

## Improvement in measures of psychological distress amongst amphetamine misusers treated with brief cognitive–behavioural therapy (CBT)

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### Abstract

This trial of cognitive–behavioural therapy (CBT) based amphetamine abstinence program ( $n=507$ ) focused on refusal self-efficacy, improved coping, improved problem solving and planning for relapse prevention. Measures included the Severity of Dependence Scale (SDS), the General Health Questionnaire-28 (GHQ-28) and Amphetamine Refusal Self-Efficacy. Psychiatric case identification (caseness) across the four GHQ-28 sub-scales was compared with Australian normative data. Almost 90% were amphetamine-dependent ( $SDS\ 8.15 \pm 3.17$ ). Pre-treatment, all GHQ-28 sub-scale measures were below reported Australian population values. Caseness was substantially higher than Australian normative values {Somatic Symptoms (52.3%), Anxiety (68%), Social Dysfunction (46.5%) and Depression (33.7%)}. One hundred and sixty-eight subjects (33%) completed and reported program abstinence. Program completers reported improvement across all GHQ-28 sub-scales {Somatic Symptoms ( $p<0.001$ ), Anxiety ( $p<0.001$ ), Social Dysfunction ( $p<0.001$ ) and Depression ( $p<0.001$ )}. They also reported improvement in amphetamine refusal self-efficacy ( $p<0.001$ ). Improvement remained significant following intention-to-treat analyses, imputing baseline data for subjects that withdrew from the program. The GHQ-28 sub-scales, Amphetamine Refusal Self-Efficacy Questionnaire and the SDS successfully predicted treatment compliance through a discriminant analysis function ( $p<.001$ ).

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## 1. Introduction

In Australia, psychostimulant (predominantly, amphetamine, cocaine, 3,4-methylenedioxymethamphetamine [ecstasy]) use is widespread. Domestically produced methamphetamine is currently the most readily available form of amphetamine. In the 2004 Australian National Drug Household Study, approximately one in ten persons aged 14 years or older reported amphetamine use on at least one occasion, approximately 1.5 million people. Just over one-third of these used in the preceding year (Australian Institute of Health and Welfare [AIHW], 2005). Amphetamine is the second most commonly used illicit drug after cannabis (AIHW, 2005). Use commonly involves multiple drug classes and represents a pattern of polydrug use predominantly amongst injecting drug users (IDUs) (Jenner & McKetin, 2004). Methamphetamine injection is far more common than intravenous cocaine use while MDMA (ecstasy) injection is rare.

Psychiatric disorders are three times more likely to co-occur in people with a substance use disorder (Sinha & Schottenfeld, 2001). An early Australian study of injecting amphetamine users reported a high occurrence of psychological problems (Hall, Hando, Darke, & Ross, 1996). Following first use of amphetamines, symptoms reported included anxiety, panic, depression, mania, hallucinations and paranoia (Hall et al., 1996). Factors significantly associated with mental health problems and amphetamine use includes: severity of amphetamine dependence, number of mental health problems prior to amphetamine use, recent amphetamine use and frequency of benzodiazepine use (Vincent, Shoobridge, Ask, Allsop, & Ali, 1999). The Australian National Household Survey included an instrument developed for screening populations for psychological distress (Kessler et al., 2002). This estimated the level of anxiety and depressive symptoms experienced by participants in the preceding 4-week period. Approximately 30% of those who reported amphetamine use in the preceding month recorded “high” or “very high” levels of psychological distress (AIHW, 2005).

The literature on amphetamine treatments is limited in both quantity and quality and this is particularly so among primary users (Baker & Lee, 2003). There is no widely accepted pharmacotherapy for amphetamine dependence (Gowing, Proudfoot, Henry-Edwards, & Teeson, 2001). Psychosocial interventions are the current treatment of choice and the available evidence favours relapse prevention and other cognitive-behavioural therapy (CBT) approaches (Baker & Lee, 2003). Recently, a stepped-care model has been proposed (Baker et al., 2005). This is based on intervention location [whether a non-treatment setting or treatment centre] and the presence or absence of depression (Baker et al., 2005).

Limited information is available on the effect of brief treatment interventions on measures of psychological distress amongst amphetamine users presenting for treatment. In this study, in addition to CBT program completion rates and a compliance measure (urinalysis) of amphetamine abstinence on treatment completion, we have applied the General Health Questionnaire (GHQ-28) as an outcome measure. The GHQ is designed to identify short-term changes in mental health. It focuses on two main classes of phenomena: the inability to carry out one's normal healthy functions and the emergence of new phenomena that are distressing (Goldberg & Williams, 1991). It includes four sub-scales: Somatic Symptoms, Anxiety and Insomnia, Social Dysfunction and Severe Depression.

Treatment was directed at improvement in participant's management of life's stressors and included coping skill training, exposure to techniques of modelling, role play and behavioural reversal.

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