriate allocation envelope to the participant at this time for them to open, and explain their allocation to them.

**Treatment Plan:**
Record the person’s treatment allocation on the case formulation, including the frequency, modality and type of intervention to be provided. For those people allocated to “therapist” or “computer” conditions, briefly explain the premises of cognitive behaviour therapy, including its focus on thoughts, and the importance of homework activities.

**Obstacles:** it is also important to anticipate potential barriers to treatment and predict difficulties that might arise during therapy. Use the information gathered from any part of the formulation (including problem list and schema) that may be relevant. If you can predict a person’s tendency, for example, to undervalue their own needs in preference for others/believe that others are responsible for their happiness, you can initiate a discussion about this issue early in treatment, to perhaps prevent premature termination of treatment. At this point it may also be possible to pre-empt any potential tendencies for homework non-compliance. Discuss the importance of homework and gauge the person’s reaction.

**Goals:** at this stage it may be premature to ask the person to set goals for therapy, particularly in the area of reducing their AOD use. However, they may have some ideas about how they want to change their current state, e.g. reduce depressive symptoms, have fewer arguments with family, not spend as much money of alcohol/other drugs etc. and these can be articulated in this section. These goals also serve as potential areas for deploying discrepancy later on in therapy between the person’s current behaviour (e.g. AOD use) and their plans/goals. Treatment goals must be concrete, even at this stage. A vague goal statement such as “feel better about myself” does not give much guidance about how to achieve it. It may be useful to ask the person to following question (Beck et al., 1979): What do you think you need to do to solve these problems?

In addition, at this point it is important to address the person’s expectancies about the treatment condition to which they have been allocated. This is particularly the case with people involved in computer-based therapy who may have had only limited previous experiences with computers. Research suggests that a person’s perception of the effectiveness and usefulness of treatment strongly predicts their response to treatment. Use the following questions to explore the client’s expectancies from therapy and discuss their responses in session:

- *What are your previous experiences with therapy?*
- *What do you expect this therapy will achieve?*
- *Do you have any concerns about this therapy?*
- *What do you feel about seeing a therapist/using a computer for therapy?*

**Conclusion**
End with a supportive, positive statement ensuring a sense of achievement. The crucial switch is for the client to feel in control of his/her situation, rather than simply reacting to events in his/her life:

“Now just before you go, I want to say that it has taken a while to get to feeling so bad. Achieving these goals will not always be easy and you will probably have some setbacks along the way. But by focussing on small things and looking at the next steps rather than the whole journey, I’m confident that things will gradually improve. Nevertheless, there will be some days when you will feel back at square one. But as time goes by, these days will be fewer and further between as you begin to take control of your low mood. So let’s meet up next week.”

**Brief check-in**

In the context of the SHADE project, therapists spent an additional 5-10 minutes at the conclusion of each session conducting a “brief check-in”. This was to confirm (especially for those allocated to the computer therapy condition) that people understood the homework set during the session and had thought about a plan for completing the homework tasks. The “brief check-in” was also used to conduct a more formal suicide risk assessment.

After the person has completed Module 1, spend a short time face-to-face with them covering the following items. Use the “Summary: Session 1” sheet.

**Review Homework Activities** (up to 5 minutes – Therapist and Computer Groups only)

Ask participants to complete some homework before their next session. Ask them to take home the completed case formulation worksheet that you have both worked through in this session, and review it in their own time. Encourage them to make alterations to the worksheet where they see appropriate, and to focus on their overall impressions/implications of the information recorded on the form.

Give the client a copy of the completed Pros and Cons Balance sheet to take home with them and revisit through the week. Pose the following question as something for them to consider over the next week (MET Manual pg29): “Over the next week, I’d like you to think about all these things we have talked about today.” If appropriate, continue with: “In particular I’d like you to think about where this all leaves you in terms of your AOD use. I’d like you to think about what you might do about all these concerns.”

In the SHADE project, all clients, regardless of their treatment allocation, were given a copy of “Taming the Black Dog” (Bev Aisbett) and a self-help booklet on alcohol, cannabis and/or amphetamine use reduction as applicable.

**Mood Monitoring**

Assign a mood monitoring sheet for homework between this and the second session, only for those clients allocated to the “therapist” and “computer” treatment groups.

Mood monitoring is an important first step in addressing negative thoughts and feelings, including those that lead to using alcohol/other drugs. It helps the client to identify the
situations in which these thoughts/feelings are most likely to occur. Explain the use of the mood monitor during the session, and ask the person to complete the daily monitor over the next week for homework.

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**Exercise: The Mood Monitor**

- Use the sheet titled “Mood Monitor”.
- Recap any links you and the client have made between their use of alcohol/other drugs and their depressive symptomatology. Explain that an important first step in managing their symptoms and urges to use, is to monitor those times of the day and night when they occur. In particular, they need to pay close attention to those times of the day when they are feeling the worst/or experiencing the strongest urges to drink/use, and those times when they are feeling the best. Be sure to communicate the importance and value of this activity to your client.
- At the end of each day, ask the person to complete the mood monitor for the times when they felt the best or when their urge to drink/use was at its weakest, and the times when they felt the worst/or the strongest urges to drink/use.
- Explain that they need to fill in the time of day that these feelings/urges occurred, along with a rating from 1-5 of the strength of their feelings. Then, in the “Situation” column, they need to describe what was happening at that time of day, including whether or not they used alcohol/other drugs.
- This activity will demonstrate to the client the link between their AOD use, negative mood and particular situations that trigger such feelings and behaviours. Encourage the client to complete the mood monitor each day over the next week and bring into next weeks’ session.

The following activities have been set for completion between now and Session 2: take home the completed case formulation worksheet that you have both worked through in this session, and review it in their own time. Encourage alterations to the worksheet where they see appropriate, and to focus on their overall impressions/implications of the information recorded on the form. In addition, give the client a copy of the completed Pros and Cons Balance sheet to take home with them and revisit through the week. Pose the following question as something for them to consider over the next week (MET Manual pg29): “Over the next week, I’d like you to think about all these things we have talked about today.” If appropriate, continue with: “In particular I’d like you to think about where this all leaves you in terms of your AOD use. I’d like you to think about what you might do about all these concerns.”

To check the client’s understanding of these tasks, ask them to describe the homework tasks in their own words.

Reinforce that just having a go at completing the homework is a success in itself. However, summarise the importance of completing homework, and explain that they will be used in next weeks’ session.

**Plan for Completing Homework (2-3 minutes)**
Briefly explore with the client any problems they anticipate in completing their homework activities, and together develop and verbalise a plan for doing homework tasks through the week.

**Suicide and Mood Assessment (5 minutes)**
Your interaction with the client should give you a general idea of what their level of mood currently is. However, it is important to test out your impressions, either by asking the person more directly about their mood/suicide ideation, or by using questionnaires to do this. If appropriate, you may like to use the Beck Hopelessness Inventory to assist your assessment.

Refer to the Suicide Risk Assessments in the first section of this manual to assist your assessment, and for a protocol for managing those people at high risk for suicide.

**Therapeutic Alliance Measure**
The SHADE project sought to evaluate therapeutic alliance from both the client and the therapist perspective at several points throughout the treatment period. All participants and therapists were asked to complete the Agnew-Davis Therapeutic Alliance questionnaire after Sessions 1 (all clients), 5, and 10 (those in therapist and computer conditions only).

The questionnaires for this purpose are contained in the handouts for sessions 1, 5 and 10.

**Confirm Next Appointment**
Arrange the client’s next appointment before they leave.
Name:

Identifying Information:

Problem List:

1. 
2. 
3. 
4. 
5. 
6. 
7. 

Diagnosis:

The role of alcohol/other drugs:

Working Hypothesis:

*Schema:*

Self:

Future:

Other:

*Precipitants:*

*Activating Situations:*

*Origins:*

*Summary of the Working Hypothesis:*


Strengths and Assets:

Treatment Plan:

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Obstacles:

Goals:
• Depression is a **common** mental health problem affecting **about 121 million people**

• Depression occurs in people of **all ages and backgrounds**.

• The question of what causes depression has **no simple answers**. Depression can be caused by a **mixture of external factors**, like life stressors, drugs, alcohol, and **internal factors**, like past bad experiences, chemical changes in the brain, medical illness, high levels of anxiety.

• Depression causes **physical symptoms** (like low energy, difficulty sleeping, changes in appetite, poor concentration). These physical symptoms **lead to negative feelings** (like feeling low, feeling helpless, feeling hopeless about the future, feelings of guilt) and **negative thoughts** (like you are no good, low self-esteem) – it’s a nasty cycle.

• **Often**, people with depression will **turn to alcohol and other drugs** like cannabis or speed to help with their depression – **perhaps** to change and **improve their negative thoughts and feelings**, or **cope with their physical symptoms**. In other people, using alcohol or other drugs cause feelings of depression. Sometimes, you can’t tell which came first – the depression or the alcohol/other drug use. The important point is that **either problem can make the other worse and lead to bigger trouble**. **Be honest about both problems** – first with yourself, and then with others.

• Depression **saps energy and self-esteem**, and **interferes with a person’s ability to get help**. They might think they are not worth the effort. Often, depression causes “**low self-efficacy**”. This means that you believe you are **not capable** enough to do anything to help you situation. You worry that the effort needed to help your depression is **way beyond your power**. Remember – **this is only your depression talking**; you can do lots of simple things to help your situation.

• **Good treatments that really work** are available for depression. Both **drug and psychological treatments** are available, and either may suit different people at different stages in their depression.

• Psychological treatments, like **cognitive behaviour therapy** can help to **change your thoughts, feelings and activities**, and help prevent relapse.

• **Fewer than one-quarter** of people with depression have **access to effective treatments**.

*Information taken from*


World Health Organisation: [http://www.who.int/](http://www.who.int/)

When a person takes cannabis, THC enters the bloodstream through the lungs (if it is smoked) or through the stomach (if it is eaten). THC is the chemical that makes you feel “high”. The blood then carries THC to your brain where you may experience a change in mood or see/feel things in a different way.

Cannabis is a depressant drug. This means that it slows down the central nervous system – slows down messages sent from the brain to the rest of the body. Cannabis can also produce mild hallucinations.

Research shows that cannabis has lots of different effects on your body. For example, it can reduce your co-ordination and balance, affect vision and your awareness of time, and can affect your memory and ability to think sensibly. These effects can be felt even from small amounts of cannabis, and can last for several hours.

In larger amounts, cannabis can make these effects even stronger, but can also cause confusion, restlessness, hallucinations, anxiety or panic and paranoia. With regular use, cannabis also can cause strong depressive reactions. These effects can be felt long after cannabis is used.

Over the long term, research shows that cannabis increases the risk of lung problems, like cancer (higher than the risk for cigarettes), leads to less energy and motivation, and can affect hormone production (particularly can lower sex drive). Cannabis can also reduce brain functions, and make it difficult to concentrate, learn and remember.

Cannabis is also linked with psychosis. It can set off psychotic episodes in people with mental illnesses (make the condition worse), it could bring forward an episode of psychosis in people who are vulnerable to developing conditions like schizophrenia or manic depression.

Some people use cannabis for pain relief. Indeed, cannabis does seem to reduce pain, lower body temperature and increase appetite. BUT, new research shows that the side effects of cannabis (such as paranoia, hallucinations and depression) are far worse than new pain-killing medications that are now available. Research shows that cannabis is no more effective than codeine in treating pain, and has far more serious side effects.

Information taken from the following publications:
When you take speed, it melts into your bloodstream, and is carried to your brain. Once in the brain speed joins to certain sites called receptors. These receptors will trigger brain cells to start or stop different brain and body tasks.

Speed joins to receptors in the brain that trigger the release of dopamine and adrenaline in the body. Dopamine and adrenaline are chemicals that produce positive feelings when released. When speed enters the brain, it causes the artificial release of these chemicals, leading to short-term feelings of satisfaction, well-being, relief, increased attention, lots of energy etc. But, these effects are not without cost. The problem is that when the effects of speed wear off, it leaves a person with the opposite feelings – radical mood swings, depression, lack of energy, confusion, total exhaustion, uncontrolled violence etc. The greater the stimulation effects of speed, the greater the negative effects and rebound from speed.

Speed is a stimulating drug. It quickens activity in many parts of the body, including the messages sent from the brain to the body. But, because it does this unnaturally, it must “borrow” from the energy reserves of the brain and body rather than creating new energy for you to use. That’s why you get the rebound effects after taking speed.

As you continue to use, your body needs to work harder to burn up the speed that you put into it. It also starts to cut down the amount of dopamine and other chemicals it releases from the receptors in the brain. This means that your body won’t give you as good a feeling as when you first started to use speed, and you’ll rebound harder each time.

Frequent, heavy use can cause hallucinations, paranoia and bizarre behaviour (psychosis). Your appetite will be reduced, and you will be less likely to eat properly, making you run down and more likely to get infections. Heavy speed users may become violent for no apparent reason, and you may also experience constant sleep problems, anxiety and tension, high blood pressure and rapid, irregular heartbeat. Another common side effect is depression.

Because speed quickly fires up pleasurable feelings, you gain confidence in being able to feel good just by using it. You lose confidence in the people, places and activities that used to give you these feelings, because the effects don’t happen so quickly. You may find yourself spending more time trying to get speed, being with people who also use, and resenting those people and activities that don’t fit in with using speed. The problem, however, is that speed only gives you a false sense of well-being, along with serious side effects.

Information taken from these publications:
High Times: http://www.pdxnorml.org/brain1.html
Speed - Psychological & Physical probs: http://www.kci.org/meth_info/sites/meth psycho.htm
A primer of drug action. By Robert Julien
When a person drinks alcohol, the stomach soaks up about 20%, and the rest is taken up by the small intestine. From here, it enters the blood and is carried throughout the body. The alcohol in the blood then enters the different tissues in our body where it has its effect.

Alcohol is a **depressant** drug, and not a stimulating one as many people think. It **slows down the activity** in many parts of the body, including the brain, affecting concentration and co-ordination.

Research shows that alcohol **affects the brain in a negative way**. Alcohol acts mainly on the nerve cells in the brain and affects the way the nerve cells talk with other cells in the body.

Unlike other drugs, alcohol doesn’t act on one part or one receptor in the brain. Rather, it **affects many areas of the brain in different ways**. For example, it reduces activity in the area of the brain that looks after learning and memory, but increases activity in the area of the brain involved in emotions and reacting to stress.

Alcohol **slows down the messages** sent between the brain and the rest of the body, and can lead to **seizures, depression, manic depression and other mental problems**.

Alcohol can also upset the part of the brain that picks up on or judges the social signals that people give out. In this way, drinkers may be more likely to feel that someone is posing a threat where no threat really existed.

Over time and continued use, alcohol has some really **serious effects** on the body. For example, it can cause liver cell death and hardening of tissue in the **liver**, reduce the total brain mass, **brain damage**, lead to ulcers in the stomach and intestines and increase blood pressure along with lots of **emotional and social problems**. The drawing below shows what some other longer-term effects of alcohol are.

People who regularly drink heavily may become **dependent** on alcohol. Dependence can be psychological or physical or both. For example, people who are **psychologically dependent** on alcohol find that drinking becomes more important than other activities in their life. In these cases, people **play all sorts of tricks** on themselves. For example, people make themselves **believe that their alcohol use is a solution to their problems** ("it relaxes me, helps me to switch off"), when really it is making their problems worse.

*Information taken from the following publications:*
A primer of drug action. By Robert Julien
Long-term effects of alcohol

Nervous system
- tingling and loss of sensation in hands and feet

Heart
- high blood pressure
- irregular pulse
- enlarged heart

Lungs
- greater chance of infections, including tuberculosis

Muscles
- weakness
- loss of muscle tissue

Liver
- severe swelling and pain
- hepatitis
- cirrhosis
- liver cancer

Pancreas
- inflamed pancreas causing pain

Sexual organs
Males
- impotence
- shrinking of testicles
- damaged/less sperm
Females
- greater risk of gynaecological problems
- damage to foetus if pregnant

Blood
- changes in red blood cells

Brain
- brain injury
- loss of memory
- confusion
- hallucinations

Skin
- flushing
- sweating
- bruising

Stomach
- inflamed lining
- bleeding
- ulcers

Intestines
- inflamed lining
- ulcers

Picture courtesy of Australian Drug Foundation. Available at
<table>
<thead>
<tr>
<th>Positives about Drinking/Using</th>
<th>Importance (0-10)</th>
<th>Negatives about Drinking/Using</th>
<th>Importance (0-10)</th>
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<tbody>
<tr>
<td>Positives about Changing My Use</td>
<td>Importance (0-10)</td>
<td>Negatives about Changing My Use</td>
<td>Importance (0-10)</td>
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<tr>
<td>Time</td>
<td>When did I feel the best today?</td>
<td>When did I feel the worst today?</td>
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<td></td>
<td>Rating (1-5)</td>
<td>Situation (include cravings &amp; drinking/using)</td>
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**Ratings:**
1=The worst I have ever felt or could ever imagine feeling
2= Spirits low and feeling pretty blue and unhappy
3=In the middle, neither very bad or very good
4= Feeling pretty good, OK
5=The best I have ever felt or could ever imagine feeling
Client ID number: ____________________________

Session (please circle): 1 5 10

Therapist: ____________________________________

Date completed: _______________________________________

Please answer each question as honestly as you can. Place a tick (✓) in the circle that best describes your feelings

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Take-home Activities

Complete the Mood Monitor every day over the next week.

Take home the “Case Formulation” handout and revise if necessary.

Take home the “Pros and Cons Balance Sheet” and think about what this means for your current situation.

Add extra items to the Balance Sheet as you need to.

Plan for Completing Take-home Activities:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
THERAPIST SUMMARY SHEET

Session 2: Introduction to CBT
Rationale for therapy, Mood Monitoring, Motivational Interviewing, Mindfulness Training, Activity Log

Aims:
- Present client with structure for the session.
- Review the previous week and homework tasks.
- Continue with Motivational Interviewing as appropriate
- Present rationale for CBT.
- Introduce client to the concepts of mindfulness training and activity scheduling.

Materials needed for Session 2
- Copy of completed Handout: Pros and Cons Balance Sheet from Session 1
- Handout: Mood Monitor
- Handout: Mindful Walking
- Handout: Activity Log
- Handout: Summary Session 2

Areas to be covered within session 2 include:
2.1 Orient person to structure of session 2
2.2 Review the previous week
2.3 Set the agenda for session 2
2.4 Review homework from session 1
2.4.1 Review Case Formulation
2.4.2 Mood Monitoring
2.4.3 Pros and Cons Balance Sheet
2.5 Present rationale for CBT
2.6 Mindfulness Training
   Exercise: Mindfulness Skills 1 – Mindful Walking
2.7 Activity Scheduling
   Exercise: Activity Log
2.8 Conclusion
2.9 Brief Check-in
2.9.1 Homework from Module 2
2.9.2 Review homework activities
   Complete mood monitor
   Practice mindful walking 10 minutes each day (+ 1 other routine activity)
   Complete activity log
   Consider current levels of AOD use
2.9.3 Plan for completing homework
2.9.4 Suicide and mood assessment
2.9.5 Confirm next appointment
Session 2: Introduction to CBT

Rationale for therapy, Mood Monitoring, Motivational Interviewing, Mindfulness Training, Activity Log

Orient person to structure of session
It is important to structure your sessions with your client to ensure you are able to teach them skills, and facilitate progress towards their treatment goals. The first step in this and every SHADE therapy session will be to orient the person to the structure of the session, where you explicitly tell the person what will happen. For example, you may use the following explanation for Session 2:

“Let’s start with a brief check in: I want to hear about your week and how you are feeling. Then, let’s set an agenda for the session, and I want to make sure that one thing on the agenda is to check your homework from last time.”

Review the previous week
For about 5-10 minutes, ask the person to briefly talk about their week. Be sure to ask about any significant events that occurred since the last session, how their mood is currently, any changes in their mood, functioning or AOD use they have observed, and any reflections they may have about the content of Session 1. Look for how the issues raised here may lead into the development of an agenda for this session.

Set the agenda
The first item on the agenda should always be reviewing homework from the previous session. This often is a useful bridge between sessions, and also reinforces the importance of completing homework tasks (Persons et al., 2001; Beck et al., 1979). Then briefly explain the other issues and activities to be covered during this session: rationale for CBT, introduction to activity scheduling, and the Mindfulness Skills. Begin with the sentence: “let’s make an agenda for our session today...”. Once complete, work through the agenda items.

Review homework
The person’s homework from session 1 was firstly to review the case formulation developed during the session and make any necessary amendments, to complete the “Mood Monitor” each day over the previous week, and to revisit their “Pros and Cons Balance Sheet” for drinking/using.

Review Case Formulation
Should the person have made some adjustments to the case formulation, discuss them in session. In addition, ask the person to reflect on how the development of the case formulation impacted on them during the week. Discuss what the person learned in the homework, any problems that arose in completing the homework and how they might solve them.

Mood Monitor
Once you have made sure the person has some information entered on the form, look for patterns that emerge in the highs and lows of mood that the person has reported. For example, is the person’s mood low at the same time each day? If so, ask the person to detail what it is
about that time of day, for example, that leads to a low mood. Are they bored? Are they doing particular activities that they don’t enjoy? Are they overwhelmed because they have too much to do, and cannot make a start? Process the form with the client until you have a clearer idea about how their mood reacts to different situations.

It is important to highlight to the client that this exercise was also a data collection exercise. The client now has evidence that their mood is reactive rather than independent of them and their environment. Assign another mood monitor for homework for the next week.

**Pros and Cons Balance Sheet**

At the conclusion of session 1, you asked the client to consider the issues raised during the session, particularly in relation to their AOD use. Spend some time in this session re-visiting the issues raised previously, particularly the decisional balance activity.

Ask the client to elaborate on their current feelings about their alcohol/other drug use. Use the prompt: “How do you feel at the moment about your alcohol/other drug use?”

If at this stage the client’s balance is in favour of the negatives associated with modifying and the positives associated with continuing use, use the following techniques to tip that balance in the other direction. Remember that weighing up the pros and cons of AOD use is not just a simple matter of number of items for and against continuing to drink/use (Miller & Rollnick, 1991). The importance the client places on these items is far more powerful. For example, a client may have 10 reasons for changing their AOD use, but one powerful reason for continuing to use/drink. So, it is important to explore these issues in detail.

You may encounter resistance during this discussion. Miller and Rollnick (1991) have identified four categories of resistance behaviour in clients: **arguing** about the accuracy, expertise or integrity of the therapist (challenging, discounting, hostility); **interrupting** in a defensive manner (talking over, cutting off); **denying** or unwillingness to recognise problems, take responsibility or co-operate (blaming, disagreeing, excusing, claiming impunity, minimising, pessimism, reluctance); and **ignoring** or not following the therapist (inattention, non-answer, no response, sidetracking). If you pick up on this, use the following techniques in response (MET Manual, pg24):

- **Reflection** – simply reflect what the client is saying.
- **Reflection with amplification** – reflect but exaggerate what the client is saying to the point where the client is likely to disavow it. (However do not overdo this and elicit hostility).
- **Double-sided reflection** - reflect a resistant statement back with the other side (based on previous statements made in the session).
- **Shift focus** - shift attention away from the problematic issue.
- **Roll with resistance** (rather than opposing it) - gentle paradoxical statements that will often bring the client back to a balanced perspective.

Once the client raises a motivational topic, it is also useful to ask them to elaborate on it (Miller & Rollnick, 1991). This will reinforce the power of the statement and can often lead
to more motivational statements about change. Miller and Rollnick (1991) suggest that one useful way to do this is to ask for specific examples and/or for the client to clarify why this particular issue is a concern.

**Explore health risks:**
Can you tell me some reasons why drinking or using may be a health risk? *Would you be interested in knowing more about the effects of drinking/using?* (if the answer to this question is “Yes”, give the client a copy of the relevant information sheet about risks associated with drinking alcohol, or using cannabis or speed.)

“How important are these issues to you?”

Explore **financial costs of using:** The client may raise the cost of drinking or using as a factor in their decision to quit. At this time, ask the client:

“Do you have any idea just how much you think you would save if you didn’t drink or use at these levels?”

If appropriate, calculate how much money they will save in one year by quitting.

“How important are these issues to you?”

Explore the **client’s history** and how they picture things in the **future:**

“What were things like before you started using?”

“How would you like things to be different in future?”

“What’s stopping you from doing what you like?”

“How does using effect your life at the moment?”

“If you decide to change, what are your hopes for the future?”

“How important are these issues to you?”

Explore the client’s perceptions of **Self versus User:**

“What would your best friend/mum say were your best qualities?”

“Tell me, how would you describe the things you like about yourself?”

“And how would you describe you the speed user?”

“How do these two things fit together?”

“How important are these issues to you?”

If the client has been talking about the importance of preventing relapse, follow up with elaboration e.g., “Tell me more about preventing a relapse to depression … why is that so important to you … what is it like when you are ill? … what was it like in hospital (if applicable)? … and how about your family – what effect did it have on them?” Reflect back the emotional material that may arise from this psychological squirm (Saunders et al., 1991). Remember to assess the importance of these issues to the client: “How important are these issues to you?”

Add any additional reasons for drinking/using on the Pros and Cons sheet, including ratings of importance for each new reason. Keep going until you are able to tip the balance in favour of the positives of changing and the negatives of drinking/using. Also, try to tip the balance of **importance** in favour of changing.
Give the client a **copy** of the revised Pros and Cons Balance Sheet you developed in this session, and ask them to consider where this information leaves them in terms of their AOD use.

**Present rationale for Cognitive Behaviour Therapy** (CBT)

The overall objective of CBT is to identify and challenge the unrealistic beliefs that maintain the person’s problematic patterns of thought and behaviour, and replace them with more adaptive beliefs. Prior to commencing with this, however, it is important to “prepare” the client for the therapy that will follow. Having established rapport with the client, present the following rationale for CBT (Beck et al., 1979; Persons et al., 2001).

“As I mentioned during the last session, we will be using a cognitive-behavioural therapy program over the next few weeks. This therapy is based on the idea that people with depression tend to think in a typical way about themselves, about their environment and about the future. Last week we started to identify some of the patterns of thinking you have about yourself and the world around you, and we wrote this down in the case formulation. There is a close relationship between the way we **think** about ourselves, the environment and our future, and our resulting **feelings, motivations and behaviour**. When we are feeling depressed, we think in a more negative way – we have a negative bias in the way we interpret just about everything that happens to us, even if there are other ways of looking at the situation. We often aren’t even aware that this is happening – it’s almost automatic. These negative thoughts and ideas then feed back into our feelings and behaviour – we feel more negative, and less motivated or hopeful about our situation. So this makes our depression worse. But, in many cases, there are other ways of looking at those situations, that are equally as likely to be true, but aren’t quite so negative. So, this therapy will try to identify those situations where you have that negative automatic bias, and look at other alternatives to thinking about those situations.

It does take some time and practice to train yourself to do this, particularly when your mood is low and you are feeling depressed. This just means you have gotten into a habit of reacting negatively to these situations. But you can change this by re-training your brain to pay attention to these thoughts in a different way, and to attack those negative thoughts and replacing them with new ones. That is what the next few sessions will look at doing, and in the process I hope we can help you cope better with the things that are happening in your life at the moment, and in the future”.

You may also like to add the following (MET Manual, pg50):

“I should also explain right up front that I’m not going to be changing you. I hope that I can help you think about your present situation and consider what, if anything, you might want to do, but if there is any changing, you will be the one who does it. I’ll be giving you a lot of information about yourself and maybe some advice, but what you do with all of that after our sessions together is completely up to you. I couldn't change you if I wanted to. The only person who can decide whether and how you change is you. How does that sound to you?”
Mindfulness Training (Segal et al., 2002)

Segal et al. (2002) explain that mindfulness is an important skill, particularly when learning how to cope with the negative automatic thoughts that are associated with depression. The central idea of mindfulness is not to prevent these negative thoughts from entering a person’s mind altogether, rather to stop them setting in and taking control when they are triggered (Segal et al., 2002). Mindfulness is a way of stepping out of this automatic thinking pattern (automatic pilot) and it teaches people to pay attention in a particular way to what is happening in the present moment, and without judgement (Segal et al., 2002).

Thoughts play a pivotal role in triggering and maintaining depression. For example, your client may be plagued by thoughts such as “am I doing well enough?”, “is my mood better today?”, “I think I’m feeling worse today, it’s happening again” etc., and spend lots of time and energy making these judgements. These thoughts if left alone can lead to a downhill slide into lower mood and eventually full-blown depression (Segal et al., 2002).

Using mindfulness skills, clients can be taught firstly to recognise how little attention they actually pay to their daily life activities (such as eating, showering, walking, driving etc.), namely because they are in their “automatic pilot” mode. When in this mode, thoughts pass through their minds quickly, and this mind wandering can allow negative thoughts and feelings to occur (Segal et al., 2002). Negative thoughts put people at risk for experiencing an episode of depression. However, by using mindfulness skills, people are taught to recognise when they are in “automatic pilot” and how to use mindfulness to “check in” with themselves, to see which thoughts or judgements might be related to depressive symptoms (Segal et al., 2002).

Exercise: Mindfulness Skills 1 – Mindful Walking (Segal et al., 2002, pages 179-180)

- Summarise the above rationale to your client.
- Explain that you would like to start mindfulness training this session by helping them to pay more attention to their daily life activities.
- Start with Mindful Walking. This activity is to show people how to use mindfulness skills to pay particular attention to a routine activity (walking) – to practice stepping out of automatic pilot by choosing a physical activity they are likely to use every day.
- First, find a place where you and your client can walk up and down without worrying about who might see you (inside your office is fine, provided you can take about 10 steps).
- Stand with your client in a relaxed posture at one end of your walk with your feet pointing straight ahead, arms hanging loosely by your sides. Look straight ahead.
- Explain to your client that you are now going to start walking, but will practice paying attention to all the physical and other sensations that occur when you are walking –
sensations that you probably would not otherwise be aware of. You will practice walking like it is the first time you and your client have ever walked.

- Start by bringing your focus to the bottoms of your feet, noticing what it feels like where your feet and ground make contact. Feel the weight of your body transmitted through your legs and feet to the ground. You may like to flex your knees slightly a couple of times to feel the different sensations in your feet and legs.

- Next, transfer your weight into the right foot, noticing the change in physical sensations and your legs and feet as your left leg “empties” of weight and pressure and your right leg takes over as support for your body.

- With the left leg “empty” allow your left heel to rise slowly from the floor, noticing the change in sensations in your calf muscles as this happens. Allow the entire left foot to lift gently off the floor until only your toes are still in contact with the ground. Slowly lift your left foot completely off the floor and move your left leg forward, noticing the physical sensations in your feet, legs and body change as your leg moves through the air.

- Place your left heel on the ground in front of you and allow the rest of your left foot to make contact with the floor. As this happens you are noticing the changes in physical sensations that occur as you transfer the weight of your body onto your left foot and off your right foot. Allow your right foot to “empty” of weight.

- Repeat this process with the right foot. Firstly lifting your right heel off the ground, followed by the rest of your right foot, and move it slowly forward, noticing the changes in physical sensations that occur throughout this motion.

- Keep repeating this process as you slowly move from one end of your walk to the other, aware of the particular sensations in the bottoms of your feet and heels as they make contact with the floor, and the muscles in your legs as they swing forward.

- Continue this process up and down the length of your walk for about 10 minutes, appreciating the complexity of walking, being aware as best you can, of the physical sensations in your feet and legs, while keeping your gaze directed ahead.

- Your minds will wander away from this activity during your 10 minutes of practice. This is normal — it is what minds do. When you notice this has happened, gently guide the focus of your attention back to the sensations in your feet and legs, paying particular attention to the contact your feet have with the floor. This will help you stay in the present moment, concentrating on what is happening now, rather than worrying about the past or the future.

- To begin with, walk more slowly than usual, to give yourselves a better opportunity to practice this exercise. Once you feel comfortable with the exercise, you may like to experiment with different speeds of walking. If your client is particularly agitated, you may like to start off walking fast, with awareness that this is what you are doing, and then to slow down naturally as they settle.

Once you have completed this activity, process with your client the experiences you both had during the exercise. Ask your client to describe their experience with this activity, including their thoughts, feelings and sensations. Allow them to comment on their experience with mindful walking. The key message here is for the client to learn that there is no success or failure with this activity. Communicate to them that you are not aiming for any special state, and not to try too hard to “get it right” (Segal et al., 2002). Rather, the task is to simply pay
attention to what is happening in the present moment. If thoughts about “am I doing it right” or worries are raised about what you might be thinking, the task for the client is to recognise that the thoughts are there (not to try to stop them coming), and once recognised, to gently bring the focus of their attention back to the present moment (and their walking) (Segal et al., 2002).

Ask your client to practice mindful walking once every day for 10 minutes or more frequently if they prefer. Give your client a copy of the “Mindful Walking” handout (Segal et al., 2002) to remind them of the basic elements of this exercise.

**Activity Log**
Activity scheduling is a key behavioural component of CBT for depression. Particularly in the early stages of therapy, it is important to focus on behavioural interventions, with a view to restoring a person’s functioning to higher levels.

When people are going through difficult times, it is rare for them to remember doing anything meaningful or fun throughout their day. This is particularly the case for people who are depressed. Their negative view of the world means they are more likely to focus on the things they have not done, or missed out on doing. In these cases, completing an activity record provides evidence of what has been accomplished, and can be a useful tool in assisting the person to challenge their negative view of the world.

In the case of people who are also using alcohol/other drugs, it is common for them to have narrowed their behaviours to those associated with drinking or using. As such, they tend to over-emphasise the importance of using or drinking in their day, and it is difficult for them to imagine how else they could fill in their time. An activity schedule is a useful way of broadening the selection of activities in which they can be involved. In the longer term, if they decide to cut down or stop using alcohol or other drugs, planning into their day specific tasks, means they may be able to distract themselves from thinking about using.

The first step in activity scheduling is to collect concrete information about what the person is currently spending their time doing (Persons et al., 2001). This may also provide useful information about the “danger” times when people are most at-risk of falling victim to their depressive thoughts and/or drinking/using. Completing a record of activities for the week also directly challenges their ideas that “I’m not accomplishing anything”, “I never see my friends anymore” etc. People are often surprised when they compare their beliefs about their activities with their activity record (Persons et al., 2001).

<table>
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<tr>
<th>Exercise: Activity Log (Persons et al., 2001)</th>
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<tr>
<td>- Use the sheet titled “Activity Log”</td>
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<td>- Explain to the client that it is important to pay attention to the things they are able to accomplish in their day, and that the Activity Log is a useful way to do this. By completing the Activity Log for the next week, your client can begin to collect evidence that they are able to function and that they are managing to get some things done. Completing an Activity Log may also start the process of recognition about the inaccurate nature of some</td>
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of their thoughts/beliefs. Be sure to communicate the importance and value of this activity to your client.

- Either during the day or at the end of each day, ask the person to complete the activity log, and detail their activities at the times listed throughout the day. Be sure they write down everything – appointments, housework (list specific activities), socialising, drinking/using etc. no matter how insignificant they feel the activity is. Remind them this is an observation/data collection exercise, not one in judging how they use their time.
- Ask the client to record the times of day when they practice their mindful walking. They may even like to plan time in advance (in session) for their 10 minutes of practice to occur, and write down “mindful walking” in the relevant timeslot on each day of their Activity Log.
- Encourage the client to complete the activity log each day over the next week and bring into next weeks’ session.

**Assign homework**
The client has the following tasks to complete for homework: mood monitoring, mindful walking for 10 minutes each day, completing the activity log and to consider their current levels of AOD use. Summarise the importance of completing these homework tasks, and explain you will use them in next weeks’ session.

**Conclusion**
The client has been asked to absorb much information during this session. Ask them to go home and think about some of the things they have learned, with a particular view to what they do with all this information.

Summarise the discussion in the following way (MET Manual pg26, 53): “Let me try to pull together what we’ve said today, and you can tell me if I’ve missed anything. I started out by asking you …and you told me several things (repeat what was said). I appreciate how open you have been to this feedback and I can see you have some real concerns about your drinking/using (if appropriate). Is that a pretty good summary? Did I miss anything?” (p26, p53 MET manual).

Be aware that you may need to modify the motivational interview based on how the client is taking on board all of these issues.

Give the client a copy of the revised Pros and Cons Balance sheet to take home with them and revisit through the week. Pose the following question as something for them to consider over the next week (MET Manual pg29): “Over the next week, I’d like you to think about all these things we have talked about today.” If appropriate, continue with: “In particular I’d like you to think about where this all leaves you in terms of your AOD use. I’d like you to think about what you might do about all these concerns.”

It is crucial at this time to offer supportive, encouraging statements. Encourage progress already made, and make mention of the strengths and assets you both identified during the case formulation session last week. Affirming the client can be helpful through strengthening
the work relationship; enhancing the attitude of self-responsibility and empowerment; reinforcing effort and self-motivational statements, and supporting client self-esteem.

**Brief check-in**
In the context of the SHADE project, therapists spent an additional 5-10 minutes at the conclusion of each session conducting a “brief check-in”. This was to confirm (especially for those allocated to the computer therapy condition) that people understood the homework set during the session and had thought about a plan for completing the homework tasks. The “brief check-in” was also used to conduct a more formal suicide risk assessment.

After the person has completed Session 2, spend a short time face-to-face with them covering the following items. Use the “Summary: Session 2” sheet.

**Review Homework Activities**
The following activities have been set for completion between now and Module 3: complete the mood monitor, record activities using the activity log, practice mindful walking for 10 minutes each day, and to consider current levels of AOD use, using their revised “Pros and Cons Balance Sheet” as a guide.

To check the client’s understanding of these tasks, ask them to describe the homework tasks in their own words.

Reinforce that just having a go at completing the homework is a success in itself. However, summarise the importance of completing homework, and explain that they will be used in next weeks’ session.

Take a copy of the client’s revised “Pros and Cons Balance Sheet” and keep in their clinical file.

**Plan for Completing Homework**
Briefly explore with the client any problems they anticipate in completing their homework activities, and together develop and verbalise a plan for doing homework tasks through the week. These plans can include a time, day, and place to complete homework, along with a time limit that establishes how long the person will spend on homework tasks per day. Also, include plans to remove distractions (such as turning off the radio/television, doing it away from the rest of the family/housemates etc.) and also not completing tasks in bed.

**Suicide and Mood Assessment**
Your interaction with the client should give you a general idea of what their level of mood currently is. However, it is important to test out your impressions, either by asking the person more directly about their mood/suicide ideation, or by using questionnaires to do this. If appropriate, you may like to use the Beck Hopelessness Inventory to assist your assessment.

Refer to the Suicide Risk Assessments in the first section of this manual to assist your assessment, and for a protocol for managing those people at high risk for suicide.
Confirm Next Appointment

Arrange the client’s next appointment before they leave.
### Mood Monitoring Form

<table>
<thead>
<tr>
<th>Day</th>
<th>When did I feel the best today?</th>
<th>Time</th>
<th>Rating (1-5)</th>
<th>Situation (include cravings &amp; drinking/using)</th>
<th>Time</th>
<th>Rating (1-5)</th>
<th>Situation (include cravings &amp; drinking/using)</th>
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**Ratings:**

1=The worst I have ever felt or could ever imagine feeling
2= Spirits low and feeling pretty blue and unhappy
3=In the middle, neither very bad or very good
4= Feeling pretty good, OK
5=The best I have ever felt or could ever imagine feeling
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<tr>
<th>Activity Log</th>
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Mindful Walking

SEGAL ET AL. (2002)

Mindful walking is a way of stepping out of “automatic pilot” and to practice paying attention to the present.

The Basics

Stand at one end of your walk, keeping your feet pointed forward and eyes straight ahead.

Start slowly at first and as best you can pay attention to the way your feet and legs feel when you take each step forward.

Start with the left foot, and follow with the right.

Slowly move from one end of your walk to the other, aware of the particular sensations in the bottoms of your feet and heels as they make contact with the floor, and the muscles in your legs as they swing forward.

Continue this process up and down the length of your walk for about 10 minutes.

Your mind will wander away from this activity during your 10 minutes of practice. This is normal. As best you can when you notice this has happened, gently re-focus your attention on your feet and legs and how they feel when they contact with the floor.
Take-home Activities

- Try to fill out the Mood Monitor every day over the next week, writing down as much information as you can about what was happening at those times when you felt the best, and those times when you felt the worst.
- Take home the “Pros and Cons Balance Sheet” and think about what this means for your current situation. Add extra items to the Balance Sheet as you need to.
- Try to practice Mindful Walking for 10 minutes each day and record on the Activity Log those times when you do mindful walking (you may also like to plan ahead when you will practice this exercise).
- Try to fill out the Activity Log, by recording your activities on the form everyday. Notice how much you enjoy each activity and place an “Enjoyment” rating from 1 to 5 for each activity.

Plan for Completing Take-home Activities:

__________________________________________________________________________
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Session 3: CBT and Introduction to Motivational Interviewing
Mood monitoring, Activity Log, Mindfulness Skills, Motivational Interviewing

Aims:
- Expand on the Activity Log exercise to include mindfulness of pleasant activities.
- Expand on the Mindful Walking exercise to include another routine activity.
- Continue with motivational interviewing around AOD use.

Materials needed for Session 3
- Handout: Interpreting Situations
- Handout: Thought Monitoring
- Handout: Activities List
- Handout: Activity Log
- Handout: Summary Session 3

Areas to be covered within session 3 include:
3.1 Orient person to structure of session 3
3.2 Review the previous week
3.3 Set the agenda for session 3
3.4 Review homework from session 2
3.4.1 Mood Monitor
3.4.1.1 Monitoring Automatic Thoughts
   Exercise: Demonstrating the Links Between Thoughts and Behaviour
3.4.1.2 Practice Thought Monitoring
   Exercise: Monitoring Thoughts about Triggers
3.4.2 Activity Log
3.4.2.1 Mindfulness of Pleasant Activities
   Exercise: Mindfulness of Pleasant Activities
3.4.3 Mindful Walking
3.4.4 Pros and Cons Balance Sheet
3.5 Informal Assessment of Change
3.6 Identify a Support Person
3.7 Conclusion
3.8 Brief Check-in
3.8.1 Homework from Module 2
3.8.2 Review homework for Module 3
3.8.3 Plan for completing homework
3.8.4 Suicide and Mood assessment
3.8.5 Confirm next appointment
Session 3: CBT and Motivational Interviewing
*Mood monitoring, Activity Log, Mindfulness Skills, Motivational Interviewing*

Orient person to structure of session
Structure this session in the same way as you did in session 2. For example, say to the client: “Let’s start with a brief check in: I want to hear about your week and how you are feeling. Then, let’s set an agenda for the session, and I want to make sure that one thing on the agenda is to check your homework from last time.”

Review the previous week
For about 5-10 minutes, ask the person to briefly talk about their week. Be sure to ask about any significant events that occurred since the last session, how their mood is currently, any changes in their mood, functioning or AOD use they have observed, and any reflections they may have about the content of Session 2. Look for how the issues raised here may lead into the development of an agenda for this session.

Set the agenda
The first item on the agenda should always be reviewing homework from the previous session. Then briefly explain the other issues and activities to be covered during this session: expanding on activity scheduling activity, continue with mood monitoring and exploration of reasons for use of alcohol/other drugs. Begin with the sentence: “let’s make an agenda for our session today…” Once complete, work through the agenda items.

Review homework
The person’s homework from session 2 was to complete a mood monitor for every day of the previous week, and to fill in an activity log detailing the behaviours and activities in which they engaged in the previous week. In addition, people were asked to practice mindful walking for 10 minutes each day, and to try to choose one other routine activity on which to practice mindfulness skills. Firstly, establish whether the person completed each activity, and if not, discuss the barriers that prevented them from doing so. Work towards a solution to these barriers with a view to preventing their occurrence in future homework tasks. If the person has no information entered onto their forms, ask them to spend the first 5-10 minutes of the session completing them before you continue with the remaining agenda items.

Mood Monitor
Once you have made sure the person has some information entered on the form, continue with the approach you took in last week’s session in looking for patterns that emerge in the highs and lows of mood that the person has reported. Process the form with the client until you have a clearer idea about how their mood reacts to different situations.

Monitoring Automatic Thoughts
Over the past few weeks, the client has learned how to monitor the highs and lows of their mood. Hopefully they will have started to observe patterns in these mood fluctuations, and possibly how their AOD use fits in to these fluxes. Next in this process is learning how to examine their mood more closely, and break down the steps occurring between a situation or
trigger for depression/AOD use and the subsequent feelings of depression or cravings for alcohol/other drugs that result. The ABC cognitive model (below) is a useful framework for this process, and can assist the client in regaining some control over their environment (Ellis, 1975; Graham et al., 2000; Beck et al., 1979).

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<th>(Activating event)</th>
<th>(Beliefs)</th>
<th>Consequences</th>
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<tr>
<td>A Situation</td>
<td>Your automatic reactions/thoughts</td>
<td>Your feelings or behaviours</td>
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Explain the ABC model to the client using the following:

“Events or situations don’t usually cause our feelings or behaviour; rather it is our interpretation (or thoughts) about those events that will directly relate to our feelings and actions. So, rather than feeling hopeless about trying to control situations that pop up (which is virtually impossible), a better approach is to learn how to change or control our response to those events and to feel more positive about our situation. The ABC model shows that when particular situations happen (A’s=activating events), they trigger certain thoughts (Bs = beliefs), and these Bs cause our feelings, or control our behaviour (Cs = our consequences). “As” (or activating situations) don’t have much to do with our feelings at all, rather it is our interpretations/response to those situations that controls how we feel. So, it is important to learn about the links between what happens out there in the world, our thoughts about those situations and our resulting feelings and behaviour.”

**Exercise: Demonstrating the link between thoughts and feelings/behaviour** (Jarvis, Tebbutt & Mattick, 1995; Persons et al., 2001, Segal et al., 2002)

- Use the sheet titled “Interpreting Situations”
- Ask the client to imagine the scenario that appears on the handout: “You see a friend across the street and call out to him/her to say hello. Your friend keeps on walking up the street...”
- Ask the client to interpret this event. What is the first thought that comes into their mind? Write this down on the handout.
- Then, ask the client to identify how they would feel or what they might do in this situation, with this interpretation of the event.
- Fit the ABC model to this exercise. A=the scenario (the activating event), B=interpretation or explanation the client generated to explain the event, and C=how they felt or what they might do.
- Summarise by explaining: “This process happens for every situation we encounter, especially those that trigger our depression or a craving to use alcohol/other drugs. Quite often, this whole process happens so quickly we don’t even realise that it has happened like this – it is almost automatic, a reflex. Usually, we just suddenly realise”
we are feeling bad, or are having a craving to use alcohol/other drugs. These feelings are often the signal that we have had an automatic thought about the present situation that has resulted in a craving, negative mood or other symptoms.”

- Give the client an example that is relevant to using alcohol/other drugs, where the “C” of the situation is drinking or using. For example: Jim/Jill is at home most days, with very little to fill his/her time. On a particular day he/she starts to get very bored and can’t find anything to do with his/her time (“A”). Then he/she starts to think: “nothing good ever happens to me, I’ve got nothing to do, nobody to do anything with, life sucks” (“B”). He/she gets very caught up in these thoughts and starts to feel depressed (“C”), then starts to drink to make himself feel better (“C”).
- Give the client a copy of this handout to take home and refer to over the next week. You need to keep your own copy of this completed handout, as you will refer back to it in Session 5.

Explain to the client:
“In working out how to manage our depression, and our AOD use, we first need to find out which situations are most likely to lead you to drink or use or to feel depressed and what you are thinking and feeling in those situations. What we want to learn is what kinds of things are triggering or maintaining your thoughts and feelings. Then, we can try to develop other ways you can deal with these “high-risk” situations without drinking/using/feeling depressed. This involves learning specific skills and strategies. What we’ll discuss over the next few sessions will relate to: identification of triggers; learning techniques for managing automatic thoughts; techniques for managing negative moods (anxiety, stress); general coping skills (communication skills, stress management and relaxation); and relapse prevention strategies. We can also talk about any areas that you are having particular difficulty in.”

Practice thought monitoring
Breaking events down into their ABCs can take a bit of practice. So, over the next week, ask the client to formally practice identifying the As, Bs and Cs of situations. Explain clearly to the client that these situation can relate to when they are feeling bad, or low, or depressed as well as those times when they feel like drinking/using (or a having a craving). The same exercise can be applied to any of these experiences.

**Exercise: Monitoring thoughts about triggers (Jarvis, Tebbutt & Mattick, 1995).**
- Use the sheet titled “Self Monitoring Record” and demonstrate its use (use the following explanation as a guide):
  - “This exercise is an important first step in taking control of your thoughts and feelings. It involves a “real world” experiment. Over the next week, please complete the self-monitoring record on each day”. Be sure to communicate the importance and relevance of the homework activity to the client.
- Explain how to use the sheet: “Over the next week, pay close attention to those times and situations when you find yourself feeling depressed and/or with the craving to use alcohol/other drugs. While you are still getting used to this activity, you might find that you don’t realise such a situation has occurred until you get those feelings (the C’s) that
are associated with depression, a craving for alcohol/other drugs. So, over the next week when this happens, try to “stop the clock”. Say to yourself STOP, SLOW-DOWN, and fill in this sheet.” Ask the client to write down the situation that led to the feelings in the “Trigger” column. Then, write down the automatic thoughts they have about that situation in the “Thoughts” column, writing down their words as if they were speaking them out loud, using the words that actually come to mind. In the “Feelings” column, ask them to describe the feelings or symptoms they are experiencing (including whether they experienced a craving). Finally, ask the client to indicate in the “Behaviours” column what they did, e.g. whether they used, drank, put themselves to bed, tried to switch off etc.

- Ask the client to bring in the completed form next session. Remind them: “The main point of this activity is that once we know about the situations and problems that contribute to your drinking/using/feeling bad, we can look for other ways to deal with those situations.”

Activity Log
Once you have established that the person has some information entered onto the form, look for any patterns that have emerged. Using the log in conjunction with the Mood Monitor can give you more detailed information about the relationship between the person’s mood and what they are doing at the time. For example, are there some activities that pull the person’s mood down, and others that elevate it? Alternatively, the client may be engaging only in activities that they do not enjoy. Are there times of the day or week when the person is not using time well? Does the person have problems in the evening hours, or at the weekend?

Also, look for discrepancies in the person’s rating of enjoyment of different tasks, e.g. are there activities that one would normally expect to be enjoyable that the person has rated very low for enjoyment (e.g. going to a movie)? Discuss these discrepancies with the client to determine whether they are evidence for the negative bias in interpreting events that was mentioned in session 2. These discrepancies may also provide clues for underlying problematic schema.

Mindfulness of pleasant activities (Segal et al., 2002)
Once you have processed the activity log with the client, move on and expand this activity.

It is important for people to learn how their thoughts and their mood alter their experience of different activities as enjoyable, unpleasant or neutral. Indeed, thought monitoring (and thought challenging in later sessions) will assist the person in this process. However it is important for people to become more mindful of pleasant activities they are doing, while they are doing them, and without allowing negative thoughts to intrude on these activities and alter their interpretations of that event (Segal et al., 2002).

The task for the person over the next week is to become mindful of doing one pleasant activity every day (preferably while they are doing this activity) and to write this down on the Activity Log.
Exercise: Mindfulness of pleasant activities

- Take out the “Activities List”
- Explain to the client the importance of noticing the positive activities in the week that they are currently involved in. Some depressed people report very little satisfaction from the things they do with their time, either because they are not spending their time doing the things they enjoy, but often because they place a negative interpretation on most of the activities that occupy their time. This exercise is an important part of stepping out of this cycle. Be sure to communicate the importance and value of this activity to your client.
- Ask the client to become aware of at least one pleasant activity they are involved in on each day over the next week, not matter how small or insignificant they feel it is. When this happens, ask the client to focus on this activity as it is happening, including their thoughts, their feelings and their bodily sensations that accompany this activity. Encourage them to really experience this activity as enjoyable, but without adding any further thoughts to the moment (such as “I wish this would last forever”, “why doesn’t this happen more often”, or “this won’t last long”)
- When they notice this pleasant activity, ask the client to write this activity down on the “Activities List” in the “Pleasant Activities” column. Ask the person to bring in the completed list next week.
- In addition, ask the client to complete another “Activity Log” for the coming week. Ask them to include in this log when these pleasant activities are occurring.

Mindful Walking (Segal et al., 2002)
Discuss with your client their impressions of the mindful walking activity they completed over the past week. Ask them to describe their actual experiences of mindful walking, including their thoughts, feelings and sensations they became aware of during their practice. Ask them for any comments on their experiences.

It is also important for you and your client to discuss any difficulties or barriers they experienced in practicing mindful walking. Segal et al. (2002) describe some typical reactions to mindfulness activities as: “I don’t think I’m doing this right”, “I couldn’t find time”, “what’s the point of doing this, I don’t see what this has to do with my problems”, “my mind wouldn’t stay still”, or “I just go too upset”. Each of these reactions is important to acknowledge and discuss with the client during this session, as they can undermine motivation to practice.

The important points to re-iterate to people in response to these issues are: Mindfulness is more about “being”, “allowing” and “non-judgmental awareness”, rather than paying attention to thoughts about doing it properly, worrying about achieving a particular state, or judging whether it is doing anything beneficial. The key is to step out of the tendency to evaluate and judge activities, and practice being in the moment (Segal et al., 2002).
Segal et al. (2002) explain that sometimes the best way to deal with problematic thoughts and emotions is not to try to change them or to “think” your way out of them. Interpretation of thoughts is often where people with depression run into problems and encounter their negative automatic bias. It is far more useful at this point, to encourage people to settle into each moment, to become aware of those times when their mind wanders off to other thoughts and worries, and to bring their focus back to the activity.

Segal et al. (2002) explain that regular practice is the best way to become accustomed to mindfulness, and so it is important for the client to continue to practice mindful walking on a regular basis every day over the next week. In addition, ask the client to try to incorporate mindfulness techniques into one other routine activity they are involved in over the next week.

**Exercise: Mindfulness of Routine Activities (Segal et al., 2002)**

- After processing your client’s experiences with mindful walking, ask them to apply their mindfulness skills to one other routine activity over the next week.
- Ask the client to choose one activity from their routine (e.g. showering, eating, brushing teeth, ironing, washing dishes, cooking etc.)
- Discuss in session with your client all the physical sensations that make up this routine activity. Break the activity down into small discrete steps, just like you did in the mindful walking exercise last session.
- Ask the client to spend time each day practicing their mindfulness skills on this routine activity and to enter this activity on the “Activity Log” for each day.
- You may even like to plan times/days for this mindfulness to occur during this session – both for mindful walking and for mindfulness of one routine activity. Enter those times/days onto the “Activity Log”.

**Pros and Cons Balance Sheet**

At the conclusion of session 2, you asked the client to consider the issues raised during the session, particularly in relation to the AOD use. Spend some time in this session re-visiting the issues raised previously, particularly the decisional balance activity.

**Informal Assessment of Stage of Change**

Miller and Rollnick (1991) explain that the decisional balance activity can be a useful method for not only assessing current motivation to change, but also can influence motivation to change.

After discussing the content of the previous session, examine the client’s use of language in talking about their AOD use. Have they started to express “intention to change” statements, or “optimism for change” statements? Now is the time to decide with the client whether to move forward into the next phase of motivational interviewing, or whether they need to consolidate and re-visit some of the ideas posed in the previous session.
Miller and Rollnick (1991) suggest that the decisional balance is one method of judging this; however informally assessing readiness to change is another approach. Prochaska and DiClemente’s (1984) stages of change model is an important concept to keep in mind – do you feel the person has moved to the contemplation stage? Are they ready for action?

You may like to pose the following questions to clients to elicit “intention to change” and “optimism for change” statements (Miller & Rollnick, 1991; Rollnick et al. 1999)
“Who do you need to talk to about your change? What would have to change to fix this?”
“Who would have to happen for it to become much more important for you to change?”
“If you were 100% successful and things worked out exactly as you would like, what would be different?”
“If you were to change, what would it be like?”
“The fact that you are here indicates that at least a part of you thinks it is time to do something. What are the reasons you see for making a change?”
“Where does this leave you now?”
“What would make you more confident about making these changes?”
“If you were to decide to change what might your options be?” Are there any ways you know about that have worked for other people? Is there anything you found helpful in any previous attempts to change?”
“What are some of the practical things you would need to do to achieve this goal? Do any of them sound achievable?”

Ask the client to reflect on this discussion over the next week, in terms of their current AOD use.

**Identify a support person**

Session 4 will ask the client to think about a plan for changing their current situation (i.e. depression and AOD use as appropriate). In making these plans, it is often useful for the client to identify a support person to assist and encourage them. Not all clients will identify or want a support person to assist them. But, support people will be useful in assisting with goals, and strategies for change. You may like to ask the client if they would like the support person to attend the next session, where you could review the client’s goals and plans. The client may like to consider ways for the support person to offer assistance and communicate this to the other person himself or herself, outside of therapy.

During this session, present a rationale for having a support person attend session 4. The support person is someone who cares about the client, and often is someone who will be affected by any changes the client makes. The support person’s input will be valuable in setting goals and developing strategies; and he/she may be of practical help in working towards whatever goal the client chooses.

Emphasise that change is the client’s responsibility but that the support person may help.
Identify with the client whether there is somebody in their lives who they consider could act in this role. Ask them to invite this person to the next session, and again if the client feels it appropriate, session 9 and 10.

**Conclusion**

It is crucial at this time to offer supportive, encouraging statements as in the last session. Encourage progress made already in relation to addressing their AOD use in particular, and commend them for considering their current habits. Thank them for completing their homework tasks from last session, and encourage them to complete the tasks set for the coming week. Affirming the client can be helpful through strengthening the work relationship; enhancing the attitude of self-responsibility and empowerment; reinforcing effort and self-motivational statements, and supporting client self-esteem.

**Brief check-in**

After the person has completed Module 3, spend 5-10 minutes face-to-face with them covering the following items:

**Homework from Module 2**

Take a copy of all completed homework activities from Module 2 and place in the client’s clinical file.

**Review Homework Activities**

The following activities have been set for completion between now and Module 4: completing the Thought Monitor, practicing mindfulness of pleasant activities and recording these on the “Activities List” and “Activity Log”, completing the “Activity Log” as per last week, practice mindful walking and applying mindfulness skills to another routine activity, and to re-visit their reasons for AOD use with a view to addressing the concerns raised in the session. In addition, the client will invite a support person to attend session 4 with them.

To check the client’s understanding of these tasks, ask them to describe the homework tasks in their own words.

Reinforce that just having a go at completing the homework is a success in itself. However, summarise the importance of completing homework, and explain that they will be used in next weeks’ session.

**Plan for Completing Homework**

Briefly explore with the client any problems they anticipate in completing their homework activities, and together develop and verbalise a plan for doing homework tasks through the week. Discuss the effectiveness of the plan developed from last session, and whether the client experienced any difficulties in completing homework from Module 2.

These plans can include a time, day, and place to complete homework, along with a time limit that establishes how long the person will spend on homework tasks per day. Also,
include plans to remove distractions (such as turning off the radio/television, doing it away from the rest of the family/housemates etc.) and also not completing tasks in bed.

Suicide and Mood Assessment
Your interaction with the client should give you a general idea of what their level of mood currently is. However, it is important to test out your impressions, either by asking the person more directly about their mood/suicide ideation, or by using questionnaires to do this. If appropriate, you may like to use the Beck Hopelessness Inventory to assist your assessment.

Refer to the Suicide Risk Assessments in the first section of this manual to assist your assessment, and for a protocol for managing those people at high risk for suicide.

Confirm Next Appointment
Arrange the client’s next appointment before they leave.
**Interpreting Situations**
*“It is up to me”*

Imagine the following situation…

“You see a friend across the street and call out to them to say hello. Your friend keeps on walking up the street…”

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<th>Possible explanations or thoughts</th>
<th>Feelings</th>
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<td>Pleasant Activities</td>
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Take-home Activities

- Try to fill out the Thought Monitor every day over the next week, for each situation where you feel depressed, negative, unhappy, bored etc. and when you feel like a drink/other drugs. As in the example, break this situation down into the A – Situation, B-thoughts, and C-feelings and behaviours. Write down your thoughts as if your were speaking them out loud – use exactly the same words the are in your thoughts without evaluating them before you write them down.

- Take home the “Pros and Cons Balance Sheet” and think about what this means for your current situation. Add extra items to the Balance Sheet as you need to.

- Try to practice Mindful Walking for 10 minutes each day and write down on the Activity Log those times when you do mindful walking (you may also like to plan ahead when you will practice this exercise).

- Use your Mindfulness Skills for another routine activity – such as eating, brushing your teeth, showering, hanging out clothes etc. and write down when you do so on the Activity Log.

- Try to fill out the Activity Log, by recording your activities on the form everyday.

- Try to pay close attention to one pleasant activity you are doing in each day. As best you can, notice all the thoughts, feelings and body sensations that go with this pleasant activity, and write it down on your Activity List and Activity Log, and bring this in next week.

Plan for Completing Take-home Activities:

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THERAPIST SUMMARY SHEET

Session 4: CBT and Motivational Interviewing
Activity scheduling, Mindfulness Skills, Thought Monitoring, Motivational Enhancement, Coping with Cravings

Aims:
- Learn thought monitoring techniques, involve support person in session
- Design an change plan worksheet for drinking/using and depression
- Teach strategies in coping with cravings to use alcohol/other drugs

<table>
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<th>Materials needed for Session 4</th>
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<tr>
<td>• Handout: Activity Log</td>
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<td>• Handout: Thought Monitoring</td>
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<td>• Handout: Change Plan Worksheet</td>
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<td>• Handout: Facts about Cravings</td>
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<td>• Handout: Coping with Cravings</td>
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<td>• Handout: Summary Session 4</td>
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Areas to be covered within session 4 include:

4.1 Orient person to structure of session 4
4.2 Review the previous week
4.3 Set the agenda for session 4
4.4 Review homework from session 3
   Mindfulness Skills
   Activity Log
   Thought Monitoring
   Reasons for AOD use
4.5 Informal Assessment of Stage of Change
   Client not ready for change
   Client ready for change
4.6 Involve Support Person
4.7 Phase 2 Motivational Interviewing
   Exercise: Change Plan Worksheet
4.8 Coping with Cravings
4.8.1 Describing a Craving
4.8.2 Learn Ways to Manage Cravings for Alcohol/Other Drugs
   Exercise: Coping with Cravings
4.9 Conclusion
4.10 Brief Check-in
4.10.1 Homework from Module 3
4.10.2 Review Homework for Module 4
4.10.3 Plan for Completing Homework
4.10.4 Suicide and Mood assessment
4.10.5 Confirm next appointment
Session 4: CBT and Motivational Interviewing

Activity scheduling, Mindfulness Skills, Thought Monitoring, Motivational Enhancement, Coping with Cravings

Orient person to structure of session
If applicable, meet the support person the client has brought with them to session 4. Ask the support person to wait in an appropriate area for about 20 minutes, after which time you will come out and ask them to join you.

Once in session with the client, present the structure in the same way as you did in session 3. For example, say to the client: “Let’s start with a brief check in: I want to hear about your week and how you are feeling. Then, let’s set an agenda for the session, and I want to make sure that one thing on the agenda is to check your homework from last time.”

Review the previous week
For about 5-10 minutes, ask the person to briefly talk about their week. Be sure to ask about any significant events that occurred since the last session, how their mood is currently, any changes in their mood, functioning or AOD use they have observed, and any reflections they may have about the content of Session 3. Look for how the issues raised here may lead into the development of an agenda for this session.

Set the agenda
The first item on the agenda should always be reviewing homework from the previous session. Then briefly explain the other issues and activities to be covered during this session: exploration of reasons for use of alcohol/other drugs. Begin with the sentence: “let’s make an agenda for our session today...” Once complete, work through the agenda items.

Review homework
The person’s homework from session 3 was to complete a mood monitor for every day of the previous week, and to fill in an activity log, scheduling enjoyment and achievement activities into each day. Firstly, establish whether the person completed each activity, and if not, discuss the barriers that prevented them from doing so. Work towards a solution to these barriers with a view to preventing their occurrence in future homework tasks. If the person has no information entered onto either form, ask them to spend the first 5-10 minutes of the session completing them before you continue with the remaining agenda items.

Thought Monitor
Hopefully, the previous week presented many opportunities for clients to identify the As, Bs, and Cs of high-risk situations for depression and AOD use. Review the thought monitoring record with the client and confirm that they were able to understand and complete the form correctly. Are any patterns evident in they way the client thinks about situations (e.g. can you detect a negative bias to the thoughts)? Were there any problems? What did they think about the activity? Process the form in session with the client, and assign another thought monitoring activity for homework.
Mindfulness Skills
Assess how the person was able implement the Mindfulness Skills activities over the past week. Were they able to find time to practice mindful walking and mindfulness of another routine activity? What benefits did they notice? What barriers were encountered in practicing? Reinforce the importance of this skill, and encourage the client to practice this on a daily basis for homework over the next week.

Activity Log
Ask how the client managed with the activity log. Were they able to carry out the mindfulness activities they scheduled? Did they encounter any difficulties completing the log, or doing the activities scheduled? What were their experiences with becoming mindful of pleasant activities? Did they add any activities to their list of pleasant tasks? What did they think of the exercise? Process the Activity Log and Activities List with the client, highlighting the importance of this activity.

Once you have processed the form with the client, move on and expand this activity. The next step in this process is to encourage the client to increase their activity level (if appropriate) and increase their involvement in activities they find pleasant or that provide them with a sense of achievement.

You may want to start with the time of day or week that seems to be the most problematic for the person – those “danger” times when people are most at-risk of falling victim to their depressive thoughts and/or drinking/using – and plan pleasant or achievement activities for the person to carry out at these times. By planning “pleasurable” activities into the day, people will realise that they can enjoy themselves, and also, by completing achievement tasks can gain a sense of control or mastery over the things in their life that they need to do.

Exercise: Identifying enjoyment and achievement tasks
- Take out the “Activities List”.
- Process the list of activities the client has already written under the “Pleasant Activities” column. Are there any additional activities they like and enjoy doing, aside from taking alcohol/other drugs. For example, going for a walk, time to themselves, visiting friends, having a cup of coffee etc. Make sure these activities are broken down into concrete things. For example, “time to myself” needs to be broken down into the actual activities that constitute time to oneself. These could include listening to the radio, practice relaxation etc. Use the Activity Log homework task as a starting point.
- Add these tasks to the “Pleasant Activities” column.
- Next, ask the client to list the things he/she needs to do. This could include attending treatment sessions, keeping appointments, therapy homework, looking after kids, housework etc. Break these activities down into discrete, concrete tasks. For example, break housework down into all the different activities that need to be done around the house eg. washing dishes, washing clothes, vacuuming, make the bed etc. “Looking after the kids” should also be broken down into concrete tasks (e.g. bathing, walking to/from school), and may also include doing fun things with them.
- List these tasks under the “Achievement Activities” column.
Be sure to list the Mindfulness Skills activity in either the Achievement or Enjoyment column – leave the choice about placement up to the client.

Together with this exercise and the mindfulness of pleasant events activity from last session, the client should have a better idea of the activities that they enjoy, and those that give them a sense of achievement.

The next step is to plan time for each of these activities to occur. Explain to the client that it is important that each day has at least one enjoyable activity and at least one achievement activity scheduled in. Work through the following exercise within this session to teach the client how to plan their week in advance.

**Exercise: The Activity Log (Beck, 1979; Persons et al., 2001)**

- Take out the sheet titled “Activity Log”
- Explain to your client the importance of including both pleasant and achievement activities into their day. This will increase their satisfaction with the way they spend their time. In addition the Activity Log can be used to break large, complex tasks down into more concrete, manageable steps, which are less overwhelming. Increasing the activity level of people with depression is a valuable exercise, and provides them with evidence contrary to their negative view of their environment. Be sure to communicate the importance and value of this activity to your client.
- Using the list of pleasant and achievement activities you have already developed, complete with the client a schedule for the following day. Ask the client to select at least 1 P (pleasant) activity and 1 A (achievement) activity for that day. Mark each activity as P (pleasant) or A (achievement) as applicable.
- In the “Evening” section of the log, schedule in time to complete the Activity Log for the following day, along with any other daily homework you have set for the client to complete over the following week. Mark these activities as “A” tasks.
- Be sure to schedule in time to complete the Mindfulness Skills activity on at least one occasion each day.
- You may also like to focus on any “high-risk” times that have been identified by the client’s Activity Log from last week. Plan with the client in session what they will do in these times to reduce the risk of elevation in symptoms or using alcohol/other drugs.
- Ask the client to sit down at the end of each day through the next week and complete the Activity Record for the following day, scheduling in at least 1 “P” and 1 “A” activity on each day. Whilst in the session, schedule in your next appointment with the client, and enter this spot on the Activity Log. If the client is aware of any appointments they must meet through the week, add those into the Activity Record during the session.
- In addition, ask the client to experience each “P” and “A” event as it is happening – to apply their mindfulness skills to the experience of each of these types of activities – the thoughts, feelings and bodily sensations that make up these tasks.
- Explain that it is impossible to plan every moment of every day in advance. Indeed there will be times when unpredictable things happen and the client will not be able to carry out the enjoyment and achievement tasks set down for that day. Discuss this with the client,
and explain that the activity log is not a rigid plan, and they should not feel guilty if they cannot stick exactly to the plan.

In addition, clients are able to substitute alternative activities into the record if something prevents them from doing what they planned. For example, on the day a client plans to go for a walk it may be raining. So, explain to the client that in these cases, they are free to substitute an alternative pleasurable task into that timeslot.

**Reasons for AOD Use**

At the conclusion of session 3, you asked the client to consider the issues raised during the session, particularly in relation to the AOD use. Spend some time in this session re-visiting the issues raised previously, particularly the decisional balance activity.

**Informal Assessment of Stage of Change**

After reviewing the issues raised in session 3, along with the client’s reflections over the past week, assess where you and the client feel they are relative to the “action” stage of change.

**The Client is not ready for action**

If the client is resisting (as indicated in session 3) they may not be ready to move forward to the next phase of motivational interviewing. If this is the case, re-visit strategies from session 3 as appropriate. Try to use techniques such as:

- Using extremes: “What concerns you the most?” “What are you fears about what might happen if you don’t make a change?”
- Looking back, looking forward; and
- Exploring goals: what goals or values the person holds most dear, and look for inconsistencies with AOD use.

You may also like to re-visit the decisional balance exercise, posing additional questions such as:

- “What would need to happen for your importance score to move up from x to y?”
- “What stops you moving up from x to y?”
- “What are some of the good things about (current behaviour). What are some of the less good things about (current behaviour)?”
- “What concerns do you have about (current behaviour)?”

It may be appropriate to introduce paradoxical discussions in the following way (Miller & Rollnick, 1991):

“One thing I find helpful is to clarify the real reasons for a change. We have started to do this a little bit already last session, but I’ve heard from you some reasons why you are reluctant to think about changing your AOD use. So, now I have a suggestion. I want to have a little debate with you. I will defend the position that you don’t really have a problem and don’t need to change, and I want you to do your best to convince me otherwise. I’m going to be you, and your job is to persuade me that there really is a problem here that I need to examine and do something about.”

**The Client is considering action**
Miller and Rollnick (1991) explain there are signs to look for that signify a person is ready to move from phase 1 motivational strategies to phase 2 strategies. These are possible signs of readiness to change and include:

- Decreased resistance;
- Decreased questions about the problem;
- Resolve (may seem more peaceful or settled, a resolution has been reached);
- Self-motivational statements;
- Increased questions about change;
- Envisioning (client talks about what life might be like after a change); and
- Experimenting (client may have begun experimenting with possible change approaches).

**Involvement of the Support Person**

If a support person is not to be involved, omit this section and proceed to the next section when the client reaches the action stage of change.

Regardless of the client’s current stage of change, still involve the support person at this point in the session.

Invite the support person to join you. Thank them for coming, and explain why you asked them to attend this session.

Then, explore their reasons for attending today’s session using the following prompts:

- “What has it been like for you?”
- “What have you noticed about [client’s] drinking/using/depression?”
- “What has discouraged you from trying to help in the past?”
- “What do you see that is encouraging?”

Emphasise the client’s positive attempts to deal with the problem. Reframe the negative experiences as normative (common in families with a dual diagnosis problem). Elaborate on risks and costs of the problem behaviour with support person.

- “How has the drinking/using affected you?”
- “What is different now that makes you more concerned about the drinking/using/depression?”
- “What do you think will happen if the drinking/using/depression continues as it has been?”

It is important to avoid overwhelming the client by eliciting supportive statements from the support person (MET Manual pg43). This is especially important if feedback from the support person is particularly aversive towards the client. The support person can be asked questions to elicit supportive and affirming comments. Examples include:

- “What are the things you like most about [client] when s/he is not drinking/using?”
- “What positive signs of change have you noticed that indicate [client] really wants to make a change?”
- “What are the things that give you hope that things can change for the better?”

Supportive and affirming statements outlined above help to enhance commitment to change. It is also important to elicit the client’s response to the support person’s comments:
“Of these things your sister has mentioned, which concern you the most?”
“How important do you think it is for you to deal with these concerns that your wife has raised?”

Phase 2 Motivational Interviewing
The next phase in motivational interviewing is to consolidate all the issues raised by the client in the first phase, and build on their motivation to change. This works best when the person has moved to the late contemplation or early action stage of change. Be aware that ambivalence will still be present, and if encountered use strategies from session 3 as appropriate (e.g. reflective listening, open-ended questions, affirming, summarising, managing resistance etc.). If your client has moved to this stage, continue to enhance their motivation to change using the following techniques. Otherwise re-visit techniques and issues covered in previous sessions.

Miller and Rollnick (1991) explain that the key components of Phase 2 are: recapitulation, key questions, information and advice, negotiating a plan and eliciting commitment. Work through these phases at your client’s pace and carry over some of these activities/discussions into session 5 if necessary. This phase may also elicit resistance from the client. If this occurs, remember to use the techniques described in session 3 to manage this reaction.

Recapitulation
The first step in phase 2 is to summarise the client’s current situation in a way that reflects you discussions to date (Miller & Rollnick, 1991). It should include the following elements:
Summary of the client’s perceptions of the problem (use their self-motivational statements);
Summary of the client’s remaining ambivalence, including what remains positive about their AOD use;
Review any evidence you have about risks/problems of continuing AOD use;
Summary of client’s statements about their intention and optimism for change;
Your own assessment of the client’s situation.

It is important to bring together as many reasons for change as possible, while still acknowledging the client’s ambivalence.

Key Questions
Some key questions may include at this time (Miller & Rollnick, 1991):
“What do you make of all this?”
“Where does this leave you in terms of your using?”
“I wonder what you’re thinking about your using at this point.”
“Now that you’re this far, I wonder what you might do about these concerns.”
“Of the things I have mentioned, which are the most important reasons for a change to you?
How are you going to do it?

To the Support Person: “How do you think you might help?” or “How do you think you support person might help?”
Information and Advice
The client may ask you for information or ideas about how to bring about change. There are many self-help booklets available to provide clients with a range of options, which the clients may find helpful. However, as Miller and Rollnick (1991) caution, wait for a direct invitation to provide advice, and do not be too eager to provide solutions. Some approaches include:

“I’ll be happy to give you some ideas, but I don’t want to get in the away of your own creative thinking – you are the expert on you.”

“I can give you ideas and strategies as part of this program of treatment, but I want to stress that you’ll have to try them out to see if they work for you.”

Negotiating a plan
Once it is apparent that the client is prepared to take some action in changing their AOD use, it is important to set some clear goals for this change. Miller and Rollnick (1991) explain that motivation is driven by an inconsistency between a person’s goals and their current state. Ideally, the client will see that both their depression and AOD use can be worked on simultaneously, with goals established for each.

**Talk through the characteristics of good, realistic goals with the client.** Make sure you cover the following points:

- Goals will help regardless of whether they are achieved. Goals the client reaches can be celebrated/rewarded, but others that aren’t achieved can be used as learning experiences.
- Goals need to be concrete, specific and realistically achievable. For example, the goal of “quitting alcohol” is not as specific or concrete as “I will stop drinking completely by XXX date.”

The client needs to choose his or her own goal(s), it is not for you to “impose” your standards on their change process. While abstinence may be your desired goal, this prospect may be overwhelming for a client to contemplate. It is far more important to maintain rapport and a good working alliance with your client, and to start with goals that he or she is motivated to achieve (Miller & Rollnick, 1991).

However, commend abstinence should this goal be chosen, and offer the following:

“Successful abstinence is a safe choice. If you don’t use you can be sure that you won’t have problems because of alcohol/other drugs. There are good reasons to at least try a period of abstinence (e.g. to find out what it’s like to live without alcohol/other drugs, and how you feel, to learn how you have become dependent on them, to break your old habits, to experience a change and build some confidence, to please your partner).”

Clients unwilling to discuss immediate and long-term abstinence might be more responsive to a short-term (trial) abstinence period (“a vacation from alcohol/other drugs”) or tapering off their drinking/use toward abstinence. Miller & Rollnick (1991) describe the following alternatives to immediate abstinence:

- Negotiate a period of trial abstinence;
- Commence a process of gradual tapering down toward abstinence; or
- Commence a period of trial moderation. Moderation may be an appropriate goal to start with, even though abstinence may be the longer-term outcome.
You may need to suggest a goal of abstinence if the client has co-existing medical conditions, psychological problems likely to be exacerbated, use of medications that are hazardous in combination with alcohol or other drugs, pregnancy, or a history of severe alcohol/drug problems and dependence. Consider whether it is appropriate to advise abstinence as a goal, and if so, use the following approach:

“It’s your choice of course. I want to tell you, however, that I’m worried about the choice you’re considering, and if you’re willing to listen, I’d like to tell you why I’m concerned.”

**Cannabis** (from Rees et al, 1999)

Although abstinence is the desired goal, some may prefer controlled use. Consider the degree of dependence, recent pattern of use, and previous attempts to control use, and discuss these issues with the client. Experience from cannabis intervention trials, suggests that restricting smoking to weekends or social occasions leads to slow but steady increases in smoking over time. Clients must have a firm, personal rule for recreational smoking (e.g. only once or week, or to never buy cannabis).

Once the client chooses a goal to work towards, it is important to explore any barriers or problems the client can forecast that may potentially impact on the achievement of their goals. Ask the client to articulate these concerns by using some of the following questions (Miller & Rollnick, 1991):

“You have said that you would like to cut down, so let’s make that a goal. What can you think of the might go wrong with this plan? What might be good, and what might be not so good about reaching this goal?”

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**Exercise: Change Plan Worksheet** (Miller & Rollnick, 1991)

- Use the handout titled “Change Plan Worksheet”
- Complete the sheet with the client in session, which includes a summary of the reasons for changing, their goals, and the benefits they are expecting from the change.
- In setting formal goals for the client, make sure that they are framed in concrete, specific, and realistic terms. If you are able, ask the client to nominate when they would like to start the modification process, and/or a date by which they are aiming to be abstinent. Record this in the goals section of the form.
- This serves as a record of the session, and the client can refer back to that list at a later stage.

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**Coping with Cravings**

AOD cravings are the sense of wishing to have a substance, or an impulse to seek out and use alcohol/other drugs. Cravings will generally increase during withdrawal and/or in the absence of AOD use. Therefore if your client is trying to abstain from or modify their use he/she will experience more intense cravings

**Describing cravings**

(Adapted from Monti, Abram, Kadden & Cooney, 1989).
The first step in coping with cravings is to become aware of all the different sensations, behaviours and thoughts that together for the craving experience, much like clients have learned to do with the mindfulness of the breath activity in session 2. With this awareness comes an ability to sense a craving in the early stages, and to intervene early in the process.

**Exercise: Describing a craving**
- Ask the person to explain what their experience is of a craving for their drug. Use the stem “Tell me a bit more about your cravings – what are they like?”
- Write down each of the feelings, thoughts, physical responses the person uses to describe their craving, grouping together those that are behavioural (e.g. fidgety), thoughts (e.g. “I must have a drink”), and physical (e.g. heart races, feeling sick) in nature.
- Explain that it is possible to fit the person’s experience of cravings into a model:
  - BEHAVIOURS + PHYSICAL REACTIONS + THOUGHTS = A CRAVING
- In coping with a craving, it is important to address each of these parts.
- Use the sheet titled “Facts about Cravings” and read through its content. This will provide your client with some additional information about cravings.

**Learn ways to manage cravings for alcohol and other drugs** (Graham et al., 2000)
Explain to your client that because cravings have many components, it is important to use strategies that can address each of these components. Strategies that have been found to be helpful in coping with cravings are listed below, and the following exercise is a useful way to start the person thinking about how they will cope with their craving.

**Exercise: Coping with Cravings**
- Provide client with information sheet titled “Coping with Cravings”.
- Give the following rationale to your client: “Sometimes, cravings cannot be avoided, and so it is necessary to find ways to cope with them. On this sheet are listed a number of strategies that seem helpful in managing cravings and urges to use alcohol/drugs. These correspond to the behavioural, physical and cognitive (thought) aspects of cravings you have just described.”
- Read through the list of techniques with the client.
- Ask the client to tick those strategies they feel most able to implement – those strategies the client has used successfully in the past, and those new techniques they are willing to try.
- Practice some techniques in session if the need arises.

**Conclusion**
It is crucial at this time to offer supportive, encouraging statements as in the last session. Encourage progress made already in relation to addressing their AOD use in particular, and commend them for considering their current habits. Thank them for completing their homework tasks from last session, and encourage them to complete the tasks set for the coming week. Affirming the client can be helpful through strengthening the work relationship; enhancing the attitude of self-responsibility and empowerment; reinforcing effort and self-motivational statements, and supporting client self-esteem.
In addition, thank the support person for attending this session.

**Brief check-in**
After the person has completed Module 4, spend 5-10 minutes face-to-face with them covering the following items:

**Homework from Module 3**
Take a copy of all completed homework activities from Module 3 and place in the client’s clinical file.

**Review Homework Activities**
The following activities have been set for completion between now and Module 5: practicing thought monitoring, mindfulness skills (walking and other routine activities) and completing the Activity Log (using the Pleasant and Achievement activities list). The client may also like to commence modifying their AOD use over the next week, experimenting with some different approaches, using the coping with cravings handouts as a guide. If the client has received self-help material to review, they may like to try some of the approaches suggested, with a view to reporting back on what was useful/not useful in next weeks’ session. The client may ask for additional self-help material for their depression, alcohol or other drug use. If appropriate and available, provide this information.

To check the client’s understanding of these tasks, ask them to describe the homework tasks in their own words.

Reinforce that just having a go at completing the homework is a success in itself. However, summarise the importance of completing homework, and explain that they will be used in next weeks’ session.

**Plan for Completing Homework**
Briefly explore with the client any problems they anticipate in completing their homework activities, and together develop and verbalise a plan for doing homework tasks through the week. Discuss the effectiveness of the plan developed from last session, and whether the client experienced any difficulties in completing homework from Module 3.

These plans can include a time, day, and place to complete homework, along with a time limit that establishes how long the person will spend on homework tasks per day. Also, include plans to remove distractions (such as turning off the radio/television, doing it away from the rest of the family/housemates etc.) and also not completing tasks in bed.

**Suicide and Mood Assessment**
Your interaction with the client should give you a general idea of what their level of mood currently is. However, it is important to test out your impressions, either by asking the person more directly about their mood/suicide ideation, or by using questionnaires to do this. If appropriate, you may like to use the Beck Hopelessness Inventory to assist your assessment.
Refer to the Suicide Risk Assessments in the first section of this manual to assist your assessment, and for a protocol for managing those people at high risk for suicide.

Confirm Next Appointment
Arrange the client’s next appointment before they leave.
<table>
<thead>
<tr>
<th>Example</th>
<th>AS - SITUATION OR TRIGGER</th>
<th>BS - THOUGHTS</th>
<th>CS - FEELINGS</th>
<th>CS - BEHAVIOURS</th>
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<tbody>
<tr>
<td></td>
<td>At home, bored, haven’t got anything to do</td>
<td>“Nothing good ever happens, I’ve got nothing to do, life sucks”</td>
<td>Sad, Angry, Useless, Worthless</td>
<td>Had a couple of drinks Watched TV on the lounge</td>
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Activity Log

*Include at least 1 Pleasant task and 1 Achievement task in each day of the week*

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</table>

P=Pleasant tasks, A=Achievement tasks
The most important reasons why I want to make a change are:
1.
2.
3.
4.
5.
6.

My main goals for myself, in making a change, are:
1.
2.
3.
4.

Other people who could help me in changing these ways are:

<table>
<thead>
<tr>
<th>Person</th>
<th>Possible ways they could help</th>
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<tbody>
<tr>
<td>1.</td>
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I hope that these changes will have these positive results:
1.
2.
3.
4.
Cravings are a natural part of changing drug use. This means that you won’t have any more difficulty changing your drug use than anybody else does. Understanding cravings helps people to overcome them, so let’s go through some simple facts.

Cravings are the result of long-term alcohol/other drug use and can continue long after your use has stopped. So, people with a heavier history of use will experience stronger urges.

Cravings can be triggered by: people, places, things, feelings, situations or anything else that has been associated with alcohol/other drug use in the past.

A craving is just like a wave at the beach. Every wave in a set starts off small, and builds up to its highest point, and then it breaks and flows away to shore. Each individual wave never lasts more than a few minutes. A craving is just the same. It starts off small, and then builds up – with physical parts, behaviours and thoughts. But, it reaches peak, just like a wave, and it will eventually break, and disappear. This whole process usually doesn’t last more than about 10 minutes.

Cravings will only lose their power if you don’t add force to them by drinking/using. Even if you use only once in a while, you will still keep those cravings alive. Cravings are like a stray cat – if you keep feeding them, they will keep coming back.

Like the picture below, each time a person does something other than drink or take drugs when they are craving, the craving will lose its power. The peak of the craving wave will become smaller, and the waves will be further apart.

Quitting alcohol/drugs totally, is the best and quickest way to get rid of the cravings.

Cravings are strongest in the early parts of quitting/cutting down, but people may continue to experience cravings for the first few months and sometimes even years after the drug use has ceased.

Each craving will not always be less intense than the previous one. Be aware that sometimes, particularly in response to stress and certain triggers, the peak will return to the maximum.
Sometimes, cravings can’t be avoided, and so you need to find ways to cope with them. Below are some things for you to try out, to cope with the physical, behavioural and psychological effects of cravings. Put a tick (✔) in the box next to those things you think you could do.

- Eat regularly, even when you don’t feel like it
- Drink plenty of water – especially when you get the craving
- Instead of drinking alcohol or using, drink water or chew gum
- Use “Mindfulness Skills” to manage the craving, by concentrating on the moment, rather than worrying about thoughts, or worrying about the past or the future. Use mindful walking, or use mindfulness skills for any other activity you enjoy to keep yourself fully in the moment.
- Use “Delaying” and “Distraction” when your craving is set off. When you experience a craving, put off the decision to drink or use for 1 hour. Go and do something else for that hour, like practice your Mindfulness Skills, go for a walk, listen to music, do the dishes etc. This breaks the habit of you immediately reaching for alcohol, pot or speed when you get a craving. You will find that once you are interested in something else, the craving will go away.
- Use relaxation and deep breathing techniques to cope with a craving once it is set off. If a craving develops in response to stressful situations, relaxation techniques and deep breathing exercises are really useful – you can’t be stressed if you are relaxed! Get yourself in a comfortable position – maybe sitting on the lounge. Close your eyes and take 3 big, deep, slow breaths. Concentrate on your breathing – fully focus on it. Breathe deeply in, and as you breathe out, say the word “relax”. Wait a few seconds between each breath. Once you are relaxed, form a picture in your mind of a wave at the beach. This is a craving wave, and remember that the craving wave will build up to its highest point, and then fall away as it rolls into shore. Picture the craving wave building up, getting ready to break, see it break, see the foam form, and see the wave fade away as it rolls into shore. Now, picture yourself riding the wave, surfing the craving wave into shore. You don’t fall off, you don’t get dumped and churned around, just picture yourself calmly surfing the craving wave into shore. Remind yourself that this little craving wave, is only a small part in your day. You can surf the craving wave at any time, and wait for it to fade away.
- Use positive talk when a craving is set off. Tell yourself that cravings only last about 10 minutes. Tell yourself “this feeling will pass”. You will find that the urges and cravings themselves will be easier to deal with. Say to yourself, “yes, this feels pretty bad, but I know it will be over soon”.
- Use your self-monitoring form to write down your thoughts and feelings about the situation that triggered your craving. Check whether you are falling into an unhelpful pattern of thinking, and see if you can think of other ways to look at the situation.

Other ideas:

Other ideas:

Other ideas:
Take-home Activities

- Try to fill out the Thought Monitor every day over the next week, for each situation where you feel depressed, negative, unhappy, bored etc. and when you feel like a drink/other drugs. As in the example, break this situation down into the A – Situation, B-thoughts, and C-feelings and behaviours. Write down your thoughts as if you were speaking them out loud – use exactly the same words the are in your thoughts without evaluating them before you write them down.

- Try to practice Mindful Walking for 10 minutes each day and write down on the Activity Log those times when you do mindful walking (you may also like to plan ahead when you will practice this exercise).

- Use your Mindfulness Skills for another routine activity – such as eating, brushing your teeth, showering, hanging out clothes etc. and write down when you do so on the Activity Log.

- Try to fill out the Activity Log one day ahead, and plan time for at least 1 pleasant and 1 achievement activity to take place on each day.

- Have a go at changing your drinking/using over the next week. Try out the “Coping with Cravings” activities to see which ones work best for you. Add any extra activities that help you deal with your cravings.

Plan for Completing Take-home Activities: ______________________________________
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Session 5: CBT
Activity scheduling, Mindfulness Skills, Managing Negative Automatic Thoughts

Aims:
• Continue with Activity Log and practicing Mindfulness Skills.
• Teach identification and management of negative automatic thoughts.
• Teach Mindfulness of the Breath

Materials needed for Session 5

• Handout: Activity Log
• Handout: Unhelpful Automatic Thought Patterns
• Handout: Steps in Managing Unhelpful Automatic Thought Patterns
• Handout: Managing Thoughts
• Handout: Mindful Breathing
• Questionnaires: Client and Therapist Questionnaires
• Handout: Summary Session 5

Areas to be covered within session 5 include:

5.1 Orient person to structure of session 4
5.2 Review the previous week
5.3 Set the agenda for session 5
5.4 Review homework from session 4
5.4.1 Activity Log
5.4.2 Mindfulness Skills
5.4.3 Modifying AOD use
5.4.4 Thought Monitoring
5.5 Identifying Unhelpful Automatic Thoughts
   Exercise: Demonstrating the link between thoughts and feeling/behaviour
   Exercise: Negative Automatic Thought Patterns
   Exercise: My Unhelpful Automatic Thought Patterns
5.6 Changing Unhelpful Automatic Thought Patterns
   Exercise: Managing Negative Automatic Thought Patterns
5.7 Mindfulness of the Breath
   Exercise: Mindfulness of the Breath
5.8 Conclusion
5.9 Brief Check-in
5.9.1 Homework from Module 4
5.9.2 Review homework from Module 5
5.9.3 Plan for completing homework
5.9.4 Suicide and Mood assessment
5.9.5 Therapeutic Alliance Measure
5.9.5 Confirm next appointment
Orient person to structure of session
Structure this session in the same way as you did in session 4. For example, say to the client: “Let’s start with a brief check in: I want to hear about your week and how you are feeling. Then, let’s set an agenda for the session, and I want to make sure that one thing on the agenda is to check your homework from last time.”

Review the previous week
For about 5-10 minutes, ask the person to briefly talk about their week. Be sure to ask about any significant events that occurred since the last session, how their mood is currently, any changes in their mood, functioning or AOD use they have observed, and any reflections they may have about the content of Session 4. Look for how the issues raised here may lead into the development of an agenda for this session.

Set the agenda
The first item on the agenda should always be reviewing homework from the previous session. Then briefly explain the other issues and activities to be covered during this session: coping with cravings, and monitoring negative automatic thoughts. Begin with the sentence: “let’s make an agenda for our session today…” Once complete, work through the agenda items. If the client has not yet reached the stage where they would like to change their AOD use habits, continue with motivational interviewing as appropriate. Depending on the level of their depression, you may still be able to teach them the thought monitoring scheduled for this session.

Review homework
The person’s homework from session 4 was to complete a mood monitor for every day of the previous week, and to fill in an activity log, scheduling enjoyment and achievement activities into each day. Firstly, establish whether the person completed each activity, and if not, discuss the barriers that prevented them from doing so. Work towards a solution to these barriers with a view to preventing their occurrence in future homework tasks. If the person has no information entered onto either form, ask them to spend the first 5-10 minutes of the session completing them before you continue with the remaining agenda items.

Activity Log
Ask how the client managed with the activity log. Were they able to carry out the activities they scheduled? Did they encounter any difficulties completing the log, or doing the activities scheduled? Were they able to add any activities to their list of enjoyment and achievement tasks? What did they think of the exercise? Have they noticed any change in mood? What happened in those “danger” or high-risk times? Process the form with the client, highlighting the importance of this activity, and assign another activity log for homework.

Mindfulness Skills
Assess how the person was able implement the mindful walking/routine activities over the past week. Were they able to find time to practice the technique? What benefits did they
notice? What barriers were encountered in practicing? Reinforce the importance of this skill, and encourage the client to practice this on a daily basis for homework over the next week.

**Modifying AOD use**
Determine whether the client experimented over the past week in modifying their use. Process their successes and slip-ups with them; ask about lessons learned, problems solved etc. Boost motivation by continuing to affirm the client’s efforts and reminding them that change is a process that takes time and practice.

**Coping with Cravings**
In the last session, clients were presented with a range of strategies to assist them in managing cravings for alcohol/other drugs and they developed an “emergency plan” to guide the implementation of these strategies. Ask the client whether they were able to put this plan into action, or practiced any of these techniques over the past week. How did they go? Were there any problems? What worked well? Did they use alcohol/other drugs? Were they able to add any different strategies to their list? Reinforce the importance of managing AOD cravings effectively, and ask the client to continue to implement these strategies as appropriate over the next week for homework.

**Thought Monitoring**
Hopefully, the previous week presented many opportunities for clients to identify the As, Bs, and Cs of high-risk situations for depression and AOD use. Review the thought monitoring record with the client and confirm that they were able to understand and complete the form correctly. Are any patterns evident in the way the client thinks about situations (e.g. can you detect a negative bias to the thoughts)? Were there any problems? What did they think about the activity? Process the form in session with the client.

**Identifying Negative Automatic Thoughts** (Beck et al., 1979; Segal et al., 2002; Persons et al., 2001)
It is likely the client is now able to separate out the automatic thoughts and subsequent feelings or behaviours that arise from situations in their everyday life. Thought monitoring will have demonstrated to the client that they tended to interpret situations that led to depression or a craving with a negative bias. Explain to the client (Segal et al., 2002; Beck et al., 1979):

“People who are vulnerable to depression tend to interpret situations with a negative bias and in ways that are usually critical of themselves. These interpretations often result in conclusions such as ‘I am worthless’ or ‘I am a failure’ [as the client has probably been able to note from their thought monitoring homework activity]. As we have talked about before, once this negative bias sets in, it is very hard to get out of, and we tend to only pay attention to those thoughts and those parts of events that fit in with our negative view of ourselves, and the world around us. Quite often, these thoughts and feelings also give us a reason to use alcohol/other drugs. But in almost every situation, there are lots of different ways to interpret or explain it. It’s just that when our negative bias sets in, our first explanation is usually negative, and we ignore all the other possibilities that are just as likely to be true.”

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Exercise: Demonstrating the link between thoughts and feelings/behaviour (Jarvis, Tebbutt & Mattick, 1995; Persons et al., 2001)

■ Use the sheet titled “Interpreting Situations” that the client completed in Session 3
■ Ask the client to again imagine the scenario that appears on the handout: “You see a friend across the street and call out to them to say hello. Your friend keeps on walking up the street…”
■ Now, ask the client to generate as many different explanations for this event as they can think of. Write all these on the handout. [Note – this exercise will link in later with identifying negative automatic thinking errors, e.g., catastrophising, personalising, black and white thinking, jumping to negative conclusions, should/oughts).
■ Then, ask the client to identify how they would feel or what they might do according to each explanation they have generated.
■ Summarise by explaining that even this one situation generated a number of possible different explanations, each of which were just as likely to be true, but resulted in lots of different feelings and behaviours (some of which were probably better than others).

You have already explained that people who are vulnerable to depression tend to think in a characteristically negative way about events. This is done automatically, without people really ever stopping to question their interpretations. So, while the first step in changing this habit was to identify those As, Bs, and Cs of situations likely to evoke depression and/or cravings for alcohol/other drugs, the next step is to teach the client to become more aware of this negative bias, and the patterns they are automatically falling into.

Exercise: Negative Automatic Thought Patterns (Beck et al., 1979; Persons et al., 2002; Segal et al., 2002)

■ Use handout titled “Unhelpful Automatic Thought Patterns”
■ Explain: “People with depression tend to fall into the same characteristic patterns of negative automatic thinking, as listed here on this form.” Take the client through the 5 types of thinking patterns listed on the form, explaining each one.
■ Refer to the handout titled “Interpreting Situations”
■ Ask the client to assign the explanations generated on the handout with a negative thinking pattern.

Explain to the client (Segal et al., 2002):

“An important part in managing your depression, and those situations that trigger low mood, depressive symptoms and also cravings to use alcohol/other drugs, is to become aware of your own negative thinking patterns. You need to work out which ones on this list [Handout: “Unhelpful Automatic Thought Patterns”] apply to you and your habits. This will also help you in the future to recognise the patterns associated with a relapse.”

Exercise: My Unhelpful Automatic Thought Patterns

■ Refer to homework activity titled “Thought Monitoring”.
■ With the client, label the Bs (thoughts) the client experienced in terms of the relevant unhelpful automatic thought pattern. Write this down on the handout.
Changing Negative Automatic Thought Patterns
Once a client has identified the “unhelpful automatic thought patterns” that apply to them, it is important to learn ways to identify and challenge them in situ. The main steps to changing unhelpful thought patterns is first to catch yourself thinking in this way, recognise the thought pattern for what it is, and substitute it with a more helpful or reasonable set of thoughts (Segal et al., 2002; Persons et al., 2001, Beck et al., 1979). Explain this to the client.

The client has already had some training in identifying the thoughts that are triggered by situations, and the previous exercise started them in the process of recognising their negative thinking biases. You now need to teach the client a method of implementing this in practice in their everyday life. This involves several key steps (Segal et al., 2002; Persons et al., 2001; Beck et al., 1979). Use the sheet titled “Steps in Managing Negative Automatic Thoughts” and explain the steps to the client in the following terms:

The client needs to recognise when these negative automatic thoughts are occurring. As indicated in the homework activity, depressive symptoms, negative feelings and cravings for alcohol/other drugs are all signs that these thoughts have been triggered. The client then needs to ask him/herself: “Have I just had an automatic thought?” The answer is most likely ‘yes’.

The next step is to teach the client to distance themselves from their thoughts so that they can see them for what they are. Explain that thoughts are just thoughts – events in the mind. Nothing more. Thoughts are not facts (even those thoughts that tell you they are facts, are still just events in the mind – not facts). Ordinarily we are so close to those thoughts, that we can’t see that they are just thoughts. When a client detects an automatic thought, ask them to stop, and step out of their automatic pilot…move their focus onto their breathing, and concentrate completely on taking long, deep, slow breaths in and out, paying attention only to making sure their lungs fill up completely with air and the are emptied completely. Next, ask the client to remind themselves: “thoughts are just thoughts, they are not facts and I am not my thoughts.” Next the client focuses on the content of their thoughts – looks at them objectively. They need to ask themselves: “Which unhelpful automatic thought has happened here? And label such thoughts as catastrophising, personalising, jumping to negative conclusions, black/white thinking or shoulds/oughts.

Then, the client asks: “What are the facts here – do these thoughts fit with the facts?” Finally, the client answers the questions: “Which other way can I interpret this situation? Is this explanation just as likely to be true? Does this explanation make me feel better?”

<table>
<thead>
<tr>
<th><strong>Exercise: Managing my Negative Automatic Thought Patterns</strong> (Segal et al., 2002; Persons et al., 2001; Beck et al., 1979)</th>
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<tr>
<td>Use the sheet titled: “Managing Thoughts”</td>
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<td>Explain to your client that this new process of monitoring and managing their thoughts will take practice and some time to get used to. So, to start with it is important to formalise the process, and write down each of these steps as they happen. Be sure to communicate the importance of this task to the person.</td>
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</table>
Take the client through the sheet, and explain how to complete each column.

Ask the client to complete that sheet for homework, for each situation that triggers a negative automatic thought.

Mindfulness of the Breath (Segal et al., 2002)
Conclude this session with a brief mindfulness exercise of about 10 minutes, where you and the client bring your attention and focus to your breathing. As Segal et al. (2002) explain, this is another step in practicing mindfulness, where the client will learn to step out of automatic pilot, and bring their attention to a single focus (their breath). By focussing on their breath, and practicing staying with this focus, their thoughts, feelings and sensations can come and go in their awareness, without being latched onto (Segal et al., 2002). This can help break the cycle of negative automatic thinking associated with depression, and that can lead to using alcohol/other drugs to cope.

Exercise: Mindfulness of the Breath (Segal et al., 2002, pgs 150-1)

- Ask your client to adjust themselves in their chair so that they feel alert and stable. Segal et al. (2002) explain that this includes sitting forward in their chair so that the chair does not support their back, and making sure their head, neck and back is roughly aligned. As the therapist, you could also adopt this position.
- Explain to your client that this new mindfulness technique can be used to help them step out of automatic pilot and to focus on the present, rather than the worries and negative thoughts of the day.
- It is likely that the client’s mind will wander throughout this exercise. Explain that this is normal and to be expected. When this happens, ask the client to do the same thing as they did for mindful walking – simply acknowledge that the mind has wandered off and gently bring their attention and focus back to their breath, no matter what the mind has wandered off too.
- Together, you and the client complete the following activity in session.
- “Close eyes and begin to breathe normally – not forced, not excessively fast or slow – just breathe as usual.
- Firstly, as best as you can, bring attention to the physical sensations of sitting on the chair. Notice where each part of the body touches on the chair – the backs of your legs, your arms and hands – and notice the pressure of your body as you sit on your chair, and where your feet touch the floor. Just spend a minute or so noticing all these sensations – pay as close attention as you can.
- Now bring your awareness to the rise and fall of your stomach as you breathe in…and out. You may like to place your hand over your stomach to help you focus on the rise and fall of your stomach as you breathe in…and out. As best you can, focus your awareness on the physical sensations of your stomach as you breathe in…and out. Once you have focussed on these sensations, move your hand away from your stomach, while still paying attention to the rise and fall of your stomach.
- Notice the slight stretching of your stomach as you breathe in…and how your stomach shrinks as you breathe out. As best you can, follow these changes all the way through as your breath enters your body…and all the way through until your breath leaves your
body, perhaps noticing the slight pause between the in-breath and the out-breath, and then between the out-breath and your next breath in.

- There is no need to control your breathing – no need to make it faster or slower – just breathe as your would on any other occasion, and let your breath breathe itself. Remember there is no special state to be achieved here, just to focus your attention onto your experiences of breathing.

- Your mind will probably wander off to other thoughts and other feelings as you focus on your breath. This is OK, this is normal, this is what minds do. It doesn’t mean you are doing this wrong, or making a mistake. Once you realise that your mind is focussing on other things – other thoughts, worries, daydreams, feelings – simply acknowledge that this has happened, and as best you can, gently bring your attention and focus back onto your breath again – the rise and fall of your stomach, the stretching and shrinking of your stomach as you breathe in…and out.

- As best you can, be patient with this experience. The idea is to keep yourself here, with your breath, focussed on these sensations as if you never have experienced them before.”

- This activity is best practiced for about 10 minutes in total. After this time has lapsed, gently end the activity.

Process the client’s experiences with this activity. Ask them to describe their own experience of their breath, including their thoughts, feelings and sensations that occurred. Ask them to comment on their experience, their difficulties and insecurities with the activity.

Ask the client to practice mindfulness of the breath once every day for 10 minutes, and to enter their practice onto the Activity Log either in advance or in retrospect of each day. Give the client a copy of the “Mindful Breathing” handout, which summarises the basics in practicing this activity.

**Conclusion**

It is crucial at this time to offer supportive, encouraging statements as in the last session. Encourage progress made already in relation to addressing their AOD use in particular, and commend them for considering their current habits. Thank them for completing their homework tasks from last session, and encourage them to complete the tasks set for the coming week. Affirming the client can be helpful through strengthening the work relationship; enhancing the attitude of self-responsibility and empowerment; reinforcing effort and self-motivational statements, and supporting client self-esteem.

**Brief check-in**

After the person has completed Module 5, spend 5-10 minutes face-to-face with them covering the following items:

**Homework from Module 4**

- Take a copy of all completed homework activities from Module 4 and place in the client’s clinical file.

**Review Homework Activities**
The following activities have been set for completion between now and Module 6: Summarise for the person the tasks you have set for homework. These include continuing with the Activity Log (using the Pleasant and Achievement activities list), and practice the Mindfulness Skills (walking, routines, breathing) over the next week. In addition, the client had been asked to complete the “Managing Thoughts” task for each time over the next week when they feel depressed, or the urge to use alcohol/other drugs.

To check the client’s understanding of these tasks, ask them to describe the homework tasks in their own words.

Reinforce that just having a go at completing the homework is a success in itself. However, summarise the importance of completing homework, and explain that they will be used in next weeks’ session.

In addition, take a copy of the client’s revised “Interpreting Situations” handout, and place in their clinical file.

Plan for Completing Homework
Briefly explore with the client any problems they anticipate in completing their homework activities, and together develop and verbalise a plan for doing homework tasks through the week. Discuss the effectiveness of the plan developed from last session, and whether the client experienced any difficulties in completing homework from Module 4.

These plans can include a time, day, and place to complete homework, along with a time limit that establishes how long the person will spend on homework tasks per day. Also, include plans to remove distractions (such as turning off the radio/televison, doing it away from the rest of the family/housemates etc.) and also not completing tasks in bed.

Suicide and Mood Assessment
Your interaction with the client should give you a general idea of what their level of mood currently is. However, it is important to test out your impressions, either by asking the person more directly about their mood/suicide ideation, or by using questionnaires to do this. If appropriate, you may like to use the Beck Hopelessness Inventory to assist your assessment.

Refer to the Suicide Risk Assessments in the first section of this manual to assist your assessment, and for a protocol for managing those people at high risk for suicide.

Therapeutic Alliance Measure
The SHADE project sought to evaluate therapeutic alliance from both the client and the therapist perspective at several points throughout the treatment period. All participants and therapists were asked to complete the Agnew-Davis Therapeutic Alliance questionnaire after Sessions 1 (all clients), 5, and 10 (those in therapist and computer conditions only).

Confirm Next Appointment
Arrange the client’s next appointment before they leave.
Activity Log

*Include at least 1 Pleasant task and 1 Achievement task in each day of the week*

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P=Pleasant tasks, A=Achievement tasks
People with depression tend to “read into” situations in a certain pattern. These patterns are often quite negative, and lead to stronger feelings of depression and cravings to use alcohol/other drugs.

Do you have any of the following unhelpful automatic thought patterns?

Are you a Black and White Thinker?

◊ Are things are either all good or all bad – with nothing in between, no balance.
◊ Because something has gone wrong once, it will always go wrong.
◊ Do you have strict rules about yourself and your life? For example, do you think that in order to be good at something, you must do it perfectly or not at all?
◊ If things don’t work out perfectly do you feel hopeless, like you have failed completely? For example: “If I fail partly, it is as bad as being a complete failure”, or “If a person is not a complete success, then life is meaningless” or “I never get what I want so it’s foolish to want anything”.
◊ Have you ever thought: “even if I use once this week, I’m a failure, so why bother” or ”I can’t change, so it’s pointless trying at all”.
◊ Black and white thinkers may also believe that in order to be a good person, everybody must like them all the time. They may think that “People will probably think less of me if I make a mistake”, or “If a person I love does not love me, it means I am unlovable”.
◊ In thinking about their depression, black and white thinkers may think things like “either I’m depressed or I’m completely happy – there is no in-between” and “I’m a bad person – there is nothing good about me”.

Do you Jump to Negative Conclusions?

◊ Do you automatically draw a negative conclusion about something more times than not?
◊ People who “jump to negative conclusions” sometimes act like “mind readers”. They think they can tell what another person is really thinking, often without really checking it out or testing it.
◊ Other times, people who “jump to negative conclusions” may do a bit of “fortune telling”. They believe that things will turn out badly, and are certain that this will always be the case. For example, they think things like “Things just won’t work out the way I want them to”, or “I never get what I want so it’s stupid to want anything”, or “There’s no use in really trying to get something I want because I probably won’t get it.”
◊ In relation to their alcohol/other drug use, people with this pattern of thinking may believe “I’ll never be able to change my drinking/drug using, it’ll never be any different.”
Do you **Catastrophise**?

◊ People with this pattern of unhelpful thinking tend to give too much meaning to situations.
◊ They convince themselves that if something goes wrong, it will be totally unbearable and intolerable. For example, “If I get a craving, it will be unbearable and I will be unable to resist it”.
◊ If “catastrophisers” have a disagreement with someone, they may think that “**the person hates me, doesn’t trust me, and things will never change**”. Or, “**if I don’t have a drink, I’ll never be able to cope with this**.”

Are you a **Personaliser**?

◊ “**Personalisers**” will blame themselves for anything unpleasant that happens.
◊ They take a lot of responsibility for other people’s feelings and behaviour, and often confuse facts with feelings. For example, “**My brother has come home in a bad mood, it must be something that I have done**” or “**I feel stupid, so I am stupid**”.
◊ People with this pattern of thinking often put themselves down, and think too little of themselves, particularly in response to making a mistake. They may think things like “**I’m weak, stupid, ugly**” or “**I’m an idiot**”.

Are you a **Should/Ought** person?

◊ People with this pattern of thinking use ‘**should**’ ‘**ought**’ and ‘**must**’ when they think about lots of situations. This often results in them feeling guilty.
◊ **Shoulds and Oughts** quite often set a person up to be disappointed, particularly if these thoughts are unreasonable. For example, “**I must not get angry**”, “**He should always be on time**”.
◊ ‘**Should**’ statements can cause a person to experience anger and frustration when that person directs these statements at others.
Steps in Managing Unhelpful Automatic Thought Patterns

(Segal et al., 2002; Persons et al., 2001; Beck et al., 1979)

1. Spot your unhelpful automatic thought.
   - Depressive symptoms
   - Negative feelings
   - Cravings for alcohol/other drugs

2. Ask yourself: “Have I just had an automatic thought?” The answer is most likely ‘yes’.

3. Distance yourself from the thought, and see it for what it is.
   When you recognise an automatic thought, **STOP, and step out of automatic pilot**…remind yourself: “thoughts are just thoughts, they are not facts and I am not my thoughts.”

4. Next look at the thought itself. Ask yourself: “Which unhelpful automatic thought has happened here?”
   And label your thoughts as catastrophising, personalising, jumping to negative conclusions, black/white thinking or shoulds/oughts.

5. Then, ask: “What are the facts here – do these thoughts fit with the facts?”

6. Ask: “Which other way can I interpret this situation? Is this explanation just as likely to be true? Does this explanation make me feel better?” Usually, the answer will be ‘yes’.
### Managing Thoughts (Segal et al., 2002; Beck et al., 1979)

<table>
<thead>
<tr>
<th>Situation</th>
<th>Thoughts</th>
<th>Feelings</th>
<th>Which automatic thought is this?*</th>
<th>Does it fit the facts?</th>
<th>What is another explanation?</th>
<th>Feelings now</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting at home, bored, nothing to do</td>
<td>I should be out doing something, but I’ve got nothing to do, nobody to do it with, life sucks, nothing good ever happens</td>
<td>Sad, Angry, Useless, Worthless</td>
<td>Jumping to negative conclusions Personalising Shoulds/oughts</td>
<td>Not really – I’ve got some friends but they are at work, &amp; I do have some things to do that I like</td>
<td>My depression is telling me I don’t have anything to do. It would be nice if I had someone to do stuff with, but I can choose to do something myself and still enjoy it.</td>
<td>A bit happier, a bit more in control, a bit more motivated and worthwhile</td>
</tr>
</tbody>
</table>

* catastrophising, personalising, jumping to negative conclusions, black/white thinking, shoulds/oughts
**Client Questionnaire**

**Client ID number:**

**Therapist:**

**Date completed:**

Please answer each question as honestly as you can. Place a tick (✓) in the circle that best describes your feelings.

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Disagree</th>
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<td>9. I feel critical or disappointed in my therapy.</td>
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<td>13. I feel accepted in therapy no matter what I say or do.</td>
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**Therapist Questionnaire**

Client ID number: ____________________________________________________________________________

Therapist: ___________________________________________________________________________________

Date completed: ______________________________________________________________________________

Please answer each question as honestly as you can. Place a tick (✓) in the circle that best describes your feelings:

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Mindful Breathing

Segal et al. (2002)

Practice mindful breathing for 10 minutes each day to help you step out of automatic pilot.

Use mindful breathing to stay focussed on the moment.

The Basics

- Mostly we are not in touch with our breathing – it’s just another routine that we don’t notice.
- Our breath will change with our moods, our thoughts, and our feelings. It will speed up when we are stressed, angry and worried, and it will slow down and deepen when we are happy and relaxed.
- Breath can be used make us more stable – to connect our body and mind.
- As best you can, just notice your breathing – not to control it, just to notice it.
- Notice the rise and fall of your stomach as you breathe in and out. Stay with this for a few minutes.
- Notice the slight stretching of your stomach as you breathe in, and how your stomach shrinks as you breathe out. Take some time, and stay with this for a few minutes.
- Notice the slight pause between the in-breath and the out-breath, and then between the out-breath and your next breath in. Stay here for a few minutes.
- Your mind will probably wander off to other thoughts and other feelings as you focus on your breath. This is OK. Once you realise that your mind is focussing on other things simply acknowledge that this has happened, and as best you can, gently bring your attention and focus back onto your breath.
- As best you can, be patient with this experience. The idea is to keep yourself here, with your breath, focussed on these sensations as if you never have experienced them before.
Take-home Activities

As best you can, fill out the Managing Thoughts sheet at those times when you notice you are feeling depressed, negative, unhappy, bored etc. and when you feel like a drink/other drugs. Write down your thoughts as if you were speaking them out loud – use exactly the same words the are in your thoughts without evaluating them before you write them down. Then go through the steps in managing these thoughts.

Practice Mindful Walking and mindfulness with other routines each day and write down on the Activity Log those times when you do mindful walking (you may also like to plan ahead when you will practice this exercise).

Use your Mindful Breathing activity for 10 minutes each day, and write down when you do so on the Activity Log.

Try to fill out the Activity Log one day ahead, and plan time for at least 1 pleasant and 1 achievement activity to take place on each day.

As best you can, continue to change your drinking/using over the next week. Try out the “Coping with Cravings” activities to see which ones work best for you. Add any extra activities that help you deal with your cravings.

Plan for Completing Take-home Activities: ___________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
________________________________________
Activity scheduling, Mindfulness Skills, Coping with Cravings, Problem-solving skills

Aims:
- Continue with Activity Log, Mindfulness Skills, Coping with Cravings and Managing Thoughts.
- Teach client how use the 3-minute Breathing Space
- Learn and apply problem solving skills.

<table>
<thead>
<tr>
<th>Materials needed for Session 6</th>
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<tbody>
<tr>
<td>Handout: Activity Log</td>
</tr>
<tr>
<td>Handout: Managing Thoughts</td>
</tr>
<tr>
<td>Handout: 3-minute Breathing Space</td>
</tr>
<tr>
<td>Handout: 6 Steps to Problem Solving</td>
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<tr>
<td>Handout: Problem-Solving</td>
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<tr>
<td>Handout: Summary Session 6</td>
</tr>
</tbody>
</table>

Areas to be covered within session 6 include:
- Orient person to structure of session 5
- Review the previous week
- Set the agenda for session 6
- Review Homework
- Problem-Solving
  - Define exactly what the problem is
  - Exercise: Defining the Problem
  - Brainstorm possible solutions
  - Exercise: Brainstorming possible solutions
  - Choosing the best options
  - Exercise: Choosing the best option
  - Generating a detailed action plan
  - Exercise: Develop an action plan
  - Putting the plan into practice
  - Exercise: Put the plan into action

Conclusion
- Brief Check-in
  - Homework from Module 5
  - Review Homework from Module 6
  - Plan for Completing Homework
  - Suicide and Mood assessment
  - Confirm next appointment
Session 6: CBT
Activity scheduling, Mindfulness Skills, Managing Thoughts, Modifying AOD use, Problem-solving.

Orient person to structure of session
Structure this session in the same way as you did in session 5. For example, say to the client: “Let’s start with a brief check in: I want to hear about your week and how you are feeling. Then, let’s set an agenda for the session, and I want to make sure that one thing on the agenda is to check your homework from last time.”

Review the previous week
For about 5-10 minutes, ask the person to briefly talk about their week. Be sure to ask about any significant events that occurred since the last session, how their mood is currently, any changes in their mood, functioning or AOD use they have observed, and any reflections they may have about the content of Session 5. Look for how the issues raised here may lead into the development of an agenda for this session.

Set the agenda
The first item on the agenda should always be reviewing homework from the previous session. Then briefly explain the other issues and activities to be covered during this session: skills to challenge negative automatic thoughts, skills to assist person to reach goals for AOD use. Begin with the sentence: “let’s make an agenda for our session today…” Once complete, work through the agenda items. If the client has not yet reached the stage where they would like to change their AOD use habits, continue with motivational interviewing as appropriate. Depending on the level of their depression, you may still be able to teach them the thought challenging scheduled for this session.

Review homework
The person’s homework from session 5 was to fill in an activity log, scheduling enjoyment and achievement activities into each day, implement strategies to cope with cravings and monitor negative automatic thoughts. Firstly, establish whether the person completed each activity, and if not, discuss the barriers that prevented them from doing so. Work towards a solution to these barriers with a view to preventing their occurrence in future homework tasks. If the person has no information entered onto either form, ask them to spend the first 5-10 minutes of the session completing them before you continue with the remaining agenda items.

Activity Log
Ask how the client managed with the activity log. Were they able to carry out the activities they scheduled? Did they encounter any difficulties completing the log, or doing the activities scheduled? Were they able to add any activities to their list of enjoyment and achievement tasks? What did they think of the exercise? Have they noticed any change in mood? What happened in those “danger” or high-risk times? Process the form with the client, highlighting the importance of this activity. Ask the client if they would like to continue to complete an Activity Log for the next week, and assign another activity log if agreeable.
Mindfulness Skills
Assess how the person was able implement the Mindfulness Skills activities (mindful walking, mindfulness of routine activities, and especially mindful breathing) over the past week. Were they able to find time to practice the techniques? What benefits did they notice? What barriers were encountered in practicing? Reinforce the importance of this skill, and encourage the client to practice this on a daily basis for homework over the next week.

3-minute Breathing Space (Segal et al., 2002)
Therapy to date has covered mindfulness of routine activities (such as walking, brushing teeth, washing dishes, showering etc.) as well as using the breath as a focus for attention. Now that clients have practiced these mindfulness techniques, it is time to teach them a form of mindfulness that is very easily incorporated into their everyday life, without taking up too much of their time (Segal et al., 2002). Segal et al. (2002) developed the 3-minute breathing space exercise as a tool for people to use regularly in their everyday lives, long after the “formal training” in mindfulness skills is complete.

<table>
<thead>
<tr>
<th>Exercise: The 3-minute Breathing Space (Segal et al., 2002)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Explain to your client that the 3-minute Breathing Space activity is a useful one to incorporate into their daily routine. It is brief, and designed to bring you into contact with the moment quickly. To facilitate this, clients need to take a fairly specific posture – similar as to that for the mindful breathing activity from last session – relaxed, stable, back erect – to give a sense of alertness.</td>
</tr>
<tr>
<td>- If the client feels comfortable, ask them to gently close their eyes.</td>
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<tr>
<td>- Continue using the following instructions: “Take some time to get yourself feeling comfortable and supported. As best you can, gently allow yourself to become aware of what is going on with you at the moment – notice what is going through your mind, what thoughts are there at the moment…As best you can, just notice that these thoughts are there, without trying to change them or control them.</td>
</tr>
<tr>
<td>- Notice what feelings are also present at the moment. Again, as best you can, simply notice that these feelings are present, without trying to change them or control them.</td>
</tr>
<tr>
<td>- In particular, notice any discomfort or unpleasant feelings that are around at the moment. Just notice that they are there, without trying to push them away or shut them out – just recognise that those feelings are there.</td>
</tr>
<tr>
<td>- Notice whether there are any physical sensations you can sense at the moment. Are there areas of stress or tension, of holding present in your body at the moment? As best you can gently acknowledge that these sensations are there without trying to change them or control them, simply notice that they are present.</td>
</tr>
<tr>
<td>- Now that you have a real sense of what is going on at the moment, you have truly stepped out of automatic pilot. The next step is to focus attention on a single thing to gather yourself together. As best you can, now bring your attention to your breathing – notice the movements of your breath as you breathe in and breathe out. As you really gather yourself, focus your attention on your breath, noticing how your stomach rises with each in-breath and falls as your breathe out. As best you can, just spend a few moments focussing on your breathing – focus on your stomach as it slightly stretches as</td>
</tr>
</tbody>
</table>

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you breathe in, and how your stomach shrinks as you breathe out. Notice your breathing so that you know when your breath is moving in and when it is moving out. As best you can, use your breathing to help anchor yourself to the present moment.

- Now you have gathered yourself, the final step is to allow your awareness to spread. So, as well as being aware of your breath, gently start to notice your body as a whole. As best you can, open out your awareness so that you get a sense of your body as a whole, including any tightness in the shoulders, neck, back, or face, and just follow the breath as if your whole body is breathing as one. Take a few moments to notice your whole body breathing as one…becoming gently aware of your body as a whole.
- Then when you are ready, allow your eyes to open.”

This exercise should only take about 3 minutes, and is an excellent one to practice daily. Ask the client to choose three times a day to practice the 3-minute breathing space over the next week, and schedule these times in on the Activity Log. Reinforce the importance of practicing this exercise in order to get the full benefits.

Give the person the sheet titled “3-Minute Breathing Space”, which summarises the basics of this activity.

Modifying AOD use
Determine whether the client experimented over the past week in modifying their use. Process their successes and slip-ups with them; ask about lessons learned, problems solved etc. Boost motivation by continuing to affirm the client’s efforts and reminding them that change is a process that takes time and practice.

Managing Thoughts
It is most likely that the previous week presented many opportunities for clients to identify their unhelpful automatic thought patterns in relation to their depression and AOD use. Review the “Managing Thoughts” record with the client and confirm that they were able to understand and complete the form correctly. Were they able to detect their unhelpful thought patterns in situ? How effectively were they able to turn off the automatic pilot and challenge these thoughts? What were the consequences (feelings, behaviours)? Were there any problems? What did they think about the activity? Process the form in session with the client, and assign another “Managing Thoughts” sheet for homework.

Problem-solving
Problem-solving is an important general skill that can be used in a variety of situations that occur in everyday life. These situations include those high-risk situations – ones that trigger the client’s unhelpful automatic thought patterns, and that pose a threat to their goals (i.e. reduced AOD intake and/or lower depressive symptoms).

Thought monitoring exercises over the past few sessions will have helped the client to identify these problematic situations. It will be clear that these situations are sometimes drug specific (e.g. being in a group where drugs are freely available), can arise from thoughts or feelings (e.g. depressing/intrusive thoughts), in interactions with others (e.g. arguments) or they can be more general (e.g. work concerns).
Explain to the client that it is important to work through these problem situations that occur in day-to-day life, rather than to ignore them or deal impulsively with them. Pressure from an unresolved problem situation could easily lead to AOD use or symptom lapse. It is important for the client to recognise situations as problematic, and take time to work out and think through the most appropriate solutions. Some of these solutions will include practical techniques and behaviours, and others may involve more cognitive approaches (i.e. managing thoughts). Problem-solving teaches the client to mobilise their cognitive and behavioural resources and to create more than one solution to a problem situation.

In general, problem-solving is broken down into six steps (Jarvis, Tebbutt & Mattick, 1995):

1. Defining exactly what the problem is.
2. Brainstorming the options to deal with the problem.
3. Choosing the best option/s.
4. Generating a detailed action plan.
5. Putting the plan into action.
6. Evaluating the results.

Give the client a copy of the “Six Steps to Problem-Solving” sheet, and explain these six steps clearly. Then take them through the sex steps using a problem they identify in their own lives.

**Define exactly what the problem is.**

The first step in problem solving is often the most difficult. It is important to define a problem in very concrete terms (concrete behaviours that can be modified). For example, simply saying “I don’t like my life”, defines a person’s problem in very vague terms – it is almost impossible to solve this problem. Alternatively, breaking the problem down into “I feel lonely because I don’t have many friends: and re-defining this as an achievable goal “I’d like to work on making some friends” more concretely identifies those aspects of the person’s life with which they are unhappy about, thereby making them more easily targeted.

Well-defined problems have the following characteristics:
- Specific and concrete.
- Realistic – behaviour/problem actually needs to be able to be changed.
- Adequate – the definition needs to be comprehensive, incorporating all aspects of the problem. Re-define the problem as an achievable goal.
- Owned by the client – the client needs to feel that the definition is truly representative of what they feel the problem is. Allow the client time to work this out for themselves.

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**Exercise: Defining the Problem** (Jarvis, Tebbutt & Mattick, 1995)

- Use the sheet titled “Problem-Solving”.
- Have your client select a problem situation. This may come from the “Managing Thoughts” homework activity, may be generated by the client in session, or alternatively come from the “Problem List” section of the case formulation sheet developed back in Session 1. Alternatively, try to identify a potentially high-risk situation with the client.
where they either may be tempted to use alcohol/other drugs or react/feel negatively about or experience symptoms.

- Help the client to frame the problem clearly, in concrete, specific, realistic, and adequate terms as an achievable goal. If the problem comes from the “Problem List” section of the case formulation, then this should already have been accomplished. If not, use the following explanation: “In choosing the problem to work on for this exercise, the first thing is to focus on something sensible, something that you reasonably can expect to change. Then look at your problem and ask ‘is the wording too fuzzy or does it clearly list behaviours or feelings that need changing? For example, saying, ‘I don’t like my life’, is a very fuzzy way to word a problem – it’s hard to work out which behaviours need changing. It is almost impossible to solve the problem when it is put like this. But, if you break this problem down and be a bit more clear about it, you might say: ‘I don’t like my life because I’m lonely’. This is a better way to word the same problem, because then you can break this down further and say: ‘I feel lonely because I don’t have many friends’. From here, you can get to the very base of the problem, the very specifics of it, and word it in terms of some behaviours that need changing, such as: ‘I need to work on making some friends’. This final wording of the problem is more specific, and identifies specific parts that the person is unhappy about – it makes the problem easier to target. Let’s do this process with your problem.

- Once the client has been able to frame their problem as an achievable goal, write the problem down in the space provided on the form.

**Brainstorm possible options to deal with the problem**

Once a problem is selected, the next step is to generate lots of alternative ways of managing this situation. Brainstorming is an effective way of doing this. The “Interpreting Situations” activity in Session 6 would have introduced the process of brainstorming to the client. Brainstorming is really just the process of dreaming up lots of different ideas about a particular issue. In this case, we are asking our clients to “dream up” lots of different ways to deal with the problem they have just identified. The quality and efficacy of the client’s solution will be better if they are able to choose the ideal strategy from a large and exhaustive list of options. Use the following rules to brainstorming as a guide:

- No criticism allowed (including from the client him/herself). Leave evaluation of the options generated until Step 3.
- Encourage the wild and adventurous ideas. Remember any idea is acceptable at this stage. Also, the less impeded the client is, the more chance there is of them coming up with a good, novel idea.
- Quantity of ideas is important.
- Think about solutions that have worked before. An old solution may be a good starting point, even if it needs to be altered.
- Always make sure the client goes first. It is important that even if you come up with a suggestion for the list, it is the client who decides whether it will be added.
Exercise: Brainstorming options (Jarvis, Tebbutt & Mattick, 1995)
- Explain the concepts of brainstorming to your client using the ideas above.
- Ask your client to “dream up” as many alternatives/options for dealing with the problem situation they identified in the last activity, making sure they don’t judge the value or practicalities of the idea.
- Write these ideas down in the space provided on the form

Choosing the best option (pros and cons of each solution)
Every idea generated by the client will have both pros and cons associated with it. It is therefore important to encourage them to think through both the positives and negatives associated with each option they have generated. This will prevent rash decision-making about a course of action to take when confronted with a problem (e.g. using drugs/alcohol to cope with social anxiety, or assuming that your partner hates you because of an argument you just had). This process will also help the client to sort out and discard any obviously impractical options.

Exercise: Choosing the best option (Jarvis, Tebbutt & Mattick, 1995)
- Have your client carefully consider each of the options they generated during the brainstorming session, and identify the pros and cons of putting that option into practice. Encourage the client to also talk about the barriers and facilitative factors associated with putting the option into practice.
- Write the pros and cons list down in the space provided on the form.
- After the list is exhausted, work with the client to identify his/her most preferred option/s.
- Circle the client’s preferred option on the sheet.

Generating a detailed action plan
The next step in successful problem solving is to break down the client’s preferred option into smaller, concrete and achievable steps. For example, if the client decided they wanted to “exercise more” and thereby feel better about themselves, the action plan would need to specify which type of exercise, when/how often it would occur, how to get there, when to start, with whom etc. It is important to make the first step in any action plan something simple so that the client can easily achieve it and experience immediate success. This will increase their motivation to continue working through the plan.

Exercise: Develop an action plan (Jarvis, Tebbutt & Mattick, 1995)
- Help the client to break their preferred option down into manageable, concrete and achievable steps. Start by asking: “What is the first thing that you need to do in order to put this idea into practice?” Quite often, the client will not generate the actual first step in this process. To test out whether they may have missed a step, ask: “How will you take this first step – what do you need to do before you take this first step?”
- Once the first step is identified, ask the client: “OK, what is the next step?” Make sure the client is including all the necessary steps in implementing this idea by asking at each ‘new step’ the following: “What do you need to do before you take this next step?”
Develop a detailed action plan to help guide the client in putting their preferred solution into practice. Write down each step on the form.

**Putting the plan into practice**

Once the plan is developed, it is important for the client to mentally think through or rehearse their plan, and you may even like to conduct a role-play around their problem to help them practice putting the plan into action.

- **Exercise: Putting the plan into action** (Jarvis, Tebbutt & Mattick, 1995)
  - If appropriate, carry out a role-play with the client that involves their problem situation. Have them practice carrying out their action plan (and even voice/rehearse what they will say to themselves when confronted with that situation). How does the client predict the plan will translate into practice?
  - Set some homework for the following week – carry out the action plan.

The final stage of problem solving (“Evaluation”) will take place in session 7.

Explain to the person that problem solving is a general, all-purpose skill that can be used in any setting, for any decision they need to make, in many situations, for many problems. Encourage the person to apply problem-solving skills to any situation they encounter.

**Conclusion**

It is crucial at this time to offer supportive, encouraging statements as in the last session. Encourage progress made already in relation to addressing their AOD use in particular, and commend them for considering their current habits. Thank them for completing their homework tasks from last session, and encourage them to complete the tasks set for the coming week. Affirming the client can be helpful through strengthening the work relationship; enhancing the attitude of self-responsibility and empowerment; reinforcing effort and self-motivational statements, and supporting client self-esteem.

**Brief check-in**

After the person has completed Module 6, spend 5-10 minutes face-to-face with them covering the following items:

**Homework from Module 5**

Take a copy of all completed homework activities from Module 5 and place in the client’s clinical file.

**Review Homework Activities**

The following activities have been set for completion between now and Module 7: continuing with the Activity Log (using the Enjoyment and Achievement activities list) if the client elects to do so, practice the Mindfulness Skills (walking, routine activities, breathing, allowing/letting be) and using the “Coping with Cravings” sheet when they experience a craving over the next week. In addition, the client had been asked to complete the
“Managing Thoughts” task for each time over the next week when they detect a negative automatic thought has occurred. In addition, the client has been asked to implement the action plan for the problem identified by them during the session.

To check the client’s understanding of these tasks, ask them to describe the homework tasks in their own words.

Reinforce that just having a go at completing the homework is a success in itself. However, summarise the importance of completing homework, and explain that they will be used in next week’s session.

Plan for Completing Homework
Briefly explore with the client any problems they anticipate in completing their homework activities, and together develop and verbalise a plan for doing homework tasks through the week. Discuss the effectiveness of the plan developed from last session, and whether the client experienced any difficulties in completing homework from Module 5.

These plans can include a time, day, and place to complete homework, along with a time limit that establishes how long the person will spend on homework tasks per day. Also, include plans to remove distractions (such as turning off the radio/television, doing it away from the rest of the family/housemates etc.) and also not completing tasks in bed.

Suicide and Mood Assessment
Your interaction with the client should give you a general idea of what their level of mood currently is. However, it is important to test out your impressions, either by asking the person more directly about their mood/suicide ideation, or by using questionnaires to do this. If appropriate, you may like to use the Beck Hopelessness Inventory to assist your assessment.

Refer to the Suicide Risk Assessments in the first section of this manual to assist your assessment, and for a protocol for managing those people at high risk for suicide.

Confirm Next Appointment
Arrange the client’s next appointment before they leave.
<table>
<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
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<td>7-8 a.m.</td>
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P=Pleasant tasks, A=Achievement tasks

*Include at least 1 Pleasant task and 1 Achievement task in each day of the week*
## Managing Thoughts (Segal et al., 2002; Beck et al., 1979)

<table>
<thead>
<tr>
<th>Situation</th>
<th>Thoughts</th>
<th>Feelings</th>
<th>Which automatic thought is this?*</th>
<th>Does it fit the facts?</th>
<th>What is another explanation?</th>
<th>Feelings now</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting at home, bored, nothing to do</td>
<td>I should be out doing something, but I’ve got nothing to do, nobody to do it with, life sucks, nothing good ever happens</td>
<td>Sad, Angry, Useless, Worthless</td>
<td>Jumping to negative conclusions Personalising Shoulds/oughts</td>
<td>Not really – I’ve got some friends but they are at work, &amp; I do have some things to do that I like</td>
<td>My depression is telling me I don’t have anything to do. It would be nice if I had someone to do stuff with, but I can choose to do something myself and still enjoy it.</td>
<td>A bit happier, a bit more in control, a bit more motivated and worthwhile</td>
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<td>This is just a thought</td>
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<td>Thoughts are not facts (even the ones that tell me they are)</td>
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<td></td>
<td></td>
<td></td>
<td>I am not my thoughts</td>
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</table>

- catastrophising, personalising, jumping to negative conclusions, black/white thinking, shoulds/oughts
You can use problem-solving for any decision you have to make in your everyday life.

1. Define exactly what the problem is.
The first step in problem-solving is often the hardest. We need to make sure that the problem we are working on is described in a really specific and detailed way. Make sure the problem you are thinking about has the following features about it:

(a) It is specific and not fuzzy.
(b) It is realistic – the problem has to be sensible, and something that you reasonably can expect to change.
(c) It is adequate – the problem needs to include all the individual parts of the problem. Re-word the problem as a goal (e.g. “I need to make more friends”).
(d) It has to be owned by you – you need to feel that what you write down as the problem really deals your worries.

2. Dream up ways to deal with the problem.
This step involves “dreaming up” as many different ideas as you can think of to deal with this problem. The more ideas the better. Just be as creative as you can. Think about things that have worked before. Don’t judge any of the ideas – just dream up as many different ways of handling the problem as you can.

3. Choose the best solutions.
Every one of the ideas you came up with in step 2 will have both positives and negatives linked with it. Now is the time to start judging those ideas that are risky, unrealistic, or not likely to work. This will prevent careless decision-making about what to do when faced with a problem (e.g. using drugs/alcohol to cope with social anxiety, or assuming that your partner hates you because of an argument you just had). Carefully think about each idea you came up with in step 2. Write down the positives and negatives of each idea. Also think about any the stumbling blocks that may come up in actually carrying out this idea, or things that might help you put the idea into practice. When you have finished, circle the idea that you like the best, and that has more positives than negatives.

4. Develop a very detailed plan to carry this out.
The next step focus on your best idea, and break it down into small practical steps. For example, if you decided to “exercise more” you need to break this down into which type of exercise, when, how often, how to get there, when to start, with whom etc. You need to work out all the little steps you need to take in order to put your idea into practice. Make the first step something simple so that you can easily do it and experience immediate success.

5. Put the plan into action.
Think through in your mind or practice your plan before putting it into action, and take some time to go through your action plan in your head. Then, try it out.

6. Evaluate the results.
The final step in problem solving is to look at whether your solution worked. Ask yourself the questions:

“Did I carry out my plan as I wrote down or did I only do part of it?”
“Was the plan successful? Why or why not?”
“Is there anything about my plan that I need to change to make sure it is successful?”
“Should I look at using one of the other ideas I came up with in Step 2?”

(Jarvis, Tebbutt & Mattick, 1995)
Step 1: My problem is ________________________________________________________________
__________________________________________________________________________________

Step 2: What are the possible solutions? _____________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Step 3: What are the positives and negatives of each solution?

<table>
<thead>
<tr>
<th>Possible Solutions</th>
<th>Positives</th>
<th>Negatives</th>
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Circle the best solution

Step 4: What are the steps in putting the best solution into practice?
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Step 5: Putting the plan into practice
When you go home today, take this problem-solving sheet with you and take some time to go through your action plan in your head. Then, tomorrow, try it out.
Use the 3-minute Breathing Space as often as you can throughout the day to help yourself step out of automatic pilot.

The Basics

Step 1: Focus on the moment
- Notice your thoughts
- Notice your feelings – including discomfort or unpleasant feelings
- Notice any physical sensations – including tension, stress
- As best you can, just notice they are present, without pushing them away.

Step 2: Focus on the breath
- Gather yourself together
- Notice your stomach rise and fall with your breathing
- Use your breathing to fix yourself to the moment

Step 3: Focus on body as a whole
- Spread your awareness out to your whole body
- Follow your breath as if your whole body is breathing as one, including any tightness in your shoulders, neck etc.
- Stay here for a few moments until you are ready to open your eyes
Take-home Activities
- As best you can, fill out the Managing Thoughts sheet at those times when you notice you are feeling depressed, negative, unhappy, bored etc. and when you feel like a drink/other drugs. Write down your thoughts as if you were speaking them out loud – use exactly the same words that are in your thoughts without evaluating them before you write them down. Then go through the steps in managing these thoughts.
- Practice Mindful Walking, Mindful Breathing and mindfulness with other routines each day and write these times down on the Activity (you may also like to plan ahead when you will practice this exercise).
- Practice your 3-minute Breathing Space 3 times each day as planned on your Activity Log.
- Try to fill out the Activity Log one day ahead, and plan time for at least 1 pleasant and 1 achievement activity to take place on each day.
- As best you can, continue to change your drinking/using over the next week. Try out the “Coping with Cravings” activities to see which ones work best for you. Add any extra activities that help you deal with your cravings.

Plan for Completing Take-home Activities: ______________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
**Session 7: CBT**

Activity scheduling, Mindfulness Skills, Coping with Cravings, Challenging Negative Automatic Thoughts, Schema Change

**Aims:**
- Continue with Activity Log, Mindfulness Skills, Coping with Craving, and managing negative automatic thought patterns.
- Teach Schema Change methods

**Materials needed for Session 7**
- Handout: Activity Log
- Handout: Managing Thoughts
- Handout: Schema Form
- Handout: Schema Continuum
- Handout: “Alternative View” worksheet
- Handout: Summary Session 7

**Areas to be covered within session 7 include:**

7.1 Orient person to structure of session 7
7.2 Review the previous week
7.3 Set the agenda for session 7
7.4 Review homework from session 6
7.4.1 Activity Log
7.4.2 Mindfulness Skills
7.4.3 Coping with Craving
7.4.4 Managing Thoughts
7.4.5 Modifying AOD use
7.4.6 Evaluating the Action Plan
7.5 Schema Change Methods
7.5.1 Identify Problematic Schema
    Exercise: Identifying Schema
7.5.2 Schema Continuum
    Exercise: Developing a Schema Continuum
7.5.3 “Alternative View” worksheet
    Exercise: “Alternative View” worksheet
7.6 Conclusion
7.7 Brief Check-in
7.7.1 Homework from Module 6
7.7.2 Review Homework from Module 7
7.7.2.1 Other Core Beliefs
7.7.3 Plan for Completing Homework
7.7.4 Suicide and Mood assessment
7.7.5 Confirm next appointment
Session 7: CBT
Activity scheduling, Mindfulness Skills, Coping with Cravings, Challenging Negative Automatic Thoughts, Drink/Drug Refusal Skills, Schema Change.

Orient person to structure of session
Structure this session in the same way as you did in session 6. For example, say to the client: “Let’s start with a brief check in: I want to hear about your week and how you are feeling. Then, let’s set an agenda for the session, and I want to make sure that one thing on the agenda is to check your homework from last time.”

Review the previous week
For about 5-10 minutes, ask the person to briefly talk about their week. Be sure to ask about any significant events that occurred since the last session, how their mood is currently, any changes in their mood, functioning or AOD use they have observed, and any reflections they may have about the content of Session 6. Look for how the issues raised here may lead into the development of an agenda for this session.

Set the agenda
The first item on the agenda should always be reviewing homework from the previous session. Then briefly explain the other issues and activities to be covered during this session: problem solving skills. Begin with the sentence: “let’s make an agenda for our session today…” Once complete, work through the agenda items. If the client has not yet reached the stage where they would like to change their AOD use habits, continue with motivational interviewing as appropriate. Problem solving is a relevant skill for people with depression, so you can attempt to cover this agenda item if appropriate.

Review homework
The person’s homework from session 6 was to fill in an activity log (if chosen), scheduling enjoyment and achievement activities into each day, implement strategies to cope with cravings and monitor and challenge negative automatic thoughts. Firstly, establish whether the person completed each activity, and if not, discuss the barriers that prevented them from doing so. Work towards a solution to these barriers with a view to preventing their occurrence in future homework tasks. If the person has no information entered onto either form, ask them to spend the first 5-10 minutes of the session completing them before you continue with the remaining agenda items.

Activity Log
Ask how the client managed with the activity log. Were they able to carry out the activities they scheduled? Did they encounter any difficulties completing the log, or doing the activities scheduled? Were they able to add any activities to their list of enjoyment and achievement tasks? What did they think of the exercise? Have they noticed any change in mood? What happened in those “danger” or high-risk times? Process the form with the client, highlighting the importance of this activity. Ask the client if they would like to continue to complete an Activity Log for the next week, and assign another activity log if agreeable.
Mindfulness Skills
Assess how the person was able implement the Mindfulness Skills activities over the past week. Were they able to find time to practice the 3-minute breathing space and other techniques? What benefits did they notice? What barriers were encountered in practicing? Reinforce the importance of this skill, and encourage the client to practice this on a daily basis for homework over the next week.

Coping with Craving
In the last session, clients were presented with a range of strategies to assist them in managing cravings for alcohol/other drugs and they developed an “emergency plan” to guide the implementation of these strategies. Ask the client whether they were able to put this plan into action, or practiced any of these techniques over the past week. How did they go? Were there any problems? What worked well? Did they use alcohol/other drugs? Were they able to add any different strategies to their list? Reinforce the importance of managing AOD cravings effectively, and ask the client to continue to implement these strategies as appropriate over the next week for homework.

Managing Unhelpful Automatic Thought Patterns
It is most likely that the previous week presented many opportunities for clients to identify their unhelpful automatic thought patterns in relation to their depression and AOD use. Review the “Managing Thoughts” record with the client and confirm that they were able to understand and complete the form correctly. Were they able to detect their unhelpful thought patterns in situ? How effectively were they able to turn off the automatic pilot and challenge these thoughts? What were the consequences (feelings, behaviours)? Were there any problems? What did they think about the activity? Process the form in session with the client, and assign another “Managing Thoughts” sheet for homework.

Modifying AOD use
Determine whether the client experimented over the past week in modifying their use. Process their successes and slip-ups with them; ask about lessons learned, problems solved etc. Boost motivation by continuing to affirm the client’s efforts and reminding them that change is a process that takes time and practice.

Evaluating the action plan
In addition to the other activities, the client was asked to implement the action plan developed during session 6 to manage a current problem. Ask the client whether or not they put this plan into action over the last week. Ask the following questions, and process with the client how successful the plan was:
“Was the plan implemented in full or only in part? Why?”
“Does the plan need improving? Is a new strategy needed?”

Remind the client that problem-solving is a general skill and process that can be applied in many different settings. Reinforce the value of problem-solving techniques as a matter of habit in everyday life.
Schema Change Methods (Young, 1999; Persons et al., 2001; Beck et al., 1979)
Schemas are organised groups of ideas about events, objects, social situations and people (Weiten, 1989). They are our underlying beliefs, which we use to make sense of the world around us (Persons et al., 2001). Schemas tend to be triggered by everyday events, like an “emotional button”, and when activated will influence a person’s perception of the situation or person they are dealing with.

People who are vulnerable to depression tend to have at least one of the following schemas – dependent (“I must be loved by others or I’m worthless”) or independent (“I must be independent or accomplish significant things or else I am worthless”) (Beck et al., 1979). These schema can be expressed in any number of ways, including: “I am not interesting to anybody”, “I can’t cope without alcohol/other drugs”, “I am fatally flawed”, “Nobody likes me” etc. Particular events will trigger these schemas, and give rise to depressive symptoms. For example, a person who has a dependent schema would not be expected to develop depressive symptoms following a problem at work, but might become depressed following an argument with his/her partner (Persons et al., 2001).

Schemas are also central to one’s sense of self, and contribute to the mental picture we have of ourselves as people. Sometimes, schemas can be dysfunctional and can cause us distress when triggered. This is certainly true for people with depression, whose schemas tend to be characterised by a negative view of themselves, the world, and their future. These negative thoughts and feelings leads to all sorts of negative emotions that can then trigger drinking alcohol or using other drugs as a means of escape (psychological withdrawal).

Schemas are usually well developed by the time a person reaches adulthood. As a child, we develop our central beliefs based on the experiences, life events and circumstances in which we are involved (Persons et al., 2001). So, Beck et al. (1979) suggests that people who develop depression in adulthood, have usually experienced negative life events and circumstances in childhood. So, your client’s schema will be based on the patterns of thinking they acquired early in their development. Over time they also become self-fulfilling – we tend to behave in ways that are consistent with our schemas. And, when we look back over our lives, we are more likely to remember those events that are consistent with our schema (Young, 1999).

Please be aware that the SHADE treatment manual only addresses schema change in this session, and only briefly. However, as explained at the conclusion of this session, the client is encouraged to continue with these schema change methods throughout the remainder of the SHADE treatment program, and indeed once therapy is completed.

Identifying Problematic Schema
The case formulation exercise back in Session 1 required you and the client to develop some initial hypotheses about the problematic schema held by the client. In addition, the past few sessions have taught clients how to identify high-risk situations for using or for activating depression. Quite often, the reason these situations are so distressing or unpleasant for the
clients (or are so high-risk), is because they are activating the client’s problematic schema –
pushing their “emotional buttons”. Their experience in therapy to date would also have
allowed clients to practice these identification skills, along with challenging their unhelpful
automatic thoughts about those situations. Unhelpful automatic thoughts can tell clients
quite a bit about their “emotional buttons” or their schema. This section of therapy aims to
teach clients what these “emotional buttons” are about, and to learn to identify and modify
their underlying schema that leads them to think and behave in certain ways (e.g. drinking,
using).

Exercise: Identifying schema (Young, 1999; Persons et al., 2001)

- Give the client a brief explanation of the role of schema in their presenting difficulties
  using the above summary as a guide. Use the term “core belief” to refer to a person’s
  schema.
- Ask the client to select a situation in the recent past, where he/she remembers feeling
  quite distressed, or felt the urge to use alcohol/other drugs. This example is best taken
  from the “Managing Thoughts” homework the client has completed over the last week.
- Take out the sheet titled “Core Beliefs” and ask the client to write down the unhelpful
  automatic thought that was triggered by the selected situation in the first box.
- Next, ask the client the following question – “if that thought was true, why would it be
  so upsetting to you?” Write down the client’s response in the second box.
- Next, follow the arrow from the second box to the third box. Repeat the question: “if
  this thought in the second box was true, why would it be so upsetting, what would it
  mean about you?” Write this new response in the third box.
- Repeat this “downward arrow” process until the client cannot go any further – until you
  have reached a core belief, that is underneath their original distressing thought. Note:
you may not use all the boxes.
- Write this core belief in the last box on the page, which has the title “My Core Belief”.
- Leave the section titled “Alternative Schema” – come back to this after the next
  exercise.

Testing the Core Belief (Persons et al., 2001)

Your client’s problematic schema/core belief is one extreme view of the world. It will have
an alternative at the other extreme (Persons et al., 2001). For example, if a person’s core
belief is “I will always fail”, then the alternative core belief at the other end of the spectrum
is “I will always succeed”. In between these two extremes lies a more balanced, rational
belief – this middle ground is what we are aiming for (Persons et al., 2001).

Persons et al. (2001) explain that people tend to describe their core beliefs in general,
absolute and fuzzy terms. As such, when asked, they will rate themselves close to the
negative extreme. But, if you can help them to become more specific about the
characteristics they associate with a particular core belief, or would use to decide whether
someone else fits into the core belief, they will rate themselves closer to the middle of the
scale. This then provides evidence that they are in fact closer to the middle ground than to
either end, and schema change can be brought about.
Exercise: Testing the Core Belief (Persons et al., 2001)

- Use the sheet titled “Testing My Core Belief”
- Write the client’s problematic core belief in the section “My Core Belief”.
- Define each end or extreme of the person’s schema (e.g. “always fail” and “always succeed”). Write each of these extreme views on the dotted line under “Where do I fit along the scale from 0 to 100 of this core belief?” Write the negative extreme (e.g. “always fail”) under the 0% and the positive extreme (e.g. “always succeed”) under the 100%.
- Next, ask the client to put a “X” on the scale, between 0% and 100%, based on where they rate themselves between these two extremes.
- Next, ask the client to identify the various criteria they might use to judge where a person they met fit on their core belief scale. For example, ask the client to say what sorts of things they would look for in a person, to judge them as either “always failing” or “always succeeding”. Try to cover the different domains listed on the form – work, social, family relationships, interests, mood – and also include criteria generated by the client that does not necessarily fit into these domains. Use the following questions: “What do you think work life would be like for someone who [always fails/use client’s core belief]? What do you think work life would be like for someone who [always succeeds/use other extreme of client’s core belief]?”
- Work your way down the page, and write down under each domain the characteristics the client expects at each extreme of the spectrum (what defines 0% and 100%). It is very important to define these extremes as the complete absence of a quality or experience (e.g. always fails, all the time) at 0%, or the perfect achievement of the same quality at the 100% end (e.g. always succeeds, all the time). You need to anchor each end of the continuum.
- Then, ask the client to rate themselves on each of these characteristics by placing an X somewhere on the continuum between 0% and 100%.
- It is likely the client will rate themselves more objectively and fairly on these characteristics than they did on their overall schema. Illustrate this discrepancy to the client, and ask them for their impressions.
- Go back to the sheet titled: “Core Beliefs”.
- Ask the client to describe an alternative, balanced belief with this “new evidence” in mind, and write in the space provided on the bottom of the form.

The Alternative View (Persons et al., 2001)

Once the client has identified an alternative, balanced and more positive belief it is important for them to develop evidence for its accuracy and validity. That is, you need to teach the client to become aware of information that confirms this new, more balanced view.

Exercise: “Alternative View” worksheet (Persons et al., 2001)

- Use the sheet titled “The Alternative View”
- Provide a rationale to the client for developing and using the alternative view to their problematic core beliefs using the following information: “As you have become aware over the last few sessions, when we are depressed, we tend to only focus on thoughts
and activities or behaviours that confirm our depressed view of the world and ourselves (i.e. that fits in with our problematic beliefs). This is the same when we are craving alcohol/cannabis/speed. When the cravings are triggered, we tend to only focus on those thoughts about using, and the relief from craving that using would give us. We don’t see that there are other ways of looking at the situation, and of coping without using. This biased view will still be there even when we are not feeling depressed, and are no longer using – it will be ready to bring us undone. So, when learning to manage depression and our alcohol/cannabis/speed use, and to prevent a relapse, we need to learn how to pay attention to all those other thoughts, activities and behaviours that are outside our problematic beliefs. We have just worked together to develop a more balanced view of yourself, based on one of your core beliefs, which we based on evidence rather than your negative bias. Now, we need to get you used to paying attention to this new belief.”

- Demonstrate how to use the “Alternative View” during the session using the following ideas: “Over the next week, I would like you to write down the date and time when you observe evidence that supports your more balanced, alternative belief, and what you have observed. Make sure you are specific about the evidence you write down on this form. So, instead of writing down “someone was nice to me”, write down “so-and-so said …”. Try to fill in the “Alternative View” as soon as possible after you observe the evidence – while it is fresh in your mind.”

- Warn the client about falling into the trap of judging the evidence. Remind them that they are trying to break out of the unhelpful automatic thought patterns and their negative biases about the world.

- There could be times when they might play down the evidence or ignore it. But, explain that this could be a function of their old belief trying to exert its power over the client again. So, remind the client to be sure to write everything down, even if they think it is unimportant.

- Discuss with the client how they might practically complete the form during the day, so as to limit the attention other might direct towards them.

**Conclusion**

It is crucial at this time to offer supportive, encouraging statements as in the last session. Encourage progress made already in relation to addressing their AOD use in particular, and commend them for considering their current habits. Thank them for completing their homework tasks from last session, and encourage them to complete the tasks set for the coming week. Affirming the client can be helpful through strengthening the work relationship; enhancing the attitude of self-responsibility and empowerment; reinforcing effort and self-motivational statements, and supporting client self-esteem.

**Brief check-in**

After the person has completed Module 7, spend 5-10 minutes face-to-face with them covering the following items:

**Homework from Module 6**
Take a copy of all completed homework activities from Module 6 and place in the client’s clinical file.

**Review Homework Activities**
The following activities have been set for completion between now and Module 8: continuing with the Activity Log (using the Enjoyment and Achievement activities list) if the client elects to do so, practicing mindfulness skills (including the 3-minute Breathing Space), using the “Coping with Cravings” sheet when they experience a craving over the next week, and completing the “Managing Thoughts” form for unhelpful automatic thoughts. In addition, the client has been asked to complete the “Alternative View” worksheet to collect evidence for the validity of their alternative, more balanced schema.

**Other Core Beliefs**
Explain to the client that the exercises completed during today’s session addressed only one of the core beliefs they currently hold. They will have many more beliefs about themselves and the world around them, some of which will also be problematic and negative. The client may already be aware of some of these other schema/core beliefs that activate their depression and/or their desire to use alcohol/other drugs. Ask them to describe some of these beliefs if appropriate.

Explain that the skills you just taught the client could be used to address any of these remaining negative core beliefs. It is simply a matter of analysing the beliefs using the “Core Beliefs” form, rating themselves using the “Testing My Core Beliefs” form, and using this to develop a more balanced belief. Then they can go out and collect evidence for this new, balanced belief using the “Alternative View” form. They can go through this process for any belief, any upsetting automatic thought, and/or any problematic situation they encounter or discover. If the client is agreeable, give them copies of the blank forms: “Core Beliefs”, “Testing My Core Beliefs” and “The Alternative View” to take home and complete for homework either for next week or throughout the remainder of therapy. Alternatively, the client might like to take extra copies of these forms to complete once their therapy with you is completed.

To check the client’s understanding of these tasks, ask them to describe the homework tasks in their own words.

Reinforce that just having a go at completing the homework is a success in itself. However, summarise the importance of completing homework, and explain that they will be used in next weeks’ session.

**Plan for Completing Homework**
Briefly explore with the client any problems they anticipate in completing their homework activities, and together develop and verbalise a plan for doing homework tasks through the week. Discuss the effectiveness of the plan developed from last session, and whether the client experienced any difficulties in completing homework from Module 6.
These plans can include a time, day, and place to complete homework, along with a time limit that establishes how long the person will spend on homework tasks per day. Also, include plans to remove distractions (such as turning off the radio/television, doing it away from the rest of the family/housemates etc.) and also not completing tasks in bed.

Suicide and Mood Assessment
Your interaction with the client should give you a general idea of what their level of mood currently is. However, it is important to test out your impressions, either by asking the person more directly about their mood/suicide ideation, or by using questionnaires to do this. If appropriate, you may like to use the Beck Hopelessness Inventory to assist your assessment.

Refer to the Suicide Risk Assessments in the first section of this manual to assist your assessment, and for a protocol for managing those people at high risk for suicide.

Confirm Next Appointment
Arrange the client’s next appointment before they leave.
# Activity Log

*Include at least 1 Pleasant task and 1 Achievement task in each day of the week*

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
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</tbody>
</table>

P=Pleasant tasks, A=Achievement tasks
### Managing Thoughts (Segal et al., 2002; Beck et al., 1979)

<table>
<thead>
<tr>
<th>Situation</th>
<th>Thoughts</th>
<th>Feelings</th>
<th>Which automatic thought is this?*</th>
<th>Does it fit the facts?</th>
<th>What is another explanation?</th>
<th>Feelings now</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting at home, bored, nothing to do</td>
<td>I should be out doing something, but I’ve got nothing to do, nobody to do it with, life sucks, nothing good ever happens</td>
<td>Sad, Angry, Useless, Worthless</td>
<td>Jumping to negative conclusions Personalising Shoulds/oughts</td>
<td>Not really – I’ve got some friends but they are at work, &amp; I do have some things to do that I like</td>
<td>My depression is telling me I don’t have anything to do. It would be nice if I had someone to do stuff with, but I can choose to do something myself and still enjoy it.</td>
<td>A bit happier, a bit more in control, a bit more motivated and worthwhile</td>
</tr>
</tbody>
</table>

* catastrophising, personalising, jumping to negative conclusions, black/white thinking, shoulds/oughts
Core Beliefs

If this was true…
Why would I be so upset…What would it mean about me?

If this was true…
Why would I be so upset…What would it mean about me?

If this was true…
Why would I be so upset…What would it mean about me?

If this was true…
Why would I be so upset…What would it mean about me?

My Core Belief

If this was true…
Why would I be so upset…What would it mean about me?

My Alternative, Balanced Belief:
My Core Belief is:

Where do I fit along the scale from 0 to 100 of this core belief?

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>At Work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Socially, with friends</td>
<td></td>
<td></td>
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<tr>
<td>Family Relationships</td>
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<tr>
<td>Interests</td>
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<td>Mood</td>
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<td>Other</td>
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</table>

What criteria would I use to judge where someone is on my core belief scale?

At Work

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<tr>
<th></th>
<th>0%</th>
<th>100%</th>
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<tbody>
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<tr>
<td>Family Relationships</td>
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<tr>
<td>Other</td>
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</tbody>
</table>
Describe your problematic schema and alternative, more balanced schema in the space provided. Then, write down each piece of evidence in support of your ALTERNATIVE schema and the date and time when you observed the evidence. Be as specific as you can. For example, rather than writing “Someone said something nice to me”, write “Tom said he liked the shoes I was wearing”. Remember, write down ALL THE EVIDENCE in support of the alternative schema, regardless of how small or unimportant you might think it is.

Problematic Belief: _________________________________________________________________

Alternative, Balanced Belief: ________________________________________________________

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Evidence in Support of Alternative, Balanced Belief</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday, 11am</td>
<td>Tanya said she liked having coffee with me</td>
</tr>
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<td></td>
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<td></td>
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Take-home Activities
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Practice Mindful Walking, Mindful Breathing and mindfulness with other routines each day and write these times down on the Activity (you may also like to plan ahead when you will practice this exercise).

Practice your 3-minute Breathing Space 3 times each day as planned on your Activity Log.

Try to fill out the Activity Log one day ahead, and plan time for at least 1 pleasant and 1 achievement activity to take place on each day.

As best you can, continue to change your drinking/using over the next week. Try out the “Coping with Cravings” activities to see which ones work best for you. Add any extra activities that help you deal with your cravings.

Finally, have a go at filling out your “Alternative View” form. Remember, you are trying to collect every little bit of proof for your “Alternative, Balanced Belief” (no matter how small you think it is).

You may also like blank copies of the “Core Beliefs” form, the “Testing My Core Beliefs” form, and the “Alternative View” form to use with other sorts of negative thoughts and feelings that come up through the week, either to do with depression or cravings. Just use the example you worked through in today’s session
Session 8: CBT

Activity scheduling, Mindfulness Skills, Coping with Cravings, Challenging Negative Automatic Thoughts, Schema Change Methods, Drink/Drug Refusal, Emergency Plan

Aims:
- Continue with Activity Log, Mindfulness Skills, Coping with Craving, Refusal Skills and managing negative automatic thought patterns, and Schema Change Methods.
- Develop an Emergency Plan and teach drink/drug refusal skills

### Materials needed for Session 8
- Handout: Activity Log
- Handout: Managing Thoughts
- Handout: Alternative View
- Handout: Allowing/Letting Be
- Handout: Refusal Skills
- Handout: Emergency Plan
- Handout: Summary Session 8

### Areas to be covered within session 8 include:
- 8.1 Orient person to structure of session 8
- 8.2 Review the previous week
- 8.3 Set the agenda for session 8
- 8.4 Review homework from session 7
  - 8.4.1 Activity Log
  - 8.4.2 Mindfulness Skills
  - 8.4.2.1 Allowing/Letting Be
  - 8.4.3 Coping with Craving
  - 8.4.4 Managing Thoughts
  - 8.4.5 The Alternative View
  - 8.5 Learn and Practice Drink/Drug Refusal Skills
    - Exercise: Refusal Skills
  - 8.6 Develop an Emergency Plan
    - Exercise: Develop an Emergency Plan
- 8.7 Conclusion
  - 8.7.1 Foreshadow treatment termination
- 8.8 Brief Check-in
  - 8.8.1 Homework from Module 7
  - 8.8.2 Review Homework from Module 8
  - 8.8.3 Plan for Completing Homework
  - 8.8.4 Suicide and Mood assessment
  - 8.8.5 Confirm next appointment
Session 8: CBT
Activity scheduling, Mindfulness Skills, Coping with Cravings, Challenging Negative Automatic Thoughts, Schema Change Methods, Drink/Drug Refusal, Emergency Plan

Orient person to structure of session
Structure this session in the same way as you did in session 7. For example, say to the client: “Let’s start with a brief check in: I want to hear about your week and how you are feeling. Then, let’s set an agenda for the session, and I want to make sure that one thing on the agenda is to check your homework from last time.”

Review the previous week
For about 5-10 minutes, ask the person to briefly talk about their week. Be sure to ask about any significant events that occurred since the last session, how their mood is currently, any changes in their mood, functioning or AOD use they have observed, and any reflections they may have about the content of Session 7. Look for how the issues raised here may lead into the development of an agenda for this session.

Set the agenda
The first item on the agenda should always be reviewing homework from the previous session. Then briefly explain the other issues and activities to be covered during this session: schema change methods. Begin with the sentence: “let’s make an agenda for our session today…” Once complete, work through the agenda items. If the client has not yet reached the stage where they would like to change their AOD use habits, continue with motivational interviewing as appropriate. Schema change methods are relevant for people with depression, so you can attempt to cover this agenda item if appropriate.

Review homework
The person’s homework from session 7 was to fill in an activity log (if chosen), scheduling enjoyment and achievement activities into each day, implement strategies to cope with cravings and monitor and challenge negative automatic thoughts. The person was also assigned the task of implementing the action plan developed from the problem-solving task from last session. Firstly, establish whether the person completed each activity, and if not, discuss the barriers that prevented them from doing so. Work towards a solution to these barriers with a view to preventing their occurrence in future homework tasks. If the person has no information entered onto either form, ask them to spend the first 5-10 minutes of the session completing them before you continue with the remaining agenda items.

Activity Log
Ask how the client managed with the activity log. Were they able to carry out the activities they scheduled? Did they encounter any difficulties completing the log, or doing the activities scheduled? Were they able to add any activities to their list of enjoyment and achievement tasks? What did they think of the exercise? Have they noticed any change in mood? What happened in those “danger” or high-risk times? Process the form with the client, highlighting the importance of this activity. Ask the client if they would like to
continue to complete an Activity Log for the next week, and assign another activity log if agreeable.

**Mindfulness Skills**
Assess how the person was able implement the mindfulness activities over the past week. Were they able to find time to practice the technique? What benefits did they notice? What barriers were encountered in practicing? Reinforce the importance of this skill, and encourage the client to practice this on a daily basis for homework over the next week.

**Allowing/Letting Be (Segal et al., 2002)**
The past few sessions will have helped demonstrate to the client the presence of negative thoughts and feelings that have a flow-on effect to their mood and to their use of alcohol/other drugs. In the past, it is likely that your client has tried to avoid these negative or unpleasant thoughts and feelings by pushing them away and burying them deep inside. Segal et al. (2002) explain that this takes a lot of effort – thoughts and feeling keep popping up regardless of how many times we try to push them away.

Up until now, mindfulness training has focussed on raising people’s awareness of how their mind wanders from one topic to another, along with the risks associated with staying in “automatic pilot”. They have learned how to bring their focus back to the present, whether it has been by attending to routine activities, such as walking, or using their breath as a focus. Segal et al. (2002) explain that the next step in this process is to now use these skills to focus on unpleasant thoughts and feelings, with a view to allowing them to come, and to let them be – to accept they are there, without trying to push them away.

---

**Exercise: Allowing/Letting Be (Segal et al., 2002, pgs 225-237, 240)**

- Explain the above rationale to your client. In your explanation, Segal et al. (2002) suggest it is important to define “acceptance” or “letting be” as a way of responding to these unpleasant thoughts and feelings by allowing them to be there, rather than by rushing in a trying to fix or change them. Your client can learn how to recognise when these thoughts and feelings are present before they decide how to respond to them.

- The first step is to allow the client to bring their mind/attention to problematic thoughts or feelings that continue to attract their attention throughout their day, or during their mindfulness practice. You may like to use the Managing Thoughts form or the Schema form as a guide, or perhaps the client is already aware of a particular pattern of thoughts they are distracted by (should/ought, black/white, personalising etc.).

- Once you and the client have discussed this thought/feelings, use the following instructions as a guide: *The easiest way to relax is to stop trying to make things different. Accepting simply means allowing yourself the time and space for whatever is going on, rather than by trying to push things out of your mind, or force yourself into some other state. We just let it be, just notice and observe what is present.*

- Ask your client to sit upright in their chair, and start their 3-minute Breathing Space activity. Once they are focussed on their breath, and paying attention to the moment, ask them to notice when their mind wanders away from their breath, and onto some other thought, feeling or sensation. This time, instead of bringing their attention back to
their breath, ask them to stay with this thought, feeling or sensation, and to start paying attention to it.

- Then continue with: “Now that we are focussing on some troubling thought, some worry or pretty strong feeling – as best you can just notice the feelings that are arising in your body at this moment. Use your breath to anchor you to the present...breath with your whole body...in...and out.

- Become aware of the physical sensations that are also happening along with these feelings, and move your focus to where these sensations are the strongest – it might be the tension in your neck and shoulders, or a sinking feeling in your stomach – just use your breath to breathe into this space in your body where you are feeling these sensations at the moment. Breathe into this part of your body on your in-breath...and breathe out.

- While you are doing this, as best you can, say to yourself – this is OK, whatever this thought or feeling is, it’s OK, let me feel it. And as you say these things to yourself, just stay with your breath, breathing into the feelings and physical sensations that are there at the moment – breathing with them, accepting them, letting them be. It might be helpful to repeat to yourself – it’s OK, whatever it is, let me feel it.

- Stay here for as long as you need to – as long as you feel these thoughts, feelings and sensations pulling your attention.

- When you notice that your attention is no longer being pulled to these thoughts, feelings and sensations, return your focus to your breath, and breathe with your body as a whole. Noticing your stomach rising and falling, stretching and relaxing as you breathe in and out.

- Stay here as long as you need to, and when you are ready, slowly open your eyes.”

Process this activity with your client, and ask them to describe their experience with this activity, and ask for their comments on the exercise.

Explain to the person that when they say “it’s OK” during this exercise, that this is not actually a command to make everything OK, or a state to be achieved. Rather it is a way of allowing themselves to pay attention to whatever it is they are thinking or feeling, instead of trying to push it away. It is giving themselves permission to think and feel these sensations (Segal et al., 2002). Segal et al. (2002) explain that by holding these sensations in their awareness, it allows your client to face them, to name them and then to work with them. This activity also give people the opportunity to work with their negative thoughts and feelings in the session – making it easier to generalise to the real world.

Ask your client to practice this mindfulness skill – Allowing/Letting Be – over the next week, at times when they notice their attention being drawn to some negative thought, feeling or craving. This might be at times when they are practicing their other mindfulness skills (e.g. walking, 3-minute breathing spaces etc.), or at other times of the day when they notice they are feeling down, or experiencing a craving. This particular skill can be used for many different thoughts and feelings, related to both depressive thoughts, unhelpful schema or coping with cravings. Explain the utility of this activity to the client, and ask them to practice this over the next week. In addition, give clients a copy of the “Allowing/Letting Be” sheet, which summarises these ideas.
Coping with Craving
In the last session, clients developed an “emergency plan” to guide the implementation of craving management strategies. Ask the client whether they were able to put this plan into action, or practice any of these techniques over the past week. How did they go? Were there any problems? What worked well? Did they use alcohol/other drugs? Were they able to add any different strategies to their list? Reinforce the importance of managing AOD cravings effectively, and ask the client to continue to implement these strategies as appropriate over the next week for homework.

Managing Unhelpful Automatic Thought Patterns
It is most likely that the previous week presented many opportunities for clients to identify their unhelpful automatic thought patterns in relation to their depression and AOD use. Review the “Managing Thoughts” record with the client and confirm that they were able to understand and complete the form correctly. Were they able to detect their unhelpful thought patterns in situ? How effectively were they able to turn off the automatic pilot and challenge these thoughts? What were the consequences (feelings, behaviours)? Were there any problems? What did they think about the activity? Process the form in session with the client, and assign another “Managing Thoughts” sheet for homework.

“Alternative View” worksheet
Ask the client about the evidence they were able to collect over the past week in support of the alternative balanced schema they developed in session 7. Did they include all evidence, or did they disregard some data? What was their impression of the activity? Any flow-on effects for their mood or AOD use? Process the activity with the client, making a point of commending them for writing ANY evidence on the log. Assign another “Alternative View” worksheet for homework over the next week.

Learn and Practice Drink/Drug Refusal Skills
In the early stages of modifying use of alcohol/other drugs it is important to consider avoiding these high-risk situations completely. However, it is acknowledged that avoidance is not a long-term solution, nor is it always a practical one. There are a number of strategies that can make saying NO easier:

Non-verbal Measures for Refusing Alcohol/Other drugs (Monti et al., 1989)
Use a clear, firm, confident and unhesitating tone of voice.
Make direct eye contact with the other person to increase the effectiveness of your message.
Stand/sit straight to create a confident air.
Do not feel guilty about the refusal and remember, you will not hurt anyone by not drinking/using.

Verbal Measures for Refusing Alcohol/Other drugs (Monti et al., 1989)
“NO” should be the first word out of your mouth. A direct statement is more effective when refusing the offer.
Suggest an alternative (e.g. something else to do/eat/drink).
Request a behaviour change so that the other person stops asking (e.g. ask the person not to offer alcohol/other drugs anymore). Change the subject to something else to avoid getting involved in a drawn out debate about using/drinking. Avoid using excuses and avoid vague answers, which will imply that at a later date you may accept an offer to use/drink.

<table>
<thead>
<tr>
<th>Exercise: Rehearsing Drug/Alcohol Refusal (Monti et al., 1989; NIDA, 1998)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Use the sheet titled “Refusal Skills”.</td>
</tr>
<tr>
<td>- Explain the rationale for learning and practicing refusal skills to the client. Use the following information: “It is often difficult to refuse someone who is offering you alcohol/other drugs. This is particularly the case if you don’t want to offend the other person. It can be tough to say “no”, particularly when you have said “yes” before. But, equally important are your feelings and your goals, so it is a good idea to practice what you might say in these situations before they happen. There are some key way to get your message across, in a way that you feel comfortable, and that won’t offend the other person. To help you say “NO” comfortably, take some time to prepare some responses you might make to different people who might offer you alcohol/other drugs.”</td>
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<tr>
<td>- Read through the essential elements of an effective refusal with the client.</td>
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<tr>
<td>- Next, ask the person to fill in the table on the sheet and nominate some responses they may use when confronted by “a friend they used to use with”, “a co-worker”, “a party”, or other potentially “high-risk” situation. Write down the exact words the client feels they can use in each of these situations, using the key principles. This sheet can then be taken with the client.</td>
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<tr>
<td>- Note – if appropriate, the client may want to practice saying these responses out loud during the session, or you may like to conduct a role-play around one of the nominated scenarios.</td>
</tr>
</tbody>
</table>

Develop an Emergency Action Plan
Reinforce the importance of managing AOD cravings effectively, and explain to the client the importance of implementing coping strategies each time a craving hits them. To formalise this process, complete the following exercise with the client that will summarise the most effective crave-reduction techniques for the client.

<table>
<thead>
<tr>
<th>Exercise: Devising an Emergency Craving plan (Kadden et al., 1995; NIDA, 1988)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Use the sheet titled “Emergency Plan”.</td>
</tr>
<tr>
<td>- In the space provided, make a list of triggers relevant for the client in generating a craving to use alcohol/other drugs. Use the “Thought Monitoring” homework task as a guide.</td>
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<tr>
<td>- Ask the person to circle the triggers he/she feels they can simply avoid or reduce their exposure to (e.g. not having the drug present in the house), thereby reducing the likelihood of experiencing a craving.</td>
</tr>
<tr>
<td>- Of the remaining triggers that cannot be avoided, go through the coping strategies the client has used successfully over the past week, and jointly identify those that he/she can</td>
</tr>
</tbody>
</table>
| put in place when he/she experiences cravings. The client may also like to add strategies that have been successful in the past.  
| Complete the “Emergency Plan” in session, and ask the client to take it home and refer to it throughout the week when a craving develops. |

**Conclusion**
It is crucial at this time to offer supportive, encouraging statements as in the last session. Encourage progress made already in relation to addressing their AOD use in particular, and commend them for considering their current habits. Thank them for completing their homework tasks from last session, and encourage them to complete the tasks set for the coming week. Affirming the client can be helpful through strengthening the work relationship; enhancing the attitude of self-responsibility and empowerment; reinforcing effort and self-motivational statements, and supporting client self-esteem.

**Foreshadow session termination (Adapted from Monti, Abrams, Kadden & Cooney, 1989)**
The therapist should at this point foreshadow the cessation of sessions following the next 2 weeks. Notice the client’s reaction at this point, e.g. discouragement, pessimism, greater reports of problems, etc. Terminating the therapist/client relationship may result in a certain level of emotional distress to the client and may in turn find expression through generalised negative feelings. Therefore, help the client understand the process of termination to help them cope more effectively.

**Brief check-in**
After the person has completed Module 8, spend 5-10 minutes face-to-face with them covering the following items:

**Homework from Module 7**
Take a copy of all completed homework activities from Module 7 and place in the client’s clinical file.

**Review Homework Activities**
The following activities have been set for completion between now and Module 9: continuing with the Activity Log (using the Enjoyment and Achievement activities list) if the client elects to do so, practicing the Mindfulness Skills, using the “Coping with Cravings” sheet when they experience a craving over the next week, and completing the “Managing Thoughts” form for unhelpful automatic thoughts. In addition, the person will practice “allowing/letting be” and take any opportunities to practice and revise their Emergency Plans and Refusal Skills.

To check the client’s understanding of these tasks, ask them to describe the homework tasks in their own words.
Reinforce that just having a go at completing the homework is a success in itself. However, summarise the importance of completing homework, and explain that they will be used in next week’s session.

Plan for Completing Homework
Briefly explore with the client any problems they anticipate in completing their homework activities, and together develop and verbalise a plan for doing homework tasks through the week. Discuss the effectiveness of the plan developed from last session, and whether the client experienced any difficulties in completing homework from Module 7.

These plans can include a time, day, and place to complete homework, along with a time limit that establishes how long the person will spend on homework tasks per day. Also, include plans to remove distractions (such as turning off the radio/television, doing it away from the rest of the family/housemates etc.) and also not completing tasks in bed.

Suicide and Mood Assessment
Your interaction with the client should give you a general idea of what their level of mood currently is. However, it is important to test out your impressions, either by asking the person more directly about their mood/suicide ideation, or by using questionnaires to do this. If appropriate, you may like to use the Beck Hopelessness Inventory to assist your assessment.

Refer to the Suicide Risk Assessments in the first section of this manual to assist your assessment, and for a protocol for managing those people at high risk for suicide.

Confirm Next Appointment
Arrange the client’s next appointment before they leave.
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<tr>
<th></th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
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</tbody>
</table>

P=Pleasant tasks, A=Achievement tasks
<table>
<thead>
<tr>
<th>Situation</th>
<th>Thoughts</th>
<th>Feelings</th>
<th>Which automatic thought is this?*</th>
<th>Does it fit the facts?</th>
<th>What is another explanation?</th>
<th>Feelings now</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting at home, bored, nothing to do</td>
<td>I should be out doing something, but I’ve got nothing to do, nobody to do it with, life sucks, nothing good ever happens</td>
<td>Sad, Angry, Useless, Worthless</td>
<td>Jumping to negative conclusions Personalising Shoulds/oughts</td>
<td>Not really – I’ve got some friends but they are at work, &amp; I do have some things to do that I like</td>
<td>My depression is telling me I don’t have anything to do. It would be nice if I had someone to do stuff with, but I can choose to do something myself and still enjoy it.</td>
<td>A bit happier, a bit more in control, a bit more motivated and worthwhile</td>
</tr>
</tbody>
</table>

* catastrophising, personalising, jumping to negative conclusions, black/white thinking, shoulds/oughts
Tips for responding to offers of alcohol/other drugs:
- Say no first.
- Make direct eye contact.
- Ask the person to stop offering drugs.
- Don’t leave the door open to future offers.
- Remember there is a difference between being assertive and being aggressive. Assertiveness means being direct but not bossy, being honest but not bigheaded, and being responsible for your own choices without forcing your opinions on everybody else.

<table>
<thead>
<tr>
<th>People who might offer me drugs</th>
<th>What I’ll say to them</th>
</tr>
</thead>
<tbody>
<tr>
<td>A friend I used to drink or use with:</td>
<td></td>
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<tr>
<td>A coworker:</td>
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<tr>
<td>At a party:</td>
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<tr>
<td>Other:</td>
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</tbody>
</table>
Emergency Plan

Remember that running into problems is part of life and triggers cannot always be avoided, but running into these triggers means you need to be particularly careful about relapse.

**My Main Craving Triggers are:**

1. _____________________________
2. _____________________________
3. _____________________________
4. _____________________________
5. _____________________________
6. _____________________________
7. _____________________________
8. _____________________________

**How can I deal with this trigger?**

Avoid OR _____________________________

Avoid OR _____________________________

Avoid OR _____________________________

Avoid OR _____________________________

Avoid OR _____________________________

Avoid OR _____________________________

Avoid OR _____________________________

Avoid OR _____________________________

**General Coping Strategies**

1. I will leave or change the situation.
   Safe place I can go: _____________________________________________________________________

2. I will put off the decision to use for 15 minutes. I'll remember that my craving usually go away in ____________ minutes and I have dealt with cravings successfully in the past.

3. I’ll use the Mindfulness Skills.

4. I’ll call my list of emergency numbers:
   Name: ___________________________ Phone: ___________________________
   Name: ___________________________ Phone: ___________________________
   Name: ___________________________ Phone: ___________________________

5. I’ll remind myself of my success to this point: ___________________________________________
   ___________________________________________________________________________________

6. I’ll challenge my thoughts about using with these positive thoughts: ____________________
   ___________________________________________________________________________________
Use these skills when you notice your focus being drawn to some negative thought, feeling or craving.

This could be when you are practicing your 3-minute Breathing Space as well as other times of your day.

**The Basics**

- If you are not already using your mindfulness skills, start your 3-minute Breathing Space.
- When you notice your mind wandering over to a negative thought, or unpleasant feeling, keep your attention on this thought or feeling. Don’t bring your attention back to your breath.
- As best you can, just notice the thought, what it feels like, what feelings it is causing, and what physical sensations in your body are also there.
- Use your breath to breathe into this space in your body where you are feeling these sensations at the moment. Breathe into this part of your body on your in-breath… and breathe out.
- While you are doing this, as best you can, say to yourself – “This is OK, whatever this thought or feeling is, it’s OK, let me feel it”.
- As you say these things to yourself, just stay with your breath, breathing into the feelings and physical sensations that are there at the moment – breathing with them, accepting them, letting them be.
- Stay here for as long as you need to – as long as you feel these thoughts, feelings and sensations pulling your attention.
- When you notice that your attention is no longer being pulled to these thoughts, feelings and sensations, return your focus to your breath, and breathe with your body as a whole. Noticing your stomach rising and falling, stretching and relaxing as you breathe in and out.

Remember, saying “It’s OK” only means that you are giving yourself the okay to pay attention to these thoughts and feelings, rather than pushing them away.
Describe your problematic schema and alternative, more balanced schema in the space provided. Then, write down each piece of evidence in support of your **ALTERNATIVE** schema and the date and time when you observed the evidence. Be as specific as you can. For example, rather than writing “Someone said something nice to me”, write “Tom said he liked the shoes I was wearing”. Remember, write down ALL THE EVIDENCE in support of the alternative schema, regardless of how small or unimportant you might think it is.

Problematic Belief: _________________________________________________________________

Alternative, Balanced Belief: ________________________________________________________

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Evidence in Support of Alternative, Balanced Belief</th>
</tr>
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<tbody>
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</table>
Take-home Activities

As best you can, fill out the Managing Thoughts sheet at those times when you notice you are feeling depressed, negative, unhappy, bored etc. and when you feel like a drink/other drugs. Write down your thoughts as if you were speaking them out loud. Then go through the steps in managing these thoughts.

Practice Mindful Walking, Mindful Breathing and mindfulness with other routines each day and write these times down on the Activity (you may also like to plan ahead when you will practice this exercise).

Practice your 3-minute Breathing Space 3 times each day as planned on your Activity Log.

Try to fill out the Activity Log one day ahead, and plan time for at least 1 pleasant and 1 achievement activity to take place on each day.

As best you can, continue to change your drinking/using over the next week. Try out the “Coping with Cravings” activities to see which ones work best for you. Add any extra activities that help you deal with your cravings.

Have a go at filling out your “Alternative View” forms. Remember, you are trying to collect every little bit of proof for your “Alternative, Balanced Belief” (no matter how small you think it is).

Practice your Refusal Skills whenever you are offered alcohol/other drugs.

Use your Emergency Plan as needed.

Plan for Completing Take-home Activities: __________________________________________

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Session 9: CBT & Relapse Prevention
Activity scheduling, Mindfulness Skills, Coping with Cravings, Challenging Negative Automatic Thoughts, Schema Change Methods, Relapse Prevention

Aims:
- Present client with structure for the session.
- Review the previous week and homework tasks.
- Continue with Activity Log, Mindfulness Skills, Coping with Craving, Refusal Skills, managing negative automatic thought patterns and schema change methods.
- Introduction to relapse prevention

<table>
<thead>
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<th>Materials needed for Session 9</th>
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<tbody>
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<td>Handout: Activity Log</td>
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<tr>
<td>Handout: Managing Thoughts</td>
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<td>Handout: “Alternative View” worksheet</td>
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<td>Handout: Seemingly Irrelevant Decisions</td>
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<td>Handout: “Breaking the Rule” Effect</td>
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<tr>
<td>Handout: “Looking After Yourself”</td>
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<tr>
<td>Handout: Summary Session 9</td>
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</tbody>
</table>

Areas to be covered within session 9 include:

9.1 Orient person to structure of session 9
9.2 Review the previous week
9.3 Set the agenda for session 9
9.4 Review homework from session 8
9.5 Seemingly Irrelevant Decisions
   Exercise: Seemingly Irrelevant Decisions
9.6 “Breaking the Rule” Effect
9.7 Preventing Relapse
   Exercise: Looking After Yourself
9.8 Conclusion
   Foreshadow treatment termination
9.9 Brief Check-in
9.9.1 Homework from Module 8
9.9.2 Review Homework from Module 9
9.9.3 Plan for Completing Homework
9.9.4 Suicide and Mood assessment
9.9.5 Confirm next appointment
Session 9: CBT

Activity scheduling, Mindfulness Skills, Coping with Cravings, Challenging Negative Automatic Thoughts, Schema Change Methods, Relapse Prevention

Orient person to structure of session
Structure this session in the same way as you did in session 6. For example, say to the client: “Let’s start with a brief check in: I want to hear about your week and how you are feeling. Then, let’s set an agenda for the session, and I want to make sure that one thing on the agenda is to check your homework from last time.”

Review the previous week
For about 5-10 minutes, ask the person to briefly talk about their week. Be sure to ask about any significant events that occurred since the last session, how their mood is currently, any changes in their mood, functioning or AOD use they have observed, and any reflections they may have about the content of Session 7. Look for how the issues raised here may lead into the development of an agenda for this session.

Set the agenda
The first item on the agenda should always be reviewing homework from the previous session. Then briefly explain the other issues and activities to be covered during this session: relapse prevention. Begin with the sentence: “let’s make an agenda for our session today…” Once complete, work through the agenda items. If the client has not yet reached the stage where they would like to change their AOD use habits, continue with motivational interviewing as appropriate. Schema change methods are relevant for people with depression, so you can attempt to cover this agenda item if appropriate.

Review homework
The person’s homework from session 7 was to fill in an activity log (if chosen), scheduling enjoyment and achievement activities into each day, implement strategies to cope with cravings and monitor and challenge negative automatic thoughts. The person was also assigned the task of implementing the action plan developed from the problem-solving task from last session. Firstly, establish whether the person completed each activity, and if not, discuss the barriers that prevented them from doing so. Work towards a solution to these barriers with a view to preventing their occurrence in future homework tasks. If the person has no information entered onto either form, ask them to spend the first 5-10 minutes of the session completing them before you continue with the remaining agenda items.

Activity Log
Ask how the client managed with the activity log. Were they able to carry out the activities they scheduled? Did they encounter any difficulties completing the log, or doing the activities scheduled? Were they able to add any activities to their list of enjoyment and achievement tasks? What did they think of the exercise? Have they noticed any change in mood? What happened in those “danger” or high-risk times? Process the form with the client, highlighting the importance of this activity. Ask the client if they would like to
continue to complete an Activity Log for the next week, and assign another activity log if agreeable.

**Mindfulness Skills**
Assess how the person was able implement the Mindfulness Skills activity over the past week. Were they able to find time to practice the technique? What benefits did they notice? What barriers were encountered in practicing? Reinforce the importance of this skill, and encourage the client to practice this on a daily basis for homework over the next week.

**Coping with Craving**
In the last session, clients developed an “emergency plan” to guide the implementation of craving management strategies. Ask the client whether they were able to put this plan into action, or practice any of these techniques over the past week. How did they go? Were there any problems? What worked well? Did they use alcohol/other drugs? Were they able to add any different strategies to their list? Reinforce the importance of managing AOD cravings effectively, and ask the client to continue to implement these strategies as appropriate over the next week for homework.

**Managing Unhelpful Automatic Thought Patterns**
It is most likely that the previous week presented many opportunities for clients to identify their unhelpful automatic thought patterns in relation to their depression and AOD use. Review the “Managing Thoughts” record with the client and confirm that they were able to understand and complete the form correctly. Were they able to detect their unhelpful thought patterns in situ? How effectively were they able to turn off the automatic pilot and challenge these thoughts? What were the consequences (feelings, behaviours)? Were there any problems? What did they think about the activity? Process the form in session with the client, and assign another “Managing Thoughts” sheet for homework.

**Drink/Drug Refusal Skills**
Check with the client whether they were able to practice their AOD refusal skills during the past week. Ask about the situation, who made the offer, and how the client felt about responding. Was the client successful in refusing the offer? If not, are they able to reflect back on the situation and suggest how it might have turned out differently? Process the experiences with the client, and encourage them to continue practicing over the next week.

**“Alternative View” worksheet**
Ask the client about the evidence they were able to collect over the past week in support of the alternative balanced schema they developed in session 8. Did they include all evidence, or did they disregard some data? What was their impression of the activity? Any flow-on effects for their mood or AOD use? Process the activity with the client, making a point of commending them for writing ANY evidence on the log. Assign another “Alternative View” worksheet for homework over the next week.

**Evaluating the action plan**
In addition to the other activities, the client was asked to implement the action plan developed during session 7 to manage a current problem. Ask the client whether or not they put this plan into action over the last week. Ask the following questions, and process with the client how successful the plan was:

“Was the plan implemented in full or only in part? Why?”
“Does the plan need improving? Is a new strategy needed?”

Remind the client that problem-solving is a general skill and process that can be applied in many different settings. Reinforce the value of problem-solving techniques as a matter of habit in everyday life.

**Seemingly Irrelevant Decisions** (Monti, Abrams, Kadden & Cooney, 1989).

Given there is only one subsequent session remaining in the SHADE intervention, it is time to focus attention on the future, namely, preventing relapse to depression and AOD use. The first step in this process is to identify those situations and patterns of thinking and behaviour that may put us at-risk for falling back into our old habits.

Explain the following ideas to the client:

“On the surface, many of our choices don’t seem to have anything to do with drinking or using, or feeling depressed. Although our decisions may not directly involve choosing to drink, use or feel depressed, they may slowly move us closer to such behaviours or feelings. It is often through “seemingly irrelevant decisions” that we gradually work our way closer to entering high-risk situations that may bring on our symptoms or lead to drinking/using.

*People often fall victim to their situations (e.g. “I always end up drinking at parties and can’t help it”). Although it is difficult to recognise the choices made when in the middle of a situation, each small decision you make over a period of time can gradually lead you closer to problems. The best way to combat this is to think about each choice you make, no matter how seemingly irrelevant it is to drinking/using/feeling depressed, so you anticipate potential dangers ahead.*

Always choose the lowest-risk option to avoid putting yourself in a high-risk situation. Remember, it is easier to simply avoid the high-risk situation before you are actually in the middle of it.”

**Exercise: Seemingly irrelevant decisions (Monti, Abrams, Kadden & Cooney, 1989, Segal et al., 2002)**

- Use the sheet titled “Seemingly Irrelevant Decisions”.
- Ask the client to think about their last relapse to either depression or AOD use and to describe the situation/events that preceded the relapse. What decisions led up to the relapse? What prevented them from noticing or acting on these triggers?
- Write this down in the space provided on the form.
- Next, take the client through the problem solving steps summarised on the form. These are essential to prevent the client’s automatic pilot from taking over, and for seemingly irrelevant decision being made.
Then, ask the client which of the skills they have learnt (and are listed on the sheet) could have assisted them in their last relapse episode.

“Breaking the Rule” Effect
It is important to talk with the client about something called the “Breaking the Rule” Effect. Often people who have been trying to change their alcohol/other drug use, or their depression will feel very bad about themselves if they have a lapse – they will probably see it as the end of the world or a finish to their attempts at quitting. Your client may have already had some of these thoughts.

Give the following explanation to your client:
The ‘Breaking the Rule Effect’ could happen if you have a slip-up and “break your rules”. These rules could be staying off alcohol, pot or speed completely, or cutting down to a lesser level. Or, your rules could be about staying well, and not getting depressed again. The “breaking the rule effect” happens, when you have slip-up and break your rules or goals for therapy, and then think something like “oh stuff it, I’ve had a drink (or hit) – broken my rule, might as well keep going”. Or, you might notice on some days you feel a bit more depressed than others. In this case, the “breaking the rule effect” would be that you thinking something like “here I go again – I knew this therapy wouldn’t work, I’m not good enough to change, so stuff it, I won’t try anymore”.

“In both of these cases, there are other ways of looking at the situation. Slip-ups will happen – everybody makes mistakes, and it doesn’t mean that you have failed completely. You can stop at one drink, one cone or one hit, and go from there - you can start with a clean slate. Also, with depression, realise that your mood will sometimes be lower than at other times. It doesn’t mean you are getting worse, or headed for a relapse, rather that you are experiencing what everybody does – a simple change in mood, that won’t last forever.” But, if you have a slip-up, it is more likely to turn into a relapse if you give into the “breaking the rule effect”.

“The main thing to help you cope with the “breaking the rule effect” is to change those unhelpful automatic thinking patterns that cause the effect. Just like in your monitoring record, you need to realise that you are falling into that pattern of unhelpful thinking. In particular, the “breaking the rule effect” is an example of black & white thinking, catastrophising and jumping to negative conclusions. So, all you need to do is to develop other ways of thinking about your slip-ups – because everybody makes mistakes, everybody will have a slip-up. It is not the end of the world, and it doesn’t mean that you have failed.”

Give your client a copy of the sheet titled “Breaking the Rule Effect”. Go through the alternative patterns of thinking he/she could adopt in response to a slip up.

Preventing relapse in the future (Segal et al., 2002)
Explain to the client that part of preventing a relapse to depression and/or AOD use is for them to gradually learn ways to take care of themselves. They need to learn that even when life seems too busy and full of things to do, it is essential to prioritise activities that the client
enjoys as well as those which provide a sense of achievement. It is important to continue to
schedule those enjoyment and achievement activities into each day, and to minimise
involvement in activities that drain their energy reserves and mood (Segal et al., 2002)

<table>
<thead>
<tr>
<th>Exercise: Looking After Yourself (Segal et al., 2002)</th>
</tr>
</thead>
</table>
| ■ Use the sheet titled “Looking After Yourself”.
| ■ Work through the sheet with the client in session, discussing ways to ensure they
  continue to include enjoyment/achievement activities into their day, and to minimise
  their participation in other activities that threaten to tax their resources. |

**Conclusion**

It is crucial at this time to offer supportive, encouraging statements as in the last session.
Encourage progress made already in relation to addressing their AOD use in particular, and
commend them for considering their current habits. Thank them for completing their
homework tasks from last session, and encourage them to complete the tasks set for the
coming week. Affirming the client can be helpful through strengthening the work
relationship; enhancing the attitude of self-responsibility and empowerment; reinforcing
effort and self-motivational statements, and supporting client self-esteem. Remind client that
next week is their final session for the SHADE program.

**Brief Check-in**

After the person has completed Module 9, spend 5-10 minutes face-to-face with them
covering the following items:

**Homework from Module 8**

Take a copy of all completed homework activities from Module 8 and place in the client’s
clinical file.

**Review Homework Activities**

The following activities have been set for completion between now and Module 10:
continuing with the Activity Log (using the Enjoyment and Achievement activities list) if the
client elects to do so, practicing the Mindfulness Skills, using the “Coping with Cravings”
sheet when they experience a craving over the next week, and completing the “Managing
Thoughts” form for unhelpful automatic thoughts. In addition, the client has been asked to
complete the “Alternative View” worksheet to collect evidence for the validity of their
alternative, more balanced schema, and using drink/drug refusal skills as necessary.

To check the client’s understanding of these tasks, ask them to describe the homework tasks
in their own words.

Reinforce that just having a go at completing the homework is a success in itself. However,
summarise the importance of completing homework, and explain that they will be used in
next weeks’ session.

**Plan for Completing Homework**
Briefly explore with the client any problems they anticipate in completing their homework activities, and together develop and verbalise a plan for doing homework tasks through the week. Discuss the effectiveness of the plan developed from last session, and whether the client experienced any difficulties in completing homework from Module 8.

These plans can include a time, day, and place to complete homework, along with a time limit that establishes how long the person will spend on homework tasks per day. Also, include plans to remove distractions (such as turning off the radio/television, doing it away from the rest of the family/housemates etc.) and also not completing tasks in bed.

**Suicide and Mood Assessment**

Your interaction with the client should give you a general idea of what their level of mood currently is. However, it is important to test out your impressions, either by asking the person more directly about their mood/suicide ideation, or by using questionnaires to do this. If appropriate, you may like to use the Beck Hopelessness Inventory to assist your assessment.

Refer to the Suicide Risk Assessments in the first section of this manual to assist your assessment, and for a protocol for managing those people at high risk for suicide.

**Confirm Next Appointment**

Arrange the client’s next appointment before they leave.
## Activity Log

*Include at least 1 Pleasant task and 1 Achievement task in each day of the week*

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
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<td>8-9 a.m.</td>
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<td>10-11 a.m.</td>
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<td>11-12</td>
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<td>12-1 p.m.</td>
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<td>1-2 p.m.</td>
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<td>2-3 p.m.</td>
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<td>6-7 p.m.</td>
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<td>Evening</td>
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</tbody>
</table>

P=Pleasant tasks, A=Achievement tasks
<table>
<thead>
<tr>
<th>Situation</th>
<th>Thoughts</th>
<th>Feelings</th>
<th>Which automatic thought is this?**</th>
<th>Does it fit the facts?</th>
<th>What is another explanation?</th>
<th>Feelings now</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting at home, bored,</td>
<td>I should be out doing something, but I’ve got nothing to do, nobody to</td>
<td>Sad, Angry,</td>
<td>Jumping to negative conclusions</td>
<td>Not really - I’ve got some friends</td>
<td>My depression is telling me</td>
<td>A bit happier, a bit more</td>
</tr>
<tr>
<td>nothing to do</td>
<td>do it with, life sucks, nothing good ever happens</td>
<td>Useless, Worthless</td>
<td>Personalising</td>
<td>but they are at work, &amp; I do have</td>
<td>I don’t have anything to do.</td>
<td>in control, a bit more</td>
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<td></td>
<td>some things to do that I like</td>
<td>It would be nice if I had</td>
<td>motivated and worthwhile</td>
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<td>someone to do stuff with, but</td>
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<td>I can choose to do something</td>
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<td></td>
<td>myself and still enjoy it.</td>
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* catastrophising, personalising, jumping to negative conclusions, black/white thinking, shoulds/oughts
Describe your problematic schema and alternative, more balanced schema in the space provided. Then, write down each piece of evidence in support of your **ALTERNATIVE** schema and the date and time when you observed the evidence. Be as specific as you can. For example, rather than writing “Someone said something nice to me”, write “Tom said he liked the shoes I was wearing”. Remember, write down **ALL THE EVIDENCE** in support of the alternative schema, regardless of how small or unimportant you might think it is.

**Problematic Belief:** _______________________________________________________________

**Alternative, Balanced Belief:** ______________________________________________________

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Evidence in Support of Alternative, Balanced Belief</th>
</tr>
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<tbody>
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</tbody>
</table>
Think about your last relapse

What situations led up to the relapse?

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________________________________________________________________________

What decisions did I make that led me to a relapse?

________________________________________________________________________
________________________________________________________________________

What prevented me from noticing these triggers?

________________________________________________________________________
________________________________________________________________________

Preparing Myself for Seemingly Irrelevant Decisions

When making any decision, whether large or small, or seemingly irrelevant, use the problem solving skills you have already learned:

- Think about what different options you have.
- Think ahead to the possible results of each option. What are the positive or negative effects you can think of, and what is the risk of relapse?
- Select one of the options. Choose one that will give you the lowest chance of relapse. If you decide to choose a high-risk option, plan how to protect yourself while in the high-risk situation.

Which skills could I have used to help me better cope with my last relapse?

- [ ] Mindfulness Skills
- [ ] Problem solving techniques
- [ ] Activity Log
- [ ] Managing Unhelpful Automatic Thoughts
- [ ] Drink/Drug Refusal
- [ ] “Alternative View” worksheet
- [ ] Coping with Cravings
- [ ] Emergency Plan
The “Breaking the Rule” Effect is simply an unhelpful automatic thought that might happen if you notice your mood is getting low again, or if you have a craving to use alcohol/other drugs. You may even have a slip-up and have a drink or use cannabis or speed again.

The “breaking the rule” automatic thought comes into these situations and says “I knew you couldn’t do this, here you are back at square one”. It gives you permission to fall back into your old habits of thinking and behaving.

But if you know about the “Breaking the Rule” effect, you can be ready for it when it happens. When you notice this effect:

Remember:

- Practice your Mindfulness Skills to switch off your automatic pilot and concentrate on the moment
- Remind yourself that everybody has a slip-up. You haven’t failed completely, and you are not back at square one.
- If you notice yourself thinking like the “breaking the rule effect”, try these more helpful thoughts instead.

**Breaking the Rule Effect:** “I’ve blown it, might as well keep going”  
**More Helpful thought:** “I’ve just had a slip and I can get back on track”

**Breaking the Rule Effect:** “I knew I wouldn’t be able to stop”  
**More Helpful thought:** “I have been able to make a change…this is only a slip and I keep on trying”

**Breaking the Rule Effect:** “I’ve messed up already so I might as well keep going”  
**More Helpful Thought:** “I’ve just made a mistake and I can learn from it and get back on course”

**Breaking the Rule Effect:** “None of this therapy worked, I’m back at square one”  
**More Helpful Thought:** “This is only a change in my mood, I can handle this. I just need to handle each moment as best as I can”
Segal et al. (2002)

Remember that part of preventing a relapse to depression and alcohol/other drug use is to little by little learn ways to take care of yourself. Even when life seems too busy and full of things to do, you still need to make an effort to do things that you enjoy as well as those which give you a sense of achievement.

What am I doing in my daily life that I enjoy or that gives me a sense of achievement?

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How can I make sure that I continue to do these things or become more aware of them?

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What am I doing in my daily life (or what have I done before) that drains my energy and lowers my mood?

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How can I make sure that these activities are done less often?

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Take-home Activities

As best you can, fill out the Managing Thoughts sheet at those times when you notice you are feeling depressed, negative, unhappy, bored etc. and when you feel like a drink/other drugs. Write down your thoughts as if you were speaking them out loud. Then go through the steps in managing these thoughts.

Practice Mindful Walking, Mindful Breathing and mindfulness with other routines each day and write these times down on the Activity (you may also like to plan ahead when you will practice this exercise).

Practice your 3-minute Breathing Space 3 times each day as planned on your Activity Log.

Try to fill out the Activity Log one day ahead, and plan time for at least 1 pleasant and 1 achievement activity to take place on each day.

As best you can, continue to change your drinking/using over the next week. Try out the “Coping with Cravings” activities to see which ones work best for you. Add any extra activities that help you deal with your cravings.

Have a go at filling out your “Alternative View” forms. Remember, you are trying to collect every little bit of proof for your “Alternative, Balanced Belief” (no matter how small you think it is).

Practice your Refusal Skills whenever you are offered alcohol/other drugs.

Use your Emergency Plan as needed.

As best you can, become aware of your Seemingly Irrelevant Decisions.

Practice “Looking After Yourself” by spending time doing things that you enjoy.

Be aware of the “Breaking the Rule” effect, and when it is happening to you.

Plan for Completing Take-home Activities:

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Session 10: Relapse Prevention

Activity scheduling, Mindfulness Skills, Coping with Cravings, Challenging Negative Automatic Thoughts, Schema Change Methods, Relapse Prevention

Aims:
- Present client with structure for the session.
- Review the previous week and homework tasks.
- Continue with Activity Log, Mindfulness Skills, Coping with Craving, Refusal Skills, managing negative automatic thought patterns and schema change methods.
- Develop Relapse Management Plan

Materials needed for Session 10
- Handout: Relapse Management Plan
- Questionnaires: Client and Therapist Questionnaires
- Any other handouts the client requests

Areas to be covered within session 10 include:
10.1 Orient person to structure of session 10
10.2 Review the previous week
10.3 Set the agenda for session 10
10.4 Review homework from session 9
   Activity Log
   Mindfulness Skills
   Coping with Craving
   Managing Thoughts
   Drink/Drug Refusal Skills
   Alternative View” worksheet
10.5 Relapse Prevention
   Then and Now
   Steps in the Development of a Relapse Management Plan
   Relapse Management Plan
   Exercise: The Relapse Management Plan
10.6 Conclusion and Termination
10.7 Arrange Follow-up Appointment
10.8 Brief Check-in
10.8.1 Homework from Module 9
10.8.2 Review Homework from Module 10
10.8.3 Plan for Completing Homework
10.8.4 Suicide and Mood assessment
10.8.5 Therapeutic Alliance Measures
Session 10: Relapse Prevention and Termination
Activity scheduling, Mindfulness Skills, Coping with Cravings, Challenging Negative Automatic Thoughts, Schema Change Methods, Relapse Prevention

Orient person to structure of session
Structure this session in the same way as you did in session 6. For example, say to the client: “Let’s start with a brief check in: I want to hear about your week and how you are feeling. Then, let’s set an agenda for the session, and I want to make sure that one thing on the agenda is to check your homework from last time.”

Review the previous week
For about 5-10 minutes, ask the person to briefly talk about their week. Be sure to ask about any significant events that occurred since the last session, how their mood is currently, any changes in their mood, functioning or AOD use they have observed, and any reflections they may have about the content of Session 7. Look for how the issues raised here may lead into the development of an agenda for this session.

Set the agenda
The first item on the agenda should always be reviewing homework from the previous session. Then briefly explain the other issues and activities to be covered during this session: relapse prevention. Begin with the sentence: “let’s make an agenda for our session today...” Once complete, work through the agenda items. If the client has not yet reached the stage where they would like to change their AOD use habits, continue with motivational interviewing as appropriate. Schema change methods are relevant for people with depression, so you can attempt to cover this agenda item if appropriate.

Review homework
The person’s homework from session 9 was to fill in an activity log (if chosen), scheduling enjoyment and achievement activities into each day, implement strategies to cope with cravings and monitor and challenge negative automatic thoughts. The person was also assigned the task of implementing the action plan developed from the problem-solving task from last session. Firstly, establish whether the person completed each activity, and if not, discuss the barriers that prevented them from doing so. Work towards a solution to these barriers with a view to preventing their occurrence in future homework tasks. If the person has no information entered onto either form, ask them to spend the first 5-10 minutes of the session completing them before you continue with the remaining agenda items.

Activity Log
Ask how the client managed with the activity log. Were they able to carry out the activities they scheduled? Did they encounter any difficulties completing the log, or doing the activities scheduled? Were they able to add any activities to their list of enjoyment and achievement tasks? What did they think of the exercise? Have they noticed any change in mood? What happened in those “danger” or high-risk times? Process the form with the client, highlighting the importance of this activity. Ask the client if they would like to continue to complete an Activity Log for the next week, and assign another activity log if agreeable.
Mindfulness Skills
Assess how the person was able implement the Mindfulness Skills activity over the past week. Were they able to find time to practice the technique? What benefits did they notice? What barriers were encountered in practicing? Reinforce the importance of this skill, and encourage the client to practice this on a daily basis for homework over the next week.

Coping with Craving
In the last session, clients developed an “emergency plan” to guide the implementation of craving management strategies. Ask the client whether they were able to put this plan into action, or practice any of these techniques over the past week. How did they go? Were there any problems? What worked well? Did they use alcohol/other drugs? Were they able to add any different strategies to their list? Reinforce the importance of managing AOD cravings effectively, and ask the client to continue to implement these strategies as appropriate over the next week for homework.

Managing Unhelpful Automatic Thought Patterns
It is most likely that the previous week presented many opportunities for clients to identify their unhelpful automatic thought patterns in relation to their depression and AOD use. Review the “Managing Thoughts” record with the client and confirm that they were able to understand and complete the form correctly. Were they able to detect their unhelpful thought patterns in situ? How effectively were they able to turn off the automatic pilot and challenge these thoughts? What were the consequences (feelings, behaviours)? Were there any problems? What did they think about the activity? Process the form in session with the client, and assign another “Managing Thoughts” sheet for homework.

Drink/Drug Refusal Skills
Check with the client whether they were able to practice their AOD refusal skills during the past week. Ask about the situation, who made the offer, and how the client felt about responding. Was the client successful in refusing the offer? If not, are they able to reflect back on the situation and suggest how it might have turned out differently? Process the experiences with the client, and encourage them to continue practicing over the next week.

“Alternative View” worksheet
Ask the client about the evidence they were able to collect over the past week in support of the alternative balanced schema they developed in session 8. Did they include all evidence, or did they disregard some data? What was their impression of the activity? Any flow-on effects for their mood or AOD use? Process the activity with the client, making a point of commending them for writing ANY evidence on the log. Assign another “Alternative View” worksheet for homework over the next week.

Relapse Prevention
Once clients have learned the skills and behaviours to help alleviate their symptoms and their use of alcohol/other drugs, they are ready to begin preparing for life after therapy where they must manage on their own. This session expands on the previous session on
Relapse Prevention/Management and is concerned with anticipating situations in the future that pose risks to the client in terms of relapsing into depression and alcohol/other drug use. This session can be a way of increasing the client’s self-efficacy about how they will cope in these high-risk situations, perhaps circumventing a relapse in the process (Wilson, 1992).

At this stage, both you and the client have the benefit of hindsight to assist you in collaboratively preparing for future high-risk situations. That is, you know how the client has responded to the different skills/techniques taught in previous sessions, as well as how they relate events, thoughts and behaviours. In addition, the client has hopefully incorporated some of the skills/techniques into their coping strategies, and will have a greater understanding of their problem (Wilson, 1992).

You will have already discussed, in general terms, the course of events that led a client to relapse in the past (Seemingly Irrelevant Decisions activity in session 9). It is now time to work out an individualised relapse prevention plan with the client that deals with situations in the future that are associated with relapse. Once you have identified with your client the chain of events that contribute to his/her acute episode OR problematic pattern of alcohol/drug use, you will find that this chain of events then forms the basis for the development of a relapse prevention plan.

Relapse prevention is a plan of action that enables your client to self-manage his/her depression or substance use by replacing existing beliefs with more realistic and accurate ones, and by learning new coping skills and making lifestyle changes.

**Then and Now (Segal et al., 2002; Graham, 2000)**

Contrast the patterns of thinking and behaviour the client was falling into when he/she initially entered treatment with the way they are thinking and behaving now. Ask the client the following questions (Segal et al., 2002):

“*What did you get out of coming to this program? What did you learn?*”

“*Looking back, can you remember why you came to this program in the first place? What were your expectations and why did you stay?*”

You may like to look back on the case formulation activity developed in session 1, and assess their progress towards their goals. Commend the client on progress made to date, and reinforce the positive changes they have made.

**Steps in developing a relapse management plan**

Remind your client of the importance of developing a lifestyle that supports the positive changes they have made, and that fits in with their goals. Developing a relapse prevention plan in advance of problematic situations is essential. It is a lot easier to recognise warning signs while mood is stable (Segal et al., 2002).

There are some key elements that make up a relapse prevention plan, which include (adapted from Kay-Lambkin, Hazell & Waring, 2000)

1. **Anticipating difficult situations** – Often the client may not be able to think about potentially threatening situations. Recognizing these situations as early warning
signs may raise the client’s awareness that he/she is thinking or behaving in unhelpful ways. Useful questions include: “What situations do you consider to be high-risk for relapse?,” “How will you know when a lapse occurs?,” “Who can help you maintain the skills you have learnt?”

2. **Regulating thoughts and feelings** – It is important to explain to the client that it is normal for him/her to lapse and that it is common when attempting to reduce substance use/change unhelpful thoughts. Reassure the client that these thoughts/feelings are temporary responses to situation that he/she can modify and learn from. Useful questions include: “What might be an unreasonable thought or feeling in response to a lapse?”, “What can I do to deal more effectively in this situation?”

3. **Diagnosing necessary support skills** – Emphasise to the client that they take stock of everything they discussed and practiced in therapy. This is a good opportunity for you to ask the client whether there are any additional skills they think they may need. When discussing relapse prevention, it is important that the client considers involving a support person. This will ensure two things: that your client has shared his/her decision to make a positive change (this will provide an additional incentive to maintain the changes achieved); and that your client can receive support from someone who he/she knows well and will find supportive to prevent/better manage relapses. An important goal when others are involved (in addition to your client) is to promote a **shared understanding** of the relapse process with all those involved. This will allow you to discuss possible strategies that will help avoid relapse with a particular emphasis on social support and positive support for change.

4. **Regulating Consequences** – Point out to the client that he/she needs to create their own reward. It is unlikely that the client will receive any accolades for maintaining high levels functioning from anyone other than from himself or herself. Useful questions include: “How will you know that you are successful in maintaining your behaviour/thoughts?”, “How can you reward yourself for a job well done?”

**The Relapse Management Plan**

Developing a relapse management plan in anticipation of problematic situations and feelings in the future is an important part of teaching your client to look after him or herself. As Segal et al. (2002) explains, planning how to manage changes in mood is more effective when your current mood is stable. In addition, the following steps will be useful when you identifying the client’s own situational/internal triggers:

If not previously known from the treatment sessions, introduce the client to examples of early warning signs of depressive relapse.

Ask your client to review the most recent episode when he/she experienced a relapse to depression or was admitted to hospital.

Identify any noticeable changes in perceptions, thoughts, feelings and behaviours, using the examples of early warning signs of depressive relapse as a prompt. Identify any particular stressful events or factors that may have triggered these changes.
Prompt the client by using open-ended questions, about any stressful or unusual events, worries or concerns he/she may have had around that time.

Identify from your discussion the chain of external events and internal events (i.e. relapse signature) that preceded him/her becoming depressed/being admitted to hospital.

Find out if this is the general chain of events leading up to him/her becoming unwell. You can do this by asking about another recent occasion and the first time he/she became unwell or were admitted. Repeat steps 2, 3 & 4 for these two episodes to pick up if there is usually a similar pattern/chain of events.

Explore the role of alcohol/drug use within the client’s relapse signature, by identifying the points along the chain of events at which he/she used alcohol/drugs. You can do this by asking the client directly whether he/she used during this episode and at which points he/she used.

Identify the client’s pattern of use by asking; What he/she used, Amount: how much he/she used, Frequency: how often he/she used, Where did he/she use and who he/she used with. It is also important to identify the reasons why the client used alcohol/drugs at each point and what were his/her beliefs about using the substance (e.g. was it to increase pleasure, to socialise, to cope?)

Explore the role of medication adherence within the relapse signature, by identifying the points along the chain of events at which the client was taking his/her medication as prescribed or not. You can do this by asking the client directly whether he/she was taking his/her medication during this episode and at which points he/she was not.

Identify the client’s pattern of medication adherence at each point along the chain by asking; What medication he/she taking, Dosage: how much was he/she taking, Frequency: how often was he/she taking it.

It is also important to identify the beliefs the client hold about his/her medication, and the reasons why he/she did or did not take his/her medication at each point in the relapse signature

**Exercise: The relapse prevention plan (Segal et al., 2002; Graham, 2000)**
- Take out the “Relapse Management Plan” and complete each section with the client in session. These sections include: identifying support people (including contact details), high-risk situations for lapses, warning signs and plans of action, and rewards.
- Ask the client to keep this plan close to hand so that it can be easily referred to in the future.

**Termination**
Formal termination should be acknowledged and discussed at the end of the tenth session. Recapitulate the client’s progress and situation through the sessions and include: Reconfirmation of the most important factors motivating the client Summarise the commitments and changes made so far Affirm and reinforce changes already made Explore additional areas of change Elicit self-motivational statements for maintenance of change and further change Support self-efficacy Deal with any special problems Remind the client about continuing follow-up sessions

**Arrange Follow-up appointment**

Therapists on the SHADE project were asked to organise an appropriate time/day during this session, for their client to attend a post-treatment follow-up assessment. Post-treatment assessments were conducted at 15 weeks after the initial assessment (5 weeks after session 10). A tentative appointment time and day was made and written down on the Relapse Management Plan, and clients were re-contacted just prior to the appointment to confirm their attendance.

At this time, therapists also explained to their clients that a different person would conduct their post-treatment assessment (someone who is not aware that the client had been receiving treatment as part of the SHADE study).

**Brief Check-in**

After the person has completed Module 10, spend 5-10 minutes face-to-face with them covering the following items:

**Homework from Module 9**

Take a copy of all completed homework activities from Module 9 and place in the client’s clinical file.

**Review Homework Activities**

Discuss with your client the activities and homework tasks they would like to regularly incorporate into their daily routine. Provide additional handouts where appropriate. Ask them to implement their Relapse Management Plan when relevant.

**Suicide and Mood Assessment**

Your interaction with the client should give you a general idea of what their level of mood currently is. However, it is important to test out your impressions, either by asking the person more directly about their mood/suicide ideation, or by using questionnaires to do this. If appropriate, you may like to use the Beck Hopelessness Inventory to assist your assessment.

Refer to the Suicide Risk Assessments in the first section of this manual to assist your assessment, and for a protocol for managing those people at high risk for suicide.
Therapeutic Alliance Measure
The SHADE project sought to evaluate therapeutic alliance from both the client and the therapist perspective at several points throughout the treatment period. All participants and therapists were asked to complete the Agnew-Davis Therapeutic Alliance questionnaire after Sessions 1 (all clients), 5, and 10 (those in therapist and computer conditions only).

The questionnaires for this purpose are contained in the handouts for sessions 1, 5 and 10.
Name: ___________________________________________________

Follow-up assessment: ________________________________

4. I will reward myself for acting on these early warning signs by:
_________________________________________________
_________________________________________________
_________________________________________________

My high risk situations for a relapse are:

_________________________________________________
_________________________________________________

Skills I will continue to use in everyday life:

☐ Look for the Unhelpful automatic thoughts I am using
☐ Manage unhelpful automatic thoughts
☐ Think about Seemingly Irrelevant Decisions
☐ Do some problem solving
☐ Look at my Emergency Plan and Coping with Cravings strategies
☐ Choose some enjoyment and achievement activities from my list and schedule them into each day using my activity record
☐ Drink/drug refusal skills
☐ Look over my Schema Continuum and use my “Alternative View” worksheet to collect evidence for a more positive schema
☐ Use my support person: __________________________________

Date, day, time__________________________________________
My early warning signs of relapse are:

- More moody or irritable
- Just not wanting to see people
- Sleep more
- Sleep less
- Eat more
- Eat less
- Getting easily tired
- Giving up on exercise
- Not wanting to deal with day-to-day things (opening mail, paying bills etc.)
- Putting deadlines off
- Putting off housework/other responsibilities
- ________________________________
- ________________________________
- ________________________________
- ________________________________
- ________________________________
- ________________________________
- ________________________________
- ________________________________
- ________________________________
- ________________________________
- ________________________________
- ________________________________

If I notice these early warning signs I will: (Segal et al., 2002)

1. Switch off my automatic pilot and take a Mindfulness Skills. Ask myself “How is my mood affecting my body? ”

2. Remind myself that the feelings and thoughts I am experiencing now just events of the mind. They are no more, they are not facts and do not mean I am back to square one. They are no different from what I experienced during the SHADE program. What helped me then will help me now.

3. Take some action:
   - Look for the Unhelpful automatic thoughts I am using
   - Manage unhelpful automatic thoughts
   - Think about Seemingly Irrelevant Decisions
   - Do some problem solving
   - Look at my Emergency Plan and Coping with Cravings strategies
   - Choose some enjoyment and achievement activities from my list and schedule them into each day using my activity record
   - Drink/drug refusal skills
   - Look over my Schema Continuum and use my “Alternative View” worksheet to collect evidence for a more positive schema
   - Use my support person: ________________
Format of therapy
Guidelines for the delivery of the treatment sessions are given for each of the ten sessions in this manual.

Session 1 is delivered face-to-face with a therapist, with the remaining nine sessions delivered via the SHADE computer program. Each session is structured in a similar way, commencing with setting the agenda for the current session, reviewing homework activities, learning/developing new skills, assigning homework and conclusion. In order to provide clients with effective motivational enhancement and coping skills, the following topics are covered:

- Motivational interviewing (Sessions 1-4 and further if necessary)
- Involvement of Support Person (Session 4, 9 and 10)
- Symptom management (Sessions 1-10 as applicable)
- Mood Monitoring (Sessions 2 & 3)
- Activity Scheduling (Sessions 2-10)
- Mindfulness Training (Sessions 3-10)
- Identifying and Managing unhelpful thoughts (Sessions 4 & 5)
- Coping with cravings and planning for emergencies (Session 6)
- Drink/Drug refusal (Session 6)
- Problem-solving (Session 7)
- Seemingly irrelevant decisions (Session 9)
- Coping with the abstinence/violation effect (Session 9)
- Relapse prevention/management (Session 10)
- Termination (Sessions 9 & 10)

Following the completion of each computer session, therapists are asked to meet briefly with the client to check that they comprehend the homework activities described during that session, and also to conduct a brief suicide and mood assessment.
Session 1: Case Formulation

As per therapist manual
THERAPIST SUMMARY SHEET

Session 2: Introduction to CBT
Rationale for therapy, mood monitoring, activity scheduling, Motivational Interviewing

Aims:

• Present client with structure for the session.
• Review the previous week and homework tasks.
• Present rationale for CBT.
• Introduce client to the concepts of mood monitoring and activity scheduling.

Areas to be covered within session 2 include:

Greet the person
Introduction Module
Commence Module 2
Brief Check-in
    Review homework activities
    Plan for completing homework
    Suicide and mood assessment
    Confirm next appointment
Session 2: Introduction to CBT

Rationale for therapy, mood monitoring, activity scheduling, Motivational Interviewing

Greet the person
Greet the person briefly when they arrive for their appointment and take them to the computer for their session. Limit your interaction with the person to non-specific topics.

Introduction Module
Start the SHADE computer program, and load the Introduction module. This is a brief module (approximately 5-10 minutes) that orients the person to the computer program, shows them how to use the mouse and keyboard, and teaches them how to navigate their way through the program.

Commence Module 2
At the conclusion of the Introduction Module, load Module 2.

Check that the person feels OK to commence this module and work their way through the activities set for this session. In addition, check that the person has copies of their homework sheets, and relevant activities from Session 1. The SHADE program will give the person the opportunity to print out and complete any homework activities that were not finished prior to this session. However, to complete Module 2, the person also needs their completed “Pros and Cons Balance Sheet” from Session 1. If they have forgotten this handout, give them a copy of the completed form that you placed in their file from last session.

Then, leave the person to work through Module 2 on his or her own, but let them know where you will be in case they get stuck.

Remind the person to check in with you before they leave.

Module 2
This module covers the following agenda items:

- Set agenda
- Review homework
- Present rationale for Cognitive Behaviour Therapy (CBT)
- Mood Monitoring
- Activity Scheduling
- Assign homework and Conclusion

Brief check-in
After the person has completed Module 2, spend 5-10 minutes face-to-face with them covering the following items:

Review Homework Activities
The following activities have been set for completion between now and Module 3: complete the mood monitor, record activities using the activity log and to consider current levels of AOD use, using their revised “Pros and Cons Balance Sheet” as a guide.

To check the client’s understanding of these tasks, ask them to describe the homework tasks in their own words.

Reinforce that just having a go at completing the homework is a success in itself. However, summarise the importance of completing homework, and explain that they will be used in next weeks’ session.

Take a copy of the client’s revised “Pros and Cons Balance Sheet” and keep in their clinical file.

**Plan for Completing Homework**
Briefly explore with the client any problems they anticipate in completing their homework activities, and together develop and verbalise a plan for doing homework tasks through the week. Write this plan down on their “Homework Summary” sheet. These plans can include a time, day, and place to complete homework, along with a time limit that establishes how long the person will spend on homework tasks per day. Also, include plans to remove distractions (such as turning off the radio/television, doing it away from the rest of the family/housemates etc.) and also not completing tasks in bed.

**Suicide and Mood Assessment**
Your interaction with the client should give you a general idea of what their level of mood currently is. However, it is important to test out your impressions, either by asking the person more directly about their mood/suicide ideation, or by using questionnaires to do this. If appropriate, you may like to use the Beck Hopelessness Inventory to assist your assessment.

**Confirm Next Appointment**
Arrange the client’s next appointment before they leave.
THERAPIST SUMMARY SHEET

Session 3: CBT and Introduction to Motivational Interviewing
Mood monitoring, Activity scheduling, Mindfulness training, Motivational Interviewing, ABC model, Thought monitoring

Aims:
- Present client with structure for the session.
- Review the previous week and homework tasks.
- Expand on the Activity Log exercise to include scheduling in enjoyable and achievement activities.
- Commence motivational interviewing around AOD use.

Areas to be covered within session 3 include:

- Greet the person
- Commence Module 3
- Brief Check-in
- Homework from Module 2
- Review homework for Module 3
- Plan for completing homework
- Suicide and Mood assessment
- Confirm next appointment
Greet the person
Greet the person briefly when they arrive for their appointment and take them to the computer for their session. Limit your interaction with the person to non-specific topics.

Commence Module 3
Load the SHADE program and go to Module 3.

Check that the person feels OK to commence this module and work their way through the activities set for this session. In addition, check that the person has copies of their homework sheets. The SHADE program will give the person the opportunity to print out and complete any homework activities that were not finished prior to this session.

Then, leave the person to work through Module 3 on his or her own, but let them know where you will be in case they get stuck.

Remind the person to check in with you before they leave.

Module 3
This module covers the following agenda items:
- Set the agenda
- Review homework
- Identifying and Scheduling enjoyment and achievement tasks
- The ABC model
- Introduction to thought monitoring (monitor ABC)
- Informal Assessment of Stage of Change
- Mindfulness Training
- Assign Homework and Conclusion

Brief check-in
After the person has completed Module 3, spend 5-10 minutes face-to-face with them covering the following items:

Homework from Module 2
Take a copy of all completed homework activities from Module 2 and place in the client’s clinical file.

Review Homework Activities
The following activities have been set for completion between now and Module 4: continuing with the Mood Monitor, scheduling activities for each day into the Activity Log (using the Enjoyment and Achievement activities list), practice the 3-minute
breathing space and to re-visit their reasons for AOD use with a view to addressing the concerns raised in the session. In addition, the client shall identify a support person to assist them in their progress towards their goals.

To check the client’s understanding of these tasks, ask them to describe the homework tasks in their own words.

Reinforce that just having a go at completing the homework is a success in itself. However, summarise the importance of completing homework, and explain that they will be used in next weeks’ session.

**Plan for Completing Homework**

Briefly explore with the client any problems they anticipate in completing their homework activities, and together develop and verbalise a plan for doing homework tasks through the week. Discuss the effectiveness of the plan developed from last session, and whether the client experienced any difficulties in completing homework from Module 2.

Write the plan down on their “Homework Summary” sheet. These plans can include a time, day, and place to complete homework, along with a time limit that establishes how long the person will spend on homework tasks per day. Also, include plans to remove distractions (such as turning off the radio/television, doing it away from the rest of the family/housemates etc.) and also not completing tasks in bed.

**Suicide and Mood Assessment**

Your interaction with the client should give you a general idea of what their level of mood currently is. However, it is important to test out your impressions, either by asking the person more directly about their mood/suicide ideation, or by using questionnaires to do this. If appropriate, you may like to use the Beck Hopelessness Inventory to assist your assessment.

**Confirm Next Appointment**

Arrange the client’s next appointment before they leave.
THERAPIST SUMMARY SHEET

Session 4: CBT and Introduction to Motivational Interviewing
Activity Scheduling, Motivational Enhancement, Coping with cravings, Change plans

Aims:
- Learn thought monitoring techniques
- Involve support person in session
- Continue with motivational interviewing around AOD use.
- Teach coping with cravings
- Change plans

Areas to be covered within session 4 include:
Greet the person
Commence Module 4
Brief Check-in
  - Homework from Module 3
  - Review Homework for Module 4
  - Plan for Completing Homework
  - Suicide and Mood assessment
  - Confirm next appointment
**Session 4: CBT and Motivational Interviewing**  
*Activity scheduling, Motivational Interviewing, Coping with cravings, change plans*

Greet the person briefly when they arrive for their appointment and take them to the computer for their session. Limit your interaction with the person to non-specific topics.

Commence Module 4  
Load the SHADE program and go to Module 4.

Check that the person feels OK to commence this module and work their way through the activities set for this session. In addition, check that the person has copies of their homework sheets. The SHADE program will give the person the opportunity to print out and complete any homework activities that were not finished prior to this session.

Then, leave the person to work through Module 4 on his or her own, but let them know where you will be in case they get stuck.

Remind the person to check in with you before they leave.

**Module 4**

This module covers the following agenda items:
- Set the agenda
- Review homework
- Activity Log
- Mood Monitor
- Monitoring Automatic Thoughts
- Practice thought monitoring
- Reasons for AOD Use
- Informal Assessment of Stage of Change
- Involvement of the Support Person
- Phase 2 Motivational Interviewing
- Recapitulation
- Key Questions
- Information and Advice
- Coping with cravings
- Developing a craving plan
- Negotiating a plan for change
- Assign homework and conclusion

**Brief check-in**

After the person has completed Module 4, spend 5-10 minutes face-to-face with them covering the following items:

**Homework from Module 3**

Take a copy of all completed homework activities from Module 3 and place in the client’s clinical file.
Review Homework Activities
The following activities have been set for completion between now and Module 5: practicing thought monitoring, the 3-minute Breathing Space and Activity Log (using the Enjoyment and Achievement activities list). The client may also like to commence modifying their AOD use over the next week, experimenting with some different approaches. If the client has printed out self-help material to review, they may like to try some of the approaches suggested, with a view to reporting back on what was useful/not useful in next weeks’ session. The client may ask for additional self-help material for their depression, alcohol or other drug use. If appropriate and available, provide this information.

To check the client’s understanding of these tasks, ask them to describe the homework tasks in their own words.

Reinforce that just having a go at completing the homework is a success in itself. However, summarise the importance of completing homework, and explain that they will be used in next weeks’ session.

In addition, take a copy of the client’s completed “Interpreting Situations” handout from Module 4, and place in their clinical file. Remind the person to bring this completed form with them to Module 5.

Plan for Completing Homework
Briefly explore with the client any problems they anticipate in completing their homework activities, and together develop and verbalise a plan for doing homework tasks through the week. Discuss the effectiveness of the plan developed from last session, and whether the client experienced any difficulties in completing homework from Module 3.

Write the plan down on their “Homework Summary” sheet. These plans can include a time, day, and place to complete homework, along with a time limit that establishes how long the person will spend on homework tasks per day. Also, include plans to remove distractions (such as turning off the radio/television, doing it away from the rest of the family/housemates etc.) and also not completing tasks in bed.

Suicide and Mood Assessment
Your interaction with the client should give you a general idea of what their level of mood currently is. However, it is important to test out your impressions, either by asking the person more directly about their mood/suicide ideation, or by using questionnaires to do this. If appropriate, you may like to use the Beck Hopelessness Inventory to assist your assessment.

Confirm Next Appointment
Arrange the client’s next appointment before they leave.
Aims:
• Present client with structure for the session.
• Review the previous week and homework tasks.
• Continue with Activity Log and practicing mindfulness.
• Identification and management of negative automatic thoughts.

Areas to be covered within session 5 include:
Greet the person
Commence Module 5
Brief Check-in
  Homework from Module 4
  Review homework from Module 5
  Plan for completing homework
  Suicide and Mood assessment
  Therapeutic Alliance questionnaire
  Confirm next appointment
Session 5: CBT  
*Activity scheduling, Mindfulness of the breath, Managing Negative Automatic Thoughts*

Greet the person
Greet the person briefly when they arrive for their appointment and take them to the computer for their session. Limit your interaction with the person to non-specific topics.

Commence Module 5
Load the SHADE program and go to Module 5.

Check that the person feels OK to commence this module and work their way through the activities set for this session. In addition, check that the person has copies of their homework sheets. The SHADE program will give the person the opportunity to print out and complete any homework activities that were not finished prior to this session. However, the person also needs to use the “Interpreting Situations” handout completed in Module 5 during this session. So, check that they have brought this sheet with them. If not, give them a copy of this completed handout that you added to their clinical file last week.

Then, leave the person to work through Module 5 on his or her own, but let them know where you will be in case they get stuck.

Remind the person to check in with you before they leave.

Module 5
This module covers the following agenda items:
- Set the agenda
- Review homework
- Activity Log
- Mindfulness of the Breath
- Modifying AOD use
- Thought Monitoring
- Identifying Negative Automatic Thoughts
- Changing Negative Automatic Thought Patterns
- Assign Homework and Conclusion

Brief check-in
After the person has completed Module 5, spend 5-10 minutes face-to-face with them covering the following items:

Homework from Module 4
Take a copy of all completed homework activities from Module 4 and place in the client’s clinical file.

Review Homework Activities
The following activities have been set for completion between now and Module 6: continuing with the Activity Log (using the Enjoyment and Achievement activities list), and practice the 3-minute Breathing Space over the next week. In addition, the client had been asked to
complete the “Managing Thoughts” task for each time over the next week when they feel depressed, or the urge to use alcohol/other drugs.

To check the client’s understanding of these tasks, ask them to describe the homework tasks in their own words.

Reinforce that just having a go at completing the homework is a success in itself. However, summarise the importance of completing homework, and explain that they will be used in next weeks’ session.

In addition, take a copy of the client’s revised “Interpreting Situations” handout, and place in their clinical file.

Plan for Completing Homework
Briefly explore with the client any problems they anticipate in completing their homework activities, and together develop and verbalise a plan for doing homework tasks through the week. Discuss the effectiveness of the plan developed from last session, and whether the client experienced any difficulties in completing homework from Module 4.

Write the plan down on their “Homework Summary” sheet. These plans can include a time, day, and place to complete homework, along with a time limit that establishes how long the person will spend on homework tasks per day. Also, include plans to remove distractions (such as turning off the radio/televison, doing it away from the rest of the family/housemates etc.) and also not completing tasks in bed.

Therapeutic Alliance Questionnaire
The SHADE project sought to evaluate therapeutic alliance from both the client and the therapist perspective at several points throughout the treatment period. All participants and therapists were asked to complete the Agnew-Davis Therapeutic Alliance questionnaire after Sessions 1 (all clients), 5, and 10 (those in therapist and computer conditions only).

Suicide and Mood Assessment
Your interaction with the client should give you a general idea of what their level of mood currently is. However, it is important to test out your impressions, either by asking the person more directly about their mood/suicide ideation, or by using questionnaires to do this. If appropriate, you may like to use the Beck Hopelessness Inventory to assist your assessment.

Confirm Next Appointment
Arrange the client’s next appointment before they leave.
Client ID number: ____________________________________________________________________________

Therapist: ___________________________________________________________________________________

Date completed: ______________________________________________________________________________

Please answer each question as honestly as you can. Place a tick (✓) in the circle that best describes your feelings

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Disagree</th>
<th>Moderately Disagree</th>
<th>Slightly Disagree</th>
<th>Neutral</th>
<th>Slightly Agree</th>
<th>Moderately Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel free to express the things that worry me.</td>
<td>○</td>
<td>○</td>
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<tr>
<td>2. I feel friendly towards my therapist.</td>
<td>○</td>
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<tr>
<td>3. I am worried about embarrassing myself in therapy.</td>
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<td>4. I take the lead when I’m in therapy.</td>
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<td>5. I keep some important things to myself, not sharing them in therapy.</td>
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<tr>
<td>6. I have confidence in the therapy and in the techniques being used.</td>
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<td>7. I feel optimistic about my progress.</td>
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<td>8. I feel I can openly express my thoughts and feelings in therapy.</td>
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<td>9. I feel critical or disappointed in my therapy.</td>
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<tr>
<td>12. The professional skills of the therapist are impressive.</td>
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<tr>
<td>13. I feel accepted in therapy no matter what I say or do.</td>
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<tr>
<td>14. I feel the therapy influences me in ways that are not beneficial to me.</td>
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<tr>
<td>15. My therapist finds it hard to understand me.</td>
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<td>16. I find therapy warm and friendly.</td>
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<td>17. I don’t get the guidance in therapy that I would like.</td>
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<td>18. My therapist is persuasive.</td>
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<td>19. My therapist is supportive.</td>
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<td>20. My therapist follows their own plans, ignoring my views of how to proceed.</td>
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<td>22. My therapist seems bored or impatient with me.</td>
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<td>28. My therapist and I are clear about our roles and responsibilities when we meet.</td>
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</table>
# Therapist Questionnaire

**Client ID number:**

**Therapist:**

**Date completed:**

Please answer each question as honestly as you can. Place a tick (✔️) in the circle that best describes your feelings.

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<th>Question</th>
<th>Strongly Disagree</th>
<th>Moderately Disagree</th>
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<td>1. My client feels free to express the things that worry him/her.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>2. My client is friendly towards me.</td>
<td>☐</td>
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<td>☐</td>
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<td>6. My client feels optimistic about his/her progress.</td>
<td>☐</td>
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</tr>
<tr>
<td>12. The professional skills are impressive to my client.</td>
<td><img src="https://example.com" alt="Strongly Disagree" /></td>
<td><img src="https://example.com" alt="Moderately Disagree" /></td>
<td><img src="https://example.com" alt="Slightly Disagree" /></td>
<td><img src="https://example.com" alt="Neutral" /></td>
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<tr>
<td>13. I accept my client no matter what he/she does.</td>
<td><img src="https://example.com" alt="Strongly Disagree" /></td>
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<tr>
<td>14. I try to influence my client in ways that are not beneficial to him/her.</td>
<td><img src="https://example.com" alt="Strongly Disagree" /></td>
<td><img src="https://example.com" alt="Moderately Disagree" /></td>
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</tr>
<tr>
<td>15. I find it hard to understand my client.</td>
<td><img src="https://example.com" alt="Strongly Disagree" /></td>
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</tr>
<tr>
<td>16. I feel warm and friendly with my client.</td>
<td><img src="https://example.com" alt="Strongly Disagree" /></td>
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<tr>
<td>17. I do not give the guidance in therapy that my client would like.</td>
<td><img src="https://example.com" alt="Strongly Disagree" /></td>
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<tr>
<td>18. I feel I am a persuasive person.</td>
<td><img src="https://example.com" alt="Strongly Disagree" /></td>
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<td><img src="https://example.com" alt="Slightly Disagree" /></td>
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</tr>
<tr>
<td>19. I feel supportive.</td>
<td><img src="https://example.com" alt="Strongly Disagree" /></td>
<td><img src="https://example.com" alt="Moderately Disagree" /></td>
<td><img src="https://example.com" alt="Slightly Disagree" /></td>
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<td><img src="https://example.com" alt="Slightly Agree" /></td>
<td><img src="https://example.com" alt="Moderately Agree" /></td>
<td><img src="https://example.com" alt="Strongly Agree" /></td>
</tr>
<tr>
<td>28. My client and I are clear about our roles and responsibilities when we meet.</td>
<td><img src="https://example.com" alt="Strongly Disagree" /></td>
<td><img src="https://example.com" alt="Moderately Disagree" /></td>
<td><img src="https://example.com" alt="Slightly Disagree" /></td>
<td><img src="https://example.com" alt="Neutral" /></td>
<td><img src="https://example.com" alt="Slightly Agree" /></td>
<td><img src="https://example.com" alt="Moderately Agree" /></td>
<td><img src="https://example.com" alt="Strongly Agree" /></td>
</tr>
</tbody>
</table>
Aims:
- Continue with Activity Log, Mindfulness strategies and Managing Thoughts.
- Teach the client problem solving skills

Areas to be covered within session 6 include:
Greet the person
Commence Module 6
Brief Check-in
  - Homework from Module 5
  - Review Homework from Module 6
  - Plan for Completing Homework
  - Suicide and Mood assessment
  - Confirm next appointment
Session 6: CBT
Problem solving skills

Greet the person
Greet the person briefly when they arrive for their appointment and take them to the computer for their session. Limit your interaction with the person to non-specific topics.

Commence Module 6
Load the SHADE program and go to Module 6.

Check that the person feels OK to commence this module and work their way through the activities set for this session. In addition, check that the person has copies of their homework sheets. The SHADE program will give the person the opportunity to print out and complete any homework activities that were not finished prior to this session.

Then, leave the person to work through Module 6 on his or her own, but let them know where you will be in case they get stuck.

Remind the person to check in with you before they leave.

Module 6
This module covers the following agenda items:
Set the agenda

- Review homework
- Activity Log
- Modifying AOD use
- Managing Thoughts
- Problem solving skills
- Assign Homework and Conclusion

Brief check-in
After the person has completed Module 6, spend 5-10 minutes face-to-face with them covering the following items:

Homework from Module 5
Take a copy of all completed homework activities from Module 5 and place in the client’s clinical file.

Review Homework Activities
The following activities have been set for completion between now and Module 7: continuing with the Activity Log (using the Enjoyment and Achievement activities list) if the client elects to do so, practice the 3-minute Breathing Space and using the “Coping with Cravings” sheet and “Emergency Plan” when they experience a craving over the next week. In addition, the client had been asked to complete the “Managing Thoughts” task for each time over the next week when they detect a negative automatic thought has occurred, and practice their drink/drug refusal skills.
To check the client’s understanding of these tasks, ask them to describe the homework tasks in their own words.

Reinforce that just having a go at completing the homework is a success in itself. However, summarise the importance of completing homework, and explain that they will be used in next weeks’ session.

Plan for Completing Homework
Briefly explore with the client any problems they anticipate in completing their homework activities, and together develop and verbalise a plan for doing homework tasks through the week. Discuss the effectiveness of the plan developed from last session, and whether the client experienced any difficulties in completing homework from Module 5.

Write the plan down on their “Homework Summary” sheet. These plans can include a time, day, and place to complete homework, along with a time limit that establishes how long the person will spend on homework tasks per day. Also, include plans to remove distractions (such as turning off the radio/television, doing it away from the rest of the family/housemates etc.) and also not completing tasks in bed.

Suicide and Mood Assessment
Your interaction with the client should give you a general idea of what their level of mood currently is. However, it is important to test out your impressions, either by asking the person more directly about their mood/suicide ideation, or by using questionnaires to do this. If appropriate, you may like to use the Beck Hopelessness Inventory to assist your assessment.

Confirm Next Appointment
Arrange the client’s next appointment before they leave.
Aims:
• Continue with previous skills
• Teach schema change methods

Areas to be covered within session 7 include:
Greet the person
Commence Module 7
Brief Check-in
   Homework from Module 6
   Review Homework from Module 7
   Plan for Completing Homework
   Suicide and Mood assessment
   Confirm next appointment
Session 7: CBT
Schema change methods

Greet the person
Greet the person briefly when they arrive for their appointment and take them to the computer for their session. Limit your interaction with the person to non-specific topics.

Commence Module 7
Load the SHADE program and go to Module 7.

Check that the person feels OK to commence this module and work their way through the activities set for this session. In addition, check that the person has copies of their homework sheets. The SHADE program will give the person the opportunity to print out and complete any homework activities that were not finished prior to this session.

Then, leave the person to work through Module 7 on his or her own, but let them know where you will be in case they get stuck.

Remind the person to check in with you before they leave.

Module 7
This module covers the following agenda items:
Set the agenda
Review homework
- Activity Log
- 3-minute Breathing Space
- Coping with Craving
- Managing Unhelpful Automatic Thought Patterns
  - Modifying AOD use
- Problem-solving
- Schema focussed therapy
- Assign Homework and Conclusion

Brief check-in
After the person has completed Module 7, spend 5-10 minutes face-to-face with them covering the following items:

Homework from Module 6
Take a copy of all completed homework activities from Module 6 and place in the client’s clinical file.

Review Homework Activities
The following activities have been set for completion between now and Module 8: continuing with the Activity Log (using the Enjoyment and Achievement activities list) if the client elects to do so, practicing the 3-minute breathing space, using the “Coping with Cravings” sheet when they experience a craving over the next week, and completing the “Managing Thoughts”
form for unhelpful automatic thoughts. In addition, the client has been asked to implement the action plan for the problem identified by them during the session.

To check the client’s understanding of these tasks, ask them to describe the homework tasks in their own words.

Reinforce that just having a go at completing the homework is a success in itself. However, summarise the importance of completing homework, and explain that they will be used in next weeks’ session.

Plan for Completing Homework
Briefly explore with the client any problems they anticipate in completing their homework activities, and together develop and verbalise a plan for doing homework tasks through the week. Discuss the effectiveness of the plan developed from last session, and whether the client experienced any difficulties in completing homework from Module 6.

Write the plan down on their “Homework Summary” sheet. These plans can include a time, day, and place to complete homework, along with a time limit that establishes how long the person will spend on homework tasks per day. Also, include plans to remove distractions (such as turning off the radio/television, doing it away from the rest of the family/housemates etc.) and also not completing tasks in bed.

Suicide and Mood Assessment
Your interaction with the client should give you a general idea of what their level of mood currently is. However, it is important to test out your impressions, either by asking the person more directly about their mood/suicide ideation, or by using questionnaires to do this. If appropriate, you may like to use the Beck Hopelessness Inventory to assist your assessment.

Confirm Next Appointment
Arrange the client’s next appointment before they leave.
Aims:
• Continue with previous skills and strategies
• Teach emergency planning, drink/drug refusal

Areas to be covered within session 8 include:
Greet the person
Commence Module 8
Brief Check-in
  Homework from Module 7
  Review Homework from Module 8
  Plan for Completing Homework
  Suicide and Mood assessment
  Confirm next appointment
Session 8: CBT
Drink/drug refusal, Emergency planning

Greet the person
Greet the person briefly when they arrive for their appointment and take them to the computer for their session. Limit your interaction with the person to non-specific topics.

Commence Module 8
Load the SHADE program and go to Module 8.

Check that the person feels OK to commence this module and work their way through the activities set for this session. In addition, check that the person has copies of their homework sheets. The SHADE program will give the person the opportunity to print out and complete any homework activities that were not finished prior to this session. However, the person may also need to refer to the Case Formulation sheet that you both completed back in Session 1. Have a copy of this completed form ready to give the client for Module 8.

Then, leave the person to work through Module 8 on his or her own, but let them know where you will be in case they get stuck.

Remind the person to check in with you before they leave.

Module 8
This module covers the following agenda items:
  - Set the agenda
  - Review homework
  - Activity Log
  - 3-minute Breathing Space
  - Coping with Craving
  - Managing Unhelpful Automatic Thought Patterns
  - Learn and Practice Drink/Drug Refusal Skills
  - Develop an Emergency Action Plan
  - Assign Homework and Conclusion
  - Foreshadow session termination

Brief check-in
After the person has completed Module 8, spend 5-10 minutes face-to-face with them covering the following items:

Homework from Module 7
Take a copy of all completed homework activities from Module 7 and place in the client’s clinical file.

Review Homework Activities
The following activities have been set for completion between now and Module 9: continuing with the Activity Log (using the Enjoyment and Achievement activities list) if the client elects to do so, practicing the 3-minute Breathing Space, using the “Coping with Cravings” sheet...
when they experience a craving over the next week, and completing the “Managing Thoughts” form for unhelpful automatic thoughts. In addition, the client has been asked to complete the Positive Data Log to collect evidence for the validity of their alternative, more balanced schema.

To check the client’s understanding of these tasks, ask them to describe the homework tasks in their own words.

Reinforce that just having a go at completing the homework is a success in itself. However, summarise the importance of completing homework, and explain that they will be used in next weeks’ session.

Plan for Completing Homework
Briefly explore with the client any problems they anticipate in completing their homework activities, and together develop and verbalise a plan for doing homework tasks through the week. Discuss the effectiveness of the plan developed from last session, and whether the client experienced any difficulties in completing homework from Module 7.

Write the plan down on their “Homework Summary” sheet. These plans can include a time, day, and place to complete homework, along with a time limit that establishes how long the person will spend on homework tasks per day. Also, include plans to remove distractions (such as turning off the radio/television, doing it away from the rest of the family/housemates etc.) and also not completing tasks in bed.

Suicide and Mood Assessment
Your interaction with the client should give you a general idea of what their level of mood currently is. However, it is important to test out your impressions, either by asking the person more directly about their mood/suicide ideation, or by using questionnaires to do this. If appropriate, you may like to use the Beck Hopelessness Inventory to assist your assessment.

Confirm Next Appointment
Arrange the client’s next appointment before they leave.
THERAPIST SUMMARY SHEET

Session 9: CBT & Relapse Prevention
Looking After Yourself, Seemingly Irrelevant Decisions, Breaking the rules

Aims:
• Continue with previously learned skills
• Introduction to relapse prevention: Looking After Yourself, Seemingly Irrelevant Decisions, Breaking the rules

Areas to be covered within session 9 include:
Greet the person
Commence Module 9
Brief Check-in
    Homework from Module 8
    Review Homework from Module 9
    Plan for Completing Homework
    Confirm Next Appointment
Session 9: Relapse Prevention

Looking After Yourself, Seemingly Irrelevant Decisions, Breaking the rules

Greet the person
Greet the person briefly when they arrive for their appointment and take them to the computer for their session. Limit your interaction with the person to non-specific topics.

Commence Module 9
Load the SHADE program and go to Module 9.

Check that the person feels OK to commence this module and work their way through the activities set for this session. In addition, check that the person has copies of their homework sheets. The SHADE program will give the person the opportunity to print out and complete any homework activities that were not finished prior to this session.

Then, leave the person to work through Module 9 on his or her own, but let them know where you will be in case they get stuck.

Remind the person to check in with you before they leave.

Module 9
This module covers the following agenda items:
Set the agenda
Review homework
- Activity Log
- 3-minute Breathing Space
- Coping with Craving
- Managing Unhelpful Automatic Thought Patterns
- Drink/Drug Refusal Skills
- Positive Data Log
- Seemingly Irrelevant Decisions
- “Breaking the Rule” Effect
- Preventing relapse in the future: Looking After Yourself
- Assign Homework and Conclusion

Brief check-in
After the person has completed Module 9, spend 5-10 minutes face-to-face with them covering the following items:

Homework from Module 8
Take a copy of all completed homework activities from Module 8 and place in the client’s clinical file.

Review Homework Activities
The following activities have been set for completion between now and Module 10: continuing with the Activity Log (using the Enjoyment and Achievement activities list) if the client elects to do so, practicing the 3-minute Breathing Space, using the “Coping with
Cravings” sheet when they experience a craving over the next week, and completing the “Managing Thoughts” form for unhelpful automatic thoughts. In addition, the client has been asked to complete the Positive Data Log to collect evidence for the validity of their alternative, more balanced schema, and using drink/drug refusal skills as necessary.

To check the client’s understanding of these tasks, ask them to describe the homework tasks in their own words.

Reinforce that just having a go at completing the homework is a success in itself. However, summarise the importance of completing homework, and explain that they will be used in next weeks’ session.

**Plan for Completing Homework**

Briefly explore with the client any problems they anticipate in completing their homework activities, and together develop and verbalise a plan for doing homework tasks through the week. Discuss the effectiveness of the plan developed from last session, and whether the client experienced any difficulties in completing homework from Module 8.

Write the plan down on their “Homework Summary” sheet. These plans can include a time, day, and place to complete homework, along with a time limit that establishes how long the person will spend on homework tasks per day. Also, include plans to remove distractions (such as turning off the radio/television, doing it away from the rest of the family/housemates etc.) and also not completing tasks in bed.

**Suicide and Mood Assessment**

Your interaction with the client should give you a general idea of what their level of mood currently is. However, it is important to test out your impressions, either by asking the person more directly about their mood/suicide ideation, or by using questionnaires to do this. If appropriate, you may like to use the Beck Hopelessness Inventory to assist your assessment.

**Confirm Next Appointment**

Arrange the client’s next appointment before they leave.
THERAPIST SUMMARY SHEET

Session 10: Relapse Management

Relapse Management Plan

Aims:
- Review the previous week and homework tasks.
- Develop Relapse Management Plan

Areas to be covered within session 10 include:
- Greet the person
- Commence Module 10
- Brief Check-in
  - Homework from Module 9
  - Review Homework for Module 10
  - Suicide and Mood assessment
  - Therapeutic Alliance Questionnaire
  - Termination
Session 10: Relapse Management and Termination

Relapse Management Plan

Greet the person
Greet the person briefly when they arrive for their appointment and take them to the computer for their session. Limit your interaction with the person to non-specific topics.

Commence Module 10
Load the SHADE program and go to Module 10.

Check that the person feels OK to commence this module and work their way through the activities set for this session. In addition, check that the person has copies of their homework sheets. The SHADE program will give the person the opportunity to print out and complete any homework activities that were not finished prior to this session.

Then, leave the person to work through Module 10 on his or her own, but let them know where you will be in case they get stuck.

Remind the person to check in with you before they leave.

Module 10
This module covers the following agenda items:
- Set the agenda
- Review homework
- Activity Log
- 3-minute Breathing Space
- Coping with Craving
- Managing Unhelpful Automatic Thought Patterns
- Drink/Drug Refusal Skills
- Schema change methods
- Steps in developing a relapse management plan
- The Relapse Management Plan
- Assign Homework and Conclusion

Brief check-in
After the person has completed Module 10, spend 5-10 minutes face-to-face with them covering the following items:

Homework from Module 9
Take a copy of all completed homework activities from Module 9 and place in the client’s clinical file.

Review Homework Activities
Discuss with your client the activities and homework tasks they would like to regularly incorporate into their daily routine. Provide additional handouts where appropriate. Ask them to implement their Relapse Management Plan when relevant
Suicide and Mood Assessment

Your interaction with the client should give you a general idea of what their level of mood currently is. However, it is important to test out your impressions, either by asking the person more directly about their mood/suicide ideation, or by using questionnaires to do this. If appropriate, you may like to use the Beck Hopelessness Inventory to assist your assessment.

Therapeutic Alliance Questionnaire
The SHADE project sought to evaluate therapeutic alliance from both the client and the therapist perspective at several points throughout the treatment period. All participants and therapists were asked to complete the Agnew-Davis Therapeutic Alliance questionnaire after Sessions 1 (all clients), 5, and 10 (those in therapist and computer conditions only).

Termination
Formal termination should be acknowledged and discussed at the end of the tenth session. Recapitulate the client’s progress and situation through the sessions and include:

- Reconfirmation of the most important factors motivating the client
- Summarise the commitments and changes made so far
- Affirm and reinforce changes already made
- Explore additional areas of change
- Elicit self-motivational statements for maintenance of change and further change
- Support self-efficacy
- Deal with any special problems
- Remind the client about continuing follow-up sessions.
Client ID number: ____________________________________________________________________________

Therapist: ___________________________________________________________________________________

Date completed: ______________________________________________________________________________

Please answer each question as honestly as you can. Place a tick (✓) in the circle that best describes your feelings

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Moderately Disagree</th>
<th>Slightly Disagree</th>
<th>Neutral</th>
<th>Slightly Agree</th>
<th>Moderately Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel free to express the things that worry me.</td>
<td></td>
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<td>2. I feel friendly towards my therapist.</td>
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<td>3. I am worried about embarrassing myself in therapy.</td>
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<td>4. I take the lead when I’m in therapy.</td>
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<td>5. I keep some important things to myself, not sharing them in therapy.</td>
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<td>6. I have confidence in the therapy and in the techniques being used.</td>
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<td>7. I feel optimistic about my progress.</td>
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<td>8. I feel I can openly express my thoughts and feelings in therapy.</td>
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<td>9. I feel critical or disappointed in my therapy.</td>
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<td>10. I can discuss personal matters I am ordinarily ashamed or afraid to reveal.</td>
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<td>11. I look to therapy for solutions to my problems.</td>
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<tr>
<td>Statement</td>
<td>Strongly Disagree</td>
<td>Moderately Disagree</td>
<td>Slightly Disagree</td>
<td>Neutral</td>
<td>Slightly Agree</td>
<td>Moderately Agree</td>
<td>Strongly Agree</td>
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<td>12. The professional skills of the therapist are impressive.</td>
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<td>13. I feel accepted in therapy no matter what I say or do.</td>
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<td>14. I feel the therapy influences me in ways that are not beneficial to me.</td>
<td>○</td>
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<tr>
<td>15. My therapist finds it hard to understand me.</td>
<td>○</td>
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<td>16. I find therapy warm and friendly.</td>
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<td>17. I don’t get the guidance in therapy that I would like.</td>
<td>○</td>
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<td>18. My therapist is persuasive.</td>
<td>○</td>
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<td>19. My therapist is supportive.</td>
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<tr>
<td>20. My therapist follows their own plans, ignoring my views of how to proceed.</td>
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<tr>
<td>21. My therapist is confident in themselves and their techniques.</td>
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<tr>
<td>22. My therapist seems bored or impatient with me.</td>
<td>○</td>
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<tr>
<td>23. My therapist expects me to take responsibility rather than be dependent on them.</td>
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<tr>
<td>24. My therapist and I are willing to work hard together.</td>
<td>○</td>
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<td>25. I take the lead and my therapist expects it of me.</td>
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<td>26. My therapist and I agree about how to work together.</td>
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<tr>
<td>27. My therapist and I have difficulty working jointly in a partnership.</td>
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<td>28. My therapist and I are clear about our roles and responsibilities when we meet.</td>
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<td>○</td>
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</table>
**Therapist Questionnaire**

**Client ID number:** ______________________________________________________

**Therapist:** _____________________________________________________________

**Date completed:** _______________________________________________________

Please answer each question as honestly as you can. Place a tick (√) in the circle that best describes your feelings.

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<th>Question</th>
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<td>4. My client takes the lead in therapy.</td>
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<td>5. My client keeps some important things to him/herself, not sharing</td>
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<td>them in therapy.</td>
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<td>6. My client has confidence in the therapy and in the</td>
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<td>techniques being used.</td>
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<td>7. My client feels optimistic about his/her progress.</td>
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<td>8. My client feels he/she can openly express his/her</td>
<td></td>
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<td>thoughts and feelings in therapy.</td>
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<td>9. My client is critical or disappointed with me.</td>
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<td>10. My client can discuss personal matters he/she is</td>
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<td>ordinarily ashamed or afraid to reveal.</td>
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<td>11. My client looks to me for solutions to his/her problems.</td>
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<tr>
<td>Statement</td>
<td>Strongly Disagree</td>
<td>Moderately Disagree</td>
<td>Slightly Disagree</td>
<td>Neutral</td>
<td>Slightly Agree</td>
<td>Moderately Agree</td>
<td>Strongly Agree</td>
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<td>12. The professional skills are impressive to my client.</td>
<td>○</td>
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<td>13. I accept my client no matter what he/she does.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<td>14. I try to influence my client in ways that are not beneficial to him/her.</td>
<td>○</td>
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<td>15. I find it hard to understand my client.</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<td>16. I feel warm and friendly with my client.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<td>17. I do not give the guidance in therapy that my client would like.</td>
<td>○</td>
<td>○</td>
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<td>18. I feel I am a persuasive person.</td>
<td>○</td>
<td>○</td>
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<td>19. I feel supportive.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>20. I follow my own plans, ignoring my client’s views of how to proceed.</td>
<td>○</td>
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<td>○</td>
<td>○</td>
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<tr>
<td>21. I feel confident in myself and my techniques.</td>
<td>○</td>
<td>○</td>
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<td>22. I feel bored or impatient with my client.</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<td>23. I expect my client to take responsibility rather than be dependent on me.</td>
<td>○</td>
<td>○</td>
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<td>24. My client and I are willing to work hard together.</td>
<td>○</td>
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<td>25. My client takes the lead and I expect it of him/her.</td>
<td>○</td>
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<tr>
<td>26. My client and I agree about how to work together.</td>
<td>○</td>
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<tr>
<td>27. My client and I have difficulty working jointly in a partnership.</td>
<td>○</td>
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<td>28. My client and I are clear about our roles and responsibilities when we meet.</td>
<td>○</td>
<td>○</td>
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</table>
Treatment Fidelity Manual© for

The SHADE Project

Self-help for Alcohol/other drug use and Depression

April 2004

Frances Kay-Lambkin (Chief Investigator/PhD Student)
Amanda Baker (Chief Investigator)
Richa Gupta (Project Officer)
Sue Startup (Project Officer)

Centre for Mental Health Studies, University of Newcastle

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This manual is designed to assist in the assessment of treatment fidelity for interventions evaluated for the SHADE Project: Self-Help for Alcohol/other Drug Use Disorders and Depression. The content of the SHADE Therapy intervention is detailed in Kay-Lambkin, Baker & Bucci (2002).

SHADE Therapy was conducted over 10 weekly session of approximately 60-minutes’ duration. In addition, a computer-delivered condition of equivalent intensity and content was compared with the therapist-delivered SHADE Therapy. At the conclusion of the computer sessions, therapists and participants met for a “Brief Check-in” session, which assessed participant progress on many fronts. Both the therapist-delivered treatment sessions and the “Brief Check-in” sessions are to be rated for fidelity.

Evans et al. (1984) outlined the following issues for raters to consider when evaluating treatment fidelity. The following is based on their manual (Evans et al., 1984). Firstly, in order to use this manual correctly, the rater must rate what he/she hears, not what he/she thinks ought to have occurred. In order to do this, the rater must apply the same standards for rating an item, regardless of:

- What other behaviours the therapist engaged in during the session;
- What ratings were given to other items within the session;
- How skilled the rated believes the therapist;
- How much the rater likes the therapist; and
- Whether the rater thinks the behaviour being rated is a good or a bad thing to do.

In addition, Evans et al. (1984) highlighted the following instructions to raters of treatment fidelity, which also apply to the SHADE project:

- Rate every item
- Attend to manual notes
- Listen before rating
- Take notes
- Use coding sheet correctly

Instructions for Rating Adherence to SHADE Therapy

This manual and accompanying rating scales are designed to measure the extent to which therapists in the SHADE project engaged in SHADE therapy, rather than the quality with which the therapy was performed. Thus, the rater should not consider the quality of the therapist behaviour when rating treatment fidelity, and concentrate on the presence or absence of particular therapy items covered by the therapist during each session.

Raters are asked to complete two sheets when assessing treatment fidelity for the SHADE project. The first sheet “Fidelity Checklist” is to be used while the rater is listening to a particular audiotaped session. The “Fidelity Checklist” is the same regardless of the session tape the rater is listening too. The second sheet is the
“Treatment Fidelity Coding Sheet”, and a separate one is provided for each individual therapy session, and one additional coding sheet for the Brief Check-in sessions. This sheet is completed by raters after listening to and assessing the tape under evaluation.

**Fidelity Checklist**

This checklist is to be used while raters are assessing individual session tapes. Each therapy item (both SHADE and non-SHADE therapy items) is listed down the left hand column of the checklist, with “therapy minutes” listed across the top of the checklist table. Raters are asked to record which therapy items listed down the left hand column are being presented during each minute of the therapy session under evaluation. As such, raters are asked to start a stopwatch at the commencement of the session tape and, at the conclusion of each “minute” of therapy, tick the therapy item in the left hand column that was being presented.

For example, a rater may listen to a session tape in 10-minute blocks before analysing the content of each individual 1-minute of therapy. Subsequently, if during the end of the first minute of the 10-minute block, the therapist was “reviewing the previous week”, the rater would tick off this item under the column 1 of the “Therapy Minutes” spreadsheet. In minute five of the same therapy session, the therapist may have spent part of the time finishing reviewing the week, and commencing a review of the homework from the previous session. In this case, the rater would tick off the “review the previous week” and “review homework” under column 5 of the “Therapy Minutes” spreadsheet. This would continue until the end of the session under review.

Alternatively, raters may wish to listen to the session tape in one complete block, ticking off the various therapy items covered according to therapy minute.

There are 27 items that could possibly occur during a therapy minute. It is possible that several of these items could be occurring simultaneously. The rater is permitted to tick more than one item per therapy minute should they consider that more than one item is being discussed. For example, during the case formulation session (Session 1), therapists could be simultaneously discussing the problem list of the case formulation (Item 4) using motivation enhancement techniques (Item 5), and discussing modification of the person’s alcohol/other drug use levels (Item 6). In this case, the rater would tick all three items (Items 4, 5, 6) as occurring within the same period of therapy. Please note, however, that in order for this to occur the rater must feel that each of these items are actually being discussed with reference to the goal for that particular skill, as opposed to the item just being mentioned in passing by the therapist.

Clarification must be made in relation to Item 3, “Non-specific Therapy Skills”. This item refers to tools of engagement and rapport building that the therapist uses during the course of therapy (e.g. paraphrasing, summarising, reflection and other microskills). This item is different from the others on the list in that the therapist is not demonstrating or teaching an actual skill or strategy (e.g. as in problem solving or thought monitoring). Although the rater may feel, for example, that a therapist is
taking a problem solving approach in listening to a client’s story, or in discussing completion of homework, he/she would only tick “non-specific therapy skills” in this instance, as the actual steps of problem solving are not being discussed/taught by the therapist. The rater should only tick the specific skill items on the “Fidelity Checklist” (e.g. problem solving, thought monitoring etc.) if the therapist is actually articulating the steps involved in developing that skill.

Once the entire session has been listened to and rated by the rater, the “Fidelity Checklist - Summary Sheet” should be completed. On this summary sheet, the rater tallies the total number of minutes spent by the therapist discussing each of the 27 items on the checklist, and records that total number in the space provided next to each item on the summary form. It is likely that the tallies for several of the 27 items will be zero, as not all items will be discussed in a particular session. These zero tallies should also be recorded next to the relevant item on the summary sheet. In addition, given several therapy items could be discussed simultaneously by the therapist, it is necessary to record the total number of minutes during which more than one therapy item is being discussed. Thus the rater should add together the number of therapy minutes where they have ticked more than one therapy item for that minute and record that tally on the space provided on the “Fidelity Checklist – Summary Sheet”. Finally, the rater is asked to write on the summary sheet the total number of minutes taken to complete that session. This completed summary sheet will be used as the reference for completing the remaining fidelity analyses.

Treatment Fidelity Coding Sheet
The “treatment fidelity coding sheet” is divided into five parts: Identifying Information, SHADE Therapy Items, Non-SHADE Therapy Items, Overlap Time, Total Session Time and Adherence Rating. This should be completed by raters after they have finished assessing each session tape, using the information recorded on the “Fidelity Checklist”.

Identifying Information
This section simply asks the rater to record their name and the specific details of the audiotaped treatment session they are assessing. This includes the therapist’s initials, session number and participant identification code.

SHADE Therapy Items
SHADE Therapy (Kay-Lambkin, Baker & Bucci, 2002) is a highly structured 10-session treatment program. Thus, it is important to know whether or not the issues covered in the session under evaluation are issues belonging to the agenda for that particular session. As such, this section is divided into items that belong to the SHADE Therapy agenda for the session under evaluation (essential and optional items), and items that belong to SHADE Therapy, but are on the agenda for other sessions.
SHADE Therapy Items list on the agenda for the session being evaluated are divided into two sections – Essential Agenda Items and Optional Agenda Items. The Essential Agenda Items will be different for each of the ten sessions of SHADE therapy. However, the items listed under the Optional Agenda Items (non-specific therapy skills and suicide/mood/AOD assessment) will remain the same regardless of which session is being evaluation for adherence.

The rater is asked to use the “Fidelity Checklist – Summary Sheet” as the basis for completing the “Treatment Fidelity Coding Sheet”. Individual item tallies on the summary sheet should be transferred to the “Treatment Fidelity Coding Sheet” and recorded in the relevant section. For example, in session 1, essential items on the agenda for that session include: introduction/review previous week, case formulation, motivational enhancement and conclusion. The rater should record the total number of minutes spent discussing each of these items in the space provided on the “Treatment Fidelity Coding Sheet”. These entries correspond with the individual item tallies recorded for these therapy items on the “Fidelity Checklist – Summary Sheet”. Optional items for session 1 include non-specific therapy skills and suicide/mood/AOD assessment. Again, the rater should transfer the tallies for these items recorded on the “Fidelity Checklist – Summary Sheet” to the space provided on the “Treatment Fidelity Coding Sheet”.

Should the therapist have discussed SHADE Therapy items not on the agenda for the current treatment session, then these items should be recorded in the appropriate section on the “Treatment Fidelity Coding Sheet”. For example, if the therapists discusses specific change plans during session one (an item not on the agenda for this session, but is a part of another SHADE treatment session), then the total minutes spent discussing this item should be recorded in the space provided in the section: “Were any additional SHADE therapy items discussed during Session X?” on the “Treatment Fidelity Coding Sheet”. Again the tallies for items in this section should be directly transferred from the “Fidelity Checklist – Summary Sheet”.

Non-SHADE Therapy Items
Should the rater identify issues discussed during the session under evaluation, that are not part of SHADE Therapy (either for that session or any other SHADE Therapy sessions), then he/she is required to answer “Yes” to the question in this section: “Were any additional items discussed during Session X, which were not part of SHADE Therapy?” Specifically, any non-SHADE therapy items should be recorded at item 24 on the “Fidelity Checklist – Summary Sheet” and transferred directly from here to the relevant section on the “Treatment Fidelity Coding Sheet”. Once the rater has determined his/her answer to this question, he/she should record (in minutes) the amount of time the therapist spent discussing the non-SHADE Therapy item at “Total C” (as per the “Fidelity Checklist – Summary Sheet”).

Overlap Time
Given several agenda items could be occurring within the same therapy minute, the total minutes spent discussing therapy items could potentially exceed the actual total session time. As such, an overlap correction is necessary. To calculate this adjustment figure, the rater goes back to the “Fidelity Checklist – Summary Sheet” and transfers the tally entered at “Total Overlap Time” to the “Treatment Fidelity Coding Sheet at “Total D”.

**Recording Session Times**
Several totals need to be tallied by the rater.

The first of these is Total A (Total time spent discussing the session agenda items). Here, the rater records the total amount of time spent (in minutes) by the therapist discussing essential and optional agenda items. This is done by adding together the minutes recorded by the rater in this section for each of the therapy items listed.

Next, Total B (Total time spent discussing other SHADE therapy items) should be calculated. Here, the rater adds together the minutes recorded next to each therapy item in this section, and records this total at Total B in this section of the form.

Total C (Total time spent discussing non-agenda items) and Total D (Total overlap time) have already been discussed in sections 3 and 4 above, and should already have been completed.

Finally, TOTAL SESSION TIME is calculated by the rater. This total is the total time spent (in minutes) on the entire therapy session, from start to finish. This total should be the sum of Total A, Total B and Total C, minus Total D, and should be equivalent to the actual session length recorded on the audiotape, and the total entered on the “Fidelity Checklist – Summary Sheet”.

**Adherence Rating**
Rating adherence to the session agenda takes place at several points on the “Treatment Fidelity Coding Sheet”. Adherence ratings should only be made once all information on the “Fidelity Checklist – Summary Sheet” has been transferred to the “Treatment Fidelity Coding Sheet”, with all therapy minutes recorded by the rater accounted for and recorded.

Firstly, the rater goes to the “Treatment Fidelity Coding Sheet”, and looks at the list of agenda items for that session, and the corresponding minutes spent discussing each particular agenda item. The rater then circles “Yes” or “No” according to whether each agenda item was present during that session.

Next, the rater looks at the section relating to SHADE therapy items not on the agenda for that session. Should the rater have identified any of these therapy items from the list as occurring in this section, then he/she should circle “Yes” to the question: “Were...
any additional SHADE therapy items discussed during Session X?” on the “Treatment Fidelity Coding Sheet”.

Finally, the rater is asked to determine whether or not they believe treatment fidelity was maintained for the session under evaluation. This is done in a structured way, according to the session content previously rated by the rater. In order for treatment fidelity to be maintained for that session, three conditions must be met:

- All items listed under “Essential Agenda Items Covered Specific to Session XX” must be circled YES; and
- at least 50% of the session should have been spent on SHADE Therapy items that were on the agenda for that session (calculated by Total A divided by Total Session Time X 100); and
- therapists should spend no more that 25% of session time on other SHADE Therapy items not on the agenda for that session (calculated by Total B divided by Total Session Time X 100); and
- no more than 10% of session time should have been spent on non-SHADE Therapy items (calculated by Total C divided by Total Session Time X 100).

If these three conditions are satisfied, the rater can circle “Yes” to the question: “Was the agenda adhered to for this session?”

A different adherence rating is required for “Brief Check-in” sessions, which were designed to be up to 15 minutes in length. In order for treatment fidelity to be maintained for “Brief Check-in” sessions, the following three conditions must be met:

(a) all items listed under “Essential Agenda Items Covered Specific to the Brief Check-in” must be circled YES; and
(b) no more than 10 minutes of the session should have been spent on Brief Check-in items; and
(b) therapists should spend no more that 5 minutes on other SHADE Therapy items not included in the Brief Check-in; and
(c) no more than 2 minutes should have been spent on non-SHADE Therapy items.

If these three conditions are satisfied, the rater can circle “Yes” to the question: “Was the agenda adhered to for this Brief Check-in session?”

Should the rater circle NO to the question “Was the agenda adhered to for this session?” then they should also go on to indicate the reasons why adherence was not met by the therapist. Several options are provided on the “Treatment Fidelity Coding Sheet” and if any of these apply to the session under evaluation, then the rater should tick the appropriate explanation. If adherence was not met for some other reason not listed in this section, the rater is asked to tick the “Other” option and briefly provide an explanation.

Inter-rater reliability
A random 20% sample of audiotaped treatment sessions was selected from each of the ten SHADE treatment sessions and the brief check-in sessions.

For the purposes of the SHADE project, adherence was rated by two independent assessors. Each rater was trained in the treatment fidelity manual and the process described above, then both raters separately rated a sample of SHADE therapy tapes that were not included in the randomly selected sample. The raters then came together to discuss their individual ratings for each practice tape, and to establish agreement about the fidelity rating for each tape. Agreement was regarded as the following:

- Both raters were required to have the same answer to the final question on the “Treatment Fidelity Coding Sheet”: *Was the Agenda adhered to for this session? No/Yes*; and
- The total session time recorded by each rater could not differ by a factor of more than 5 minutes.

If the raters disagreed with each other’s ratings, the chief investigator and author of the treatment fidelity manual met with the raters to discuss the discrepancy. Together, the group worked toward agreement. This process served as a “calibration” for the raters, to ensure they had both interpreted the training and the treatment fidelity manual in the same way.

Once this “calibration” had occurred, the raters had no further contact with each other.

References:

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<thead>
<tr>
<th>THERAPY ITEM</th>
<th>Therapy Minutes</th>
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<tbody>
<tr>
<td>1  Introduction and Review Previous Week (includes agenda setting)</td>
<td></td>
</tr>
<tr>
<td>2  Review Homework Tasks</td>
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<tr>
<td>3  Non-specific Therapy Skills: such as rapport building, use of microskills (reflecting, etc.), engagement, facilitating story telling etc.</td>
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<td>4  Case Formulation: includes generating problem list, discussing diagnoses, potential schema, developing working hypotheses</td>
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<td>5  Motivational Enhancement: includes raising the issue of alcohol/other drugs, alcohol/other drug expectancies, pros/cons decisional balance, informal assessment of change, phase II strategies</td>
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<td>6  Modifying Alcohol/Other Drug Use: includes goals for reduction</td>
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<td>7  Change Plan Worksheet</td>
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<td>8  Rationale for CBT</td>
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<tr>
<td>9  Mood Monitoring</td>
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<tr>
<td>10 Thought Monitoring: includes demonstration of ABC model, applying ABC model to triggers</td>
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<tr>
<td>11 Activity Log: includes monitoring daily activities, generating an activities list, scheduling in pleasant and achievement activities</td>
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<td>12 Cognitive Restructuring: identifying automatic thoughts, linking thoughts &amp; feeling/behaviour, discuss &amp; identify automatic thought patterns, changing automatic thought patterns</td>
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<tr>
<td>13 Schema Therapy: includes identifying problematic schema, downward arrow, schema continuum, “Alternative View” exercise</td>
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<tr>
<td>14 Problem Solving: includes defining the problem, brainstorming possible solutions, choosing the best options, generating an action plan, putting the plan into practice</td>
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<td>Number</td>
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<td>15</td>
<td>Mindfulness Training: includes mindful walking, mindfulness of routine activities, mindfulness of pleasant activities, mindful breathing, 3-minute space, allowing/letting be exercise</td>
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<td>16</td>
<td>Coping with Cravings: includes describing a craving and developing a craving plan</td>
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<td>17</td>
<td>Emergency Planning</td>
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<td>18</td>
<td>Drink/Drug Refusal</td>
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<td>19</td>
<td>Seemingly Irrelevant Decisions</td>
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<td>20</td>
<td>“Breaking the Rule” Effect</td>
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<td>21</td>
<td>Looking After Yourself</td>
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<td>22</td>
<td>Relapse Management Plan</td>
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<tr>
<td>23</td>
<td>Suicide/Mood Assessment</td>
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<tr>
<td>24</td>
<td>Conclusion: includes making referrals termination, alliance q’aire etc</td>
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<tr>
<td>25</td>
<td>Review the Computer Session (Computer Therapy Only)</td>
</tr>
<tr>
<td>26</td>
<td>Alcohol and Other Drug Assessment (Computer Therapy Only)</td>
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<td>27</td>
<td>Non-SHADE Therapy Skills</td>
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<td>THERAPY ITEM</td>
<td>Therapy Minutes</td>
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<tr>
<td>1   Introduction and Review Previous Week (includes agenda setting)</td>
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**TOTAL OVERLAP TIME (IN MINUTES)** - ____________________

**TOTAL SESSION TIME (IN MINUTES):** _____________________
TREATMENT FIDELITY CODING SHEET

Session 1: Case Formulation and Rapport Building

Identifying Information

Name of Rater: ___________________________________________________________

Therapist Initials: _________________________________________________________

Participant ID Number: __________________________________________________

Session Number: _________________________________________________________

SHADE Therapy Items

AGENDA ITEMS COVERED SPECIFIC TO SESSION 1:

<table>
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<tr>
<th>Covered in session?</th>
<th>Duration spent discussing this item</th>
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<td>Non-specific Therapy Skills</td>
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TOTAL A = (Time Spent Discussing Session 1 Agenda Items): ____________________ minutes
ITEMS ON THE AGENDA FOR OTHER SHADE THERAPY SESSIONS:

Were any additional SHADE therapy items discussed during Session 1? Yes/No

If YES, using the list below, tick those additional SHADE Therapy items covered during session 1, and indicate the amount of time spent discussing these items.

- Modifying Alcohol/other Drug use
- Change Plan Worksheet
- Rationale for CBT
- Mood Monitoring
- Thought Monitoring
- Activity Log
- Cognitive Restructuring
- Schema Therapy
- Problem Solving
- Mindfulness Training __ mins
- Coping with Cravings __ mins
- Emergency Planning __ mins
- Drink/Drug Refusal __ mins
- Seemingly Irrelevant Decisions
- “Breaking the Rule” Effects
- Looking After Yourself __ mins
- Relapse Management Plan __ mins

TOTAL B = (Time Spent Discussing Other SHADE Therapy Items): ____________ minutes

Non-SHADE Therapy Items

Were any additional items discussed during Session 1, which were not part of SHADE Therapy? Yes/No

TOTAL C (Time Spent Discussing Non-Agenda Items): ________________ minutes

Total Overlap Time

Were there any therapy minutes where several agenda items were being discussed simultaneously? Yes/No

TOTAL D (Total overlap time): ___________________ minutes

TOTAL SESSION TIME = (Total A + Total B + Total C) – Total D

= ____________________________ minutes
Adherence Rating for Session 1:

In order for treatment fidelity to be maintained for that session, three conditions must be met:

- all items listed under “ESSENTIAL Agenda Items Covered Specific to the Session” must be circled YES; and
- at least 50% of the session should have been spent on SHADE Therapy items that were on the agenda for that session (calculated by Total A divided by Total Session Time X 100); and
- therapists should spend no more that 25% of session time on other SHADE Therapy items not on the agenda for that session (calculated by Total B divided by Total Session Time X 100); and
- no more than 10% of session time should have been spent on non-SHADE Therapy items (calculated by Total C divided by Total Session Time X 100).

**WAS THE AGENDA ADHERED TO FOR THIS SESSION?**

Yes/No

If NO (agenda NOT adhered to for this session), please indicate reasons why:

(please tick as many options as are applicable to this session, and add additional explanations if required)

- [ ] Tape unclear or inaudible
- [ ] Tape ran out before session end and was not re-started
- [ ] Client not at action stage of change *(i.e. not able to focus on skills)*
- [ ] Client non-compliant with homework *(i.e. session time spent on homework)*
- [ ] Client in crisis and required discussion around that issue

If ticked, please specify type of crisis:

- [ ] Major life event
- [ ] Suicide attempt
- [ ] Severe relapse to depression
- [ ] Sever relapse to alcohol/other drug use
- [ ] Other, please specify: ___________________________

- [ ] Session terminated prematurely *(i.e. before all agenda items could be covered)*

If ticked, please specify reasons for premature termination:
- [ ] Therapist safety issues *(e.g. aggressive/angry client)*
- [ ] Therapist indicated time for session had lapsed *(e.g. client was late, therapist was late, and appointment had to be cut short etc.*

- [ ] Other, please specify: ___________________________________________

- [ ] Other, please specify: ___________________________________________

- [ ] Other, please specify: ___________________________________________
**Session 2: Introduction to CBT**

**Identifying Information**

Name of Rater: ___________________________________________________________

Therapist Initials: _________________________________________________________

Participant ID Number: __________________________________________________

Session Number: ________________________________________________________

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**SHADE Therapy Items**

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<th>Duration spent discussing this item</th>
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<td>Yes</td>
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| **OPTIONAL AGENDA ITEMS**                  |                      |                                   |
| Non-specific Therapy Skills                | Yes                  | _________________________________ minutes |
| Suicide/Mood/AOD Assessment                 | Yes                  | _________________________________ minutes |

TOTAL A = (Time Spent Discussing Session 1 Agenda Items): ________________________ minutes
ITEMS ON THE AGENDA FOR OTHER SHADE THERAPY SESSIONS:

Were any additional SHADE therapy items discussed during Session 2?  Yes / No

If YES, using the list below, tick those additional SHADE Therapy items covered during session 2, and indicate the amount of time spent discussing these items.

- Case Formulation
- Modifying Alcohol/other Drug use
- Change Plan Worksheet
- Mood Monitoring
- Thought Monitoring
- Cognitive Restructuring
- Schema Therapy
- Problem Solving

- Coping with Cravings __ mins
- Emergency Planning __ mins
- Drink/Drug Refusal __ mins
- Seemingly Irrelevant Decisions
- "Breaking the Rule" Effects __ mins
- Looking After Yourself __ mins
- Relapse Management Plan __ mins

TOTAL B = (Time Spent Discussing Other SHADE Therapy Items): ________________ minutes

Non-SHADE Therapy Items

Were any additional items discussed during Session 1, which were not part of SHADE Therapy?  Yes / No

TOTAL C (Time Spent Discussing Non-Agenda Items): ________________ minutes

Total Overlap Time

Were there any therapy minutes where several agenda items were being discussed simultaneously?  Yes / No

TOTAL D (Total overlap time): ________________ minutes

TOTAL SESSION TIME = (Total A + Total B + Total C) – Total D

= ________________ minutes
Adherence Rating for Session 2:

In order for treatment fidelity to be maintained for that session, three conditions must be met:

- all items listed under “ESSENTIAL Agenda Items Covered Specific to the Session” must be circled YES; and
- at least 50% of the session should have been spent on SHADE Therapy items that were on the agenda for that session (calculated by Total A divided by Total Session Time X 100); and
- therapists should spend no more that 25% of session time on other SHADE Therapy items not on the agenda for that session (calculated by Total B divided by Total Session Time X 100; and
- no more than 10% of session time should have been spent on non-SHADE Therapy items (calculated by Total C divided by Total Session Time X 100).

WAS THE AGENDA ADHERED TO FOR THIS SESSION?

Yes/No

If NO (agenda NOT adhered to for this session), please indicate reasons why:

(please tick as many options as are applicable to this session, and add additional explanations if required)

- Tape unclear or inaudible
- Tape ran out before session end and was not re-started
- Client not at action stage of change (i.e. not able to focus on skills)
- Client non-compliant with homework (i.e. session time spent on homework)
- Client in crisis and required discussion around that issue

If ticked, please specify type of crisis:

- Major life event
- Suicide attempt
- Severe relapse to depression
- Severe relapse to alcohol/other drug use
- Other, please specify: ___________________________________________

- Session terminated prematurely (i.e. before all agenda items could be covered)

If ticked, please specify reasons for premature termination:

- Therapist safety issues (e.g. aggressive/angry client)
- Therapist indicated time for session had lapsed (e.g. client was late, therapist was late, and appointment had to be cut short etc.
- Other, please specify: ___________________________________________

- Other, please specify: ___________________________________________

- ___________________________________________

- ___________________________________________
### Identifying Information

Name of Rater: ___________________________________________________________

Therapist Initials: _________________________________________________________

Participant ID Number: ____________________________________________________

Session Number: _________________________________________________________

### SHADE Therapy Items

#### AGENDA ITEMS COVERED SPECIFIC TO SESSION 3:

<table>
<thead>
<tr>
<th>Item</th>
<th>Covered in session?</th>
<th>Duration spent discussing this item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction &amp; Review Previous Wk</td>
<td>Yes</td>
<td>_______________ minutes</td>
</tr>
<tr>
<td>Review Homework</td>
<td>Yes</td>
<td>_______________ minutes</td>
</tr>
<tr>
<td>Thought Monitoring</td>
<td>Yes</td>
<td>_______________ minutes</td>
</tr>
<tr>
<td>Mindful Pleasant/Routine Activities</td>
<td>Yes</td>
<td>_______________ minutes</td>
</tr>
<tr>
<td>Motivational Enhancement</td>
<td>Yes</td>
<td>_______________ minutes</td>
</tr>
<tr>
<td>Conclusion</td>
<td>Yes</td>
<td>_______________ minutes</td>
</tr>
</tbody>
</table>

#### ESSENTIAL AGENDA ITEMS

- Introduction & Review Previous Wk: Yes
- Review Homework: Yes
- Thought Monitoring: Yes
- Mindful Pleasant/Routine Activities: Yes
- Motivational Enhancement: Yes
- Conclusion: Yes

TOTAL A = (Time Spent Discussing Session 1 Agenda Items): _______________ minutes
ITEMS ON THE AGENDA FOR OTHER SHADE THERAPY SESSIONS:

Were any additional SHADE therapy items discussed during Session 3?  Yes/No

If YES, using the list below, tick those additional SHADE Therapy items covered during session 3, and indicate the amount of time spent discussing these items.

- Case Formulation
- Modifying Alcohol/other Drug use
- Change Plan Worksheet
- Rationale for CBT
- Mood Monitoring
- Activity Log
- Cognitive Restructuring
- Schema Therapy
- Problem Solving

- Coping with Cravings _____ mins
- Emergency Planning _____ mins
- Drink/Drug Refusal _____ mins
- Seemingly Irrelevant Decisions
- “Breaking the Rule” Effect
- Looking After Yourself _____ mins
- Relapse Management Plan _____ mins
- Coping with Cravings _____ mins
- Emergency Planning _____ mins
- Drink/Drug Refusal _____ mins
- Seemingly Irrelevant Decisions
- “Breaking the Rule” Effect
- Looking After Yourself _____ mins
- Relapse Management Plan _____ mins

TOTAL B = (Time Spent Discussing Other SHADE Therapy Items): ________________ minutes

Non-SHADE Therapy Items

Were any additional items discussed during Session 1, which were not part of SHADE Therapy?  Yes/No

TOTAL C (Time Spent Discussing Non-Agenda Items): ____________________ minutes

Total Overlap Time

Were there any therapy minutes where several agenda items were being discussed simultaneously?  Yes/No

TOTAL D (Total overlap time): ________________________________ minutes

TOTAL SESSION TIME = (Total A + Total B + Total C) – Total D

= ________________________________ minutes
Adherence Rating for Session 3:
In order for treatment fidelity to be maintained for that session, three conditions must be met:

- All items listed under “ESSENTIAL Agenda Items Covered Specific to the Session” must be circled YES; and
- At least 50% of the session should have been spent on SHADE Therapy items that were on the agenda for that session (calculated by Total A divided by Total Session Time X 100); and
- Therapists should spend no more than 25% of session time on other SHADE Therapy items not on the agenda for that session (calculated by Total B divided by Total Session Time X 100; and
- No more than 10% of session time should have been spent on non-SHADE Therapy items (calculated by Total C divided by Total Session Time X 100).

**WAS THE AGENDA ADHERED TO FOR THIS SESSION?**

Yes/No

If NO (agenda NOT adhered to for this session), please indicate reasons why:

(please tick as many options as are applicable to this session, and add additional explanations if required)

- Tape unclear or inaudible
- Tape ran out before session end and was not re-started
- Client not at action stage of change (i.e. not able to focus on skills)
- Client non-compliant with homework (i.e. session time spent on homework)
- Client in crisis and required discussion around that issue

If ticked, please specify type of crisis:

- Major life event
- Suicide attempt
- Severe relapse to depression
- Severe relapse to alcohol/other drug use
- Other, please specify:

- Session terminated prematurely (i.e. before all agenda items could be covered)
  - Therapist safety issues (e.g. aggressive/angry client)
  - Therapist indicated time for session had lapsed (e.g. client was late, therapist was late, and appointment had to be cut short etc.

- Other, please specify:___________________________________________________________

- Other, please specify: _______________________________________________________
TREATMENT FIDELITY CODING SHEET

Session 4: CBT and Motivational Interviewing

Identifying Information

Name of Rater: ___________________________________________________________

Therapist Initials: _________________________________________________________

Participant ID Number: __________________________________________________

Session Number: ___________________________________________________________________

SHADE Therapy Items

**AGENDA ITEMS COVERED SPECIFIC TO SESSION 4:**

| Item                          | Covered in session? | Duration spent discussing this item |
|-------------------------------|____________________|-------------------------------------|
| Introduction & Review Previous Wk | Yes                | _______________________________ minutes |
| Review Homework               | Yes                | _______________________________ minutes |
| Activity Log                  | Yes                | _______________________________ minutes |
| Motivational Enhancement      | Yes                | _______________________________ minutes |
| Modifying Alcohol/other Drug use | Yes            | _______________________________ minutes |
| Change Plan Worksheet         | Yes                | _______________________________ minutes |
| Coping with Cravings         | Yes                | _______________________________ minutes |
| Conclusion                    | Yes                | _______________________________ minutes |

**TOTAL A = (Time Spent Discussing Session 1 Agenda Items):** _______________________________ minutes
ITEMS ON THE AGENDA FOR OTHER SHADE THERAPY SESSIONS:

**Were any additional SHADE therapy items discussed during Session 4?**    Yes/No

If **YES**, using the list below, tick those additional SHADE Therapy items covered during session 3, and indicate the amount of time spent discussing these items.

<table>
<thead>
<tr>
<th>Item</th>
<th>Time (mins)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Formulation</td>
<td></td>
</tr>
<tr>
<td>Rationale for CBT</td>
<td></td>
</tr>
<tr>
<td>Mood Monitoring</td>
<td></td>
</tr>
<tr>
<td>Thought Monitoring</td>
<td></td>
</tr>
<tr>
<td>Cognitive Restructuring</td>
<td></td>
</tr>
<tr>
<td>Schema Therapy</td>
<td></td>
</tr>
<tr>
<td>Problem Solving</td>
<td></td>
</tr>
<tr>
<td>Mindfulness Training</td>
<td></td>
</tr>
<tr>
<td>Emergency Planning</td>
<td></td>
</tr>
<tr>
<td>Drink/Drug Refusal</td>
<td></td>
</tr>
<tr>
<td>Seemingly Irrelevant Decisions</td>
<td></td>
</tr>
<tr>
<td>“Breaking the Rule” Effects</td>
<td></td>
</tr>
<tr>
<td>Looking After Yourself</td>
<td></td>
</tr>
<tr>
<td>Relapse Management</td>
<td></td>
</tr>
<tr>
<td>Mindfulness Training</td>
<td></td>
</tr>
<tr>
<td>Emergency Planning</td>
<td></td>
</tr>
<tr>
<td>Drink/Drug Refusal</td>
<td></td>
</tr>
<tr>
<td>Seemingly Irrelevant Decisions</td>
<td></td>
</tr>
<tr>
<td>“Breaking the Rule” Effects</td>
<td></td>
</tr>
<tr>
<td>Looking After Yourself</td>
<td></td>
</tr>
<tr>
<td>Relapse Management</td>
<td></td>
</tr>
</tbody>
</table>

**Total B** = (Time Spent Discussing Other SHADE Therapy Items): ________________ minutes

Non-SHADE Therapy Items

**Were any additional items discussed during Session 1, which were not part of SHADE Therapy?**

Yes/No

TOTAL C (Time Spent Discussing Non-Agenda Items): ________________ minutes

**Total Overlap Time**

**Were there any therapy minutes where several agenda items were being discussed simultaneously?**

Yes/No

TOTAL D (Total overlap time): ________________ minutes

**TOTAL SESSION TIME** = (Total A + Total B + Total C) – Total D

= __________________________ minutes
Adherence Rating for Session 4:

In order for treatment fidelity to be maintained for that session, three conditions must be met:

- all items listed under “ESSENTIAL Agenda Items Covered Specific to the Session” must be circled YES; and
- at least 50% of the session should have been spent on SHADE Therapy items that were on the agenda for that session (calculated by Total A divided by Total Session Time X 100); and
- therapists should spend no more than 25% of session time on other SHADE Therapy items not on the agenda for that session (calculated by Total B divided by Total Session Time X 100; and
- no more than 10% of session time should have been spent on non-SHADE Therapy items (calculated by Total C divided by Total Session Time X 100).

**WAS THE AGENDA ADHERED TO FOR THIS SESSION?**

Yes/No

If NO (agenda NOT adhered to for this session), please indicate reasons why:

(please tick as many options as are applicable to this session, and add additional explanations if required)

- Tape unclear or inaudible
- Tape ran out before session end and was not re-started
- Client not at action stage of change (i.e. not able to focus on skills)
- Client non-compliant with homework (i.e. session time spent on homework)
- Client in crisis and required discussion around that issue

If ticked, please specify type of crisis:

- Major life event
- Suicide attempt
- Severe relapse to depression
- Sever relapse to alcohol/other drug use
- Other, please specify: ____________________________

- Session terminated prematurely (i.e. before all agenda items could be covered)
  If ticked, please specify reasons for premature termination:
  - Therapist safety issues (e.g. aggressive/angry client)
  - Therapist indicated time for session had lapsed (e.g. client was late, therapist was late, and appointment had to be cut short etc.
  - Other, please specify: ____________________________

- Other, please specify: __________________________________________
  ___________________________________________________________
  ___________________________________________________________
**TREATMENT FIDELITY CODING SHEET**

Session 5: CBT

## Identifying Information

Name of Rater: ___________________________________________________________

Therapist Initials: _________________________________________________________

Participant ID Number: ____________________________________________________

Session Number: _________________________________________________________

## SHADE Therapy Items

**AGENDA ITEMS COVERED SPECIFIC TO SESSION 5:**

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Covered in session?</th>
<th>Duration spent discussing this item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction &amp; Review Previous Wk</td>
<td>Yes</td>
<td>_____________________________ minutes</td>
</tr>
<tr>
<td>Review Homework</td>
<td>Yes</td>
<td>_____________________________ minutes</td>
</tr>
<tr>
<td>Cognitive Restructuring</td>
<td>Yes</td>
<td>_____________________________ minutes</td>
</tr>
<tr>
<td>Mindful Breathing</td>
<td>Yes</td>
<td>_____________________________ minutes</td>
</tr>
<tr>
<td>Conclusion</td>
<td>Yes</td>
<td>_____________________________ minutes</td>
</tr>
</tbody>
</table>

**OPTIONAL AGENDA ITEMS**

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Covered in session?</th>
<th>Duration spent discussing this item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-specific Therapy Skills</td>
<td>Yes</td>
<td>_____________________________ minutes</td>
</tr>
<tr>
<td>Suicide/Mood/AOD Assessment</td>
<td>Yes</td>
<td>_____________________________ minutes</td>
</tr>
</tbody>
</table>

**TOTAL A = (Time Spent Discussing Session 1 Agenda Items):** _____________________________ minutes
ITEMS ON THE AGENDA FOR OTHER SHADE THERAPY SESSIONS:

Were any additional SHADE therapy items discussed during Session 5? Yes/No

If YES, using the list below, tick those additional SHADE Therapy items covered during session 5, and indicate the amount of time spent discussing these items.

- [ ] Case Formulation ☐ Problem Solving ____ mins
- [ ] Motivational Enhancement ☐ Coping with Cravings ____ mins
- [ ] Modifying Alcohol/other Drug use ☐ Emergency Planning ____ mins
- [ ] Change Plan Worksheet ☐ Drink/Drug Refusal ____ mins
- [ ] Rationale for CBT ☐ Seemingly Irrelevant Decisions
- [ ] Mood Monitoring ☐ “Breaking the Rule” Effects
- [ ] Thought Monitoring ☐ Looking After Yourself
- [ ] Activity Log ☐ Relapse Management ____ mins
- [ ] Schema Therapy ☐ ____ mins

TOTAL B = (Time Spent Discussing Other SHADE Therapy Items): ___________ minutes

Non-SHADE Therapy Items

Were any additional items discussed during Session 1, which were not part of SHADE Therapy? Yes/No

TOTAL C (Time Spent Discussing Non-Agenda Items): ___________ minutes

Total Overlap Time

Were there any therapy minutes where several agenda items were being discussed simultaneously? Yes/No

TOTAL D (Total overlap time): ___________ minutes

TOTAL SESSION TIME = (Total A + Total B + Total C) – Total D

= ___________ minutes
Adherence Rating for Session 5:

In order for treatment fidelity to be maintained for that session, three conditions must be met:

- all items listed under “ESSENTIAL Agenda Items Covered Specific to the Session” must be circled YES; and
- at least 50% of the session should have been spent on SHADE Therapy items that were on the agenda for that session (calculated by Total A divided by Total Session Time X 100); and
- therapists should spend no more that 25% of session time on other SHADE Therapy items not on the agenda for that session (calculated by Total B divided by Total Session Time X 100; and
- no more than 10% of session time should have been spent on non-SHADE Therapy items (calculated by Total C divided by Total Session Time X 100).

WAS THE AGENDA ADHERED TO FOR THIS SESSION?
Yes/No

If NO (agenda NOT adhered to for this session), please indicate reasons why:
(please tick as many options as are applicable to this session, and add additional explanations if required)

- Tape unclear or inaudible
- Tape ran out before session end and was not re-started
- Client not at action stage of change (i.e. not able to focus on skills)
- Client non-compliant with homework (i.e. session time spent on homework)
- Client in crisis and required discussion around that issue

If ticked, please specify type of crisis:

- Major life event
- Suicide attempt
- Severe relapse to depression
- Sever relapse to alcohol/other drug use
- Other, please specify: ___________________________________________

Session terminated prematurely (i.e. before all agenda items could be covered)
If ticked, please specify reasons for premature termination:

- Therapist safety issues (e.g. aggressive/angry client)
- Therapist indicated time for session had lapsed (e.g. client was late, therapist was late, and appointment had to be cut short etc.

If ticked, please specify reasons for premature termination:

- Other, please specify: ___________________________________________

Other, please specify: ___________________________________________

Other, please specify: ___________________________________________
Session 6: Problem Solving

Identifying Information

Name of Rater: ___________________________________________________________

Therapist Initials: _________________________________________________________

Participant ID Number: ____________________________________________________

Session Number: _________________________________________________________

SHADE Therapy Items

AGENDA ITEMS COVERED SPECIFIC TO SESSION 6:

<table>
<thead>
<tr>
<th></th>
<th>Covered in session?</th>
<th>Duration spent discussing this item</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESSENTIAL AGENDA ITEMS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introduction &amp; Review Previous Wk</td>
<td>Yes</td>
<td>__________________________ minutes</td>
</tr>
<tr>
<td>Review Homework</td>
<td>Yes</td>
<td>__________________________ minutes</td>
</tr>
<tr>
<td>Mindfulness: 3-minute Space</td>
<td>Yes</td>
<td>__________________________ minutes</td>
</tr>
<tr>
<td>Problem-Solving</td>
<td>Yes</td>
<td>__________________________ minutes</td>
</tr>
<tr>
<td>Conclusion</td>
<td>Yes</td>
<td>__________________________ minutes</td>
</tr>
</tbody>
</table>

| OPTIONAL AGENDA ITEMS    |                     |                                     |
| Non-specific Therapy Skills | Yes               | __________________________ minutes |
| Suicide/Mood/AOD Assessment | Yes               | __________________________ minutes |

TOTAL A = (Time Spent Discussing Session 1 Agenda Items): _______________________ minutes
ITEMS ON THE AGENDA FOR OTHER SHADE THERAPY SESSIONS:

Were any additional SHADE therapy items discussed during Session 6?  Yes/No

If YES, using the list below, tick those additional SHADE Therapy items covered during session 6, and indicate the amount of time spent discussing these items.

- Case Formulation
- Motivational Enhancement
- Modifying Alcohol/other Drug use
- Change Plan Worksheet
- Rationale for CBT
- Mood Monitoring
- Thought Monitoring
- Activity Log
- Cognitive Restructuring

- Schema Therapy  _____ mins
- Coping with Cravings  _____ mins
- Emergency Planning  _____ mins
- Drink/Drug Refusal  _____ mins
- Seemingly Irrelevant Decisions
- “Breaking the Rule” Effect
- Looking After Yourself
- Relapse Management Plan
- _____ mins

TOTAL B = (Time Spent Discussing Other SHADE Therapy Items): ___________ minutes

Non-SHADE Therapy Items

Were any additional items discussed during Session 1, which were not part of SHADE Therapy?  Yes/No

TOTAL C (Time Spent Discussing Non-Agenda Items): ________________ minutes

Total Overlap Time

Were there any therapy minutes where several agenda items were being discussed simultaneously?  Yes/No

TOTAL D (Total overlap time): _____________________________ minutes

TOTAL SESSION TIME = (Total A + Total B + Total C) – Total D

= _____________________________ minutes
Adherence Rating for Session 6:
In order for treatment fidelity to be maintained for that session, three conditions must be met:
- all items listed under “ESSENTIAL Agenda Items Covered Specific to the Session” must be circled YES; and
- at least 50% of the session should have been spent on SHADE Therapy items that were on the agenda for that session (calculated by Total A divided by Total Session Time X 100); and
- therapists should spend no more that 25% of session time on other SHADE Therapy items not on the agenda for that session (calculated by Total B divided by Total Session Time X 100; and
- no more than 10% of session time should have been spent on non-SHADE Therapy items (calculated by Total C divided by Total Session Time X 100).

WAS THE AGENDA ADHERED TO FOR THIS SESSION?
Yes/No

If NO (agenda NOT adhered to for this session), please indicate reasons why:
(please tick as many options as are applicable to this session, and add additional explanations if required)

☐ Tape unclear or inaudible
☐ Tape ran out before session end and was not re-started
☐ Client not at action stage of change (i.e. not able to focus on skills)
☐ Client non-compliant with homework (i.e. session time spent on homework)
☐ Client in crisis and required discussion around that issue

If ticked, please specify type of crisis:
☐ Major life event
☐ Suicide attempt
☐ Severe relapse to depression
☐ Sever relapse to alcohol/other drug use
☐ Other, please specify: ___________________________________________

☐ Session terminated prematurely (i.e. before all agenda items could be covered)
If ticked, please specify reasons for premature termination:
☐ Therapist safety issues (e.g. aggressive/angry client)
☐ Therapist indicated time for session had lapsed (e.g. client was late, therapist was late, and appointment had to be cut short etc.
☐ Other, please specify: ___________________________________________
☐ Other, please specify: ___________________________________________

____________________________________________________________________
____________________________________________________________________
Session 7: Schema Therapy

Identifying Information

Name of Rater: ___________________________________________________________

Therapist Initials: _________________________________________________________

Participant ID Number: __________________________________________________

Session Number: _________________________________________________________

SHADE Therapy Items

AGENDA ITEMS COVERED SPECIFIC TO SESSION 7:

<table>
<thead>
<tr>
<th>ESSENTIAL AGENDA ITEMS</th>
<th>Covered in session?</th>
<th>Duration spent discussing this item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction &amp; Review Previous Wk</td>
<td>Yes</td>
<td>___________________ minutes</td>
</tr>
<tr>
<td>Review Homework</td>
<td>Yes</td>
<td>___________________ minutes</td>
</tr>
<tr>
<td>Schema Change Methods</td>
<td>Yes</td>
<td>___________________ minutes</td>
</tr>
<tr>
<td>Conclusion</td>
<td>Yes</td>
<td>___________________ minutes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OPTIONAL AGENDA ITEMS</th>
<th>Covered in session?</th>
<th>Duration spent discussing this item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-specific Therapy Skills</td>
<td>Yes</td>
<td>___________________ minutes</td>
</tr>
<tr>
<td>Suicide/Mood/AOD Assessment</td>
<td>Yes</td>
<td>___________________ minutes</td>
</tr>
</tbody>
</table>

TOTAL A = (Time Spent Discussing Session 1 Agenda Items): ___________________ minutes
ITEMS ON THE AGENDA FOR OTHER SHADE THERAPY SESSIONS:

**Were any additional SHADE therapy items discussed during Session 7?**  Yes / No

If **YES**, using the list below, tick those additional SHADE Therapy items covered during session 7, and indicate the amount of time spent discussing these items.

- [ ] Case Formulation
- [ ] Motivational Enhancement
- [ ] Modifying Alcohol/other Drug use
- [ ] Change Plan Worksheet
- [ ] Rationale for CBT
- [ ] Mood Monitoring
- [ ] Thought Monitoring
- [ ] Activity Log
- [ ] Cognitive Restructuring
- [ ] Problem Solving _____ mins
- [ ] Mindfulness Training _____ mins
- [ ] Coping with Cravings _____ mins
- [ ] Emergency Planning _____ mins
- [ ] Drink/Drug Refusal _____ mins
- [ ] Seemingly Irrelevant Decisions
- [ ] “Breaking the Rule” Effects
- [ ] Looking After Yourself
- [ ] Relapse Management

**TOTAL B = (Time Spent Discussing Other SHADE Therapy Items):** ____________ minutes

**Non-SHADE Therapy Items**

_Were any additional items discussed during Session 1, which were not part of SHADE Therapy?_  Yes / No

**TOTAL C (Time Spent Discussing Non-Agenda Items):** ____________ minutes

**Total Overlap Time**

_Were there any therapy minutes where several agenda items were being discussed simultaneously?_  Yes / No

**TOTAL D (Total overlap time):** ____________ minutes

**TOTAL SESSION TIME =** (Total A + Total B + Total C) – Total D

= ____________ minutes
Adherence Rating for Session 7:

In order for treatment fidelity to be maintained for that session, three conditions must be met:

- all items listed under “ESSENTIAL Agenda Items Covered Specific to the Session” must be circled YES; and
- at least 50% of the session should have been spent on SHADE Therapy items that were on the agenda for that session (calculated by Total A divided by Total Session Time X 100); and
- therapists should spend no more that 25% of session time on other SHADE Therapy items not on the agenda for that session (calculated by Total B divided by Total Session Time X 100; and
- no more than 10% of session time should have been spent on non-SHADE Therapy items (calculated by Total C divided by Total Session Time X 100).

**WAS THE AGENDA ADHERED TO FOR THIS SESSION?**

Yes/No

If NO (agenda NOT adhered to for this session), please indicate reasons why:
(please tick as many options as are applicable to this session, and add additional explanations if required)

- Tape unclear or inaudible
- Tape ran out before session end and was not re-started
- Client not at action stage of change (i.e. not able to focus on skills)
- Client non-compliant with homework (i.e. session time spent on homework)
- Client in crisis and required discussion around that issue

If ticked, please specify type of crisis:

- Major life event
- Suicide attempt
- Severe relapse to depression
- Severe relapse to alcohol/other drug use
- Other, please specify: ____________________________________________________

- **Session terminated prematurely** (i.e. before all agenda items could be covered)

If ticked, please specify reasons for premature termination:

- Therapist safety issues (e.g. aggressive/angry client)
- Therapist indicated time for session had lapsed (e.g. client was late, therapist was late, and appointment had to be cut short etc.

- Other, please specify: ____________________________________________________
- Other, please specify: ____________________________________________________

____________________ ______________________________________________
____________________ ______________________________________________
**Session 8: Emergency Planning**

### Identifying Information

Name of Rater: ___________________________________________________________

Therapist Initials: _________________________________________________________

Participant ID Number: ____________________________________________________

Session Number: _________________________________________________________

---

**SHADE Therapy Items**

**AGENDA ITEMS COVERED SPECIFIC TO SESSION 8**:

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Covered in session?</th>
<th>Duration spent discussing this item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction &amp; Review Previous Wk</td>
<td>Yes</td>
<td>_________________________ minutes</td>
</tr>
<tr>
<td>Review Homework</td>
<td>Yes</td>
<td>_________________________ minutes</td>
</tr>
<tr>
<td>Mindful: Allowing/Letting Be</td>
<td>Yes</td>
<td>_________________________ minutes</td>
</tr>
<tr>
<td>Drink/Drug Refusal Skills</td>
<td>Yes</td>
<td>_________________________ minutes</td>
</tr>
<tr>
<td>Emergency Plan</td>
<td>Yes</td>
<td>_________________________ minutes</td>
</tr>
<tr>
<td>Conclusion</td>
<td>Yes</td>
<td>_________________________ minutes</td>
</tr>
</tbody>
</table>

**OPTIONAL AGENDA ITEMS**

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Covered in session?</th>
<th>Duration spent discussing this item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-specific Therapy Skills</td>
<td>Yes</td>
<td>_________________________ minutes</td>
</tr>
<tr>
<td>Suicide/Mood/AOD assessment</td>
<td>Yes</td>
<td>_________________________ minutes</td>
</tr>
</tbody>
</table>

**TOTAL A = (Time Spent Discussing Session 1 Agenda Items):** _________________________ minutes
ITEMS ON THE AGENDA FOR OTHER SHADE THERAPY SESSIONS:

Were any additional SHADE therapy items discussed during Session 8? Yes/No

If YES, using the list below, tick those additional SHADE Therapy items covered during session 8, and indicate the amount of time spent discussing these items.

- Case Formulation
- Motivational Enhancement
- Modifying Alcohol/other Drug use
- Change Plan Worksheet
- Rationale for CBT
- Mood Monitoring
- Thought Monitoring
- Activity Log

Cognitive Restructuring ____ mins
Schema Therapy ____ mins
Problem Solving ____ mins
Coping with Cravings ____ mins
Seemingly Irrelevant Decisions
“Breaking the Rule” Effect __ mins
Looking After Yourself ____ mins
Relapse Management Plan ____ mins

TOTAL B = (Time Spent Discussing Other SHADE Therapy Items): ____________ minutes

Non-SHADE Therapy Items

Were any additional items discussed during Session 1, which were not part of SHADE Therapy? Yes/No

TOTAL C (Time Spent Discussing Non-Agenda Items): ________________ minutes

Total Overlap Time

Were there any therapy minutes where several agenda items were being discussed simultaneously? Yes/No

TOTAL D (Total overlap time): ________________________ minutes

TOTAL SESSION TIME = (Total A + Total B + Total C) – Total D

= _________________ minutes
Adherence Rating for Session 8:
In order for treatment fidelity to be maintained for that session, three conditions must be met:
- all items listed under “ESSENTIAL Agenda Items Covered Specific to the Session” must be circled YES; and
- at least 50% of the session should have been spent on SHADE Therapy items that were on the agenda for that session (calculated by Total A divided by Total Session Time X 100); and
- therapists should spend no more that 25% of session time on other SHADE Therapy items not on the agenda for that session (calculated by Total B divided by Total Session Time X 100; and
- no more than 10% of session time should have been spent on non-SHADE Therapy items (calculated by Total C divided by Total Session Time X 100).

WAS THE AGENDA ADHERED TO FOR THIS SESSION?  
Yes/No

If NO (agenda NOT adhered to for this session), please indicate reasons why:  
(please tick as many options as are applicable to this session, and add additional explanations if required)
- Tape unclear or inaudible
- Tape ran out before session end and was not re-started
- Client not at action stage of change (i.e. not able to focus on skills)
- Client non-compliant with homework (i.e. session time spent on homework)
- Client in crisis and required discussion around that issue

If ticked, please specify type of crisis:
- Major life event
- Suicide attempt
- Severe relapse to depression
- Sever relapse to alcohol/other drug use
- Other, please specify: _____________________________

Session terminated prematurely (i.e. before all agenda items could be covered)
If ticked, please specify reasons for premature termination:
- Therapist safety issues (e.g. aggressive/angry client)
- Therapist indicated time for session had lapsed (e.g. client was late, therapist was late, and appointment had to be cut short etc.

Other, please specify: ________________________________________________

Other, please specify: ________________________________________________
TREATMENT FIDELITY CODING SHEET

Session 9: CBT & Relapse Prevention

Identifying Information

Name of Rater: ___________________________________________________________

Therapist Initials: _________________________________________________________

Participant ID Number: __________________________________________________

Session Number: _________________________________________________________

SHADE Therapy Items

AGENDA ITEMS COVERED SPECIFIC TO SESSION 9:

<table>
<thead>
<tr>
<th>Item</th>
<th>Covered in session?</th>
<th>Duration spent discussing this item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction &amp; Review Previous Wk</td>
<td>Yes</td>
<td>___________________ minutes</td>
</tr>
<tr>
<td>Review Homework</td>
<td>Yes</td>
<td>___________________ minutes</td>
</tr>
<tr>
<td>Seemingly Irrelevant Decisions</td>
<td>Yes</td>
<td>___________________ minutes</td>
</tr>
<tr>
<td>“Breaking the Rule” Effect</td>
<td>Yes</td>
<td>___________________ minutes</td>
</tr>
<tr>
<td>Looking After Yourself</td>
<td>Yes</td>
<td>___________________ minutes</td>
</tr>
<tr>
<td>Conclusion</td>
<td>Yes</td>
<td>___________________ minutes</td>
</tr>
</tbody>
</table>

OPTIONAL AGENDA ITEMS

<table>
<thead>
<tr>
<th>Item</th>
<th>Covered in session?</th>
<th>Duration spent discussing this item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-specific Therapy Skills</td>
<td>Yes</td>
<td>___________________ minutes</td>
</tr>
<tr>
<td>Suicide/Mood/AOD assessment</td>
<td>Yes</td>
<td>___________________ minutes</td>
</tr>
</tbody>
</table>

TOTAL A = (Time Spent Discussing Session 1 Agenda Items): ___________________ minutes
ITEMS ON THE AGENDA FOR OTHER SHADE THERAPY SESSIONS:

Were any additional SHADE therapy items discussed during Session 9?  Yes / No  

If YES, using the list below, tick those additional SHADE Therapy items covered during session 9, and indicate the amount of time spent discussing these items.

- Case Formulation
- Motivational Enhancement
- Modifying Alcohol/other Drug use
- Change Plan Worksheet
- Rationale for CBT
- Mood Monitoring
- Thought Monitoring
- Activity Log

- Cognitive Restructuring ___ mins
- Schema Therapy ___ mins
- Problem Solving ___ mins
- Mindfulness Training ___ mins
- Coping with Cravings ___ mins
- Emergency Planning ___ mins
- Drink/Drug Refusal ___ mins
- Relapse Management Plan ___ mins

TOTAL B = (Time Spent Discussing Other SHADE Therapy Items): ____________________ minutes

Non-SHADE Therapy Items

Were any additional items discussed during Session 1, which were not part of SHADE Therapy? Yes/No

TOTAL C (Time Spent Discussing Non-Agenda Items): ____________________ minutes

Total Overlap Time

Were there any therapy minutes where several agenda items were being discussed simultaneously? Yes/No

TOTAL D (Total overlap time): ____________________ minutes

TOTAL SESSION TIME = (Total A + Total B + Total C) – Total D

= ____________________ minutes
Adherence Rating for Session 9:
In order for treatment fidelity to be maintained for that session, three conditions must be met:

- all items listed under “ESSENTIAL Agenda Items Covered Specific to the Session” must be circled YES; and
- **at least 50% of the session should have been spent on SHADE Therapy items that were on the agenda for that session** (calculated by Total A divided by Total Session Time X 100); and
- therapists should spend no more that 25% of session time on other SHADE Therapy items **not on the agenda for that session** (calculated by Total B divided by Total Session Time X 100; and
- no more than 10% of session time should have been spent on non-SHADE Therapy items (calculated by Total C divided by Total Session Time X 100).

**WAS THE AGENDA ADHERED TO FOR THIS SESSION?**

Yes/No

If NO (agenda NOT adhered to for this session), please indicate reasons why:
(please tick as many options as are applicable to this session, and add additional explanations if required)

- Tape unclear or inaudible
- Tape ran out before session end and was not re-started
- Client not at action stage of change (*i.e.* not able to focus on skills)
- Client non-compliant with homework (*i.e.* session time spent on homework)
- Client in crisis and required discussion around that issue

If ticked, please specify type of crisis:
- Major life event
- Suicide attempt
- Severe relapse to depression
- Sever relapse to alcohol/other drug use
- Other, please specify:

- **Session terminated prematurely** (*i.e.* before all agenda items could be covered)
  If ticked, please specify reasons for premature termination:
  - Therapist safety issues (*e.g.* aggressive/angry client)
  - Therapist indicated time for session had lapsed (*e.g.* client was late, therapist was late, and appointment had to be cut short *etc.*
  - Other, please specify: ___________________________________________

- Other, please specify: ______________________________________________
  ______________________________________________
  ______________________________________________
TREATMENT FIDELITY CODING SHEET

Session 10: Relapse Prevention

Identifying Information

Name of Rater: ___________________________________________________________

Therapist Initials: _________________________________________________________

Participant ID Number: __________________________________________________

Session Number: _________________________________________________________

SHADE Therapy Items

**AGENDA ITEMS COVERED SPECIFIC TO SESSION 10:**

<table>
<thead>
<tr>
<th>ESSENTIAL AGENDA ITEMS</th>
<th>Covered in session?</th>
<th>Duration spent discussing this item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction &amp; Review Previous Wk</td>
<td>Yes</td>
<td>_________________________________minutes</td>
</tr>
<tr>
<td>Review Homework</td>
<td>Yes</td>
<td>_________________________________minutes</td>
</tr>
<tr>
<td>Relapse Management Plan</td>
<td>Yes</td>
<td>_________________________________minutes</td>
</tr>
<tr>
<td>Conclusion and Termination</td>
<td>Yes</td>
<td>_________________________________minutes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OPTIONAL AGENDA ITEMS</th>
<th>Covered in session?</th>
<th>Duration spent discussing this item</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-specific Therapy Skills</td>
<td>Yes</td>
<td>_________________________________minutes</td>
</tr>
<tr>
<td>Suicide/Mood/AOD assessment</td>
<td>Yes</td>
<td>_________________________________minutes</td>
</tr>
</tbody>
</table>

TOTAL A = (Time Spent Discussing Session 1 Agenda Items): ___________________________ minutes
ITEMS ON THE AGENDA FOR OTHER SHADE THERAPY SESSIONS:

Were any additional SHADE therapy items discussed during Session 10? Yes / No

If YES, using the list below, tick those additional SHADE Therapy items covered during session 10, and indicate the amount of time spent discussing these items.

- Case Formulation
- Motivational Enhancement
- Modifying Alcohol/other Drug use
- Change Plan Worksheet
- Rationale for CBT
- Mood Monitoring
- Thought Monitoring
- Activity Log
- Cognitive Restructuring

- Schema Therapy _____ mins
- Problem Solving _____ mins
- Mindfulness Training _____ mins
- Coping with Cravings _____ mins
- Emergency Planning _____ mins
- Drink/Drug Refusal _____ mins
- Seemingly Irrelevant Decisions
- “Breaking the Rule” Effects
- Looking After Yourself _____ mins

TOTAL B = (Time Spent Discussing Other SHADE Therapy Items): ________________ minutes

Non-SHADE Therapy Items

Were any additional items discussed during Session 1, which were not part of SHADE Therapy? Yes/No

TOTAL C (Time Spent Discussing Non-Agenda Items): ________________ minutes

Total Overlap Time

Were there any therapy minutes where several agenda items were being discussed simultaneously? Yes/No

TOTAL D (Total overlap time): ________________ minutes

TOTAL SESSION TIME = (Total A + Total B + Total C) – Total D

= ________________ minutes
Adherence Rating for Session 10:

In order for treatment fidelity to be maintained for that session, three conditions must be met:

- all items listed under “ESSENTIAL Agenda Items Covered Specific to the Session” must be circled YES; and
- at least 50% of the session should have been spent on SHADE Therapy items that were on the agenda for that session (calculated by Total A divided by Total Session Time X 100); and
- therapists should spend no more that 25% of session time on other SHADE Therapy items not on the agenda for that session (calculated by Total B divided by Total Session Time X 100; and
- no more than 10% of session time should have been spent on non-SHADE Therapy items (calculated by Total C divided by Total Session Time X 100).

WAS THE AGENDA ADHERED TO FOR THIS SESSION?

Yes/No

If NO (agenda NOT adhered to for this session), please indicate reasons why:

(please tick as many options as are applicable to this session, and add additional explanations if required)

- Tape unclear or inaudible
- Tape ran out before session end and was not re-started
- Client not at action stage of change (i.e. not able to focus on skills)
- Client non-compliant with homework (i.e. session time spent on homework)
- Client in crisis and required discussion around that issue

If ticked, please specify type of crisis:

- Major life event
- Suicide attempt
- Severe relapse to depression
- Sever relapse to alcohol/other drug use
- Other, please specify: ________________________________________________

- Session terminated prematurely (i.e. before all agenda items could be covered)
  If ticked, please specify reasons for premature termination:
  - Therapist safety issues (e.g. aggressive/angry client)
  - Therapist indicated time for session had lapsed (e.g. client was late, therapist was late, and appointment had to be cut short etc.
  - Other, please specify: ________________________________________________
  - Other, please specify: ________________________________________________

- Other, please specify: ________________________________________________
Brief Check-in Sessions

Identifying Information

Name of Rater: ___________________________________________________________

Therapist Initials: _________________________________________________________

Participant ID Number: ____________________________________________________

Session Number: _________________________________________________________

Brief Check-in Items

**AGENDA ITEMS COVERED SPECIFIC TO THE BRIEF CHECK-IN:**

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Covered in Session</th>
<th>Duration spent discussing this item</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ESSENTIAL AGENDA ITEMS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review the Computer Session</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Review Homework</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Conclusion</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td><strong>OPTIONAL AGENDA ITEMS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-specific Therapy Skills</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Suicide/Mood/AOD assessment</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

TOTAL A = (Time Spent Discussing Session 1 Agenda Items): ________________________ minutes
ITEMS ON THE AGENDA FOR OTHER SHADE THERAPY SESSIONS:

Were any additional SHADE therapy items discussed during the Brief Check-in?  
Yes/No

If YES, using the list below, tick those additional SHADE Therapy items covered during the Brief Check-in, and indicate the amount of time spent discussing these items.

- Case Formulation: ____ mins
- Motivational Enhancement: ____ mins
- Modifying Alcohol/other Drug use: ____ mins
- Change Plan Worksheet: ____ mins
- Rationale for CBT: ____ mins
- Mood Monitoring: ____ mins
- Thought Monitoring: ____ mins
- Activity Log: ____ mins
- Cognitive Restructuring: ____ mins
- Schema Therapy: ____ mins
- Problem Solving: ____ mins
- Mindfulness Training: ____ mins
- Coping with Cravings: ____ mins
- Emergency Planning: ____ mins
- Drink/Drug Refusal: ____ mins
- Seemingly Irrelevant Decisions: ____ mins
- “Breaking the Rule” Effect: ____ mins
- Looking After Yourself: ____ mins
- Relapse Management Plan: ____ mins

TOTAL B = (Time Spent Discussing Other SHADE Therapy Items): ________________ minutes

Non-SHADE Therapy Items

Were any additional items discussed during Session 1, which were not part of SHADE Therapy?  
Yes/No

TOTAL C (Time Spent Discussing Non-Agenda Items): ________________ minutes

Total Overlap Time

Were there any therapy minutes where several agenda items were being discussed simultaneously?  
Yes/No

TOTAL D (Total overlap time): ________________ minutes

TOTAL SESSION TIME = (Total A + Total B + Total C) – Total D = ________________ minutes
Adherence Rating for Brief Check-in Session:

- A different adherence rating is required for “Brief Check-in” sessions, which were designed to be up to 15 minutes in length. In order for treatment fidelity to be maintained for “Brief Check-in” sessions, the following three conditions must be met:
  - all items listed under “Agenda Items Covered Specific to the Brief Check-in” must be circled YES; and
  - no more than 10 minutes of the session should have been spent on Brief Check-in items; and
  - therapists should spend no more that 5 minutes on other SHADE Therapy items not included in the Brief Check-in; and
  - no more than 2 minutes should have been spent on non-SHADE Therapy items.

**WAS THE AGENDA ADHERED TO FOR THIS Brief Check-In SESSION?**

Yes/No

If NO (agenda NOT adhered to for this session), please indicate reasons why:
(please tick as many options as are applicable to this session, and add additional explanations if required)

- Tape unclear or inaudible
- Tape ran out before session end and was not re-started
- Client not at action stage of change (i.e. not able to focus on skills)
- Client non-compliant with homework (i.e. session time spent on homework)
- Client in crisis and required discussion around that issue

If ticked, please specify type of crisis:

- Major life event
- Suicide attempt
- Severe relapse to depression
- Sever relapse to alcohol/other drug use
- Other, please specify: __________________________________________________________________________

- Session terminated prematurely (i.e. before all agenda items could be covered)

If ticked, please specify reasons for premature termination:

- Therapist safety issues (e.g. aggressive/angry client)
- Therapist indicated time for session had lapsed (e.g. client was late, therapist was late, and appointment had to be cut short etc.
- Other, please specify: __________________________________________________________________________

- Other, please specify: __________________________________________________________________________
E.6 STUDY 5 DATA ANALYSIS

E.6.1 Alcohol use
Alcohol-use status was calculated at the 12-month follow-up mark for those people meeting hazardous alcohol use criteria at entry to the study, as a function of treatment allocation. No person in the brief intervention – control condition or the computer-delivered SHADE therapy reported abstinence at the 12-month follow-up, in contrast to one person in clinician-delivered SHADE therapy (6%) who was abstinent from alcohol at 12-months. Six control participants (50%) were using alcohol at a non-hazardous level at this follow-up occasion, as were ten clinician-delivered SHADE therapy participants (63%) and seven (54%) computer-delivered SHADE therapy clients. In addition, a further six control participants were using alcohol above a hazardous threshold at 12-months, compared with five (31%) of clinician-delivered SHADE therapy participants and six (46%) people in the computer-delivered SHADE therapy group. Pearson chi-squared analysis indicated that these differences were not statistically significant ($\chi^2 = 2.453, p = 0.653$).

Readiness to change scores were calculated for alcohol use at each assessment timepoint; the details of which can be seen in Table E.6.1. Stage of change varied over the follow-up phases of assessment. At the three-month follow-up, the majority of the brief intervention – control participants (58%) and those in the clinician-delivered SHADE therapy group (44%) indicated they were in the action stage of change for their alcohol use. In contrast, the majority of people in the computer-delivered SHADE therapy group reported being in the pre-contemplation
stage of change for their alcohol use. Despite these apparent differences, Pearson chi-squared analysis indicated no significant differences existed between these groups ($\chi^2_{4}=6.004, p=0.199$).

Table E.6.1 Readiness to change scores for alcohol use for people participating in a study of treatment for coexisting depression and substance use disorders, according to treatment allocation, meeting criteria for harmful use of alcohol at the initial assessment (n=41).

<table>
<thead>
<tr>
<th>Assessment Occasion</th>
<th>Initial</th>
<th>3-months</th>
<th>6-months</th>
<th>12-months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>PRE-CONTEMPLATION</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brief Intervention – control</td>
<td>0</td>
<td>0%</td>
<td>1</td>
<td>8%</td>
</tr>
<tr>
<td>Clinician-delivered SHADE therapy</td>
<td>3</td>
<td>20%</td>
<td>3</td>
<td>19%</td>
</tr>
<tr>
<td>Computer-delivered SHADE therapy</td>
<td>6</td>
<td>46%</td>
<td>6</td>
<td>46%</td>
</tr>
<tr>
<td>CONTEMPLATION</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brief Intervention – control</td>
<td>7</td>
<td>58%</td>
<td>4</td>
<td>33%</td>
</tr>
<tr>
<td>Clinician-delivered SHADE therapy</td>
<td>10</td>
<td>67%</td>
<td>6</td>
<td>38%</td>
</tr>
<tr>
<td>Computer-delivered SHADE therapy</td>
<td>4</td>
<td>31%</td>
<td>4</td>
<td>31%</td>
</tr>
<tr>
<td>ACTION</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brief Intervention – control</td>
<td>5</td>
<td>42%</td>
<td>7</td>
<td>58%</td>
</tr>
<tr>
<td>Clinician-delivered SHADE therapy</td>
<td>2</td>
<td>13%</td>
<td>7</td>
<td>44%</td>
</tr>
<tr>
<td>Computer-delivered SHADE therapy</td>
<td>3</td>
<td>23%</td>
<td>3</td>
<td>23%</td>
</tr>
</tbody>
</table>

At the six-month follow-up assessment, the situation had changed in relation to readiness to address alcohol use. That is, the majority of people in the brief intervention – control condition indicated they were in the contemplation stage of change for alcohol use (55%), as did over one-third of clinician-delivered SHADE therapy participants (38%). In contrast, people in the computer-delivered SHADE therapy condition were largely in the action stage of change for their alcohol use. However, Pearson chi-squared analysis indicated that these differences were not statistically significant ($\chi^2_{4}=4.203, p=0.379$).
A slightly different picture was reported in stage of change for alcohol at the 12-month follow-up assessment. That is, both the clinician- and computer-delivered SHADE therapy groups were largely in the action stage of change for their alcohol use (63% and 46% respectively). However, 42% of those in the brief intervention – control condition reported being in the contemplation stage of change. Pearson chi-squared analysis indicated that these differences were not statistically significant ($\chi^2_{4}=3.285$, $p=0.511$).

E.6.2 Cannabis use
Readiness to change cannabis use was calculated for participants at each assessment timepoint. Table E.6.2 displays the rates at which participants reported being in the pre-contemplation, contemplation and action stages of change for their cannabis use. At the three-month assessment, participants in the clinician-and computer-delivered SHADE therapy conditions largely reported being in the contemplation stage of change for their cannabis use (64% and 54% respectively). The majority of participants (50%) in the control condition reported being in the action stage of change for their cannabis use at this assessment. Pearson chi-squared analysis indicated no significant differences existed between treatment groups in their stage of change for cannabis use at this follow-up ($\chi^2_{4}=1.422$, $p=0.840$).
Table E.6.2 Readiness to change cannabis use among people participating in a study of treatment for coexisting depression and substance use disorders, according to treatment allocation, who met criteria for hazardous use of cannabis at entry to the study (n=43).

<table>
<thead>
<tr>
<th>Assessment Occasion</th>
<th>Initial</th>
<th>3-months</th>
<th>6-months</th>
<th>12-months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td><strong>PRE-CONTEMPLATION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brief Intervention – control</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinician-delivered SHADE therapy</td>
<td>1</td>
<td>6</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Computer-delivered SHADE therapy</td>
<td>1</td>
<td>8</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>29</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td><strong>CONTEMPLATION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brief Intervention – control</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinician-delivered SHADE therapy</td>
<td>5</td>
<td>31</td>
<td>7</td>
<td>44</td>
</tr>
<tr>
<td>Computer-delivered SHADE therapy</td>
<td>8</td>
<td>67</td>
<td>7</td>
<td>64</td>
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<td></td>
<td>8</td>
<td>57</td>
<td>7</td>
<td>54</td>
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<tr>
<td><strong>ACTION</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Brief Intervention – control</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinician-delivered SHADE therapy</td>
<td>10</td>
<td>63</td>
<td>8</td>
<td>50</td>
</tr>
<tr>
<td>Computer-delivered SHADE therapy</td>
<td>2</td>
<td>14</td>
<td>5</td>
<td>39</td>
</tr>
</tbody>
</table>

Similarly, at six-months, most people in the clinician-delivered SHADE therapy condition reported being in the contemplation stage of change for their cannabis use (55%). Control group participants were also chiefly in the contemplation stage of change (47%), while the majority of computer-delivered SHADE therapy participants had moved to the action stage of change (43%). These differences were not statistically significant ($\chi^2 = 3.063$, $p=0.547$).

By the 12-month follow-up, little had changed among those people in the clinician-delivered SHADE therapy group, with 46% indicating they were still in the contemplation stage of change for their cannabis use. The majority of control participants (40%) reported they were in the action stage of change, while those in
the computer-delivered SHADE therapy group reported equal rates of contemplation (46%) and action (46%) stages of change. Again, Pearson chi-squared analysis indicated no significant differences existed between these groups ($\chi^2_4=1.478$, $p=0.831$).

**E.6.3 Abstinence Rates**

Abstinence rates for alcohol remained relatively constant over the follow-up period (between 12-29%), with the exception of the clinician-delivered SHADE therapy group at 12-month follow-up who reported a reduced alcohol abstinence rate of 9%, close to the baseline level of abstinence among this group of 4%. Despite this difference at 12-months, Pearson chi-squared analysis indicated no significant differences existed in the rates of alcohol abstinence at this assessment between the three treatment groups ($\chi^2_2=2.055$, $p=0.358$, see Table E.6.3).

**Table E.6.3** Abstinence rates for alcohol and cannabis for people participating in a study of treatment for coexisting depression and substance use disorders, according to treatment allocation (n=67).

<table>
<thead>
<tr>
<th></th>
<th>Initial</th>
<th>3-months</th>
<th>6-months</th>
<th>12-months</th>
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</thead>
<tbody>
<tr>
<td><strong>ALCOHOL</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Brief Intervention</td>
<td>5</td>
<td>24</td>
<td>6</td>
<td>29</td>
</tr>
<tr>
<td>Clinician-delivered</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>17</td>
</tr>
<tr>
<td>Computer-delivered</td>
<td>6</td>
<td>26</td>
<td>4</td>
<td>17</td>
</tr>
<tr>
<td><strong>CANNABIS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brief Intervention</td>
<td>11</td>
<td>48</td>
<td>13</td>
<td>57</td>
</tr>
<tr>
<td>Clinician-delivered</td>
<td>7</td>
<td>30</td>
<td>10</td>
<td>44</td>
</tr>
<tr>
<td>Computer-delivered</td>
<td>7</td>
<td>30</td>
<td>10</td>
<td>44</td>
</tr>
</tbody>
</table>
Similarly, at the three- and six-month assessments, no significant differences existed between treatment groups on rates of abstinence from alcohol (Pearson $\chi^2=1.090$, $p=0.580$ and Pearson $\chi^2=0.141$, $p=0.932$, respectively).

Rates of abstinence from cannabis were consistently higher among those in the clinician-delivered SHADE therapy group at each assessment occasion. However, over time, participants in the computer-delivered SHADE therapy reached equivalent levels of abstinence. Pearson chi-squared analysis revealed no significant differences existed between the three treatment groups in their abstinence rates at the three-month ($\chi^2=2.411$, $p=0.300$) and six-month ($\chi^2=3.627$, $p=0.163$) follow-up assessments. A non-significant trend emerged in the 12-month abstinence rates to suggest that rates of abstinence were higher among clinician- and computer-delivered SHADE therapy participants relative to the control group. Despite reporting almost half the rate of abstinence as the two SHADE therapy groups, Pearson chi-squared analysis revealed that those in the control groups were not significantly different ($\chi^2=6.206$, $p=0.045$).
Appendix F

Published Work

Where there’s smoke, there’s fire: High prevalence of smoking among some sub-populations and recommendations for intervention

Amanda Baker, Rowena G. Ivers, Jenny Bowman, Tony Butler, Frances J. Kay-Lambkin, Paula Wye, Raoul A. Walsh, Lisa Jackson Pulver, Robyn Richmond, Josephine Belcher, Kay Wilhelm & Alex Wodak

Abstract: 172 words; Text: 5116, plus references

Drug and Alcohol Review, In press, December 2005

Key words: Aboriginal and Torres Strait Islander people, cultural diversity, ethnicity, smoking, smoking cessation, psychosis, mental disorder, alcohol, drug use, prisoners.

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Abstract

Issue: In Australia, the prevalence of smoking is higher among certain sub-populations compared to the general population. These sub-populations include Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, as well as people with mental and substance use disorders and prisoners.

Approach: The aims of this article are to: describe the high prevalence of smoking among these particular sub-populations and harms associated with smoking; explore possible reasons for such high prevalence of smoking; review the evidence regarding the efficacy of existing smoking cessation interventions; and make recommendations for smoking interventions and further research among these groups.

Key Findings: In addition to low socio-economic status, limited education and other factors, there are social, systems and psycho-biological features associated with the high prevalence of smoking in these sub-groups.

Implications: General population based approaches to reducing smoking prevalence have been pursued for decades with great success and should be continued with further developments that specifically aim to affect Aboriginal and Torres Strait Islander people and some cultural groups. However, increasing attention, more specific targeting and flexible goals and interventions are also required for these and other distinct sub-populations with high smoking prevalence. Recommendations include: more funding and increased resources to examine the most appropriate education and treatment strategies to promote smoking cessation among people from Aboriginal and Torres Strait Islander and some culturally and linguistically diverse backgrounds; larger and better designed studies evaluating smoking cessation/reduction interventions among distinct sub-groups; and system wide interventions requiring strong leadership among clients and staff within mental health, drug and alcohol and prison settings.
Introduction
There is accumulating clinical and epidemiological evidence to suggest that smoking is more common among some sub-populations compared to the general population in Australia. While a range of public health tobacco control strategies in Australia have succeeded in lowering daily tobacco use to 17% in the general population (Australian Federal Department of Health and Ageing, 2005), a high prevalence of smoking remains among some key marginalised sub-populations, including Aboriginal and Torres-Strait Islander people (Statistical Information Management Committee, 2004); people from culturally and linguistically diverse backgrounds (Rissel, McLellan, & Bauman, 2000); people with mental or substance use disorders (Degenhardt & Hall, 1999); and prisoners (Polgar, McGartland, Borlongan, Shytle, & Sanberg, 1996). People from these subgroups may suffer severe social, health and psychological disadvantage, and stigma (Butler & Milner, 2003). Common among them are features such as poor educational attainment, unemployment, social isolation, interpersonal conflicts and financial dependence. Significant overlap exists between these sub-populations, for example, indigenous heritage, mental disorders and alcohol and drug problems are features common to prison populations (Butler & Allnutt, 2003; Butler & Milner, 2003) and many people with drug and alcohol problems experience mental health disorders and vice versa (Degenhardt & Hall, 1999). The aims of the present article are to: (i) describe the high prevalence and associated harms of smoking among these sub-populations; (ii) explore possible reasons for such high rates of smoking; (iii) review the evidence regarding the efficacy of existing smoking cessation interventions; and (iv) to make recommendations for further research among these sub-groups of people.

High prevalence and harms associated with smoking among specific sub-populations
The prevalence of smoking among Aboriginal and Torres Strait Islander Australians, residents of Australia from some cultural backgrounds, people with mental health or substance use disorders and prison inmates is more than double that of other Australians.

Aboriginal and Torres Strait Islander Populations
Around 54% of people of Aboriginal and Torres Strait Islander descent report that they are current smokers (Ivers, 2004). The prevalence of smoking is slightly higher among Aboriginal and Torres Strait Islander males than females (56% versus 52%, (Statistical Information Management Committee, 2004)). The average age of onset of regular smoking is 15 years among people of Aboriginal and Torres Islander descent, which is significantly younger than the general population (Statistical Information Management Committee, 2004). Early initiation to regular tobacco use is associated with increased nicotine dependence and reduced success at cessation attempts later on in life (Hymowitz et al., 1997). Consequently, tobacco use is overwhelmingly seen as a normal behaviour and is reinforced by family and within the community (Roche & Ober, 1997). Tobacco use is the leading cause of
premature morbidity and mortality among Aboriginal and Torres Strait Islander people (Cunningham, 1995), who also experience higher rates of cardiovascular and respiratory problems relative to the general population in Australia (Statistical Information Management Committee, 2004).

Culturally and Linguistically Diverse Communities
As indicated by Loxley et al. (Loxley et al., 2004) around one-quarter of the Australian population is born overseas, with around 14% immigrating from countries of non-English speaking backgrounds. This represents a significant proportion of the Australian community.

In general, surveys of the patterns of tobacco use reveal that as a group, those from culturally and linguistically diverse backgrounds report similar or slightly reduced levels of smoking relative to the 17% detected in population surveys of the general Australian community (Loxley et al., 2004). However, within particular cultural groups, smoking levels do appear elevated. For example, Rissel et al. (Rissel et al., 2000) report that smoking is more highly prevalent among people from Vietnamese, Chinese and Arabic backgrounds living in Australia, with prevalence rates upwards of 50%.

Interestingly, levels of current smoking are different for males and females within these cultural groups. That is, while rates of current smoking are around 50% for males born in Vietnam, Laos, Cambodia, or Lebanon, females born in these countries report much lower rates than their male counterparts (around 1.3%), and indeed have reduced rates of current smoking relative to Australian-born women (Public Health Division, 2000). In a similar way, males speaking languages other than English also report higher rates of smoking relative to the Australian population. This is particularly the case for males speaking Croatian, Vietnamese and Arabic languages at home (Public Health Division, 2000) with rates of current smoking between 36-51%. In contrast, women speaking these languages report much lower rates of current smoking than their male and Australian-born equivalents (Public Health Division, 2000; Statistical Information Management Committee, 2004). Higher rates of smoking among these cultural groups are associated with poorer self-assessed respiratory, cardiovascular and general health (Public Health Division, 2000).

People with Co-occurring Problems
Mental health problems have been found to be strongly associated with tobacco use (Degenhardt & Hall, 1999). The prevalence of smoking among people with psychotic disorders is especially high, with reported rates of 70 to 88% (de Leon, 1996; Fowler, Carr, Carter, & Lewin, 1998; Goff, Henderson, & Amico, 1992; Hughes, 1998). A 20% reduction in life expectancy has been reported for people with schizophrenia (Hughes, 1998) and the most common cause of death among people with schizophrenia is ischaemic heart disease (de Leon et al., 1995), both of
which may be related to the very high rates of smoking among people with psychotic disorders.

The great majority of people with alcohol and drug problems also smoke tobacco. Smoking rates among drug treatment populations range from 74 to 100% (Batel, Pessione, Maitre, & Rueff, 1995; Clarke, Stein, McGarry, & Gogineni, 2001; John, Hill, Rumpf, Hapke, & Meyer, 2003; Richter, Gibson, Ahluwalia, & Schmelzle, 2001; Shakeshaft, Bowman, & Sanson-Fisher, 2002). While a strong relationship has been established between alcohol and nicotine dependence (Drobes, 2002), use of tobacco is also strongly associated with the use of substances including cannabis (Hight, 2004), heroin (Frosch, Shoptaw, Nahom, & Jarvik, 2000) and cocaine (Roll, Higgins, & Tidey, 1997). Those with substance abuse problems and who also smoke tobacco are at particularly high risk of experiencing harm as a consequence of a typically heavier pattern of tobacco use (Batel et al., 1995; Keenan, Hatsukami, Pickens, Gust, & Strelow, 1990) and due to the synergistic effects of these substances (Bowman & Walsh, 2003; Castellsagué et al., 1999). It has been estimated that the combined health risks of smoking and alcohol use are 50% higher than the sum of their individual risks (Bien & Burge, 1990; Brady, 1995). For example, in the case of oesophageal cancer, the excellent solvent properties of alcohol may take the carcinogens in tobacco smoke to basal layers. In addition, people with severe alcohol and drug dependence are more likely to die from tobacco-related causes (Hurt, Offord, & Croghan, 1996), such as coronary heart disease, cancer, stroke and chronic lung disease, than from causes related to the use of any other drugs.

**Prison Populations**

Among prisoners in New South Wales (NSW), Australia, who are largely comprised of the three sub-populations above, smoking is more common among those with a 12-month ICD-10 diagnosis of substance-use disorder (92% vs 70%). Nearly all (90%) of prisoners with a history of intravenous drug use smoke (Belcher, Butler, Richmond, Wilhelm & Wodak, unpublished observations). Thus, belonging to more than one marginalised sub-group increases the likelihood of smoking, with more than five times more drug using prisoners smoking compared to the general community.

**Possible reasons for such high rates of smoking**

As Nichter (Nichter, 1998) explains, articulating the interactions between various social, economic and individual factors, as well as psycho-biological and contextual issues associated with cigarette uptake, will lead to an improved understanding of the essential components of smoking cessation and risk reduction. It is evident that these interactions contribute to the higher prevalence of smoking among Aboriginal and Torres Strait Islander Australians and those from some cultural backgrounds, people with mental health and substance use disorders and prison inmates. In general, social factors common to these sub-groups that potentially increase the likelihood of smoking include: poverty; limited education; unemployment; and peer
pressure (Ziedonis & Williams, 2003). Of note is that these particular socioeconomic issues predispose all individuals to increased rates of smoking, regardless of background or situation. However, it is important to consider whether cultural background, mental health status etc. lead to additional differences in relation to smoking after accounting for these factors (Nichter, 1998). For example, members of disadvantaged groups are more likely to have begun smoking at an early age and disadvantaged groups are less likely to access preventive health services such as smoking cessation programs (Australian Institute of Health and Welfare, 2002; Butler & Milner, 2003; Darrall & Figgins, 1998; Kraft, Svendsen, & Hauknes, 1998).

Aboriginal and Torres Strait Islander Populations
In addition to social factors, broader systems commonly operate to discourage smoking cessation attempts. Tobacco has long been used by some Aboriginal people (Brady, 2002; Low, 1987), with the earliest reports of use in Northern Australia dating back to the 1600s as introduced by Macassan fishermen. Colonisation of Aboriginal and Torres Strait Islander people has resulted in dispossession and family dislocation (Ministerial Council on Drug Strategy, 2005), with acculturation increasing their susceptibility to smoking and other substance use, and contributing to lower socioeconomic status, high unemployment and low levels of educational attainment (Ivers, 2004). For example, members of the Stolen Generations are more likely than other Aboriginal and Torres Strait Islander people to smoke (Cunningham, 1997). Aboriginal and Torres Strait Islander people were additionally given tobacco rations on the missions and the cattle stations (Brady, 2002; Ivers, 2004), a practice which continued until 1967, and likely served to embed tobacco use firmly within their culture and accepted mores (Ivers, 2004). Inadequate access to culturally appropriate health services (Deeble et al., 1998) is associated with low self-esteem and other social/cultural factors (Ministerial Council on Drug Strategy, 2005) and may also have contributed to the high prevalence of tobacco use in this population.

Culturally and Linguistically Diverse Communities
Very little firm evidence exists to suggest any culturally-bound variables that are associated with cigarette smoking among people from culturally and linguistically diverse communities (Edwards & MacMillan, 1990) in Australia. However, acculturation ((Landrine & Klonoff, 2004)) may play a role in the initiation and maintenance of smoking among people from diverse cultural backgrounds, albeit in different ways.

Evidence is emerging to suggest that acculturation has a negative effect on commencement of regular smoking, however for people already smoking, the relationship appears to be reversed. For example, one survey of school-aged Australians in South-Western Sydney revealed that rates of smoking were significantly lower among adolescents from Vietnamese and Arabic backgrounds relative to students from English-speaking backgrounds (Rissel et al., 2000). This
result suggests a delay exists for these young people, who quickly take up regular smoking with increased immersion in Australian culture, increased contact with English-speaking peers, and decreased controls imposed by parents (Rissel et al., 2000). In contrast to this finding, however, several US-based studies of Vietnamese and other South-East Asian adults found that acculturation exerted a protective effect in terms of smoking behaviours (Ji et al., 2005; Rahman et al., 2005). That is, those who were less immersed in American culture, did not speak English and maintained close links with friends in their home country smoked at higher rates than did their immigrant counterparts (Rahman et al., 2005).

It may also be that the strong anti-smoking messages that people in the general community in Australia have been receiving via the media for decades, have been missed or not understood by those immigrating to Australia, particularly those from non-English speaking backgrounds (Culpin, Gleeson, Thomas, & Bekiaris, 1996). Further more, it is likely that for people immigrating to a new country, smoking may be used as a stress-reduction strategy adopted in response to the pressures of adapting to a new environment (Baron-Epel & Haviv-Messika, 2004). As such, there remains an important need to ensure that health promotion and anti-smoking messages targeted to the English-speaking population are applied in an accessible and appropriate format for people from culturally and linguistically diverse backgrounds.

People with Co-occurring Problems
Mental health and drug and alcohol treatment systems can act to reinforce smoking and discourage cessation. Treatment providers sometimes consider smoking a benign problem compared to mental disorders or other substance dependencies (Bobo, Slade, & Hoffman, 1995). Such perceptions are likely reinforced by the common presentation of other mental health or drug problems with a sense of urgency, often in the context of a life crisis (such as relationship, employment or legal), in comparison to the longer lead-time and less strident nature of tobacco-related problems. Other beliefs held by treatment providers have included fears that smoking cessation would lead to poorer treatment outcomes for other substance use or indeed that smokers would not wish to quit (Bowman & Walsh, 2003). However, research suggests a lack of evidence supporting such concerns. Proportions ranging from 46% to 80% of clients in drug treatment express interest in quitting smoking (Campbell, Krumenacker, & Stark, 1998; Ellingstad, Sobell, Sobell, Cleland, & Agrawal, 1999; Richter et al., 2001), often motivated by health consequences (Myers & MacPherson, 2004). Burling et al found that initiating smoking cessation during alcohol treatment did not endanger abstinence from alcohol (Burling, Burling, & Latini, 2001).

In addition, negative attitudes among treatment staff have been acknowledged as potentially undermining efforts to introduce change with respect to treatment for nicotine dependence (Hurt, Croghan, Offord, Eberman, & Morse, 1995). Staff who smoke themselves have been shown to be less likely to initiate smoking cessation
among clients, and may not be as effective when they do (Bobo & Davis, 1993; Bobo & Gilchrist, 1983; Burling, Ramsey, Seidner, & Kondo, 1997; Olive & Ballard, 1992). Despite its probable importance as a determinant of smoking care provision, objective data concerning the views of staff are scarce. A recent Australian study confirmed the ambivalence and inconsistency of management and staff within alcohol and other drug agencies concerning systematic implementation of smoking cessation care. A considerably higher rate of smoking has been reported among staff (36%) compared to the general population, and there are disturbing views among some managers and staff, that there is utility in staff sometimes smoking with clients in order to further the therapeutic relationship (Walsh, Bowman, Tzelepis, & Lecathelinais, 2005). The prevalence of smoking among prison staff (Belcher, Butler, Richmond, Wilhelm & Wodak, unpublished observations) and Aboriginal Health Workers and service staff is also high, with evidence suggesting these workers are less likely to promote activities and actions about smoking cessation (Harvey et al., 2002).

Further, mental health and alcohol and other drug agencies are themselves somewhat unique in the field of health care, with a substantial proportion permitting smoking in at least some internal areas, thus reinforcing the notion of smoking as acceptable drug using behaviour (Walsh et al., 2005). Smoking is largely ignored in mental health and drug and alcohol treatment settings and may even be used as a reward (Williams & Ziedonis, 2004). Certainly, neither mental health nor general medical providers routinely diagnose nicotine dependence, which would better allow for the opportunity to discuss smoking cessation (Ziedonis & George, 1997).

Prison Populations
Prisoners have a preference for higher nicotine and tar content pouch tobacco (Butler & Milner, 2003; Darrall & Figgins, 1998; Kraft et al., 1998). However, smoking cessation strategies such as those employing pharmacotherapies, nicotine replacement therapy (NRT), as well as counselling interventions based on cognitive-behavioural principles, which are readily accessible in the community, are not routinely available in prisons. Further, prisoners are often required to cover the cost of pharmacotherapies themselves. This expectation is unrealistic considering most inmates have little or no money and often use their weekly allowance (around $20 per week in NSW) to buy food items and other creature comforts.

Although it is beyond the scope of this article, in addition to systems factors, there are numerous biological and psychological factors that may act to increase the risk of nicotine dependence among people with mental health or substance use problems, with nicotinic receptor activation resulting in increased transmission of numerous neurotransmitters (Degenhardt & Hall, 1999). In psychotic disorders, biological factors include: possible reduction in negative symptoms associated with enhancement of dopamine transmission; improvement in poor attention to and processing of sensory stimulation associated with better sensory gating; improvements in stress, anxiety and depression, mediated via alpha-7 nicotinic
receptors; genetic influences; and enhanced metabolism of many antipsychotic medications, with consequent impacts on the management of side-effects (Ziedonis & Williams, 2003).

Evidence regarding the efficacy of existing smoking cessation interventions
There is a paucity of studies evaluating smoking cessation among these sub-groups.

Aboriginal and Torres Strait Islander Populations
A review of tobacco programs for Aboriginal and Torres Strait Islander people showed only four published evaluations of tobacco interventions, none of which measured or were able to demonstrate an effect on cessation rates (Ivers, 2003). They included an evaluation of a brief intervention for use in primary care in north Queensland (Harvey et al., 2002), a trial of a CD-ROM on tobacco for use with indigenous schoolchildren (Johnston, Beecham, Dalgleish, Malpraburr, & Gamarania, 1997), a qualitative evaluation of the National Tobacco Campaign among Koori Victorians (Research and Evaluation Committee of the National Expert Advisory Committee on Tobacco, 1999) and a pilot study of smoke-free workplaces, evaluated by qualitative methods (Seibold, 2000). The review also showed that a range of culturally specific health promotion material including posters, pamphlets and stickers, had been developed for numerous Aboriginal communities although none had been evaluated (Ivers, 2003). Another report assessed the use of nicotine patches and/or a brief intervention for smoking cessation in 111 Aboriginal smokers and had quit rates similar to those in other populations (15% vs 17%) as a result of using nicotine patches (Ivers et al., 2003). No randomised controlled trials have been conducted on tobacco interventions for Aboriginal or Torres Strait Islander people to date.

Culturally and Linguistically Diverse Communities
Experts suggest that approaches to smoking cessation, such as NRT and counselling, can be used with people of different ethnic backgrounds (Coleman, 2004). However, very little research exists that directly tests the application of these approaches to people from culturally and linguistically diverse backgrounds, as the majority of smoking cessation research has been conducted in mainstream society, using white, middle-class participants (Benowitz, 2002). It is not immediately clear how the needs and perspectives of people from culturally and linguistically diverse communities fit within these approaches, nor whether doing so will influence smoking cessation. Research is also emerging that suggests people from culturally and linguistically diverse backgrounds react differently to the effects of nicotine and inhale more deeply on their cigarettes than do their counterparts. For example, Benowitz and colleagues (Benowitz, Perez-Stable, Herrera, & Jacob, 2002) examined a sample of Chinese Americans and found that this group metabolises nicotine at a slower rate than their anglo-counterparts. As such recommendations for NRT, other substitution therapies and psychological interventions need to be much more closely developed, tailored and tested for
particular cultural groups, rather than being directly applied from existing approaches.

Certainly it is important that messages regarding the dangers of smoking and the importance of smoking cessation should be culturally relevant, presented in a language that the target audience can easily understand, and reinforced by prominent members within the cultural community, instead of being imposed from the outside (Islam & Johnson, 2003; Ji et al., 2005; Zandes, 2003). Given the influence of social and economic factors on smoking, Loxley et al. (Loxley et al., 2004) further suggest a broader approach to the promotion of general health and well being may well be preferable in these cases to one that employs tobacco-specific strategies. However, despite the many challenges facing different cultural groups in surmounting language and other access barriers to treatment, the potential to provide education and treatment services through community and other social networks in which these people are already engaged seems an important way forward (Ministerial Council on Drug Strategy, 2005).

Further, a survey of adolescents from culturally and linguistically diverse backgrounds in Australian (Rissel, McLellan, Bauman, & Cho Tang, 2001) revealed the importance of family values and attitudes against smoking contributed to the lower rates of tobacco use among Vietnamese and Arabic youth. In addition, these students identified the imposition of strict rules about non-smoking by schools and family members as key issues in their decision not to take up smoking (Rissel et al., 2001). Clearly, enhancement of these factors within these communities is important.

People with Co-occurring Problems

Studies have found that smoking cessation rates among people with schizophrenia are comparatively low, around 10% at six months following a smoking cessation program (Johnston et al., 1997; Research and Evaluation Committee of the National Expert Advisory Committee on Tobacco, 1999), compared to 20 to 25% in the general population (Lichtenstein & Glasgow, 1992). Several trials have been conducted among smokers with schizophrenia, including motivational interviewing to encourage treatment for tobacco dependence (Steinberg, Ziedonis, Krejci, & Brandon, 2004) and with combinations of either nicotine replacement therapy (NRT) (Addington, el-Guebaly, Campbell, Hodgins, & Addington, 1998; George et al., 2000) or bupropion with group interventions (Evins et al., 2004; Evins et al., 2005; George et al., 2002; Weiner, Ball, Summerfelt, Gold, & Buchanan, 2001). Harm reduction (eg, decrease in carbon monoxide levels) as well as cessation outcomes have been reported (Weiner et al., 2001). However, trials of available treatments for smokers with schizophrenia have been criticised on methodological grounds, including heterogeneous samples, small sample sizes, and lack of defined interventions and control groups, with cessation being achieved among very few participants and the recommendation being that further examination of smoking...
cessation interventions be made using more rigorous methodology (McChargue, Gulliver, & Hitsman, 2002).

In a large randomised, single-blind controlled comparison of routine care with a program of routine care plus an eight session, individually administered smoking cessation intervention consisting of NRT, motivational interviewing (MI) and cognitive-behaviour therapy (CBT) among 298 people with a psychotic disorder, Baker et al (unpublished observations) found no significant differences in point prevalence and continuous abstinence rates measured at 3, 6 and 12 months between the treatment and control groups on an intention to treat analysis (Baker et al, unpublished observations). However, a significantly higher proportion of smokers with a psychotic disorder who completed all treatment sessions had quit smoking at all follow-up occasions and participants completing all treatment sessions were also significantly more likely to have reduced the number of cigarettes smoked by 50% or more compared to the control group.

Among people with alcohol problems, client preference should be considered in the timing of tobacco treatment and this has been highlighted as an area worthy of further investigation (Flach & Biener, 2004). In fact, this client group have reported less temptation to use alcohol than cigarettes (Stotts, Schmitz, & Grabowski, 2003), and there is some evidence that smoking cessation reduces the rate of alcohol relapse (Toneatto, Sobell, Sobell, & Kozlowski, 1995). In monitoring changes in smoking status and other drug use among an alcohol and drug treatment population over 12 months, Kohn et al concluded that ‘self-initiated smoking cessation does not appear to be detrimental to substance abuse treatment outcomes, and may be beneficial’ (p61) (Bobo, Mcilvain, Lando, Walker, & Leed-Kelly, 1998).

Finally, a lack of research into smoking and other alcohol and drug use generally, and the development and testing of cessation strategies in particular, has served as an excuse for relative inaction. Research to date suggests that sustained smoking cessation is clearly not easily achieved with substance abusers (Bobo et al., 1998; Campbell, Wander, Stark, & Holbert, 1995; Gariti et al., 2002; Haug, Svikis, & DiClemente, 2004; Hurt, Eberman, Croghan, & et al, 1994; Joseph, Nichol, & Anderson, 1993; Shoptaw et al., 2002).

**Prison Populations**

Surprisingly, prison inmates are a fairly health conscious group. This is evidenced by the high levels of current smokers wanting to quit smoking (75%), with 21% planning to quit in the next three months (Butler & Milner, 2003). Many prisoners engage in exercise in prison (66% had exercised for at least 30 minutes per day for the previous four weeks) and 62% had concerns about the health value of the food consumed in prison (Butler & Milner, 2003). Within Australian prisons, there is little consensus regarding ‘what works’ best for prisoners and a wide range of approaches have been adopted, including outright smoking bans. The use of non-nicotine pharmacotherapies, such as the use of sub-clinical doses of antidepressants,
is important for several reasons. Smokers are more likely to have a history of major depression than non-smokers, and nicotine may act as an antidepressant in some smokers (Richmond & Zwar, 2003). Smokers with depression were estimated to be 40% less likely to quit smoking than non-depressed smokers (Anda et al., 1990). Smoking cessation may result in the development of depression and this may lead to relapse (Hall, Munoz, & Reus, 1994; Richmond & Zwar, 2003; Shiffman, 1982).

In 2002 Richmond et al conducted a pilot study of smoking cessation at a maximum-security prison on the outskirts of Sydney (Richmond et al., submitted for publication). Potential participants were screened and most were found to have very high levels of nicotine dependence. Focus groups identified a range of issues likely to hinder quitting attempts during incarceration such as the entrenched nature of smoking in the prison culture and the role of tobacco as a de facto currency.

Considering the high level of mental disorder in prison and the high level of dependence, a multi-component approach adopted by Jorenby et al was considered appropriate. This combined brief CBT, bupropion (Zyban) and patch NRT (Jorenby et al., 1999). The results at six months found a 26% point prevalence abstinence and 22% continuous abstinence. We believe this is the first attempt to systematically validate the results of a quit smoking program in the prison setting. Notwithstanding the stresses of prison life, these abstinence rates are high and provide evidence that smoking cessation programs in prison are feasible, well accepted and effective.

Reasons for relapse were identified and provided insights into the problems of quitting in this environment: transfers between prisons without prior notice (in prison this is considered to be a highly stressful event), boredom, lock-downs (prolonged periods of time where prisoners are confined to their cells), and family and legal stressors. Reassuringly, an overwhelming majority (95%) of inmates who relapsed during the trial indicated a willingness to try quitting again with the intervention.

The pilot study also resulted in several unexpected positive outcomes. Other inmates, prison officers and health staff who were directly or indirectly involved in the trial expressed interest in quitting and were directed to appropriate services. A major conclusion of the pilot study was that smoking cessation studies in the correctional environment are feasible and attractive to inmates, prison staff and prison authorities alike.

Thus, despite evidence that many people belonging to sub-groups in which smoking is highly prevalent are interested in reducing smoking, and some promising initial results of interventions, few intervention studies have been conducted. There is an urgent need for further research into preventive and treatment approaches among these sub-groups.

Recommendations for smoking interventions and further research
Recommendations addressing the social and systems problems and psychobiological vulnerabilities contributing to high smoking prevalence among some subgroups are made below. An over-arching recommendation is that more funding is required to determine the most suitable approaches to the prevention and cessation of smoking among these groups. The 2004-2009 National Tobacco Strategy (Ministerial Council on Drug Strategy, 2005) recommends the following approaches to encourage smoking cessation:

- Promotion of Quit and Smokefree messages;
- Cessation services and treatment (pharmaco- and behavioural support therapies);
- Community support and education;
- Addressing social, economic and cultural determinants of health;
- Research, evaluation, monitoring and surveillance; and
- Workforce development.

Adequately resourcing the adaptation of each of these approaches to each sub-group should occur as a matter of priority, given the potential for health, economic and other benefits of smoking cessation among these groups. In addition, the integration of these methods to networks in which these groups are already engaged could serve to break down the many barriers that currently prevent access to treatment.

As such, a two-tiered approach to the management of smoking and related harms is suggested from the above review: universal prevention and education programs and targeted interventions for particular groups.

### Universal Prevention and Education Programs

A major review of the evidence for the prevention of substance misuse and related harms in Australian (Loxley et al., 2004) suggested the importance of universal prevention strategies that occur at the broader, population level, in addition to those that target particularly risky or disadvantaged groups. This recommendation is in light of research indicating that the majority of people who engage in risky smoking behaviour in adulthood are those who exhibit only low-level risk factors during adolescence (Loxley et al., 2004).

Tobacco control programs may be better addressed through comprehensive health program delivery rather than by specifically focusing on tobacco (Velicer, Prochaska, & Redding, this issue). This could occur for all adolescents during their schooling career, as part of a universal program of health promotion covering alcohol/other drug use, mental health promotion, cardiovascular disease and cancer and education about tobacco-related harms and other risk-taking behaviours (Loxley et al., 2004). In addition, positive role modelling from parents and important community figures about smoking attitudes and behaviour in line with these education strategies would likely be of benefit (Rissel 2001).

It is important that those from Aboriginal and Torres Strait Islander and culturally and linguistically diverse communities have access to these programs. More
funding for prevention and intervention programs targeted to Aboriginal and Torres Strait Islander people are required, as are increased resources to examine the most appropriate education and treatment strategies to promote smoking cessation among people from culturally and linguistically diverse communities, and system-wide interventions among clients and staff within mental health, drug and alcohol and prison settings are recommended. The recent introduction of an Enhanced Primary Care item for Aboriginal and Torres Strait Islander people by the Health Insurance Commission, involving a two yearly preventive medical check including advice on cessation is encouraging as funding is available nation-wide for delivery of such advice (Mayers & Couzos, 2004).

Targeted Interventions
Larger and better-designed studies evaluating smoking cessation/reduction interventions among these disadvantaged groups is urgently required. Because of the dearth of research specifically assessing tobacco control programs, quality research is required to inform the delivery of best practice services. Ongoing surveillance of the prevalence of tobacco use in these populations, for example through National Drug Strategy household surveys, or through national Aboriginal and Torres Strait Islander people surveys, for example, is critical to assess trends in prevalence of smoking behaviours.

Service delivery in relation to smoking cessation among Aboriginal and Torres Strait Islander people has been characterised by inadequate funding, an absence of specialist tobacco workers and those trained to deliver appropriate cessation advice, and poor access to pharmacotherapies and health promotion materials. Similar criticisms can be made of service delivery to the sub-groups from some cultural backgrounds reviewed in this article. More ongoing funding is required to address these deficits.

Remarkably, however, the allocation of mainstream funding to specific programmes for Aboriginal and Torres Strait Islander people is still often criticised despite the appalling health outcomes of indigenous Australians. Following consultation with Aboriginal and Torres Strait Islander people across the nation in 2000-2002, a report (Lindorff, 2002) showed that informants advocated community controlled tobacco programs acknowledging the cultural context of smoking and involved Aboriginal or Torres Strait Islander people at every stage of program development. Improvements in health outcomes are likely to result from adequate, sustained funding (Briggs, Lindorff, & Ivers, 2003). Coordination of existing programs is also critical to improving communication and reducing duplication of services; the recent establishment of the National Centre of Excellence in Indigenous Tobacco Control bodes well for improvements in national program coordination. Harm minimisation, including prevention of exposure to environmental tobacco smoke, and advocating reductions in the volume smoked, may also be appropriate in view of the very high prevalence of and normalisation of tobacco use in this population (Roche & Ober, 1997) and among those from some cultural backgrounds.
Loxley et al. (Loxley et al., 2004) further suggest that for Aboriginal and Torres Strait Islander communities in particular, handing over control for regulating smoking behaviour to the communities themselves shows promise as a method for addressing the increased rates and associated harms with tobacco use. This approach has worked well for the use of alcohol, and together with an appropriate education and prevention program could potentially be implemented with success for tobacco use.

Possible avenues for future research among people with psychotic disorders include longer-term use of NRT (Degenhardt & Hall, 1999) and/or extended CBT interventions allowing for resumption of treatment following relapse as needed. Further, reduction-focused smoking interventions among smokers with schizophrenia who do not wish to abstain from cigarettes should be evaluated (Evins et al., 2004). We have recommended that reduction-focused and abstinence-based interventions are not incompatible among smokers with severe mental illness (Baker et al, unpublished observations). While cessation should be recommended and encouraged for all smokers, those who do not want to cease smoking or who have experienced repeated failed attempts, should be given more support to reduce their tobacco intake as a step towards possible future cessation. There are important harm reduction considerations such as financial and potential health benefits (e.g., potentially lower risk of disease, morbidity and mortality, (Hughes, 2000)) of smoking reduction among people with severe mental illnesses and smoking reduction has been found to promote cessation among those able to reduce smoking (Falba, Jofre-Bonet, Busch, Duchovny, & Sindelar, 2004).

It also seems apparent that what is required in the area of smoking among people with substance use disorders are intensive psychosocial interventions, tailored to meet the needs and characteristics of substance abusers, augmented by pharmacological aids such as NRT and appropriate environmental support (Bowman & Walsh, 2003). It seems likely that quit smoking attempts are undermined by the method of quitting, rather than the level of motivation (Richter et al., 2001). Behavioural treatments may be more effective if developing coping skills are generalised to multiple addictive behaviours (Drobes, 2002; Stein & Anderson, 2003).

Using NRT greatly enhances an individual’s ability to quit smoking (Ahluwalia, McNagny, & Clark, 1998), and tailoring treatment and individualising doses of NRT may yield better results (Hughes, Callas, & High Dose Study Group, 2003). In the context of people using other substances however, the use of NRT may also entail consideration of issues such as some abstinence-oriented agencies having a philosophical objection to drug substitution in any form, and the likely need to closely monitor adherence with a protocol for ‘appropriate use’. Nicotine-dependence treatment is clearly an imperative among such a high-risk population: the appropriate question is not whether to treat nicotine dependence in people who
are dependent on other substances, but when and how to do so (Bowman & Walsh, 2003). Combined treatments for tobacco and other alcohol and drug problems may lead to more positive outcomes for both.

Many people with drug dependence problems are interested in and would like to cease smoking. There is a responsibility upon treatment agencies and prisons and their staff, not currently being realised, to provide smoking care. Undoubtedly, this will entail culture change and appropriate provision of training and support for staff, including provision of cessation care for staff themselves. It will involve top down policy and other environmental support, as well as the ongoing development and evaluation of tailored interventions for smokers.

Smoking among prisoners is unacceptably high and poses a danger to the health of other inmates and staff working in correctional facilities, regardless of smoking status. However, smoking is one of the few remaining privileges left to inmates. There should be a concerted effort to reduce the levels of smoking through the provision of smoke-free wings, smoke-free cells, support and counselling, and subsidised or free treatments rather than blanket bans. We advocate an evidence-based approach to the provision of treatments for smoking cessation rather than the provision of ad hoc and unevaluated programs and interventions currently on offer in many correctional centres. Incarceration represents a valuable public health opportunity to implement smoking cessation interventions in marginalised groups with unacceptably high rates of smoking.

Conclusions

Further declines in the prevalence of daily tobacco smoking are unlikely to be achieved unless specific attention and interventions are directed to high prevalence sub groups in the Australian community. While the high rates of smoking are associated with low socio-economic status, limited education and other factors, there are specific and potentially correctable factors associated with smoking that need to be considered for each sub-population.

General population based approaches to reducing smoking prevalence have been pursued for decades with great success and should be continued with further developments that specifically aim to affect Aboriginal and Torres Strait Islander people and some cultural groups (Loxley et al., 2004). Increasing attention and more specific targeting of programs with flexible goals are required for distinct populations with very high smoking prevalence.

Recommendations include: more funding and increased resources to examine the most appropriate education and treatment strategies to promote smoking cessation among people from Aboriginal and Torres Strait Islander and some culturally and linguistically diverse backgrounds; larger and better designed studies evaluating smoking cessation/reduction interventions among distinct sub-groups; and system wide interventions requiring strong leadership among clients and staff within mental
health, drug and alcohol and prison settings. Steps to reduce social, economic and other differentials among these groups are also recommended, along with a commitment to broad-based treatment approaches that could potentially address multiple problems simultaneously. This is especially important for Aboriginal and Torres Strait Islander groups, who would undoubtedly benefit from approaches to decrease disadvantage and strengthen community resources (Loxley et al., 2004).

In the US, Williams and Ziedonis suggested a national strategic plan to address smoking among vulnerable populations including policy development, prevention and treatment (Williams & Ziedonis, 2004). In Australia, it is acknowledged that sub-populations with a high prevalence of smoking should be identified and a coordinated evidence-based approach to policy, prevention and treatment should be developed for each sub-population. At all times, input from representatives of each of these groups is paramount to the development and implementation of appropriate and accessible strategies.

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Introduction
Smoking is one of the most preventable causes of premature death and morbidity worldwide and depression is now the leading cause of disability worldwide, measured by the number of years lived with a disabling condition. Smoking is responsible for 20% of all deaths in the US and 45% of smokers will eventually die of a tobacco-induced disorder. Smoking also frequently co-occurs with depression and depression rates among smokers are quoted between 22% to 61%, compared to 17% in the general population.

This paper aims to review research on the association between smoking cessation and depression, noting areas for future research. Medline and psycINFO were employed for the literature review, supplemented by relevant Cochrane studies. All levels of evidence cited comply with NHMRC guidelines.

Depression and smoking
While one could argue that depression could be normal in smokers who are having to ‘give up’ an important part of their life, there are patterns suggesting significant relationships between depression and types and severity of smoking. Compared to nonsmokers, regular smokers report more depressive symptoms, more frequent and severe episodes of depression, higher rates of both suicidal ideation and of suicide. Smokers with a history of depression, who abstain from smoking are also significantly more likely to develop a new episode of major depression. Along with unemployment and having a medical condition, smoking is one of the strongest correlates of current major depression (MD), with smokers more than two and half times more likely to be depressed (using DSM criteria) than those who have never smoked.

Smokers presenting with MD tend to smoke more and report higher rates of nicotine dependence than their non-depressed counterparts. Smokers are more likely to start, restart or increase their smoking during periods of distress, with those reporting recurrent depressive episodes consistently recording the highest rates of smoking. Depressive symptoms in those seeking smoking cessation
treatment are associated with a prolonged nicotine withdrawal profile and lower abstinence rates.

The lack of attention to increased morbidity and severity of symptoms amongst these individuals relative to people without such comorbidity limits our understanding of the relationship between depression and smoking and impacts on the development of optimal treatment approaches. Despite this, several models developed to describe the co-occurrence of comorbidity have been applied to the relationship between depression and nicotine use. These include:

1. **Primary depression models**: smokers use nicotine as a means of self-medicating their depressive symptoms, or to cope with distress related to depressive symptom development. Support for this model comes from evidence which suggest that nicotine produces an elevation in mood and subjective improvements in well-being. Nicotine is thought to have antidepressant properties, as it is considered to increase the activity of the serotonergic system, acting in a similar manner to common antidepressants by targeting serotonin transmission.

2. **Primary smoking models**: smoking behaviour precedes the presence of their first depressive symptoms, and that smoking (or smoking cessation) produces depression. Several authors have identified a link between smoking and various neurochemical processes in the brain, with smokers showing depleted monoamine oxidase (MAO) levels compared to non-smokers, consequently putting them at greater risk to psychopathology. The withdrawal of nicotine may also affect these pathways, increasing a person’s vulnerability to depression.

3. **Bidirectional models**: an ongoing, interactional effect between smoking and depression may account for the high rate of comorbidity. For example, smoking could trigger depression in a biologically vulnerable individual, which is subsequently maintained by continued smoking due to learned social behaviours.

4. **Common-factor models**: There is indication of a common genetic basis for depression and nicotine dependence, whereby a genetic vulnerability may increase the risk of major depression and the likelihood of experiencing the positive effects of nicotine. Kendler and colleagues evaluated the association between smoking and lifetime MD and found that the genetic liability to smoking could be explained by the genetic liability to MD, giving support to a non-causal genetic model. Other common factors, such as social difficulties and stressful events were also shown to contribute to an increased risk of depression and smoking, a finding which has been backed by other researchers.

There is limited evidence to support adopting one of these models over another, and each has inherent problems when applied to clinical settings. Possible reasons for this include (i) the differential effects of nicotine (and other agents) and (ii) the differential effects of genotypes and depression histories in the relationship between
smoking and depression. It has been suggested that it may be more helpful to focus treatment on comorbidity, allowing for the consideration that multiple issues are likely to impact on their response to any treatment program.

The impact of other comorbid conditions
While this paper focuses on smoking and depression, high rates of comorbidity with other substance dependence disorders, as well as medical and psychiatric disorders are worth noting. Eighty per cent of alcohol dependent people currently smoke and the concurrent cannabis use is becoming increasingly relevant to smoking cessation as it has been linked to depression, suicidal ideation and difficulty of tobacco cessation. Cannabis smoking rates are growing, particularly among younger age groups, where cannabis use has been reported higher than tobacco use.

High tobacco smoking rates are seen in people with post traumatic stress disorder (approximately 60%) and panic disorder, and there is evidence of a direct causal relationship between smoking and the first panic attack. Both male and female smokers with high neuroticism scores have higher smoking relapse rates and are more vulnerable to repeated episodes of depression.

Comorbid medical illnesses
Many medical illnesses (including cardiovascular, cerebrovascular disease, chronic obstructive pulmonary disease, diabetes) are associated with higher rates of MD complicated by continued smoking. Nicotine-dependent smokers are also more likely to have smoking-related health problems such as cardiovascular disease, cerebrovascular disease and emphysema, increasing both the risk of depression and the complexity of their medical and psychiatric management.

Treatment approaches for depression and smoking cessation
Need for greater discrimination in depression history
Most cessation treatment guidelines have failed to address the need for detection of depression and anxiety among smokers. There is an argument for more critical consideration of depression subtypes and ‘depression history’, which is typically a measure of lifetime episodes of MD, without consideration of whether depression is early or late onset, or melancholic or non-melancholic in nature. Factors such as anxiety disorders (particularly panic disorder), vascular disease, ‘vascular depression’, and other medical illnesses should also be considered in the context of smoking cessation, as all have likely implications on treatment, recovery and relapse. Studies have begun to address these issues, either by categorizing depressive episodes as single or recurrent or by undertaking studies in the context of specific medical illnesses known to precipitate and complicate MD. For example, studies that profile depressed smokers with diabetes who smoke despite knowing the dangers or use of antidepressants and psychological approaches in depressed patients with illnesses such as chronic airways disease that are known to have high rates of depression.

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Need for greater consideration of special groups

Although there is a decreasing smoking prevalence in western cultures, rates among some ethnic minorities remain high. For example, rates of smoking among indigenous persons in the US and Australia are more than double that of general population. There is currently insufficient research examining the effectiveness of broad-spectrum anti-smoking interventions among different ethnic groups and we need a greater awareness that some groups adopt multiple harmful methods of tobacco use (such as chewing), in addition to smoking. Population-based surveys report that ethnic minorities contemplating cessation are less likely to seek help, possibly due to the lack of culturally appropriate programs and when programs are adapted for specific groups, post-intervention abstinence rates are higher when programs are adapted for specific groups. Research conducted with prison inmates and the unemployed show similar patterns of high nicotine dependence, but high rates of motivation to quit, suggesting that such populations potentially stand to benefit the most from targeted smoking cessation treatments.

Psychological interventions

Compared to ‘never-depressed smokers’, regular smokers with a history of depression (depressed heavy smokers, DHS) report lower scores on tests of coping with negative moods and automatic thoughts, indicating the potential value of psychological treatments. Given the relationship between smoking cessation and depressed mood in smokers with a history of major depression (DHS), a number of psychological and lifestyle strategies have been combined with standard cessation treatments to increase success. Psychological interventions applied to smoking cessation and depression include problem solving techniques, coping skills and social support training, substitution therapy, stress management (such as physical activity and meditation) and mood management.

While psychological interventions are important in enhancing motivation and decreasing patients’ vulnerability to depression, findings on their effectiveness are mixed when considering both depression and smoking related outcomes. A review of group behavior therapy programs for smoking cessation indicated therapy was no more effective than ‘no intervention’, ‘self-help’ or other less intensive interventions. Other studies have reported that structured psychological approaches to smoking cessation add to the benefits of antidepressants and nicotine replacement therapy (NRT), particularly for smokers with high nicotine dependence and repeated MD episodes.

One research group compared the benefits of standard smoking cessation behavioral group treatment (including self-monitoring, self-management, nicotine fading, relapse prevention, and social support training) to group cognitive behaviour therapy (CBT) for depression (mood rating, increasing pleasant activities, cognitive restructuring, assertiveness). Both treatment groups received 2mg of nicotine gum. Group CBT was found to improve abstinence rates but not patients’ mood state, with high abstinence rates observed in both CBT and standard groups.
(approximately 20%). These results are unsurprising, however, given only one third of the sample had a previous history of depression at entry to the study, with a minimal level of current depression reported across the sample. Another group randomly assigned heavy smokers with a history of depression to group sessions of standard CBT smoking cessation treatment with and without additional parallel treatment for depression (CBT-D). Both treatments produced high rates of abstinence. A non-significant trend for better outcome in the CBT-D group was observed, however, heavier smokers and those with recurrent MD achieved significantly higher abstinence rates in the CBT-D group than their matched counterparts in the standard CBT, with no apparent difference for those with a single MD episode. In support of the Brown et al. study Haas and colleagues pooled and re-analysed data from Hall et al.’s randomized clinical trials (RCTs). Results indicated that higher rates of abstinence were found among people with recurrent episodes of depression when they participated in CBT treatment (35%), compared with the standard smoking reduction treatment provided in that study (18%).

Integrated psychological treatments addressing both depression and nicotine use have potential in developing better management skills for both conditions by incorporating strategies from both fields to address and relieve current distress. Such treatments can more easily be tailored to the particular needs of the individual by targeting areas of high distress and addressing both acute and chronic symptoms and should provide a coherent treatment plan which can be delivered in a cost-and time-effective manner.

**Exercise, complementary and alternative interventions**

‘Lifestyle’ interventions, such as exercise and acupuncture, tend to be well accepted by the general public as treatment options for both smoking cessation and depression. Few well-designed studies test the application of exercise and other complementary interventions on smoking cessation and depression. Exercise is cheap and accessible and has the potential to assist with problems commonly associated with smoking cessation and depression (e.g. insomnia and weight gain). Its value appears particularly relevant for women, a group who report more depressive symptoms during withdrawal and a greater fear of post-cessation weight gain.

A number of studies and a meta-analysis have highlighted the ameliorating effect of exercise on depression alone, but a Cochrane review assessing the effectiveness of exercise on smoking cessation could not reach a similar conclusion. It was acknowledged, however, that the papers included were limited, both by the number of available experimentally controlled studies, and by the small sample sizes used in all of the studies. These papers define ‘exercise’ broadly, including anything from gardening to structured aerobics classes and report on inadequate measures of exercise and exercise adherence have also been reported.
The usefulness of other complementary therapies in assisting with smoking cessation has been investigated to some extent, but without consideration of depression history. While few studies have reported on the effectiveness of acupuncture, electrostimulation and hypnotherapy for reducing smoking cravings, the systematic reviews could not conclude that any had a clear effect on smoking cessation over and above the sham alternatives.

Pharmacological treatments for smoking cessation
The possible association between nicotine, neurochemical changes in the brain and development of depression have encouraged research examining the use of pharmacological treatments to improve outcomes for people facing a quit attempt.

NRT
Numerous randomised controlled trials (RCTs) have confirmed the efficacy of NRT for nicotine dependence, and these treatments are incorporated in current guidelines. Both slow-acting NRTs (transdermal patch, TP) and faster-acting formulations (gum, nasal spray, inhaler and sublingual tablets/lozenges), have been approved as first line agents to treat nicotine dependence, and there is evidence for combining these modes to further enhance their benefit. In addition to reducing withdrawal symptoms and almost doubling the rate of abstinence among quitting smokers, NRTs also have some antidepressant qualities. A study of 608 smokers (one third of which were depressed), were provided with nicotine or placebo gum combined with behavioural counseling. The depressed nicotine gum group reported 12 month abstinence rates of 15.1% (5.7% in the depressed placebo group) and significantly lower self-reported depression. In a more recent study of psychological responses to NRT, Strasser and colleagues randomised 335 current smokers to receive TP or nicotine gum in addition to behavioural counseling over seven sessions. Results indicated that there was no difference in abstinence rates or withdrawal profiles between the study groups, however TP was associated with significantly greater positive mood over time relative to the gum. It was noted that negative mood in this sample peaked in the week following quitting and this was associated with increased risk of relapse to smoking. As such, the authors suggested that mood be closely monitored in the week following a quit attempt, with similar negative mood indicative of the need for a complementary NRT or additional psychological treatment.

The antidepressant qualities of NRT have also been demonstrated in non-smokers with major depression. Salin-Pascual and colleagues showed the effectiveness of nicotine patches in reducing depressive symptoms. Patients, however, relapsed 3-4 days following the cessation of NRT. While only minor side effects were reported over the treatment period in this study, due to the nicotine’s high risk health, NRT is not recommended as a treatment option by either Salin-Pascual and colleagues, or by this current research group.
The availability of NRT without prescription has increased over the last decade with numerous studies supporting the efficacy of NRT treatment in smoking cessation (see Silagy for review). However, emerging evidence suggests that the completion of standard NRT is associated with a higher rate of relapse compared to a placebo control. Experts are therefore starting to consider the cost/benefit issues for NRT over the longer term (e.g. up to 12 months following cessation), particularly with the recognition of nicotine dependence as a chronic, relapsing condition. This issue may have particular salience for those with the combination of high levels of depressive symptoms or MD relapse and higher nicotine use dosage, where longer term NRT and extended psychological therapy may be required. Concerns surrounding the effectiveness of NRT also suggest that future research should centre around non-nicotine related pharmacotherapies.

Bupropion and nortriptyline
Antidepressants have an important role in reducing the depressive symptoms associated with nicotine withdrawal and/or reducing the dysphoria maintaining smoking behaviour. Antidepressants targeting specific neural pathways (most probably the dopaminergic and noradrenergic neurotransmission system) may reduce symptoms of nicotine addiction, independent of their mood stabilizing effects. There is considerable Level 1 evidence for the effectiveness of both bupropion and nortriptyline in reducing smokers’ cravings and increasing the chances of smoking cessation.

A comprehensive review of the role of bupropion in smoking cessation found that abstinence rates for bupropion-use groups were double that for the placebo groups at 6 and 12 months, with approximately 35% of smokers who received bupropion and NRT remaining abstinent after 12 months, compared to 16% who received NRT alone. There has been increasing interest in the benefits of nortriptyline, as evidenced in a recent RCT. Compared with the NRT/placebo group (abstinence rates of 10%), the nortriptyline/NRT group recorded abstinence rates of 23% at 6-month followup but no significant improvements in withdrawal symptoms. Nonetheless, this treatment combination may provide a viable option for smokers where standard therapy has failed.

The effectiveness in smoking cessation is not common to all classes of antidepressants and appears to be independent of their antidepressant properties. Selective serotonin reuptake inhibitors do not appear to aid in smoking cessation: two different studies using fluoxetine in the two to three weeks prior to quitting found no effect on abstinence rates but significant reductions in depression, anger and tension following the cessation date, relative to placebo. Tricyclic antidepressants (particularly doxepin) have recorded effects specific to smoking cessation, ameliorating associated insomnia and nicotine withdrawal symptoms. A reversible monoamine oxide inhibitor (moclobemide) was found useful for heavy smokers, although its utility for smokers with a depression history was not considered. The effectiveness of newer ‘broad action’ antidepressants (eg, the
SNRIs) in lessening the nicotine withdrawal effects has yet to be determined and a potential role for reboxetine has been discussed.

Several RCTs comparing the efficacy of nortriptyline and bupropion have reported similar positive consequences on smokers’ abstinence. One study considered patients’ depression history and the development of a depressive episode after ceasing treatment and participants were given the option to continue antidepressant treatment to combat continuing depressive symptoms or relapse at the study’s conclusion. Another study using randomised participants who had demonstrated abstinence for 7 weeks, were treated for 45 weeks with either sustained release bupropion or a placebo. After a 12 month followup, the group who had been on bupropion had gained less weight and had higher continuous abstinence rates, although the differences were not evident at the two year followup. At the 12 month followup, it was not clear whether buproprion was having a continued effect by reducing cravings, or an antidepressant effect, or both. There are no equivalent studies using nortriptyline, however Hall’s group have allowed for nortriptyline to be continued after the study period has finished. Further research may find that nortriptyline and bupropion require greater prominence in treatment for those with repeated depressive episodes or melancholic depression.

**Anxiolytics**

A Cochrane review found no evidence to confirm the usefulness of anxiolytics in aiding smoking cessation and provided little justification for their use.

**Clinical implications of current knowledge**

The knowledge that depressed, heavy smokers are more likely to be nicotine dependent and to require pharmacotherapy is now being incorporated into clinical research studies. Treatment planning should consider longitudinal history, depression type as well as smoking history. Antidepressants and CBT strategies commenced prior to the quit date allow mood stabilization and avoid depression onset. When pharmacotherapy is eventually withdrawn, those with a depression history run the risk of subsequent dysphoria and depressive episodes that can be ameliorated by giving patients the option of continuing antidepressant treatment after the study finishes. To date, few RCTs have made direct comparisons between NRTs and antidepressants. As NRT and antidepressants have different effects, it would seem more fruitful to examine how they complement each other rather than pitting them against each other.

The development of a menu of options for clinicians to select and tailor a treatment program specific to patients’ needs is also important. We know that some people benefit from minimal interventions, such as assessment/monitoring and self-help material, yet others require more intensive treatment, including psychological intervention and/or pharmacotherapy. A stepped care approach which involves applying a series of tiered interventions, with less intensive treatments being offered as a first step, and more intensive, targeted treatments being made available.
contingent on the individual’s response to the previous tier of treatment and their symptoms present has been suggested and tested in several different settings, including depression and smoking cessation.

Within a stepped care framework, a first step for all people who screen positive for nicotine use could include feedback on their screening/assessment, followed by the provision of self-help material, brief guidance and education about the effects of cigarette smoking on health and well being. Suggestions about other lifestyle factors that might be enhanced or reduced may also be included at this time. This could be carried out by general practitioners, incorporating information about the association between depressive symptoms and smoking cessation, especially for those with nonmelancholic depression. At this stage, psychological treatment (such as CBT approaches) could be offered to all people attempting to reduce their smoking, and tailored to include depression-specific components when indicated. It is important to emphasise non-pharmacological treatments for people with depression and substance use comorbidity, with a view to teaching the self-regulation of moods and substance use, while avoiding problematic interactions between medications and alcohol/other drug use.

Patients who continue to report difficulties upon review of depression and nicotine use within one month of receiving the initial phase of treatment could be offered a second step, involving more intensive psychological treatments (such as CBT), which have shown promise in influencing both smoking and depression outcomes.

Following completion of the second step and a screening/assessment review, those people whose depression and/or nicotine use remain problematic could “step up” to the third step where psychological interventions are combined with pharmacotherapy for nicotine use and/or depression. Some individuals would benefit by going directly to the third step: it is likely that heavy smokers (15 per day or more) who are highly nicotine dependent will likely require NRT, and people with a history of past or current melancholic depression or ‘severe’ levels of depression will also require antidepressants. Antidepressants (such as nortriptyline and bupropion) may also be commenced prior to quitting, as adjunct to NRT among those with current depression. Although a study of veterans given both CBT and NRT over a 3 month course recorded no additional benefits with the addition of bupropion to their treatment program, their depression status was not considered during the course of the study. The potential for extended use of NRT as a maintenance therapy in this group should be explored, along with the use of long-term antidepressants following smoking cessation to ameliorate levels of depression, anger and tension amongst smokers with a depression history.

There is currently limited research examining the efficacy of the stepped care framework in clinical settings, and implementation cannot occur without the support of policy makers and the appropriate training of health practitioners in
screening and assessment techniques, CBT and other counselling approaches.

**Research questions**

We need greater understanding of the characteristics of people who persist smoking, despite knowledge of its' adverse effects. This includes understanding the barriers to cessation and the impact of lifestyle factors, depression history and medical illnesses. Overcoming these potential hurdles is likely to involve the encouragement of activities which promote mood stability and maximize health by identifying situations (psychological, interpersonal and medical) that have previously been associated with relapse.

We need focus attention on those who have successfully overcome nicotine dependence and ceased smoking despite a depression history.

A greater understanding is required for whether some ex-smokers need to continue antidepressant or other pharmacological treatments to prevent relapse and assist with weight gain.

We need a greater understanding of the role of antidepressants and their relationship with other pharmacotherapies and other substances (in particular, alcohol and cannabis) in terms of immediate treatment and long-term outcomes. This should include consideration of whether there are differential effects for those with a history of melancholic or bipolar depression.

We need more research to determine the most effective elements of pharmacological and psychological interventions for smoking cessation in depression history smokers who are also more likely to have other mental and physical health problems. Targets for treatment should arguably include relief of nicotine withdrawal and symptoms of depression and anxiety, addressing the specific depression type, mood management and depression relapse prevention, maintenance of smoking cessation and abstinence from other substances (alcohol and cannabis). Individual sessions specifically tailored to the individual’s symptoms and needs may enhance results over group-based CBT. Preliminary research has shown that the development and evaluation of smoking cessation treatment programs targeting the needs of smokers with a history of depression and substance abuse and/or complex medical problems have the potential to impart significant physical and mental health benefits.

We need more understanding of the desirability and likelihood of ceasing all substances simultaneously while taking full advantage of the pharmacological and psychological interventions being offered at the time.

We require more research on how to address currently depressed smokers, who are frequently excluded from clinical research studies despite great clinical need.
More research is needed about the use of reducing smoking as a form of ‘harm minimisation’ among smokers with a high nicotine dependence and psychiatric comorbidity. A recent paper has indicated that smoking 1-4 cigarettes a day confers a significant physical health risk, yet the relationship with mental health, and in particular, depression, is not as clear. Evidence does exists to suggest that smoking reduction improves the chances of making a successful quit attempt at some stage in the future and there are important economic and physical health-related benefits associated with smoking reduction that are relevant to people with schizophrenia and other mental health problems, who consume about half the cigarettes produced. Prisoners similarly have high rates of nicotine dependence and mental health problems and similar health and financial issues.

Finally, we also need to establish how to acknowledge and involve those formal and informal carers who play a significant role in outcome and may have nicotine dependence problems themselves.

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Drug use patterns and mental health of regular amphetamine users during a reported ‘heroin drought’

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ABSTRACT

Aims The present study extends the findings of a pilot study conducted among regular amphetamine users in Newcastle, NSW, in 1998. It compares key features between current participants in a state capital city (Brisbane) and a regional city (Newcastle) and between the 1998 and current Newcastle sample.

Design Cross-sectional survey.

Setting Brisbane and Newcastle, Australia.

Participants The survey was conducted among 214 regular amphetamine users within the context of a randomized controlled trial of brief interventions for amphetamine use.

Measurements Demographic characteristics, past and present alcohol and other drug use and mental health, treatment, amphetamine-related harms and severity of dependence.

Findings The main findings were as follows: (i) the rate of mental health problems was high among regular amphetamine users and these problems commonly emerged after commencement of regular amphetamine use; (ii) there were regional differences in drug use with greater accessibility to a wider range of drugs in a state capital city and greater levels of injecting risk-taking behaviour outside the capital city environment; and (iii) there was a significant increase in level of amphetamine use and percentage of alcohol users, a trend for a higher level of amphetamine dependence and a significant reduction in the percentage of people using heroin and benzodiazepines among the 2002 Newcastle cohort compared to the 1998 cohort.

Conclusions Further longitudinal research is needed to elucidate transitions from one drug type to another and from recreational to injecting and regular use and the relationship between drug use and mental health in prospective studies among users.

Implications Intervention research should evaluate the effectiveness of interventions aimed at: preventing transition to injecting and regular use of amphetamines; toward reducing levels of depression among amphetamine users and interventions among people with severe psychopathology and personality disorders; and toward reducing the prevalence of tobacco dependence among amphetamine users.

KEYWORDS Amphetamines, comorbidity, methamphetamine, polydrug, psychostimulants.
Brief cognitive behavioural interventions for regular amphetamine users: a step in the right direction

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ABSTRACT

Aims The present study sought to replicate and extend a small pilot study conducted by Baker, Boggs & Lewin (2001) which demonstrated that brief interventions consisting of motivational interviewing and cognitive-behaviour therapy (CBT) were feasible and associated with better outcomes compared with a control condition.

Design Randomized controlled trial (RCT).

Setting Greater Brisbane Region of Queensland and Newcastle, NSW, Australia.

Participants The study was conducted among 214 regular amphetamine users.

Measurements Demographic characteristics, past and present alcohol and other drug use and mental health, treatment, amphetamine-related harms and severity of dependence.

Findings The main finding of this study was that there was a significant increase in the likelihood of abstinence from amphetamines among those receiving two or more treatment sessions. In addition, the number of treatment sessions attended had a significant short-term beneficial effect on level of depression. There were no intervention effects on any other variables (HIV risk-taking, crime, social functioning and health). Overall, there was a marked reduction in amphetamine use among this sample over time and, apart from abstinence rates and short-term effects on depression level, this was not differential by treatment group. Reduction in amphetamine use was accompanied by significant improvements in stage of change, benzodiazepine use, tobacco smoking, polydrug use, injecting risk-taking behaviour, criminal activity level, and psychiatric distress and depression level.

Conclusions A stepped-care approach is recommended. The first step in providing an effective intervention among many regular amphetamine users, particularly those attending non-treatment settings, may include provision of: a structured assessment of amphetamine use and related problems; self-help material; and regular monitoring of amphetamine use and related harms. Regular amphetamine users who present to treatment settings could be offered two sessions of CBT, while people with moderate to severe levels of depression may best be offered four sessions of CBT for amphetamine use from the outset, with further treatment for amphetamine use and/or depression depending on response. Pharmacotherapy and/or longer-term psychotherapy may be suitable for non-responders. An RCT of a stepped-care approach among regular amphetamine users is suggested.
The ‘co-morbidity roundabout’: a framework to guide assessment and intervention strategies and engineer change among people with co-morbid problems

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Abstract
This paper describes the nature and consequences of co-morbidity, as applied to co-occurring mental health and alcohol/other drug (AOD) use problems. The ‘co-morbidity roundabout’ is introduced as a useful metaphor for conceptualizing the current experiences of people with co-occurring mental health and AOD use problems. In order to successfully negotiate the ‘roundabout’, the ‘drivers’ (people with co-morbid mental health and AOD use problems) must consider a range of internal and external conditions (knowledge about services, support from family, friends, health providers, motivation to change, etc.), account for their vehicle’s characteristics (other conditions and demands, including social/legal/financial issues), keep their travel itinerary in mind (plans for change including treatment) and navigate through the many detours and dead-ends that they may confront (eligibility for services, accessibility of treatments, etc.). Co-morbidity is a major contributing factor in ‘drivers’ failing to successfully negotiate, or even becoming ‘stuck’ on, the ‘roundabout’. A summary of relevant treatment research is also presented, including descriptions of brief interventions and more intensive treatment approaches. Finally, the ‘co-morbidity roundabout’ metaphor is expanded to assist clinicians to translate the findings from this treatment research into clinical practice. Further suggestions are made for improved navigation through and exit from the ‘roundabout’, including recommendations for the use of a stepped-care approach to the assessment and treatment of clients with co-morbid mental health and AOD use problems. [Kay-Lambkin FJ, Baker AL, Lewin TJ. The co-morbidity roundabout: a framework to guide assessment and intervention strategies and engineer change among people with co-morbid problems. Drug Alcohol Rev 2004;23:407 – 423]

Key words: co-morbidity, stepped care, treatment.

Introduction
Population surveys in recent times have revealed a high co-occurrence of mental health and alcohol/other drug (AOD) use disorders, with the rate of problematic substance use among people with mental health problems being higher than that reported by the general population [1]. For example, in Australia, the National Survey of Mental Health and Well Being (NSMHWB) revealed that around two-thirds of the individuals identified as having a drug-use disorder also met criteria for an anxiety, affective or other mental health problem [2]. Of the 6% of Australians identified in the NSMHWB as having an alcohol use problem, 40% also experienced at least one other co-morbid disorder such as depression [3]. Conversely, one in four respondents to the NSMHWB who had depression also met criteria for an AOD use disorder. However, approximately 50% of the people with depression have co-occurring AOD problems that do not meet strict criteria for a ‘disorder’ [4]. Similar results are seen in anxiety disorders [5].

It would come as no surprise to mental health and AOD health care professionals that co-morbidity is common. Indeed, co-morbidity is the rule rather than the exception in clinical settings. Yet when formulating a treatment plan for people who present with co-morbid problems, it is difficult for clinicians to know where to start. Should the mental health condition be addressed first? Should the substance use problem be resolved as a first step? Should the conditions be addressed in an integrated way, and if so, whose responsibility is it to design and deliver such treatment?
Randomised controlled trial of cognitive behaviour therapy for substance use disorders among people with a psychotic disorder

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ABSTRACT

**Background** Few randomised controlled trials have been aimed specifically at substance use reduction among people with psychotic disorders.

**Aims** To investigate whether a 10-session intervention comprised of motivational interviewing (MI) and cognitive behaviour therapy (CBT) was more efficacious than routine treatment in reducing substance use and improving symptomatology and general functioning.

**Method** A community sample of people meeting diagnostic criteria for a psychotic disorder and reporting hazardous alcohol, cannabis, and/or amphetamine use during the last month was recruited. Participants were randomly allocated to MI/CBT (n=65) or treatment as usual (n=65) and assessed on multiple outcomes at baseline, 15-weeks, 6- and 12-months.

**Results** There was a short-term improvement in depression and a similar trend for cannabis use among those receiving the MI/CBT intervention, together with impacts on general functioning at 12-months. There was no differential benefit of the intervention on substance use at 12-months, except for a potentially clinically important effect on amphetamine use. Assessment and brief advice in the context of ongoing monitoring appeared to have an overall beneficial effect, particularly on alcohol consumption.

**Conclusions** The MI/CBT intervention was associated with modest improvements. Further research is needed to evaluate the specific impacts on regular amphetamine use and to develop more efficacious interventions among regular cannabis users. A stepped care approach to interventions for excessive alcohol consumption among people with a psychotic disorder is recommended.

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INTRODUCTION

The co-occurrence of psychosis and substance use disorders is widespread (Jablensky et al., 2000), as are the adverse effects of substance use on functioning and other outcomes (Addington & Addington, 1998). However, few randomised controlled trials (RCTs) have been specifically aimed at reducing substance use among people with psychotic disorders. Two large RCTs have reported encouraging but short-term effects of single-session motivational interventions among psychiatric hospital inpatients with mixed diagnoses and co-existing alcohol and/or other drug use (AOD) problems (Baker et al., 2002; Hulse & Tait, 2003). In a pilot study among 25 inpatients with early psychosis, Kavanagh et al. (2004) reported that three hours of individual motivational interviewing (MI) over 6-9 sessions within 10 days resulted in significantly better 12-month outcomes. Cognitive behaviour therapy (CBT) has been shown to be effective for alcohol (Shand et al., 2003), cannabis (Copeland et al., 2001) and amphetamine use disorders (Baker et al., 2005a), psychotic symptomatology (Haddock et al., 2003), and in related service contexts (Graham et al., 2004).

In the first RCT to investigate the efficacy of CBT among people with co-existing schizophrenia and substance use disorder, Barrowclough and colleagues (2001) reported modest yet promising findings. They randomly assigned 36 patient-caregiver dyads to either routine care alone or routine care combined with MI and CBT (total 29 sessions) plus a family intervention of 10-16 sessions, over nine months. At each assessment of substance use (3-, 6-, 9- and 12-months after recruitment), there was no statistically significant difference in the percentage of days abstinent relative to baseline. However, the aggregate change in the percentage of days abstinent from all substances over these four time points was significantly greater for the intervention group. In contrast, the same comparison was not statistically significant for the most frequently used substance. Eighteen months following entry to the study, the treatment group had significantly superior general functioning (GAF) and negative symptom scores, but there was no differential effect on the percentage of days abstinent from substances (Haddock et al., 2003). The authors suggested that studies with larger numbers of subjects are required, examining the efficacy of the different components of CBT interventions. The aim of the present study was to investigate whether a 10-session MI/CBT intervention among a relatively large sample of people with psychosis and substance use disorders was more efficacious than routine treatment in reducing substance use and improving symptomatology and general functioning.
METHODS

Design
In the current RCT, all participants provided written informed consent and were assessed at baseline (pre-treatment), 15-weeks (post-treatment), 6- and 12-months following initial assessment. Participants were randomly allocated to one of two groups: (a) treatment condition, comprising ten, one-hour sessions of MI and CBT (in addition to an assessment schedule, treatment as usual and provision of self-help material for substance use); or (b) control condition, which included the provision of self-help material for substance use, treatment as usual, and the same assessment schedule as the treatment condition. Following the initial assessment, participants drew a card from an envelope, which allocated them to either the treatment or control group.

Participants
Participants were 130 regular users of alcohol, cannabis and/or amphetamines with a non-acute psychotic disorder, who were recruited from the Hunter region, 150 kilometres north of Sydney, New South Wales, Australia. Substance use intervention thresholds included: alcohol consumption exceeding National Health and Medical Research Council (NHMRC) recommended levels – an average of four standard drinks per day for men and two standard drinks per day for women (Pols & Hawks, 1992); or at least weekly use of cannabis or amphetamines as recorded on the Opiate Treatment Index (OTI; Darke et al., 1991) for the month prior to initial assessment. Other inclusion criteria were: aged at least 15 years; English speaking; and having a confirmed ICD-10 psychotic disorder. Exclusion criteria were: failure to meet at least one of the specified substance use thresholds; having an organic brain impairment; or intending to move from the geographical area within the subsequent 12 months. Referrals to the present study were received from community health agencies (33.8%), inpatient psychiatric hospital units (33.1%), an early psychosis service (27.7%), media advertisements (3.1%), and the Neuroscience Institute of Schizophrenia and Allied Disorders (NISAD, Loughland et al, 2001) schizophrenia register (2.3%). Participants initially approached through inpatient units were re-contacted two months post discharge and invited to participate in the study.

Procedure
Participants read an information sheet before providing written consent to participate in the study. Parental/guardian consent was sought for people less than 18 years of age. Participants
were informed that they would be randomly assigned to one of two conditions. Each participant was reimbursed $20 for their time, travel and participation on each assessment occasion (but not for treatment sessions). This amount is considered small enough to not unduly influence participants’ responses, but sufficient to reduce non-compliance caused by inconvenience associated with attending assessment sessions. Preferably, treatment sessions were conducted at the research centre or a community clinic. However, if participants were unable to attend these centres, sessions were conducted in the participant’s home. Any participant who missed three consecutive treatment sessions was considered a treatment dropout. Follow-up assessments were conducted by clinical interviewers who were blind to intervention status.

**Measures**

Key demographic, clinical characteristics and outcome measures are reported in this paper. The assessment instruments used have been reported previously (Baker *et al*, 2005b) and are described only briefly here. Data were collected on various demographic characteristics, treatment history (mental health and AOD), and current substance use. Diagnosis in accordance with the ICD-10 was achieved through administering the Diagnostic Interview for Psychosis (DIP; Jablensky *et al*, 2000) and applying the Operational Criteria for Psychosis (OPCRIT; McGuffin *et al*, 1991). The diagnoses obtained from this interview were later collapsed to match the psychosis categories reported in the Low Prevalence Disorders Study of the National Survey of Mental Health and Wellbeing (LPDS: NSMHWB, Jablensky *et al*, 2000): severe depression with psychosis (F32.3); bipolar-mania (F30, F31); schizophrenia (F20); schizoaffective disorder (F25); and other psychosis (F22, F28, F29).

The Drug Use Scale of the OTI (Darke *et al*, 1991, 1992), which was the primary AOD measure, was administered at each assessment. The OTI yields an average daily consumption score for 11 classes of drug during the month (28 days) prior to interview, with weekly use of a single dose of cannabis or amphetamines being equivalent to an OTI score of 0.14 (4/28). The OTI also provides a polydrug use score which identifies the number of drug classes used that month. An aggregate substance use index score was also used as a global measure to describe the number of ‘day equivalents’ of hazardous use. This was necessary because the substance use measures varied in the units recorded (e.g. number of standard drinks vs. number of cannabis use occasions). For each illicit substance, the estimated number of days of consumption in the last 28 days was determined, while, in regards to alcohol, the number of
days that consumption exceeded NHMRC recommended levels was calculated. Ten substances were included in the aggregate index (i.e. excluding nicotine). Thus, it was theoretically possible to have a score ranging from 0-day equivalents to 280-day equivalents. The alcohol use disorders and non-alcohol psychoactive substance use disorders sections of the SCID-I-RV (First et al, 2003) were also used at the baseline assessment and 6- and 12-month follow-ups to determine current, past 12-months, and lifetime substance abuse or dependence. A modified version of Heather and Rollnick’s (1993) Readiness to Change Questionnaire (RCQ) was use to assess stage of change for alcohol, cannabis and amphetamines.

Psychiatric symptomatology was assessed using the Brief Psychiatric Rating Scale (BPRS; Ventura et al, 1993), which was also administered at each assessment occasion. Thomas et al (2004) have recently reviewed the published factor analyses of the 24-item BPRS and undertaken a two-tiered analysis (exploratory and confirmatory factor analyses) of BPRS data from 640 psychiatric inpatients. Unfortunately, their four-factor solution effectively discarded over one-third of the items (9/24), many of which have reasonably consistent loadings in the earlier studies and in Ventura et al (2000). In the interests of finding a more parsimonious solution, we factor analysed the 1,531 sets of BPRS ratings collected as part of the present study and a concurrent treatment study among smokers with a psychotic disorder (see Baker et al, 2005b), comprising a total of 427 participants assessed at baseline and on up to three follow-up occasions. The solution that was extracted, based on a principal components analysis with an oblique rotation, resulted in the assignment of five items to each of four factors (with scores ranging from 5-35 for each factor): factor 1 – mania (motor hyperactivity, excitement, tension, distractibility, elevated mood); factor 2 – dysphoria (depression, guilt, anxiety, suicidality, somatic concern); factor 3 – negative symptoms (blunted affect, emotional withdrawal, motor retardation, disorientation, self-neglect); and factor 4 – positive symptoms (unusual thought content, grandiosity, hallucinations, bizarre behaviour, suspiciousness). These factors are generally consistent with those reported previously (see Table 1 of Thomas et al, 2004 and Ventura et al, 2000) and have acceptable reliability estimates (alpha coefficients): 0.73, 0.75, 0.70, and 0.70, respectively; with an overall reliability estimate of 0.82 for the BPRS total score (range 24-168).

At each assessment occasion, the Beck Depression Inventory II (BDI-II; Beck et al, 1988, 1996) was also employed to measure severity of depression within the preceding two weeks,
while the Global Assessment of Functioning scale (GAF; American Psychiatric Association, 1994) was used to measure overall functioning. On all AOD and psychiatric symptomatology scales, higher scores indicate worse functioning, except for the GAF, where higher scores indicate better functioning.

Components of the intervention
The treatment was manualised (see Baker et al, 2004) and comprised 10 weekly, one hour sessions: MI in sessions 1-4; and CBT in sessions 5-10, with the last two sessions concentrating on relapse prevention for mental health and substance use problems. A treatment contract was established early in the intervention, which outlined both therapist and participant expectations. A therapist checklist, adapted from the National Institute on Drug Abuse (Schuster, 1989), was completed at the end of each treatment session to monitor therapist compliance with core treatment components. Therapists were three state registered psychologists, with a minimum of two years postgraduate clinical training, who received training and weekly clinical supervision from the first author.

Motivational Interviewing (MI)
Treatment sessions commenced with MI the week after the baseline assessment. Therapists worked with the four general principles outlined by Miller and Rollnick (2002), expressing empathy, developing discrepancy, rolling with resistance and supporting self-efficacy. Feedback was given regarding current AOD levels and the possible interaction with symptoms. Information was delivered interactively regarding current substance use and safer consumption levels, covering each problematic substance used (except nicotine). Participants were asked to complete self-monitoring records (Jarvis et al, 1995) for their symptoms and AOD use to prepare them for the subsequent transition into CBT. Therapists also completed a case formulation sheet in collaboration with the participant. When a participant demonstrated that they had arrived at the ‘determination’ or ‘action’ stage of change (Prochaska & DiClemente, 1986), the cognitive behavioural component of the intervention commenced.

Cognitive Behaviour Therapy (CBT)
An agenda was set at the beginning of each session and homework from the previous week’s session was reviewed before continuing with the CBT goals for that session. Material covered in sessions was applied flexibly according to the needs of each individual and included: presenting the rationale for CBT and the process of therapy; the cognitive model of
problematic substance use and psychotic symptoms (Graham et al, 2004); specific techniques for more effectively managing AOD use and symptoms; and identification of situational triggers and beliefs that could lead to substance use and exacerbation of psychotic symptoms (Jarvis et al, 1995; Graham et al, 2004). Finally, identifying and avoiding high-risk situations (Monti et al, 1989) that could lead to maintenance of substance use was explored, and various coping strategies were practiced in the form of role-plays. Other topics included: discussion of seemingly irrelevant decisions (Monti et al, 1989); problem solving strategies (Jarvis et al, 1995); identification and management of “unhelpful” patterns of thinking (Graham et al, 2004); management of cravings, the abstinence/rule violation effect, and drink/drug refusal skills (Monti et al, 1989); and lifestyle issues. The final two sessions focused on relapse prevention strategies (Marlatt & Gordon, 1998).

_Treatment as usual_

Participants were informed that they were using substances at above recommended levels. They received a self-help booklet on substance use (CEIDA, 2000) and encouragement to maintain or increase their engagement with local health services.

_Statistical analysis_

Data were analysed using SPSS for Windows (version 12.0). For the continuous outcome variables (e.g. alcohol, cannabis, amphetamine use), analysis of variance (ANOVA) based planned comparisons were used to examine differences between groups and patterns of change across occasions. Categorical variables were analysed using chi-square tests. As a partial control for the number of statistical tests, the threshold for significance was set at P<0.01.

It should be acknowledged that there are several different analytical strategies for assessing change, each with advantages and disadvantages, ranging from simple change scores (e.g. paired t-tests, or repeated measures ANOVAs), and other more complex linear combinations (e.g. polynomial trend contrasts), to analyses of covariance (ANCOVAs) in which, for example, baseline scores are controlled when assessing differences at follow-up (e.g. Vickers & Altman, 2001). On the one hand, analyses based on traditional change scores may ignore variance (in change) that is associated with baseline levels, leading to treatment estimates with higher variability; in essence, valuing one unit of change as the same across the full range of scores. On the other hand, when baseline differences are real (e.g. naturally occurring
groups), ANCOVAs may introduce directional biases, magnifying post-baseline differences in one direction and masking those in the other (Jamieson, 1999, 2004). What is clear, however, is that decisions about the basic choice of analysis strategy should be made without reference to the data collected (Jamieson, 1999). In the current study, we opted for a traditional change score based approach, in the form of planned comparisons between (blocks of) occasions, from repeated measures ANOVAs, where the primary focus is on group by time interaction contrasts. We also (planned and) conducted preliminary baseline analyses of key (non-outcome) variables to determine their likely suitability as conventional covariates. In this instance, there were no significant differences between the treatment and control groups in key socio-demographic or clinical characteristics (e.g. age, gender, education or marital status, illness onset or course, family history), and, therefore, no covariates were used.

In circumstances, such as the current study, where there are several possible bases for study entry (e.g. separate thresholds for alcohol, cannabis and amphetamine use), and a range of outcomes of interest (e.g. substance use, symptomatology, general functioning), it becomes increasingly difficult to assume that post-randomisation baseline differences between groups (across all of these outcome measures) are essentially measurement error (i.e. not real), and, consequently, appropriate for inclusion in an ANCOVA based strategy for assessing change. One solution may have been to adopt a complex, stratified randomisation procedure, taking account of baseline levels across all (or most) of the key outcome variables in making initial group allocations, but such was not done here.

The current study was primarily concerned with treatment efficacy. That is, whether or not the actual treatments received were associated with the desired outcomes among those who completed the study, whilst noting and/or adjusting for any observed or likely recruitment, allocation or participation biases. Arguably, treatment efficacy needs to be demonstrated first, followed by attempts to optimise treatment implementation and effectiveness in real-world settings. However, to facilitate comparisons with other RCTs, we also conducted a parallel series of traditional intention-to-treat (ITT) or program effectiveness analyses (Wright & Sim, 2003). For these analyses, missing follow-up data were imputed by carrying forward the last available observation.
RESULTS

Characteristics of participants at the baseline assessment

Overall recruitment and attrition profiles are presented in Figure 1. The recruited sample consisted of 130 people with an ICD-10 psychotic disorder and co-existing alcohol, cannabis and/or amphetamine problems (hazardous levels). Baseline (pre-treatment) sample characteristics and patterns of substance use have been reported elsewhere (Baker et al, 2005b). Among those who met the intervention threshold for alcohol use at baseline, 37.7% were at the pre-contemplation stage of change and 26.4% at the contemplation stage, based on RCQ responses (Heather & Rollnick, 1993). The corresponding baseline rates for the other substances were suggestive of somewhat higher levels of motivation to change (cannabis: pre-contemplation, 25.0%; contemplation, 48.8%; and amphetamine: pre-contemplation, 13.6%; contemplation, 50.0%).

The demographic and clinical characteristics of participants who completed the first three assessment occasions (n=119) are reported in Table 1 (58 treatment and 61 control group participants). The mean age was 28.83 years and the majority of the sample was male (78.2%), Australian born (90.8%), single (78.2%), and receiving welfare support (88.2%). Schizophrenia was the primary diagnosis (62.2%), and the majority of the sample met past 12-months and/or lifetime alcohol and cannabis abuse or dependence criteria, whilst 42.0% of the sample reported past 12-months abuse or dependence for amphetamine. The intervention thresholds for current substance use were met by: 43.7% for alcohol (treatment group: 21/58; control group: 31/61); 61.3% for cannabis (treatment group: 39/58; control group: 34/61); and 16.8% for amphetamine (treatment group: 11/58; control group: 9/61). More than half the sample experienced a psychosocial stressor prior to the onset of their disorder. The majority of participants (67.7%) used anti-psychotic medication, which was reported by most (82.9%) as helpful. Approximately two-thirds of participants had at least one hospital admission within the past 12-months.

Treatment attendance and follow-up completion

Among the treatment group, 12.3% (8/65) did not attend any sessions, 16.9% (11/65) attended some sessions, and 70.8% (46/65) attended all ten sessions. Approximately one-fifth of those who completed more than half the treatment sessions (9/50, 18.0%) required six to eight MI
sessions before making the transition to CBT. Overall, 28.3% of treatment sessions (143/506) and 12.6% of assessments (60/478) involved home visits, while 30.5% of follow-up assessments (106/348) were conducted by telephone. There were similar patterns of attendance at the 15-week (93.1%) and 6-month (94.6%) follow-ups, with the lowest participation rate at 12-months (80.0%), although attendance still remained high. Two separate data sets were established to take into account these different patterns of follow-up: (a) participants who completed the baseline, 15-week and 6-month follow-ups (n=119, 91.5%), and (b) participants who completed all four assessments (n=97, 74.6%). There were no significant differences between groups in the patterns of follow-up completion. In the analyses which follow, planned comparisons between the first three assessment occasions were based on the first block (n=119), while comparisons between the final phase and each of the earlier phases were based on the second block (n=97).

Changes in substance use across assessment occasions

Mean baseline, 15-week, 6- and 12-month follow-up scores for the key substances are displayed in Table 2 for participants who were above the relevant substance use thresholds at baseline, together with standardised differences (in effect size units) between baseline and 12-months. As shown in Table 2, there were significant time effects for alcohol, polydrug use and the aggregate hazardous use index, but no group main effects or group by time interactions. Alcohol consumption fell significantly for the sample as a whole, with the 15-week, 6- and 12-month follow-ups yielding lower OTI scores than at baseline. The reduction in alcohol consumption between baseline and 12-months was equivalent to an overall effect size change of 0.80 units. This difference tended to be more marked for the control group (0.97) than the treated group (0.54).

| Insert Table 2 about here |

There were no significant time effects for either cannabis or amphetamine use. For cannabis, the treatment group tended to have higher consumption compared with the control condition initially (8.18 vs. 4.80), and there was a non-significant trend for a differential cannabis reduction between the baseline and 15-week assessments for the treatment group compared with controls ($F_{(1,71)} = 6.25$, $p=0.02$). For this period, mean daily cannabis consumption fell 0.36 standardised units for the treatment group versus -0.02 for the control condition, a
differential change of 0.38 standardised units (a moderate effect size), which was not maintained at the subsequent phases (see Table 2).

For amphetamine, there was a non-significant trend for a differential (baseline vs. 6-months) reduction in amphetamine use in the treatment condition compared to the control condition ($F_{(1,18)} = 4.70, p=0.04$). Mean daily occasions of amphetamine use fell 1.33 standardised units for the treatment condition versus -0.40 for the controls, which represents a differential change of 1.73 standardised units, a large effect size. As shown in Table 2, this differential was less marked (0.95) for the 12-month follow-up, but still strong. Reflecting the significant reduction in alcohol use among the whole sample and the trends towards change in amphetamine use, there was a significant overall reduction in polydrug use scores over time, with significant differences between baseline and each of the follow-up assessments (see Table 2). For the aggregate hazardous use index, a similar pattern emerged.

Table 3 displays the percentage of participants remaining above the alcohol, cannabis and amphetamine thresholds at each follow-up and the corresponding abstinence rates. There were no significant group differences in threshold rates or abstinence rates for any substance at any phase.

Changes in symptomatology over assessment occasions
Table 4 shows symptom profiles for the intervention and control groups, together with standardised change scores between baseline and 12-months. There was a significant improvement between baseline and 12-months on the BPRS mania factor, and between baseline and each of the follow-up occasions on the BPRS negative symptoms factor. The overall standardised change in BPRS negative symptoms between baseline and 12-months was around half a standard deviation. There were no other significant effects for the BPRS scales (i.e. for dysphoria, positive symptoms, or BPRS total scores). BDI-II depression scores were also significantly lower at each of the follow-up occasions compared to baseline, with a more marked reduction between baseline and 6-months among the intervention group compared with the control group (0.78 versus 0.28 standardised units, or a half a standard deviation differential impact). While there were no main effects in the GAF analyses, there was a significant group by time interaction, with a deterioration in global functioning between
baseline and 12-months for the control group and a small improvement in the treatment group. This is reflected in the standardised change scores for this variable being negative for the treatment group, indicating an improvement in functioning. Thus, the fall of -0.15 units in the treatment condition versus 0.43 for the control condition represents a differential impact of over half a standard deviation (0.58), a moderate effect size.

Insert Table 4 about here

**Intention-to-treat analyses (ITT)**

A series of ITT analyses was also conducted that paralleled those reported in Tables 2 to 4. Reflecting the relatively low attrition rate in this study (see Figure 1), there were no differences in the patterns of significance from those already reported. That is, all of the statistically significant planned comparisons reported in Tables 2 and 4 remained significant after imputation of missing data and there were no additional effects that reached significance. To facilitate comparisons with other RCTs utilising ITT analyses, Tables 2 and 4 also report standardised differences (in effect size units) between baseline and 12-months for the ITT data set. Likewise, Table 3 reports ITT based abstinence rates for each of the follow-up occasions.

**DISCUSSION**

The current study appears to be the first moderately sized RCT of an MI/CBT intervention for AOD use among a sample of people with psychosis. Collectively, there was little evidence of treatment specific benefits, with no statistically significant differential improvements in substance use at 12-months (see Table 2), nor any differences in abstinence rates between the treatment and control conditions (see Table 3). However, among those receiving the MI/CBT intervention, there were: short-term improvements in depression (differential impact at 6 months: 0.50 standardised units); a similar, but less marked trend for cannabis use (differential impact at 3 months: 0.38 standardised units); effects on general functioning (differential impact at 12 months: 0.58 standardised units); and a potentially clinically important effect on amphetamine use (differential impact at 12 months: 0.95 standardised units). As detailed below, whilst the overall results of this 10-session intervention were modest, they were, nevertheless, similar to those obtained from a longer and more complex intervention reported by Barrowclough and colleagues (2001; Haddock et al, 2003) among a sample of 36 patient-caregiver dyads.
Modest differential treatment benefits for AOD use

Both the study by Barrowclough and colleagues (2001; Haddock et al, 2003) and the present study reported short-term benefits of intervention on substance use. At pre-treatment, their MI/CBT group had a median of 19.1% days abstinent from all substances, which was approximately doubled across the treatment and follow-up phases. Minimal changes in substance use were reported by the control condition. In the present study, heavy users of cannabis appeared to benefit from the intervention whilst it was being conducted, but cannabis use returned to previously high levels once the intervention was completed. There was also a potentially clinically important treatment benefit for amphetamine use. Although not statistically significant, possibly due to the low numbers of regular amphetamine users, the large effect size associated with the intervention, combined with previous evidence of the effectiveness of CBT among regular amphetamine users (Baker et al, 2005a), suggests that further studies of CBT among people with psychotic and amphetamine use disorders should be conducted. However, some caution needs to be exercised in relation to the current amphetamine findings, as the control group had a relatively low baseline rate, and therefore less opportunity to demonstrate change, but conversely, they had the highest abstinence rate at 12-months (see Tables 2 and 3).

Treatment effects for current functioning and depression

Barrowclough and colleagues selected the GAF as their primary outcome measure, specifically to enable the detection of overall changes in symptoms and functioning resulting from the interaction between psychosis and substance use and the multi-component nature of their intervention. Both the present study and Barrowclough et al (2001, Haddock et al, 2003) reported differential improvement in blindly rated GAF scores at the final follow-up (12-months in the present study, 18- months in the Barrowclough study, both of which occurred nine months post-treatment). In the current study, this was due primarily to a deterioration in GAF scores among the control group, with a net change of 0.58 standardised units, whereas the net change of 0.76 units in the Barrowclough study was due to the sustained superiority in GAF scores for the CBT group (2001, Haddock et al, 2003). Notwithstanding this, two RCTs have shown that interventions comprising MI and CBT for substance use problems among people with psychosis can impact on general functioning. A modest, delayed advantage of CBT on GAF scores at 12-months was also reported by Kemp and colleagues (1998), following a ‘compliance therapy’ intervention. To help clarify the relevance of these changes
in functioning, future studies of MI and CBT interventions should include the GAF, together with symptomatology and substance use measures. Haddock et al (2003) also recommend that further trials should seek to identify the active and most important ingredients of successful therapy.

As we have noted previously (Baker et al, 2005b), the current sample had relatively high levels of functioning. Their average GAF score at baseline was 68.75 (SD=12.80, n=130), which was approximately 33% higher than that reported in Barrowclough et al’s study (2001; Haddock et al, 2003) and 85% higher than that reported in Kemp et al’s (1998) inpatient study. Perhaps people who present or are referred to community-based treatment studies are generally better functioning than those recruited directly from mental health service contexts. In any event, the outcomes of treatment studies based on better functioning or more highly motivated samples may not generalize to other treatment contexts. Higher levels of functioning at baseline may influence treatment engagement and retention but they may also make it more difficult to detect particular treatment benefits. For example, higher functioning individuals with co-existing psychotic and alcohol use disorders may respond positively to the assessment process and advice to reduce use, within the context of ongoing monitoring.

Barrowclough and colleagues (2001; Haddock et al, 2003) also reported significant benefits of intervention compared to routine care at 12-months on positive symptoms and relapse rates, and at 9-, 12-, and 18-months for negative symptoms. As noted previously, there was a relatively low rate of psychotic symptoms among the current sample (Baker et al, 2005b). There was a reduction in negative symptoms (and, to a lesser extent, mania scores) across the sample as a whole in the present study. The observed initial improvement in depression among the treatment group is likely to have been due to either the generalization of cognitive and behavioural strategies for substance use to low mood or to the non-specific support received in attending therapy. The possible non-specific effect of CBT for substance use on depression has previously been noted by us in a study among regular amphetamine users (Baker et al, 2005a). Thus, it appears that people with concurrent depression and substance use disorders (whether or not accompanied by psychosis) may derive at least short-term benefits in terms of mood from CBT for substance use disorder.
Possible study participation effects

There were significant improvements over time for the sample as a whole for alcohol consumption, polydrug use, and on the aggregate hazardous use index. Similar improvements in alcohol use were reported for the sample as a whole in the study by Baker et al. (2002) among psychiatric inpatients. Hulse and Tait (2003) also reported that, compared with matched controls, general hospital psychiatric inpatients (10% with psychosis) who received either a motivational interview or an information pack had significantly fewer mental health inpatient episodes and other health benefits. They suggested that information plus the research process (assessment, etc), plus psychiatric treatment, may be sufficient to bring about change.

The need for alternative approaches

In combination, the findings from the present study, previous RCTs (Barrowclough et al., 2001; Haddock et al., 2003) and recent reviews of this treatment outcome literature (Baker & Dawe, 2005; Kay-Lambkin et al., 2004), suggest that a more complex framework is needed, which integrates the available evidence into a coherent treatment and research strategy. A stepped care approach to treatment is one such framework, within which a series of tiered interventions are applied, with less intensive treatments being offered first, and more intensive, targeted treatments being made available contingent on the clients’ response to the previous tier of treatment (Schippers et al., 2002; Baker & Dawe, 2005). Stepped care approaches have been tested in several different settings, including: depression (Scogin et al., 2003); anxiety (Baillie & Rapee, 2004); alcohol problems (Sobell & Sobell, 2000); smoking (Smith et al., 2001); and heroin dependence (King et al., 2002).

The excellent therapy attendance figures attest to the beneficial experiences of participants in therapy. Approximately 70% of the present sample attended all ten therapy sessions and the median attendance in the Barrowclough et al. (2001) study was 22 sessions. Clearly, this challenging client group is able to be engaged in CBT and appear to derive benefits from it. By examining changes in the percentages of participants remaining above the initial substance use intervention thresholds (see Table 3), we can also gain insight into the intensity of interventions that may be required. For example, in the control condition more than two-thirds of those meeting intervention thresholds for alcohol or amphetamine were already below those thresholds at 15-weeks. Such findings reinforce the available research evidence that even minimal “control” interventions (including assessment alone) can result in significant changes. For some people, giving brief advice, within the context of ongoing assessment and
monitoring, may be sufficient to stimulate the initiation of changes in life circumstances. For others, specific therapy programs may be required. For example, in both the current study and our previous study among psychiatric inpatients (Baker et al., 2002), more than 50% of cannabis users remained above the intervention threshold at 12-months.

Limitations
Finally, there are several study limitations that need to be acknowledged. We did not evaluate the psychometric properties of the key self-report or clinician rated measures within the current sample (particularly, inter-rater reliability). However, the OTI has similar features to other timeline follow-back substance use measures and has been found to have acceptable validity (Darke et al., 1992), while the BPRS (Ventura et al., 1993) and BDI (Beck et al., 1988) have well established properties. Likewise, inter-rater reliabilities on the GAF were not measured but have been documented by Startup et al. (2002) and found to be satisfactory. Similarly, there was no formal assessment of breaks in blindness, however, this was unlikely to have been a problem, with the clinicians conducting the follow-up interviews reporting that participants appreciated the importance of the request not to disclose their group allocation. The absence of a supportive counselling or other non-specific control condition means that we cannot determine the extent to which any of the benefits were due primarily to therapist contact. Also, therapy sessions were not tape-recorded, however, a therapist checklist was completed at the end of each treatment session. Direct ratings of therapist adherence to the treatment manual should probably be included in future studies. Another area for possible concern relates to sample representativeness. Relative to the study by Barrowclough et al. (2001), there were differences in levels of current functioning and in the nature and duration of the interventions. However, despite differences in sampling strategies and interventions delivered, there were broad similarities in the findings. Recruitment and retention of sufficiently large samples is always a methodological concern. In addition, studies such as this and the Barrowclough et al. (2001) study typically have lower statistical power to detect differences among users of particular substances than overall treatment effects on aggregate indexes of substance use, as illustrated by the uncertainties associated with the low numbers of regular amphetamine users in the current study. Finally, while we would encourage clinicians to use the treatment manual prepared for this study (Baker et al., 2004), further research is needed to develop more effective MI/CBT interventions among people with psychosis who use substances heavily, especially cannabis, and to extend these
interventions to young people with mental health problems who have not yet progressed to
substance dependence.

**Clinical implications**

- Over two-thirds of the current sample of people with psychotic disorders who were
assigned to an MI/CBT (motivational interviewing and cognitive behaviour
therapy) intervention for substance use attended all 10 treatment sessions.

- There was a short-term improvement in depression and a similar trend for cannabis
use among those receiving the MI/CBT intervention, together with improved general
functioning at 12-months. There was no differential benefit of the intervention on
substance use at 12-months, except for a potentially clinically important effect on
amphetamine use.

- Assessment and brief advice in the context of ongoing monitoring appeared to have
an overall beneficial effect, particularly on alcohol consumption, prompting calls
for a consideration of alternative approaches, such as stepped care.

**Limitations**

- There was no control for the extra therapy time associated with the MI/CBT
intervention, therapy sessions were not recorded, and inter-rater reliability was not
assessed.

- At recruitment, there were low numbers of participants currently using
amphetamines.

- The relatively high levels of functioning in the current sample may have
compromised the generalizability of study findings.
ACKNOWLEDGEMENTS

This work was funded by the National Health and Medical Research Council (grant number: 100967). In particular, we would like to thank the participants, Hunter Mental Health, the ward and medical staff at James Fletcher Hospital, and the Psychological Assistance Service (PAS) for their enthusiasm and support. The authors would also like to thank the NISAD Schizophrenia Research Register, Australia, for assisting with the recruitment of volunteers participating in this research.
REFERENCES


Table 1: Characteristics of participants who completed the baseline, post-treatment and 6-month follow-up phases (n=119)

<table>
<thead>
<tr>
<th>Participants’ characteristics</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Demographic factors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean age (years) (SD, range)</td>
<td>28.83 years (10.27, 15-61)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>78.2%</td>
<td></td>
</tr>
<tr>
<td>Australian born</td>
<td>90.8%</td>
<td></td>
</tr>
<tr>
<td>Single, never married</td>
<td>78.2%</td>
<td></td>
</tr>
<tr>
<td>Mean age left school (years) (SD, range) (n=116)</td>
<td>16.01 (1.50, 10-20)</td>
<td></td>
</tr>
<tr>
<td>Post-school qualifications obtained</td>
<td>65.5%</td>
<td></td>
</tr>
<tr>
<td>Receiving welfare support</td>
<td>88.2%</td>
<td></td>
</tr>
<tr>
<td><strong>ICD-10 primary diagnosis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe depression with psychosis</td>
<td>4.2%</td>
<td></td>
</tr>
<tr>
<td>Bipolar, mania</td>
<td>9.2%</td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>62.2%</td>
<td></td>
</tr>
<tr>
<td>Schizoaffective disorder</td>
<td>12.6%</td>
<td></td>
</tr>
<tr>
<td>Other psychosis</td>
<td>11.8%</td>
<td></td>
</tr>
<tr>
<td><strong>SCID-1 diagnosis of abuse (only) / dependence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- past 12-months</td>
<td>11.8% / 55.5%</td>
<td></td>
</tr>
<tr>
<td>- lifetime</td>
<td>13.4% / 72.3%</td>
<td></td>
</tr>
<tr>
<td>Cannabis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- past 12-months</td>
<td>7.6% / 65.5%</td>
<td></td>
</tr>
<tr>
<td>- lifetime</td>
<td>6.7% / 82.4%</td>
<td></td>
</tr>
<tr>
<td>Amphetamine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- past 12-months</td>
<td>10.1% / 31.9%</td>
<td></td>
</tr>
<tr>
<td>- lifetime</td>
<td>10.1% / 43.7%</td>
<td></td>
</tr>
<tr>
<td><strong>Patterns of substance use (OTI past month)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol status: ≥hazardous use (NHMRC)</td>
<td>43.7%</td>
<td></td>
</tr>
<tr>
<td>Cannabis status: ≥weekly use</td>
<td>61.3%</td>
<td></td>
</tr>
<tr>
<td>Amphetamine status: ≥weekly use</td>
<td>16.8%</td>
<td></td>
</tr>
<tr>
<td><strong>Illness factors</strong></td>
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<tr>
<td>Family history of schizophrenia</td>
<td>36.1%</td>
<td></td>
</tr>
<tr>
<td>Psychosocial stressor prior to onset of illness</td>
<td>60.5%</td>
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<tr>
<td><strong>Course of psychotic disorder:</strong></td>
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<td></td>
</tr>
<tr>
<td>- Single episode, good or unknown recovery</td>
<td>19.3%</td>
<td></td>
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<tr>
<td>- Multiple episodes, good recovery</td>
<td>41.2%</td>
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<tr>
<td>- Multiple episodes, minimal recovery or deterioration</td>
<td>30.3%</td>
<td></td>
</tr>
<tr>
<td>- Chronic, clear deterioration</td>
<td>9.2%</td>
<td></td>
</tr>
<tr>
<td><strong>Medication</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Usage of anti-psychotic medication</td>
<td>67.7%</td>
<td></td>
</tr>
<tr>
<td>- Anti-psychotic medication helpful</td>
<td>82.9%</td>
<td></td>
</tr>
<tr>
<td><strong>Mean age of onset of illness (years) (SD, range)</strong></td>
<td>19.32 (6.70, 5-38)</td>
<td></td>
</tr>
<tr>
<td><strong>Service utilisation (past 12-months)</strong></td>
<td></td>
<td></td>
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<tr>
<td>Hospital admissions (past 12-months)</td>
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<td></td>
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<tr>
<td>- At least one admission</td>
<td>62.3%</td>
<td></td>
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<tr>
<td>- Mean number of admissions (SD, range) (n=81)</td>
<td>1.03 (1.22, 0-6)</td>
<td></td>
</tr>
<tr>
<td>- Average length of admission (days) (SD, range) (n=78)</td>
<td>28.91 (22.95, 7-105)</td>
<td></td>
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</tbody>
</table>
Table 2 Substance use patterns across phases

<table>
<thead>
<tr>
<th>Group/Phase</th>
<th>Estimated daily consumption during past month (OTI)</th>
<th>Aggregate Hazardous Use Index (day equivalents)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Alcohol</td>
<td>Cannabis</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>Mean (SD)</td>
</tr>
<tr>
<td>Treatment (T)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline (B)</td>
<td>21</td>
<td>6.15 (4.94)</td>
</tr>
<tr>
<td>15-weeks (15W)</td>
<td>21</td>
<td>4.92 (4.69)</td>
</tr>
<tr>
<td>6-months (6M)</td>
<td>21</td>
<td>3.73 (4.07)</td>
</tr>
<tr>
<td>12-months (12M)</td>
<td>18</td>
<td>3.58 (4.80)</td>
</tr>
<tr>
<td>Control (C)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline (B)</td>
<td>31</td>
<td>6.30 (4.49)</td>
</tr>
<tr>
<td>15-weeks (15W)</td>
<td>31</td>
<td>3.35 (4.10)</td>
</tr>
<tr>
<td>6-months (6M)</td>
<td>31</td>
<td>2.52 (4.20)</td>
</tr>
<tr>
<td>12-months (12M)</td>
<td>28</td>
<td>2.19 (3.04)</td>
</tr>
</tbody>
</table>

Standardised change between B and 12M (effect size units)²

| Group/Phase      |     |                  |     |                  |     |                  |     |                  |
| Treatment        | 18  | 0.54 [0.52]      | 29  | 0.04 [0.14]      | 9   | 1.28 [1.00]      | 44  | 0.21 [0.31]      | 44  | 0.48 [0.43]      |
| Control          | 28  | 0.97 [0.93]      | 29  | 0.06 [0.01]      | 8   | 0.33 [0.13]      | 53  | 0.40 [0.28]      | 53  | 0.58 [0.51]      |
| Overall          | 46  | 0.80 [0.77]      | 58  | 0.01 [0.08]      | 17  | 0.83 [0.62]      | 97  | 0.31 [0.30]      | 97  | 0.53 [0.47]      |

Pattern of significant differences³

| Time:             |     |                  |     |                  |     |                  |     |                  |
| Treatment v 15W:  | F(1,50)=7.34*  |     |                  |     |                  |     |                  |
| B v 6M: F(1,50)=14.95** |     |                  |     |                  |     |                  |
| B v 12M: F(1,44)=16.57** |     |                  |     |                  |     |                  |

| Time:             |     |                  |     |                  |     |                  |     |                  |
| Control v 15W:    | F(1,117)=12.48** |     |                  |     |                  |     |                  |
| B v 6M: F(1,117)=16.19** |     |                  |     |                  |     |                  |
| B v 12M: F(1,95)=9.91* |     |                  |     |                  |     |                  |

OTI, Opiate Treatment Index.

1 Excludes participants who were below the relevant substance use threshold at baseline. Data (means, SD) for B, 15W, 6M are for participants who completed the first three assessment phases, and 12M is for participants who completed all four assessment occasions.

2 Using as a reference point the grand standard deviation for the relevant variable (i.e. across all assessment occasions). Values in square brackets are from comparable ITT based analyses.

3 There were no significant Treatment vs. Control differences for any substance (either as main effects or interactions).

* P<0.01.     ** P<0.001.
Table 3  Threshold and abstinence rates at follow-up for the key substances: alcohol, cannabis, and amphetamine

| Group/Phase     | Alcohol N | % Above threshold | % Abstinent | | | Cannabis N | % Above threshold | % Abstinent | | | Amphetamine N | % Above threshold | % Abstinent |
|-----------------|-----------|-------------------|-------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| Treatment (T)   | [22]      |                   |             | | | [45]          |                  |               | | | [13]           |                  |               |
| 15-weeks (15W) | 21        | 52.4              | 9.5 [13.6]  | | | 39             | 64.1            | 23.1 [22.2]     | | | 11             | 36.4           | 54.5 [46.2]     |
| 6-months (6M)   | 21        | 38.1              | 9.5 [13.6]  | | | 39             | 69.2            | 25.6 [26.7]     | | | 11             | 35.4           | 45.5 [38.5]     |
| 12-months (12M) | 18        | 38.9              | 11.1 [13.6] | | | 29             | 58.6            | 37.9 [33.3]     | | | 9              | 33.3           | 55.6 [38.5]     |
| Control (C)     | [32]      |                   |             | | | [37]           |                  |               | | | [10]           |                  |               |
| 15-weeks (15W) | 31        | 32.3              | 12.9 [12.5] | | | 34             | 73.5            | 23.5 [21.6]     | | | 9              | 22.2           | 44.4 [40.0]     |
| 6-months (6M)   | 31        | 22.6              | 22.6 [21.9] | | | 34             | 61.8            | 35.3 [35.1]     | | | 9              | 33.3           | 44.4 [50.0]     |
| 12-months (12M) | 28        | 17.9              | 21.4 [18.8] | | | 29             | 55.2            | 34.5 [27.0]     | | | 8              | 0.0            | 87.5 [70.0]     |

1 Excludes participants who were below the relevant substance use threshold at baseline. Data for 15W and 6M are for participants who completed the first three assessment phases, and 12M is for participants who completed all four assessment occasions. Values in square brackets are from comparable ITT based analyses.

2 There were no significant Treatment vs. Control differences for any phase.
Table 4 Symptom scores across phases

<table>
<thead>
<tr>
<th>Group/Phase</th>
<th>BPRS Total score</th>
<th>Mania</th>
<th>Negative symptoms</th>
<th>BDI-II</th>
<th>GAF</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean (SD)</td>
<td>N</td>
<td>Mean (SD)</td>
<td>N</td>
</tr>
<tr>
<td>Treatment (T)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline (B)</td>
<td>58</td>
<td>36.76 (14.40)</td>
<td>58</td>
<td>6.79 (3.77)</td>
<td>58</td>
</tr>
<tr>
<td>15-weeks (15W)</td>
<td>58</td>
<td>35.31 (9.04)</td>
<td>58</td>
<td>6.43 (2.46)</td>
<td>58</td>
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<tr>
<td>6-months (6M)</td>
<td>58</td>
<td>35.47 (9.34)</td>
<td>58</td>
<td>6.38 (2.23)</td>
<td>58</td>
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<tr>
<td>12-months (12M)</td>
<td>44</td>
<td>35.43 (8.59)</td>
<td>44</td>
<td>6.07 (1.63)</td>
<td>44</td>
</tr>
<tr>
<td>Control (C)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline (B)</td>
<td>61</td>
<td>35.51 (11.12)</td>
<td>61</td>
<td>7.39 (3.51)</td>
<td>61</td>
</tr>
<tr>
<td>15-weeks (15W)</td>
<td>61</td>
<td>34.46 (11.24)</td>
<td>61</td>
<td>6.57 (3.56)</td>
<td>61</td>
</tr>
<tr>
<td>6-months (6M)</td>
<td>61</td>
<td>34.52 (8.53)</td>
<td>61</td>
<td>6.18 (2.32)</td>
<td>61</td>
</tr>
<tr>
<td>12-months (12M)</td>
<td>53</td>
<td>32.58 (8.19)</td>
<td>53</td>
<td>5.94 (2.26)</td>
<td>53</td>
</tr>
</tbody>
</table>

Standardised change between B and 12M (effect size units)\(^2\)

<table>
<thead>
<tr>
<th></th>
<th>Treatment</th>
<th>Control</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time:</td>
<td>B v 12M: F(_{1,95})=8.46(^*)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>B v 15W: F(_{1,95})=13.66(^**)</td>
<td>B v 6M: F(_{1,95})=18.45(^**)</td>
<td>B v 12M: F(_{1,95})=14.57(^**)</td>
</tr>
<tr>
<td></td>
<td>B v 15W: F(_{1,95})=20.41(^**)</td>
<td>B v 6M: F(_{1,95})=36.34(^**)</td>
<td>B v 12M: F(_{1,95})=21.59(^*)</td>
</tr>
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<td>Group x Time:</td>
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<td></td>
<td>B v 6M: F(_{1,117})=8.02(^*)</td>
<td></td>
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</tbody>
</table>

BPRS, Brief Psychiatric Rating Scale. BDI-II, Beck Depression Inventory II. GAF, Global Assessment of Functioning.

1. Data (means, SD) for B, 15W, 6M are for participants who completed the first three assessment phases, and 12M is for participants who completed all four assessment occasions.
2. Using as a reference point the grand standard deviation for the relevant variable (i.e. across all assessment occasions). Values in square brackets are from comparable ITT based analyses.
3. For this variable, negative effect sizes indicate an improvement in functioning over time.
4. There were no significant Treatment vs. Control main effects.

* P<0.01. ** P<0.001.
Fig. 1 Recruitment and attrition profiles.