

“Methamphetamine: Myths & Facts”

“The improvement of understanding is for two ends: first, our own increase of knowledge; secondly, to enable us to deliver that knowledge to others.”

John Locke (1632-1704)

Speed, Tweak, White cross, and Yellow cross. In a smokable form it is known as: Cristy, Hanyak, Ice, L.A. glass, and Quartz.

Routes of Administration

Methamphetamine can be manufactured in several forms. It can be taken orally as a pill or tablet or snorted as a powder. It can be mixed with a small amount of water and be injected intravenously. Methamphetamine powder can be “smoked” when heated on aluminum foil and the vapor is inhaled. Another “smoking” method, very popular in Hawaii, is to process the methamphetamine into clear crystals, referred to as “Ice” or “glass” and inhale the vapor from the heated product. Of these three routes the injection and smoking methods lead to the most intense effect, or “rush”.

A Brief History of Methamphetamine

Amphetamine, the forerunner to methamphetamine, became commercially available in 1932 as a nasal spray to treat asthma. By 1937 amphetamines were being used to treat narcolepsy, a sleep disorder, and attention deficit/hyperactivity disorder.

The next three issues of the Addiction Messenger will provide you with information on the stimulant drug methamphetamine and what we know about treating methamphetamine dependence. You probably have clients who have used methamphetamine and you may have questions about how the drug has affected them, best or recommended treatment approaches for those who are dependent, and what your clients can do to prevent a relapse. This series of articles will address these questions.

Street Names for Methamphetamine

Some common street names for methamphetamine include: Crank, Crypto, Crystal, Crystal meth, Meth, Quill,

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ders. Since then, new and more potent forms of amphetamine have been developed: dextro-amphetamine sulfate and methamphetamine.

Due to its stimulant properties methamphetamine were used initially as performance enhancers. Methamphetamine was used by soldiers during WWII to fight fatigue and boost performance and by pilots to stay awake for long periods of time. After WWII, Japan made their military supply of methamphetamine available to the public and intravenous methamphetamine abuse became epidemic in Japan.

In the 1950s methamphetamine was used legally in America by truckers, athletes, and students. During this period the use of stimulants was not considered a form of substance abuse. The dangers of methamphetamine use became more apparent in the 1960s with its intravenous use by a sub-culture of young people who became known as "speed freaks". Concern over the abuse and dependence produced by pharmaceutical amphetamine products led to substantial restrictions on their use and availability. As the supply of pharmaceutical methamphetamine decreased, the illicit production of the drug increased in the black market. In 1965 federal control measures on production were employed and the 1970s saw a nationwide decrease in its production and distribution.

The continuing demand for methamphetamine led to illegal laboratory production. Since these laboratories smuggled in methamphetamine production precursor chemicals from Mexico, they were initially located in the American West and Southwest and often associated with motorcycle gangs. By the mid-1980s the number of these makeshift labs in rural communities mushroomed, especially in California and Oregon.

Methamphetamine began being smuggled into Hawaii from the Philippines, Taiwan and South Korea during this time and was widespread throughout the state by 1988. The methamphetamine epidemic has been historically regional. Although most of its use has been in the western States and Hawaii, there is concern about an increase in methamphetamine trafficking in the Southwest, Midwest and some southeast regions in America.

Myths and Facts

Myth: Special treatment programs are needed to treat individuals with methamphetamine dependence.

Fact: Every individual requires a treatment plan that is aimed at their particular needs and situation. Treatment does work for those addicted to methamphetamine. Treatment for methamphetamine dependence includes many of the elements of effective treatment protocols for other substance use disorders. Treatment providers, however,

may need special training to understand and treat the nature and severity of symptoms experienced by methamphetamine addicts.

Myth: 93% of methamphetamine addicted clients will relapse within 6 months of treatment.

Fact: Addiction is a chronic and relapsing disorder. A study conducted by CSAT, the Methamphetamine Treatment Project, found that half of their participants resumed methamphetamine use. Within the first six months 36% relapsed, with another 15% within seven to 19 months. What seems clear is that treatment episodes of 90 days or more with a strong relapse component produce better outcomes than briefer periods of treatment.

Myth: Clients addicted to methamphetamine do not complete treatment.

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Fact: An analysis of completion rates done by Washington State's Division of Alcohol and Substance Abuse (DASA) shows that the rates are not very different than those of other illicit drugs.

Myth: Methamphetamine addiction is unique and creates damage unlike other drugs including alcohol.

Fact: The process of addiction to all psychoactive substances has many similarities. All addictive drugs can cause physiological damage. Methamphetamine, like alcohol and some other drugs, can cause temporary and long-term neurological damage. Methamphetamine can induce behaviors like paranoia, hallucinations and mood disturbances, which pose some challenges in treating these individuals. In addition, methamphetamine users do tend to have high drop-out rates, high relapse rates, frequent paranoia and psychosis, severe craving and protracted depression.

Short and Long-term Effects of Methamphetamine Use

Short-term effects include: increased attention and activity, decreased fatigue levels and appetite, euphoria/rush, increased respiration and hypothermia. Long-term use can lead to dependence, methamphetamine induced psychosis (paranoia, hallucinations, mood disturbances, repetitive motor activity), stroke, and weight loss.

Effects on the Brain

The brain, an elaborately wired communication system, is organized into lobes. These lobes are

responsible for specific functions. Each lobe is made up of complex circuits that involve direct connections between billions of specialized cells. The basic functioning of the circuits is done through a specialized cell called a neuron. Neurons convey information electrically and chemically between each other. Each neuron consists of a main cell body, a large number of offshoots called dendrites, and one long fiber, the axon. Connections to other neurons are made at the end of the axon.

Communication between neurons is carried in an electrical impulse. This electrical impulse must cross a gap, the synapse, between the neurons. That electrical impulse is changed to a chemical signal when it crosses the synapse to the other neuron. The chemical signal is sent by messenger molecules called neurotransmitters. The neurotransmitters attach to receptors on the surface of the neuron being sent the signal. Neurotransmitters have different effects which depend on the receptor they activate.

When a person takes methamphetamine the normal communication among brain neurons and brain circuits is either modified or disrupted. This is because the use of methamphetamine increases the amount of dopamine, a neurotransmitter, in the synapse. The increase in dopamine levels leads to a mood elevation and increased motor

activity (known as "the rush"). As the level of methamphetamine begins to subside, after 10-12 hours, the dopamine level also decreases and drops below normal for a period of time, resulting in a feeling of dysphoria (known as "the crash").

Implications for Chemical Dependency Professionals

The challenges presented by methamphetamine dependent clients require new knowledge and skills for many treatment providers. We need to be skilled in understanding the treatment needs of clients with co-existing mental disorders, sexual problems (men), and body image and weight problems (women) that are prevalent among users. We need to engage clients for longer periods of treatment to prevent relapse. Treatment issues will be addressed in the next two issues of the "Addiction Messenger"

Source:

Center for Substance Abuse Treatment (1999)
Treatment for Stimulant Use Disorders
 Treatment Improvement Protocol (TIP) Series, Volume 33
 Free to download at:
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Next Issue:

**"Methamphetamine Tx:
 The Matrix Model"**

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Pre-Test

Series 5

Circle the correct answer for each question

#1

Methamphetamine has been used to treat:

- a. Narcolepsy
- b. Attention Deficit/Hyperactivity Disorder
- c. Fatigue
- d. "a" and "c"
- e. All of the above

#2

Successful treatment of methamphetamine dependence requires giving special attention to client retention and a thorough understanding of chronic depression.

True False

#3

A neurochemical most responsible for "the rush" experienced by methamphetamine users is:

- a. Dextroamphetamine sulfate
- b. Hanyak
- c. Dopamine
- d. Dendrite
- e. None of the above

#4

The most intense effects of methamphetamine are experienced through which of the following routes of administration:

- a. An intravenous injection
- b. A pill or tablet
- c. A crystal that is smoked
- d. A powder that is snorted
- e. All of the above

#5

The treatment approach called Community-Reinforcement-Plus Vouchers involves which of the following?

- a. Promotion of lifestyle changes conducive to recovery
- b. Earning vouchers for obtaining retail items
- c. Leading large group meetings in the community
- d. "a" and "b"
- e. "a" and "c"

#6

Contingency Management is an intervention that is designed to either increase or decrease target behaviors by providing immediate reinforcing or punishing consequences when the behavior occurs.

True False

#7

Which of the following facts are true about the Matrix Model?

- a. Stresses importance of involvement in 12-Step program
- b. Is an intensive 16-week program followed by after-care
- c. The core component is a 2-week inpatient program
- d. "a" and "b"
- e. Won 4 Academy Awards for Technical Excellence and stars Keanu Reeves.

#8

Which of the following items describes the Relapse Prevention component of the Matrix Model?

- a. A series of group meetings organized around specific topics
- b. Provides information, support, and camaraderie
- c. Is led by a therapist and co-leader
- d. All of the above
- e. None of the above

#9

The Social Support Group component of the Matrix Model:

- a. Is presented during the initial stage of recovery
- b. Is a program that is focused on maintaining sobriety
- c. Focuses on several topics during a meeting
- d. None of the above
- e. All of the above

#10

Several pharmacotherapies have been developed to effectively treat stimulant abuse disorders.

True False

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“Methamphetamine: Myths & Facts”

Methamphetamine Treatment: The Matrix Model

*“There is nothing so
annoying as a
good example!!”*

Mark Twain (1835-1910)

The last issue of the *Addiction Messenger* provided you with information on myths and facts regarding the stimulant drug methamphetamine. This issue focuses on various treatment approaches for methamphetamine addiction with an emphasis on the Matrix Intensive Outpatient Program (IOP) for the Treatment of Stimulant Abuse.

History

The first treatment approaches for stimulant abuse were used in the 1980's. The Minnesota Model, a 28-day program developed by the Hazelden Institute, adapted its alcohol treatment strategies to provide services for stimulant abusers. Other, more unconventional, treatment approaches during this time period included: health foods, amino acids, hot tubs, and electronic brain tuners.

Treatment Approaches for Stimulant Users

Effective and scientifically documented psychosocial treatment approaches have mainly been derived from studies with cocaine users. Evidence indicates that both cocaine and methamphetamine users respond similarly to psychosocial interventions. Some of these scientifically documented approaches include:

Community-Reinforcement-Plus-Vouchers

This approach is a 24-week individually designed program to promote changes in lifestyle that are conducive to successful recovery. Clients can earn vouchers that are exchangeable for retail items contingent on having stimulant-free urinalysis tests during the initial 12 weeks of treatment. This voucher-based incentive program facilitates initial abstinence from stimulants and increases retention.

Contingency Management

The voucher system is an example of a contingency management intervention. An intervention designed to increase or decrease desired behaviors by providing immediate reinforcing or

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punishing consequences when the desired behavior occurs.

Relapse Prevention

Relapse prevention teaches clients:

- (1) how to cope with cravings,
- (2) refusal and assertiveness skills,
- (3) how decisions can affect the probability of later substance use,
- (4) coping and problem solving skills, and
- (5) strategies to prevent a complete relapse if an episode of substance use occurs.

Other models of psychosocial treatment that have not been scientifically documented as being effective with stimulant users include: Behavioral Family/Couples Therapy, Network Therapy, Acupuncture, Inpatient Treatment, and Residential/Therapeutic Community Treatment.

The Matrix Model

The Matrix IOP for the Treatment of Stimulant Abuse, developed in 1984, is a 16-week treatment program designed to give clients the knowledge and support they need to achieve abstinence and recovery. During the 16 weeks clients typically attend program activities seven days per week. The Matrix model integrates elements from several strategies such as: relapse prevention, motivational interviewing, psychoeducation, family

therapy, and the 12-Step program. It has been evaluated in at least seven different research projects. The application of this model has been shown to be associated with significant reductions in cocaine and methamphetamine use.

Program Description of the Matrix Model

The treatment protocol for the Matrix model includes both individual and group sessions. An outline of the protocol and description of how it is structured follows:

Individual Sessions

Three individual sessions provide an important basis for the development of the client/therapist relationship and serve to increase retention. The first meeting is used to orient the client to the Matrix Model, complete administrative documentation, and to establish rapport and encouragement for treatment entry. The second session is used to provide a progress review at 30-45 days after admission, or to deal with any crisis situation that may have developed. The third session focuses on helping the client create a continuing-care plan that includes both professional and self-help support for long term recovery. Extra sessions are sometimes provided during times of crisis.

Early Recovery Skills Group

This group consists of 8 one-

hour group sessions during the first month of treatment. Groups are typically small (6-8 clients) and last about 50 minutes. The group begins with an initial orientation for participants. The group leader then introduces the skill topic for the meeting and the participants are asked how they are currently using that skill. The last portion of the meeting is used to discuss how each participant will be scheduling their time between the present meeting and the next meeting. This group helps clients learn the basic skills needed to gain initial sobriety. Clients are also taught how to use cognitive tools to reduce cravings, how to schedule their time, the importance of discontinuing secondary substances, and how to connect with community support services. An introduction to the 12-Step program is provided and the value of participation is discussed.

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Family Education Group

Family members and clients attend this group for 12 weeks during the later part of treatment. The group meetings are designed to be interactive to allow the group leader to address the most pressing issues for all group members. Some issues presented include: (1) the biology of addiction, brain functioning and drug tolerance, (2) concepts regarding conditioning and addiction such as conditioned cues and extinction, (3) the medical effects of stimulants on the heart, lungs, reproductive system and brain, and (4) information on how relationships are affected during addiction and recovery.

Family involvement improves the probability of retaining the client in treatment the entire 16 weeks.

Relapse Prevention Group

This group is the central element of the Matrix model. Clients participate in this group at the beginning and end of each week during the 16-week program. The meetings are structured with a specific format and topics. Thirty-two topics are covered in this group. Information, support, and camaraderie are provided to clients as they are taught how to stay sober and proceed through recovery. The next issue of the Addiction Messenger will focus on the topic of relapse preven-

tion in greater depth.

Social Support Group

This group is designed to teach resocialization skills in a safe environment. This group begins during the last month of treatment at the end of the family education series. Clients establish new nondrug-related friends and activities and are encouraged to continue the lifestyle changes they are making. The content of these group meetings is determined by the needs of the members attending.

Importance of 12-Step Program

The Matrix model emphasizes the importance of clients participating in a 12-Step program. Having clients gain familiarity with 12-Step programs is an essential part of treatment in the Matrix model. An "Introduction to 12-Step Meetings" presentation can be provided on site one night a week during treatment. Attending these meetings may make it easier for the client to go to an outside 12-Step meeting the first time. Clients are encouraged to use this program in the initial phase of treatment in order to establish a basis for ongoing support.

Pharmacological Treatments

Research on medication for methamphetamine addiction is underway. Medications are being explored that may alleviate

some of the medical/psychiatric symptoms associated with methamphetamine intoxication and withdrawal. For example, antidepressants have been useful in treating clients who have discontinued using methamphetamine.

Matrix Model Manual

A therapist manual with details about how to implement the Matrix model is available from NFATTC. This 186 page manual will cost \$10. To order a copy send your request and a check made out to the NFATTC to Judi Wangler at 3414 Cherry Ave. NE, Suite 100, Salem, OR 97303

Sources:

Center for Substance Abuse Treatment (1999)
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 Free to download at:
www.samhsa.gov
 and
 Rawson, R.A.; Obert, J.L.; and McCann, M.J. (1995)
The Matrix Intensive Outpatient Program Therapist Manual
 The Matrix Center, Inc.
 Los Angeles, CA

Next Issue:

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“Methamphetamine: Relapse Prevention”

*“Motivation is what gets you
started. Habit is what
keeps you going.”*

Jim Ryun (1947 -)

The last issue of the Addiction Messenger provided you with information on the “Matrix Model” of treatment for methamphetamine addiction. This issue continues that discussion with a focus on relapse prevention strategies. Many stimulant users can discontinue their use of methamphetamine for periods of time. You may have observed this in some of your clients. Stopping methamphetamine use, however, is just the “warm-up act” - maintaining abstinence is the “main event”. A primary challenge for stimulant users is avoiding relapse.

Once methamphetamine use is discontinued and the client’s sleeping and eating routines have stabilized, the “crash” symptoms usually lessen. But what about brain functioning? It is usual for a methamphetamine user to have biological and psychological symptoms that continue to influence their functioning for 3-4 months or even longer following initiation of abstinence. Your clients may describe symptoms such as: mild dysphoria (anxiety or restlessness), difficulty con-

centrating, anhedonia (loss of pleasurable feelings), low energy, difficulty with short-term memory, and irritability. As a counselor it is important to consider your client’s difficulties with concentration and short-term memory. These issues should be taken into consideration when you are presenting educational materials and developing relapse prevention strategies.

Common Patterns to Relapsing

Relapse episodes have some common characteristics and patterns for stimulant users. Relapses are often associated with:

- ❖ Using alcohol and/or other secondary substances,
- ❖ Returning to substance-using friendships,
- ❖ Engaging in sexual behaviors that have been associated with stimulant use,
- ❖ External and internal stimuli that elicit cravings, and,
- ❖ Negative emotional states such as anger, depression, loneliness, frustration and boredom.

Abstinence Techniques

Strategies for establishing abstinence often include behavioral and cognitive-behavioral methods derived from the notion that a client can be taught a set of information along with specific skills to maintain abstinence and prevent relapse.

Functional Analysis

This strategy teaches the client to recognize the specific conditions that lead to or are associated with drug use. The core components involve: 1) teaching clients to examine the circumstances, thoughts, and feelings that could lead to substance use, 2) examining the positive immediate and short-term consequences of use, and 3) encouraging the client to also review the negative consequences associated with drug use.

Contingency Management

Contingency management (described in Vol. 5, Issue 2) can be used in conjunction with a behavioral contract based on attending group therapy sessions and drug-free urinalysis results. Contingency management reinforcers can involve receiving “points”, credits, money or other incentives that can be “earned” by the client. Such strategies have proven particularly effective with stimulant users.

Cognitive-Behavioral Skill Building

Techniques that assist clients in recognizing high-risk situations, and implementing coping strategies to manage high-risk circumstances can help stop an isolated episode of substance use that could lead to a full blown relapse. There are several categories of such relapse prevention techniques:

1. Psychoeducation about the relapse process and how to stop it.
2. Identification of high-risk situations and relapse warning signs.
3. Development of coping and stress management skills.
4. Enhancing self-efficacy in handling potential relapse situations.
5. Counteracting euphoric recall and the desire to test personal control

over use.

6. Development of a balanced lifestyle that includes positive leisure and recreational activities.
8. Responding to slips in a manner that doesn't escalate into a relapse.
9. Establishing accountability for slips and relapses through urinalysis and breathalyzer testing.

The Matrix Model: Relapse Prevention Group

The Matrix model strategy utilizes a group process that has been documented in a Therapist Manual and Patient Workbook. They include handouts for the client and therapist instructions for conducting a relapse prevention group.

Relapse is not considered a random event but rather a process that can follow a predictable pattern. Helping your client recognize when s/he may be headed for a relapse will allow you to assist them in redirecting their behaviors. The purpose of the Relapse Prevention (RP) group is to provide a forum for clients to receive assistance in dealing with issues of recovery and avoiding relapse. Clients enter the RP group at the beginning of treatment and remain in the group for the entire 16 week period. The sense of camaraderie and cohesion that is experienced by clients is valuable to the entire treatment process. This is developed through the opportunity the group provides to solicit input and encouragement from the other group members.

The RP group is facilitated by a leader and a co-leader. The leader's role is to maintain the group's focus and direction while the co-leader's role is to provide a positive role model and reinforce

suggestions and advice based on personal experience. Each group is devoted to a particular topic. The format for each meeting begins with introducing new members. Each new member is asked to give a brief history of their drug use. The next 15 minutes is focused on the leader presenting the specific topic for the meeting. The topic is then discussed for the next 45 minutes with a “wrap-up” of important issues provided by the leader. The last 30 minutes of the meeting is used to explore any recent problems that members may be having.

RP Group Topics

Each RP Group meeting focuses on a central topic. The following list includes all 32 topics used in RP groups.

1. Alcohol – The Legal Drug

Focus on alcohol as a drug and situations a client may encounter.

2. Boredom

Assists clients in taking action to avoid boredom and to plan their life with new activities.

3. Avoiding Relapse Drift/Mooring Lines

Exploring what behaviors are “working” for clients to ensure

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their abstinence.

4. Work and Recovery

Focus on work issues that impact recovery whether the client is unemployed or a workaholic.

5. Guilt and Shame

Encourages clients to explore issues of guilt and shame with a focus on the difference between “bad behaviors” and being a “bad person”.

6. Staying Busy

Structuring daily schedules to avoid idle time becoming a “trigger”.

7. Motivation for Recovery

Highlights personal reasons for staying sober and how motivation can change during recovery.

8. Truthfulness

Concentrates on how adherence to truthfulness can ground recovery in reality.

9. Total Abstinence

Clarifies logic behind agreement to remain abstinence and the commitment that entails.

10. Sex and Recovery

Explores difference between sexuality in an intimate relationship and impulsive sexual behavior that is related to drug use.

11. Relapse Prevention

Identification of relapse indicators and establishing an intervention plan.

12. Trust

Explores how continued abstinence can facilitate the return of trust in relationships.

13. Be Smart; Not Strong.

Emphasizes maintaining a maximum distance from drugs and avoiding high-risk situations.

14. Defining Spirituality

Clarifies differences between “religion” and “spirituality”.

15. Taking Care of Business/Managing Money

Explores how the resources of time

and money may have been neglected by the client.

16. Relapse Justification I

Examines susceptibility to relapse justification thoughts.

17. Taking Care of Yourself

Highlights improving self-esteem and lowering stress levels through positive self-care practices.

18. Dangerous Emotions

Assists understanding of how negative emotional states can be “triggers”.

19. Illness

Forewarning of how a weakened physical state can lead to relapse.

20. Recognizing Stress

Recognizing and attending to signs of stress.

21. Relapse Justification II

Continuation of Relapse Justification I.

22. Reducing Stress

Techniques to alter behavior to reduce stress.

23. Managing Anger

Provides alternative ways to deal with anger and avoid relapse.

24. Acceptance

Focus on process of reclaiming control of life.

25. Making New Friends

Differentiating between drug-related relationships and positive friendships.

26. Repairing Relationships

Explores what interventions are appropriate for repairing relationships.

27. Serenity Prayer

Understanding concepts presented in the Serenity Prayer.

28. Compulsive Behaviors/Preventing Relapse to Sex

Understanding there is no “right way” and to raise awareness of what works for the individual.

29. Dealing with Feelings of Depression

Raising awareness and acceptance of emotions.

30. Twelve-Step Programs

Presents benefits of attending meetings and encourages involvement.

31. Looking Forward: Dealing with Downtime

Emphasis on positive vision of the future.

32. One Day at a Time

Allows focusing on the present to decrease feelings of overwhelm.

Matrix Model Manual

A therapist manual with details on implementing the Matrix model is available from NFATTC. This 186 page manual will cost \$10. To order a copy send your request and a check made out to NFATTC to Judi Wangler at 34414 Cherry Ave. NE, Suite 100, Salem, OR 97303

Source:

Center for Substance Abuse Treatment (1999)
Treatment for Stimulant Use Disorders
 Treatment Improvement Protocol (TIP) Series, Volume 33
 Free to download at:
www.samhsa.gov
 and
 Rawson, R.A.; Obert, J.L.; and McCann, M.J. (1995)
The Matrix Intensive Outpatient Program Therapist Manual
 The Matrix Center, Inc.
 Los Angeles, CA

Next Issue:

**“Dual-Diagnosis:
The Facts”**

NAME: _____

POST-TEST

Series 4

#1

Methamphetamine has been used to treat:

- a. Narcolepsy
- b. Attention Deficit/Hyperactivity Disorder
- c. Fatigue
- d. "a" and "c"
- e. All of the above

#2

Successful treatment of methamphetamine dependence requires giving special attention to client retention and a thorough understanding of chronic depression.

True False

#3

A neurochemical most responsible for "the rush" experienced by methamphetamine users is:

- a. Dextroamphetamine sulfate
- b. Hanyak
- c. Dopamine
- d. Dendrite
- e. None of the above

#4

The most intense effects of methamphetamine are experienced through which of the following routes of administration:

- a. An intravenous injection
- b. A pill or tablet
- c. A crystal that is smoked
- d. A powder that is snorted
- e. All of the above

#5

The treatment approach called Community-Reinforcement-Plus-Vouchers involves which of the following?

- a. Promotion of lifestyle changes conducive to recovery
- b. Earning vouchers for obtaining retail items
- c. Leading large group meetings in the community
- d. "a" and "b"
- e. "a" and "c"

#6

Contingency Management is an intervention that is designed to either increase or decrease target behaviors by providing immediate reinforcing or punishing consequences when the behavior occurs.

True False

#7

Which of the following facts are true about the Matrix Model?

- a. Stresses importance of involvement in 12-Step programs
- b. Is an intensive 16-week program followed by after-care
- c. The core component is a 2-week inpatient program
- d. "a" and "b"
- e. Won 4 Academy Awards for Technical Excellence and stars Keanu Reeves.

#8

Which of the following items describes the Relapse Prevention component of the Matrix Model?

- a. A series of group meetings organized around specific topics
- b. Provides information, support, and camaraderie
- c. Is led by a therapist and co-leader
- d. All of the above
- e. None of the above

#9

The Social Support Group component of the Matrix Model:

- a. Is presented during the initial stage of recovery
- b. Is a program that is focused on maintaining sobriety
- c. Focuses on several topics during a meeting
- d. None of the above
- e. All of the above

#10

Several pharmacotherapies have been developed to effectively treat stimulant abuse disorders.

True False

SEE BACK OF THIS PAGE

Mail or FAX your completed test to NFATTC

You can still register for continuing education hours for Series 1, 2, 3 or 4

Contact Mary Anne Bryan at (503) 373-1322 ext. 224

