Vancouver CoastalHealth

Low-Barrier Contingency Management

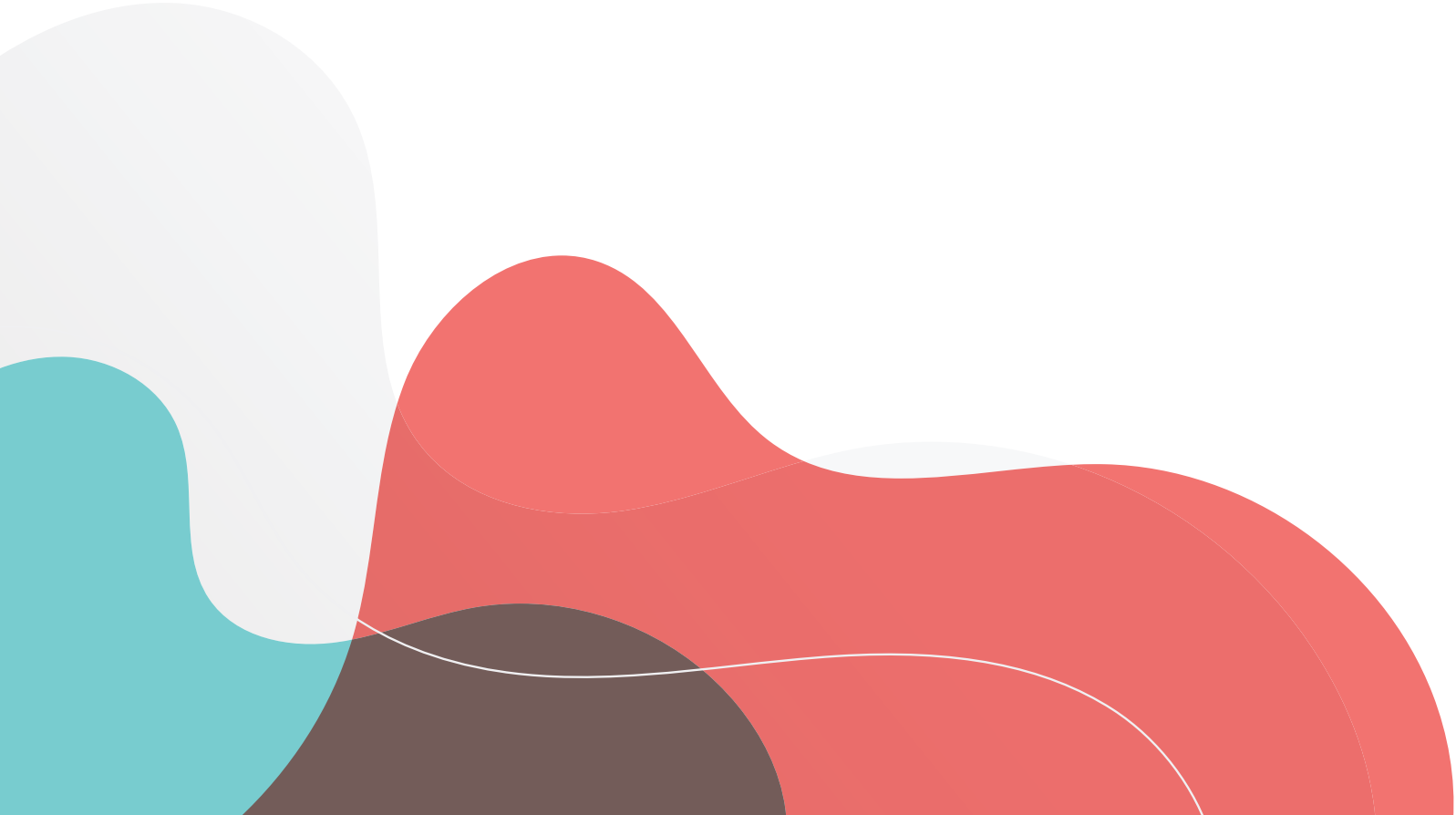
HOW-TO GUIDE

MAY 2022

Vancouver CoastalHealth

Welcome to the "Low-Barrier Contingency Management How-To Guide. This guide was produced and shared on the unceded, occupied ancestral homelands of the the xʷməθkwəy̓əm (Musqueam), Skwxwú7mesh (Squamish), and Sə̓l̓ílwətaʔ/Selilwitulh (Tsleil-Waututh), Shíshálh, Tla'amin, Wuikinuxv, Heiltsuk, Nuxalk, Kitasoo-Xai'xais, Lil'wat, Samahquam, Xa'xtsa, Skatin, N'Quatqua Nations.

The purpose of this guide is to offer instruction on how to provide a contingency management program in a low barrier setting.



Contents

What is Contingency Management (CM)?

Contingency Management (CM) is an evidence based treatment model of behavioural modification theory. A key concept in contingency management is positive reinforcement. Positive reinforcement is thought to be particularly helpful for people who use stimulants. Stimulants activate reward pathways in our brains, sometimes so strongly that it's difficult to meet other goals in life. Providing tangible rewards for meeting health goals can help "re-wire" reward pathways in our brains. Positive reward pathways help people to work toward vocational, social, emotional or educational goals promoting connectedness and recovery.

"C" is for *Contingency*

A **contingency** is a linked event or condition; something that is liable to happen as an add-on or result of something else

"M" is for *Management*

Management refers to supervising, supporting or overseeing something; in the case of CM this would mean overseeing the agreed upon program participation, behaviours and contingencies and offering support to those struggling with the program.

Below is a common program design for CM. However, every program is designed to suit the particular community it is meant to serve and match the provider's resources.

Duration	12-16 weeks
Number of participants	12
Weekly sessions	Each participant usually completes: • One 15-20 minute one-to-one session with a staff member • One 30-60 group session co-facilitated by a staff and PWLE • *Optional:* One PWLE led drop-in session
Time of day	Ask community when they would like to attend meetings, it may be morning, afternoon or evening
Prizes	Each participant can draw up to 3 times per attended session

How does Contingency Management work?

A key concept (or idea) in CM is positive reinforcement (referred to as "reinforcement" through this document).

The idea of using reinforcement and consequences to shape behaviour is known as operant conditioning. Research has shown that applying consistent positive reinforcement over time can help change, shape, or teach targeted behaviours. An important tenet of CM and other behavioural approaches is that rewards work better and seem to have more lasting impact in shaping new behaviour than do punishments. In other words, the most successful strategies involve rewarding or positively recognizing achievement rather than punishing or applying negative sanctions to a lack of achievement. In CM studies with stimulant users and more specifically, folks engaging in chemsex, rewards (reinforcers) in the form of incentives have been successfully utilized. These incentives have included extra privileges, vouchers for inexpensive prizes such as retail goods, or actual cash payments. The incentives that a program uses to reinforce client behaviour are usually guided by factors such as culture, input from participants and People With Lived and Living Experience (PWLE), program philosophy, and resources available to the program.

Your CM program will typically range in length from 12 to 16 weeks and can be flexible to meet the needs of individual participants. Some folks may miss a few sessions and need to make up their sessions at the end of the planned program. The focus of your groups and individualized sessions is around making and achieving weekly goals and planning the next week's overall goals, substance use and recovery planning. Rewards are given according to your program design, however most CM programs offer rewards immediately after a one on one session or during a group session when a participant self reports meeting their goals. Different programs offer different kinds of incentives and rewards, and ways of physically winning the reward. Some programs use the fishbowl method, putting varying rewards in a bowl and having participants blind draw a token or chip that reflects the monetary value of the reward. Research shows that having a physical (not virtual) part of the winning can increase the feeling of positive enforcement. Cash or a gift card is then provided to match the pulled denomination. This aspect of CM is determined by your resources allocated and what you have learned by engaging PWLEs and community in your program design.

Research demonstrates that the most optimal health outcomes occur when CM participants are supported through reward programs when they are combined with other psychosocial supports such as group counselling and/or cognitive behavioural therapy. Engaging participants in a holistic and fulsome program can be achieved by developing partnerships to provide in-reach/outreach by PWLEs or clinicians and/or by creating an in house role in addition to your lead facilitators.

Integrating harm reduction

There has been little research on the impacts of integrating harm reduction strategies and philosophy into the CM framework, as many current programs do not offer harm reduction. However, the absence of a harm reduction approach within the CM model has potentially limited the opportunity CM groups and services provide to individuals who require lower barrier services, such as people with low socioeconomic status, those who are street-involved, precariously housed or experiencing homelessness, and who may also be involved in sex work or have sex work experience. Harm reduction is an essential component of low barrier services, and developing strategies to integrate appropriate and PWLE led services like overdose prevention training, drug testing and providing harm reduction supplies is recommended. Your program should provide information about overdose prevention sites and drug use monitoring apps like Lifeguard and the National Overdose Response Service (NORS). Keep in mind CM participants are at risk of overdose and keeping folks on track to meet their goals around reduced stimulant use and abstinence needs to include harm reduction.[1]

Some ways to integrate harm reduction philosophy and strategies into your CM group:

- Leave out safer use supplies (meth pipes, naloxone, safer smoking kits, injection equipment) and safer sex supplies (condoms, lube) at all CM drop-ins
- Start all groups with a reminder that your space is one that does not focus on abstinence and that understands everyone needs to be met where they're at without judgment
- Integrate harm reduction into your group discussions and content areas regularly (this will help participants see that harm reduction is embraced by group facilitators)
- drug checking information fentanyl testing strips, and OPS sites to avoid accidental toxic drug contamination

Who are you engaging?

Identifying your target population:

When planning a recovery focused program like CM, having a clear understanding of the populations you want to engage can be informed by identifying clients/participants/members accessing other services at your agency and engaging with them in consultation. Ensuring staff and PWLE input will help you to better understand the needs of your audience.

This How-To Guide to CM is designed to promote and support CM programing across the VCH region, so that agencies and service providers have more tools to engage and support people who use crystal methamphetamine, cocaine, and other stimulants and may or may not engage in chemsex (sex while using stimulants), sex work or other high risk activities. Beyond this guide, reaching out to other service providers who serve similar populations may expand your reach when providing a CM program.

Indigenous cultural safety and CM considerations

Consultation:

Consult and include Indigenous perspectives, voices and direction during program design and delivery, and seek out an approach that fosters a decolonizing lens on treatment models. This can be achieved by engaging people in a trauma informed, culturally safe process, and inviting all voices to contribute to the design and goals of the CM program through meetings and focus groups. Ensure you demonstrate the value of this feedback by expressing verbal gratitude and offering a stipend or honorarium to people who participate and share. Listen for what types of supports are identified as valuable by Indigenous voices; what types of incentives are identified as most appreciated.

Safe spaces:

Ensure your space looks and feels welcoming to the population you are engaging. A welcoming environment will improve program retention and support program PWLE's/staff's ability to nurture connections with program participants. Take direction from program participants to include art, information, posters, furniture etc that reflect the diversity of the community.

Cultural considerations:

Engage Elders and Knowledge Keepers to provide culturally safe support and Ceremony as a component of your services. Plan your engagement ahead of time so you have the financial resources to support Elders and Knowledge Keepers with the correct method of and amount.

PWLE engagement in CM work

In this guide people with living and lived experience (PWLE) is defined as a person that has used or uses illicit substances (stimulants) and has the life experience of accessing services as a drug user, procuring illicit substances on the street, maintaining housing and navigating the justice system as a drug user, may have sex work experience.

When developing an inclusive and equitable program or service, including PWLE expertise from the outset provides the most meaningful engagement and input.

From a health equity perspective, low barrier harm reduction services must be accessible and accommodating. Including people with the distinct expertise of living/lived experience in all aspects of program development and delivery offers a more responsive[2], informed and culturally safe initiative which will support you to meet your program goals, retention targets and outcomes. Include PWLE in every stage of dreaming, planning, creating, implementing, evaluating and celebrating the program.

Positions such as a PWLE facilitator and a PWLE intake support worker can be created to ensure the faces of the program reflect the people accessing the service. Creating a PWLE advisory group can create space for community stakeholders to provide feedback and input. Additionally, offering a drop in session led by a PWLE facilitator where participants can have a snack, engage in a planned activity like watching a movie and connect with others in the program increases the number of possible contact a participant will have with the program in a week with little impact on the budget.

Planning your CM group

In order to get started there are a few things to consider. Below are some key questions to ask your team:

Are we employing a decolonizing approach to CM that can help create a greater experience of **welcome, cultural safety, and inclusivity for First Nations, Inuit and Metis people?**

Do we have a culturally safe space that is **purposely inclusive of LGBTQIA2S+ individuals?**

How have we included **Lived and Living Experienced PWLEs** in decision processes from program design to implementation?

How have we included **community and participant engagement** to inform program design? What do members/participants want from this initiative and how would they best engage?

How have we explicitly included **harm reduction approaches** and philosophy into programming in ways that can be felt by participants?

Do we have **someone who can facilitate group sessions** and one-on-one goal-setting chats, or do we need a recruitment plan?

Do we have **PWLEs** to co-facilitate goal setting, group sessions and one-on-one, PWLE-to-PWLE counselling?

Does our budget **ensure sufficient staffing, rewards, and program supplies** (food, snacks)?

What is our **training plan** for staff and PWLEs?

How do we **plan to track goals** and rewards and keep those records safe?

What is our **plan for assigning incentives/rewards** that meets our budget?

Will we use **chips or vouchers** that have varying denominations as per budget and program design?

How do we plan to **evaluate our program**? How have we included PWLEs and participants in this evaluation?

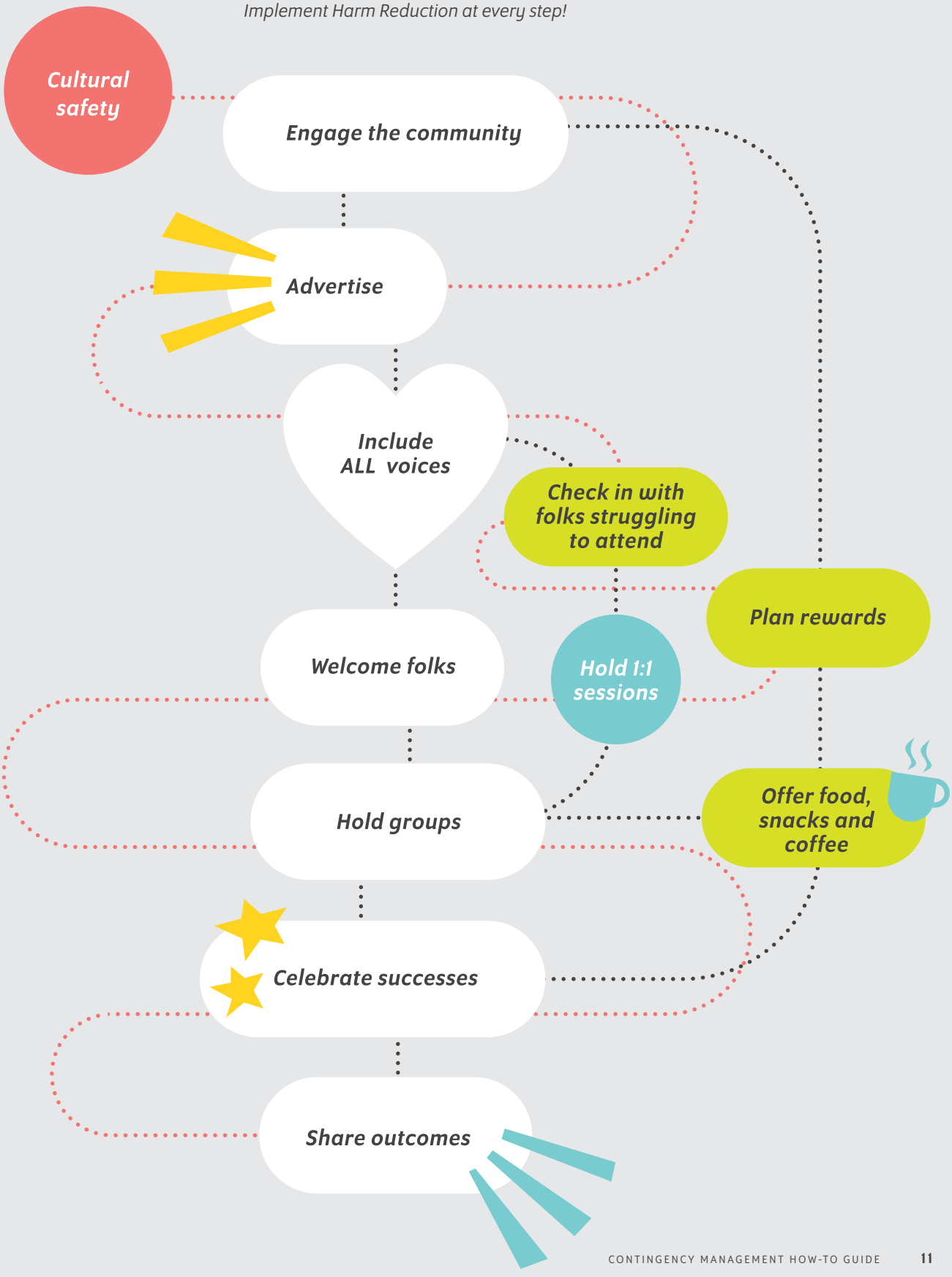
When required: Have we included a **stakeholder and partner engagement plan** to provide in-reach psychosocial supports that address the social determinants of health?

Do we have **other partners** and complimentary services to refer CM participants to when appropriate?

CONTINGENCY MANAGEMENT PROGRAM

ROAD MAP

Implement Harm Reduction at every step!



Building a logic model for your group

Developing a logic model for your program will help you visualize and track your program's planned outputs, outcomes and activities. Please see a sample below.

SAMPLE LOGIC MODEL

INPUTS	ACTIVITIES	OUTPUTS	SHORT TERM OUTCOMES	LONG TERM OUTCOMES
Resources received and program space identified	Hire and train PWLEs and program facilitator	12 people registered for CM group	PWLEs and staff have built trust and relationships	Capacity for CM programs remains stable
	Hold community and PWLE engagement sessions to inform program and tailor culture	Rewards are purchased	12 people have attended a group session	12 people completed CM
		Intake process begins	10 people have booked 1:1 sessions	12 people self reported reduced substance use
				The evaluation is completed and the outcomes are shared

Planning

Eligibility Criteria

This program is designed for:

- People who use stimulants
- People who want to set goals with respect to changing or reducing substance use
- People who are able to participate in a 15 – 20 minute 1:1 session, able to participate in 30 minute – 1 hour group session one a week for 12-16 weeks (understanding that some participants may need to make up missed sessions)

Referral Process

- Develop a simple referral form and a clear referral process
  (example attached Appendix A)
- A self referral along with a referral process from partners will provide a lower barrier for stimulant users to gain access to CM

Marketing/promoting the program

- Advertise your program so your target population is aware
- Posters, social media, info sessions and community engagement
- In some communities word of mouth through participant networks and PWLEs will be very effective

Planning rewards

- Incentives/rewards need to be consistent so participants know what to expect
- Incentive/reward types and denominations should be guided by PWLE and participant feedback prior to purchasing and within your budgeted amount. Consultation with your community will inform this part of your planning
- Ensuring the incentives/rewards are culturally appropriate is key.
  Have you meaningfully engaged your target population and PWLEs and listened to their feedback?

Group preparation

Group preparation tips:

Lead facilitator roles/duties:

- Recruit a PWLE to co-facilitate
- Co-facilitate group and one-to-one meetings
- Record attendance, goals and milestones
- Prize draw
- Shop for and maintain rewards log
- Pre-group set up: Store supplies somewhere easy to access and easy to pack up. Some programs store their supplies in marked storage bins.

PWLE duties:

- Co-facilitate group and one-to-one meetings
- Support with clean up
- Support with recording goals
- Snack shopping: typically around $10/group

Materials/supplies you will need:

- SMART goals info sheets *(Appendix C)*
- CM prize draw box & chips
- Goal setting slips *(Appendix B)*
- Facilitators' binder, including things like:
  - Group attendance record
  - One-to-one attendance record
  - PWLE drop-in session attendance record
  - Individual participant goal tracking sheet
  - Incentives / $ dispensed
  - Participant notes

Sample group agenda – tips to run a one hour group:

- **5 minutes:** Welcome, Land Acknowledgement and check in question & introductions
- **2 minutes:** Review of Group Guidelines
- **10 minutes:** Review of Goals from Previous Week (may have to split into groups if more than 8 participants)
- **20 minutes:** Goal Setting for Current Week
- **20 minutes:** Prize Draws
- If graduating, recognition circle to appreciate and celebrate the graduate

How to record activities and outcomes:

During Group: Keep track of goals, incentives, and attendance

After Group: Record attendance, create a 'GROUP NOTE'. (e.g. participants attending Contingency Management Group today to support changes to their stimulant use).

Goal setting:

- Use SMART model of goal setting *(Appendix C)*
- Set 3 goals in each group examples: healthcare, leisure, recovery, ceremony, connection to a cultural event, safer stimulant use
- The focus is to have participants make goals that are individual and important to them, are achievable by next group, and keep them challenged in a healthy and supportive way

Prize draw suggestions:

Can receive up to three draws at a max per group

- Receive 1 draw for self reported abstinence or reduced stimulant use
- Receive 1 draw for achieving the three goals set the previous week
- Receive 1 draw for attending three consecutive groups

Suggested prize distribution/purchasing

- Based on a brief literature review and comparison with other CM groups operating in Vancouver prizes are divided into small , medium and large
- Fishbowl contains a total of 51 chips:
    - 40 small chips (75-80% of total)
    - 10 medium chips (about 20% of total)
    - 1 large chip (less than 5% of total)

Programming for group sessions

Programming for your group session can be planned by engaging the people you intend to recruit into CM and asking them what kind of support groups have worked for them in the past and what hasn't. This may inform what you offer and may create an opportunity to learn about alternatives that are new to you and your team. Interventions like SMART, motivational interviewing and cognitive behavioural therapy are commonly used in CM group sessions and have proven to be useful in supporting people to meet their goals and stay engaged.

Group session resources:

https://www.smartrecovery.org/smart-recovery-toolbox/
https://positivepsychology.com/cbt-cognitive-behavioural-therapy-techniques-worksheets/
https://ireta.org/resources/motivational-interviewing-toolkit/

Tips for Facilitators

- Establish a routine of **brief weekly check-in sessions** with participants to review goals, attendance, and wellness, and to reinforce harm reduction principles and to build relationships.
- Facilitators or team members who do not identify as Indigenous and are welcomed to run groups that include Indigenous community members will benefit from **remaining curious and humble**. Taking time to include an Indigenous lens in program design and delivery improves cultural safety.
- Keep in mind that different people have different relationships with stimulants, different reasons for use, and different goals. If people are using to meet basic needs like staying awake for safety or to watch their belongings while homeless, support them in meeting their needs for housing and safety before addressing goals around substance use.

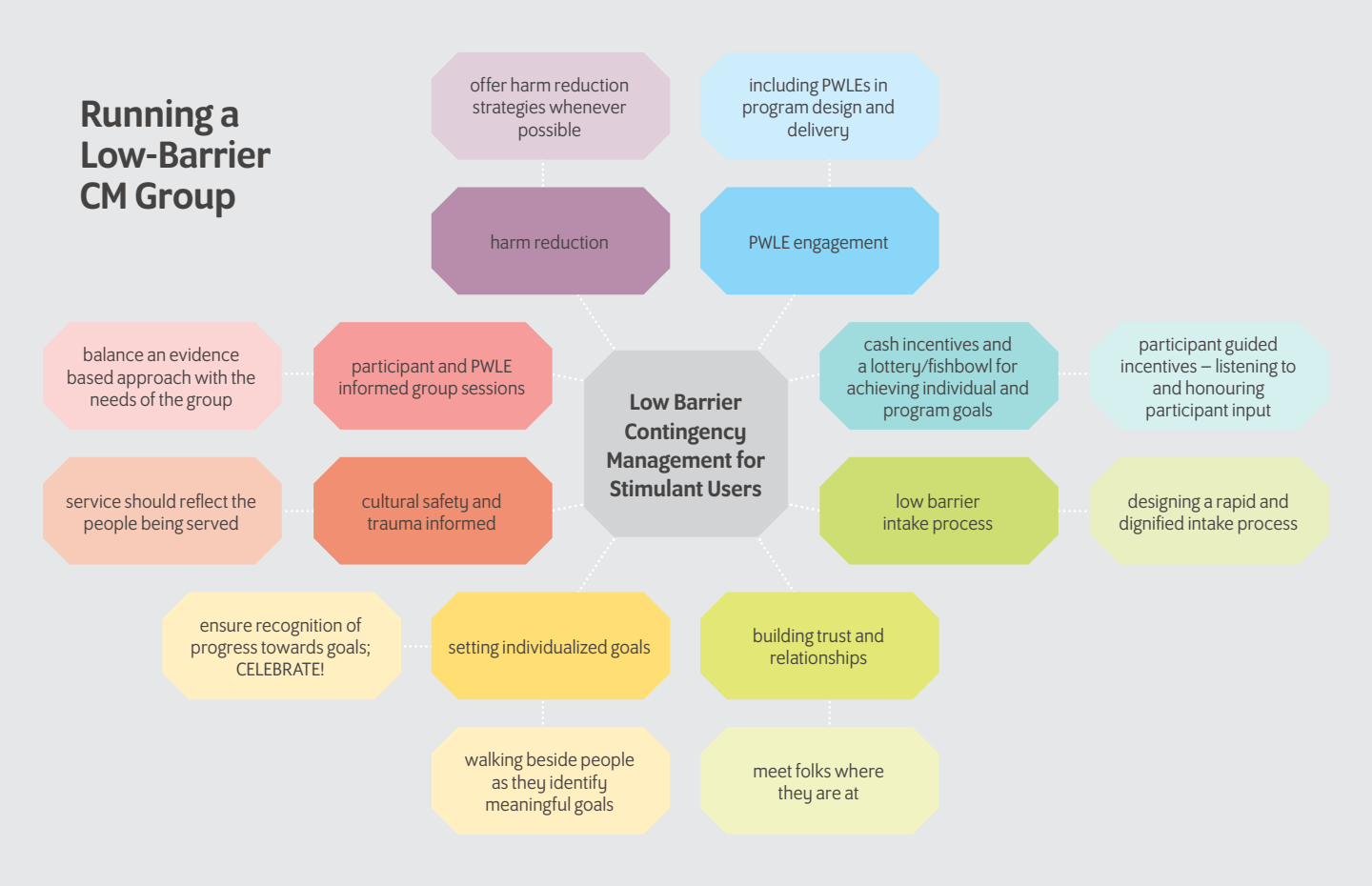
Tips for Organizations

- Pay attention to factors of organizational readiness for a CM intervention within your program. Philosophical differences and ideas about how the protocol will be carried out **should be resolved collectively** including the voices of those with living and lived expertise.
- CM will be most effective when the whole team is "on board," with **all staff and peers receiving training** on the parameters of CM as an intervention.
- Develop connections with social services in your area that can support basic needs like food security, shelter, and primary health care. The Overdose Outreach Team in Vancouver is one service that can help clients in the VCH region get connected to care if they do not have a primary care clinic.

Guidelines and participation policies

Guidelines and participation policies should reflect those of your agency/organization/group. Confidentiality and Anti-Bullying and Harassment policies are needed for staff, PWLEs and participants.

You may want to develop soft framework or a decision tool for when participants arrive too intoxicated to participate and a plan to follow if someone will be excluded from the program that day. Ask your team how they would like to be engaged and treated in those moments and develop a protocol based on meeting your participants where they are at.



Budget planning

When designing a CM program, budget and budget management are needed to create a sustainable and equitable program. Once you have developed your PWLE-inclusive staffing model, you will need to plan for food, program supplies and workshop content which could include guest speakers. Below is an example of the types of expenditures a CM program may have.

Facility costs	
Staffing/ Peers/Elders	
Food and Beverage	
Incentives/ rewards	
Program supplies	
Workshops/ speakers	

Staff training

It will be essential to have staff and PWLEs trained in key areas that will prepare them for the work of providing a safe and supportive CM program. Some recommended training areas are:

- **Indigenous Cultural Safety***
- **Trauma-Informed Practice**
- **Best Practices in Harm Reduction**
- **Overdose Prevention Training**
- **Peer-to-Peer Counselling Training**
- **Supporting Peer Workers**
- **Resisting Stigma on Substance Use***
- **Stimulants 101**
- **Online Street Degree***
- **Agency-Specific Confidentiality Training**

* Any courses on Learning Hub – you will need to create a login to make links work. How to create a login doc linked here: http://www.vch.ca/Documents/Overdose-Prevention-How-to-access-Online-Street-Degree-Instructions.pdf

Additional topics to consider:

- lateral violence
- de-escalation
- motivational interviewing basics

Collecting feedback/ evaluation

In order to assess your program, participant journeys and outcomes you may need to plan for an external evaluator. This can be done in partnership with your funder or independently.

In the event there are limited resources, you and your team can develop a feedback tool or questionnaire for participants to fill out at the middle and end of the 12-16 week program.

Feedback from participants provides vital information and offers you and your team a chance to review and reflect on ways to improve your program, what worked and what didn't.

Thank you for taking the time to review this guide. The hope is you are well on your way to understanding CM and ready to explore designing and implementing CM at your agency. If you need further support please email: regionaladdictionprogram@gmail.com

Appendix A: **Example referral form**

CONTINGENCY MANAGEMENT GROUP REFERRAL INTAKE FORM

FAX to: _____ **Email to:** _____ **or drop off to** _____

Questions? Call _____

Date: _____

PARTICIPANT CONTACT DETAILS

Contact details: _____ Okay to leave phone message: ☐ Yes ☐ No

Address: _____ Email: _____

Emergency contact phone: _____ Relationship to participant: _____

Okay to phone/text: ☐ Yes ☐ No

In event of emergency, okay to tell them what group you were involved in? ☐ Yes ☐ No

---

ELIGIBILITY CRITERIA:

☐ Active Stimulant Use ☐ Active Stimulant Use Disorder (any severity) ☐ In Early Remission (less than 3 months)

TREATMENT GOAL: ☐ Reduce stimulant use ☐ Abstain from stimulant use

☐ Participant is group appropriate: Able to respectfully and meaningfully participate in a 1 hour co-ed session

☐ Participant is willing to commit to a 12-week group 16-week group

☐ Participant is not currently actively engaged with psychosocial supports for substance use (prioritizing those not connected)

If actively engaged, what programs: _____

REFERRAL SOURCE

Referred by: (name) _____ Organization: _____ Contact number: _____

SUBSTANCE USE HISTORY

Substance	Age of first use	Method of use	Date of last use	# Days of use in last 30 days	Typical Day amount used	Current Pattern	Stage of Change	Actions/Thoughts
Methamphetamine								
Cocaine								
Other:								

Other current substance use: ☐ Opiates ☐ Alcohol ☐ Nicotine ☐ GHB ☐ Other: _____

Appendix B: **Example goal slip**

Date:	Name:
Health Goal:	
Leisure/ Cultural/ Spiritual Goal:	
Recovery Goal:	

Appendix C: **SMART model of goal setting**

S	**SPECIFIC**	What do you want to do?
M	**MEASURABLE**	How will you track your process?
A	**ATTAINABLE**	How will you do it?
R	**RELEVANT**	Is this relevant to your life right now?
T	**TIMELY**	When do you want to do it?

Appendix D: **Crystal Meth Resource Guide**

Online courses

- **Crystal Meth E-Learning Series (St Stevens Community House):**
  Five free, short, self-directed online modules that are a great start to learning about crystal meth (~ one hour to complete all)
  https://www.youtube.com/watch?v=XIFiwWg-uFU&list=PLDbIF5zAAxztLNV99VcpdbSpSghThaiEZ&index=3

- **Crystal Meth Expert Panel (VCH):**
  Webinar for front-line staff featuring experts with clinical, community and lived experience sharing their insights on caring for people who use crystal meth (90 min)
  https://www.youtube.com/watch?v=3rAx3xY2e44

Videos

- **Chemsex video playlist from David Stuart**
  Lectures, talks and discussions about the role that crystal meth plays communities of gay, bi and men who have sex with men (GBMSM)
  https://www.youtube.com/playlist?list=PL59WY5a9gIGRlzWD3FWp9MCBj6x8hI2qy

Factsheets / articles

- **Crystal Meth Factsheet**
  Overview of crystal meth myths, facts, harm reduction and treatment options
  https://drugpolicy.org/drug-facts/methamphetamines

- **Party and play in Canada: What is its impact on gay men's health?**
  Overview of "party and play" for GBMSM from Catie.ca
  https://www.catie.ca/prevention-in-focus/party-and-play-in-canada-what-is-its-impact-on-gay-mens-health

Resources

1. https://scholarworks.seattleu.edu/cgi/viewcontent.cgi?article=1023&context=dnp-projects
2. The Role of Peers: Prepared by Jane Buxton, Physician Lead for Harm Reduction at BC Centre for Disease Control, Janine Stevenson Harm Reduction Nurse Specialist at First Nations Health Authority, Katie LaCroix, Peer Research Assistant and Charlene Burmeister, Peer Research Assistant. http://www.bccdc.ca/resource-gallery/Documents/Educational%20Materials/Epid/Other/Peer%20primer%20for%20BCOAE.pdf
3. https://www.emcdda.europa.eu/system/files/publications/2726/POD2014_Treatment%20for%20cocaine%20dependence.pdf
4. https://store.samhsa.gov/sites/default/files/d7/priv/tip35_final_508_compliant_-_02252020_0.pdf
5. Treatment of stimulant use disorder: A systematic review of reviews https://www.ncbi.nlm.nih.gov › articles › PMC7302911
6. Optimizing Contingency Management with Methamphetamine-Using Men who Have Sex with Men https://pubmed.ncbi.nlm.nih.gov/32461714/
7. Long-term efficacy of contingency management treatment based on objective indicators of abstinence from illicit substance use up to 1 year following treatment: A meta-analysis. https://pubmed.ncbi.nlm.nih.gov/33507776/
8. Contingency management treatment for substance use disorders: How far has it come, and where does it need to go? https://www.ncbi.nlm.nih.gov › articles › PMC5714694
9. Re-Wired: treatment and peer support for men who have sex with men who use methamphetamine https://pubmed.ncbi.nlm.nih.gov/29754597/
10. https://www.nice.org.uk/guidance/cg51/chapter/appendix-c-contingency-management-key-elements-in-the-delivery-of-a-programme
11. https://www.emcdda.europa.eu/system/files/publications/3162/TDAU13001ENN.pdf
12. Effects of Social Support and 12-Step Involvement on Recovery among People in Continuing Care for Cocaine Dependence Lookatch, Samantha J.; Wimberly, Alexandra S.; McKay, James R.; Substance Use & Misuse, 2019; 54(13): 2144-2155. (12p) (Article - research, tables/charts) ISSN: 1082-6084 AN: 139257713 https://pubmed.ncbi.nlm.nih.gov/31322037/
13. Targeting the Barriers in the Substance Use Disorder Continuum of Care With Peer Recovery Support. Subst Abuse. 2021 Jun 17;15:1178221820976988. Stanojlović M(1), Davidson L(1). https://pubmed.ncbi.nlm.nih.gov/34211275/
14. Provision of peer support at the intersection of homelessness and problem substance use services: a systematic 'state of the art' review. BMC Public Health. 2020 May 7;20(1):641. Miler JA(1), Carver H(2), Foster R(2), Parkes T(2). https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-020-8407-4
15. Psychosocial interventions for psychostimulant misuse By: Minozzi S; Saulle R; De Crescenzo F; Amato L, The Cochrane database of systematic reviews, ISSN: 1469-493X, 2016 Sep 29; Vol. 9; AN: CD011866; PMID: 27684277; https://pubmed.ncbi.nlm.nih.gov/27684277/
16. http://ibr.tcu.edu/wp-content/uploads/2013/09/TMA05Dec-CM.pdf
17. https://crismprairies.ca/wp-content/uploads/2016/12/Walker-2010.pdf
18. https://www.emcdda.europa.eu/system/files/publications/2726/POD2014_Treatment%20for%20cocaine%20dependence.pdf
19. https://www.smartrecovery.org/smart-recovery-toolbox/
20. https://positivepsychology.com/cbt-cognitive-behavioural-therapy-techniques-worksheets/
21. https://ireta.org/resources/motivational-interviewing-toolkit/