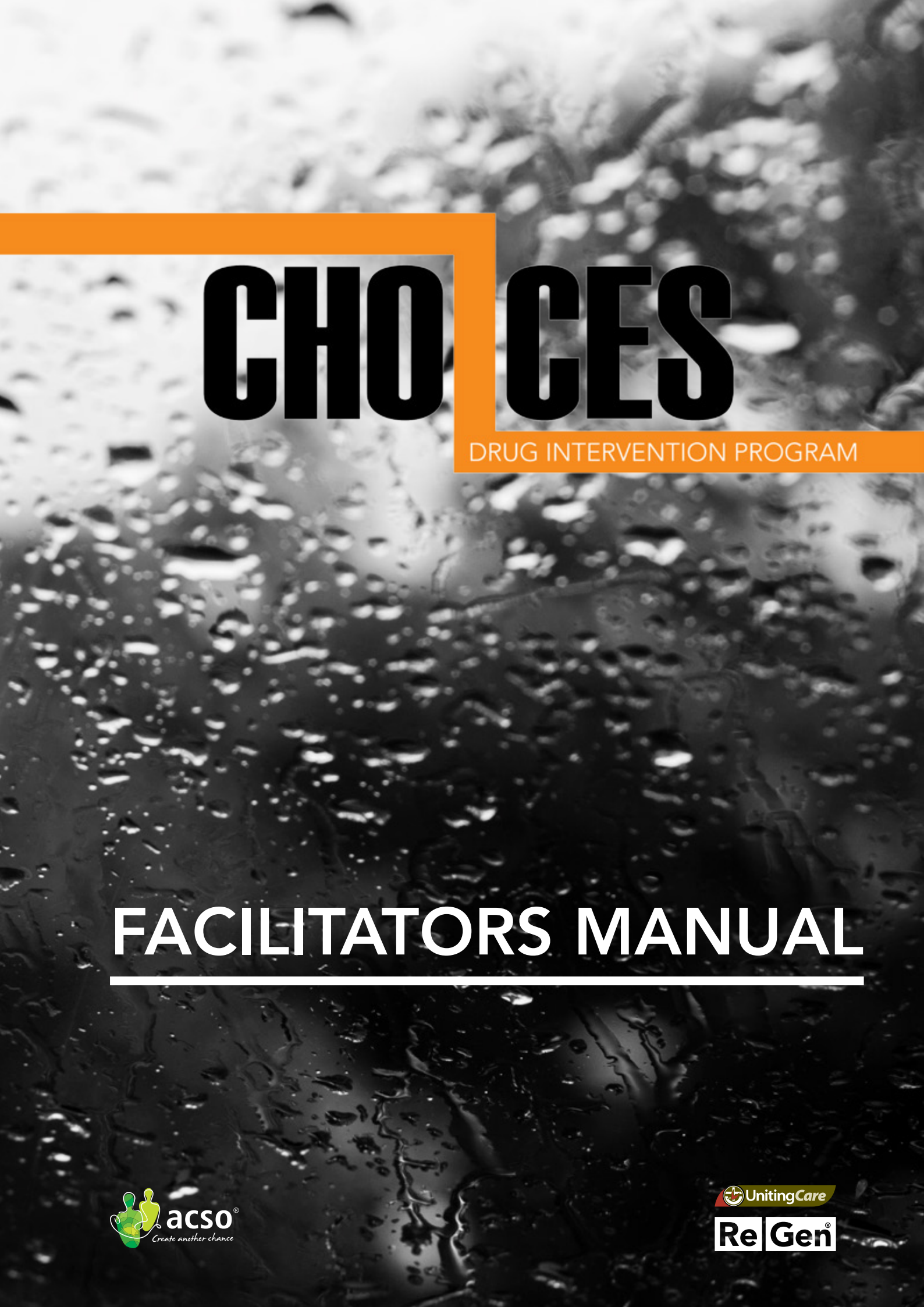
CHOICES
DRUG INTERVENTION PROGRAM
FACILITATORS MANUAL
acso
Create another chance
UnitingCare
ReGen

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ABOUT UNITING CARE

UnitingCare ReGen (ReGen) is the leading AOD treatment and education agency of UnitingCare Victoria and Tasmania. ReGen is a not-for-profit agency, which has over 40 years' experience delivering a comprehensive range of AOD services to the community.

ReGen has an extensive history in the development and delivery of quality education and has provided AOD client education programs since 2000.

As one of the largest providers of community based forensic AOD treatment services in Victoria, ReGen has extensive experience in the development and implementation of forensic programs.

ABOUT ACSO

ACSO is a leading provider of community support services, delivering programs to support people in the criminal justice system, along with a range of diversion and early intervention programs that help prevent people from getting there.

For 18 years, ACSO has delivered the centralised, state-wide Intake, Triage, Assessment and Brokerage (referral) for all forensic AOD consumers in Victoria. ACSO brings a proven track record of working with Corrections clients via the Community Offenders Advice and Treatment Service (COATS).

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ReGen and ACSO acknowledge the legal holders of the copyrights pertaining to the video excerpts included in slides 27 & 40. These videos are available to watch via youtube and cannot be downloaded.

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PART 01

INTRODUCTION

INTRODUCTION:

About Choices

The Choices Drug Intervention Program is a three-hour alcohol and other drugs (AOD) brief psychoeducational program for low risk offenders. It was commissioned by the Victorian Department of Health and Human Services (DHHS) and Corrections Victoria in September 2016. The program is designed for offenders deemed to be at low risk of reoffending, and the majority of participants will have been issued a community correction order with an attached AOD treatment and rehabilitation condition.

The program is designed to explore the interrelationship between AOD use and offending behaviour. It encourages and invites participants to explore behavioural change. The title of the program (Choices) was chosen as it emphasises the choice the individual has when they attend and choose to participate in the program. Furthermore, it highlights the therapeutic underpinnings of the program of Motivational Enhancement and Cognitive Behavioural Therapy.

The program is interactive, with a strong focus on activities. This will ensure that the program meets adult learning principles, while at the same time takes into consideration the different levels of language, literacy and numeracy of the participants.

The Choices Program provides an alternative to the assessment and counselling treatment which is generally targeted at higher risk offenders. This is an essential pathway to provide to low risk offenders, as evidence indicates that:

- Approximately 30% of Victorian supervised court orders with an AOD treatment and rehabilitation condition are assessed as low risk of reoffending (using the Level of Service, Risk/Need/Responsivity risk assessment tool).
- Delivering intensive interventions to low risk offenders can increase their risk of re-offending or have no impact at all.

(Dept. Health and Human Service, 2016)

Key Objectives

The program aims to identify and address harms associated with AOD use.

The key objectives of the program are to:

- Increase self-awareness of the relationship between AOD use and offending.
- Identify the range of potential harms associated with alcohol and different types of drugs and methods of use.
- Understand the short and long term effects of use on physical and mental health.
- Identify the drivers and patterns of use and the interrelationships with other issues.
- Improve knowledge of concepts of cravings, tolerance, dependence and withdrawal.
- Understand the stages of change and how to plan for changing behaviour.
- Develop strategies to identify levels of risk and reduce impacts and consequences.
- Provide strategies and interventions for self-monitoring and relapse prevention.
- Inform, support and motivate clients to access additional help where required.
- Be culturally safe and responsive to the needs of particular clients, including Aboriginal people.
- Be appropriate to the offending population as the target cohort.

Therapeutic Approach

To achieve these key objectives, UnitingCare ReGen and Australian Community Support Organisation (ACSO) worked in partnership to develop a psychoeducation program that incorporates didactic, cognitive-behavioural and motivational enhancement strategies. The three-hour duration of this program limits the nature and extent of strategies used but the intent is to inform, prompt thinking about choices, provide some strategies for behaviour change and motivate participants to begin making changes that they may deem to be necessary. There is a body of evidence that demonstrates that education or information provision only programs for offenders tend to be ineffective as a strategy for behaviour change (Miller & Day, 2015).

Psychoeducational groups are professionally delivered interventions (stand-alone or one component of a treatment program for those with more serious issues) designed to integrate psychotherapeutic and educational interventions. Delivered in health care and community settings, this empirically-supported approach aims to facilitate dialogue and social learning within the group (Lukens & McFarlane, 2004). Groups provide information from facilitators and group members, which participants can use to make informed decisions about their own lives.

These groups are consistent with a 'brief intervention approach', in which feedback is provided regarding behaviour patterns and consequences, taking responsibility for behaviour is encouraged and specific strategies for goal setting and changing behaviours are provided. Brief intervention approaches within a psychoeducational program do more than educate; they examine the need to change, provide advice and strategies for change and attempt to enhance participants' motivation for change (Higgins-Biddle & Dilonardo, 2013). Brief interventions of varying duration have been found to be effective in reducing AOD consumption (Proude et al., 2009).

The change strategies employed in a psychoeducational brief intervention are typically based on cognitive behaviour therapy techniques that provide a strong evidentiary basis for reduced AOD use and offending behaviour (Latessa, 2006). Underpinning the psychoeducational approach is the empathic style of the facilitator and the motivational enhancement techniques used. This approach has been demonstrated to be effective, particularly with those who are resistant to change. Research consistently shows significant, albeit small to moderate, effects in terms of improved retention in treatment, enhanced motivation to change, and reduced offending (Miller & Rollnik, 2002; Hettema et al., 2005; Rubak et al., 2005, McCurran, 2009).

Program Structure

The Choices Drug Intervention Program is comprised of six modules:

01. Module 01 – Welcome and Introduction
02. Module 02 – Offending and Alcohol and Other Drugs (AOD) Use
03. Module 03 – AOD and their Effects and Mental Health Impacts
04. Module 04 – Risks, Harms, AOD & Offending
05. Module 05 – Making Changes
06. Module 06 – Maintaining Change
07. Module 07 – Support and Other Information

About This Manual

The manual is designed to support facilitators in the preparation and delivery of the Choices Program, and includes additional information that will support facilitators to respond to questions that may arise. The 'Context' chapter provides a broad overview of the evidence associated with providing AOD programs to low-risk offenders, underpinning the need to develop a program of this type in Victoria.

ReGen and ACSO continue to work together to deliver this program:

- Coordinating the delivery of this state-wide program (ACSO).
- Maintaining an online support resource for organisations and facilitators (ReGen).
- Implementing continuous improvement processes to ensure the resource remains up-to-date and relevant (ReGen).
- Training facilitators in the delivery of the program (ACSO and ReGen).

About the Participant Workbook

The Participant Workbook is to be distributed at the beginning of the program. The workbook contains information covered in the program as well as the Activity Sheets used within the program, except for Activity 4, which the facilitator will need to copy prior to delivering the program.

The workbook also includes some additional tools that can be completed post program to support behaviour change.

About the Implementation Manual

The implementation manual provides information for consideration when setting up a group work program, staffing requirements and managing challenging behaviour within a group context.

About the Online Support Resource

The online resource provides facilitators with access to the latest version of the program, evidenced based reading material and brochure information that further supports the delivery of the program.

It provides organisations with latest version of the implementation manual and templates for the administration and promotion of the program.

Furthermore, the online resource provides a place where facilitators and organisations can pose questions and receive responses on the administration and delivery of the program.

CONTEXT:

Overview of Participant Cohort

LOW RISK OFFENDERS

The identification of low risk offenders is determined through a low risk offenders assessment conducted by Corrections Victoria. The assessment is based on the Risk-Needs Responsivity principles/model.

The Risk-Need-Responsivity (RNR) principle was developed by Andrews and Bonta (2006). The Risk principle refers to the probability of re-offending. Low risk suggests those offenders have low probability of recidivism with few risk factors (Lowenkamp & Latessa, 2004; Andrews & Bonta, 2006). Andrews and Bonta (2006) report that intensive rehabilitation treatment and supervision should be reserved for higher risk offenders, and lower risk offenders should receive lowers levels of treatment and supervision.

Offenders assessed as low risk have more identified personal strengths and few treatment needs compared to high risk offenders (Andrews & Bonta, 2006), and "often, the treatment needs of low risk offenders are only weakly associated with their criminal behaviour" (Lowenkamp & Latessa, 2004, p.2). These needs are non-criminogenic, such as depression and anxiety. Low risk offenders have more pro-social attitudes, some have good employment, positive family relationships, pro-social acquaintances and limited criminal history and few, if any, substance use problems (Lowenkamp & Latessa, 2004). (N.B. The majority of participants in ReGen/ACSO's Choices Program will have been issued a community correction order with an AOD treatment and rehabilitation condition – meaning that they are likely to have some substance use in their lives, although levels of dependence will be variable.)

Andrews and Bonta state that low risk offenders would benefit more from being referred to non-criminal justice agencies for services to address these non-criminogenic needs. Evidence supports the notion that minimal treatment should be provided to low risk offenders. According to meta-analyses, intensive treatment and supervision can reduce the probability of recidivism amongst higher risk offenders; however, it can actually increase the risk of recidivism for lower risk offenders (Lowenkamp & Latessa, 2002; Bonta, Wallace-Capretta, & Rooney, 2000; Lauen, 1997).

Programs for low risk offenders should involve teaching new behaviours and cognitions, and should be tailored to their learning style, including their verbal and cognitive thinking ability (Andrews & Bonta, 2006).

COMMUNITY CORRECTION ORDERS

What is a Community Correction Order?

The majority of participants in the Choices Program will have been issued a community correction order (CCO), generally with a treatment and rehabilitation condition.

A community correction order is a flexible sentencing order which is served in the community. The order can be issued instead of or in addition to imprisonment or a fine.

Terms and Conditions for CCOs

Offenders sentenced to a CCO must abide by standard terms, such as:

- Not leaving Victoria without permission.
- Not reoffending.
- Reporting to a community corrections centre.
- Abiding by written directions from the Secretary of the Department of Justice.

(Sentencing Advisory Council, 2014)

Every CCO must also abide by one additional imposed condition. One of these conditions requires the offender to undertake treatment and rehabilitation for a substance use issue.

CCO Data

In Victoria, slightly less than 11,000 CCOs were made by magistrates in 2012 – 2013. Of these, 3.9% were for drug specific crimes (Cultivation, Manufacture & Traffic 2.7% and Possess/Use, 1.2%). Assessment and Treatment conditions (for example, for AOD abuse/dependence or mental health) can be added to a CCO and in the period 2012 – 12, 81.8% (8,910) of CCOs received an assessment and treatment condition (Sentencing Advisory Council, 2014).

Data from Community Corrections provides further information on low risk offenders in Victoria who also have a treatment and rehabilitation condition placed on their order. In 2015 – 2016 there were 1,624 offenders who were identified as being low risk who also received an AOD treatment order. Of these, 86% were male and 14% female. The age ranges for males are generally well distributed between the ages of 18 – 50 (91%) with 9% aged 51 or above. A similar trend occurs for females. The majority of males are employed (61%), whereas 36% of females are either employed (24%) or undertaking home duties (12%). Slightly less than 2% of males and females are students (Low Risk Offender Community Correction Order Data, 2015/16).

Drug Use of Offenders

There is a dearth of research exploring AOD use and offending within the low risk offending population, with most studies focusing on people in police detention or prisons. The Drug Use Monitoring Australia (DUMA) program reports on adult detainees in police custody in selected cities around Australia. It is one of the key sources of information in understanding AOD use and criminal involvement. In 2013 – 14, a total of 3,456 adult detainees were interviewed in the DUMA program, of whom 81% were male, a gender ratio that is consistent with the Victorian Community Corrections population (Coghlan et al., 2015; Sentencing Advisory Council, 2014).

The provision of a urine sample for analysis from police detainees at sites for the DUMA study is voluntary, with 1,551 people electing to do so in 2013 – 2014 (286 women and 1, 265 men). Of these, 73% tested positive to at least one drug. Cannabis was the most commonly detected substance (46% positive tests), followed by amphetamines (37%), benzodiazepines (24%), heroin (8%), methadone (5%), buprenorphine (9%) (Coghlan et al., 2015).

Coghlan et al (2015) also identify drug use within each of the gender samples; however, note that comparisons between men and women should be done with caution due to the small number of women within this sample. Within the male cohort, positive tests were found for cannabis (46%), amphetamines (34%) benzodiazepines (22%) and opiates (18%). Within the female cohort, positive tests were found for amphetamines (50%), cannabis (42%), benzodiazepines (31%) and opiates (30%). Alcohol use was self-reported with 41% identifying consuming alcohol in the 48 hours prior to arrest.

These data highlight that offending and AOD use co-occur at a high rate. Reliable studies establish that most individuals who commit a crime are substance involved and that nearly half of all offenders are intoxicated at the time of offending (Payne & Gaffney, 2012). But this alone doesn't tell us about causative relationships between specific drugs used, whether intoxication or dependence was the issue and the relationship with offending behaviour.

We do know that some drugs have specific effects that can lead to higher rates of offending. For example, psychotic symptoms such as paranoia and delusions are often experienced by people who use methamphetamine, with recent estimates of up to approximately 40% of users affected. Symptoms can occur irrespective of any prior history of psychosis. Although transient in a large proportion of users, acute symptoms can include agitation and violence (Glasner-Edwards & Mooney, 2014). It has also been demonstrated that there is a dose-related increase in violent behaviour during periods of methamphetamine use that is largely independent of the violence risk associated with psychotic symptoms (McKetin et al., 2014).

There is a well-established link between petty acquisitive crime such as shoplifting and use of drugs such as opiates. This might reflect an escalating pattern of drug use. Around 25% of police detainees identify this as a cause of offending. Although it should be noted that this pattern of offending is more likely to be associated with dependent use (Pierce et al., 2015; Gaffney et al., 2010).

That alcohol was attributed in as many offences as all illegal drugs combined in Australian police detainees in 2010 highlights that alcohol intoxication plays a major role in offending (Payne & Gafney, 2012). There are many theories that seek to explain this association. For example, Zhang and colleagues (2002) summarise three theories:

01. alcohol has a disinhibiting effect (i.e. that alcohol has pharmacological effects that loosen behavioural constraints);
02. alcohol is deliberately consumed prior to intended criminal behaviour in order to subsequently excuse that behaviour ('deviance disavowal'); and
03. alcohol is consumed in order to achieve the required 'courage' to offend (the 'embolden' hypothesis).

The literature on psychosocial risk factors for problematic AOD use and offending behaviour in young people suggests that some may be shared (Curcio et al., 2013) and warrant focus in this low-risk offender program. For example, high levels of impulsivity or sensation-seeking may be exacerbated during periods of AOD use such as binge-drinking. This combined with a peer group influence and unstructured social time activities may heighten the possibility of re-offending (Eker & Mus, 2016).

These are just some examples of associations between AOD use and offending behaviour. They represent grounds for heightened awareness or concern for low-risk offenders who may need to make changes to avoid further offending. These associations provide the basis for discussion and the development of avoidance strategies for participants in this psychoeducational program.

CONSIDERATION

FOR DELIVERING THE PROGRAM TO CULTURALLY DIVERSE COMMUNITIES:

The provision of AOD treatment services to all culturally diverse communities by mainstream providers requires that services are culturally respectful. Components of cultural respect were outlined in the Alcohol Treatment Guidelines for Indigenous Australians (Commonwealth of Australia, 2007), but are applicable across diverse cultural groups, including women and people who identify as lesbian, gay, bisexual, transgender, intersex or queer (LGBTIQ).

CULTURAL RESPECT

In summary, the term **cultural respect** is comprised of:

01. **Cultural awareness** – having knowledge and understanding of different cultures and being aware of and appreciating the potential for differences. It involves personal reflection about one's culture, biases and tendency to stereotype. It is not about becoming 'expert'.
02. **Cultural competence** – capacity to provide effective care to a client who has a different cultural background. This requires blending cultural knowledge with evidence-based clinical competence to bring about better health outcomes.
03. **Cultural safety** – from a client's perspective in regards to their experience with a health care provider. It is based on the capacity of the healthcare provider to acknowledge and respect differences in cultural identity. Unsafe cultural practice is any action that diminishes, demeans or disempowers the cultural identity and wellbeing of an individual (p.14).

Broadly, facilitators need to ensure that all people in a program group are given space to speak and participate, without being dominated by the majority. The facilitator also needs to ensure that any casual or overt discrimination in the group is not tolerated. They should also consider commencing groups with an Acknowledgement of Country (for guidance, see http://www.dpc.vic.gov.au/index.php/aboriginal-affairs/protocols-for-recognising-traditional-owners).

Below is some information which will help facilitators to ensure the program is inclusive to the following groups:

CULTURALLY AND LINGUISTICALLY DIVERSE (CALD) CLIENTS

Facilitators need to be aware of the following factors when addressing culturally and linguistically diverse participants in a group:

- Owen et al. (2011) found that cultural sensitivity is an important factor in supporting client engagement.
- Clients from culturally and linguistically diverse communities typically experience fewer AOD-related problems than the general Australian population, but they are also under-represented in treatment services (DAMEC, 2001).
- Barriers to service entry include feelings of shame; lack of treatment service awareness; lack of culturally appropriate, translated material; treatment service reluctance to engage families in the treatment process; and, lack of adequate translator services (DAMEC, 2001).
- Translators will sometimes be required and should be booked ahead of time.
- Participants may wish to bring a support person instead of/in addition to the translator to assist with understanding of course materials.

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

Facilitators need to be aware of the following factors when addressing Aboriginal and Torres Strait Islander people in a group:

- Aboriginal and Torres Strait Islander people comprise many different groups, cultures and languages. There is no one-size-fits-all approach.
- Aboriginal and Torres Strait Islander people are minorities in Australian society and may experience many levels of disadvantage. The Australian Institute of Health and Welfare (2014) reported that in 2008 – 2012, due to a range of factors such as chronic disease, the life expectancy of Aboriginal and Torres Strait Islander Peoples was approximately ten years less than that of non-Indigenous Australians.
- Violent victimisation rates among Aboriginal and Torres Strait Islander people are two – three times higher than those among non-Indigenous Australians. This increases to four – six times higher in the case of family violence (Australian Institute of Criminology, 2015).
- The Koori Alcohol Action Plan 2010 – 2020 states that high levels of AOD consumption increase the risk of chronic disease in Aboriginal and Torres Strait Islander people and are also factors in the likelihood of injury, violence, suicide and self-harm, overdose, drowning and road trauma.
- Studies show that while Aboriginal and Torres Strait Islander people are less likely than non-Indigenous Australians to drink alcohol, those who do are more likely to use at risky and high-risk levels (Commonwealth of Australia, 2007).
- Aboriginal and Torres Strait Islander people experience contact with the criminal justice system (both as offenders and victims) at significantly higher rates than non-Indigenous Australians (Australian Institute of Criminology, 2015).
- Despite forming less than three per cent of the Australian population, Aboriginal and Torres Strait Islander people are vastly overrepresented in prison. Imprisonment rates are around 12 times those of non-Indigenous Australians (Australian Institute of Criminology, 2015).

WOMEN

In Australia, the overall offender population constitutes significantly more males than females, with around 80% of offenders being male (Sentencing Advisory Council, 2014). With this in mind, it is important to be aware that program groups will often be imbalanced in terms of male/female ratio. The facilitator needs to ensure that all voices are heard and that female participants are given the space to speak and share their thoughts without being interrupted or dominated by male participants. Ideally, all groups would include more than one female, but this is not always possible.

Other factors to be aware of include:

- In studies of women who use substances and offend, there is frequently a history of childhood abuse, experiences of violence as an adult and the experience of mental health illness and a lack of social supports (Johnson, 2004; Bowles et al., 2012; DeHart et al., 2014).
- It is acknowledged that many women on correction orders have experienced trauma (Trotter & Flynn, 2016). Generally, women presenting for AOD treatment have disproportionately higher rates of trauma and victimisation than men (Green, 2006; Weiss et al., 2003).
- Women with young children may need to arrange childcare for the duration of the program. Although most services providing the program will not have the capacity to offer childcare, options for the individual can be discussed during telephone registration. The program can be scheduled inside school/day-care hours and in some cases an infant or child may need to be brought along to the program.
- In Australia, women comprise 70% of primary carers of people with a disability or elderly people (Australian Bureau of Statistics, 2015). Options for the individual should be discussed during telephone registration.
- Johnson (2004) identifies that females are more likely to commence substance use before engaging in offending behaviour (whereas men tend to commence offending behaviour before substance use), and that women's offending is more likely than men's to be acquisitive in nature.
- Aboriginal and Torres Strait Islander women who offend are more likely to associate their offending with alcohol intoxication (60%) than non-indigenous women (16%) (Johnson, 2004).

LESBIAN, GAY, BISEXUAL, TRANSGENDER, INTERSEX, QUEER (LGBTIQ) CLIENTS

Miller et al. (2013) report that whilst people identifying as lesbian, gay, bisexual and transgender are over-represented among substance-use treatment seekers, there are very few programs designed with their needs in mind and program staff generally received little to no education about the needs of LGBT people. Barriers to access may include fear of stigma or previous stigma. McNair et al. (2014) found that almost one quarter of same-sex attracted women have had experiences of discrimination within health care. Program providers need to be aware and conscious of the stigma that minority groups experience, ensuring they have the opportunity to be heard within the group, that language is inclusive (and assumptions aren't made about sexuality, gender or lifestyle) and that any overt or casual discrimination in the group is not tolerated.

YOUNG PEOPLE

The Choices Program is designed for people 18 years and above. In the interest of protection, younger offenders should never be mixed with older offenders. In the event that this program is being adapted for younger offenders, program providers need to be aware of the following factors:

- The program needs to be developmentally appropriate. Content and delivery styles for adults are not always appropriate for young people. This is further complicated due to the marked differences between potential clients in regard to maturity, needs and social expectations. When developing intervention strategies, it is important that they are built around appropriate expectations and changing developmental needs (Yates & Masten, 2004). For more information about adapting AOD programs to development stages, see YSAS's Youth AOD Tool Box: http://www.youthaodtoolbox.org/theories-frameworks
- YSAS's Youth AOD Tool Box lists 10 characteristics of effective youth AOD programs. Whilst this generally refers to programs which are broader in scope and longer in duration, it is a good starting point for the Choices Program. The characteristics are: 1. Client centred/socio-culturally relevant; 2. Relationship-based/focus on relationships; 3. Developmentally appropriate; 4. Comprehensive, holistic, ecological, multi-systemic and integrative; 5. Incorporate of family involvement; 6. Sufficient duration and intensity; 7. Include engagement and retention strategies; 8. Behavioural, experiential and skill focused; 9. Building on strengths; 10. Use of theory and evidence to guide program design and refinement (Bruun & Mitchell, 2012).
- Crime is committed disproportionately by young people. People aged 15 – 19 years are more likely to be processed by police for a crime, than members of any other population group (Richards, 2011).
- It is generally accepted that the majority of young offenders 'grow out' of offending. Rates of offending generally peak in late adolescence and start to decline in early adulthood (Fagan & Western, 2005).
- In comparison with adults, juvenile offenders tend to: be less experienced at committing offences; commit offences in groups; commit offences in public areas such as on public transport or in shopping centres; and, commit offences close to where they live. They also tend to commit crimes which are attention-seeking, episodic, unplanned and opportunistic (Cunneen & White, 2007 cited in Richards, 2011).
- With young people, the causes of drug use are not the same as the causes of problematic drug use. Drug use can be part of the normal risk-taking behaviour associated with adolescence (Logan, 2016).
- Problematic drug use is not an isolated behaviour. It is one of a number of risk behaviours – including withdrawal from school, unprotected sexual intercourse and delinquency, and psychosocial disorders, which share common causes and can co-exist and exacerbate each other (Logan, 2016). Failure to see problematic drug use as part of a larger pattern of behaviour can be a barrier to effective interventions, particularly as each risk behaviour could be contributing to another risk behaviour (Spooner, Mattick, & Howard, 1996).
- A range of individual, family, social, environmental and other risk factors have been identified for problematic youth drug use. These include: genetic factors; gender identity; attitudes and personality traits; family factors; childhood physical and sexual abuse; ethnicity; socio-economic status; macro-economic factors; locus of control; mental health; knowledge; stress and coping mechanisms; peer factors; school factors; age of first use (Logan, 2016).
- Studies show that young people from culturally and linguistically diverse backgrounds are strongly represented in the AOD service system (MacLean et al., 2009; YSAS, 2011).

PREPARING

FOR DELIVERY:

A range of materials have been provided to support the delivery of the Choices Program, including:

- The Choices Program Facilitator Manual
- The Choice Program PowerPoint Presentation
- A number of interactive animated presentations
- A number of video resources
- The Choices Program Participant Workbook (containing an introduction to the program, activity sheets and information on how to access further resources).

It is expected that you orient yourself to the materials prior to delivering the course. You will also need to access to the following resources in order to deliver the training:

- A computer
- Whiteboard and markers
- Data projector
- Copies of the Participant Workbook
- Computer Speakers
- Pens for each participant
- ReGen Drug and Alcohol fact sheets http://www.regen.org.au/resources/drug-factsheets
- Drugs and mental health brochures

ACTIVITY SHEETS

The activity sheets for this program are found in the participant's workbook, aside from Activity 4 Effects of AOD. This handouts for this activity are found at the back of Part 2 of this manual (pg. 163) and will require photocopying prior to delivery.

Facilitators' instructions for the activities are located in the facilitators' notes for delivery of the program.

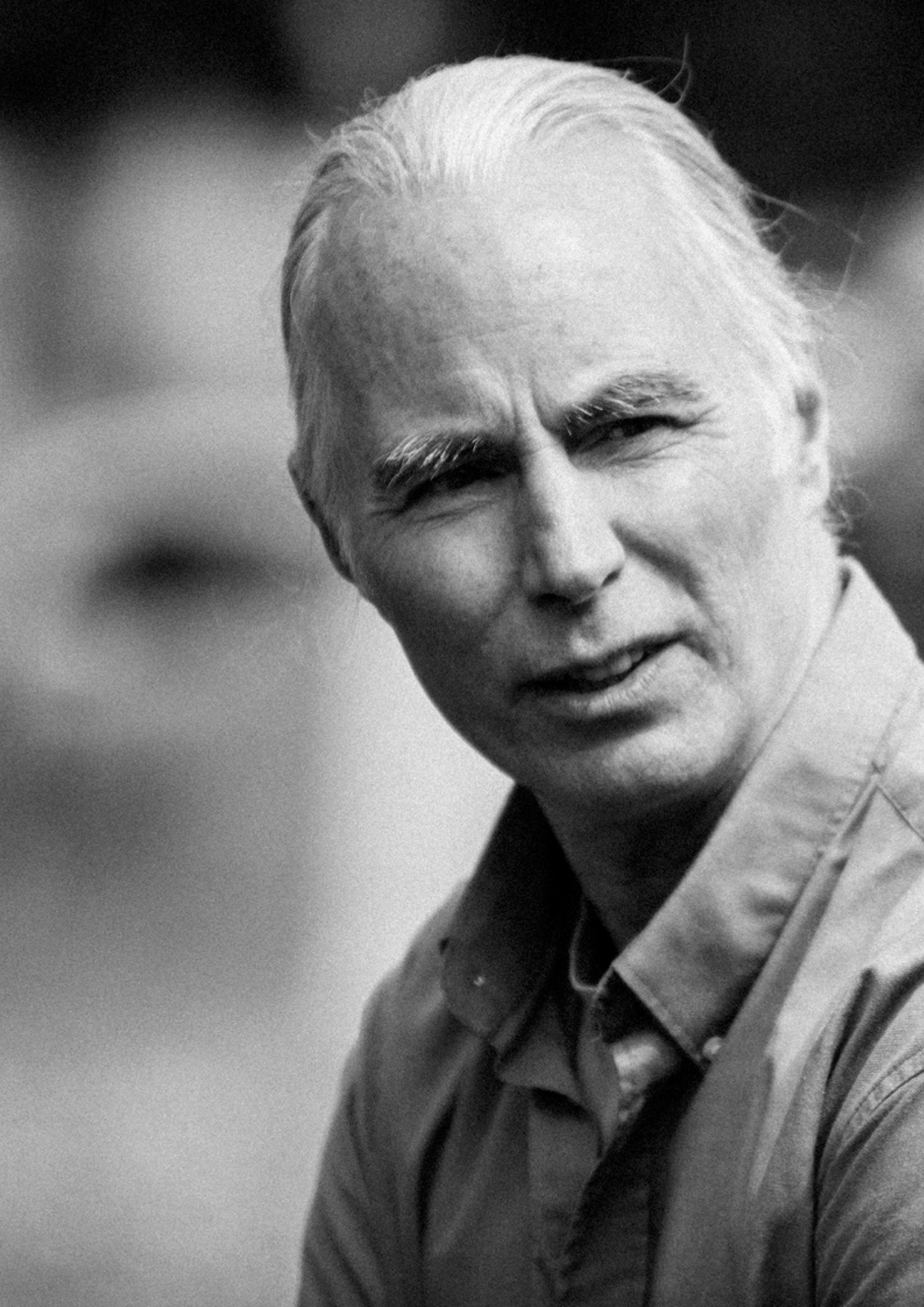
VIDEOS AND INTERACTIVE PRESENTATIONS

All videos are embedded in the PowerPoint presentation. This means that you will need to use the USB key provided or copy the Choices Program Folder onto your computer. If you are copying these files onto your main computer and using the program from there, please ensure that you copy the whole folder from the USB, to ensure that the links between the PowerPoint and the various video resources continue to operate correctly. To display the PowerPoint presentation you will need to access it within the Choices Program Folder.

DELIVERY PLAN:

MODULE	TOPIC / ACTIVITY	TIME
01. Welcome and Introduction Total Time = 10 minutes	Acknowledge traditional owners Housekeeping Title and Aims of Program Participant Introduction Group Guidelines	10 minutes
02. Offending and Alcohol and Other Drug Use Total Time = 35 minutes	Introduce module and discussion: Why are you here? **ACTIVITY 01 – Function and Consequences of AOD Use** (Decisional Balance, Group) **ACTIVITY 02: How does AOD use relate to the offending for which you are here?** (Group Discussion)	5 minutes 15 minutes 15 minutes
03. Alcohol and Drugs, Mental Health and their impact Total Time: 30 minutes (40 minutes with activity)	Introduction to AOD and effects – CNS and drug classifications. **ACTIVITY 03: Short and Long Term Effects** (optional activity) Overview of Tolerance, Dependence & Withdrawal **ACTIVITY 04: Is there a problem?** Mental Health & AOD Use Video: Bucket of Vulnerability (optional video)	5 minutes (10 minutes - optional) 5 minutes 10 minutes 10 minutes
BREAK - 10 MINUTES		

MODULE	TOPIC / ACTIVITY	TIME
04. Risks, harms, AOD use and Offending Total Time: 30 minutes	Risks, harms, AOD use & Offending ▪ Drug Interaction Model ▪ OD, ▪ Poly Drug Use **ACTIVITY 05: Risks and Harms (scenarios, risk rating and strategies to reduce harm)** (Group Activity)	15 minutes 15 minutes
05. Making Changes Total Time: 30 minutes	Making Changes ▪ Stages of Change (pp 51-55) (Video is optional) **ACTIVITY 06: What stage of change are you at?** (Self-reflection) ▪ Strategies for Not interested in change - Harm Reduction ▪ Strategies for "yes … but" (ambivalence) ▪ Strategies for "Ready for Change" – controlled/reduced use & withdrawal ▪ Strategies for "Making changes" (Action) **ACTIVITY 07: Activities other than drug use**	20 minutes 10 minutes
06. Maintaining Change Total Time: 25 minutes	High Risk Situations that can trip us up in achieving our goals Strategies to manage HRS Thoughts that can trip us up **ACTIVITY 08: Managing High Risk Situations** Planning in the event that things go off the rail Relapse	5 minutes 10 minutes 10 minutes
07. Support, Summary Evaluation Total Time: 5 minutes	Support Services Summary and Questions Evaluation/Certificate Handout	5 minutes



PART 02

BACKGROUND READING

01:

WELCOME AND INTRODUCTION – BACKGROUND READING

Engaging participants is a crucial first step in the delivery of the Choices Program. This can require a significant level of understanding and skills in application, regarding:

- The variance in levels of motivation presented within the group.
- Working with both extrinsic and intrinsic motivations.
- The variety of desired goals presented by individual participants.

Given that the Choices Program targets offenders who are deemed as being at a low risk of reoffending and are generally on community correction orders, it's reasonable to expect that a significant number of participants undertaking the program will be:

- AOD treatment naïve, and/or
- Extrinsically motivated to attend, due to their correction order.

However, there is the potential for participants in the program to demonstrate varying degrees of motivation and to have a wide range of reasons for engaging. In a study of non-custodial offenders coerced into mandatory AOD treatment, Ip et al. (2008) found that participants had mixed levels of motivation, which could alter during treatment. They also found that some participants regarded their mandatory treatment as an opportunity to make changes in their lives.

Owen et al. (2011) found that gender and cultural sensitivity in the therapist are also important factors in supporting client engagement.

Credibility

Acknowledge that participants bring their own knowledge and expertise to the room.

Be authentic – acknowledge that you don't know something if asked a question you don't know the answer to, but then make a commitment to find out and follow up with the participant.

Acknowledge your own experience as a clinician – use analogies or examples drawn from your own clinical experiences where you can.

Be yourself.

Avoid self-disclosure of AOD use or any offending history.

Extrinsic and Intrinsic Motivation

Many people who enter alcohol and other drug interventions are under some form of external pressure, legal or otherwise, to do so. This does not mean that the internal motivation for engagement is necessarily low, and even if it is at the commencement of the intervention, it is a dynamic process that can and frequently does change (Prendergast, 2009; Ip et al., 2008, Colman & Vander Laenen, 2012).

In other words, all of our clients have some kind of 'wolf' that chases them through the door. Sometimes this wolf is an intrinsic motivator, at other times it may be some external force. In the case of low risk offenders, it may be external or external and internal motivators.

When delivering the Choices Program, it is important that the facilitators meet people where they are at. This means addressing the client's reason for wanting/not wanting to change – as expressed by the client – with respect and empathy. Being mindful of Prochaska and Di Clemente's Stages of Change model and stage-appropriate interventions can assist in ensuring that facilitators place emphasis on particular content, according to the needs of the participants present.

It will also be important for facilitators to use a Motivational Interviewing framework when delivering the program, and utilise strategies to work with and highlight participants' 'change talk' (statements or discussion that can be seen to support change) as it is raised throughout the session. This may support movement from one stage of change to another (Miller & Rollnik, 2013). This approach has been demonstrated to be effective, particularly with those who are resistant to change. Research consistently shows significant, albeit small to moderate, effects in terms of improved retention in treatment, enhanced motivation to change, and reduced offending (Miller & Rollnik, 2002; Hettema et al., 2005; Rubak et al., 2005, McMurran, 2009).

Acknowledgement Motivation

- Acknowledge that people will have different reasons for attending the program.
- Acknowledge that some people may have been coerced to attend the program, highlighting the benefits of completing the program, (e.g. meeting obligations, completing order) while also framing it as an opportunity to obtain factual information and strategies to assist in relation to AOD use and may be of some use in completing their order.
- Acknowledge the functionality of AOD use as perceived by participants while also providing accurate information.
- Acknowledge and work with ambivalence
- Acknowledge the different goals that each individual brings to the room (goals may range from wanting to find out a little more, meeting legal obligations, through to ceasing use and/or maintaining abstinence).
- Maintain a non- judgemental approach.

Summary

Facilitators need to focus on engagement and should be prepared to work flexibly, emphasising components of the Choices Program that:

- Are appropriate to the level of motivation presented by participants.
- Address and normalise both extrinsic and intrinsic motivations for change.
- Attend to the goals identified by participants.

A non-judgmental, authentic approach to group facilitation best supports the delivery of the program and can make as much – if not more – of an impact than the program content upon overall outcomes for participants.


Platform 2
Platform 1

02:

OFFENDING AND ALCOHOL AND OTHER DRUGS (AOD) – BACKGROUND READING

This module explores the interrelationship between AOD and offending. Drug-specific offending includes the use, possession, cultivation and trafficking of illicit drugs, as well as drink or drug driving. Drug-related offending includes other offending behaviour that, whilst not drug-specific, can be associated with drug use.

Different Types of Drug Offences

When considering alcohol and drug use and offending, there are offences that are 'drug offences' arising from the application of the Victorian Drugs, Poisons and Controlled Substances Act 1981 and offences associated with Driving under the Influence of Alcohol or Drugs as applied from the Road Safety Act 1986.

Drug-related offending can take many forms, but is related to substance use – most commonly through actions taken whilst intoxicated, withdrawing, or trying to finance the use of a substance.

LEGISLATION CONCERNING AOD

The Drugs, Poisons and Controlled Substances Act 1981 makes provision for a range of offences relating to drugs that participants need to be particularly aware of and include:

- Possession/Use
- Cultivation
- Manufacturing
- Trafficking
- There are also additional laws pertaining to the sale and/or display of bongs, 'ice pipes'

POSSESSION/USE

In Victoria, it is an offense to 'use' a drug of dependence, including smoking, inhaling, injecting, swallowing or by other means of introducing the drug into the body.

According to the Drugs, Poisons and Controlled Substances Act 1981, an individual is considered to possess a drug of dependence if they have physical control or custody of the drug. Individuals can be charged with 'possession' if they know of the presence of a drug and intend to possess it. However, in certain circumstances, even if the individual does not know of the presence of a drug and they do not intend to possess it, they can still be charged with a criminal offence. For example, if:

- the individual is the occupier of a room in a motel where drugs are found, or
- they are the owner/driver of a car containing drugs.

Being in possession of a substance entails a person being in physical control or custody of the drug to the exclusion of others not acting with the person. Possession can include having the drug on any land or premises occupied by the person, or used, enjoyed or controlled by the person in any place whatsoever.

CULTIVATION

In Victoria, it is illegal to grow, tend or harvest any plant from which illegal drugs are derived. Cannabis and opium are the most frequent plants associated with this offence. Penalties vary for the quantity of plants cultivated.

TRAFFICKING OFFENCES

Trafficking is the movement of a drug of dependence from its source to the ultimate user. Trafficking also includes the manufacture of the drug. Therefore trafficking includes:

- Preparing a drug of dependence for trafficking (e.g. a person who cuts MDMA powder or packages quantities of an illicit drug (e.g. Cannabis, methamphetamine).
- Manufacturing or making a drug of dependence.
- Selling, exchanging, agreeing to sell, offering for sale, or possessing for sale, a drug of dependence.

Selling may be evidenced by:

- Direct evidence (e.g. observation of or participation in a sale).
- Possession of a drug in a quantity much greater than a quantity which would be for personal use.
- An admission that the person intended to sell the drug.

An individual can also be charged with trafficking if they sell or offer to sell a person a harmless substance that they believe is a drug, or if they admit to the police that they have done one of these things. It can also be determined that a trafficking offence has occurred if an individual sells drugs to a friend, or if a person gives another person money to buy drugs for them (even if they don't use the drugs or make any money from the sale).

Further information regarding the Drugs, Poisons and Controlled Substances Act can be found at: Fitzroy Legal Service Law Handbook

Driving-Related Offences

The Road Safety Act 1986 includes offences for both drink and drug driving charges.

Whilst drink driving laws allow a driver on a full license to drive at or under a blood alcohol concentration (BAC) of 0.05, a zero-tolerance approach is being taken with drug driving laws. The oral swab test used by Victoria Police to conduct roadside drug tests detects amphetamines, 3,4-methylenedioxy-N-methylamphetamine (MDMA or 'ecstasy') and cannabis. Police can also ask a driver suspected of being impaired by a drug – based on observation – to submit to a blood test, which will identify the presence of other illicit drugs not captured by the oral swab test.

In 2016, Victoria Police will increase Roadside Drug Testing (RDT) to 100,000 tests per year, compared to over 3 million breath tests for the detection of alcohol.

The current more prevalent offences from the Road Safety Act 1986 that pertain to Drug Driving are:

- **s49 (1)(a) – Driving under the influence** of an intoxicating liquor or any drug to 'such an extent as to be incapable of having proper control of the motor vehicle'.
- **s49 (1)(ba) – Drives a motor vehicle or is in charge of a motor vehicle while impaired** by a drug (other than alcohol). This offence includes all drugs, legal and illegal. This 'driving while impaired' provision was regarded by the legal profession as being easier to prove than a charge of driving under the influence and was added to legislation in 2000.
- **s49 (1) (bb); s49 1(h) s49 (1)(i) – Driving whilst illicit drug present** as detected in blood or oral fluid. Typically this relates to cannabis, ecstasy and methamphetamine.
- **S49 (1)(bc) – Driving whilst both the prescribed concentration of alcohol or above is present in blood or breath (BAC offence) and with illicit drugs present in the blood or oral fluid.** This is the combined offence, drivers are now tested for both drugs and alcohol.

It is also an offence to refuse to undergo assessment for drug impairment or refuse to comply with request for a blood or urine sample.

Statistics Relating to Drug-Specific Offending

Victorian crime statistics (available from Victoria Police) separate drug offences into two categories: consumer (possess/use) and provider (cultivate, manufacture and trafficking) offences. The ratio of consumer offences to provider offences was 3:1 in 2013/2014 (Victoria Police, 2014).

There were 17,698 offences for possession/use of a drug in 2013/2014 with cannabis offences being the most frequent, as shown below:

- Cannabis – 7,260
- Amphetamine type stimulants – 4,801
- Ecstasy – 902
- Heroin – 837
- Cocaine – 153
- Other (steroids, hallucinogens, pharmaceutical and others not classified – 3,745)

In the same time period, there were 5,746 offences for cultivation, manufacture and trafficking of drugs, with cannabis offences slightly higher than amphetamine-type stimulant offences (1,854 and 1,815 respectively) followed by heroin offences (319) and ecstasy offences (282).

As can be seen, cannabis and amphetamine-type stimulants (amphetamine, methamphetamine) are the drugs most likely to be associated with drug-specific offences, with smaller numbers of offences associated with heroin and ecstasy.

DRUG DRIVING OFFENCES

In 2013, 1 in 16 drivers who were tested for drugs, tested positive at RDT (2,522), with the majority of positive drug driving tests finding methamphetamines (60%) followed by methamphetamines and cannabis together (18%), cannabis only (17%) methamphetamine and MDMA combined (2%), MDMA alone (1.6%). All three drugs were present in 0.5% of positive tests (Tester, 2014).

Drug-Related Offending Behaviour

Understanding the drugs/crime nexus has been a focus of research for quite some time, with a correlation between substance use and offending clearly established (Coghlan et al., 2015; Copes et al., 2015, Payne & Gaffney, 2012). The three key correlations between AOD and crime are economic (to procure funds to pay for AOD), psychopharmacological (as a result of intoxication or withdrawal) or systemic (related to the drug trade). Substance abuse or dependence are identified as criminogenic need (risk factor) in the Risk, Needs and Responsivity framework for Offender Rehabilitation used in Victoria.

In Australia, the overall offender population constitutes significantly more males than females, with around 80% of offenders being male (Sentencing Advisory Council, 2014). As a result, our understanding of AOD and offending is largely influenced by a male gendered lens; however, there have been some small studies involving women. Where studies have addressed female offending specifically, the numbers in study cohorts are generally quite small. In this section, much of the data provided represents self-reported information from studies of AOD-using offenders in Australia, largely from those in police custody or prisons, and not specifically the low risk offender cohort.

TEMPORAL ORDER OF OFFENDING AND AOD USE

Makkai & Payne (2003) identify that for males, offending most often precedes drug use, with offending increasing as substance use escalates and that males are more likely to engage in violent crime and property crime. Aboriginal and Torres Strait Islander men who use substances and engage in offending behaviour related to self-reported alcohol consumption at the time of offending at higher rates than non-Aboriginal and Torres Strait Islander equivalents (43% vs 28%). Self-reporting of involvement with illicit drugs in relation to crime is rated the same for both groups (Putt et al., 2005).

Johnson (2004) identified that females are more likely to commence substance use before engaging in offending behaviour, and that women's offending is more likely to be acquisitive in nature. In the studies of women who use substances and offend, there is frequently a history of childhood abuse, experiences of violence as an adult and the experience of mental health illness and a lack of social supports (Johnson, 2004, DeHart et al., 2014). Aboriginal and Torres Strait Islander women who offend are more likely to associate their offending with alcohol intoxication (60%) than non-Indigenous women (16%) (Johnson, 2004).

Further gender differences are discussed in the Context section at the beginning of this manual. Facilitators should acquaint themselves with this material for Module 2.

RELATIONSHIP BETWEEN AOD USE AND OFFENDING

There is a dearth of information specifically identifying the relationship between AOD use and offending in the low risk offender cohort; however, studies of other offender cohorts provide some insight. The Drug Use Monitoring Australia (DUMA) program reports on adult detainees in police custody in selected cities around Australia. It is one of the key sources of information in understanding AOD use and criminal involvement. In 2013 – 14, a total of 3,456 adult detainees were interviewed in the DUMA program, of whom 81% were male, a gender ratio that is consistent with the Victorian Community Corrections population (Coghlan et al., 2015; Sentencing Advisory Council, 2014).

The provision of a urine sample for analysis from police detainees at DUMA study sites is voluntary, with 1,551 people electing to do so in 2013 – 2014 (286 women and 1, 265 men). Of these, 73% tested positive to at least one drug. Cannabis was the most commonly detected substance (46% positive tests), followed by amphetamines (37%), benzodiazepines (24%), heroin (8%), methadone (5%), buprenorphine (9%) (Coghlan et al., 2015).

Alcohol use was self-reported with 41% identifying consuming alcohol in the 48 hours prior to arrest. According to the National Health and Medical Research Centre guidelines for drinking, alcohol consumption within this cohort is considered very risky, with self-reported drinking, on average, 19 standard drinks on the last drinking occasion, with some consuming as many as 31 standard drinks. Drinks were consumed at an average rate of 4 drinks per hour (Coghlan et al., 2015).

Of police detainees in Australia who use substances, 45% associated their offending with their use of substances; with alcohol the most commonly associated with offending (Coghlan et al., 2015, Payne & Gaffney, 2012). Payne and Gaffney (2012) conducted qualitative interviews with illicit drug users who were offenders, and identified that 54% of those who used heroin associated their drug use with offending followed by 33% of amphetamine users and 13.5% of cannabis users. 27% of non-heroin illicit opiate users and 10% of ecstasy users attributed use to offending. However, due to very low numbers of people in the latter two groups, the authors recommend that caution be used in interpreting the figures.

When considering the main association between their illicit drug use and offending, of all detainees who tested positive and identified an association between drug use and offending, 60% cited being intoxicated or 'hanging out for drugs' as the association with their offending, and 25% identified financial reasons, such as the need to fund dependence/use, as the association (Coghlan et al., 2015).

Financial reasons for offending behaviour were most commonly reported by those using opioids (heroin – 45% and non-heroin opiates – 33%). Financial reasons were also identified as the reason for offending for slightly less than one quarter of those using amphetamines; however, for this group it was not the most likely reason for offending (Coghlan et al., 2015).

Intoxication and 'hanging out' for drugs as the association with offending was most commonly related to alcohol, amphetamines, illicit benzodiazepine, cannabis, and ecstasy (Coghlan et al., 2015). A proportion of heroin users identified that intoxication or 'hanging out' were associated with their offending; however, heroin users were more likely to identify financial reasons for the association (Coghlan et al., 2015). Offending related to the use of amphetamines/methamphetamine is most commonly associated with the psychopharmacological effects of intoxication and 'coming down' (Gately et al., 2011).

Alcohol is commonly associated with driving under the influence offences, disorder offences and violent offences, whilst illicit drug use is commonly associated with drug offences, property offences and traffic offences. Offences such as breaching an intervention order appear to be relatively evenly distributed to both alcohol and drugs (Coghlan et al., 2015).

Miller and colleagues (2013b), in a large interview-based study of people attending nightclub precincts in various Australian locations, found that the practice of pre-loading (consuming alcohol prior to going out) was common, and was associated with higher BAC levels throughout the drinking session. This study also found that those who engaged in pre-loading were more likely to have engaged in risk behaviours in the three months prior to the interview (aggressive behaviours – 18%, property crime while intoxicated – 5%, drink driving – 16%) and experience alcohol-related accidents and injuries. In addition, those who pre-loaded were more likely to use illicit drugs and mix energy drinks with their alcohol (Miller et al., 2013b). Reasons given for pre-loading were mainly associated with financial considerations; smaller numbers cited reasons for pre-loading as 'for fun' or an intention to become intoxicated prior to going out (Miller et al., 2013b).

ALCOHOL AND VIOLENT OFFENDING

Alcohol intoxication has been shown to increase the likelihood and amplitude of aggressive and violent behaviours (Miller et al., 2013a). The pharmacological effects of alcohol consumption have been found to reduce an individual's cognitive and verbal capacity to resolve conflict, thereby increasing the likelihood of involvement in arguments and fights (Miller et al., 2013a). However, it is worth noting that not all people who become intoxicated will act out in a violent or aggressive manner; individual factors, such as pro-aggressive attitudes and anger are important determinations of violence (Miller et al., 2013).

METHAMPHETAMINES AND VIOLENT OFFENDING

Intoxication by, and 'coming down' from, amphetamines/methamphetamines is largely associated with assault and property offences (Gately et al., 2011).

The effects of methamphetamine (particularly the role methamphetamine plays in increasing the release of noradrenalin) can inhibit the cues that normally control behaviour, increase arousal, interfere with communication and intensify emotions (Brecht & Herbeck, 2015) and there is also a strong association with violent behaviour when a person uses methamphetamine in combination with alcohol (McKetin et al., 2006).

> *"..we find that the perceived relationship of methamphetamine use and violence in our sample appears strongest for those with the most severe methamphetamine problems and addiction severity, suggesting methamphetamine-related violence may be part of a complex set of problems, in which paranoia is particularly prominent " (Brecht & Herbeck, 2015 p. 482).*

The current research suggests that methamphetamine-related violence involves a complex interaction between the individual, the substance and the situation. McKetin et al. (2006) posit that individual factors (e.g. childhood aggression and conduct disorders) are associated with the uptake of methamphetamines and may also be important determinants of later violence, with methamphetamine use exacerbating the violence.

Summary

While the data outlined above illuminate the relationship between AOD and offending – generally as a result of intoxication or post use effects or as a means to fund substance use – a significant proportion of drug using offenders, that is, 65%, did not, at the time of the charge, associate their offending to their substance use (Coghlan et al., 2015), whether this is the situation with the low risk offender cohort is currently unknown. This may be an issue to consider when delivering the behaviour change modules that come later in the Choices Program.

03:

AOD AND THEIR EFFECTS AND MENTAL HEALTH IMPACTS – BACKGROUND READING

This module provides participants with evidence-based information regarding AOD and their effects, both short term and long term, in relation to physical and mental health. This module also addresses the concepts of tolerance, dependence and withdrawal.

Prior to engaging in a discussion regarding the effects of AOD, the Choices Program introduces the Decisional Balance to both engage the group and to provide an opportunity for clients in the program to reflect on the pros and cons of their use to consider their need for change.

The Decisional Balance has been identified as one of the ten processes of change that support progress in the direction of change (Prochaska & Velicer, 1997) through an evaluation process. Miller and Rollnick (2013) suggest using this strategy when the clinician is avoiding influencing the direction of choice, taking a neutral stance. In this context, the neutral stance serves as an engagement tool with the group.

Central Nervous System Effect

The Central Nervous System (CNS) is like a biological form of data cabling, carrying signals from the brain to different parts of the body. To move a limb requires the brain to form the required messages. These messages are then carried via the CNS to the muscles required to make the limb move. The CNS also carries signals from the senses to the brain. Information gathered via taste, touch, sight, smell and hearing are all gathered by the senses and transmitted via the central nervous system to the brain which then interprets these experiences.

Drugs have their effect on the CNS and act on the brain to change the way a person thinks, feels and behaves. The three main types of drugs are typically classified as having three main effects at the CNS Level:

Stimulants tend to stimulate or 'speed up' the CNS. Examples of CNS stimulants include amphetamines/ methamphetamines, caffeine, nicotine, ecstasy (MDMA) and cocaine.

Depressants tend to depress, inhibit or 'slow down' the CNS. Examples of CNS depressants include alcohol, opioids, benzodiazepines, GHB, ketamine & cannabis.

Hallucinogens tend to alter perceptions by distorting messages at the CNS. Hallucinogens include lysergic acid diethylamide (LSD), psilocybin (magic mushrooms), mescaline (Peyote Cactus)

Cannabis and ecstasy mainly fit into the category as listed above; however, at high doses, they can both cause hallucinogenic effects.

Intoxication/Short Term Effects

An individual's subjective experience of the short term effects (intoxication) of AOD will be mediated by the dosage and frequency of dosing. The likelihood of adverse effects relating to intoxication are increased with higher doses and/or more frequent dosing (NDRI et al. 2007). Despite this caution, it is possible to identify common and potential symptoms experienced by people when they use AOD.

Longer Term Effects

It is important to note that research regarding the long term effects of AOD is often confounded by a range of variables, including the potential for pre-existing or comorbid health/mental health disorders and poly drug use (NDRI et al 2007).

The short (intoxication) and long term effects for each of the main drugs that would be associated with offending behaviours is listed in the tables below. The sources of information for this section include, The Australian Drug Foundation, the National Drug Research Institute, and The Australian Institute of Criminology.

Short and Long Term Effects of Individual Drugs

CNS DEPRESSANTS

ALCOHOL

Short Term Effects (Intoxication)	Long Term Effects
▪ Feeling relaxed ▪ Slower reaction times ▪ Feeling more confident ▪ Reduced inhibitions ▪ Reduced concentration At higher doses (more than 4 standard drinks): ▪ Poor memory ▪ Difficulty thinking and making judgements ▪ Intense moods – angry, sad, happy (depends on underlying mood) ▪ 'Blackouts', where you don't remember what happened ▪ Slurred speech ▪ Blurred vision ▪ Difficulty walking and clumsiness ▪ Slowed heart rate and breathing – leading to passing out, coma and possible death	▪ Dependence ▪ Brain damage – poor memory, dementia ▪ Liver diseases ▪ Stomach and bowel diseases and cancers ▪ Damage to the nervous system ▪ High blood pressure ▪ Heart failure ▪ Damage to testicles leading to impotence ▪ Muscle weakness ▪ Difficulty sleeping ▪ Mental health issues – depression, anxiety

CANNABIS

Short Term Effects (Intoxication)	Long Term Effects
▪ Feeling relaxed and tired ▪ Laughter ▪ Increased appetite (feeling hungry) ▪ Can become quiet and engrossed in thought At higher doses: ▪ Problems concentrating ▪ Blurred vision ▪ Reflexes become slow ▪ Can become clumsy ▪ Anxiety and paranoia ▪ Seeing or hearing things that aren't there (hallucinations) ▪ Bloodshot eyes ▪ Heart rate increases ▪ Blood pressure reduces	▪ Regular use may cause increased respiratory problems associated with smoking, including cancer ▪ Memory loss ▪ Difficulties learning ▪ Some mood swings ▪ Reduced sex drive ▪ Low fertility, which can make it difficult to have children (for both men and women) ▪ Dependence ▪ Decreased motivation – affecting work, study and concentration

BENZODIAZEPINES

Short Term Effects (Intoxication)	Long Term Effects
▪ Feeling happy and relaxed ▪ Headache ▪ Drowsy or sleepy ▪ Confusion ▪ Impaired thinking ▪ Memory loss ▪ Slurred speech ▪ Impaired coordination, dizziness ▪ Blurred or double vision At higher doses: ▪ Over sedation – asleep ▪ Aggression and mood swings ▪ Slowed breathing ▪ Unconscious ▪ Death (particularly if mixed with alcohol or other depressant drugs)	▪ Impaired thinking or memory loss ▪ Anxiety and depression ▪ Irritability, paranoia and aggression ▪ Changes to personality ▪ Weakness, tiredness and lack of motivation ▪ Difficulty sleeping or disturbing dreams ▪ Headaches ▪ Nausea ▪ Skin rashes and weight gain ▪ Dependence

GHB (GAMMA HYDROXYBUTYRATE)

Short Term Effects (Intoxication)	Long Term Effects
▪ Feeling happy and relaxed ▪ Feeling confident and more sociable ▪ Increased sense of touch ▪ Can feel excited or may feel upset ▪ Increased sex drive At higher doses: ▪ Headaches and/or feeling dizzy ▪ Incontinence ▪ Reduced coordination ▪ Vomiting ▪ Feeling confused, irritable, agitated or disorientated ▪ Seizures ▪ Reduced heart rate and temperature ▪ Can become drowsy	▪ Long term effects are unclear

KETAMINE

Short Term Effects (Intoxication)	Long Term Effects
▪ Feeling happy and relaxed ▪ Feeling disconnected from body ▪ Confusion ▪ Anxiety, panic, aggression ▪ Slurred speech ▪ Blurred vision At high doses: ▪ Hallucinations	▪ Headaches ▪ Flashbacks ▪ Depression ▪ Psychosis ▪ Problems with memory and concentration

CNS STIMULANTS

AMPHETAMINE/METHAMPHETAMINE

Short Term Effects (Intoxication)	Long Term Effects
▪ Feeling happy ▪ Increased confidence and perception of increased energy and physical strength ▪ Talkative ▪ Increased energy (increased sex drive, alertness and reduced fatigue, reduced appetite, enhanced reflexes) ▪ Restlessness (irritation, anxiety, agitation, teeth grinding) ▪ Confusion ▪ Increased heart rate and irregular heart beat ▪ Excessive sweating ▪ Large pupils ▪ Picking and scratching skin At higher doses: ▪ Possible psychotic symptoms	▪ Deficits in memory, attention and cognitive processes ▪ Weight loss and poor nutrition ▪ Potential for damage to heart due to cardio toxicity and repeated exposure ▪ Depression ▪ Kidney disease ▪ Anxiety ▪ Paranoia ▪ Depression ▪ Chronic problems regarding sleep ▪ Poor dental health ▪ Dependence ▪ Increased risk of stroke ▪ Dependence

MDMA – ECSTASY (3,4-METHYLENEDIOXY-METHAMPHETAMINE)

Short Term Effects (Intoxication)	Long Term Effects
▪ Feeling happy, energetic and confident ▪ High pleasure from touch ▪ Heightened senses ▪ Large pupils ▪ Excessive sweating ▪ Reduced appetite and nausea ▪ Jaw clenching and teeth grinding ▪ Extremely high body temperature (can be life threatening) ▪ Increased heart rate ▪ Muscle aches and pains ▪ Dehydration At higher doses: ▪ Light-headed ▪ Anxiety, irritability, paranoia, aggression ▪ Hallucinations ▪ Vomiting ▪ Irrational behaviour ▪ Seizures	▪ Little is known about the long term effects of ecstasy but some users have experienced ▪ Depression and anxiety ▪ Cognitive damage – thinking problems ▪ Some memory impairment

Cocaine effects are similar to amphetamines and have not been included in this resource due to relatively low levels of use.

HALLUCINOGENS

LSD (LYSERGIC ACID DIETHYLAMIDE)

Short Term Effects (Intoxication)	Long Term Effects
▪ Intense feelings of happiness and wellbeing ▪ Large pupils ▪ Seeing and hearing things that aren't there (hallucinations) ▪ Confusion and trouble concentrating Headaches ▪ Nausea ▪ Fast or irregular heart beat ▪ Increased body temperature ▪ Breathing quickly ▪ Vomiting ▪ Facial flushes, sweating and chills	▪ Regular users may experience flashbacks

PSILOCYBIN (MAGIC MUSHROOMS)

Short Term Effects (Intoxication)	Long Term Effects
▪ Intense feelings of happiness and wellbeing ▪ Tripping – change in thoughts, perceptions, mood and consciousness ▪ Large pupils ▪ Seeing and hearing things that aren't there (hallucinations) ▪ Confusion and trouble concentrating ▪ Headaches ▪ Nausea & vomiting ▪ Fast or irregular heart beat ▪ Increased body temperature ▪ Rapid breathing ▪ Facial flushes, sweating and chills A 'bad trip' might entail: ▪ Unpleasant or intense hallucinations ▪ Anxiety ▪ Paranoia ▪ Panic or fear	▪ Flashbacks

It is recommended that facilitators print out the AOD Information Brochures developed by ReGen for the Choices Program participants. These brochures provide a summary of the short term and long term effects of drugs, withdrawal and harm reduction information. These brochures are located http://www.regen.org.au/resources/drug-factsheets. Additional fact sheets are available from the Australian Drug Foundation, for a range of less frequently used substances.

Neurotransmission

The information provided on neurotransmission is not directly discussed during this module. However, the role of AOD in altering or interacting with neurotransmitters can provide insight into how different drugs may result in mental health problems or be associated with offending, for example, impulse control. As the facilitator, you may wish to draw on this information while delivering the Choices Program.

Brain activity is mediated by a range of different chemicals endogenous to the human body that carry signals from nerve cell to nerve cell in the brain. These chemicals are called neurotransmitters. Different neurotransmitter chemicals serve different purposes. When an individual is exposed to a drug, the normal patterns of neurotransmission are changed, resulting in changed operations in the brain. It is these changes to the brain that lead to the psychoactive effects of the drug.

AOD use alters concentrations of a range of neurotransmitters in the brain. Different drugs impact different neurotransmitters, including:

- Dopamine
- Serotonin
- Noradrenaline
- GABA (gamma-aminobutyric acid)/glutamate
- Endorphins

NORADRENALIN

Noradrenalin (also referred to as norepinephrine or adrenalin) is a neurotransmitter that is important for attentiveness, emotions, sleeping, dreaming and learning. It is also released as a hormone into the blood, where it causes blood vessels to contract and heart rate to increase.

Noradrenalin is an important neurotransmitter in the functioning of our 'fight or flight' response. When confronted with a perceived danger, the brain and body is flooded with noradrenalin, causing a biological response which readies the individual to either enter combat or to run and hide.

Stimulant drugs impact on noradrenaline, such as amphetamine/methamphetamine (Karila et al., 2010), cocaine (Sofuoglu & Sewell, 2009), MDMA (Freye, 2009) and nicotine (Benowitz, 2009) and it is this action that may be associated with violent and aggressive behaviour (McKetin, 2006; Brecht & Herbeck, 2015; Rusyniak, 2013).

DOPAMINE

Dopamine is a chemical messenger that is not very common in the brain. Scarcely more than 0.3% of the neurons in the brain produce dopamine. Nevertheless, these neurons play an essential role in many of our behaviours.

Certain dopamine-producing neurons come into play when an individual experiences desire or pleasure. Dopamine is usually released when people are engaged in activities such as sex, eating and healthy physical exercise. It could be viewed that dopamine acts as a natural teaching tool providing positive reinforcement of activities that perpetuate survival.

All drugs are believed to interact with the dopaminergic pathways (NIDA, 2007). AOD use stimulates the release of dopamine and a subsequent reduction in the number of dopamine receptors ('down regulation'). It is believed that this reduction in dopamine receptors is associated with a lack of impulse control (Trifilieff & Martinez, 2014). It is also believed that the extremely high levels of dopamine released with the use of methamphetamines is associated with the development of drug induced psychosis (Rusyniak, 2013).

SEROTONIN

Serotonin contributes to various functions such as regulating body temperature, sleep, mood, appetite and pain. A deficiency in serotonin has been linked with depression and anxiety (Anderson & Shivakumar, 2013).

Methamphetamine interacts with serotonin (Karila et al., 2010) as do ecstasy, cocaine and LSD (NIDA, 2007). Following the use of these drugs, a user will experience a depletion in the availability of serotonin for a period of time, which explains the depression associated in the 'crash' phase (Copeland, Dillon & Gascoigne, 2004). The literature has suggested a link between serotonin depletion and aggression; however, this finding is inconclusive (Duke et al., 2014).

GABA/GLUTAMATE

GABA (Gamma Amino Butyric Acid) is the main inhibitory neurotransmitter found in many places in the brain and glutamate (glutamic acid) is the main excitatory neurotransmitter. Both of these work with a range of other neurotransmitters in the brain to maintain a balance between excitation and inhibition (Advokat et al., 2014).

Alcohol inhibits glutamate, leading to impairments in motor performance and memory. In response, more glutamate is released to counteract it. One of the reasons for seizures in alcohol withdrawal is that the increased release of glutamate may continue for a period after alcohol is no longer consumed (Advokat et al., 2014).

Alcohol and benzodiazepines activate GABA, the inhibitory neurostransmitter, resulting in sedation, relaxation and inhibition of cognitive and motor skills. It is this action on GABA that is seen to assist in managing anxiety (Advokat et al., 2014; Nuss, 2015).

ENDORPHINS

Endorphins are neurotransmitters that have a role in the management of pain by binding to the opioid receptors. When activated, they also trigger the release of dopamine (Sprouse-Blum et al., 2010).

Opioids (e.g. heroin, morphine, codeine, opium) bind to the same receptor site as endorphins, creating a stronger bond than the endogenous endorphins (Advokat et al., 2014).

Mental Health

The impacts of AOD use are not limited to physical health implications. The 2007 Australian National Survey of Mental Health and Wellbeing found that more than 41% of Australian adults (45% of men and 38% of women) had experienced a substance use, anxiety, or mood disorder in their lifetime, with around 10% experiencing two disorders co-occurring (Australian Bureau of Statistics, 2008).

According to the findings of the 2013 National Drug Strategy Household Survey (AIHW, 2015):

- Recent illicit drug users were almost twice as likely as non-illicit drug users to be either diagnosed with or treated for a mental illness.
- Recent users (any use reported in the previous 12 months) of illicit drugs were also twice as likely to report high or very high levels of psychological distress as those who had not used illicit drugs in the last 12 months (17.5% compared with 8.6%).

Mental health symptoms associated with AOD use can be identified with periods of intoxication, or can emerge during withdrawal, or as a result of long term use/dependency.

There is a range of confounding factors that make identifying the epidemiological relationship between AOD use and mental health difficult, including:

- Many people who use alcohol and other drugs are poly substance users or have a history of using a number of drugs over the course of their lifetime (NDRI et al 2007).
- Distinguishing between potential symptoms of mental illness and substance induced symptoms is problematic (McKetin et al 2011).

Lee et al. (2012) identify a number of theories that have been asserted as a potential explanation for the link between drug use and mental health more generally including:

- The Primary Mental Health Theory – where the mental health issue is the primary issue and AOD are used to 'self-medicate' or relieve symptoms.
- The Primary Substance Use Theory – where drug use is assumed to: be a causative factor resulting in a chronic mental health condition; or exacerbating existing mental health symptoms; or triggering symptoms of a condition to which the individual was already predisposed.
- Shared Environmental & Biological Factors Theory – which predispose the individual to both substance use and mental health issues resulting in a comorbid presentation.

Current evidence does not demonstrate a clear indication about which of the above theories best describes the relationship between AOD use and the development of mental health problems. Given the very clear evidence indicating the much higher prevalence of mental health issues presented by people who use AOD when compared to the general population, it is important to ensure that clients accessing treatment are provided with factual information regarding the association between mental health issues and AOD use. They also need to be provided with strategies to reduce the likelihood and severity of incidence of mental health symptoms.

It is also recommended that facilitators print out the Mental Health information brochures for the Choices Program participants. These brochures are located xxxxxxx

Stress-Vulnerability Model

The stress-vulnerability model was developed in 1977 by Joseph Zubin and Bonnie Spring, two American researchers in Biometrics and Psychiatry. Although the model was initially developed to look at specific types of mental disorders, it has since been expanded to look at other mental health disorders (Goh & Agius, 2010) which we often see co-occurring with substance use (Proudfoot & Teesson, 2008). The model can be seen as a useful way of explaining why people react differently to stress and have different thresholds for tolerating it.

Zubin and Spring's model suggests that each of us has a certain level of vulnerability that can, when combined with other stressors, make us more or less likely to suffer from mental health or substance use disorders.

The model describes how vulnerability can be categorised into two components:

01. Inborn vulnerability, which is acquired from a number of different genetic interactions
02. Acquired vulnerability, which is due to the influence of traumas, diseases and other negative experiences

The factors contributing to an individual's level of vulnerability can be categorised according to three broad contributing factors:

01. Intrinsic factors, including predisposition as indicated by family history and/or biological factors
02. Psychosocial stressors, including substance use, life stressors, environment
03. Lack of protective factors, including a lack of social support, coping skills, stress management and, potentially, medications

(Zuckerman, 1999)

The model differs from other explanations of mental health and substance use disorders as it suggests a time-limited episode from which the individual can return, rather than a pre-determined life-long event from which there is no possible way they can escape.

One way of conceptualising the stress-vulnerability model is the 'bucket of vulnerability' analogy.

The basic idea is that we all have some level of vulnerability or likelihood of developing problems, whether they are substance use problems, mental health problems or a combination of both. Using the bucket idea, those who have low vulnerability have a bigger bucket, whilst those who are more vulnerable (based on genetic predispositions and life experiences that are static or unchangeable) have smaller buckets, and are not able to deal with as much stress in their bucket before they overflow.

The size of your bucket (in other words, how vulnerable you are) is dependent on a number of factors. These might include:

- Genetic predisposition to mental health conditions and personality
- Family history of mental health or substance use problems
- Abuse as a child
- Loss of a parent when young
- Being placed in out-of-home care
- Not feeling loved as a child

If we imagine stress as water filling up the bucket, when the water reaches the top, the bucket overflows. The idea is that if the bucket overflows, the result will be the development of mental health problems. Obviously, if you have a larger bucket, you can handle more stress before the bucket overflows.

- Factors that may cause stress can include:
- Relationship problems
- Money problems
- Family problems
- Housing problems
- Employment problems
- Being bullied
- Big changes happening in your life
- Illness
- Death of friends or family

So the person with the smaller bucket may find that even if they use less of a substance than their friends, it may still have more of a negative effect on them than their friends, creating a number of mental health problems for them. Whilst the person with the bigger bucket may use more substances and engage in more risky behaviour, it may affect them less. The use of AOD is a bit like blocking the outlet tap; we believe it is helping to manage stress, yet the reality is that AOD use often increases stressors.

There's not much any of us can do about the size of our buckets because it is related to static factors in our lives. However, a person who has useful strategies to manage life stressors as they arise has, in a way, created an outlet tap, which can prevent the bucket from becoming full and overflowing, regardless of the size of the bucket.

Anxiety

Studies in Australia and internationally have identified that it is not uncommon for those who use AOD to experience anxiety and/or anxiety disorders (Wu et al., 2009, Gordon, 2008) and that the use of most drugs has some relationship with the user experiencing anxiety; however, as previously mentioned, the directionality of the relationship may vary from person to person.

According to Gordon (2008):

- Anxiety is common in **cannabis** users and is often associated with use commencing at a young age or for those who use frequently or in heavy doses. Intoxication on cannabis can create anxiety, though experimenters may be more prone to this effect. On the other hand, anxiety may be moderated by cannabis for those who use it in the long term. This may indicate that anxiety may have precedes cannabis use for some people.
- **Alcohol use** and anxiety disorders commonly co-occur. Alcohol use can exacerbate anxiety and anxiety can, in turn, increase the use of alcohol. Additionally, alcohol withdrawal can cause anxiety.
- People who have anxiety disorders are more likely than those who don't to use **opioids** and generally report a more severe dependency.
- Anxiety is common in people who use **stimulants**, with higher levels of use related to more severe anxiety (Gordon, 2008, Lee et al., 2012); however, even low to moderate doses of methamphetamine can induce symptoms of anxiety (Cruicshank et al 2009). Anxiety is also one of the features of stimulant withdrawal.
- It is thought that people who experience anxiety in childhood are at an increased risk of using stimulants.

Depression

Depression is a commonly co-occurring disorder with both anxiety and substance use. Stigma, poverty and isolation associated with depression can lead to substance use, yet these psychosocial issues can also be associated with substance use and may lead to, or exacerbate depression (Gordon, 2008).

- Depression is common in people who use **cannabis** and is thought to be particularly so for those who initiated cannabis use at a young age. In addition, the use of larger quantities is seen as a predictor of more severe depression (Gordon, 2008).
- **Alcohol** dependence and heavy use are also strongly associated with depression, particularly for women who drink. High levels of consumption of alcohol can exacerbate depressed mood and is frequently associated with increased suicide risk. Alcohol withdrawal can include symptoms of depression (Gordon, 2008).
- Depression is common among users of **opiods**, with heavy use associated with more severe depression; however, rates of depression decrease upon initiation of opioid substation pharmacotherapies (Gordon, 2008).
- The prevalence of depression amongst **methamphetamine** using cohorts appears to be significantly higher than that demonstrated by the general population. In an Australian study of 400 people entering AOD treatment services in relation to methamphetamine use (conducted by McKetin et al., 2011) it was found that four in ten methamphetamine participants met DSM-IV criteria for a major depressive episode in the previous year, and a further 44% had substance-induced depressive symptoms that were similarly severe and disabling.
- Depression is a significant feature of the 'crash' phase of stimulant use (McKetin et al., 2005) and withdrawal (Cruickshank & Dyer 2009) and can be exhibited for an extended period post withdrawal (Scott et al., 2007).

Psychosis

A drug induced psychosis can occur in some individuals following the consumption of AOD. This is more likely with specific drugs such as methamphetamine, cannabis, ecstasy and cocaine (Basu & Basu, 2015).

- Gordon (2008) found that **cannabis** use can induce a temporary state of psychosis in those with no prior experience of psychosis; however, it generally resolves after a period of abstinence. Cannabis is commonly used by people who already have a diagnosed psychotic disorder, and for these individuals, use can trigger a psychotic episode. Currently, there is no evidence to indicate that cannabis 'causes' schizophrenia; however, it is believed that for those who have a predisposition to a psychotic mental illness, the use of cannabis is associated with an earlier onset of the illness.

- Use of **methamphetamine** can induce a state of psychosis for some individuals during intoxication (Cruickshank et al., 2009) and withdrawal (Grund et al., 2010). For many people, this state is temporary and is often perceived as being 'drug-induced', frequently resolving after cessation of use. However, for some people, it may persist for some time.

  An Australian study conducted in 2006 with 309 people who used methamphetamine found that the prevalence of psychosis amongst the sample was 11 times higher than the prevalence of psychosis amongst the general population (McKetin et al., 2006). While this figure is concerning, it must be noted that the prevalence of psychosis in the general population is quite low.

  While use of amphetamine type substances has been found to induce psychotic states in people with no prior history or predisposition for psychotic illness, people with a pre-existing serious mental health issue may be at greater risk, with amphetamine type substances exacerbating both the course and severity of the pre-existing mental health issue (NDRI et al., 2007).

Tolerance, Dependence and Withdrawal

TOLERANCE

Repeated and prolonged exposure to AOD leads to the development of tolerance, which is a decreasing responsivity to the same dose, resulting in the requirement for increased doses to obtain the same effects.

According to Advokat et al. (2014), tolerance can be identified as both a behavioural and a pharmacological phenomenon. Pharmacologically, an individual can develop either (a) metabolic tolerance, that is, the more a person uses, the more rapidly the enzymes that metabolise the drug become available and in greater quantities, leading to a reduction in the concentration of the drug; or (b) pharmacodynamic tolerance, in which receptors in the brain adapt to drugs being continually present. This adaptation (known as down regulation) results in either a reduction in the number of receptors available for the drug or a reduction in the sensitivity of the receptors to the drug – in both instances, more of the drug is required to achieve the same effect.

'Dabbing', a relatively new method for administering cannabis, by using a butane hash oil, consists of a far more potent THC concentration than cannabis buds/flowers and is thought to lead to higher tolerance for cannabis and dependence (Loflin & Earleywine, 2014). At this stage, it is unclear how common this practice is becoming in Australia.

DEPENDENCE

Development of tolerance to AOD is an indicator of potential dependence; however, the development of tolerance cannot be used in isolation as an identifier of drug dependency.

Usually dependence is also marked by symptoms of withdrawal, experienced by a dependent person when the drug is no longer present. As well as the physiological symptoms of dependence – as exhibited by tolerance and withdrawal – there is also a range of behavioural and psychological symptoms that can be indicative of dependence upon a drug.

> *"The Tenth Revision of the International Classification of Diseases and Health Problems (ICD-10) defines dependence syndrome as being a cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value. A central descriptive characteristic of the dependence syndrome is the desire (often strong, sometimes overpowering) to take the psychoactive drugs (which may or not have been medically prescribed), alcohol, or tobacco."*

(World Health Organisation, 2016)

According to the World Health Organisation's ICD 10, a diagnosis of dependence is premised upon three of the following criteria being present at the same time in the previous year:

- A strong desire or sense of compulsion to take the substance.
- Difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use.
- A physiological withdrawal state when substance use has ceased or been reduced, as evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms.
- Evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses (clear examples of this are found in alcohol and opiate dependent individuals who may take daily doses sufficient to incapacitate or kill non-tolerant users).
- Progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects.
- Persisting with substance use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking, depressive mood states consequent to periods of heavy substance use, or drug-related impairment of cognitive functioning; efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and extent of the harm.

(World Health Organisation, 2010, p. 5)

Dependence on alcohol continues to be the leading reason for people accessing treatment, with 40% of all treatment episodes occurring with alcohol as the principle drug; however, the proportion of treatment episodes for this drug in isolation has been reducing (AIHW, 2015 b).

The use of amphetamines has been increasing as the key drug for those seeking treatment in Australia, with 17% of all treatment episodes being attributed to the use of amphetamines, an increase of 10% since 2010. In addition, the number of people smoking/inhaling and injecting amphetamines has increased six times compared to 2010 (AIHW, 2015b). Smoking or injecting amphetamines has been associated with the development of dependency (NDRI et al., 2007)

Volkow et al. (2014) reported that approximately 9% of cannabis users become dependent on it. Higher rates of dependence are associated with a younger age of commencement of use: approximately 17% will develop a dependence with use commencing in teen years. Increased frequency of use also impacts on the development of dependence, with daily users more likely to develop dependence than non-daily users. In Australia, 24% of AOD treatment episodes were for cannabis use (AIHW, 2015 b).

Opioid dependence is associated with prescribed use of opioids and heroin. It is believed that dependence on prescribed opioids is associated with extended duration of treatment, not the dose per se, and in a subset of research into those prescribed opioids for chronic pain it was found that around 8 – 12% develop a dependence (Brady et al., 2015). Figures for dependence on heroin are difficult to ascertain; however, 7% of all AOD treatment episodes in Australia were for heroin (AIHW, 2015 b).

WITHDRAWAL

Put simply, withdrawal is the reversal of the changes that have occurred in the body due to neuroadaptation (as described in the earlier sections regarding tolerance and dependence). While individuals will experience a range of symptoms associated with this reversal, clinicians should also be mindful that many of symptoms exhibited during withdrawal will be directly related to the particular drug the individual is dependent on.

For further information on drug specific withdrawal symptoms for key drugs of dependence – please refer to the Appendices 1.

It is recommended that facilitators print out the AOD Information Brochures developed by ReGen for the Choices Program participants. These brochures provide a summary of the short term and long term effects of drugs, withdrawal and harm reduction information. These brochures are located http://www.regen.org.au/resources/drug-factsheets. Additional fact sheets are available from the Australian Drug Foundation, for a range of less frequently used substances.

Summary

AOD use impacts a range of neurotransmitters including dopamine, serotonin, noradrenalin, GABA/glutamate and endorphins. Both the short term effects of intoxication and the impact of longer term use of AOD is associated with a range of adverse health effects, including impacts upon mental health. Regular exposure to AOD can result in the development of tolerance and, potentially, dependence. People who are dependent upon AOD will experience a range of withdrawal symptoms when they cease use and in the case of alcohol and benzodiazepine dependence, medical supervision is required.


ONE
WAY

04:

RISKS, HARMS, AOD AND OFFENDING – BACKGROUND READING

Patterns of Use and Risk Associated with AOD

It is important to be clear with all participants that any drug use at all carries with it the potential for harm. It is also important to acknowledge that, despite these risks, some people in the group may continue to use a variety of drugs (possibly in breach of the order they are on). It is for this reason that harm reduction strategies are included in this program.

From a health perspective, utilising Thorley's (1982) model of AOD-related harm, risks and harms are associated with the toxic effects of substance use; effects of intoxication (for example, injury or violence) and long term effects of chronic, dependent or regular use (including mental health problems, blood borne viruses (BBVs) & a range of lifestyle impacts associated with dependence (Degenhardt & Hall, 2012). From a psychosocial perspective, harms are related to legal issues, social relationships and lifestyle impacts.

The problematic use of amphetamine, heroin, and cocaine have been associated with high risks of death, illness and disability (Degenhardt & Hall, 2012). Typically, cannabis is associated with less severe health risks compared with other illicit drugs due to the lack of capacity to inject and that its use does not result in fatal overdose (Degenhardt & Hall, 2012). Consumption of alcohol above recommended levels has been associated with morbidity and mortality from alcohol-related illness, such as liver diseases, brain damage and cancers (Shield et al., 2013)

Overdose risk for heroin is increased with the concomitant use of other CNS depressants or after a period of abstinence where tolerance has been reduced (Degenhardt & Hall, 2012). Stimulant overdoses can result in cardiac arrest or stroke, which are typically rare in the age groups who most typically use these substances. Degenhardt and Hall (2012) suggest that current evidence indicates that mortality rates for amphetamine users are similar to those of opioid users.

The effects of cannabis and alcohol on cognition and behaviour increase the risks of road traffic accidents where an affected person drives a vehicle, with a greater risk at higher doses. Degenhardt and Hall (2012) also report that injuries (road trauma and falls, etc) more commonly result in death for amphetamine and heroin users than non-illicit drug users.

In considering the potential for risk associated with different patterns of use, dependent use can be considered the 'most risky' as the frequency and quantity of use increases the likelihood of experiencing negative health effects (Paneka et al., 2012).

Chronic dependent use of methamphetamines has been associated with a higher prevalence of mental health issues (McKetin et al 2005) and a higher risk of suicide (Marshall et al 2011) and smoking or injecting methamphetamine can lead to a higher risk of overdose (NDRI et al., 2007)

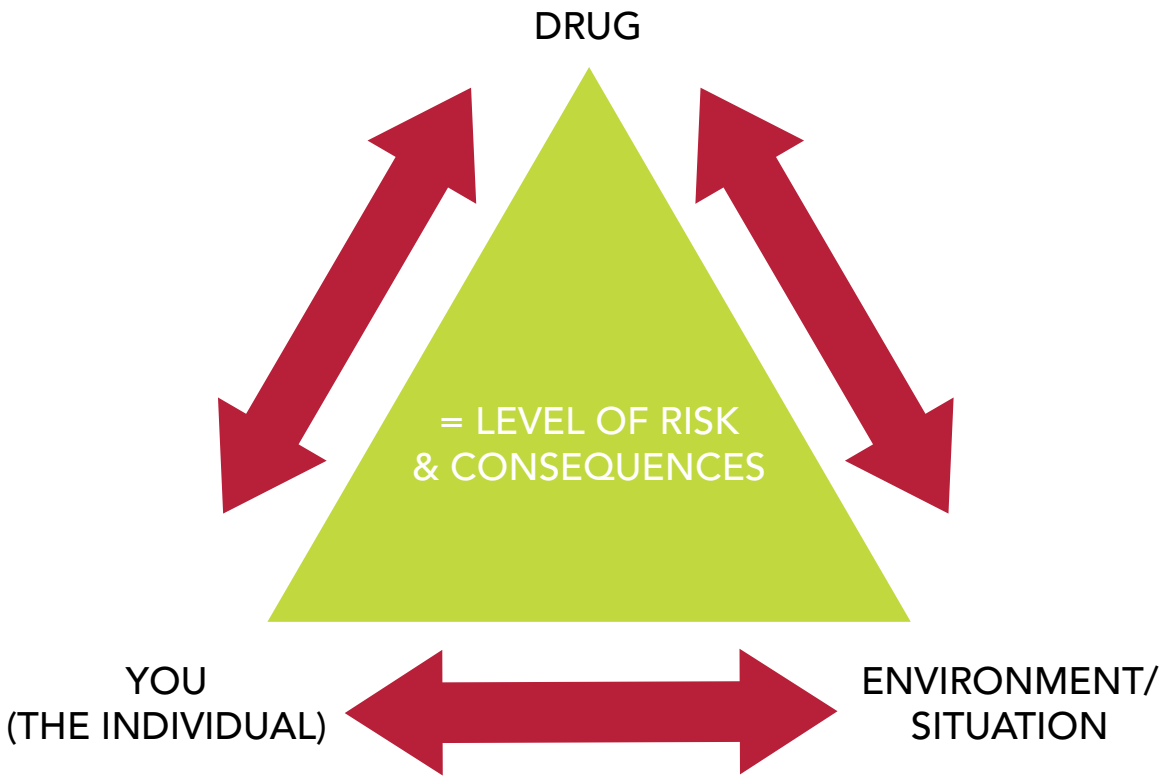
Mortality and morbidity risks can also be impacted upon by the coexistence of a range of health and mental health concerns. For example, in the case of methamphetamine, the risk of cardiac events occurring in users of methamphetamines cannot be explained by dose and level of use alone;

"Other factors, such as individual variations in responsiveness, tolerance, and pre-existing cardiovascular health, interact to play an important but unquantifiable role in the physical reaction to any one occasion of use. For this reason, information about the potential for methamphetamine to induce cardiovascular complications should be targeted to all users of the drug, not just dependent and chronic users."

(Kaye et al., 2005)

The Drug Interaction Model

The drug interaction model is one way conceptualising potential for risks and harms associated with the use of AOD, including the risk of offending consequences. The three corners of the triangle – individual, drug and environment – present the different factors that can contribute to, or reduce the potential harms for any given drug use experience.



The harms associated with the use of AOD may indeed be the product solely of the drug itself; however, often the likelihood for harm is increased or decreased according to a complex interplay of multiple factors. The presentation of the drug interaction model to participants asks them to consider the potential factors associated with AOD-related risks and harms in a holistic manner.

DRUG FACTORS

Dose, purity, route of administration and poly drug use can all contribute to the likelihood of harm.

Dose and Purity

As discussed in the section on overdose, drug dosage is but one factor that can potentially contribute to overdose. Additionally, the nature of illicit drug markets means that people who use AOD can never be assured of what they are consuming, both in terms of purity of the drug itself as well as the adulterants used to either bulk up or to enhance the effects. Adulterants used in the production of illicit drugs may have toxic effects, as well as a range of other health implications (Busardo et al., 2016).

As previously mentioned, high levels of alcohol consumption, either during a session or in concert with pre-loading) in the offending population leads to more risky behaviour and is associated with higher levels of offending behaviour.

Route of Administration

Different routes of administration pose different kinds of risk. The table below outlines a number of potential risks associated with different routes of administration.

Route of administration	Potential harms
Injecting	▪ Potential for blood borne virus (BBV) transmission ▪ Collapsed veins, and infected injecting sites ▪ Higher potential for dependence ▪ Higher potential for mental health issues (methamphetamine)
Smoking	▪ Higher potential for dependence (methamphetamine) ▪ Higher potential for mental health issues (methamphetamine) ▪ Oral health issues pertaining to exposure of teeth and gums to the smoke in addition to the dehydrating properties of the drug itself (methamphetamine) ▪ Some research has raised the potential for BBV transmission via pipe sharing (methamphetamine) ▪ Increased risk of bronchitis (cannabis) (Tashkin, 2015) ▪ Smoking heroin (chasing the dragon)has been associated with the development of leukoencephalopathy (a disease of the white matter of the brain (Buxton et al., 2011)
Intranasal	▪ Necrosis (death of tissue) of the lining of the nose ▪ Sinusitis: Inflammation of the sinus which can result in headaches, facial pains and/or nasal discharge. ▪ Nosebleeds
Oral	▪ Considered to be the least risky way to administer the drug, although oral administration has been associated with nausea, vomiting and diarrhoea

As already established in earlier sections, there is a higher affinity with episodes of poor mental health and dependence associated with injecting drugs (McKetin et al., 2005; Lee et al., 2007, Young et al, 2010). Injecting as a route of administration can also pose risks in regard to vein damage and potential collapse, scarring, abscesses, and blood clots.

Additionally, injecting poses a significant risk of the transmission of blood born viruses such as Hepatitis C and HIV. Degenhardt et al. (2010) observed with methamphetamine users (M/A) that:

> *"M/A injectors are at risk of HIV and other infections, such as viral hepatitis and bacterial infections, through unsafe injecting practices. M/A injectors may be more likely than those injecting other drugs to engage in risky injecting practices (Degenhardt et al., 2007). Risk is elevated by re-use of equipment, hurried injecting, and frenetic injecting when on 'binges'"*

Other routes of administration have also been linked to the potential for the transmission of BBVs. Young et al. (2010) identified that that there is the potential for BBV transmission when sharing snorting equipment. Additionally, the Ontario Needle Exchange Network (2007) asserts that frequent smoking of methamphetamine can cause burns and sores on the lips of the smoker as well as inner-oral sores.

COMMON FEATURES OF OVERDOSE

Listed below are the common signs and symptoms of overdose for drugs classified as depressants (e.g. alcohol, opiates, benzodiazepines) and stimulants (e.g. amphetamines, methamphetamine, MDMA and cocaine).

The common features of **depressant overdose** include:

- Vomiting
- Lack of response
- Pale and/or clammy face
- Cyanosis (bluish) lips and/or fingernails
- Slow and shallow breathing, with gurgling or choking sounds or not breathing
- Decreasing levels of consciousness, leading to coma

(Australian Drug Foundation, 2016)

The common features of **stimulant overdose** include:

- Agitation and paranoia
- Chest pain – cardiac arrest
- Very fast heart rate
- Rapid respiration
- Hypertension (high blood pressure)
- Temperature above 41.5°C
- Difficulty breating
- Pulmonary oedema (excessive fluid in the lungs) and/or congestion
- Kidney and/or liver failure
- Decreasing levels of consciousness, leading to coma

(Cruickshank et al., 2009; Petit et al., 2012)

POLY DRUG USE AND IMPLICATIONS FOR OVERDOSE AND OTHER HARMS

A factor that can contribute to the potential for overdose is poly drug use. When two drugs are used in combination, the interaction has the potential to exacerbate the risk of harm through the processes of addition and synergism (de Crispigny & Talmet, 2012). Mixing two or more drugs is unpredictable and depends on the user, the drugs involved, the amount used and the duration of effect of each drug. For example, it is not uncommon for heroin users to overdose on a combination of heroin and benzodiazepines, which may be due to the longer half-life (refers to the time it takes for the concentration of the drug to reduce by half) of the benzodiazepines taken at some time prior to the use of heroin. Poly drug use considers that two drugs are interacting together if they are both affecting the person, not only when a person uses them at the same time. Poly drug use includes the use of any drugs in combination, for example, antidepressants mixed with methamphetamine, or alcohol use in combination with antihistamines.

Given the prevalence and ready availability of alcohol, this is perhaps the most likely combination with many drugs. Alcohol in combination with depressant drugs tends to increase the sedative effects of each drug, thereby increasing the risk of respiratory arrest.

Mixing alcohol and methamphetamine increases the heart rate more than methamphetamines alone, thus increasing the potential for cardiac events and stroke. (Kaye et al., 2005). Aside from the risks associated with combining two or more drugs at the same time, the consumption of alcohol has been shown to increase the probability of the use of methamphetamines, particularly binge drinking and was stronger for those not dependent on methamphetamines (Bujarski et al., 2014).

INDIVIDUAL FACTORS

There are a number of individual factors that can contribute to, or mitigate potential risk. These factors include age, gender, employment, relationship status, mood, experience with AOD, physical and mental health.

Age of commencement of drug use can have implications for future drug use. The National Drug Research Institute et al. (2007) (citing research conducted by Mattick and Darke, 1995) assert that:

> *"It is recognised that some young people who engage in drug use are at risk of developing chronic patterns of use, including frequent, harmful binge use."*

However, in older populations there are a number of morbidities that are more common, increasing risk for older people who use AOD. Older people may also be more sensitive to lower doses of alcohol or drugs.

In those with pre-existing diseases or defects of the heart, methamphetamine use and cannabis use can contribute to an increased risk of significant adverse health outcomes and potentially death (Kaye et al., 2005; Thomas et al., 2014).

In addition to the potential for physical health to impact upon the likelihood of harm, pre-existing mental health issues can also increase risk.

In relation to the risks of potential violent behaviour, mood at the time of consumption is likely to have an impact, as well as past experiences of violent behaviour. For example, the disinhibiting nature of alcohol consumed in heavy doses by someone who is angry may lead to risks of violence.

Sociological factors such as involvement in employment and education may pose a protective factor; however anecdotally, the hangovers and the crash effect that is experienced by many people who use stimulants can have implications for work performance. In addition, some employment industries are more associated with the use of drugs than others.

Pidd et al. (2008) found that the highest prevalence for drug use (where use of drugs in the last 12 months was indicated) was for those employed in the hospitality, construction, retail and transport industries. Cannabis use was most prevalent in the construction, hospitality and retail industries, whereas methamphetamine use was most prevalent amongst tradespersons in contrast with other occupations. The use of stimulants has also been associated with the transport industry (Mabbot et al., 1999, Williamson 2007), often utilised in meeting the functional requirements of an occupation that demands long periods of work without rest. This occupational use of stimulants such as methamphetamine can contribute to potential harms particularly when we take into account the environmental factors that co-contribute to risk in this example (e.g. drugs and driving). Alcohol consumption at risky to high risk levels is most likely associated with the mining, construction, utilities and transport industries (AIHW, 2013). Although in all industries identified, a proportion of workers consumed alcohol at risky to high risk levels, which is not surprising given that alcohol is the most widely used substance in Australia.

ENVIRONMENTAL FACTORS

Environmental factors that can exacerbate or mitigate potential risk of harm include where the substance use is taking place, with whom, the law, cultural/social factors and what activities people are undertaking while impaired.

AOD intoxication impairs cognition and perceptions and can result in increased risk taking. Avoidance of activities such as driving (Drummer, 2003), swimming (Driscoll et al., 2004) and operation of machinery is advised as undertaking such activities while intoxicated can contribute to risk.

Environmental factors can either increase or decrease the likelihood of higher levels of intoxication and the possibility of offending when intoxicated. In relation to alcohol, consumption in particular locations, such as pubs or clubs with a large group of friends can increase risk, particularly when an individual becomes intoxicated, as there is more opportunity to become engaged in disagreements with others at the pub, and less capacity to apply self-control due to intoxication (Wells et al, 2008).

Wells et al, (2008) found that some social groupings can increase pressure to consume high levels of alcohol, leading to higher levels of intoxication and risk of offending. For males, the presence of a female partner at a drinking event can either decrease risks or increase risks depending on the level of stability within the relationship. Peer associations while intoxicated can also lead to a range of offending behaviours, as has been described in the AOD and offending section.

The following experience shared by a participant in a qualitative study highlights the interaction between drug, individual and environment resulting in risky consequences.

> *"Speed makes me scandalous. Shoplifting and stuff like that. One day we just planned this whole day to go shoplifting in different stores. It was really weird. I was gone. I was like this brain dead zombie going, 'Let's shoplift.'"*

(Copes et al., 2015)

Summary

Risks and harms occurring as a consequence of an episode of AOD use (including offending) are the result of a complex interplay between three factors: drug, individual and environment. Harms may be reduced by making changes to one or all of these factors, depending on the contribution to risk of the factor.

05:

MAKING CHANGES– BACKGROUND READING

This module is chiefly concerned with the exploration of behaviour change. It must be remembered that behaviour change is not limited to a linear progression from using AOD to a state of abstinence, nor does it need to be limited to AOD use. A client-centred approach will work towards supporting the participant to make the changes that they determine will be of most benefit to their circumstances. It needs to be recognised that an effective therapeutic interaction must meet the client according their stage of change. Facilitators need to be prepared to discuss both harm reduction and methods to assist in behaviour change Including reduced use, abstinence and offending. In essence, we are identifying which stage of change a person is at in relation to both their AOD use and offending, and working with each.

Stages of Change

Prochaska and DiClemente's Transtheoretical Model (often referred to as the 'Stages of Change' model) is a fitting framework for addressing the potential multiple levels of motivation and goals presented by participants attending the Choices Program. With this in mind, the program content has been developed to address these potentially different needs. The following table links the different stages of change, as identified by Prochaska and Di Clemente, with appropriate clinician tasks.

STAGE APPROPRIATE TASKS

Stage	Worker's task
Pre-Contemplation	Raise doubt. Increase the client's perception of risks and problems associated with current behaviour. Provide information and advice that may assist in the reduction of behavioural-related harm (to self, others and the community.)
Contemplation	Tip the balance – evoke reasons to change and the risks of not changing. Strengthen the client's belief that they can change the behaviour.
Preparation	Assist the client to determine the best course of action to take in seeking change. This can include providing referral information to appropriate services and other practical advice and information about how to make the desired changes.

Stage	Worker's task
Action	Assist the client to take steps toward change. Assist the client to develop problem solving strategies and goals. Helping to develop skills to address any challenges they may face while making changes in behaviour.
Maintenance	Assist the client to identify and use strategies to prevent lapse/relapse. Reinforce the positive outcomes of behaviour change.
Lapse/relapse	Assist the client to renew the process of change.

(Adapted from Addy et al., 2000)

HARM REDUCTION

Harm reduction information should be provided to all participants, regardless of their stage of change, as motivation is not static. The delivery of appropriate harm reduction information may inform decisions that reduce the likelihood of harm or offending, if the individual lapses or relapses post-delivery of the program. In the Choices Program, the concept of harm reduction is included for those in pre-contemplation.

It is recommended that facilitators print out the AOD Information Brochures developed by ReGen for the Choices Program participants. These brochures provide a summary of the short term and long term effects of drugs, withdrawal and harm reduction information. These brochures are located **http://www.regen.org.au/resources/drug-factsheets**. Additional fact sheets are available from the Australian Drug Foundation, for a range of less frequently used substances.

CONTEMPLATION – AMBIVALENCE

When a person is in the contemplation phase, they are aware of both the function and consequences of their behaviour, be it AOD use or offending. As Miller and Rollnick (2013) identify, when a person is ambivalent, it can be uncomfortable and will generally make a decision one way or another to resolve the discomfort of ambivalence. Behaviour change interventions aim to support movement in the direction of change.

Exploring personal motivations for change is important at this time. This can be achieved by inviting the person to reflect on the consequences of their behaviour and any conflict between their current behaviour and important life goals and values, as well as the importance of change. At times, people may be ambivalent because they do not believe they are able to change. The Choices Program provides some strategies to support change should a participant be motivated to do so.

PREPARING FOR CHANGE

Developing a Change Plan & Goal Setting

A person's goals in relation to changing their AOD use will largely depend on their relationship with AOD and their patterns of use and their reasons for change, that is, what they want to be different.

Making changes to AOD use includes controlled (moderated) use, as well as abstinence-based approaches. The aim of controlled, or moderated, use is to reduce the harms associated with problematic AOD use by reducing the amount and/or frequency of use. Research suggests that moderation goals (typically drinking at levels that reduce risk) are generally more appropriate for those who use drugs in a non-dependent risky pattern, rather than for dependent users, for whom abstinence is recommended (Australian Centre for Addiction Research, Controlled Drinking).

The low risk offender cohort may comprise both AOD dependent users and those who use drugs in a non-dependent – though risky – manner. Therefore discussing different types of AOD goals supporting behaviour change will be important.

People making changes to their AOD use, whether the goal is abstinence or controlled use, will need to develop a range of strategies to address the underlying issues associated with their AOD use, such as anxiety and depression, and may also need to change a range of environmental factors associated with use. Having an understanding of their reasons for use will assist this process.

In relation to offending behaviour, the same process applies, that of goal setting. Goal setting is based on having an understanding the settings, or circumstances in which the target behaviour occurs and identifying what it is that a person wants to achieve and identifying potential barriers to the achievement of the goal. In changing offending behaviour, a person may need to develop strategies to effectively use time, or to generate income in a legal manner. It may also require addressing social and family relationships that maintain offending behaviour.

In a study of probationers, recidivism reductions were found in those who reduced the number of drug and alcohol use days along with reductions in family criminal networks and increases in legal income (through employment) and those who were less likely to self-report drug use increased time in leisure and recreational activities (Woodich et al., 2015). Colman and Vander Laenen (2012) found that substance using offenders see themselves as drug users, not offenders and that in this group, ceasing problematic AOD use precedes cessation of crime.

The goal setting process involves identifying a longer term goal, and then identifying the smaller achievable steps that put together, will achieve the longer term goal. SMART goals are specific, measurable, achievable, relevant (to the person) and have a clear timeframe. Smaller SMART goals if reviewed regularly, provide the opportunity for more frequent feedback and provide an impetus to maintain movement toward achieving the main goal.

Planning change will also include identifying barriers to change and developing strategies to address these as well as supports to change (e.g. linking in to other services to address underlying needs/issues or social networks).

It is also useful to explore if changes of this type have been attempted before or if there were times when the behaviour did not occur when it usually does. This exploration can then uncover strategies and strengths that have been helpful in the past, as well as those that were not so helpful.

MAKING CHANGES

When a person is making changes, they are taking action, working toward their goals and implementing strategies from their change plan. It will be useful in this stage for people to maintain a focus on their reasons for change as this supports the motivation to work through the challenges that may arise as they take steps. In relation to changing AOD, individuals may use a self-help approach or engage in specific treatment.

Making changes might require reviewing & altering plans, strategies and supports. It is also generally useful to identify rewards to assist in maintaining momentum.

When making changes, it is helpful to develop a range of alternative, non AOD using activities to undertake, as AOD use and/or offending may have been associated with a perceived lack of interesting activities to do; or for some, engagement in an AOD using lifestyle may have taken up a great deal of time. Engagement in non AOD related activities can also serve as a vehicle for developing new social networks who are not involved in AOD/crime culture.

Implementing alternative strategies to address the function of AOD use and/or offending is also crucial in this phase. These may include implementing strategies to manage anxiety, depression and issues with sleep. Strategies that are useful include, relaxation, mindfulness, exercise, nutrition, and problem solving to name a few. For some, addressing financial and housing problems may be required and others may benefit from specific counselling services. The Participant Workbook has some links to websites and services that may be of assistance to manage a range of underpinning issues to AOD use.

It will also be important for facilitators to provide a range of brochures providing information on the services available in the local community that may assist in addressing the range of holistic needs of participants.

TREATMENT INTERVENTIONS FOR AOD USE

It is important that facilitators provide information to group participants about the effectiveness of treatment options, and provide strategies that can be utilised by participants if they are in the process of entering treatment or considering entering treatment.

Treatment modalities available to people wishing to address their AOD use and associated harms include:

- Withdrawal services – outpatient, non-residential and residential
- Counselling and psychological interventions
- Rehabilitation – non-residential day programs and residential rehabilitation
- Self-help groups (e.g. Narcotics Anonymous, SMART Recovery)
- Substitution pharmacotherapies for opioids
- Web-based interventions, such as Reduce Your Use for cannabis (NCPIC, 2012)

A review of the literature conducted by Baker et al. (2004) regarding the effectiveness of a range of treatments found that in regard to psychological interventions, cognitive behavioural therapy (including relapse prevention) is the most effective, evidenced treatment for people who use AOD, which is currently utilised in Australia (Lee et. al 2007). Additionally cognitive behavioural therapy has been demonstrated to be an effective strategy for treating co-occurring depression (Hollon et al 2005). The use of Motivational Interviewing (MI), another widely used tool in the AOD sector in Australia, has been demonstrated to reduce use, at least in the short-term (Ciketic et al., 2012, Baker et al., 2003).

PREPARING FOR WITHDRAWAL

Information about withdrawal syndromes has previously been discussed (see pg.171). Undertaking withdrawal is recommended for those who are experiencing dependence on AOD.

Providing clients with knowledge – about how withdrawal services work, what symptoms can be expected and over what timeframe – can also decrease potential anxiety. According to Kenny et al. (2009)

> *"Supportive care is a key component of drug withdrawal care for all classes of drugs. Frequent monitoring, reassurance, providing information and a suitable environment can help reduce withdrawal symptom severity."*

People who use AOD can undertake withdrawal with assistance in home-based or outpatient settings; however, supervised residential withdrawal is suggested where:

- Multiple drug dependency is identified.
- The severity of withdrawal symptoms is likely to be severe.
- There is a likelihood of medical or psychiatric complications.
- The home environment is unfavourable to home-based or outpatient care.
- There has been a history of multiple unsuccessful attempts to undertake withdrawal.

(Kenny et al., 2009)

OPIOID SUBSTITUTION PHARMACOTHERAPIES

In most situations, when undertaking a supported withdrawal, whether it is home-based, outpatient or residential, the person will be provided with a range of medications that assist in alleviating the key withdrawal symptoms. This is why it is useful to discuss withdrawal with a GP.

It is generally **not** recommended that a person suddenly withdraw from opiates due to the increased risk of overdose should a lapse or relapse occur (Sharma et al., 2016; Brady et al., 2015).

Methadone and Buprenorphine/Naloxone (Suboxone®)

Both methadone and Suboxone® are used to prevent withdrawal/cravings associated with ceasing heroin and other opiates. Both are also opiates, and therefore act on the same receptor sites in the brain as heroin, etc. There are several reasons why they are the treatment of choice to manage opiate/heroin dependence: they are longer lasting; pure; not injected; given in prescribed doses; legal; relatively inexpensive.

Methadone can be used short term to support the withdrawal process but both methadone and Suboxone® are commonly known as maintenance treatment (longer term). Maintenance treatment allows the client to develop space from a drug, using lifestyle and time to make changes and improvements to their lives, like sorting out accommodation, employment, health and complying with their correction order. As maintenance drugs, they work because they are taken and stop working when they are not. They aren't cures. Sustained treatment is associated with a better outcome.

Both methadone and Suboxone® are supplied via the Pharmaceutical Benefits Scheme (PBS), though pharmacies charge a dispensing fee. To access methadone or Suboxone® a person will need to see a GP who can write prescriptions for these drugs, as well as pick up the medications from the same dispensing chemist, generally daily.

Summary

Making changes, whether it be implementing harm reduction strategies, reducing use or ceasing use altogether, requires planning and the development of a range of strategies. People who identify that they will continue to use AOD, either in an unchanged way or through controlled use, will benefit from the provision of harm reduction strategies and information however, need to be aware that legal risks associated with illicit drug use cannot be remove. People seeking to reduce or cease use, or change offending behaviour require adequate information supporting change.


NO
ENTRY

06:

MAINTAINING CHANGE – BACKGROUND READING

Maintaining change requires an individual to plan for and successfully deal with those situations that may put them at risk of re-engaging in the behaviour they are trying to change, be it AOD use or offending. In the AOD sector, we typically refer to this as 'relapse prevention'; however, relapse prevention is defined as…

> *"... a self-management program designed to enhance the maintenance stage of the habit-changing process. The goal of (relapse prevention) is to teach individuals who are trying to change their behaviour how to anticipate and cope with the problem of relapse. In a very general sense, relapse refers to a breakdown or setback in a person's attempt to change or modify any target behaviour" (Marlatt and Gordon, 1985).*

In their model of relapse prevention for AOD use, Larimer et al. (1999) propose that some situations "frequently serve as the immediate precipitators of initial alcohol use after abstinence" (refer to Figure 1). As noted in the general definition of relapse prevention above, this concept can also be applied to offending more broadly. Situations that precipitate a return to behaviour following a period of change are known as High Risk Situations (HRS) – high risk because they inevitably trigger a craving for a drink or to use drugs, or to engage in offending behaviour. Some HRS are common to most people making changes to AOD use, for example:

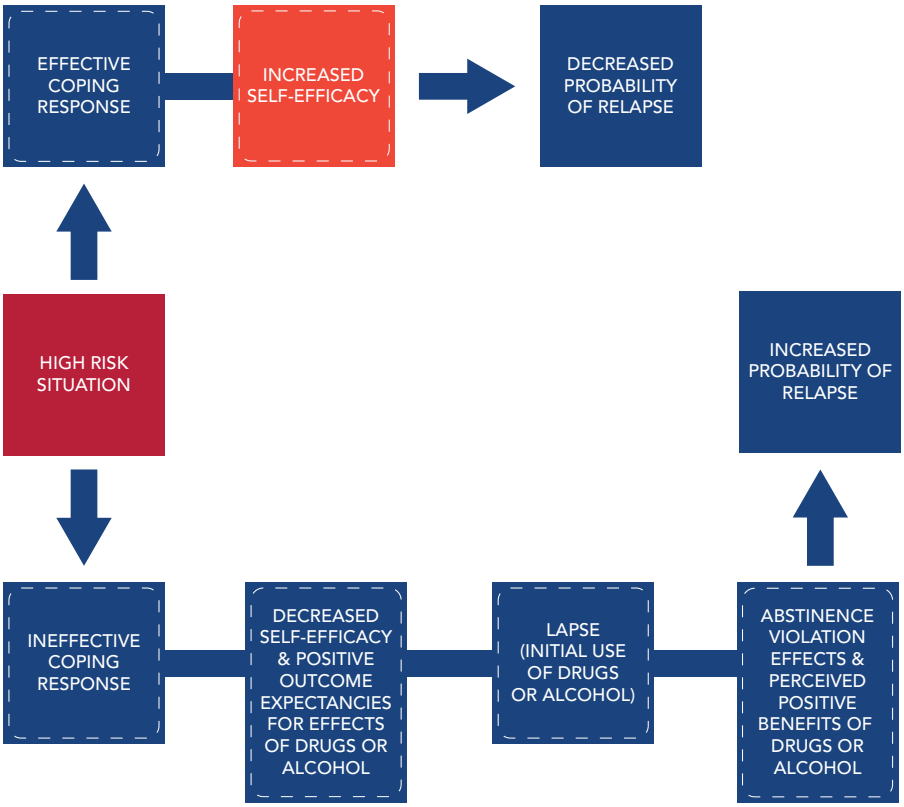
- Being in places where they used to drink/use.
- Being around people with whom they used to drink or use.
- Being offered drugs or alcohol.

In general, situations that are stressful, upsetting, anxiety provoking, joyful or boring are likely to promote cravings for AOD and thus are usually high risk for a lapse or relapse. Alcoholics Anonymous suggests that people watch out for **HALT**s, an acronym for **H**unger, **A**nger, **L**oneliness and **T**iredness, as these states can also trigger cravings.

Other HRS may be highly idiosyncratic, such as a person associating playing golf with alcohol, because she always used to carry a few cans around the greens, or someone associating the end of a working day with smoking cannabis. Identification of common high risk situations for an individual can be supported by the use of the Decisional Balance and the Self-Monitoring Diary.

The offender literature identifies that preventing a return to offending behaviour is based on the development of plans that support and maintain change, including strategies to avoid peers and situations closely related to offending, e.g. lack of pro-social activities and substance use (Colman & Vander Laenen, 2012).

Figure 1. Model of relapse prevention



Source: Witkiewitz & Marlatt (2005)

Marlatt and Gordon argue that a person with problematic alcohol or drug use has ineffective coping skills and low self-efficacy, combined with positive expectations of the effects of alcohol or other drugs (Larimer, Palmer & Marlatt, 1999, p. 152). This can lead to a lapse being triggered by a HRS which challenges a person's limited ability to cope. After a lapse, the Abstinence Violation Effect (AVE) occurs. This is when the individual thinks "well I've had a bust now ... I might as well keep on drinking/using". Skills and techniques that can help an individual avoid a lapse or prevent a lapse from becoming a full blown relapse include identifying their HRS, identifying strategies to help them cope better with HRS (which could be more effective communication skills, relaxation techniques, knowing whom to contact), and learning how to manage cravings.

Marlatt and Witkiewitz revamped the relapse prevention model, arguing that the process of relapse was far more multidimensional and dynamic than originally proposed (2007). They argue that "in every situation, an individual is faced with the challenge of balancing multiple cues and consequences" (Marlatt & Witkiewitz, 2007, p. 22).

The individual responds to situations according to the **interrelationship** of a number of factors, including:

- Distal risk factors
  - Years of dependence
  - Family history
  - Social support
  - Comorbid psychopathology
- Cognitive processes
  - Self-efficacy
  - Outcome expectancies
  - Craving
  - The abstinence violation effect (AVE)
  - Motivation
  - Cognitive distortions

- Coping skills
  - Meditation, relaxation and/or mindfulness practice
  - 3 Ds (Delay, Distract and the Decision)
  - Urge surfing
  - Problem solving
  - Scheduling alternative pleasurable activities
- Perceived effects
  - Reinforcement (e.g. improved mood, enjoyment, disinhibition, etc.)
  - The abstinence violation effect

The new model also acknowledges the usefulness, and allows for the integration of, other treatment interventions, such as pharmacotherapy (for withdrawal, cravings and/or mood), family therapy, meditation practice, mental health interventions and so on.

An important aspect of any AOD relapse prevention program is helping participants to manage their urges and cravings to use AOD. Cravings can be characterised as an intense desire – felt either physically or emotionally – to use. An urge is sometimes characterised as an unwelcome thought, or intention to use. In our experience these terms are often used interchangeably – 'urge surfing', for example, is designed to deal with cravings – and attempting to make a distinction between them can cause confusion. For the purposes of this program we use both the terms 'craving' and 'urge' to mean an unwelcome desire, thought or intention to use.

Not every person trying to reduce or cease AOD use will experience cravings, but most will at some point. Cravings are both commonplace and entirely normal and do not represent weakness or lack of motivation or willingness to change behaviour. Cravings may be experienced as more or less intense, may arise in response to stressors that can be anticipated, but may also arise seemingly 'out of the blue', and may occur at any time, even years after ceasing AOD use.

Although traditional relapse prevention is based on ceasing a behaviour, the principles can be applied to controlled or moderated use. Identifying those situations where it will be difficult to maintain the lower level of use and developing strategies to manage these to maintain their goals will still be required. In addition, the development of strategies to record consumption will be required to assist in knowing when the moderated dose has been reached.

DEALING WITH SLIPS

When people are maintaining change, they will also need to develop a plan to manage any slip to prevent them becoming a relapse. The lapse plan will include seeking support (from a friend or worker), challenging thoughts about the slip – viewing it as just that, rather than 'all is lost', and reconnecting with their reasons for change. At the same time, reviewing what led to the slip or lapse can assist in developing new strategies to cope with challenging situations. It is important that people are aware that slips can occur and are part of the learning process associated with change. After all, there are some functions that behaviours serve that we may not be aware of until we make changes.

Summary

Maintaining changes to behaviour involves relapse prevention planning, that is, identifying circumstances that are likely to lead to AOD use, to using more than intended (in controlled use scenarios) or to engaging in offending; and then planning strategies to manage high risk situations, (including urges and cravings) as well as developing a range of skills to address challenges. Clients seeing lapse as a learning curve will assist in relapse prevention.


ONLY

07:

SUPPORT AND OTHER INFORMATION

AOD Services

In Victoria, people who are experiencing problems with their AOD use are able to access a range of publicly funded treatment options including:

- Counselling
- Longer term care and recovery support
- Withdrawal services – residential, non-residential and outpatient
- Pharmacotherapies for opiates and alcohol
- Rehabilitation – non-residential AOD day programs, residential rehabilitation programs
- Self-help/peer support programs (e.g. AA/NA or SMART Recovery)
- Families can access counselling and family group education programs

Telephone Services and Online Counselling

AOD SUPPORTS

- Directline - 1800 888 236 – information, support and referral for AOD issues
- Counselling online: **https://www.counsellingonline.org.au/** - online counselling for anyone concerned about AOD issues
- National Cannabis information and helpline – 1800 30 40 50
- National Cannabis Information and Prevention Centre: **https://ncpic.org.au/** – self-help resources to assist with cutting down or quitting cannabis
- ICE Advice – 1800 423 238 – information, support and referral for methamphetamine (ICE) related issues
- Reconnexion (03) 9819 3671 – support for people experiencing anxiety and benzodiazepine/analgesic problems
- SMART Recovery Australia - **https://smartrecoveryaustralia.com.au/** find support groups to help you manage changes to AOD use

MENTAL HEALTH SUPPORT SERVICES

- Beyond Blue – 1300 2246 36 – telephone support for mental health issues (including anxiety and depression)
- Beyond Blue - online chat: **https://www.beyondblue.org.au/get-support/get-immediate-support**

CRISIS SUPPORT

If you or someone you know is suicidal call:

- Lifeline 13 11 14
- Suicide Call Back Service 1300 659 467
- Ambulance 000

NON AOD SUPPORT SERVICES

- Financial counselling helpline – 1800 007 007
- Financial counselling service https://www.financialcounsellingaustralia.org.au/Corporate/Home - free service, links to finding a free financial counsellor
- Gambling Help – 1800 858 858 – telephone support to help with gambling issues
- Gambling Help Online - http://www.gamblinghelponline.org.au/ 24/7 online counselling to help with gambling issues
- Housing Services – 1800 825 955 - Crisis line
- Housing Services and Information - http://www.housing.vic.gov.au/ - information about housing issues.

Online Self-Help Resources

There are quite a lot of helpful resources available online – listed below are some, but a quick Google on a topic you want help with will give you a good list too.

SELF HELP TIPS TO CUT DOWN DRINKING

- Control Your Drinking Online: A Web-Based Self-Change Program http://www.acar.net.au/online.asp
- Moderation Management: http://www.moderation.org/

MANAGING SLEEP ISSUES

- Get a Good Night's Sleep
  http://www.sleepcouncil.org.uk/wp-content/uploads/2013/01/Get-a-Good-Nights-Sleep.pdf

  This booklet has some useful information and tips to help you get better sleep without using AOD.

MANAGING ANXIETY

- Anxiety Disorders Association of Victoria offer support groups to help manage anxiety and have some tip sheets on their website: https://www.adaa.org/tips-manage-anxiety-and-stress

MANAGING DEPRESSION

- Check out the website below for tips on coping with depression
  http://www.helpguide.org/articles/depression/dealing-with-depression.htm
- Mood Gym – Learn skills for preventing and coping with depression
  https://moodgym.anu.edu.au/welcome

MANAGING ANGER

- Moodjuice Self-Help Guide for Anger – can be printed and has some useful information.
  http://www.moodjuice.scot.nhs.uk/Anger.asp

RELAPSE PREVENTION TOOLS

- Free relapse prevention workbooks from US Drug Rehab Centres
  http://www.usdrugrehabcenters.com/the-relapse-prevention-plan/

Please note these resources and others are also identified within the Participant Workbook.

It is recommended that facilitators make available information on any local services that may be of interest, including information on the Central Assessment and Intake Service in your region.

PART 03

CHOICES PROGRAM DELIVERY GUIDE

DELIVERY PLAN:

MODULE	TOPIC / ACTIVITY	TIME
01. Welcome and Introduction Total Time = 10 minutes	Acknowledge traditional owners Housekeeping Title and Aims of Program Participant Introduction Group Guidelines	10 minutes
02. Offending and Alcohol and Other Drug Use Total Time = 35 minutes	Introduce module and discussion: Why are you here? **ACTIVITY 01 – Function and Consequences of AOD Use** (Decisional Balance, Group) **ACTIVITY 02: How does AOD use relate to the offending for which you are here?** (Group Discussion)	5 minutes 15 minutes 15 minutes
03. Alcohol and Drugs, Mental Health and their impact Total Time: 30 minutes (40 minutes with activity)	Introduction to AOD and effects – CNS and drug classifications. **ACTIVITY 03: Short and Long Term Effects** (optional activity) Overview of Tolerance, Dependence & Withdrawal **ACTIVITY 04: Is there a problem?** Mental Health & AOD Use Video: Bucket of Vulnerability (optional video)	5 minutes (10 minutes - optional) 5 minutes 10 minutes 10 minutes
BREAK - 10 MINUTES		

MODULE	TOPIC / ACTIVITY	TIME
04. Risks, harms, AOD use and Offending Total Time: 30 minutes	Risks, harms, AOD use & Offending ▪ Drug Interaction Model ▪ OD, ▪ Poly Drug Use **ACTIVITY 05: Risks and Harms (scenarios, risk rating and strategies to reduce harm)** (Group Activity)	15 minutes 15 minutes
05. Making Changes Total Time: 30 minutes	Making Changes ▪ Stages of Change (pp 51-55) (Video is optional) **ACTIVITY 06: What stage of change are you at?** (Self-reflection) ▪ Strategies for Not interested in change - Harm Reduction ▪ Strategies for "yes … but" (ambivalence) ▪ Strategies for "Ready for Change" – controlled/reduced use & withdrawal ▪ Strategies for "Making changes" (Action) **ACTIVITY 07: Activities other than drug use**	20 minutes 10 minutes
06. Maintaining Change Total Time: 25 minutes	High Risk Situations that can trip us up in achieving our goals Strategies to manage HRS Thoughts that can trip us up **ACTIVITY 08: Managing High Risk Situations** Planning in the event that things go off the rail Relapse	5 minutes 10 minutes 10 minutes
07. Support, Summary Evaluation Total Time: 5 minutes	Support Services Summary and Questions Evaluation/Certificate Handout	5 minutes

DELIVERY GUIDE:

Display this slide on the screen as participants arrive.

Welcome attendees to the program and introduce yourself.

Acknowledge the traditional owners of the land,

> *"I would like to acknowledge the traditional owners of the land (the xxxxx people) and pay my respect to elders past and present. I also want to welcome any community members who are here today."*

Ensure all participants sign the attendance form and complete any paperwork required.

Inform the group participants that this is a 3-hour program and that there will be 1 break.

Provide information on where the toilets are and other housekeeping (tea/coffee/food as appropriate).

Explain OHS issues, for example, in the event of a fire what the group is expected to do, etc.

Check in on willingness to participate:

> *"Who wants to be here?"*

If people say they don't want to be here, ask

> *"What has motivated you to come?"*

Wrap discussion up by saying:

> *"We understand attendance is a requirement of your corrections order. Some of you are more willing to be here than others, though you all have some reasons for being here."*

Explain that to complete the program, it is expected that participants will contribute to discussions, participate in activities, and stay for the whole program. A certificate of attendance will be provided at the completion of the program that you can show or provide to your CCO.

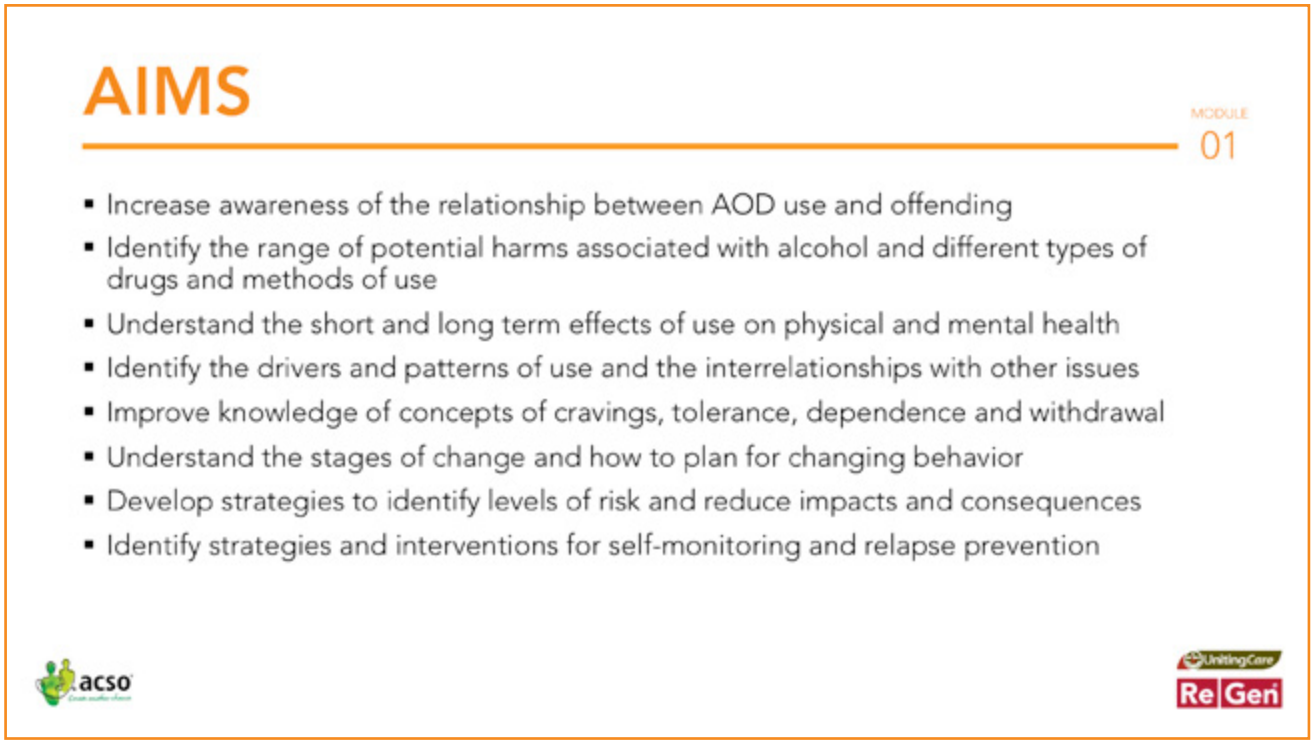
We are also required to complete some paperwork which provides evidence that you have attended the program.

Ask participants to introduce themselves by first name and to tell the group their favourite movie (or some other interest you think is appropriate). Ask someone to start and continue until all participants have introduced themselves.

Note:

It is also important that you acknowledge that some people may have already made changes to their drug use before coming to this program and to let them know that we will be talking about alcohol and drugs in this program, which people sometimes find triggering. Explain that we will also be talking about strategies that assist in maintaining change which we believe will be helpful for you.

Encourage participants to care for themselves and each other during the program and explain that you (the facilitator/s) will be available at the end of the session if anyone needs or wants to check in before they leave.



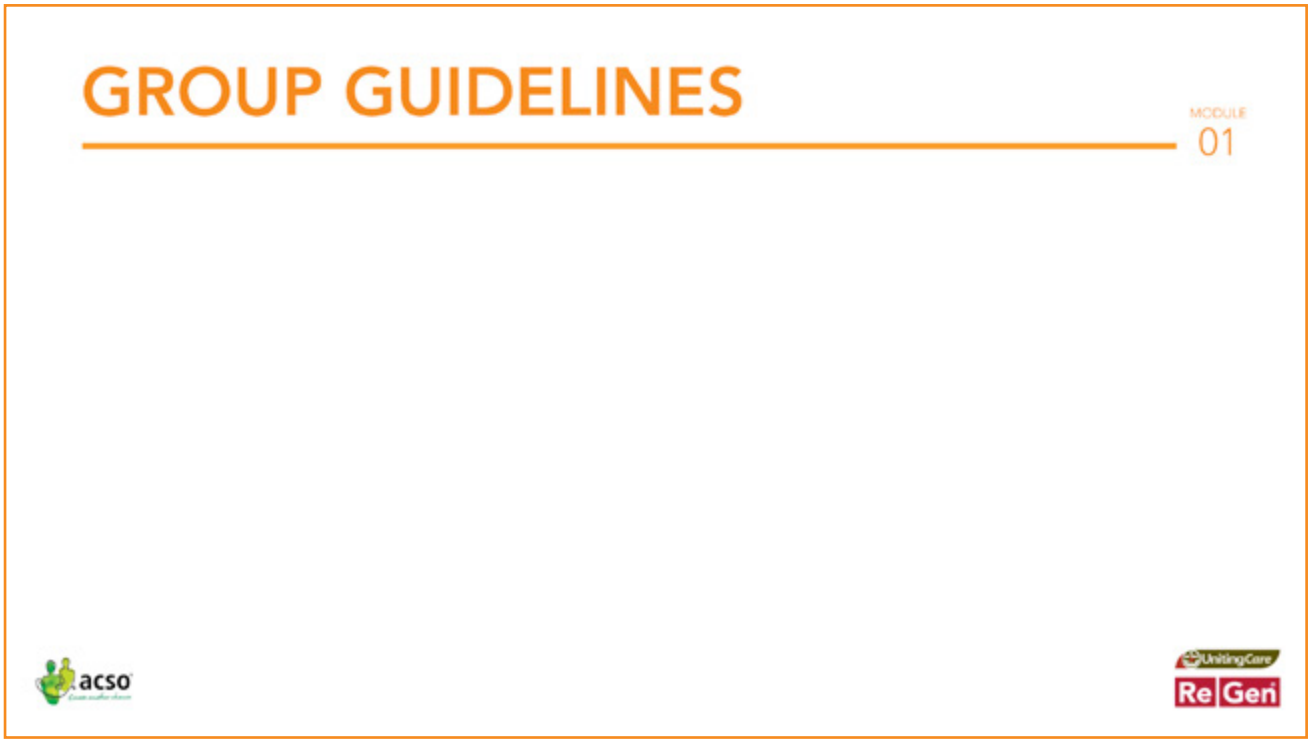
(The heading on this slide will come up when you progress the slide show, but not the list of aims.)

Suggested discussion:

"What would you like to get out of attending this program?"

Facilitate the discussion.

Mouse click or arrow down to reveal the list of aims and discuss how the program will meet any other aims or issues raised by the group.



Resources: Butcher's paper, textas, Blu Tack

The aim of this exercise is to develop a set of group guidelines that will make it safe for group members to participate. The guidelines will also assist if you need to intervene in any unhelpful group behaviour.

Suggested discussion point:

> *"To make this session today work for all of us, what are some guidelines that can make you feel comfortable to contribute and feel safe?"*

Write the guidelines on a piece of butcher's paper and attach to a wall when complete.

There are some key group guidelines that we need to establish; therefore, if the group does not come up with these, you will need to add them to the list:

- Confidentiality – what does this mean?
- Respecting each other – what does this look like? Listening, not talking over the top of each other etc.
- Allowing people to talk (not taking over the group).
- No violence or aggression.
- No talking up alcohol and/or drug use or offending (glorifying). Remember, people are in different places with their AOD use and have different life stories.
- Not offering drugs to anyone or arranging to offer drugs. Explain that if this occurs, the police will be called.

Module Aims:

- Increase the awareness of the relationship between AOD use and offending.
- Identify the drivers and patterns of use and the interrelationship with other issues.

Introduce the module.

Suggested script:

The first part of this program is about having some conversations about AOD use and offending. We do encourage your participation, but we also want you to be aware that you don't have to share everything. In fact, there are some things that are not really appropriate in this setting for safety of people in the group, so we are not going to ask you to go into a lot of detail publicly about the nature of your crime/s.

Suggested discussion:

"Why are you here? What made the magistrate add an AOD treatment condition to your order?"

Facilitate the discussion.

Note:

Do not get into arguments about the role of police in relation to the charges. You can address any arguments by identifying that there may be grievances about your charges and order; however, that is something that is up to the courts. What we are looking at is how we can assist you to reduce the likelihood of you being on an order again in the future, or putting your current order in jeopardy.

Key points:

This conversation raises the idea that AOD use was identified as an issue at the time the person was charged or sentenced.

Summarise reasons people believe their order has an AOD condition and use as a segue to the next activity, for example,

"The reason you are here at the Choices Program is because you are or have been using AOD. This now leads us to our next discussion/activity."

Time frame: 15 minutes

Resources: Butcher's paper, textas, and Blu Tack

Use butcher's paper for this activity, which you will attach to a wall in the room at the completion of the activity. The program provides opportunities to reflect back on the content raised in this activity at various points.

You will need 2 pieces of butcher's paper: one with the heading Function of AOD use (Good things), and the other, Consequences of AOD use (Not-so-good things).

Introduce the activity

Suggested script:

> *"As we have just discussed, AOD use is something that you have all done or are doing. Using AOD is a behaviour. When we think of behaviour, there are generally reasons we do the behaviour, something we get out of it that we believe is useful in some way."*

Reveal the butcher's paper with the heading "Function of AOD Use" and ask the group for their responses.

"What are the good things about drugs? What functions do they serve for you? Everyone has their own reasons and they might be different for each of you. They will also differ based on the drugs you use/d."

Facilitate the discussion and write participants' points on the butchers' paper. At times you may need to allow some silent pauses, and encourage people to participate.

When the group have run out of ideas for the function of AOD, move on to the consequences of AOD use.

"As with all behaviours, there are the good things that keep us doing the behaviour, and there may also be consequences or not-so-good things associated with the behaviour that we generally put up with."

Reveal the piece of butcher's paper with "Consequences of AOD use" and seek feedback.

"What are the consequences of AOD use, the things that are not so good about it?"

Facilitate the discussion and list on butcher's paper.

You may want to explore some of the points in more detail, for example, losing friends/family (focus on those that are associated with people's goals and values in particular).

With both sides of the completed list, discuss some of the key points raised by the group. There are a couple of common issues generally raised in this activity that are worth addressing at this stage:

- Mental health issues (anxiety/depression). Managing these may be raised as a function of AOD use, and may also be raised as a consequence of AOD use. Discuss the vicious cycle.
- Sleep. It may be worth discussing that although some AOD (e.g. Alcohol and cannabis) may help someone get to sleep, we know they interfere with getting the right type of sleep, can increase the number of times we wake up in our sleep cycle and can reduce the number of hours of sleep we get , so we still end up being tired.[1]

1 Vandrey, R., Babson, K., Herrmann, E.S., & Bonn-Miller, M.O.(2014) Interactions between Disordered Sleep, Post Traumatic Stress Disorder, and Substance Use Disorders. International Review of Psychiatry. 26 (2) 237-247

Summarise the activity.

Suggested script:

> *"Although you are aware of some of the things you get from AOD use, you are also aware of some of the negative consequences of use. As we go through the program today, it is an opportunity for you all to think about where AOD fits into your life. Maybe you are thinking, 'I don't want to change'. If that's where you are at, you might want to think about ways of reducing the negative consequences, the harms,"* (point to the consequences list). *"Though, if you do want to keep using, there will be some risks and harms that will exist. Maybe you are thinking, 'AOD use is causing me problems and I need to do something about it', or maybe you have already made changes. If this is where you are at, and you decide to change your AOD use, it will be important for you to think about other ways to meet the needs you have. There are other ways to meet these needs that don't involve AOD use,"* (point to the function list). *"Either way, the choice about what you do is yours. Through this program today, you will have the opportunity to be aware of the consequences for your life as a result of the choices you make about your AOD use, and you will also learn some strategies that will assist you to make or maintain changes if that is what you want to do."*

Put the butcher's paper up on the wall using the Blu Tack and tell the group that this activity is in their workbook for them to do independently (pg. 10).

Time frame: 15 minutes

Resources: Pens, workbooks

Introduce this activity as a lead-on from the previous activity, in which the group probably raised legal issues, or getting caught as a consequence of use.

Ask the participants to complete the self-reflection questions about their AOD Use and Offending in the workbook, Activity 2 on page 11. Give the group 5-10 minutes to complete this self-reflection.

Suggested script:

> *"You mentioned that one of the consequences of AOD use was legal problems and you are all here with a corrections order. So, we are going to spend a little bit of time exploring that relationship. On page 11 in your workbook there are some questions for you to think about and answer. I'll give you 5-10 minutes to do this. We will then discuss some of your thoughts."*

Note:

As there may be some people in the room who may not be able to read well, read the questions for reflection out loud. This will ensure that people know what the questions are and those that do not feel comfortable writing, are still able to complete the reflection.

Self-Reflection Questions:

01. What crimes did you commit that lead to your current order?
02. Where were you when you committed the offence?
03. Who were you with?
04. What role did other people you were with play in your crime?
05. What role did your use of alcohol and/or other drugs play (for example, were you intoxicated, hanging out, needing to get money, not really connected?)
06. If you hadn't been using alcohol and drugs, would you have committed the offence?
07. How has being on the corrections order affected you? What has been the impact on your life?
08. Is reducing offending behaviour something that is important to you?

Call the group back from individual reflection and discuss the relationship between offending and AOD use.

Suggested script:

> *"I'm not going to make you disclose your information about the specifics of your crime or AOD use, but I'm wondering, what thoughts do you have about how alcohol and/or drug use is/was associated with your current legal situation, the crime you committed?"*

Discuss and explore the role of AOD use associated with offending, providing information about the mechanism of the action of drugs that play a role (as per key points).

You may want to discuss whether they would still have offended if they hadn't used AOD.

Key points:

- Being intoxicated on, or hanging out from, AOD impacts on the decision-making ability of people – e.g. driving, theft, burglary or engaging in behaviour that we wouldn't normally do if we weren't intoxicated.
- Being intoxicated on or hanging out/coming down from AOD impacts on how we interpret situations and on how we act. It can affect our impulse control (we might get into fights, or use other drugs that we don't normally use) or we can become disinhibited and act in ways we would not normally act.
- Coming down from drugs can impact our moods and impact on how we behave, for example, methamphetamines can make us irritable.
- A fear of not having drugs when we need them, hanging out, might lead us to crime in order to pay for them.
- Being intoxicated can lead to overconfidence and risk-taking behaviours.
- Using AOD costs quite a lot of money, which may be hard to maintain. (Be aware that for some of the group, financial problems may be associated with using drug in the first place.)

- The drug use was the offending behaviour. (Be aware this can lead to a big argument about how unfair the laws are regarding drugs for personal use. It is recommended you acknowledge their frustration, and add that regardless of what we think, the laws are what they are and we need to be aware how our decisions affect us and impact on our lives. Sometimes, there's just no point arguing with what is real.

Note:

Note: some people may not associate their drug use – particularly intoxication or hanging out – as the reason for their offending. Rather, they may indicate that it was someone else's fault, e.g. peer pressure.

If this is the case, ask, "How would this situation have been different if you hadn't used drugs?"

Others may not associate their AOD use with offending, e.g. Cannabis and graffiti, as the person may do graffiti when they are not using. So both conditions exist.

Ask the group what impact being charged has had on their life – discuss and reflect reasons for change.

"What has been the impact of being charged on your life?"

Explore motivation to reduce offending.

"Is reducing offending something that is important to you, for your life?"

Discuss.

Summarise relationship between AOD and offending, emphasising that making changes to AOD use is something that might be important in reducing offending behaviour.

Raise the issue that if a person offends and is found guilty while on a community order, they will have their original charge resentenced, as well as a further sentence for the breach of the order, and the sentence for the new charge. Breaching your order can result in a 3 month prison term.

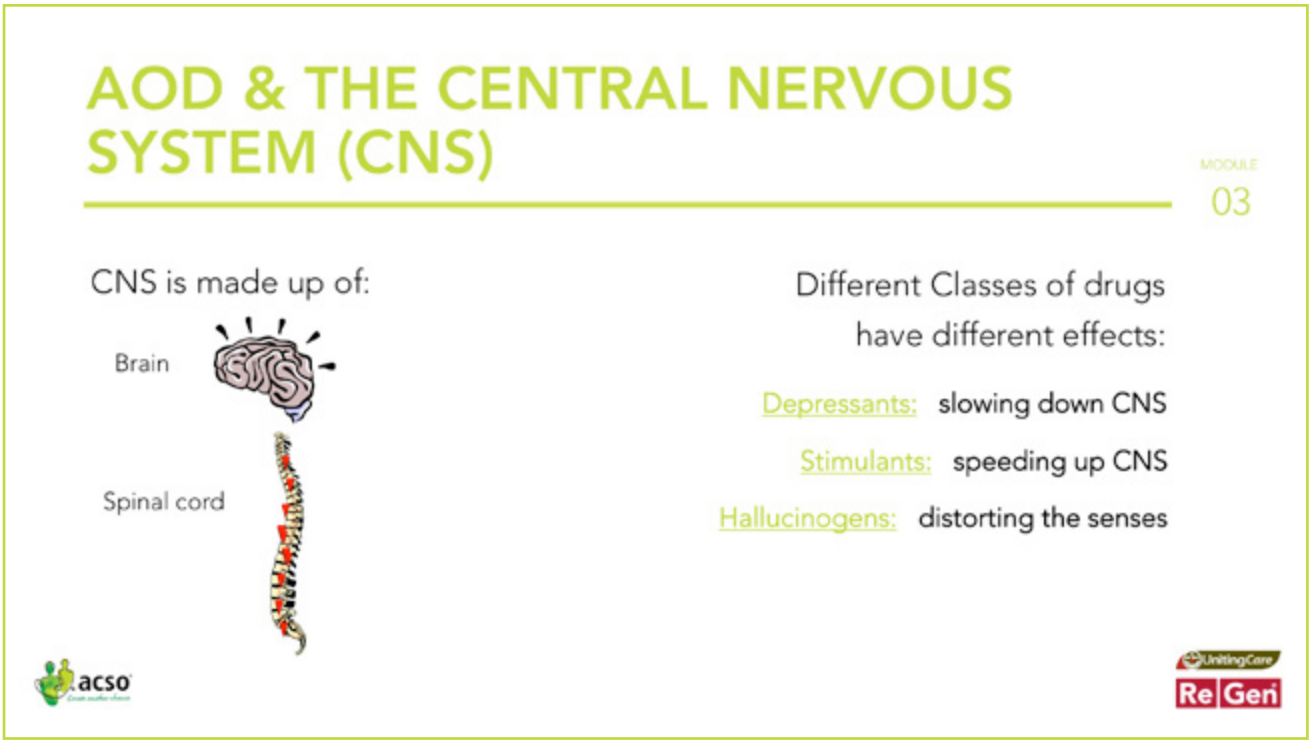
Module Aims:

- Understand the short and long term effects of use on physical and mental health.
- Improve knowledge of concepts of cravings, tolerance, dependence and withdrawal.

Introduce this module.

Suggested script:

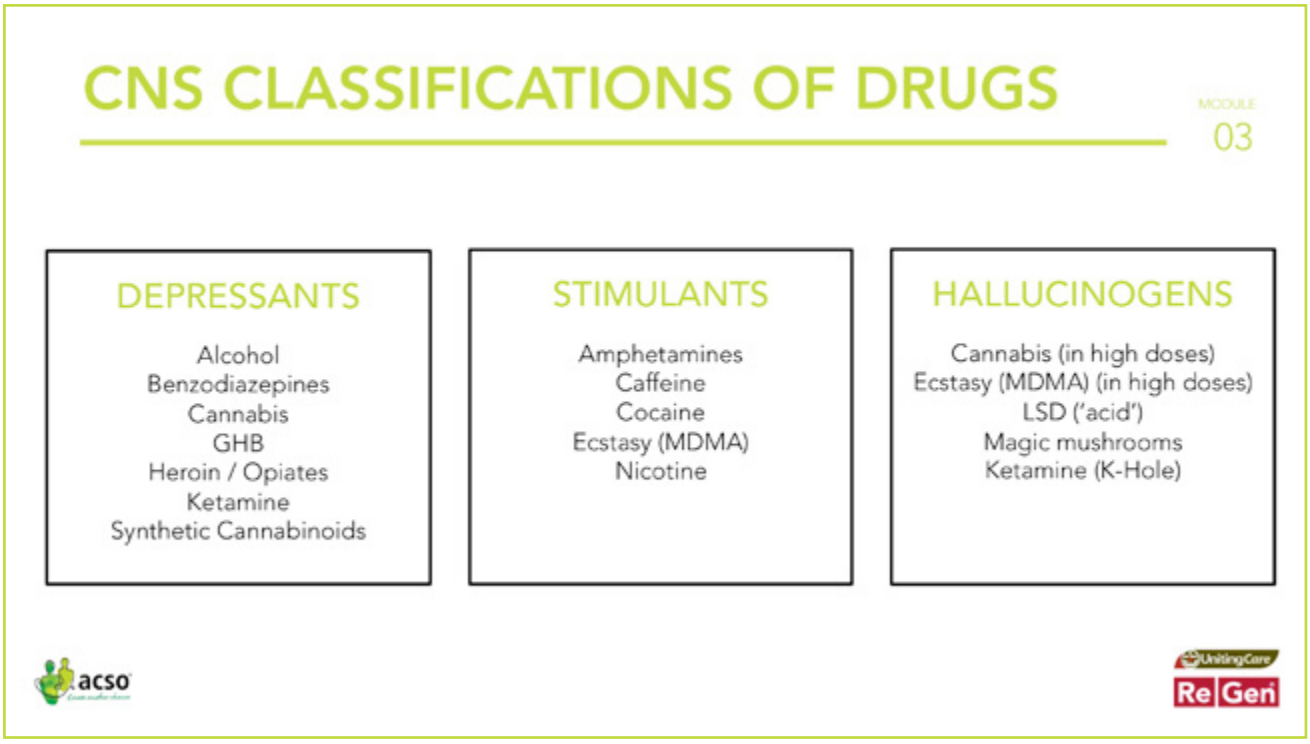
"We are going to spend a little bit of time understanding how AOD affect us in the short term and long term, including their relationship to mental health issues."



Explain how drugs affect the CNS and the classifications of drugs according to their effect on the CNS.

Suggested points:

- Alcohol and other drugs have an effect on our mood, behaviours, perceptions & thinking. They do this by impacting on our physiology, or bodily processes. While different people will have different experiences of the same drug (depending on circumstances and their own unique situation), it is possible to categorise drugs depending on the kind of effect the drug has on the body, specifically the central nervous system (CNS).
- The CNS is made up of the brain & spinal cord, & regulates all the functions of the body. It does this by processing information from our peripheral sensory nervous system & sending motor commands to the body, including controlling heart rate, breathing & movement.
- Some drugs can make us feel 'up' or 'hyper', such as amphetamines & ecstasy. These are called stimulants, in that they stimulate or speed up activity in the CNS. Other drugs scramble signals in the brain & may cause distorted perceptions (i.e. hallucinations). These are hallucinogens (e.g. LSD & magic mushrooms). Finally, there are drugs that slow down the CNS. These drugs include heroin, benzodiazepines & of course alcohol.
- CNS depressants such as cannabis slow down the brain's arousal, motor & sensory centres, & have an effect on coordination, speech, thinking & reaction to stimuli.
- Effects on the CNS are not to be confused with emotional states (though of course they do impact on each other).



(Heading will come up first on slide.)

Key points:

- Identify which drugs are classified in which way.
- Some drugs, at high doses, can fit into two classifications.

Suggested discussion:

"When you think about the drugs you have used, you probably have a good idea of which drugs may be stimulants, depressants and hallucinogens."

Reveal slide contents (mouse, arrow).

"Some drugs can fit across two categories. Cannabis at low doses is classified as a depressant, but at high doses it has hallucinogenic effects. Similarly, ecstasy in low doses can be a stimulant, but in high doses, and for some people, it can have hallucinogenic effects.

Ketamine is a complex drug, it is a depressant, but can also have dissociative effects, where there is a separation between mind and body, which could be seen as hallucinogenic."

(Optional Activity)

Time frame: 5 minutes

Resources: Pens, Activity Sheet on pg. 164 of this guide (1 copy of each drug sheet)

Introduce the activity.

Suggested script:

> *"We are now going to have a quick look at drugs and their effects on the person who has used them – both when someone is intoxicated and the effects of using in the long term. As you have had experience using some of these drugs, we will start with what you know."*

There are two options for this activity:

Option 1:

> *"In a moment, I will get you to work in groups. I have some worksheets here for different drugs. What I want you to do, is think about what it is like to be intoxicated on that drug, what you know, what you see in other people and write those in the first column,"* (show one of the sheets). *"In the second column, write down what you know about how the drug can affect someone if they use it for a period of time, so the long term effects of using the drug,"* (show one of the sheets and point to the column).
>
> *If you think you know about cannabis, you can go in this group,"* (place the worksheet in one area of the room).

(Do this for all of the drugs.)

"If you finish the one you are working on, you can have a look at the sheets for other drugs you may know and add anything else that may not have been included.

This won't take long, so I'll give you 5 minutes to do this."

After the groups have finished, ask the groups to provide feedback on the experience of intoxication (following slides).

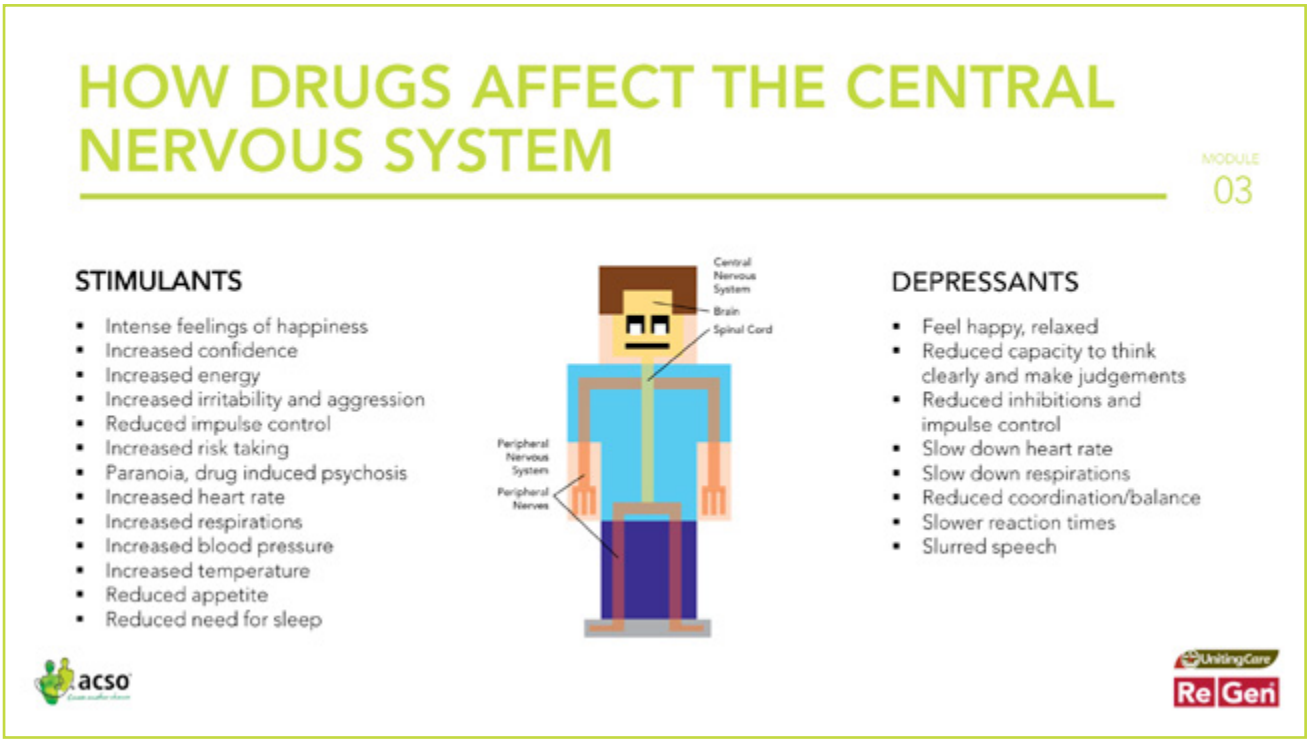
Option 2:

Place the Actvity Sheets on the walls of the room (or on tables around the room). Explain that the **worksheets around the room are for different drugs**.

"The first column has space to write down what it is like to be intoxicated by the drug" (show one of the sheets). *"The second column has space to write down what you know about how the drug can affect someone if they use it for a period of time, so the long term effects of using the drug,* (show one of the sheets and point to the column).

What I want you to do, is walk around the room and write down on the sheets what you know about intoxication and long term effects of each of these drugs, the idea is to get one list, so don't repeat what others have written, if you know something that hasn't been written, add it to the list."

After the group have finished, ask the group to provide feedback on the experience of intoxication (following slides).



Seek feedback from the groups – as the slide is animated to reveal depressants first, commence with those who looked at alcohol, cannabis, benzodiazepines and opiates to provide feedback on the activity completed.

"What were the effects of intoxication?"

Discuss

- This slide is animated, the first list that will come up is signs of intoxication for depressants.
- Show the list 'Effects of Depressants' and address any gaps.

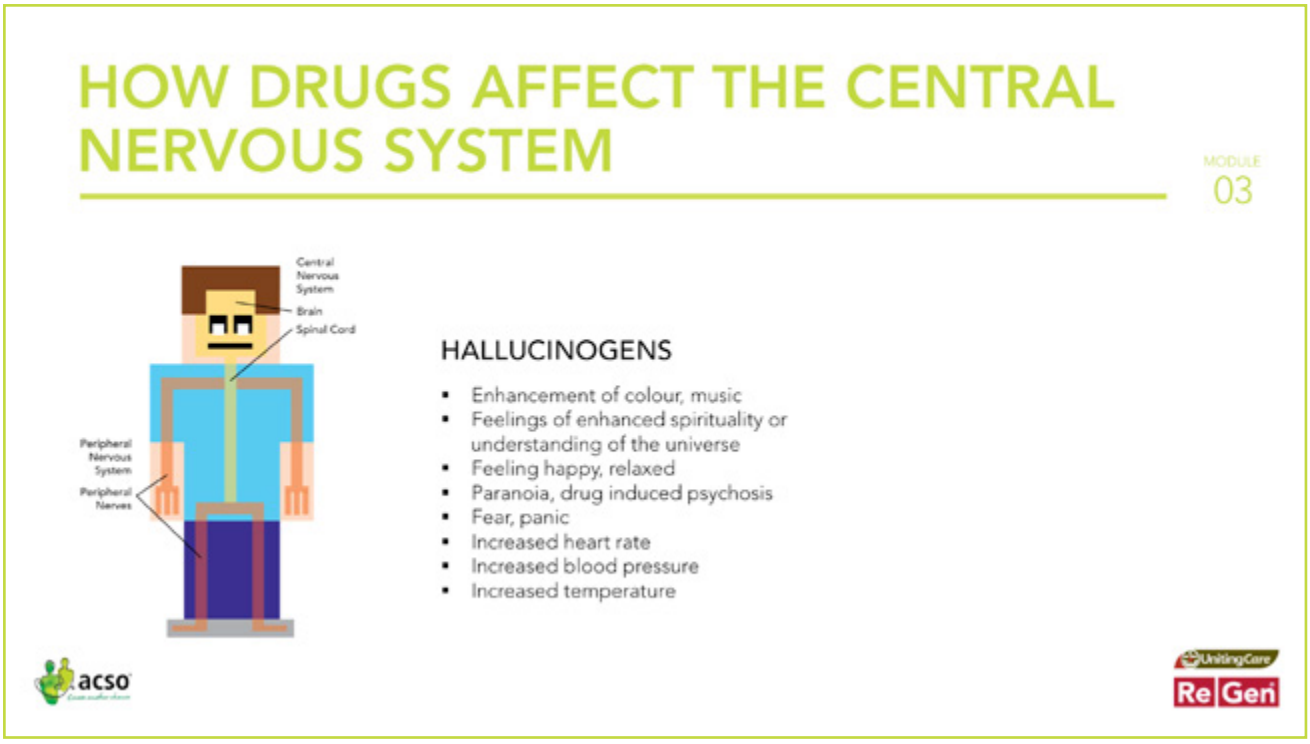
Ask the groups who looked at ecstasy and amphetamines/methamphetamines for what they thought the signs of intoxication are. Discuss.

- Show the list 'Effects of Stimulants' and address any gaps.

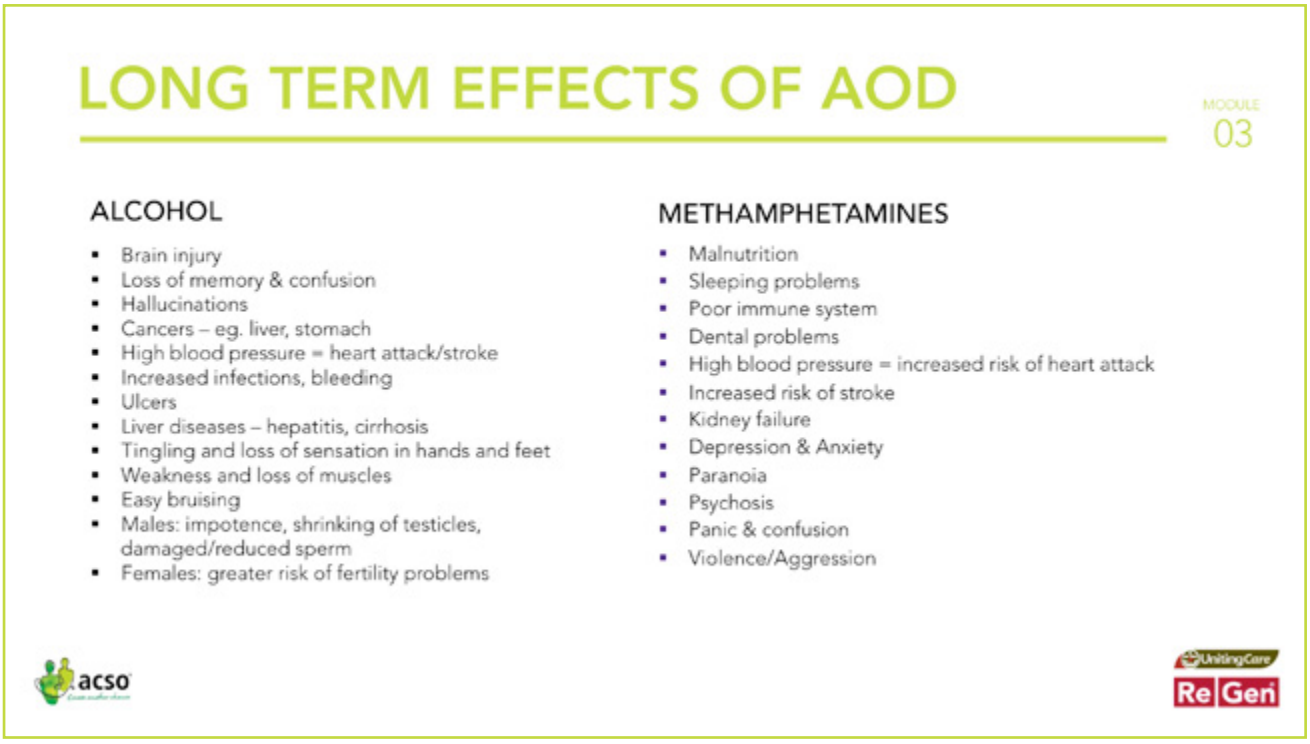
Ask the groups who looked at hallucinogenic drugs for effects of intoxication.

Discuss.

- Reveal the next slide.



Click on the mouse button and reveal the list "Effects of hallucinogens" and address any gaps based on what the groups raised.



Ask the group who looked at alcohol,

"What long term effects did you identify?"

Click the mouse button to reveal the list of long term effects of alcohol. Briefly discuss.

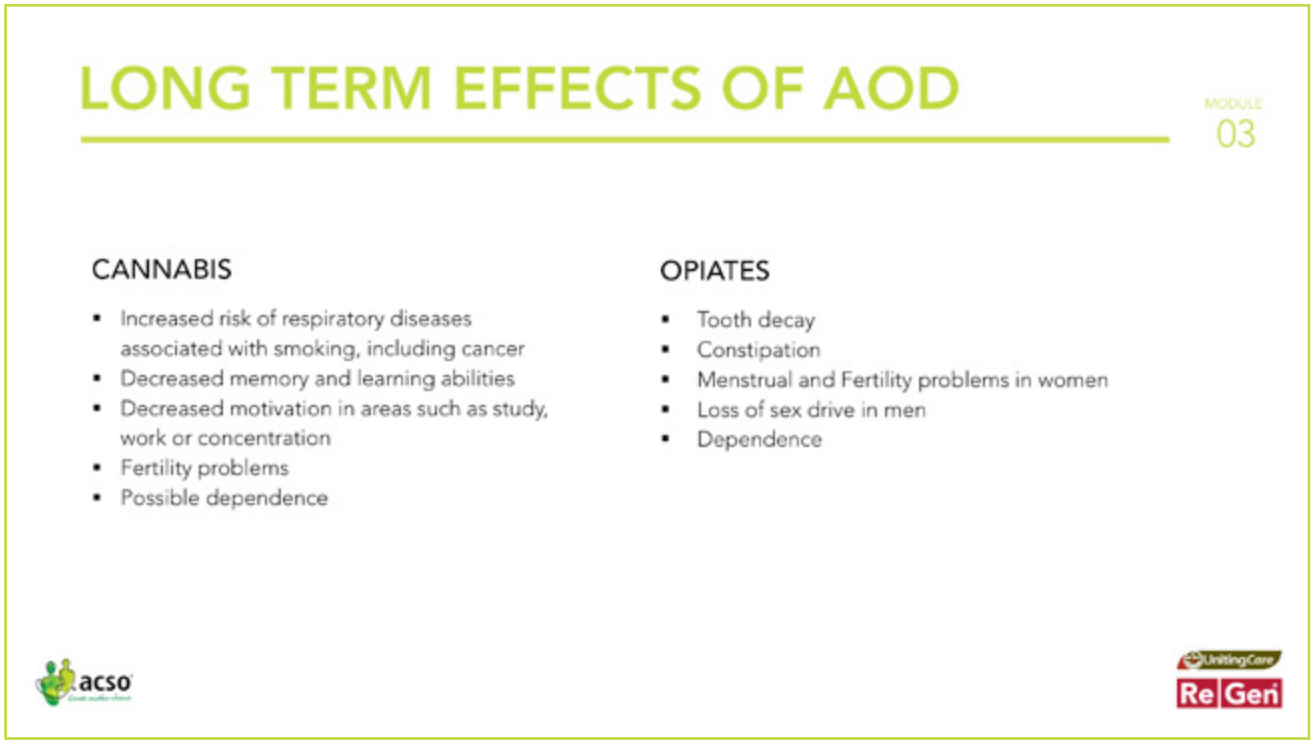
Ask the group who looked at amphetamines/methamphetamines,

"What long term effects did you identify?"

Click the mouse and reveal the list of long term effects of methamphetamines. Briefly discuss.

Discuss the following:

In relation to long term effects of ecstasy, there is very little information available at this stage, but there is some possibility of increased levels of depression and some cognitive impairment. This largely depends on how much is used.



Ask the group who looked at cannabis,

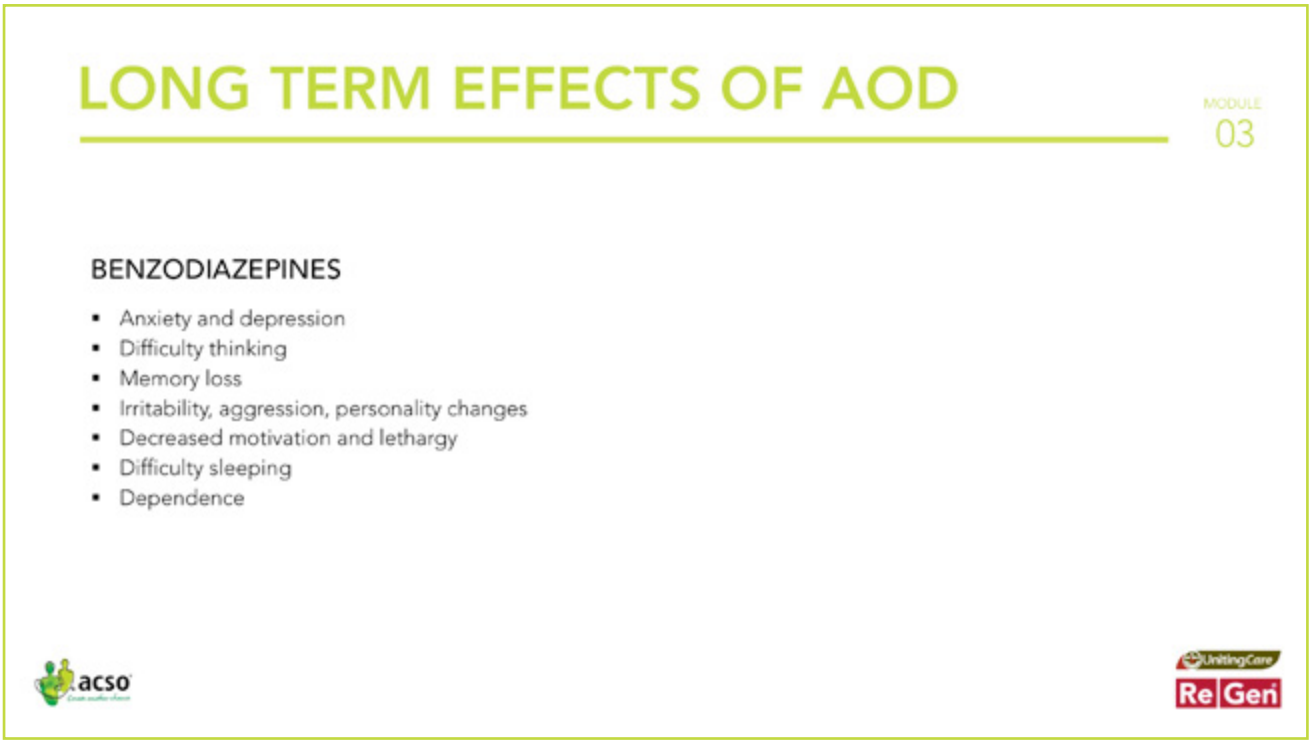
"What long term effects did you identify?"

Click the mouse button to reveal the list of long term effects of cannabis. Briefly discuss.

Ask the group who looked at heroin & other opiates,

"What long term effects did you identify?"

Click the mouse and reveal the list of long term effects of opiates. Briefly discuss.



As the group who looked at Benzodiazepines,

"What long term effects did you identify?"

Summarise this section:

- Drugs all have an effect on the central nervous system, which has an effect on you mood, thinking and behaviour. Everyone is different and may experience drugs in different ways, though there are generally similar effects.
- As well as the desired effects, AOD use has a range effects on your body, in terms of heart rate, temperature and blood pressure. These effects can sometimes cause problems for people and lead to some health risks.
- Long term use can cause a range of health risks.

(This slide is animated. The heading will appear before the remaining text on the slide.)

Suggested script:

"When we think about AOD use, there are some other things to be aware of: tolerance, dependence and withdrawal."

"What is your understanding of what we mean by tolerance?"

Discuss.

Key points:

- When people who have been tolerant stop using for a period of time, and then use again, it is important that they use a lot less than they used to because their tolerance will be low. Using the same amounts as before stopping, may result in an overdose.
- Tolerance can also develop to different aspects of the drug you are using. You may become tolerant to the relaxing effects of a drug, and need more to get that feeling, but you may not have become tolerant to other impacts of the drug, for example, the impact on reflexes. You may lose your awareness of these impacts and engage in some risky behaviour.

"What is your understanding of what we mean by dependence?"

Discuss

Key points:

- Dependence is a physiological response to the presence of the drug and can also include psychological aspects.
- When someone is dependent on a drug, they need the drug for normal functioning. If they stop, or don't get the dose they need, they may experience withdrawal symptoms.

"What is your understanding of what we mean by withdrawal?"

Discuss

Key points:

- When someone is dependent on a drug and stops using it, they will experience withdrawal symptoms. These occur because the body, having been used to the presence of the drug, now needs to get used to a lack of the drug. Our bodies are constantly adjusting to get the right balance, for example, if we start to get hot, we sweat, once we have cooled down, we stop sweating. So when we are dependent, our body has had to do things to adapt to the drug being there, when the drug is not there, it has to readapt to it not being there. This can take some time.
- Withdrawal symptoms can include effects that are opposite to how the drug feels, for example, stimulant withdrawal may include hunger, tiredness etc.

Reveal the slide to reiterate what has been discussed.

Timeframe: 5 minutes

Resources: Participant Workbook, pens

Introduce the activity.

Suggested script:

> *"When we want to think about our AOD use, it is sometimes helpful to check in and see how our relationship with AOD is going. One of the standard tools to see how we are travelling is this short questionnaire, CAGE-AID. On page 18 of your workbook, there are some questions for you to answer."*

The questions are:

01. Have you felt you ought to cut down on your drinking or drug use?
02. Have people annoyed you by criticizing your drinking or drug use?
03. Have you felt bad or guilty about your drinking or drug use?
04. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?

Responses are either yes or no.

Allow time for completion.

Explain what the score means and discuss responses to the activity.

> *"A score of 2 or more yes answers can indicate that a person may be experiencing problems or dependence associated with AOD use. It might be worth thinking about making change to your use. Is anyone surprised by their score?"*

Briefly discuss and identify that later in the program we will look at what you might do if you are concerned with your AOD use.

Before revealing the content of the slide, connect this point to the previous activity.

"The score on the previous activity was about thinking about if there is a problem with your use of drugs. Some signs that problems may be associated with dependence are…" (reveal the list).

Key points:

- People can experience harms and problems with AOD use, whether dependent or not.
- Dependence is associated with the likelihood of incurring more risks and harms.
- It is recommended that if people are dependent on AOD, abstinence is the best option, though cutting down may reduce some harm if someone is not ready to stop.

(This slide is animated, the heading will come up automatically, but not the text.)

To introduce the topic of mental health and AOD, it is useful to explore participants' understandings of this relationship. The content in this part of the module provides an opportunity to correct myths.

Suggested script:

> *"What is your understanding of AOD and mental health? What have you heard?"*

Discuss.

Reveal the contents of the slide. (It is likely that the points on this slide will be raised in the discussion, so complete the discussion revisiting the points as you reveal the remaining text on the slide.)

Note:

You may also want to relate this to any relevant points raised in the function and consequences of AOD exercise previously completed as it is not unusual that mental health issues are raised in that activity.

Discuss the complex relationship between anxiety and AOD use.

Suggested script:

Different drugs, due to the way they work on the brain, and interact with brain chemicals can either increase anxiety or decrease anxiety.

This slide looks at what the research has found about cannabis and alcohol and anxiety.

- Regular cannabis users may be more likely to experience anxiety.
- Cannabis may cause anxiety in some users on a short term basis or whilst they are intoxicated.
- Alcohol use can make anxiety worse in the long run.
- Anxiety can occur during alcohol withdrawal.

This slide identifies what the research has found about stimulants and anxiety.

- Anxiety is common with stimulant use, with more severe anxiety associated with higher levels of use.
- Anxiety is common in stimulant withdrawal.

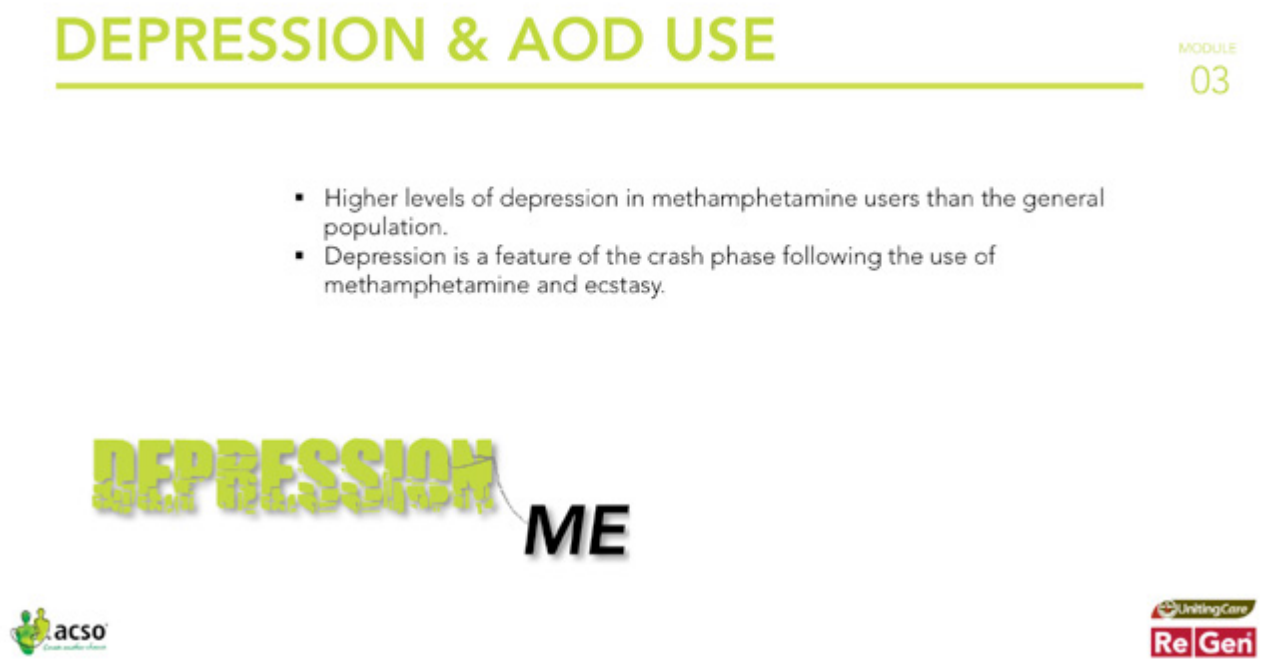
Suggested script:

> *"Does this information about AOD use and anxiety match your experience, or the experience of others?"*

Discuss briefly, unless it came up in the first discussion.

Discuss depression and cannabis and alcohol use, raising the key points on this slide.

- Cannabis is seen as one of a number of factors that may contribute to anxiety and depression.
- Some evidence exists that heavy or frequent cannabis use may predict depression later in life (young women more prone to this than men).
- Heavy use of alcohol and alcohol dependence are strongly associated with depression, particularly in women.
- Alcohol withdrawal can include symptoms of depression.



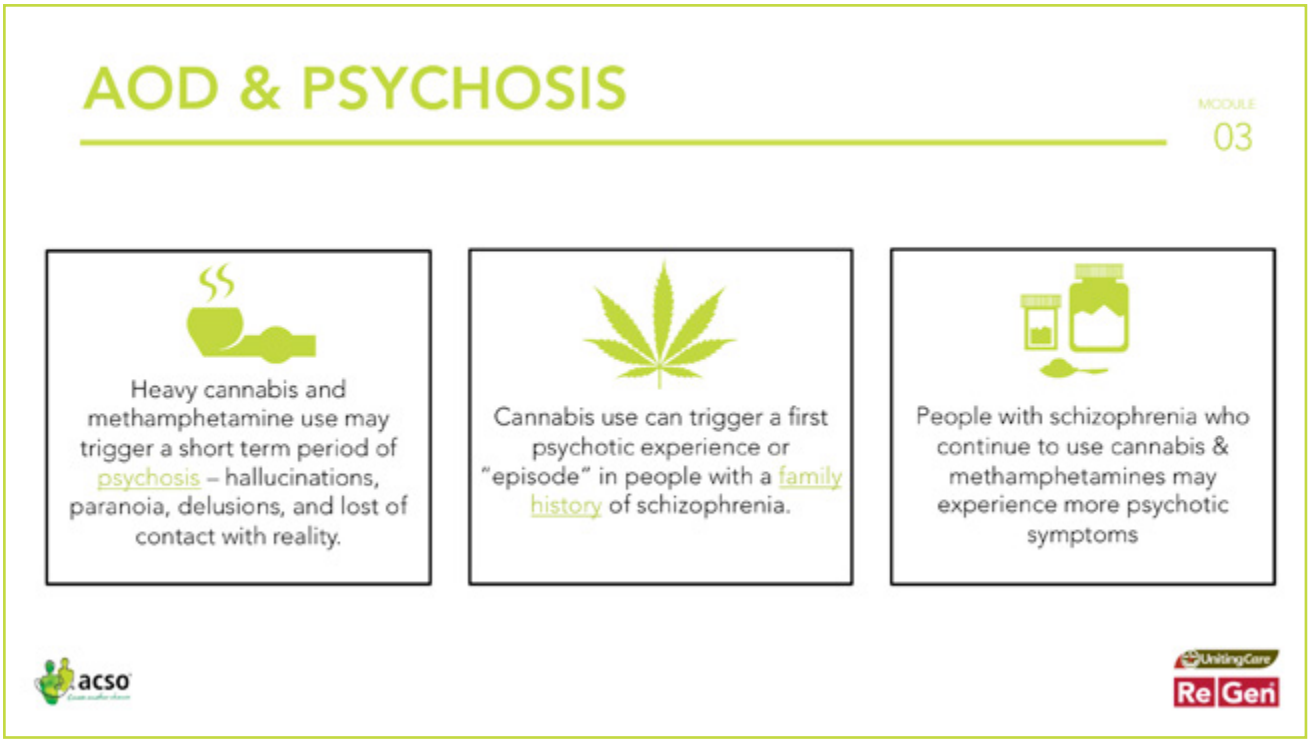
Discuss depression and amphetamine use, raise the key points on this slide.

- Higher levels of depression in methamphetamine users than the general population.
- Depression is a feature of the crash phase following the use of methamphetamine and ecstasy

Suggested script:

"Does this information about AOD use and depression match your experience, or the experience of others?"

Discuss briefly, unless it came up in the first discussion.



(The text on this slide is animated to come up after the heading)

Ascertain groups' understanding of AOD and psychosis and discuss.

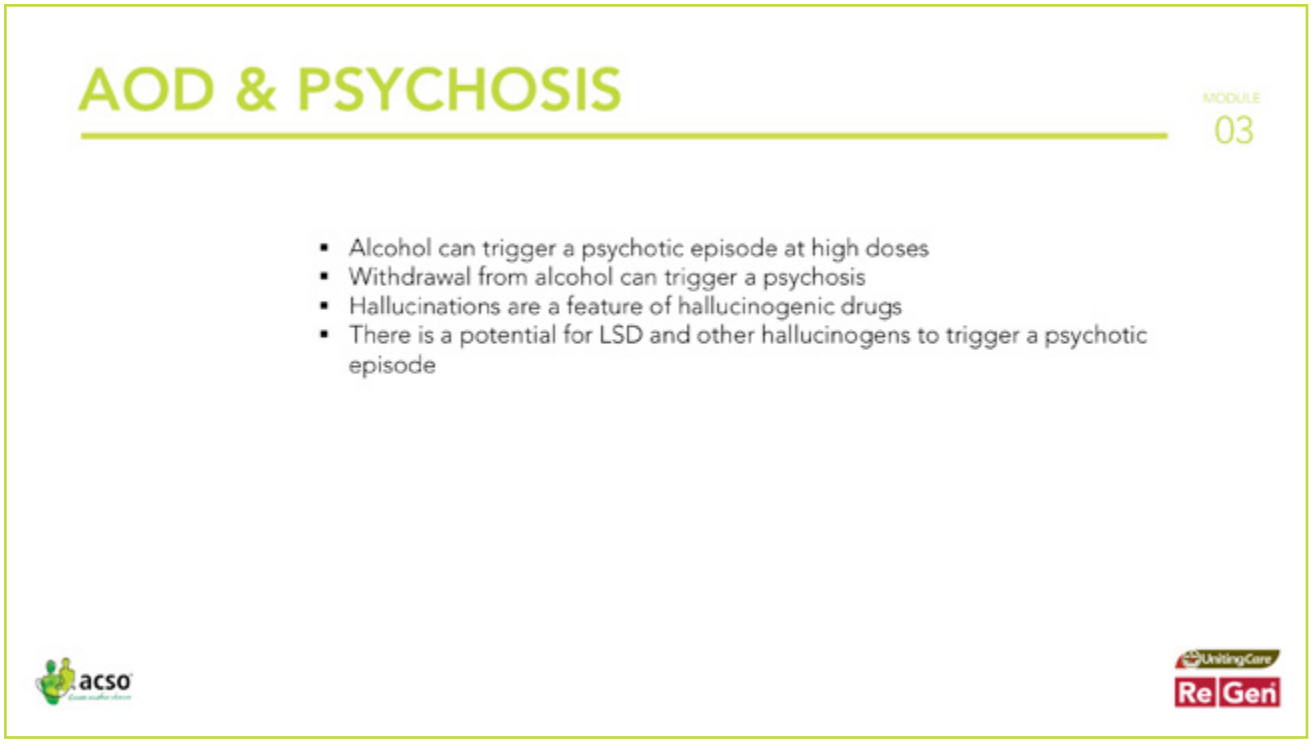
Suggested script:

"What is your understanding about drugs and psychosis? What have you heard?"

Discuss issues raised.

Reveal the text on the slide and discuss the findings.

- Heavy cannabis and methamphetamine use may trigger a short term period of psychosis – hallucinations, paranoia, delusions, and loss of contact with reality. There is a dose-related association, with the risk increasing with higher doses and days used.
- Cannabis use can trigger a first psychotic experience or "episode" in people with a family history of schizophrenia.
- People with schizophrenia who continue to use cannabis & methamphetamines may experience more psychotic symptoms.



Explain the following points:

- Alcohol can trigger a psychotic episode during high levels of intoxication or withdrawal and has also been seen when a person reduces alcohol intake severely. [2]
- Cocaine can also trigger a psychotic episode.
- Although hallucinations are a feature of LSD etc., there is not enough information to clarify the relationship between this drug and psychosis, the occurrence is low, but there is the potential for it to do so.[3]

2 Larson, M.F. (2011) Alcohol-Related Psychosis. Medscape Reference. http://emedicine.medscape.com/article/289848-overview Accessed on 26/9/2016

3 Basu, S. & Basu, D. (2015). The relationship between psychoactive drugs, the brain and psychosis. International Archives of Addiction Research and Medicine, 1, 003.

Note:

You will need access to the internet to play this video. You will also need your computer linked in to speakers for this video. The video should play on computers with Windows Media Player installed or on Apple default media players. It is recommended you test this before running a program and if there are problems, please contact ReGen.

(Optional Video)

Introduce this video.

Suggested script:

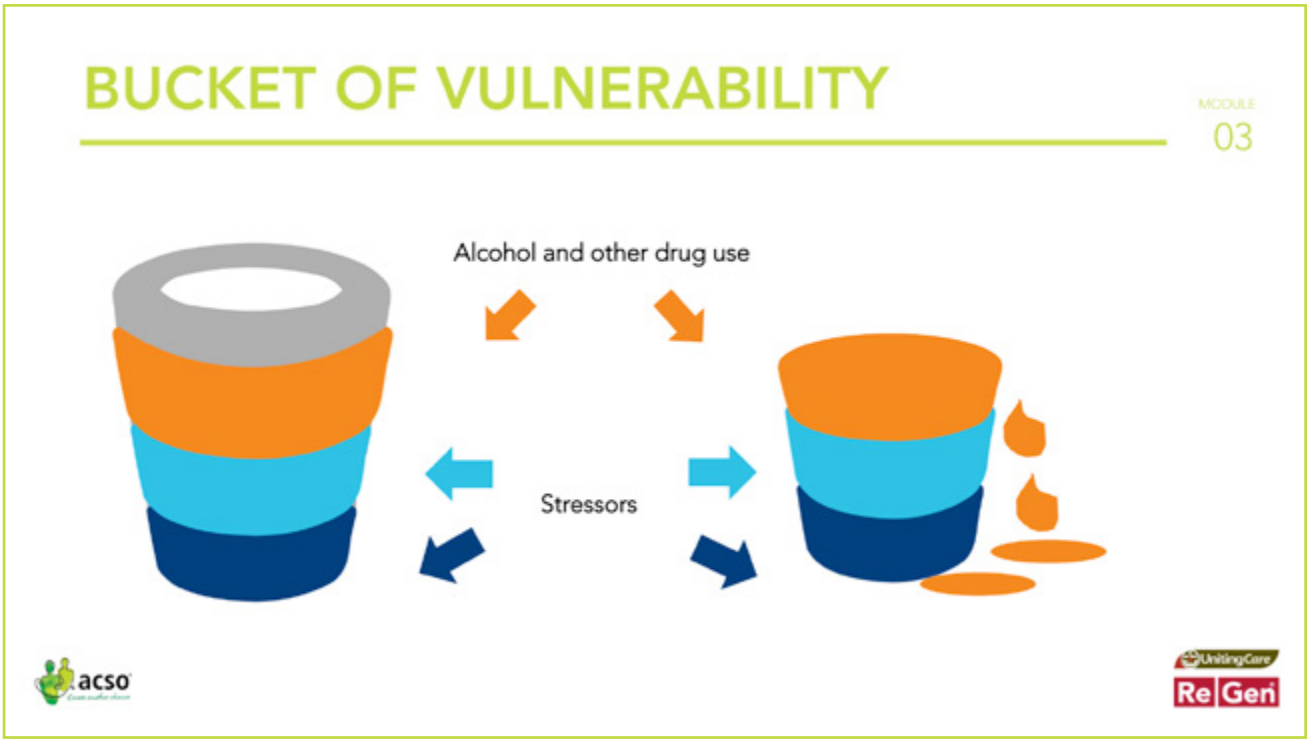
"The video I am about to play explains why some people might develop mental health issues and others not. Although the video talks about psychosis, it is relevant for all mental health issues.

We will have a look at the video now and we will discuss it after."

When the video is complete discuss and clarify.

"What are your thoughts on this? Does it make sense?"

Discuss briefly, using the next slide to reiterate the points as required.



Summary:

Some people, because of their life experiences may be more vulnerable to developing mental health problems, and may do so at lower levels of AOD use.

However, most people – given enough stressors without tools to reduce or manage stress – may develop mental health problems. We know that AOD use, although it seems to assist in managing life's stressors, actually increases the risk of developing mental health problems, because it doesn't really help us manage the stressors.

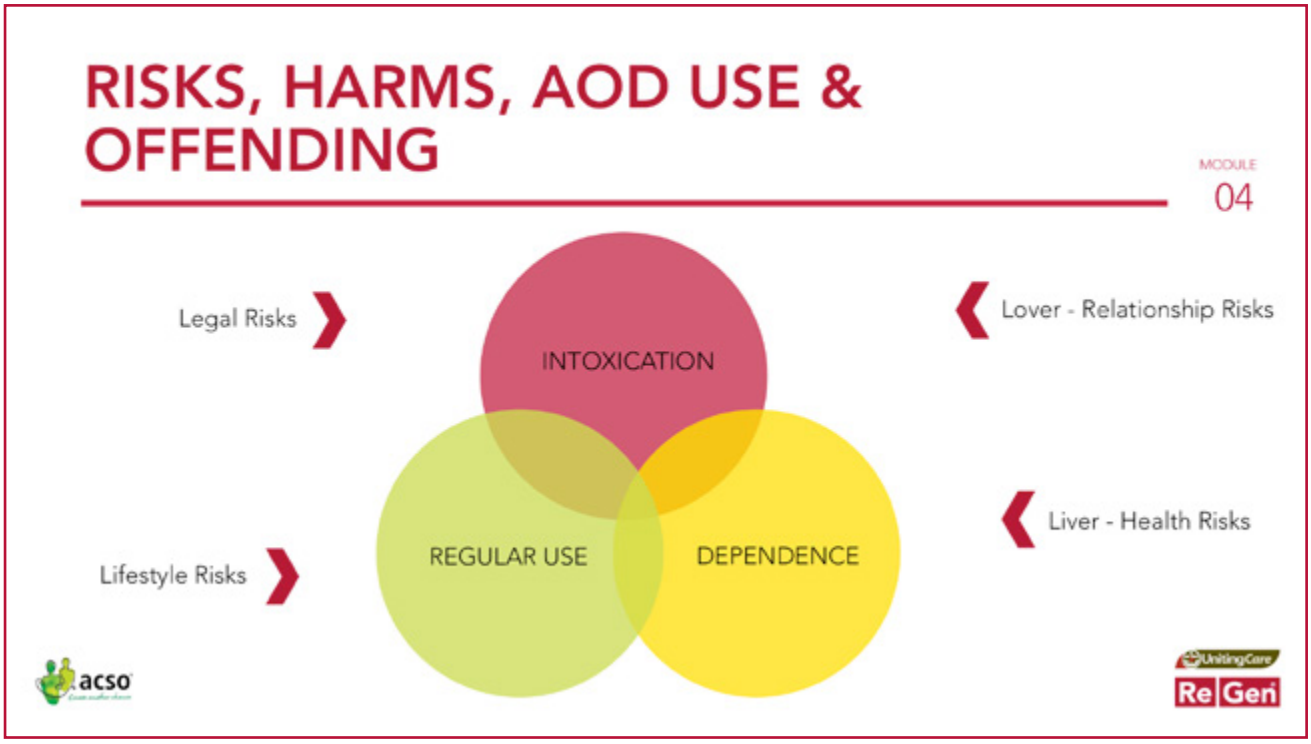
Module Aims:

- Increase self-awareness of the relationship between AOD use and offending.
- Develop strategies to identify levels of risk and reduce impacts and consequences.

Introduce this module.

Suggested script:

"We have already identified the relationship between AOD and offending, and some of the drug-specific risks and harms. We are now going to have a look at some of this in more detail, and also think about what we can do to reduce the risks, harms and consequences."



(This slide will be animated so that the following come up in order.)

Discuss different patterns of use and harms associated with them according to Thorley's theory. Identifying that harms can be categorised into the Liver, Lover, Lifestyle, Legal (4 L's frameworks).

Suggested script:

> *"When we think about drug use and risks and harms we can think about harms associated with,"*

(mouse or down arrow).

> *"Intoxication – what might the risks and harms be here?"*

Facilitate discussion. Accidents, offending (fights, arguments, etc.), injury.

(Hit down arrow.)

> *"Regular use – what might the risks and harms be here?"*

Facilitate discussion. Someone who uses regularly might have harms of intoxication, but are there others?

(Hit down arrow or mouse.)

"Dependence – what might the risks and harms be here?"

Facilitate discussion.

When we try and categorise the harms, or problems we can think of what we call the 4 L's as these come up, link the harms already raised by the group, both on consequences of AOD use activity (activity 2) and anything raised in the discussion here.

Hit mouse or arrow

Harms associated with Legal issues

Harms associated with Lifestyle issues

Harms associated with Lover – or relationship issues

Harms associated with Liver – or physical and mental health.

Summarise

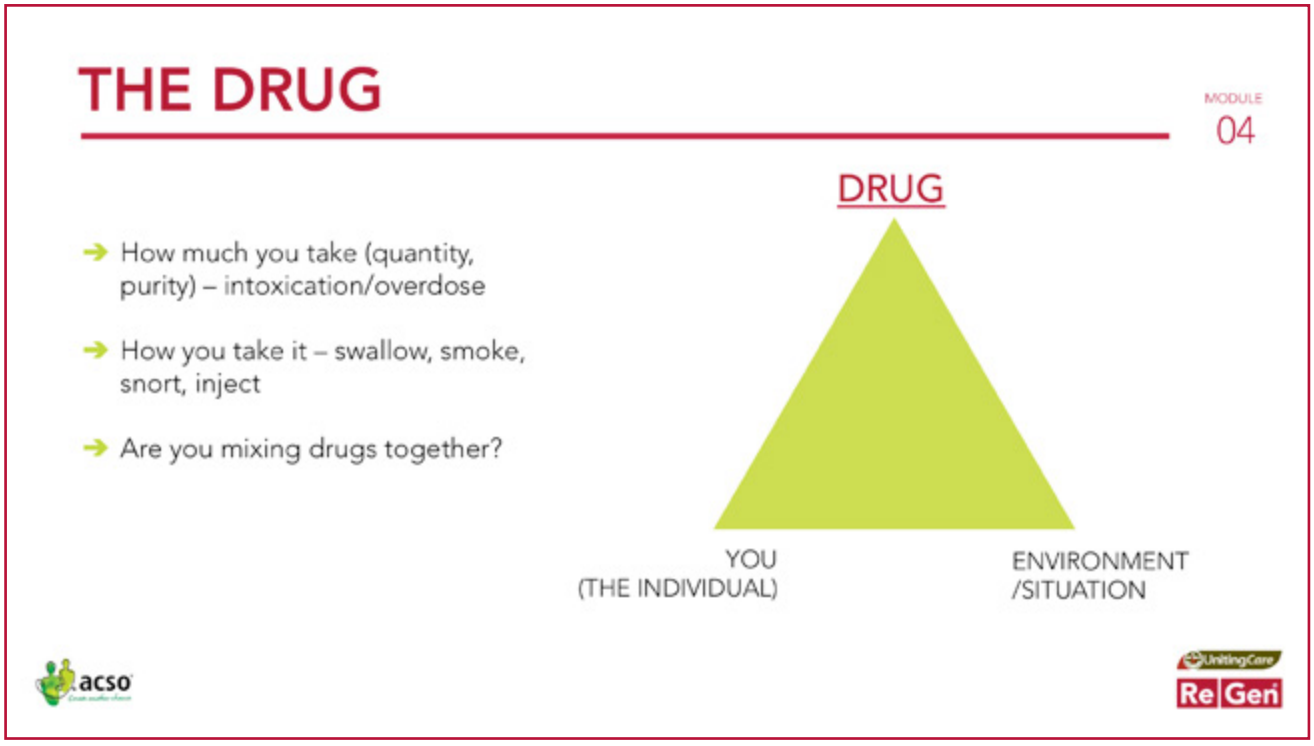
So we can see that different patterns of use can link with different harms, that in some cases, AOD use can create some harms and problems, it's not just drug dependence that is the issue.

Introduce the drug interaction model.

Suggested script:

> *"Risks, harms and consequences associated with AOD use aren't just about the drug, because each time we use, there may be different outcomes. So these risks, harms and consequences occur through a complex interaction of the drug(s) used at the time, the person using them and the environment or circumstances in which the alcohol or drugs are used."*

Provide some examples of different scenarios e.g.: changing one or two components to either increase or decrease harm.



Discuss aspects risks harms associated with the drug component of the drug interaction model.

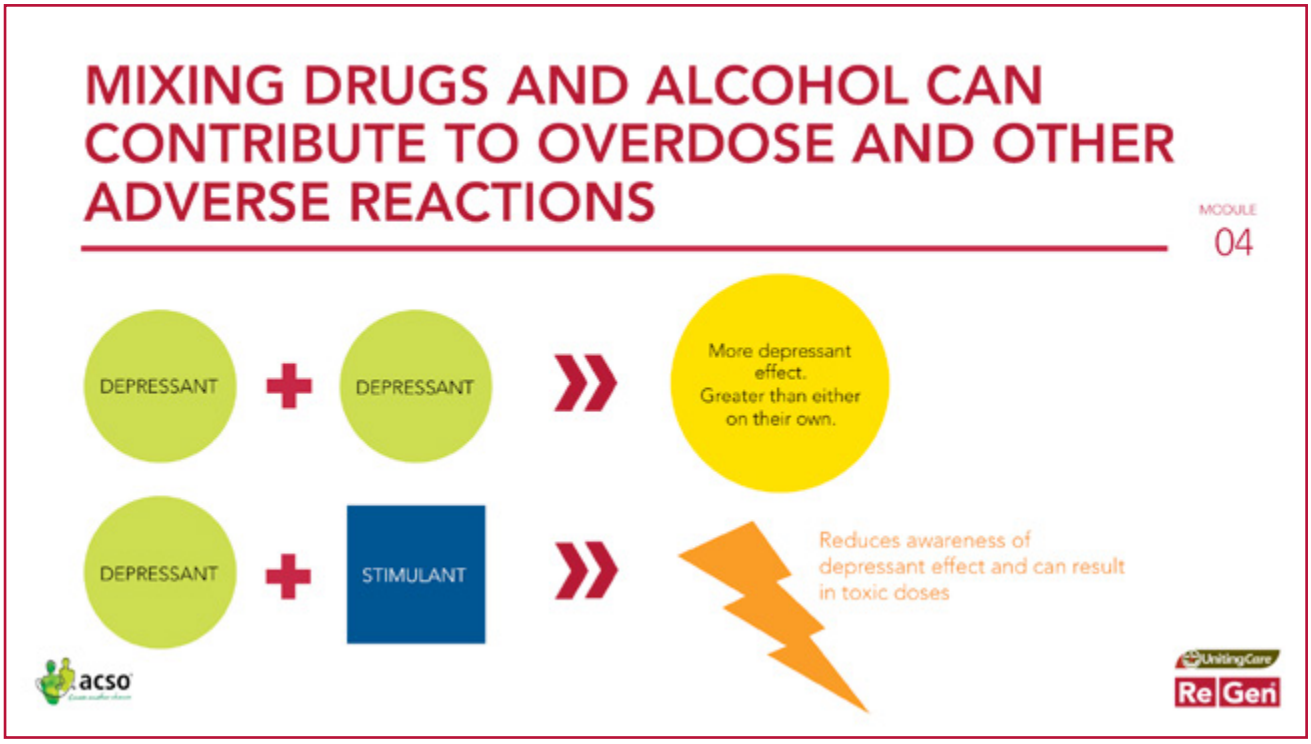
Suggested script:

"We have already had a look at the effects of drugs and intoxication for different drugs, though when we think about drugs, it's about the amount and purity. The more you use or the stronger the substance is, the more you are likely to be affected and the risks, harms and consequences may change.

How you use the drug can impact on how much of the drug gets into your brain, but can also change the risks. For example, injecting drug use adds more risks, and potential harms and consequences than using other methods, like oral use.

Mixing two drugs or more together can also change the risks harms and consequences"

(next slide)



Explain the concepts of potentiation.

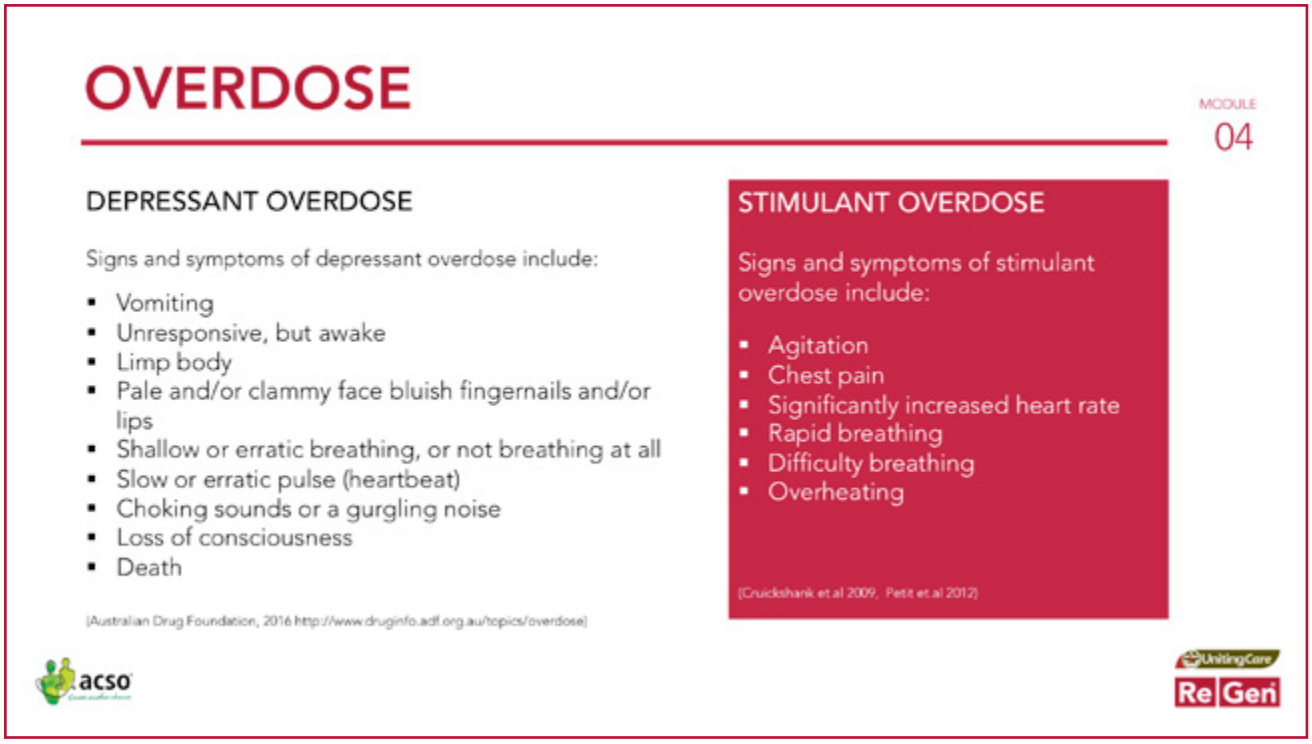
Suggested script:

"Two drugs of the same class when used together can increase the effect of each other to have a net effect that is far greater than either drug used individually, and this is not always predictable."

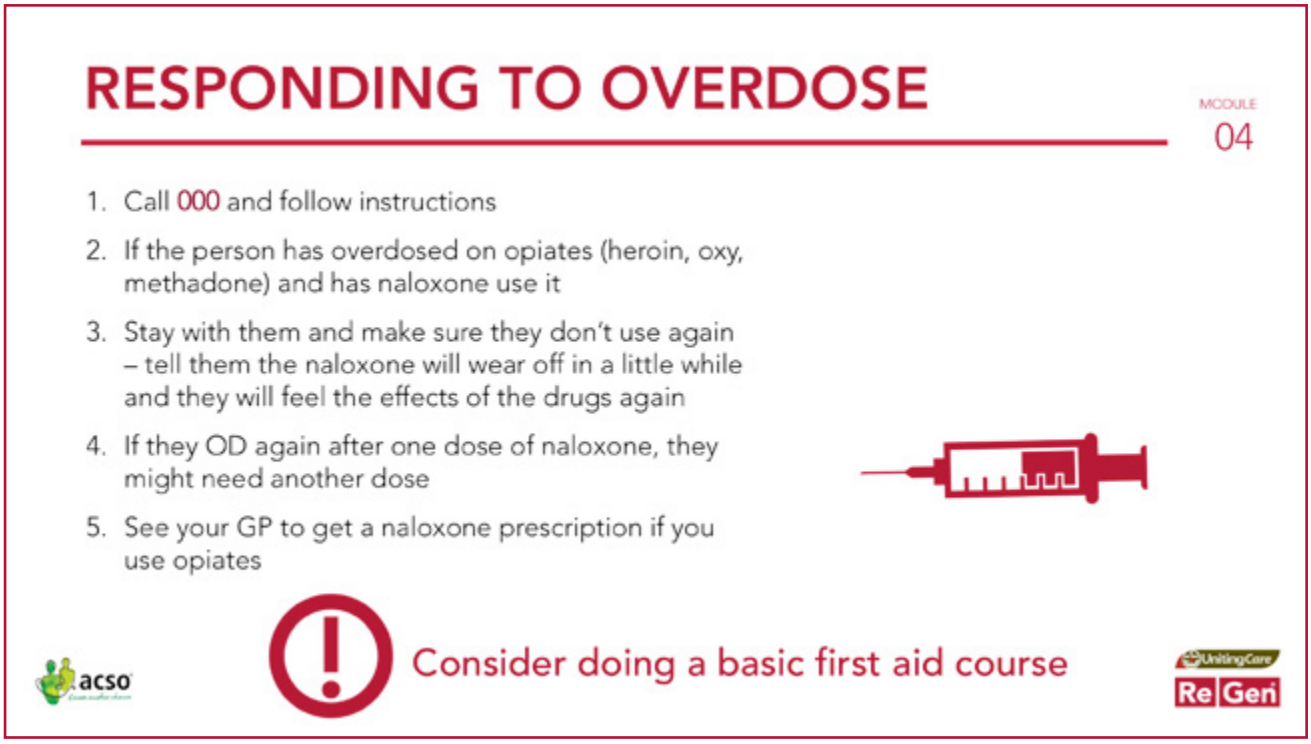
The use of stimulants can mask the level of intoxication from alcohol, for example. Yet those effects are still occurring and can lead to increased risks and harms, including alcohol toxicity.

Mixing drugs can be unpredictable, and can lead to overdose situations. Heroin mixed with benzodiazepines that were taken a short time ago for example, or when GBH is mixed with alcohol…

The safest thing to do is not mix alcohol and other drugs at all."



Briefly discuss signs of overdose for depressants and stimulants as outlined on the slide.

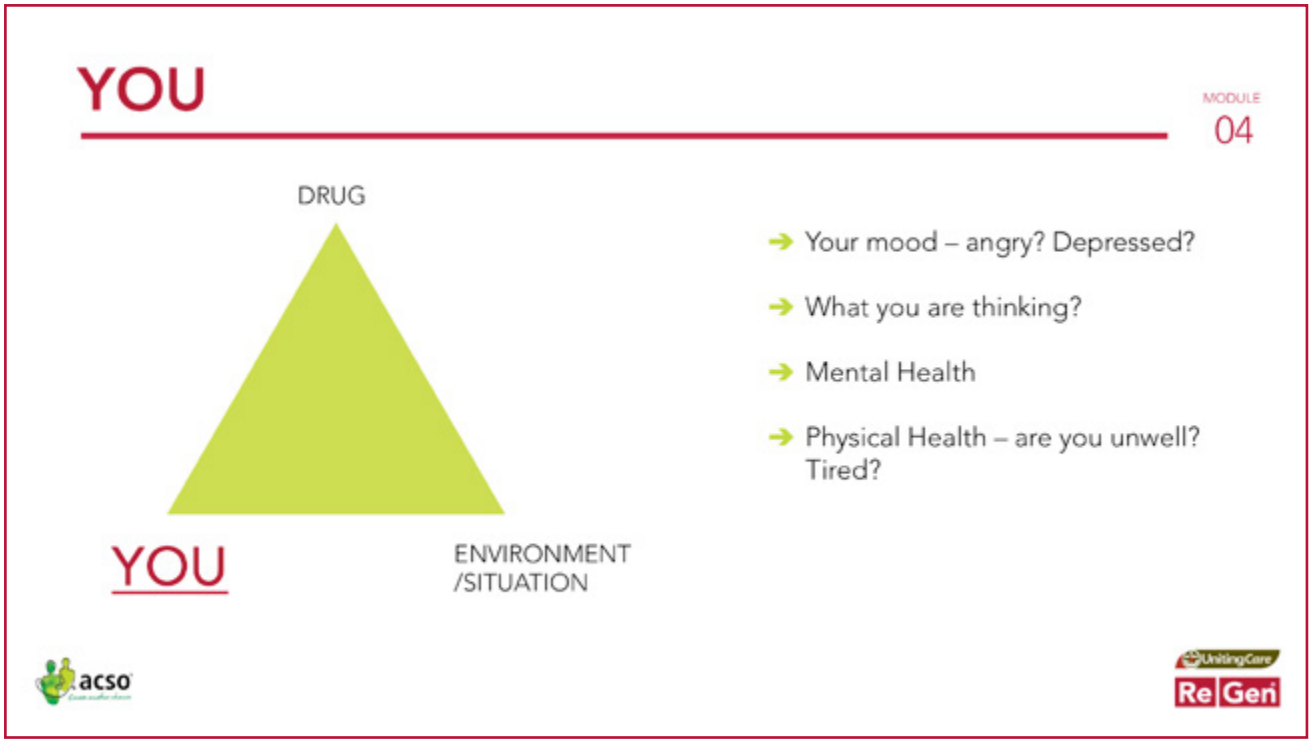


Provide the information on the slide as a brief discussion to respond to overdose.

Encourage opiate users to talk to a GP to access a prescription for Naloxone or to ask a chemist for over the counter supply which is now legally available.

Encourage people to undertake Basic First Aid.

> *"You never know when a friend will need you, both in an AOD context, or just in life."*



Introduce the Individual (You) part of the Drug Interaction Model and discuss.

Suggested script:

> *"We have looked at the drug component of the complex part of the equation in risk harm and consequences, so now let's look at the 'Individual' part. That's you, or the person using AOD."*

Your mood – angry? Depressed?

> *"What impact might these moods have on what you might do when you are using drugs? I wonder, if we step out of this for a minute, what might your mood mean for your risk of offending, even without using drugs? How does this change if you add drugs?"*

What you are thinking?

> *"What might we mean here?"*

Explain that our thoughts can be associated with our feelings and behaviours. What kind of thinking gets us wanting to use drugs, or use a lot? What kind of thinking might be connected with offending? (If you want to change either of these, it's a good idea to look at how your thoughts keep you stuck). Note: the idea of thoughts and maintaining change is raised later in the program).

Mental Health

"The risks here are that you could use to manage your mental health issues; however, using could make your mental health issues worse."

Physical Health – are you unwell? Tired?

"Drugs may have more of an impact if you are not well."

Introduce and discuss how the environment or situation impacts on risk in the drug interaction model.

Suggested script:

"The other piece of the complex relationship in this risk, harms, consequences picture is the environment or the circumstances or situation.

What environments or situations are likely to increase your risk of using and getting into risky situations that can lead to harms, including offending?"

Discuss.

Key points:

- Association with friends or the culture of the group can affect your experience. (If this one is raised, explore it: Are there certain friends with whom you're more likely to use? Is it about how big the group of friends you are with is? Are there friends that egg you on? Friends that have access to other drugs, etc.) What about if you are with a partner? Research has identified that being with a partner can reduce the risks in some situations, but increase the risk in others. For example, in relation to being heavily intoxicated on alcohol, a person sees their partner flirting and they have some feelings of jealousy, this can create problems.
- What you are doing – engaging in certain activities, driving, dancing, at work etc., can increase the risk due to the impact of AOD on your capacity to act, react and think logically.

- Place – an issue in some environments can be the misinterpretation of actions by others due to the effects of AOD, particularly the actions of those not in the social group, which can lead to arguments that can escalate (due to a lack of cognitive capacity to use conflict resolution skills & lower impulse control). In relation to offending and AOD use, there are some environments where visibility is an issue, for instance, we are pretty aware that police do monitor festivals, etc.
- Laws – this might relate to the laws pertaining to drugs in any community; however, the risks can also be increased if someone is already on an order, and risky behaviour can result in a breach of the order.

Time frame: 15 minutes

Resources: Pens, participant workbook activity 5, pgs. 25-28

Explain that for this activity people will work in small groups to look at one scenario. Their task is to identify:

01. What the possible consequences could be for the person in the scenario,
02. What factors have made this situation risky, and
03. Some ways to reduce the harm in the scenario.

Break the large group into 3 smaller groups (or 4) depending on group number (3-4 per group). Using the numbering off method. Tell each group the scenario they are doing and read it aloud to the group (this will ensure that people who may not be able to read or write are still aware of the scenario).

Give each group 5 minutes to complete the questions for the scenario.

The scenarios are:

01. Stavros has been out with a group of friends to a nightclub. While he was there, he and his friends were shouting drinks. After a few hours, Stavros had had around 10 drinks, a mix of beer and spirits and was feeling pretty drunk. He told his mates that he thought he would go home. One of his mates, Carmen, told him he had just the thing, and took him to the bathroom where he gave him a point of ice. Stavros felt more alert after that and continued drinking for a few more hours. Later, Stavros asked Carmen for more ice, and Carmen said it would cost him money this time, which Stavros didn't have. Stavros and another mate decided they needed some money, and set off to find it.

02. Tom has had a bad day at work. His boss was giving him a hard time and told him that if he didn't lift his game, he would sack him. Tom went home and had quite a few beers. His 10 year old daughter, Belinda, sent him an SMS telling him she had won a trophy in basketball that afternoon. He started to think about not being able to see his kids, because his partner had put an intervention order on him following an episode where he went around drunk and hit her. The more he thought about the situation, the sadder he felt, and the more he drank. Eventually he got on his bike and rode over to see his daughter.
03. Susan has been on a meth binge for a couple of days. She hasn't slept and is pretty wired. She realises she has no money in the bank and knows she has to pay her rent. She calls Centrelink to see if she can get any help, but they have already given an advance. She smokes a pipe and walks down the street where she sees a handbag on the front seat of a car.
04. Joe is out with his mates at a dance party. It's a hot night and the music is fantastic. He pops an ecstasy and dances for a while. He tries to find more ecstasy, and gets hold of something from a dealer he doesn't know, though he's told it is ecstasy. After about 20 minutes Joe decides to take another pill because he is not getting the buzz he wanted.

Bring the group back together. Read one scenario, ask the appropriate group for their responses to the three questions. Discuss. Ask others in the larger group if they have anything to add.

Do this for all scenarios.

Summarise this section

Suggested script:

"Risks and harms are associated with a combination of the drug used, the person using, and the environment or situation in which drugs are consumed. Being intoxicated in certain situations increases the risk of negative consequences, such as accidents, injury and offending. We also know that for some people, consequences, such as offending, are not always related to being intoxicated, but hanging out from drugs, or as a means to pay for drugs. For some, use of drugs may not be associated with offending, but can pose some risks and harms in other life areas."

Module aims:

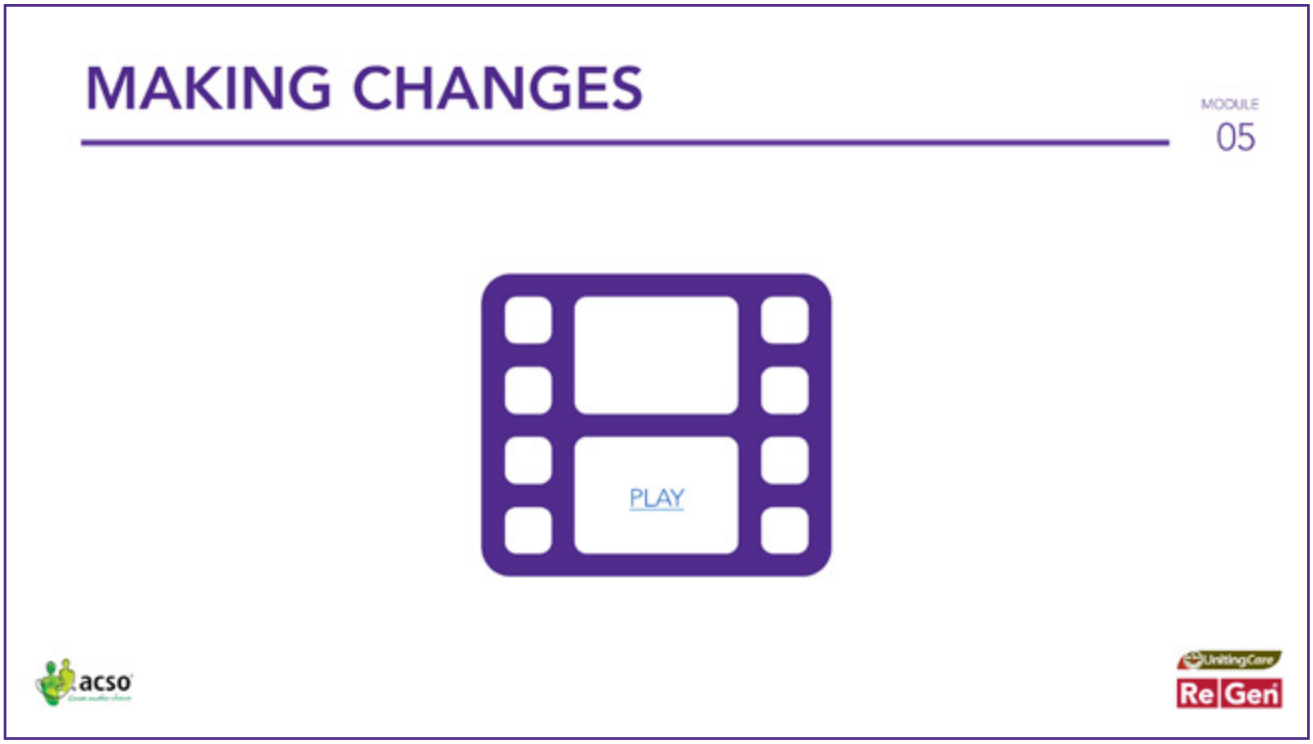
- Understand the stages of change and how to plan for changing behaviour.
- Provide strategies and interventions for self-monitoring and relapse prevention.
- Inform, support and motivate clients to access additional help where required.

Introduce this module.

Suggested script:

"We have spent a bit of time looking at the effects of alcohol and drugs, risks and harms and how this fits into offending and also some ideas about how we can reduce the risks.

We are now going to look at change. Some of you may have already made changes to your AOD use, or to offending, or both. Some of you may be in different positions, thinking or planning to make changes. We are going to work through some strategies that may be helpful for you, depending on where you are at in relation to changing your behaviour."



(Optional Video)

Introduce the video which explains the stages of change model.

Suggested script:

> *"Quite a lot research has been done into this idea of change, and has found that there are specific stages that people go through and this is the situation for a range of behaviours, including AOD use and offending. I'm going to play a video to explain it for you."*

Play the video.

Issues to address after the video include:

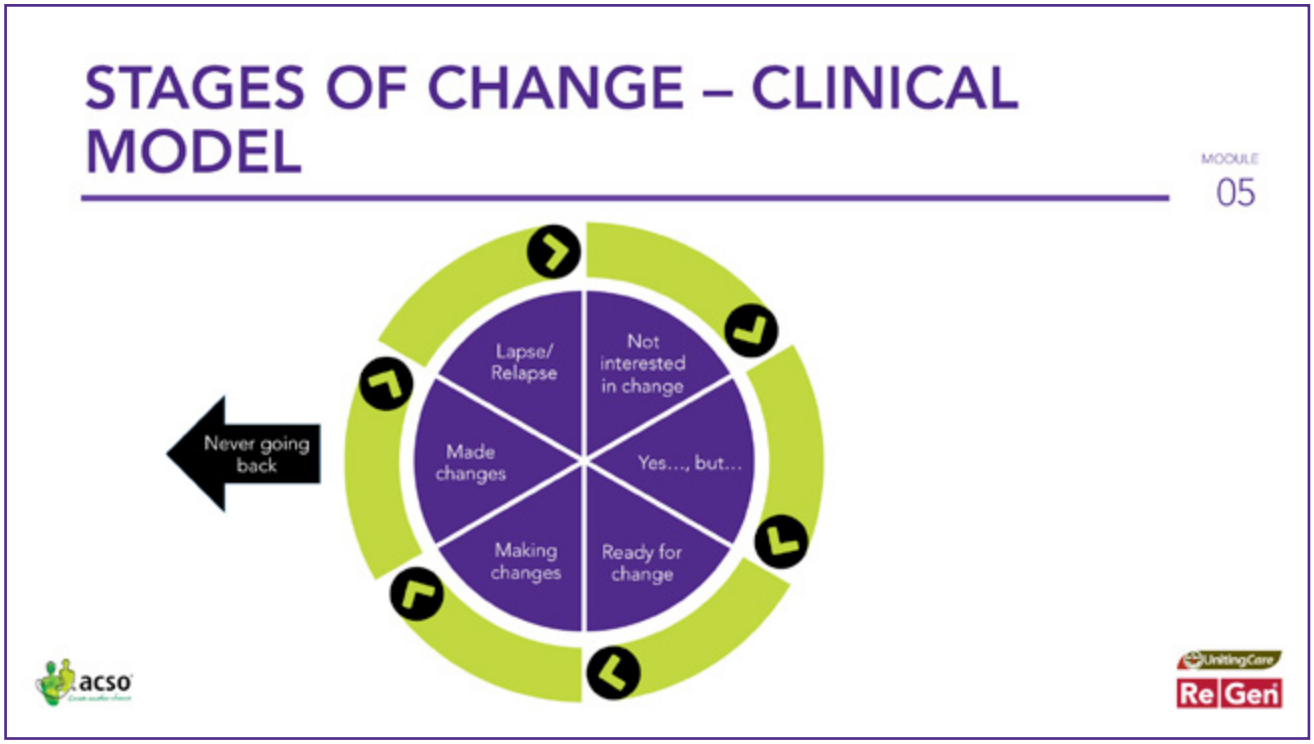
- The video raises AA/NA - offer alternative options.
- The video is focused on abstinence. Discuss other AOD goals.
- The video does not mention lapse. Discuss this.

Discuss.

> *"Did that make sense? Any comments? Questions?"*

Note:

If you feel confident to explain the Stages of Change model you can do so yourself, using the following slide:



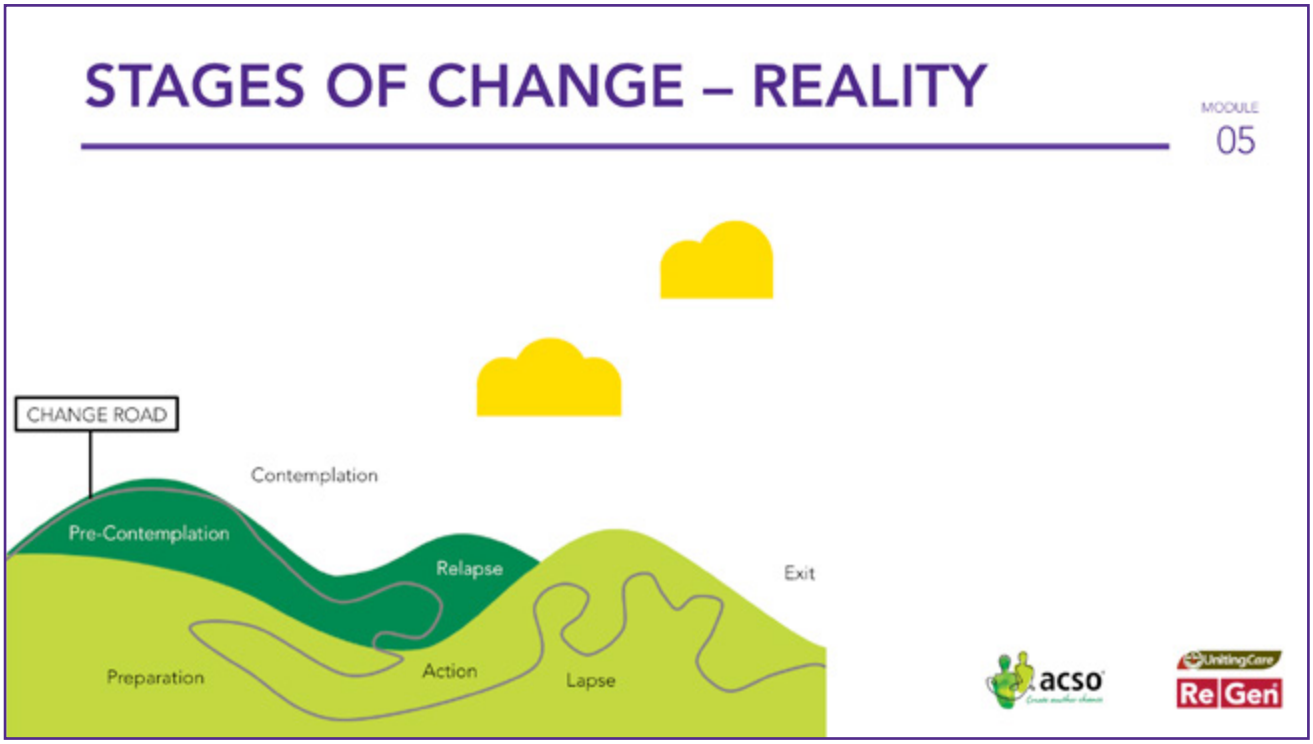
This slide can be used in 2 ways:

01. As a summary to reinforce the video.

"There are different stages in the change process and not everyone will necessarily be in the same stage. This model is applicable to all behaviour change, be it AOD, offending, exercise and so on."

OR

02. If you feel confident to explain the Stages of Change model, you can use this slide to show the stages as you explain it.

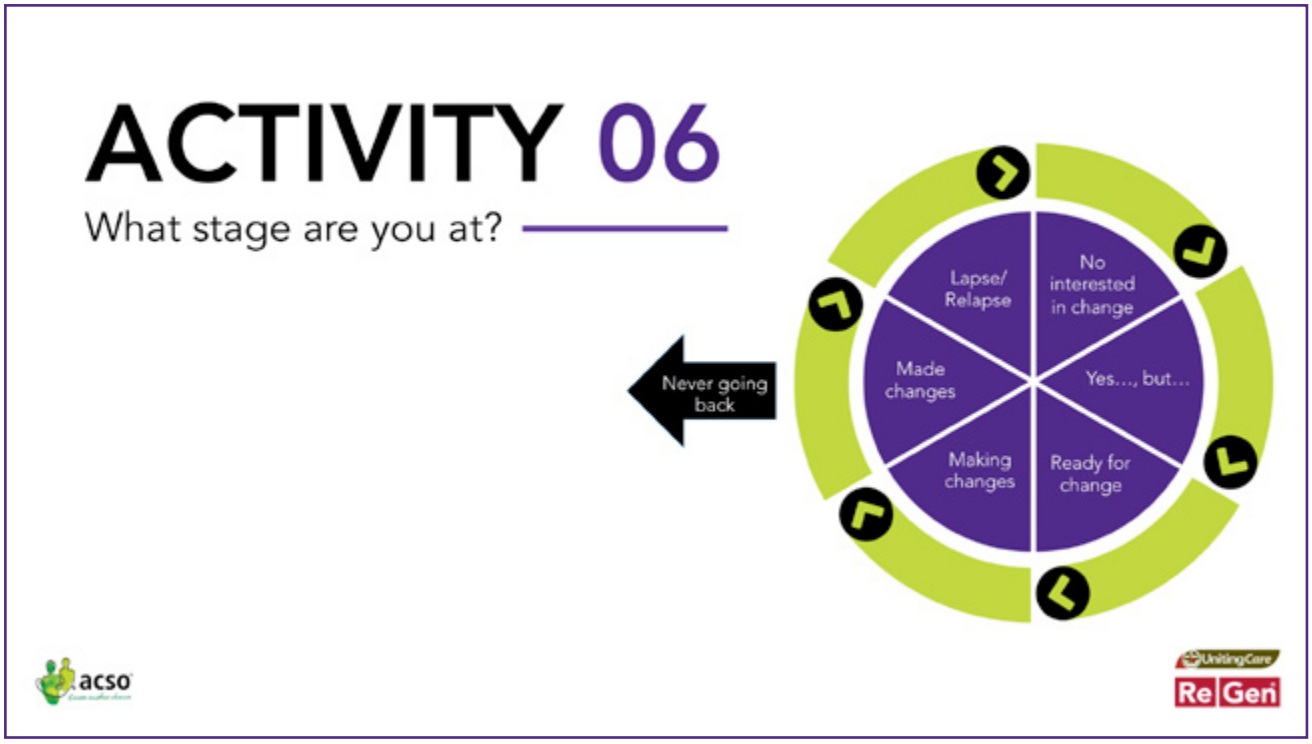


Discuss that the Stages of Change model makes the process look quite linear. Whilst some people may steadily move through the stages in order, others can move in a different order or move back and forward between stages.

Suggested script:

(Show the slide)

> *"For some people, the reality of change is that we can move along and slip back a bit, and it might take a few tries before we actually make and maintain the change to behaviour that we want or need to change.*
>
> *Sometimes making changes to one behaviour requires changes in other parts of our lives, so it is a bit more complex in reality."*



Timeframe: a few minutes (self-reflection)

Resources: Participant workbook pg. 30, pens

Ask the group to think about where they are at in relation to change (they don't have to share):

- In relation to their offending?
- In relation to changing their AOD use?

Allow a moment for them to think about these questions and note that there is a place to record their thoughts in their workbook on pg. 30.

Suggested script:

Then ask the group to now think about (again, without sharing)

"Are you at different stages for each?" Pause and allow a thought

"Think about which of these behaviours is important for you to change to help them get through your order, or both? Do any of these need to change for you to live the life you want?" Pause and allow a thought.

"If you are not ready to change either of these, think about what this might mean for completing your corrections order."

End this short reflection time by saying: *"We are going to look at strategies that have been helpful for different people in different stages of change. So, you will connect with some ideas more than others right now, but maybe later on at some time, other information might be what you need."*

Suggested script:

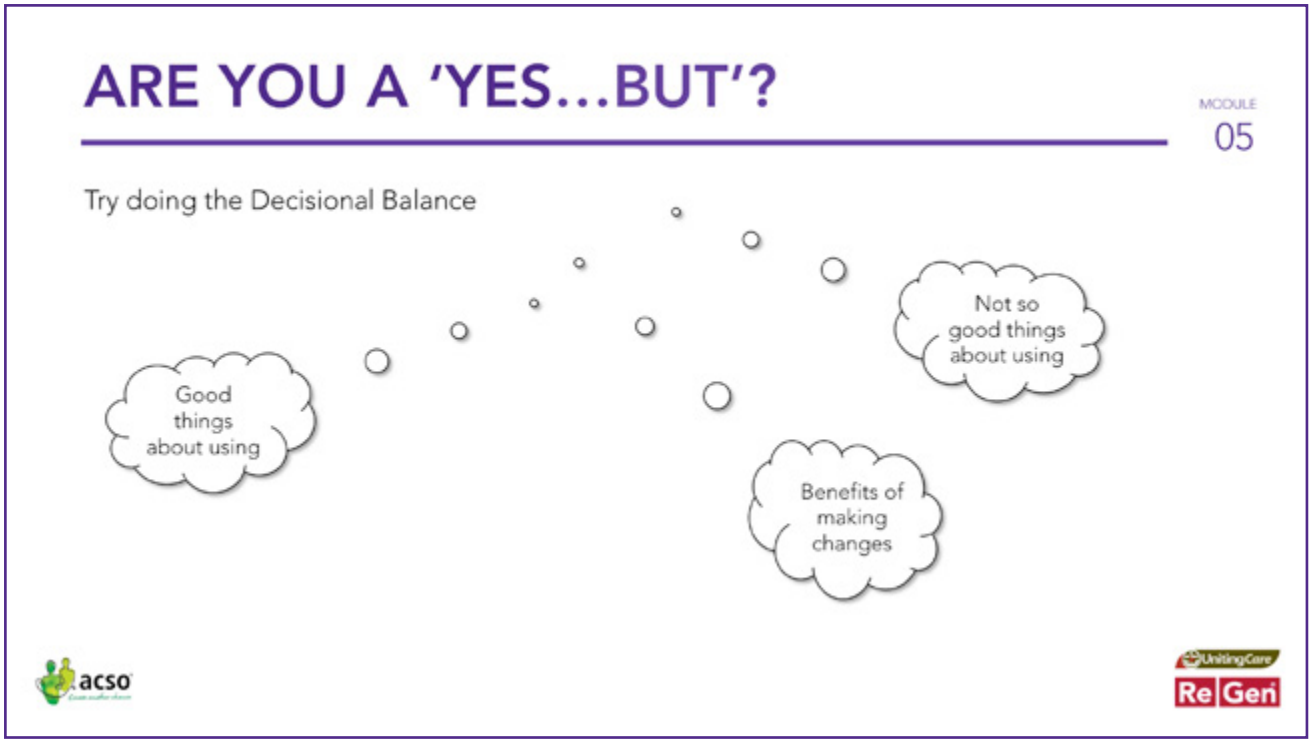
"If you are not ready to change or not interested in changing, it may be worth thinking about how you can reduce the harms associated with continuing your AOD use, or offending. The best way to reduce harms is to stop using illicit drugs and stick to safe levels of alcohol consumption. We say this because illicit drug use does carry with it the risk of being charged for drug-specific crimes (use, possession, etc.), whereas alcohol use is not illegal for those over 18. Having said that, if you are using drugs, there are some actions you can take to minimise some of the risks. We have already talked about thinking about you and the environment, so remember those.

There is also a range of drug-specific harm reduction information and, given that there are potentially a lot of drugs to talk about, we are going to encourage you to read through the information in your workbook that is relevant to the drugs you use.

What about offending? If you are not interested in changing, then the risks and harms are hard to reduce.

If you are at this stage, it is worth thinking about this – if you are not ready to change now, what might be happening at some stage in the future that might make you say, 'I really need or want to make a change to….. AOD use, or offending'?"

(The rationale for the last point is to plant a seed, so that if that situation or something arises, the participant might remember this.)



Suggested script:

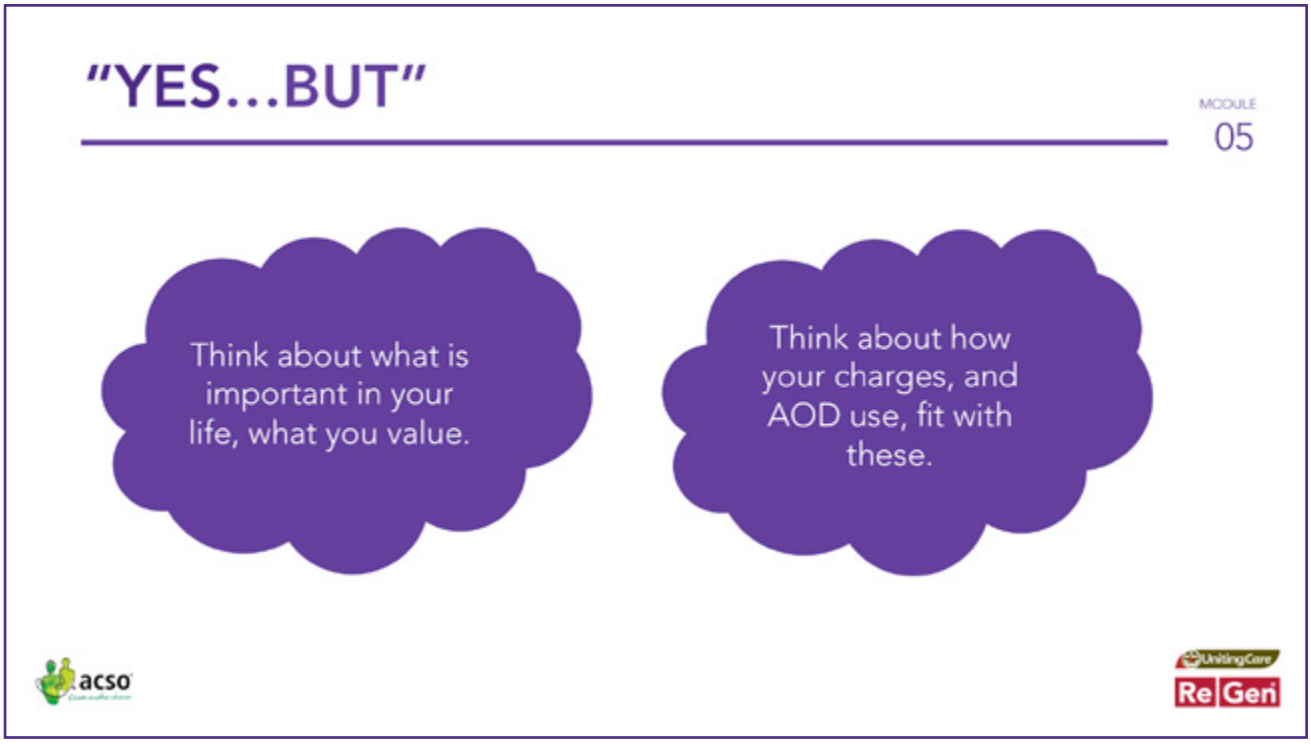
"Perhaps you are ambivalent. Part of you still sees the benefit of your behaviour, the other part is aware of the not-so-good consequences… you're just not sure.

It is useful for you to write down your own list of the benefits of using and then look at the negative consequences of using. There is a Decisional Balance in your workbook on pg. 39 if you want to do that. Sometimes it helps to rate each of the points out of 10, where 10 means it is pretty important, and 1 means it's not so. Tally up the scores for each side. Which way is the balance going for you?

Then imagine, if you were to make a change to your AOD use, what would the benefits be for you?

Then think about where you are at.

If you are at this stage with your offending, you could do the same, what function does it serve? What are the consequences? What would life be like if you stopped offending? Depending on how your offending and AOD use are related, would you need to change AOD use as well?"



Suggested script:

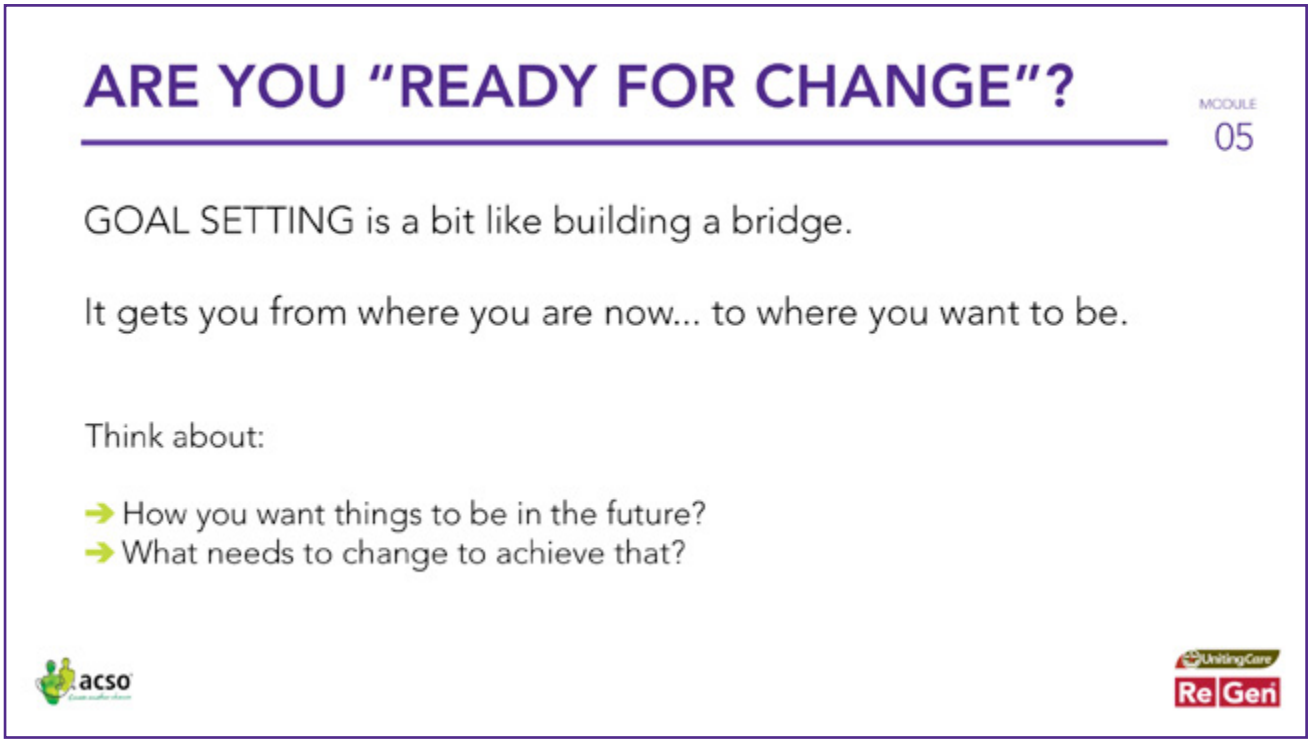
"Another idea if you are still not sure, is to think about how your current behaviour, AOD use or offending, fit with your goals for the life you want. How do they fit with your values, those things that are important to you?"

Suggested script:

"The idea of thinking about how much you spend on AOD can be a useful strategy, particularly if you have other financial goals.

Work out what your daily or weekly spending on AOD use is (if you use different drugs, you might want to do it as a separate activity for each. Then ask yourself, 'How would having that money available to you, be able to help you get other things you want? Think about which is more important for you?"

Some other questions that are useful for participants to consider are on page 40 of the workbook.



Suggested script:

"If you have thought through where you are at in relation to your drug use or offending and have realised you want/need to do something about it, this is the time to start working out what changes you want to make. What changes are important to you? What will it look like if you are doing something different?

This is what goal setting is about. You are standing on one side of the river, where you are doing the behaviour, the other side of the river is what you want instead…

What is that goal?

The next part of planning and goal setting, is working out what steps you need to take that will 'build the bridge' and get you to the other side of the river, to reach the larger goal you have. These are smaller steps that are achievable… So ask yourself, what is the first small step I can take that will help me get to where I want to be?"

Explain that using SMART goals is a good way of helping you get where you want to be.

Specific – the goal is really clear about what you will do.

Measurable – the goal has some way of knowing you have done it, for example, I will not have any alcohol on 4 days a week for the next four weeks, starting on Monday the (date) – this is both specific and measureable.

Achievable – is the goal something you can realistically do

Relevant – is the goal something you really want, is it relevant to you?

Time Limited – small goals will have a time limit, or a "due by date'… this aims to help you stay focused on the goal, and allows you to review it at set times.

Suggested script:

"In relation to AOD, we typically think of either quitting or taking some control of use. For some people, it may be quitting some drugs and controlling others. The decision comes down to how they are impacting on you. What is the best choice? In relation to offending, which drugs and patterns of use relate to your offending?

For example, use of heroin is so expensive that I have to do crime to pay for it... Perhaps stopping may be best…

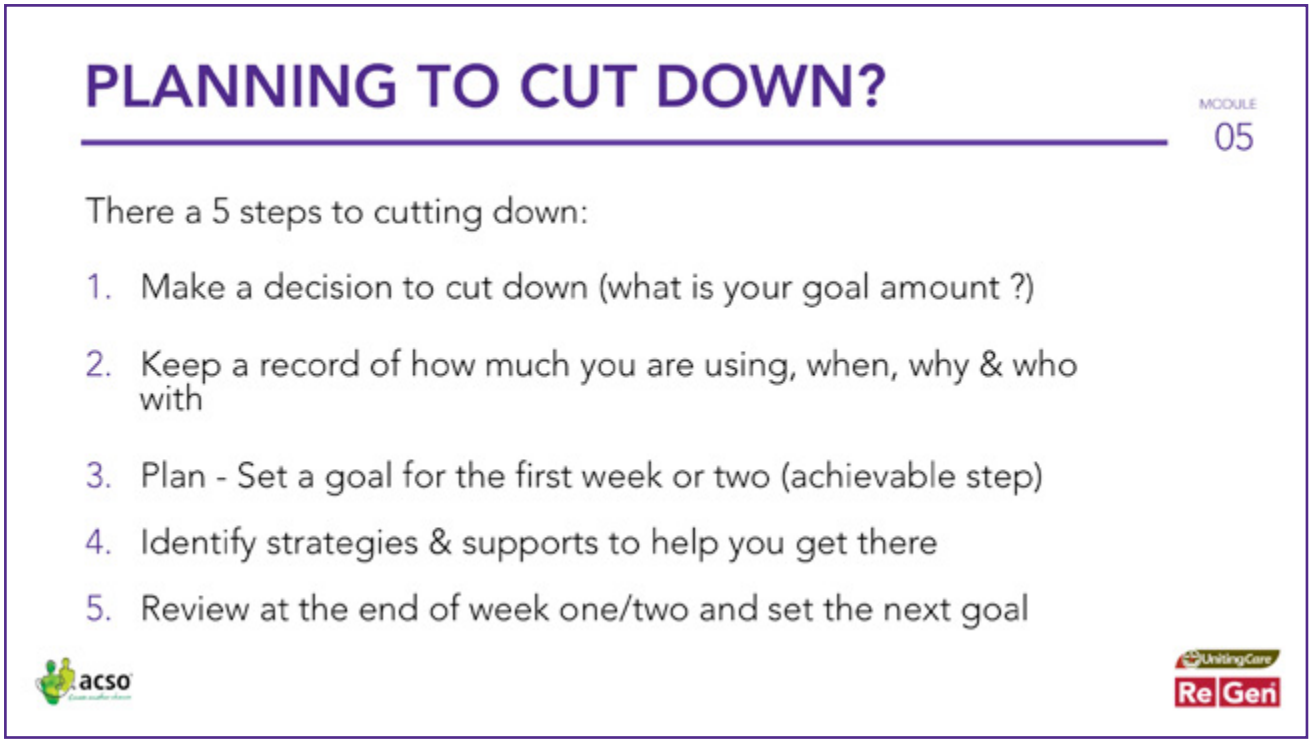
Or maybe your offending is always related to being drunk? Perhaps thinking about how to reduce your level of intoxication is your preferred choice?

What if your offending isn't related to your AOD use at all? What might you need to do to change your offending? Change the people you socialise with? Find other things to do if you are bored?

Sometimes it is helpful to write a positive and negative list for each approach in relation to its usefulness in achieving the desired goal."

You could draw the following table on the whiteboard, or refer to it on pg. 43 of the participant workbook.

	Cutting Down	**Quitting**
Positives		
Negatives		



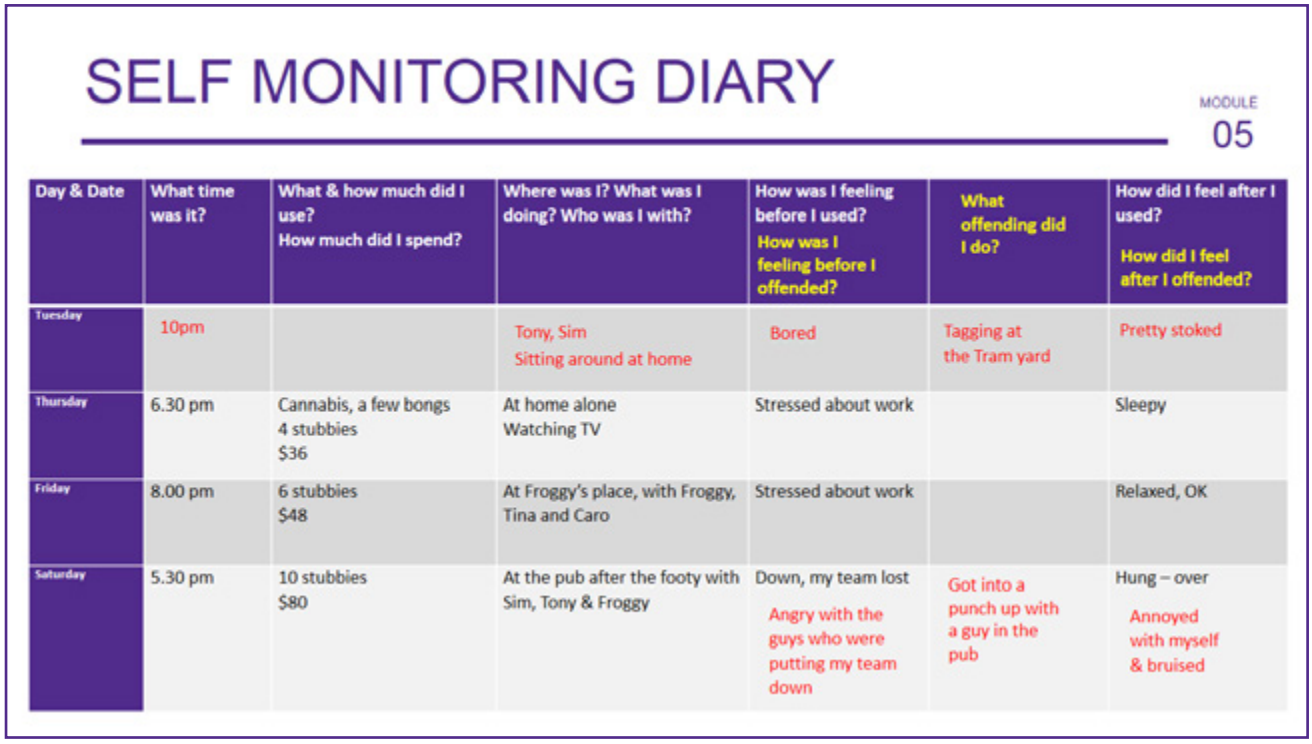
Suggested script:

"The process of planning is pretty important in achieving your goals.

In relation to cutting down, sometimes it's a good idea to keep a record of your AOD use to get some sense of when, why and how much you use. Knowing this can help you work out your small steps. You can look at the record and work out where you are going to start cutting down… Are you going to start later in the day? Are you going to reduce the number of days you use? Are you going to use less when you do use? Or a combination of these?"

Discussion point:

"How can someone keep track of their drinks or quantity of drugs so that if they have set a limit, they know when they have reached it?"



SELF MONITORING DIARY

MODULE 05

Day & Date	What time was it?	What & how much did I use? How much did I spend?	Where was I? What was I doing? Who was I with?	How was I feeling before I used? How was I feeling before I offended?	What offending did I do?	How did I feel after I used? How did I feel after I offended?
Tuesday	10pm		Tony, Sim Sitting around at home	Bored	Tagging at the Tram yard	Pretty stoked
Thursday	6.30 pm	Cannabis, a few bongs 4 stubbies $36	At home alone Watching TV	Stressed about work		Sleepy
Friday	8.00 pm	6 stubbies $48	At Froggy's place, with Froggy, Tina and Caro	Stressed about work		Relaxed, OK
Saturday	5.30 pm	10 stubbies $80	At the pub after the footy with Sim, Tony & Froggy	Down, my team lost Angry with the guys who were putting my team down	Got into a punch up with a guy in the pub	Hung – over Annoyed with myself & bruised

(This slide is animated – the image comes up to show a traditional AOD self-monitoring diary first.)

Suggested script:

"This is Bob's diary for a week.

He wants to cut down his drinking to only Saturday nights, with no more than 4 standard drinks on that occasion.

What might some small steps, or short term goals be for Bob, to help him cut down?

What might get in the way or make it hard for Bob?" (Look at his reasons for use)
"How can he manage those issues?"

Discuss.

Explain that the same process can be used for offending behaviour, and it will help provide more understanding of the situations or feelings that can result in offending behaviour.

For example, is it that certain people are more associated with doing offending? Or certain moods/feelings, e.g. boredom, anger, etc. What strategies might be helpful to deal with boredom? What may be helpful to deal with the people who you offend with? (e.g. keep them as friends but learn to say no to offending, hang out more with those who don't offend?)

Click the mouse to show how recording offending can now be included in this self-monitoring record.

- First click will add some additional headings
- Second click will add some additional records.

Tell the participants that there is a blank copy of this Recording form in their workbook if they want of copy it and use it themselves (pg. 42).

Discuss quitting AOD use.

Suggested script:

"For some people, quitting may not require formal withdrawal if there is no dependence on the drug, and can be done with minimal support or using self-help resources.

If you are dependent on AOD, it may be useful to seek additional support to get through withdrawal, including the use of medication to manage symptoms of withdrawal.

Pharmacotherapies such as methadone or buprenorphine are recommended for people dependent on heroin and are available through prescription from specific doctors."

Discuss the warning regarding withdrawal from alcohol and benzodiazepines.

This information relates more specifically to quitting AOD use; however, for some people who are cutting down their use of AOD, addressing other needs may also be required and desired.

Suggested script:

> *"Once you have decided and planned to quit or cut down your AOD use, making changes is about following your plan and recasting new goals as you head in the direction of achieving your goals.*
>
> *In relation to AOD use, it will be helpful to have a range of strategies to help you get your needs met that in some way, were being managed by the use of AOD. When we looked at the function of AOD at the beginning of the program, you identified what role it serves. You are likely to still have these needs when you are taking action, therefore, developing alternative strategies is will help you as you make and maintain change."*

Explore some tips for managing key issues associated with AOD use, such as managing anxiety and depression (you can ask the group what they know is helpful).

- You may want to see a GP who can assess you, prescribe medication if needed and refer you to a counsellor who can work with you to address anxiety/depression.
- Relaxation exercises
- Deep breathing exercises, e.g. breathe in to the count of 4, hold for a count of 4, breathe out for a count of 4 and hold for a count of 4 and repeat for a few minutes

- Mindfulness (there are courses available)
- Exercise
- Eating healthily
- Planning activities to help take the place of using (or offending) – both for pleasure and a sense of achievement.
- Tips on getting to sleep without using, there is a link to a useful resource in the resource section of your workbook. More tips can also be found for anxiety, depression and anger in the resource section.

Refer participants to pg. 46 of their workbook to help them identify their needs.

Time frame: 10 minutes

Resources: pens, workbook

Suggested script:

"In your workbook on pg. 47 is a list of activities that you could potentially do instead of using AOD (or offending). Take a moment to read through these and tick the ones that might be helpful or of interest to you.

The Participant Workbook has the following list of activities as alternatives to AOD use for you to consider:"

- Reading
- Garden
- Play golf or mini golf with friends
- Going to a gym (or park with gym equipment)
- Check out podcasts to listen to
- Take up bike riding
- Take up a course or hobby
- Go for a hike
- Try out new food you've never had
- Take up a sport
- Catch a train (or drive) to a new place and explore it

- Learn to cook
- Take a walk, run
- Have a movie night at home (or at the movies)
- Take up photography
- Meditate
- Listen to music
- Go abseiling or rock climbing
- Do yoga
- Play a musical instrument
- Go camping
- Do volunteering
- Go bowling with friends
- Plan a holiday

"Then spend a moment to think of any other non-drug using activities you could do. And write them in the space below."

Bring the group back together and discuss.

"Does anyone want to share any of the new ideas that were not on the typed list?"

Discuss.

Encourage people to write down those that may be helpful to them if they don't already have it on the list.

Note:

Be prepared to manage ideas that may not be helpful through respectful questioning.)

Summarise the activity.

Suggested script:

"This activity has given you some ideas about what you can do instead of using, which can be helpful if you want to cut down or stop. Some of these ideas can also be useful if you find your offending is related to having nothing to do."

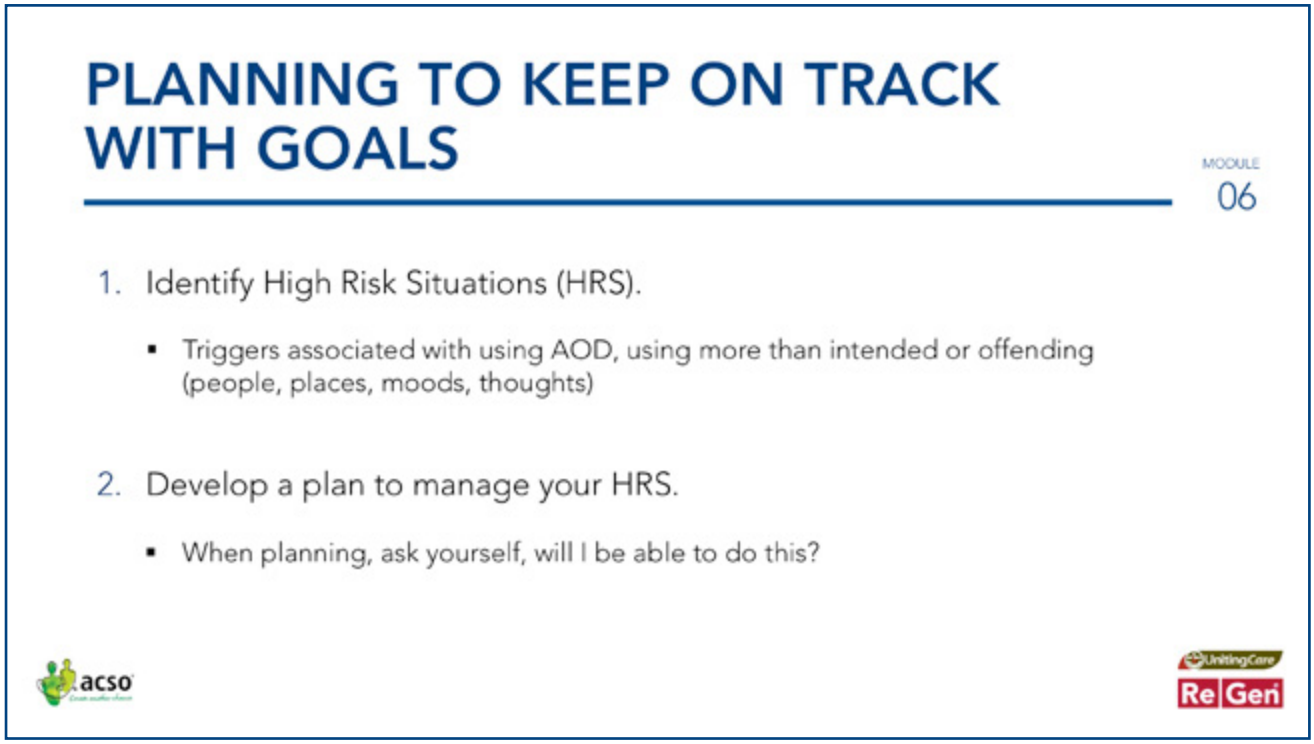
Module aims:

- Provide strategies and interventions for self-monitoring and relapse prevention.
- Inform, support and motivate clients to access additional help where required.

Introduce the module.

Suggested script:

> *"If you are making changes or have already made changes, there are a few things that can assist you to stay on track, which is what we are going to have a quick look at now. Sometimes, we can get tempted to go and do the things that are familiar to us, but by having plans, and reminding ourselves of why we decided to change in the first place can keep us going."*



Suggested script:

"High Risk Situations (HRS) are those situations in which you may be tempted to use, use more than you plan, or even offend. They can be certain people, places, moods.

For example, walking past an old dealer's house, feeling stressed or down, bumping in to old friends that we used to use or offend with…

If you have completed a record of using or offending, there will be some clues about the situations where you usually use (or offend). The list we developed of the function AOD serves for you will also give you some clues.

We can develop a list of broad types of HRS that might trip us up and then come up with a plan about how we could manage them so we don't get tripped up, 'forewarned is forearmed.

Some strategies are being able to refuse the offer of alcohol or drugs, or refuse going along and joining in on offending.

Some strategies are to initially avoid those high risk situations. Other strategies might take a bit of thought.

If people have been dependent on drugs, or used pretty frequently, they may experience cravings – these are pretty normal and can be managed by the 3 D's – Delaying decision to use, doing something else to Distract yourself and making a Decision not to use, remembering your reasons for making the change. The more you feed into cravings, the more they hang around, it's a bit like feeding a stray cat. They will reduce in intensity and frequency over time."

Key points:

- Identifying and having plans for high risk situations for drug use and/or offending is a key to maintaining change.

ACTIVITY 08

Managing High Risk Situations

Time Frame: 10 minutes

Resources: Workbook, pens

Suggested script:

"In your workbook on pg. 49 is a table. In the first column, there are some high risk situations for different people – spend a few minutes thinking about what you could to manage these situations if you came across them."

High Risk Situations	**What could I do to manage that situation so I don't use, use more than intend or offend?**
Being offered alcohol or other drugs	
Being at a party when someone starts smoking methamphetamine when you have stopped using methamphetamine	
Seeing your dealer in the street	
Planning on having 3 beers and someone joins the group starting up a shout	

High Risk Situations	What could I do to manage that situation so I don't use, use more than intend or offend?
Getting a call from a friend who wants you to score and deliver drugs for him	
Having a bad day and feeling angry	
A friend you really want to see invites you to the club you used ecstasy at	

(Alternative approach – group brainstorm this activity – whiteboard, whiteboard markers)

Some ideas for managing high risk situations:

- Leaving the situation – if you are not coping and feeling at risk, why not just leave?
- Call someone – this could be a counsellor, a good friend or an anonymous telephone counselling line. You can also utilise a self-help group such as Narcotics Anonymous (NA)/Alcoholics Anonymous (AA)
- Make a list of the benefits of not using drugs or alcohol and repeat these to yourself out loud.
- Rehearse how you will refuse (e.g. "No thank you, I don't use ICE anymore") before you need it, so that it comes out smoothly and without hesitation.
- Divert an invitation to a high risk situation event to meeting elsewhere.
- If you are being asked to get drugs for others, you might need to think about changing your phone number to break the contact, you might also need to cut people off on social media, such as Facebook.
- Have in your mind a list of activities that you know will help you manage particular feelings (e.g. seeing a movie, going to the gym, going out for a meal or taking a walk). Pick one and do it.
- Congratulate yourself and reward yourself for making it through a HRS without using. Remember the strategy you used. Maybe even write it down, so that you have it available for next time.

Suggested script:

"Some high risk situations can be the thoughts we have – they can trip us up. So we need to be aware of the thoughts that are not really helpful in assisting us to achieve and maintain our goals, and then be able to challenge them by using alternative, though realistic, thoughts that will help us keep on track.

Everyone is getting out of it tonight, I couldn't handle it if I didn't. Ask yourself, is thinking this helping me achieve what I want to achieve? Ask yourself, what would be the best thing that would happen if you didn't join in? Would not joining in tonight be a problem in a weeks' time?

I've been doing well, I deserve a break… Ask yourself, are there other ways you can reward yourself? Will this reward be helpful to me in the long run?

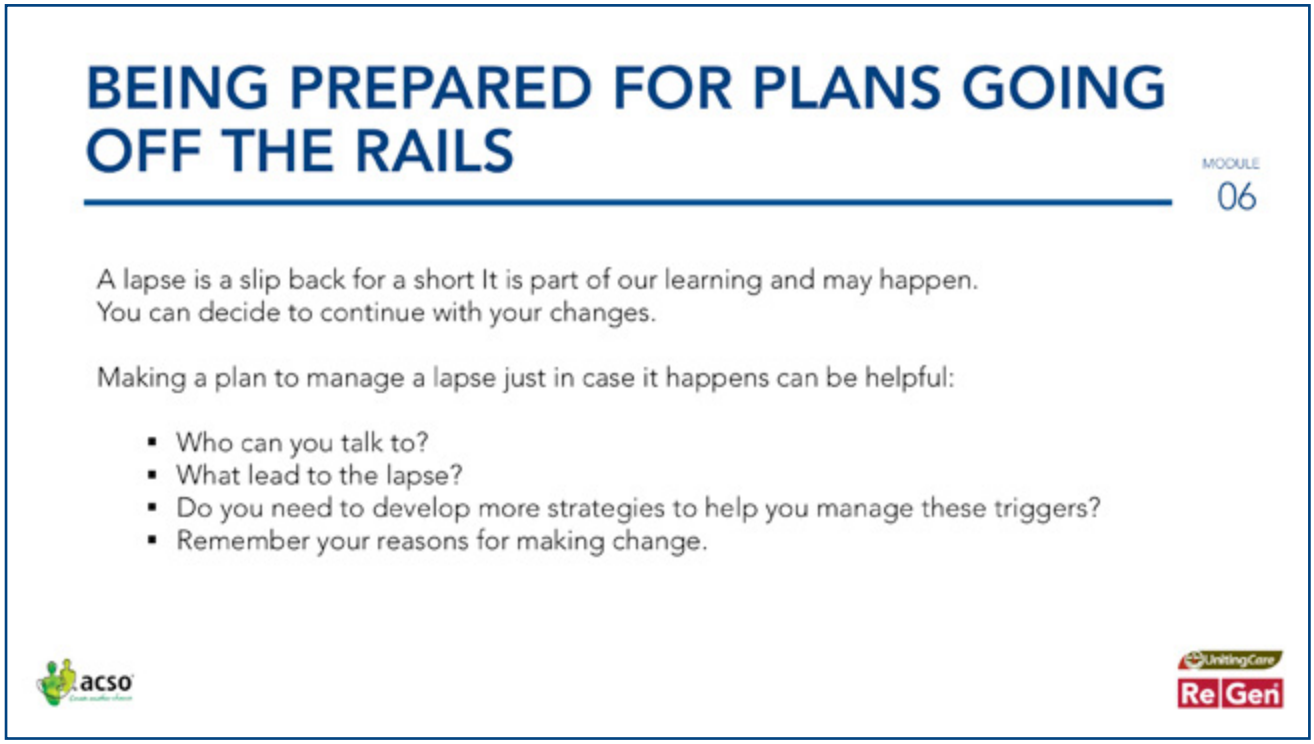
I won't get caught… – well, sometimes you might, others you might not, but what would happen if you did? Is that something you want?"

Depending on time, you may wish to discuss that it is our thoughts about events/situations that lead us to feel in certain ways, not the event itself.

"If your feelings are becoming a problem for you in relation to maintaining change, it can be helpful to identify the thoughts leading to the feeling and questioning them to develop more realistic thoughts to any situation, that will ultimately lead to emotional states that are less distressing, and likely to allow a person to choose not to use AOD, but implement other strategies."

Key points:

- Thoughts can trip us up when we are making changes.
- Being aware of thoughts that might lead us to use or offend is important.
- Questioning our thoughts, and working out how they help us achieve our goals is important in maintaining change.

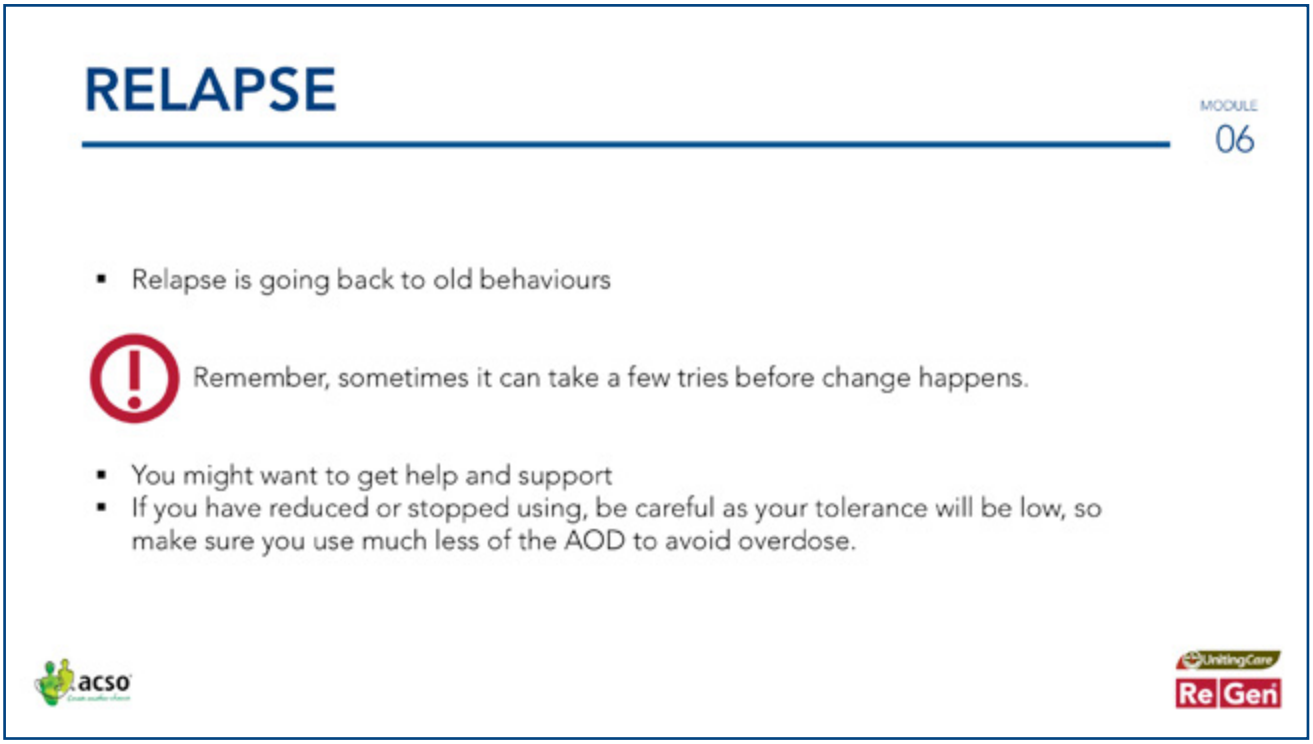


It is important to frame a lapse as a learning opportunity rather than as a failure, due to lack of strength or willpower. Having a plan to manage a lapse can help them turn it around so it doesn't have to turn into a full relapse. This will also help in getting them through their order.

Remind participants that motivation is not static and that it is frequently changing. Additionally a lapse or relapse may indicate that they require new strategies.

Key points:

- A slip is not a sign of weakness
- It is part of change for some people
- It is a learning opportunity
- Being prepared for a slip doesn't mean you will
- Being prepared for a slip and following a plan can help you get back on track with your change and prevent the slip from becoming a reversal in behaviour (relapse)



Suggested script:

"Relapse is typically known as going back to the old behaviour, no longer working towards or maintaining changes made, this can be either using the same as before, or offending the same as before.

With AOD use, a relapse can be risky if you have abstained because your tolerance could be low, so use much less than you used before you stopped to prevent overdose.

If you relapse, this might impact your capacity to get through the corrections order. It is probably a good idea to get help, by calling an AOD service or using some of the online supports available.

Remember, behaviour change can sometimes take a few tries. The important thing, is to remember why you wanted to make change and keep trying."

07

SUPPORT & OTHER INFORMATION

Module aims:

- Inform, support and motivate clients to access additional help where required.

Introduce the module.

Suggested script:

"As we are coming to an end of this program, we just want to let you know of the services available that you can access to assist you with making changes to your AOD use and offending."

Introduce the reason for knowing about support services and explain those available"

"It's important to be aware that there are services and supports that you can access after this program, should you want or need to.

In your workbook (pg. 51) there is a list of a range of services and supports that you can access should you wish to do so. Some are specifically to help you with your AOD use, others are to help you manage issues associated with AOD use, e.g. mental health issues and some are more general services that may be of use to you."

Explain the nature of services and supports listed.

- Directline is a 24 hour support and referral line. You can ring and talk to someone if you need help in making or maintaining change, or they can link you in with services you might need.
- Local Community & Health Services – explain what is available in your region (make sure you have information brochures available) – e.g. financial assistance, housing, jobs, counselling.
- You can access alcohol and other drug services – brochures for your region with the central screening & assessment service phone number listed. Explain the range of services available, counselling, withdrawal support, rehabilitation – resi or day programs, etc.
- Self-help support services available in your region – AA/N.A, Smart Recovery, local initiatives.
- If available in your region, inform participants of any family and support services.

Note:

Make sure you have a range of local community support services brochures available for people to take away, including non AOD specific services, such as financial counselling, housing, neighbourhood house information, etc.

Briefly describe the online supports available.

- Counselling online – AOD online confidential counselling
- Control Your Drinking Online: An Australian Web-Based Self-Change Program

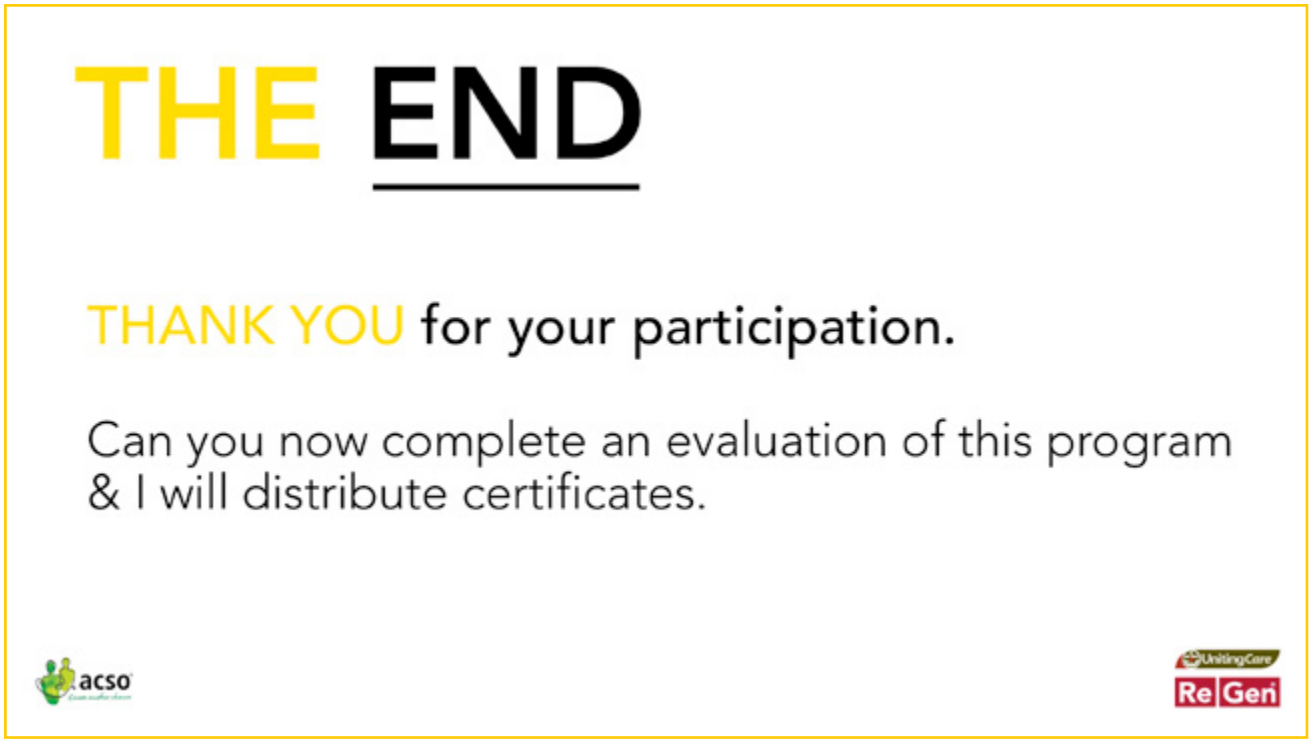
There are also

- Cannabis online resources
- Beyond Blue for mental health

"Information about these and others are available in your workbook."

Are there any questions?

Respond as appropriate.



Suggested script:

"Thank you for your participation. We have covered quite a lot in this program, from the effects of drugs, to identifying risks and harms in relation to offending, and then what you can do to help change either your drug use, offending or both. I want to wish you well as you leave here and don't forget, help is available should you want it.

In a minute I will give you an evaluation form for this program. Your feedback will be helpful for us in improving this program.

When you hand me your evaluation form, I will then provide you with your certificate of attendance and you are free to leave.

Remember, if anyone wants to talk about something, whether it is about how to access more support or just more questions, I will be here for a little while. If you are feeling triggered, please talk to me (or someone you know who is supporting you) – also use your relapse prevention strategies."

Distribute evaluation forms.

Collect evaluation forms and provide certificate.

ACTIVITY 03

WORKSHEETS

WORKSHEET - ALCOHOL

WHAT ARE THE EFFECTS OF INTOXICATION ON ALCOHOL?	WHAT ARE THE LONG TERM HEALTH EFFECTS OF DRINKING ALCOHOL?

WORKSHEET - CANNABIS

WHAT ARE THE EFFECTS OF INTOXICATION ON CANNABIS?	WHAT ARE THE LONG TERM HEALTH EFFECTS OF USING CANNABIS?

WORKSHEET - HEROIN AND OTHER OPIATES (E.G. OXYCONTIN, ETC)

WHAT ARE THE EFFECTS OF INTOXICATION ON HEROIN?	WHAT ARE THE LONG TERM HEALTH EFFECTS OF USING HEROIN?

WORKSHEET - BENZODIAZEPINES (E.G. VALIUM, TEMAZEPAM)

WHAT ARE THE EFFECTS OF INTOXICATION BY BENZODIAZEPINES?	WHAT ARE THE LONG TERM HEALTH EFFECTS OF BENZODIAZEPINES?

WORKSHEET - METHAMPHETAMINE/AMPHETAMINE

WHAT ARE THE EFFECTS OF INTOXICATION ON METHAMPHETAMINE?	WHAT ARE THE LONG TERM HEALTH EFFECTS OF METHAMPHETAMINE?

WORKSHEET - ECSTASY

WHAT ARE THE EFFECTS OF INTOXICATION ON ECSTASY?	WHAT ARE THE LONG TERM HEALTH EFFECTS OF USING ECSTASY?

WORKSHEET - HALLUCINOGENS (EG. LSD, PSILOCYBIN)

WHAT ARE THE EFFECTS OF INTOXICATION ON HALLUCINOGENS?	WHAT ARE THE LONG TERM HEALTH EFFECTS OF USING HALLUCINOGENS?

APPENDICES 01:

WITHDRAWAL

Withdrawing from Alcohol

Medical assessment and management is required for withdrawal from alcohol due to possible life-threatening withdrawal symptoms.

The physical symptoms of withdrawal from alcohol depend on the period of use and the amount used. For most people, the worst is over within a week. After that, appetite, mood and sleep patterns will start to improve and general health is likely to have improved significantly. Psychologically, it can take a bit longer to get used to living without alcohol, but there are techniques which can be used to manage the cravings. People should talk to their AOD worker for more information.

Withdrawal Symptoms

Everyone experiences withdrawal differently but common symptoms of alcohol withdrawal include; anxiety, restlessness, sweating, cravings for alcohol, feeling irritable, stomach cramps, nausea, vomiting and diarrhoea, trouble sleeping and nightmares. Less common withdrawal symptoms include tremors and hallucinations.

Withdrawal symptoms generally start within four to 12 hours after the last drink and can last up to four to five days.

Withdrawing from Methamphetamines

Most people experience a 'crash' period when they stop using methamphetamine. This usually lasts a few days. Generally, people do not need medical support during this time; however, people who have been using methamphetamine regularly, or for a long time can find it particularly hard. Due to the changes in their brain chemistry, they can experience intense cravings during their withdrawal period, as well as extreme tiredness, depression and lack of motivation.

Withdrawal Symptoms

Everyone experiences withdrawal differently but common symptoms of methamphetamine withdrawal include severe exhaustion and need for sleep, strong cravings, flat mood/depression and/or restlessness, anxiety & paranoia, decreased energy and motivation, mood swings/irritability, increased appetite and sleep disturbance/insomnia.

After about a week and a half, most symptoms will start to settle down, with some people still experiencing mood swings, irritability and restlessness. Continuing poor sleep and feeling run down can lead to feelings of tiredness and lack of energy, and some people report they find it hard to feel pleasure, even from usually enjoyable activities.

After the first month, symptoms start to disappear, but people who had been using methamphetamine heavily can feel ongoing symptoms like depression or difficulty with motivation for months or even years.

Withdrawing from Opioids

Physical symptoms of withdrawal usually occur within a few hours after the last use, and peak between 24 and 48 hours. Most people will experience cravings in the form of physical discomfort, agitation and constant thoughts about using.

While is it normal to experience a range of withdrawal symptoms, these can be managed. People should talk to their GP or AOD service to find out how they can access support.

Withdrawal Symptoms

There are common symptoms of opioid withdrawal, but everyone's experience is different. People may find that they experience some, all or no symptoms, depending on the tolerance developed. Many people describe their withdrawal as similar to having the flu, with sweats, hot and cold flushes, goose-bumps, sweating, headaches, joint pain, muscle cramping and weakness. Other symptoms can include feeling restless and irritable, having trouble concentrating, muscle twitching and 'restless legs', a reduced capacity to cope with pain and strong cravings.

After two to four days, the physical symptoms should start to settle down and should disappear within a couple of weeks. Some people find that they continue to feel tired, irritable and have trouble sleeping for longer.

The psychological symptoms of withdrawal can last longer and can be more difficult to deal with. Some people experience cravings for some months after their physical symptoms have disappeared, and it is often the difficulty of this adjustment that puts people at risk of relapse after completing their withdrawal.

It's important that people are aware that if they haven't used for a while, their tolerance will have decreased. By using the same amount of the drug they used to, they increase their risk of overdose.

Withdrawing from Tobacco

Many people experience negative symptoms when they withdraw from tobacco. These usually peak within 48 hours, but have usually disappeared within a month of giving up smoking. The urge to use tobacco can be present for longer, but most people find that after a month they get only occasional cravings that decrease over time.

Withdrawal Symptoms

People may experience the following symptoms: cravings to use tobacco, restlessness and difficulty sleeping, irritability and difficulty concentrating, headaches and anxiety, increased appetite, decreased heart rate, cold symptoms (as the lungs start to clear).

Withdrawing from Cannabis

People used to think that ceasing cannabis use was as simple as just stopping, but we now know that there are a number of withdrawal symptoms people can experience. Some people compare the experience of cannabis withdrawal to tobacco withdrawal, but it's different for everyone. Withdrawal can be influenced by how long the person has been smoking, how much they smoke and other factors.

Cannabis withdrawal can be completed at home or with extra support. An AOD service or GP can help to develop a withdrawal plan and work out what kind of supports are needed.

Most symptoms disappear within a couple of weeks, although sleep disruption can continue for longer.

Withdrawal Symptoms

Generally, cannabis withdrawal symptoms peak in the first week. Common symptoms include: headaches, tiredness, vivid dreams or trouble sleeping, loss of appetite, nausea or diarrhoea, aches and pains, sweating, anxiety, cravings, depression or irritability.

Withdrawing from Benzodiazepines (or Other Prescription Medication)

Medical assessment and management is required for withdrawal from benzodiazepines. The best way to safely withdraw is to stabilise, substitute and reduce dose in close consultation with a GP and an AOD treatment service.

Withdrawal symptoms

Common withdrawal symptoms include: abdominal pain, nausea, anxiety, depression, breathing difficulties, heart palpitations, sensitivity to light and sound, insomnia, nightmares, lack of energy or co-ordination, aches and pains, restlessness, sweating, irritability, headaches or seizures.

Other symptoms may also be experienced, or no symptoms at all. However, given the potential seriousness of some symptoms, it's recommended that people don't undertake withdrawal without support.

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