The SAOL Project Presents

Reduce the Use

3rd Edition

A Cognitive-behavioural inspired manual for professionals working with people with contextualised poly-drug use who want to reduce or stop their substance use

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Foreword

First launched in 2007, 'Reduce the Use' (RTU) is now a 'household' name in Irish addiction services. Since December 2011 (to 28th February 2017), when RTU 2 was first made available on SAOL's website[1], there have been 8730 downloads of the manual and a further 12579 downloads of other RTU material (e.g. RTU individual worksheets, RTU for gambling etc.). In total, over 21,300 downloads for RTU2 plus 1000 hard copies given away can be added to the 3600 downloads and 1000 hard copies of the original RTU. We are proud and a little taken aback that a programme initially launched to respond to the 'new' cocaine use in the north inner city of Dublin has been accessed nearly 27,000 times.

This manual was developed with our participants; indeed every new exercise was first tried out by our Wednesday RTU group. I want to pay tribute to the strong women of SAOL who have made all of our resources (particularly RTU) so relevant and useful; and to offer gratitude for their partnership in making this manual (as well as the participant-led research into RTU) such a vibrant process. I am also aware of the women from BRIO who have joined the staff of SAOL and the Probation service in delivering RTU to the women of Dochas and for the generosity of your time and expertise I wish to say a very big thank you.

It is gratifying to read in the new National Drug Strategy 2017-2025 (Reducing Harm, Supporting Recovery) that there is renewed emphasis placed on the importance of the service user's voice in treatment and rehabilitation settings. Such peer involvement has been a central part of SAOL since our inception in 1995 and continues to be present in our current strategic plan. I know that RTU is an example of a programme that works best when the participant voice is encouraged and supported and we are very happy that this third edition aims to strengthen the voice of the 'service user' in its approach.

I applaud the Minister and the team who wrote the National Drug Strategy for finally including women as an 'at risk group'. We wholeheartedly support the call for a greater cognizance of women's particular situations: "*There is a need for greater awareness of the implications of domestic violence, trauma and mental health for treatment and rehabilitation of women with addictions*" (P 43).

We hope that RTU, which was originally written for women, supports this particular request and I draw your attention to the section in the facilitator's guidelines exploring some of these issues. You might note that pregnancy is not referenced and childcare is only referred to as a barrier to attending groups. Motherhood is a great thing; but women are more than motherhood and services and policy will do well to expand its understanding of womanhood for the betterment of all women who are in need of addiction treatment services. I am reminded, in this year marking the 100 year anniversary of the vote for (some) Irish women, the words of Hannah Sheehy-Skeffington, "Until the women of Ireland are free, the men will not achieve emancipation." And until we treat the women of Ireland who use substances more appropriately I fear we will not serve the men of Ireland who use substances properly either.

I would like to pay tribute to the staff of SAOL Project. In particular I would like to thank Jane McNicholas for her Trojan work in creating and collating the work for this third edition of RTU. As always profound thanks to SAOL's wonderful and creative Director, Gary Broderick. Thanks to the rest of the team and to my Board of Management for all your support and hard work; and thank you to our Funders in the HSE, Probation Service, DSP, Pobal and CDETB without who this work would not be possible.

Catriona Crowe,
Chairperson SAOL Project

[1] http://www.saolproject.ie/resources-rtu2.php

Acknowledgements

SAOL Project would like to thank everyone who contributed to the development of **Reduce the Use 3©**, particularly:

Thanks to community drug projects and other individuals and agencies working with drug users in the field who have taken part in the 10 –year evaluation research on the resource.

Thanks to the participants of SAOL whose contributions, feedback and willingness to 'test run' new topics and new exercises, all made the rewriting process possible.

Thanks to the Board of SAOL for their unwavering belief in the project and their enthusiastic support of new initiatives. This belief and support has made it possible for SAOL to remain an innovator in the field of drug rehabilitation for women in Ireland.

Special thanks to the writing contributions that put together the original Reduce the Use in 2007, Reduce the Use 2 in 2011 and this latest incarnation **Reduce the Use 3©** in 2018.

To download this resource free of charge log on to:

www.saolproject.ie

While this resource is downloadable free of charge,
SAOL Project asks that its use is acknowledged.

SAOL Project, 2018

We hope you enjoy this new edition of **Reduce the Use** and we are happy to hear any feedback from you. We are also happy to answer any queries you may have.
Contact us at:
admin@saolproject.ie

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Introduction

This Manual has been written by the SAOL Project and represents the latest edition of the original Reduce the Use Programme[2] published in 2007, and the revised edition Reduce the Use 2 published in 2011.

Reduce the Use 3 has been produced based on SAOL's experience of delivering the programme over the past 10 years; the experience and feedback of other projects who have delivered Reduce the Use; and the experience and feedback of participants who have taken part in Reduce the Use. The experience and feedback from other projects and participants has been captured in a collaborative piece of research work between SAOL Project and Dublin City Community Cooperative. The key methodology for this piece of work was a questionnaire survey carried out by community researchers.
(Report can be viewed on http://www.saolproject.ie/resources-rtu2.php)

The **Reduce the Use 3** manual comes in two main parts.

Part 1 gives a background to the production of this manual outlining the key issues and context for our work:

- **Section 1** Background to **Reduce the Use**
- **Section 2** Key issues for running **Reduce the Use 3**
- **Section 3** The structure of the Programme
- **Section 4** Assessment for **Reduce the Use 3**

Part 2 covers the updated modules and includes sections on:

- ***Facilitator guidelines*** – which take you step by step through the implementation of all aspects of the programme
- ***Handouts*** – all handouts needed to deliver the programme are in a separate section making them easier to find for photocopying purposes.
- ***Certification***

The Manual is meant for retention by yourself or your agency/project as a Master Copy. All material should be photocopied and used as appropriate.

While this third edition- **Reduce the Use 3©** has been written with the needs of the poly-drug user in mind, all the exercises are designed so that they can be adapted and used to address any drug or alcohol addiction

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[2] **SAOL** (2007) Reduce the Use - An eight session course on reducing

There are no sources in the current document.

SECTION 1

Background to **Reduce the Use 3** and some key issues for consideration

This section describes the development of our Reduce the Use programme since 2007 and explains the changing context and emerging need for an updated version.

We provide some brief insights into some of the principles and approaches used by SAOL Project in its work with women drug users.

1.1 From 2007, through 2011, to now

1.2 So what's new? *From working with a cocaine user, to a poly drug user, to poly drug use in context*

1.3 Community Education and Community Development

1.4 Working with Women – a gendered approach

1.5 Working within a Trauma informed approach

1.6 Working within a Human Rights perspective

1.7 Validating learning

1.8 The good news!

SECTION 1

1.1 From 2007, through 2011, to now

In 2007, SAOL Project Ltd produced a range of innovative addiction resources which were designed to help individuals, drug projects, agencies and communities to primarily address the gap in accessible practical intervention tools for those wishing to stop or reduce their cocaine use. Communities, at that time, were experiencing major disruption to their traditional ways of life as a result of the surge in cocaine use from the early 2000's onwards. Many young people were dying as a result of a combination of drug and alcohol use with the mixture of cocaine and alcohol causing particular problems.

In 2004, Citywide Drugs Crisis Campaign published a survey carried out amongst community drug projects of cocaine use[3] which showed an increase in cocaine use, projects struggling to cope and a pattern on poly-drug use emerging. They produced a follow up survey in 2006[4] which showed an alarming increase in cocaine use reported amongst drug projects – from a figure of 14% in 2004 to 62% in 2006.

In areas like Dublin's North Inner City it is not uncommon to find grandparents rearing children whose parents have either died or are in very poor health as a result of drug or alcohol use. Indeed some local neighbourhoods feel that they have lost a whole generation of their young people to drug use and are concerned that they are witnessing the onset of the next generation of drug users. Grandparents have stepped into the breach in many of these cases but there is a growing concern that the next generation of young people will not have the benefit of this support for their children as the older population dies off. This impending gap in family and social support is likely to play a critical role in the development of young people in these communities. What is known is that drug use is both a response to social breakdown and an important factor in worsening the resulting inequalities in health.[5]

It is therefore becoming more and more urgent that we, as community drug projects, put emphasis into helping participants control or stop their drug use so that they have the best opportunity to become functioning, supportive members of their families and communities.

In 2007 the National Advisory Committee on Drugs produced a second report on cocaine use in Ireland [6] and its first four recommendations were:

[3] **Citywide Drugs Crisis Campaign** (2004) *Cocaine in Local Communities, Survey of Community Drug Projects*

[4] **Citywide Drugs Crisis Campaign** (2006) *Cocaine in Local Communities, Citywide Follow-Up Survey*

[5] **World Health Organisation**, (2003) Social Detriments of Health – the Solid Facts, second edition

[6] **National Advisory Committee on Drugs (NACD)** (2007) *An Overview of Cocaine Use in Ireland: II.* A *Joint Report from the National Advisory Committee on Drugs (NACD) and the National Drugs Strategy Team (NDST)*

Recommendation 1: Establish stimulant specific interventions in areas where cocaine problems are acute

Recommendation 2: At a service delivery level (opiate focused services in particular) need to adapt, develop and standardise response to increasing levels of cocaine use (and poly-drug use) among their clients

Recommendation 3: Given the current context of poly-drug use, in the long-run a re-orientation of drug services from drug specific interventions to treatment tailored towards the individual regardless of the drug(s) they use. This approach will provide a series of options for the drug user, appropriate to his/her needs and circumstances and should assist in their reintegration back into society

Recommendation 4: Dispel the myth among services users and providers that there is no effective treatment for cocaine/crack use. Cocaine/crack use can be treated

SAOL responded to the emerging evidence of increased cocaine use by producing a Resource Pack of three different interventions and made these tools accessible and available free to download from their website. These intervention tools were launched in June 2007 at a Conference in Croke Park.

- **Reduce the Use©** – an eight module group programme on reducing cocaine use
- **Cocaine Relapse Worksheets** – a brief intervention tool for drugs workers to assist individuals who are in cocaine relapse
- **Cocaine CD** – a complimentary audio resource for individuals who want to address their cocaine use/relapse

Four years passed which took us to 2011. As an agency, we saw that communities were increasingly expressing concern about the level of poly drug use amongst their drug using population. The most common drugs include cocaine and its derivatives, tablets, stimulants, alcohol, opiates (heroin and methadone) and cannabis (in all forms). There was an alarming increase in the use of psychoactive substances which were purchased legally in the colloquially named 'Head Shops' and, while legislation was introduced in 2010 to make it illegal to buy or sell products containing mephedrone, benzylpiperazine, methylone, methedrone, butylone, flephedrone, and MDPV - anecdotal evidence suggests that these products were still widely available on a lucrative black market.

Given the changing nature of drug use and the fact that more and more projects were dealing with poly-drug users, SAOL Project decided that they would update their original **Reduce the Use©** so that it could be used for those presenting with a poly-drug addiction. The Handouts, Worksheets, Exercises and Facilitator Guidelines were amended to reflect a broad range of drugs, including alcohol.

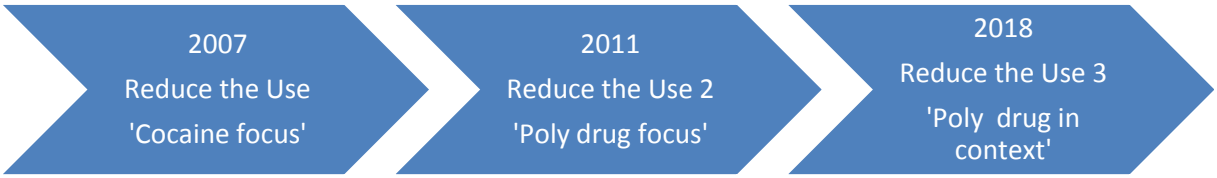
The updated version of **Reduce the Use 2** followed similar lines to the original in that it outlined in detail a brief module-based programme to help the drug user to gain tools and

techniques to recognise, avoid and cope with drug and alcohol addiction. Similar to the original version, it was largely based on cognitive behaviour type interventions, in that it remained structured, goal oriented and focused on immediate problem solving. A new feature of **Reduce the Use 2** was that it included a guideline structure for a Pre-Programme Assessment Meeting.

1.2 So what's new?

SAOL's experience within North Inner City Dublin has led us to consider the impact of context on our participants. We specifically work with vulnerable women and children already marginalised by the impact of poverty, escalating violence, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities. It is becoming increasingly apparent that we need to look at these factors and how they affect people's vulnerability to and capacity for effectively dealing with drug-related harms.

Reduce the Use 3, therefore has developed an emphasis on poly drug use in context.



We have achieved this in several ways:

- Inclusion of material such as the Biopsychosocial model of addiction
- Inclusion of a Case Study which is developed through the programme
- Reference to trauma-informed practice

The updated **Reduce the Use 3** follows the familiar structure of a logical sequence of Modules, presented with clear Facilitator Guidelines and corresponding Handouts.

The Programme now has 12 Modules instead of 10.

Reduce the Use 3 takes more time to develop the cognitive behavioural interventions. Key concepts such as triggers, automatic thinking, and permissive beliefs are introduced one at a time so that the ideas have a chance to be embedded before being drawn together for the Drug Diary work. The Drug Diary work still plays a central role as does the Safety Planning. Safety Plans have been developed by focussing each one on a different aspect – matching to a Module's topic. So for example there are Safety Plans that look at Refusal Skills, Triggers, Cravings, and Positive Thinking etc.

There are specified Learning Outcomes for each Module. These have been designed in anticipation of developing formal accredited learning for the programme (QQI Level 4).

Some of the written exercises are designed with accreditation in mind, so ultimately the participant's portfolio of work will be suitable as submission for evidence of learning.

Other changes in **Reduce the Use 3** have been made in response to a collaborative piece of research work between SAOL Project and Dublin City Community Cooperative. The key methodology for this piece of work was a questionnaire survey carried out by community researchers and completed by other projects and participants who have either delivered or participated in Reduce the Use.
Changes made as a result of these research findings include:

- More emphasis on Safety Planning
- Greater exploration of the Drug Diaries within groups
- Greater emphasis during training on group facilitator skills, assessment and promotion of safety within groups
- Specific reference to social isolation
- Clear learning objectives for each Module to reinforce learning

1.3 Community Education Approach

Reduce the Use 3 uses a community education approach to learning. Community Education promotes personalised learning and flexibility within the group. Participants are involved as equal partners in identifying needs and goals and adapting them on an ongoing basis. Community Education with adults is concerned, not with preparing people for life, but rather with helping people live more successfully. "In this way adults are assisted to increase competence or negotiate transitions in their social roles" [7] It is not intended to be prescriptive but rather to enable people to assume more responsibility for their health and become more aware of the choices and constraints facing them.

The goals of community education, however, include not just individual development but also community advancement, especially in marginalised communities. It allows people to challenge existing structures and enables and encourages them to influence the society in which they live. A key feature of community education programmes is that they work particularly well within the context of a community setting and provide the supports necessary for successful access to learning such as:

- guidance
- one to one mentoring and support
- group support
- feedback
- childcare supports

[7] Reproduced from: **Darkenwald, G. G. and Merriam, S. B**. (1982) *Adult Education. Foundations of practice*, New York: Harper and Row.

Reduce the Use 3 brings all of these key elements together and in this way meets the criteria of community education.

The world of illegal drug use in communities is complex. Many families have been endemically involved in drug or alcohol use and many of the presenting clients are second generation drug users. Drug use has become a norm for many individuals who have backgrounds in familial and community drug misuse. Problem drug and alcohol use does not occur in a vacuum and what constitutes 'a problem' is by no means universally agreed, being influenced by values, cultural norms, attitudes and social conditions.

Facilitators of this programme should familiarise themselves with the community context in which they are delivering the programme. It is with this in mind that all positive changes in drug and alcohol using behaviour must be seen as significant.

SAOL's particular Community Education approach is inspired by feminism and Paulo Freire. In 'Pedagogy of the Oppressed', Freire says, '*Any situation in which some men prevent others from engaging in the process of inquiry is one of violence;… to alienate humans from their own decision making is to change them into objects*.' (Freire, 2007) We therefore think it is vitally important to provide creative and socially appropriate education programmes for the people we work with.

Further, this Community Education sits within a community development philosophy in which the following principles underpin this **Reduce the Use 3** programme:

- **Empowerment** – working with people to enable them to take more control of decisions that affect them and their communities

- **Working collectively** – supporting people to come together to identify the things that they want to change and to work together with others to achieve that change

- **Social justice and equality** – The programme is focussed on achieving social change that enables individuals, groups and communities to realise their full potential, uninhibited by unfair or discriminatory social structures and systems.

- **Respecting and valuing pre-existing capacities**

- **Being responsive to context**
  Context refers to the range of physical, economic, political, organisational and cultural environments within which a programme sits. The programme will be aware of the current context and be ready to respond to changes in context. It will aim to meet individuals and situations separately.

- **Developing a sustainable approach**
  Capacity building needs to work at multiple levels including individuals, groups and across communities of practice

1.4 Working with Women – a gendered approach

SAOL project is a women's drug rehabilitation project and as such all of our programmes are designed to take into account the specific issues of gender in addiction.

At a societal level substance use is still a male dominated area. However, a detailed look at this issue however reveals a more complicated picture. While men are more likely to misuse illegal drugs[8], women predominate in the misuse of prescription type drugs such as tranquillisers and anti-depressants[9].

The Department of Health & Children's Benzodiazepine Committee found higher usage amongst females of all age groups[10].

Alcohol use by women is increasing gender related issues coming to the fore. "The age and gender profile of alcoholic liver disease has changed radically in Ireland in the same time period (*1995 – 2013*) – from being a disease of middle-aged and older men to affecting both men and women in large numbers with the highest rate of increase observed in the age group 15 to 34"[11]. Dr Orla Crosbie is quoted on the Alcohol Action Ireland website saying,

> "It's important to remember that while the gap between male and female alcohol consumption is closing, women experience greater health risks from alcohol than men and the onset of alcohol-related health problems begins earlier. Women are more vulnerable to tissue damage, cirrhosis of the liver and alcohol dependence"[12].

Recent Irish research carried out for the European School Survey Project on Alcohol and Other Drugs (ESPAD) found that girls are now drinking more than boys and more girls (37.1%) than boys (34.9%) reported drinking during the previous month[13]. Given Crosbie's comment above, this is an early pattern of alcohol use that is of concern.

Fewer girls use substances when compared to boys with the exceptions of painkillers and tranquilisers. While overall use of tranquilisers fell up to 2011, the 2015 figures show no fall in use and girls are using more than boys. Girls are using more painkillers than boys and more girls drink alcohol with pills than boys. It seems that the difference in substance use starts early in life[14].

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[8] Lifetime prevalence rates for males are higher for men than women (e.g. All illegal drugs: 38.8 for men; 22.6 for women. Cannabis use sees a difference of 35.8 to 20.0 men to women; heroin use 1.2 men to 0.5 women. The difference comes in the lifetime use of prescribed medications. Antidepressant use is 8.6 for men to 14.5 for women and sedatives or tranquilisers are 12.4 for men and 15.3 for women. While rates for drug use are increasing for men and women, prescribed medications are the only area where women's use is greater than men's (Prevalence of Drug Use and Gambling in Ireland and Drug use in Northern Ireland, 2014/15, page 14)

[9] **The Women's Health Council** (2009) Women and Substance misuse in Ireland

[10] **Department of Health & Children** (2002). Report of the Benzodiazepine Committee. Dublin:

[11] Joe Barry, Sept 12th 2016, Irish Times, online edition

[12] Dr. Orla Crosbie, http://alcoholireland.ie/facts/women-and-alcohol/

[13] **Taylor, K et al** (2016). ESPAD 2015: Results for Ireland. Dublin: Department of Health & Children. Downloadable from http://www.lenus.ie/hse/handle/10147/620637

[14] ibid

Women tend to experience drug misuse differently than men. There are physical differences, stronger familial influences, more severe effects on mental health and emotional well-being and deeper levels of shame and guilt.

In delivering **Reduce the Use 3** to your group it is important that you are cognisant of the special circumstances of women drug users and build in a gender analysis to the delivery of the programme.

Physical differences

Women appear to be more vulnerable than men to the adverse effects of alcohol and drug misuse on physical health. Women have been found to develop alcohol-related health problems earlier in their drinking careers than men and may also progress to problematic drug use and dependency more quickly than men[15]. Women develop alcohol-related liver disease, such as cirrhosis or hepatitis, after a shorter period of time and after lower levels of drinking than men, and they are more likely to die from these conditions than are men[16].

Female drug users are more likely than their male counterparts to report a range of physical and mental health complaints, in spite of their shorter histories of drug use and shorter injecting careers[17]. Women's biological make-up is partly responsible for the negative effects on their health; since women have a proportionally higher ratio of fat to water than men they are less able to dilute alcohol or other substances within the body, and will therefore have a higher concentrations in their blood than men after taking in the same amounts.

Women's hormones also affect how much and how quickly alcohol or drugs are absorbed. A woman's drinking or drug use may also leave her more vulnerable to violence/attack by others[18]. Indeed the recent ESPAD report notes that 46% of girls are afraid in a public place due to alcohol; 24% of girls (compared to 17% of boys) experienced injury or accident due to alcohol and 6.8% girls (aged 15 or 16) experienced unwanted sexual advances as a result of alcohol (compared to 4.6% of boys). ESPAD reports that,

> "A significantly higher number of female students report being in an accident or sustaining an injury, damaging or losing clothing or property, and deliberately injuring themselves".[19]

Family influences

Research also shows that a woman's family background is an important influence on substance misuse. In the first instance the behaviour of other family members can influence a woman's own behaviour, so that research has shown that having a family background of

[15] **Cox, G., Kelly, P. and Comiskey, C**. (2008). ROSIE findings 5: Gender similarities and differences in outcomes at 1-year. Dublin: National Advisory Committee on Drugs

[16] http://www.ias.org.uk/Alcohol-knowledge-centre/Alcohol-and-women/Factsheets/The-effects-of-alcohol-on-women.aspx (2017)

[17] Cox, G. and Lawless, M. (2000). Making contact: An evaluation of a syringe exchange programme. Dublin: Merchant's Quay Project.

[18] **Poole, N. and Dell, C. A.** (2005). Girls, women and substance use. Ottawa: Canadian Centre on Substance Abuse & BC Centre for Excellence for Women's Health

[19] Taylor, K et al (2016). ESPAD 2015: Results for Ireland. Dublin: Department of Health & Children. Downloadable from http://www.lenus.ie/hse/handle/10147/620637 page 31

heavy drinking or drug misuse and abuse can increase the likelihood of a woman having problems with substance misuse herself[20] [21]

Secondly, lack of cohesive and supportive family life is a significant predisposing factor to substance misuse among women and it has been suggested that girls are more responsive than boys to parental influences on substance use[22]. Parental disapproval and 'bonding' to family, particularly to parents, tend to act as restraining factors in substance use [23]

Research also indicates that drug-dependant women have great difficulty abstaining from drugs when the lifestyle of their male partner is one that supports drug use. They tend to be very influenced by their partner's drug taking and often become very dependent on them to access their drugs[24].

Women and Mental Health

Strong links have been found between substance misuse and depression, and it has been suggested that depression may be a reason for, as well as a product of, substance misuse[25]. Women in the general population are twice as likely as men to suffer from depression [26] and it may therefore be an important pathway to substance misuse for them, as well as being a significant consequence. The greater use of tranquilizers and anti-depressants by women compared to men may be symptomatic of this.

High rates of depression have been found among substance misusers, and alcohol and drug use have been linked with higher rates of suicide. Particularly high rates of depression have been found among drug users, who are at greater risk of suicide than those who do not misuse drugs[27]. HRB reports that for drug related deaths in 2015, 2/3 drug related deaths involved polydrug use; 2 in 3 deaths involved prescription drugs and 3 in 10 involved Diazepam. 24% of non-poisoning deaths were due to hanging (n=83), 3/5 of which had a history of mental health. Drugs most commonly used by those who took their lives through hanging was cannabis and cocaine. Most deaths by hanging were of younger men (median age 34)[28]

By its very nature, alcohol is a depressant and it can facilitate suicide by increasing impulsivity, changing mood and deepening depression. It is the drug implicated most in poisonings and was responsible for 14% of such deaths; 66% of such deaths were male.

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[20] Associations Between Family History of Substance Use, Childhood Trauma, and Age of First Drug Use in Persons With Methamphetamine Dependence. (2017) Svingen L1, Dykstra RE, Simpson JL, Jaffe AE, Bevins RA, Carlo G, DiLillo D, Grant KM.

[21] Family Risk Factors Among Women With Addiction-Related Problems: An Integrative Review (2016) Imaneh Abasi1 and Parvaneh Mohammadkhani

[22] **The National Center on Addiction & Substance Abuse at Colombia University**, (2006),

[23] Grube & Morgan, 1990.

[24] "Promoting a gender responsive approach to addiction", (2015) O'Neil and Luca, Editors, UNICRI

[25] **Needham, B. L.** (2007). 'Gender differences in trajectories of depressive symptomatology and substance use during the transition from adolescence to young adulthood'. Social Science & Medicine

[26] **Women's Health Council** (2005). Women and mental health; Promoting a gendered approach to policy and service provision. Dublin: The Women's Health Council

[27] **Lyons, S., Lynn, E., Walsh, S. and Long, J**. (2008). Trends in drug-related deaths and deaths among drug users in Ireland, 1998 to 2005. Dublin: Health Research Board

[28] Health Research Board (2017) National Drug-Related Deaths Index 2004 to 2015 data. Available at: http://www.drugsandalcohol.ie/28086 and at www.hrb.ie/publications.

Women's mental health suffer disproportionately as women often experience more stigma due to substance misuse than their male counterparts. There is still a double standard that judges women's substance misuse more harshly than men's, particularly if the woman has children. This greater stigma can result in greater guilt and shame for women and for their families, and may lead to women being reluctant to seek treatment.

> "Stigma based on drug use and incarceration works to increase the needs of women for health and social services and at the same time, restricts their access to these services. These specific forms of stigma may amplify gender and race-based stigma. Punitive drug and social policies related to employment, housing, education, welfare, and mental health and substance abuse treatment make it extremely difficult for women to succeed"[29] [30]

There have been many studies carried out worldwide which show clear evidence of the link between a history of child physical abuse, rape, incest, sexual assault and domestic violence and subsequent drug misuse[31] [32]. It is therefore essential that facilitators are aware of the particular pathways and background factors that lead to women misusing drugs and alcohol so that their needs can be fully addressed through the supports offered.

As emotional and relational reasons are often at the crux of women's misuse of drugs and/or alcohol, services for women may require an increased emphasis on care and support (Poole & Dell, 2005). In this regard, support structures and one to one work are important methods of encouraging women to engage and stay engaged[33][34]

Women and cocaine/stimulants

Women experience drug use differently from men and this is as true for cocaine/stimulant drug use. While increased HIV/HVC risks and more dangerous sexual activity has been recorded for some time[35] a telescoping of problems relating to later uptake of stimulant use but earlier onset of problematic health and social problems is also noted[36]; a higher likelihood of reporting psychotic symptoms (delusions of grandeur, paranoia and tactile and olfactory hallucinations, body dissatisfaction and even inappropriate dressing) which can act as blocks to effective treatment has been verified[37] . Waldrop, et al, note the role of stressors in uptake of stimulant drug use and suggest that women, in response to stress (and thereby interpersonal triggers) are more likely to turn to cocaine and stimulants than

[29] Nowhere to go: How stigma limits the options of female drug users after release from jail Juliana van Olphen et al (2009) sourced at www.ncbi.nlm.nih.gov/pmc/articles/PMC2685368/

[30] See also CityWide's 'Stop the Stigma' campaign at http://stopthestigma.ie/?page_id=21

[31] Cormier, R. A., Dell, C. A. and Poole, N. (2004). 'Women and substance abuse problems'. BMC Women's Health, 4

[32] Roberts, M. and Vromen, N. (2005). Using women. London: DrugScope

[33] Farrell, E. (2001). 'Women, children & drug use'. In Pike, B. (Ed) A collection of papers on drug issues in Ireland. Dublin: Drug Misuse Research Division, The Health Research Board

[34] For more information you can access videos of presentations from our conference on relationality at http://www.saolproject.ie/MakingConnectionsConference.php

[35] Joe, G.W. & Simpson, D.D. (1995) HIV risks, gender and cocaine use among opiate users

[36] Kay, A. et al., (2010) Substance Use and Women's Health, Journal of Addictive Diseases, 29 pp139-163

[37] Mahoney, J.J. et al (2010). Relationship between gender and psychotic symptoms in cocaine-dependent and methamphetamine dependent participants

their male counterparts, also recording that such use will result in greater impact on relapse[38].

All of the above is in keeping with SAOL's own experience of working with women using cocaine/stimulants. In case-study research conducted in 2010, stimulants were being used by almost all cases (13 out of 14) and although they were predominantly reported as being used as their secondary drug of choice, such use resulted in serious relapses with their primary drug of choice; increased use of stimulants or graduation to more serious stimulant use (example introduction of IV use or use of crack cocaine); marked deterioration in mental and physical health; decrease in self-care – with particular reference to poor hygiene, lack of care in use of drug equipment, carelessness in relation to sexual health and also weight-loss and poor diet; breakdown in relationships with partners, children and family of origin; and increased debt often resulting in illegal activities. While all of the above can be experienced by males, it is important to note that women seem to be experiencing more of the above examples than their male counter-parts, experiencing these issues with greater levels of intensity than men and experiencing them in a shorter timeframe. Each of these issues should be noted by the Facilitator and taken into account when determining goals and establishing support systems with female participants.
More recently the use of crack cocaine by women has been a recurring issue and seems to be particularly noteworthy among women with trauma experiences[39].

Shame and guilt
Many drug using women cite shame and guilt as a major issue for them around their drug misuse. These feelings of shame, which produce a sense of worthlessness or inadequacy, often delays them from seeking help, with the result that more damage has been done to their health and well-being as a result. In SAOL's experience women are also reluctant to disclose the extent of their drug use because of the stigma associated with being a woman drug user. Indeed, many women are driven to hide the extent of their drug misuse for fear of scrutiny and censure by family, community and relevant figures in authority. This is particular true for women who are caring for children.

1.5 Working within a Trauma informed approach

SAOL considers that trauma-informed care should be the norm. Based on emerging evidence-based research, it is known that the vast majority of people (women and men) presenting with addiction issues, are traumatized[40]. This trauma is past / present and is often re-triggered through current events. Addiction services in their entirety need to be viewed through a trauma lens. Our approach in **Reduce the Use 3,** as with every programme we work with in SAOL, is considered through this trauma lens.

[38] Waldrop, A.E. et al. (2010) Community-dwelling cocaine-dependent men and women respond differently to social stressors versus cocaine cues

[39] For example: "Crack cocaine addiction, early life stress and accelerated cellular aging among women" (2016) Levandowski, ML et al; "Childhood trauma, impulsivity, and executive functioning in crack cocaine users", (2012) Joana C.M.Narvaez et al

[40] See Covington, http://mhcc.org.au/media/25322/covington-2008.pdf and Najavits, L "Seeking Safety : A Treatment Manual for PTSD and Substance Abuse (2002)

Therefore we pay attention to the relationship between Facilitator and participants, ensuring that everybody has an opportunity to find their voice; we don't 'sshh' people if they are talking out of turn, rather we try to explain how to work respectfully in a group; we ensure that for any written requirement, or any verbal requirement on the programme, that participants are supported and are given the option of not participating. Simple things like expecting a participant to walk into a room when the group has already started are anticipated, and participants in as far as possible are minded. We invite participants in 20 minutes before the group starts to get a cup a cup of tea. Then we can start a group relaxed and together.

The Programme does not directly work through the trauma that people present with. Awareness that it might be present is sometimes enough, so as not to re-traumatise and to make an appropriate onward referral if necessary.

1.6 Working within a Human Rights perspective

According to Paulo Freire education can be viewed as a 'political process'[41]. This is politics with a small 'p'. Along the way in groups in **Reduce the Use 3** issues such as discrimination, equality, stigma, and rights are often part of the discussions. This is to be encouraged as participants (and Facilitators) increase their understandings of the social context of addiction. This does not mean the Facilitator has to take a 'Political' (with a large 'P') stance.

It does mean however that having an understanding of addiction as a public health issue is becoming more significant (mirroring the Reducing Harm, Supporting Recovery A health-led response to drug and alcohol use in Ireland 2017-2025, Department of Health). This approach understands that criminalisation of vulnerable populations serves only to further marginalise them. It pushes them to undertake more dangerous activities, such as sharing syringes or injecting in alleyways, and prevents them from accessing much needed health and social services which could help them to improve and often gain control of their lives.

These ideas are highlighted in Module 9 – Reducing Harm and Relapse Prevention and bring this debate into **Reduce the Use 3.** This challenges us to think about these questions (samples below) and how they impact on a person's opportunity and capacity to minimize the harms of drug use.

- With regard to reducing substance use, small gains for many people have more benefit for a community than heroic gains achieved for a select few
- People are much more likely to take multiple tiny steps rather than one or two huge steps
- Human rights apply to everyone. People who use drugs do not forfeit their human rights
- People who use drugs should be involved in decisions that affect them

[41] Freire, Paulo. **Pedagogy of the Oppressed**. New York: Herder and Herder, 1972

1.7 Validating learning

SAOL is working towards the development of formal accredited learning for the **Reduce the Use 3** programme (QQI Level 4).

To achieve this level, **Reduce the Use 3** will satisfy evidence of participant learning in the following categories:

• Knowledge Breadth	Broad range of knowledge
• Knowledge Kind	Mainly concrete in reference and with some elements of abstraction or theory
• Know-How & Skill Range	Demonstrate a moderate range of practical and cognitive skills and tools
• Know-How & Skill Selectivity	Select from a range of procedures and apply known solutions to a variety of predictable problems
• Competence Context	Act in familiar and unfamiliar contexts
• Competence Role	Act with considerable amount of responsibility and autonomy
• Competence Learning to Learn	Learn to take responsibility for own learning within a supervised environment
• Competence Insight	Assume partial responsibility for consistency of self understanding and behaviour

The revised **Reduce the Use 3** has been rewritten with these criteria in mind, specifically with the inclusion and amendments of learning outcomes, and exercises that demonstrate learning.

Beyond QQI accreditation, at SAOL we believe it is very important to celebrate achievements. For this reason we always ensure that on the final session, we award Certificates either of Attendance or Completion to every participant. This is an opportunity to reinforce progress, encourage, and motivate others to join in. It is also an opportunity for cake and photos!

1.8 The good news!

SAOL has built up a wealth of experience and learning from its ongoing running of **Reduce the Use**. As a result of tailoring **Reduce the Use** to suit groups and participants, we have found that the majority of our participants were successfully able to reduce their dependency on a variety of substances over time as a direct result of their participation on the programme. Indeed, the very process of creating an awareness of the amount of drug ingested, the harm being caused and the personal, social, financial and emotional consequences for the participant has a great impact on their future choices around drug use.

The **Reduce the Use** programme is a journey of discovery that begins with tentative steps taken by the Facilitator and the participants. On this journey the learner sometimes becomes the teacher, and the teacher will learn from the learner. Be open to the programme changing you too!

SECTION 2

Key Issues for running **Reduce the Use 3**

This section explains the key issues involved in the successful implementation of this programme. It will help the Facilitator understand who the programme is aimed at, what the participants might expect from the programme, how long it should take to deliver, how to use the group effectively, how to manage a variety of possible emerging themes, the role of written work and guidance on managing referrals and information.

This section also explains the skills and experience needed to implement **Reduce the Use 3** as well as the optimum ratio of participants to Facilitator.

This section covers:

2.1 Target group

2.2 A word of caution

2.3 Programme Duration

2.4 Ratio of Facilitator to participants

2.5 Commitment Contract

2.6 What will this programme do for the participant?

2.7 Using the Group Effectively

2.8 What Skills does the Facilitator need?

2.9 Group motivation

2.10 Managing Resistance

2.11 Managing Disclosures

2.12 Managing Group Confidentiality

2.13 Managing Attendance

2.14 The role of written work

2.15 Literacy Issues

2.16 Storage of Information

2.17 Referrals In

2.18 Referrals Out

2.19 Flexibility, flexibility, flexibility

2.1 Target Group

This course is designed for people who are contemplating reducing or stopping their use of a specific drug or a number of drugs.

No two people in your group will be at the same level in terms of their drug or alcohol use or, indeed, their level of initial commitment and comprehension. The skilled facilitator will recognise this and will be able to use their group work skills to identify those with additional needs so as to bring out the best from each client's participation. Some people may need more time than others to grasp the concepts of **Reduce the Use 3** and it is your job as the Facilitator to respond to everyone's needs in the group.

In the event that there are some clients who need more intensive support than others, this can be provided in a one-to-one environment outside of the course time – perhaps in discussion with their key worker or case manager if one is available. We have also found that running the group with a co-facilitator, sometimes a volunteer or student placement, can be useful to help those participants who need more support in the group setting.

This programme has been designed for groups no larger than 12 participants but with an ideal range of between 8 and 10. It can work, however, for groups as small as 3 or 4 people. The reason for this maximum number is that the group needs to be small enough for members to practice the skills being taught[42]. A larger group will not have the time to process the information learned, practice the techniques and feedback to its members.

2.2 A word of caution

For those wishing to use **Reduce the Use 3** with participants, it should be noted that some substances may require medical supervision when detoxifying. Alcohol and tablets are particular cases in point.

In this event, **no attempt** should be made by the Facilitator to encourage an individual to simply stop taking these drugs without medical supervision or a programme of slow withdrawal. The abrupt cessation of any drug can have severe consequences, particularly if the person has been a chronic, long term user and it is always advised to seek medical advice and support in the event a client wishes to stop their drug use altogether.

SAOL's policy is to encourage all participants engaged in **Reduce the Use 3** to inform their doctor and to be guided by them throughout the process.

It is important that you, as the Facilitator, make efforts to become aware of the extent of your participants drug or alcohol use. Some clients may under-estimate the extent of their drug or alcohol use at the time of the Assessment Meeting. This can happen for many reasons – denial, embarrassment, shame, deceit, habit, lack of personal awareness of real extent of drug use, etc. We find that the real extent of the participant's actual drug or

[42] US Dept of Health & Human Services (2005) *Substance Abuse Treatment Group Therapy – A Treatment Improvement Protocol TIP41*

alcohol use usually reveals itself as you establish a good, trusting relationship with them and as they engage deeper with **Reduce the Use 3.**

2.3 Ratio of Facilitator to participants

Ideally two Facilitators should be assigned per group but SAOL recognises that this may not always be possible within limited project resources.

However in SAOL's experience we recommend that if the group size is more than six participants, that two Facilitators should be assigned. Both Facilitators will need to be complimentary and need to set aside adequate space for reflection and review outside of the programme.

Bear in mind that if reading and writing is an issue for some participants, assistance will also need to be on hand to help with written work.

2.4 Programme Duration

Reduce the Use 3 is designed with 12 modules plus an additional assessment meeting beforehand. However this is merely a guideline and each project should decide what suits them and their clients best. We are aware, for example, of one drugs project who delivers the programme over a period of 20 modules.

If you decide to alter the programme to suit your own needs, please remember the following:

- there should be a clear finish to the programme as it was not designed as an ongoing piece of work.
- you should make sure you cover all aspects of the Modules

We find there are no hard and fast rules about programme duration. This manual is simply a guide to a tried and tested brief intervention model and therefore must be reasonably time restricted. The most important thing is to run the Modules on a consistent basis, get through all of the material and make sure that your group understands every step.

In SAOL, we tend to run the Modules on a weekly basis. This gives time for each member to absorb the information or practice the techniques learned. However it is quite feasible to decide to run the Modules on, say, a bi-weekly basis. We also make sure that the Modules are not going to be interrupted by Bank Holidays for example as a longer break between Modules can affect the flow of the group.

2.5 Commitment Contract

This course requires the following level of commitment from each group member:

- Attending regular programme workshops

- Adhering to the Group rules – decided in the first session
- Completing in-group and homework tasks

Participants need to be made aware of the commitment involved in the course in the first assessment meeting. The use of a Commitment Contract is encouraged as this strengthens the level of commitment from the individual. The Commitment Contract is introduced in the first session.

2.6 What will this programme do for the participant?

This programme will allow the client to go on a journey of self discovery and give them new insights into their drug use. It should help them to:

- increase self esteem and self efficacy
- learn from others experiences
- gain a deeper understanding of their addictive behaviours
- gain an awareness of the impact of their drug and alcohol use on self and others
- create an awareness of how they can control and change the thought patterns that lead to addictive behaviours
- learn how to set goals around reducing their use
- learn skills on avoiding situations of risk
- have an opportunity to practice new skills
- learn how to cope with cravings
- gain a practical approach to keeping safe and planning safety
- learn how to cope with a lifestyle that is drug and alcohol free or self-controlled

The programme is informed by cognitive behaviour type interventions and is therefore structured, goal oriented and focused on immediate problem solving. It focuses on analysing thought processes and skills training designed to help participants unlearn old habits associated with their drug and alcohol use and learn or relearn healthier skills.

2.7 Using the group effectively

The greatest resource a Facilitator has available are the group members. Your members will bring with them a wealth of information and ideas and it is your task to ensure that these ideas are facilitated and shared with the group. The course takes the members through a journey that focuses on practical ways to problem solve. A group works best at problem solving if:

- The problem can be defined in different ways
- Information is brought in from different sources
- It is a very specialised problem
- The problem has implications for many people
- There are likely to be many possible solutions
- It is a complex problem with many different aspects

The advantages to taking a group approach to this programme is that each member will bring a different experience, knowledge, point of view, values and, as a result, a larger number of ideas for problem solving can be generated. The exchange of ideas can act as a stimulus to the imagination, encouraging individuals to explore ideas they would not have otherwise considered.

Individual beliefs can be challenged by the group, forcing the individual to acknowledge them and rethink their beliefs. The Group can also encourage individuals to accept that change is needed.

Groups of individuals can bring a broad range of ideas, knowledge and skills to bear on a problem. This creates a stimulating interaction of different ideas which results in a wider range of better quality solutions.

It is therefore crucial that the Facilitator is skilled in working with groups and understands the dynamic of their group and how to get the most out of them by encouraging discussion throughout the duration of the programme. The programme is designed to encourage collaboration rather than be delivered in a wholly 'instructive' manner.

2.8 What skills does the Facilitator need?

The Facilitator must have training in group work and addiction in order to run this programme. They should be able to:

- effectively manage group discussions
- have a good understanding of group dynamics
- to communicate new concepts
- to respond to questions posed by group members
- to think on their feet and facilitate unplanned group discussions
- have the ability to develop good, supportive relationships with group members
- to handle conflict
- have experience and a good understanding of addiction work
- to handle congruence
- display empathy
- be patient
- to show unconditional positive regard
- display an awareness of cultural sensitivities
- maintain a high level of group leader focus

Before embarking on delivering the programme, the Facilitator will need to become familiar with the programme and fully understand the concepts being put forward. They should:

- **read the complete Reduce the Use 3 manual thoroughly**
- **understand the exercises and handouts**
- **clarify any outstanding queries**

SAOL will be happy to clarify anything for you – please feel free to contact us at admin@saolproject.ie The more familiar you are with the programme, the more confidence you will transfer to the participants.

The Facilitator of **Reduce the Use 3** should understand how best to work with clients in order to encourage them to explore their beliefs, thoughts, feelings and mindsets. If the group process is managed effectively it can be an extremely powerful tool for change.

Once a motivational topic has been raised by a group member, Facilitators should encourage deeper contributions by asking the client to elaborate – ask for clarification, ask for an example, ask for a description, etc. Always use affirming tones by commenting positively on the client's statement. Use reflecting as a means of getting the client to continue the contribution. Ask evocative questions designed to elicit change talk. Some examples of these are:

- How would you like things to be different?
- Where do you see yourself in five years time? How does alcohol fit into that?

Experienced addiction workers should be familiar with Motivational Interviewing[43] principles and these should be borne in mind and applied when facilitating group discussions. To assist you here is an overview of these general principles:

- **Express empathy, warmth and genuineness** in order to facilitate engagement and build rapport.
- **Support self-efficacy**. Build confidence that change is possible.
- **Roll with resistance**. Arguing, interrupting, negating and ignoring are signs a client is resistant to change.
- **Develop discrepancy**. Generate inconsistency between how the client sees his/her current situation and how he/she would like it to be. This strategy is based on the notion that discomfort motivates change and internal inconsistency or ambivalence is a cause of human discomfort.

2.9 Group Motivation

Using an experiential group model to challenge drug use has many advantages. The individual in the group gets to benefit from the sharing of experiences of others and in so doing raises the consciousness level of the group as a whole. The space for self reflection is created by the coming together of the group and the opportunities for re-evaluation are presented in a safe, supported environment[44].

The overall aim of **Reduce the Use 3** is to motivate and support the client to reduce or stop their drug use. The very act of engaging with the programme in the first instance

[43] **Miller & Rollnick (Editors)** 2002, Motivational Interviewing, Preparing people for Change , Second Edition, Guildford Press

[44] **Mary Marden Velasquez, et al** *(2001) Group Treatment for Substance Abuse – A Stages-of-Change Therapy Manual* The Guilford Press

should be viewed as a potential motivational tool. It is SAOL's experience that clients will present to the Programme for various reasons. For some it is the fact that they are in a serious crisis regarding their drug use and are desperate for help - others will be curious to know what it is all about and may seek to dip in and out of the concepts and others will be referred by ourselves or other agencies who want to seek some intervention for their clients that might help them with their addictions.

We find that using the Wheel of Change Model is a useful way for the client and Facilitator to determine just exactly where the client is at in terms of their readiness for change and helps the Facilitator to get a clearer understanding of the composition of their group.

Whatever the reason for engagement, the Facilitator has a responsibility to ensure that the client gets the most benefit from their engagement. All of the individual modules will teach the participant something and the aim is that they will leave each workshop having learned something new about themselves, their addiction and means of change. The learning gained will not be lost.

As they progress through the various modules on **Reduce the Use 3**, and as awareness grows, participants may decide that they are not ready for the commitment to change – that the reality of change is far bigger than they thought – but small changes are acceptable and bigger changes will follow. Efforts to help them work through this resistance and find a compromise should be made.

During the duration of the programme, there is an opportunity for each individual to make a clear choice from three options:

- Make no substantial change and continue with their current drug or alcohol use habits
- Gain techniques for self control and reduce their drug or alcohol use
- Stop their drug or alcohol use

If a participant decides that they do not want to progress further and efforts have been made to work through their resistance, then they should be assisted to leave in the knowledge that they can come back again at any time. Their departure from the programme should not be seen as a sign of failure on their part or the programme's part – they will have learned something about themselves and their drug use and will likely be much better equipped the next time around to make the commitment to change.

In the event of a participant leaving, the facilitator should ensure that every effort is made to maintain contact with the participant to offer support by:

- ensuring that they have access to relevant harm reduction information/ services
- ensuring that they have access to appropriate one to one supports where resistance might be explored further
- working on the non drug related issues that they are willing to change or address

- If appropriate, contacting the referrer to make them aware of the participant's disengagement so as to enable further supports from that source

By keeping the participant engaged with you, they are more likely to be in a position to re-commence the programme at a future date.

2.10 Managing Resistance

It is quite normal to meet levels of resistance during the delivery of the programme. Some participants may start off feeling positive and enthusiastic but as the reality of the changes they need to make begin to hit home they can start to self sabotage. Resistance can arise for a number of reasons and the Facilitator needs to be aware of when it is happening and develop strategies to work with it. The table below may provide some useful tips for you:

Type of Resistance	Strategies
Revelling those who are having too good a time to change	• Stimulate concern about the negative consequences • Raise doubt about their illusory sense of elevated self-efficacy • Focus on how their behaviour affects others. • Shift focus from problematic issue
Reluctant Those who are simply unwilling to consider change.	• Counter the hesitance by working through their concerns about changing. • Build confidence in their ability to change. • Use the support of individuals who have made similar changes.
Resigned Those who feel hopeless and helpless, may have a history of failed attempts and do not feel they can change.	• Provide hope. • Share success stories of similar individuals. • Evaluate prior attempts and suggest different. strategies to use.
Rebellious Those who actively resist attempts to encourage change.	• Link autonomy and freedom to change. • Shift high-energy levels from rebellion to change. • Make sure they feel in charge of the change at all times. • Offer choices and options for managing their change.
Rationalising Rationalises why the addictive behaviour does not pose a problem. Appears to have all the answers.	• Continue to make a clear connection between behaviour and consequences. • Do not deride their reasons but try and work with them to your advantage. • Build confidence in their potential to change

2.11 Managing disclosures

It is SAOL's experience that occasionally participants may make disclosures which are not appropriate to the group setting of the programme. Disclosures can come in many forms – they can be disclosures of past traumas, current traumas, illegal activities, etc. If this should happen we recommend that you handle the disclosure with extreme sensitivity and let the participant know that you are happy to see them directly after the group has finished. If there are two facilitators in the group, one of them may be in a position to talk to the participant straight away and privately. In this way you can explore the best way forward with regard to the disclosure. Depending on the nature of the disclosure the facilitator may be in a position to handle the support needs of the participant or it may be necessary to refer them on to another service or agency for support with this issue.

It is important that the group setting is not used for any disclosures or talk about named people, places or things who are not in the room. It is the job of the Facilitator to manage any such talk effectively, letting the group know that it is not appropriate and why it is not appropriate.

2.12 Managing Group Confidentiality

As a Facilitator, please remember that it is not within your power to guarantee confidentiality of the group. You can only promote it. In SAOL's experience we have tended to look for a group 'spirit of goodwill' rather than get caught up with the issue of Confidentiality. It is important, however, to remind participants that they should not repeat another participant's personal discussions or disclosures with people outside the group.

As group discussions play a major part in the workshops of this programme the Facilitator needs to take an active role in moving discussions on and keeping the group focussed. You should strike your own balance between the needs of your participants and the course programme content. It is absolutely normal that groups will stray from the point – particularly if it is challenging to them and their current behaviours. As Facilitator you are expected to be cognisant of this and to respond appropriately. The programme is designed to be delivered to a group but you should, at all times, be considerate to the needs of the individual members of your group.

2.13 Managing Attendance

If a participant misses a module for some reason, they should be given the opportunity to catch up prior to the commencement of the next module.

Depending on your project's resources, this may be done on a one-to-one basis and more intensive homework may be required. If a number of modules have been missed by an individual, the facilitator must decide whether or not that person can re-enter the group or whether it would be more appropriate to wait until the start of another group. In either event a meeting should be called with them to find out why they are not attending.

There may be valuable communication and feedback gleaned from such meetings which may benefit the participant, programme and/or style of delivery. If, after such meeting, it is determined that the person is not yet ready to engage fully with the programme, work should continue with that individual on a one-to-one basis to ensure that they are supported and have access to basic drug/alcohol and harm reduction information and services.

Remember, participants should not be made to feel like they have 'failed' in their efforts but rather encouraged for the efforts they have made. This will help to build self esteem and help with their re-engagement with the programme in the future. Remember – ***There is merit in the attempt, and a whole lot accomplished along the way.***

2.14 The Role of Written Work

Witten work is an intrinsic part of **Reduce the Use 3** as it allows the participant to reflect on the group learning at their own pace. In the experience of SAOL, writing has proven to be a disciplinary act that gives participants new insights into themselves and their relationships. It settles the mind, it's a de-stressor and it relieves tension. It can also act as an important outlet as it can help to let go of negative thoughts.

Studies have also shown that emotional disclosure through expressive writing can increase a person's working memory. All in all, the benefits of writing as a form of expression cannot be over-stated.

Writing (both in the group and later at home) allows the participant the opportunity to reflect on their learning and can help them create new roadmaps for change.

The course demands that some written work is completed outside of the module attendance (e.g. **Drug Diary**). Some people's living environment may not be conducive to writing at home and in this case a place should be suggested or made available where this can be done privately. In addition participants with literacy difficulties may need assistance with completing their drug diaries. Consideration should be given to providing a 'private' space before or after each module for anyone who needs to avail of it.

Cognitive behavioural techniques encourage written work as a way of processing emotions, seeing the problem in a different light and working a way towards a solution. It helps the individual to retain the learning of new skills so that these skills eventually become an automatic part of daily life. For this to happen, participants need to practice these new skills as often as possible.

The written exercises in this programme are designed to allow for significant reflection on a participants drug or alcohol use and its impact on their lives and those around them. This can be a difficult process for the learner as the reality of their situation becomes more and more evident. It is important that the participant is supported to safely get through these potentially difficult phases.

2.15 Literacy Issues

In your initial interview with the participant, you will have established the extent of their literacy skills and those that need additional help with writing should be assigned this support.

While **Reduce the Use 3** is designed for those who have competency in reading and writing, it has been our experience that some participants present with literacy difficulties and may need extra support to feel comfortable to take part in the workshops. We have found the following strategies to be useful:

- Offering the use of a 'scribe' to assist the learner in the modules
- Using more discussion based formats during Modules as opposed to written work
- Introducing a set of symbols, short-hand or emoticons for drug diaries
- Using a tape recording as a means of recording drug diaries or feelings and experiences
- Using a 'buddy' system with another participant in the Modules to help with writing, spelling, etc.

2.16 Storage of Information

As a general rule we encourage participants to leave their Course folders with us for safe-keeping in between modules. If they have completed written work during the group, they may want to take this home to continue the writing. In this event we suggest that you photocopy their class work and store a copy in their folder. Some participants will not wish to take work home because of privacy or safety issues and this is to be expected. Keeping a copy of all participant work will ensure that no information is lost or forgotten for the next module.

All Participant Assessment Information, Course folders and flip chart sheets should be stored safely and securely in accordance with the usual storage and data protection protocols within your agency/project.

2.17 Referrals In

We recommend that projects establish a relationship with referrers so as to ensure that the referrer has a broad awareness of the type of programme on offer and that the goal of the programme is conducive to the participant's care plan. A minimum referral requirement is that the participant has shown motivation and a desire to reduce or stop their drug or alcohol use.

Some of our participants are repeat attendees on **Reduce the Use 3**. They may have had a relapse or are finding themselves slipping back into old habits and they have requested a place on the programme again. We are happy to offer this repeat support, as each group will generate new insights for its members.

If a client wishes to self refer, SAOL will carry out an assessment of their readiness and ensure that we have an 'in case of emergency' contact number which could include their Drug Treatment Centre, GP, Family Member or other significant other.

2.18 Referrals Out

When a participant comes to the end of the programme, SAOL will always offer aftercare support for as long as is needed. Our Aftercare can provide other courses / groups and also offers a one to one support service. If the participant has been referred to us from another agency, the agency is informed that the participant has completed the programme and is either attending Aftercare or is no longer regularly attending. This is to ensure that the participant's ongoing support needs are being met.

If it is deemed that the participant needs ongoing intensive support, SAOL will make every effort to secure this support and will keep the participant in a holding situation with us until that support need is met.

2.19 Flexibility, flexibility, flexibility

The Facilitator will need to display a high degree of flexibility as each Module will present with new ideas, information and challenges. A competent Facilitator will know how to read the mood of the group and how to adjust the Module and exercises accordingly.

Remember that the **Reduce the Use 3** manual is given to you as a guideline only and you must determine the appropriate focus given the make-up of your group and its environs.

The notes in this manual, while comprehensive enough to allow you to frame and deliver each Module, cannot replace the important skills of being able to respond dynamically to emerging group issues and discussion.

SECTION 3

The Structure of Reduce the Use 3

This section explains, in detail, the practical structure of the modules and the materials required to deliver them. It also explains how the Handouts are referenced for ease of use.

Remember that the pack is designed to be photocopied for use and the original should be retained by the agency/project for ongoing use

This section covers:

3.1 Module Structure

3.2 Materials Required

3.3 Explaining the Handouts

3.4 The Case Study

3.5 Using the Flipchart

3.1 Module Structure

Each of the twelve modules have Facilitator guidelines and Module Handouts. This will help the Facilitator to keep the programme focused and on track. The Facilitator guidelines will take you step by step through the module providing notes to assist you.

Each Module progresses through several linked topics, with Handouts designed to reinforce and personalize the learning.

Each module follows a similar structure with a standard beginning and end to each one. The module begins with a group ***check-in*** and ends with a group ***check out***.

While each ***check in*** is related to the content of that particular module, they help give the facilitator an opportunity to check the mood of the group that day. They also get everybody talking immediately and generate a sense of group togetherness as well as acting as a short, separation technique from the external environment, i.e. they bring everybody 'into the room'.

Check-outs can give the facilitator an opportunity to gain feedback and/or an opportunity for participants to reflect on the learning that took place. Examples of these **Check in** and **Check Outs** are given in the Facilitator Guidelines for each module, but feel free to use your own ones as preferred.

The Modules can vary in length. Generally speaking, we would recommend between 2 – 3 hours in total (which includes a midway break for tea/coffee). If you find that this length of time doesn't suit your group you may adjust the module content to rollover some of the inputs into the next module.
A suggested timeline is included in this pack as a general guide to assist you when planning the module. For ease it has been completed on a Module duration of 2 hours – but this will leave lots of flexibility if you have more time. Don't worry if you get through something quicker than expected or if it took longer to cover something else. Provided you keep within the broad parameters of the suggested timing you will get through the Modules.

3.2 Materials required

The course is designed to be simple and cost effective to run. Materials required are basic and include:

- Handouts (photo-coped from this pack)
- A Notebook and pen for each participant
- A folder for each participant to hold their Handouts and Notebook
- Flip Chart
- Markers
- Balloons (Module 5)
- Credit card sized pieces of card paper (Module 7)
- Award Certificates (photocopied from this pack or feel free to design your own)
- Record of Attendance Certificates (photocopied from this pack)

3.3 Explaining the Handouts

Handouts are referred to throughout the programme and they are referenced as follows:

- Each handout begins with the letter **H**
- This is then followed by the Module number
- This is then followed by its sequence in that module

For example, the **Commitment Contract** is given to participants during the first module and is the first handout of that module. Therefore it is referenced as follows:

H❶1 Commitment Contract

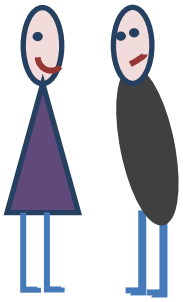
All handouts appear in the Handouts Section at the back of this manual.

Handouts are to be photocopied in advance of each group session – one for every participant.
Participants hold their handouts in their folders.
Some handouts cover key concepts and so can act as a record for each participant to review.
Some handouts are exercises for participants to complete. They are part of the necessary cognitive behaviour intervention tools. Some will be written into during the group time and others will be written into at home.

Facilitators should feel free to adapt the exercises to the needs of their group while ensuring that the main concepts are covered. During each exercise, it is important to regularly check that the group understand the information presented and you do this by asking them.

The Drug Diary Handout H❼4 is one that will be repeatedly used, and is one that participants will take home to complete in between sessions. Please ensure that you always have plenty of copies available.

3.4 The Case Study



One of the new features of **Reduce the Use 3** is the introduction of 'Dave and Davina'. These two fictional characters make their first appearance in Module 2 and continue throughout the programme.
Case Studies can be a useful way to help explain ideas, and can often provide a 'safe' way to discuss issues that may be sensitive for participants. Additionally, case studies will provide a benchmark scenario for assessment of understanding.

SAOL came up with 'Dave and Davina', developing their 'stories' and issues in one of our groups, but you might want to develop your own characters.

Encourage the group to come up with details of 'Dave and Davina's' life. Write up the ideas on a flipchart. It will be most useful if the characters you develop reflect the groups own or local experience. For example decide:

- Age
- Gender
- Substance use
- Family
- Relationships
- Health / mental health
- Environment

You will need to write up and have a copy of your 'Dave and Davina' for Module 3 onwards.

3.5 Using the Flipchart

The use of the Flip Chart is important as a means of reflecting what the group are saying and as a record for review and evaluation at later stages.

It will be useful to either retain or type up some Flip Chart sheets. This will be indicated in the guidelines.
For example, the Group Rules Flip Chart sheet could be retained and displayed in the room for all sessions. Or it could be typed up and handed out to all participants. Or both! Try to be flexible and work out what works best for you and your group.

SECTION 4

Explaining the course to the participant and assessing readiness for the programme

This section covers the individual assessment phase and includes guidelines for the first one to one meeting. It also includes a sample assessment form and referrer acceptance letter. These do not have to be used but are provided for your convenience.

Finally, we have included a short 'Information Handout' for the client which is a simplified version of what the programme is about and what will be expected from them if they decide to take part. We suggest you copy this to give to all participants prior to attending the programme.

4.1 Facilitator Guidelines for Assessment Meeting

4.2 Drug/Alcohol Use

4.3 Assessment

4.4 Sample Assessment Form

4.5 Sample Acceptance Letter to Referrer

4.6 Course Information Handout for participant

4.1 Facilitator guidelines for assessment meeting

Welcome!

We recommend that before starting the course you meet with each participant on a one to one basis to assess their readiness for the programme and to determine if the person is an appropriate 'fit' for the group. We find that this usually takes between 45 and 60 minutes.

Welcome the client to the meeting and help them to relax e.g. you could offer them a cup of tea or coffee. Remember they are probably very nervous and it is your responsibility to put them at their ease. To get to this meeting, either themselves, a friend, a drugs worker, key worker or other person will have realised that they have a problem with their use of drugs or alcohol and they will have expressed a desire to do something to change it.

Whatever their circumstances are, you can assure them that they will learn something from taking part in **Reduce the Use 3** that will change the way they think about their drug or alcohol use.

Remember - be warm and welcoming – it could be the start of a very fruitful relationship.

4.2 Drug/Alcohol use

During this meeting you will need to establish the type of drug or alcohol use the client is engaged in and which ones they want to reduce or stop.

As already mentioned, remember that some drugs (notably alcohol and tablets) may require medical support for detoxification and the Facilitator should be fully aware of any dangers associated with abrupt cessation of such drugs and should strongly discourage this approach. We find it useful to have information to hand which explains the danger of abruptly stopping certain drugs.
The HSE have a range of downloadable information leaflets which you might find useful (Guide to Substance Misuse for Medical Professionals) and can be found here:

https://www.hse.ie/eng/services/publications/socialinclusion/addiction/subabusemedprof-part1.pdf

Another useful site for information is: http://www.drugs.ie/

If the participant wishes to stop using these drugs altogether, the Facilitator, with their permission, should engage with the participant's medical/addiction team to agree the best way forward.

4.3 Assessment

Explain to the client that you will need some information from them so that you get a better idea as to whether the programme is suitable for them. Please remember to be sensitive, warm, empathic, considerate and non judgemental. The client has made a big step in accessing the programme and should be affirmed for taking this step. The manner in

which you engage with the client during the assessment will help form the type of relationship you will have with them for the duration of the programme.

You may use the Sample Assessment Form attached to this section of the programme or use your own method of collecting information. In the case of the latter, please remember to cover the following areas:

- What are the motivations for coming to the programme?
- What do they expect to get out of the programme?
- Current type and extent of problematic drug or alcohol use (make sure to prompt client to cover all possible drug types including drugs like alcohol, cocaine, mephedrone, tablets, etc)
- Explain the overall aim of the course – to reduce or stop their drug or alcohol use through a process of self awareness and practical techniques.
- What is expected from them in terms of commitment to attendance, engagement and reflection
- Stress the importance of client choice in determining their own goals in relation to drug or alcohol use
- Stress the importance of writing/reflecting as a technique for enhancing learning and the literacy supports available if required
- The course is designed for groups and they will be expected to respect the group's agreed rules
- Explain the supports available to them during the programme
- Explain dates, times, venue for the programme, etc

If the client is suitable for the programme, congratulate them and make sure to get all contact details.
Give the client a copy of the 'Course Information Handout' (*contained in this section*).
Make sure you notify the client of starting dates and times, and send a reminder in advance if possible.

A sample letter is provided which you should feel free to copy and use to inform the Referrer of their client's acceptance onto **Reduce the Use 3.**

If either you or the client feel that they are not suitable for the programme at this time, affirm them for making the contact and make sure that they understand why the programme is unsuitable for them at this stage and that they may apply again when they are more ready in the future.

4.4 Sample Assessment Form

Name: _____

Address: _____

Tel: _____ **Date of Birth:** _____

Referred by: _____

Contact details: _____

1. Drug Treatment Programme details – Name, address & contact

2. Why does client want to come onto Reduce the Use 3 ?

3. What do they hope to get out of taking part in Reduce the Use 3

4. What type of supports would you need to be able to attend the programme?

Childcare ☐
Literacy ☐
Other ☐
Details:

6. What drug(s) are you using on an ongoing basis ?

Description		**Describe approximate Usage**
Heroin	☐	_____
Methadone	☐	_____
Cocaine ☐		_____
Crack Cocaine	☐	_____
Tablets	☐	_____
Alcohol	☐	_____
Hash	☐	_____
Head Shop Stimulants	☐	_____
Other Stimulants ☐		_____
Other _____	☐	_____
_____	☐	_____

Notes: (Use back of page if necessary)

7. Is there one specific drug that client would like to concentrate on reducing? Yes ☐No ☐

Explain: _____

_____

Client is deemed suitable for commencement on the **Reduce the Use 3** programme ☐

Client may be suitable for **Reduce the Use 3**, but in view of risks associated with reducing/detoxing from their chosen substance it is deemed appropriate to seek medical advice/guidance as to the best way forward. (In this event, written permission needs to be sought from the client before contact can be made with their Drug Treatment Centre or Doctor) ☐

Client is not suitable at this time for commencement on **Reduce the Use 3**. Explain: (Use back of page if necessary) ☐

Signed: _____ (Assessor) Date: _____

4.5 Sample Acceptance Letter to Referrer

Re: (Participant name and address)

Offer of a place on our Reduce the Use Programme

Dear (insert Referrer name)

Thank you for referring the above named to our **Reduce the Use 3** Programme.

I am pleased to inform you that we met with your client today and have offered her/him a place commencing on (insert date)

We look forward to working with (insert participant first name) and hope that you will keep in touch with us as the programme progresses.

Kind regards

_____

What is the Reduce the Use programme about?

This programme is designed for you. It will create a self awareness in you that will help you understand your drug/alcohol use. By becoming more aware of how you think, you will learn how to control impulses to use and make positive changes to your life. This course will help you to learn how to reduce and/or stop your drug or alcohol use.
The course aims to build on your strengths and teach you some tips on how to change the way you think about yourself and your drug or alcohol use.

Who is it for?

This programme is for anyone who is having problems with their drug or alcohol use. It doesn't focus on any one particular drug but rather it focuses on giving you the means to reduce, refuse or stop taking whatever drug or drugs are causing problems for you in your everyday life.

What if I am not ready to stop?

This programme aims to help you reach your own goals in relation to your drug or alcohol use. You may decide that you wish to continue using drugs or alcohol in the same way, you may decide that you wish to reduce your consumption of drugs or alcohol or you may decide to stop using drugs or alcohol completely. The choice will be yours and the programme will support you in those choices.

How long should I expect to be on this Programme?

Expect to be on this programme for approximately 12 weeks – meeting once a week. Each group will last between two and three hours and will include a break for tea and coffee.

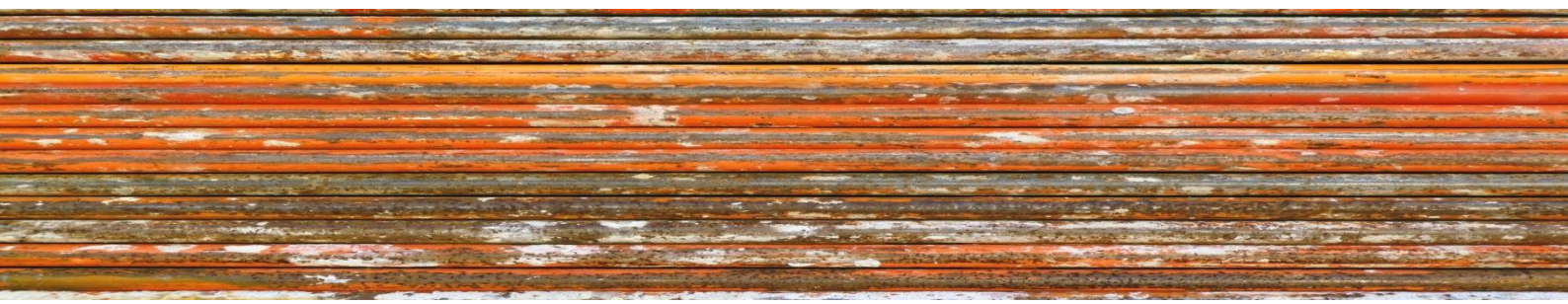
What is expected of me?

- You will need to commit to attending and taking part in each group meeting.
- You will be encouraged to keep a diary of your drug and alcohol use between each meeting.

Don't worry if you have any concerns about reading or writing.
We will help you with this.

Reduce the Use

Facilitator Guidelines



Aims

- To get to know each other
- To establish ground rules
- To establish commitment to the course
- To explain the format of the course and the group
- To introduce the Wheel of Change Model
- To introduce Safety Planning

Learning Outcomes

At the end of Module 1, participants will be able to:

- Articulate an understanding of group rules
- Name the stages of the Wheel of Change Model
- Have an understanding of the stages of the Wheel of Change model so as to be able to place a person (self) on the appropriate stage of the model

Materials Needed

- Large notebook and pens for each participant
- Folder for each participant to store handouts, etc.
- Flip chart paper and marker for noting discussions.
- Copies of Handouts H ❶1, H ❶2, H ❶3, H ❶4 for each participant
- Copy of Module ❶ Signing in Attendance Sheet

		Approximate guide (minutes)
1.	Check-in	10
2.	Introductions, motivations and expectations	25
3.	Reflecting on Overview of Course (Commitment Contract)	15
4.	Establish Ground Rules	10
	Tea / Coffee Break	15
5.	The Wheel of Change	25
6.	Safety Plan	15
7.	Check out	5

FACILITATOR GUIDELINES

1. Check-in

- Ask the participants to say their name and to say how they feel about starting this course. Name any worries they have about starting and write up these comments on the flip chart
- Send around the signing in sheet
- Hand out the folders (with paper and pens). Ask each participant to put their name on the folder and explain that they are to be used for keeping all the Handouts and written exercises safe. They can leave the folders with you each session, where they will be kept safely – nobody else will have access to them; or participants can take them home. If they choose this option it is important that you stress the need that they bring their folders with them to each session.

2. Introductions, motivations and expectations

- Ask each person to introduce themselves, why they are here and what they expect to get from the programme

3. Overview of Course (Commitment Contract)

We have found that the following are important points to emphasise with the group:

- Explain the overall aim of the course – to reduce or stop or maintain their drug or alcohol use through a process of self-awareness and practical techniques
- Stress the importance of client choice in determining their own goals in relation to drug or alcohol use
- Stress the importance of writing/reflecting as a technique for enhancing learning and the literacy supports available if required. Highlight the important role of reflection, written work and practicing the new techniques. Learning new behaviours will be greatly enhanced with practice. Participants will be expected to complete a small amount of written work outside of the course hours.
- Attendance – highlight that each module in this course is important and participants should work towards attending all 12 classes. If your agency is in a position to provide 'catch-up' sessions for anyone who could not attend one, then this should be explained. All participants who complete the course will receive a Certificate of Completion. Inform the participants that there will be a signing-in sheet at the beginning of every class.

Explain the commitment expected from each participant, i.e. in terms of attendance, engagement, etc. and then ask each participant if they are happy to sign the Commitment Contract H ❶1. The facilitator should retain these sheets, co-sign and return the original to the participants for inclusion in their folders, keeping a copy for their own records.

4. Establish Ground Rules

Explain that all groups establish Ground Rules. These are an agreed way of working together and they will be displayed at all times during the Course Programme. We have included below some sample ground rules from previous courses to help initiate the discussion if needed.

Record the group rules on a flipchart and if possible display these at all times. (For example the flipchart sheet could be taped to the back of the door or wall). Also we have found it useful to type them up separately and give a copy to each participant for their folder at the following module.

Some sample ground rules from previous groups we have run:

- Respect — Treat other group members respectfully — e.g. let people talk without interrupting
- Mobile phones should be switched off or put on silent during the programme. No one should take or make calls during this time.

- Confidentiality of the group should be kept. While this is something that all groups tend to aim for, no facilitator can absolutely guarantee confidentiality as they do not control the individual's behaviours. Therefore it is important to remind people of their personal safety and security when making disclosures.
- Good time keeping – the group should agree the time of their breaks and should discuss why time keeping is important to the group as a whole.

5. The Wheel of Change

The Wheel of Change was developed to give a clear way for understanding the cycle of addiction. The diagram H ❶2 is an adaptation of the Wheel of Change and reflects the reality that relapses can occur at any stage. The diagram is simply a tool to understand the cycle of addiction and to help put a 'name' to the stage a client is at today.

Give each participant a copy of H ❶3. Read through the different stages with the group, checking understanding at all stages.
Ask each participant to say where they would place themselves at this time in relation to their addiction. Ask them to mark this on their copy of H ❶2.

6. Supports and Safety

Discuss with the group the importance of paying attention to safety. State that each week, time will be spent looking at safety plans. Talking about addiction may be difficult. It may bring up topics that are uncomfortable, and therefore it is very important that during the course, participants will explore and find effective ways of staying safe.

Ask each member to write in their Safe Plan H ❶4 at least <u>one way</u> in which they could mind themselves or stay drug or alcohol safe until the next meeting. This may include identifying who or what their supports are. They can share this if they desire with other group members just prior to the check-out.

7. Group Check-Out

Ask the group:

"What are you most looking forward to in the programme at this point?"

Finish by positively affirming each group member for starting this journey and tell them how much you are looking forward to seeing them engage with the rest of the programme.

Aims

- To look at addiction in the context of the biopsychosocial model
- To introduce a Case Study approach – Dave and Davina make their first appearance
- To establish current drug or alcohol use

Learning Outcomes

At the end of Module 2, participants will be able to:

- Outline an understanding of the biopsychosocial model of addiction
- Link the context of a person's life and experience (biopsychosocial) to addiction
- Make an accurate inventory of their own current drug and alcohol use

Materials Needed

- Folders with paper and pens from Module 1 for each participant
- Signed and photocopied Commitment Contract from Module 1
- Group Rules from Module 1 (typed out)
- Flip chart paper and marker for noting discussions.
- Copies of Handouts H❷1, H❷2, H❷3, H❷4, H❷5, H❷6 for each participant
- Copy of Module ❷Signing in Attendance Sheet

		Approximate guide (minutes)
1.	Check-in	10
2.	Recap of Module 1	15
3.	Introduction to Dave and Davina	25
4.	The Biopsychosocial Model	10
Tea / Coffee Break		15
	The Biopsychosocial Model (continued)	15
5.	Current drug and alcohol use	15
5.	Safety Planning	10
6.	Check out	5

M2

FACILITATOR GUIDELINES

1. Check-in

- Ask the participants to state their name and say one fact about themselves that other people may not know (for example they may be the oldest child in their family; they may love watching soccer; they may be a good cook). It may be useful after everybody has contributed to get some idea of what it was like for them to do this check-in.
- Send around the signing in sheet

2. Recap of Module 1

- At this early stage in the programme it is important to reiterate what it is all about.
  Restate the aim of the course – to reduce or stop or maintain their drug or alcohol use through a process of self-awareness and practical techniques.
  Stress the importance of client choice in determining their own goals in relation to drug or alcohol use.
  Highlight the commitment expected from each participant. This could be an opportunity to give back the signed Commitment Contract H ❶1 from Module 1.
  Recap the Group Rules, and give each participant a copy of the typed up rules (if you ve decided to do this)

3. Introduction to Dave and Davina

- Dave and Davina H ❷1

  Give each participant a copy of the handout. Explain that over the course of Reduce the Use, you will be using 2 fictional people as a Case Study. Case Studies can be a useful way to help explain ideas, and sometimes it can be easier looking at another example rather than our own experience.

  We came up with 'Dave and Davina', but you might want to develop your own characters

  Ask the group what they think of 'Dave and Davina'. What do they think might be going on in their lives?

  Encourage the group to come up with details of 'Dave and Davina's' life. Write up the ideas on a flipchart.

  Sample story: H ❷2

  After the group has come up with a few ideas, give out H ❷2. This is an example of what one group developed for their stories. Read this together as a group.

  Ask the group again what they think of Dave and Davina. Do they recognise any of the elements of their story? Is their story believable?

  If you are going to develop your own characters, ask the group do they want to change or add anything to their stories. It will be most useful if the characters you develop reflects the groups own or local experience.

  Write up and have a copy of your groups Dave and Davina for Module 3

4. The Bio Psycho Social Model

- Give out H ❷3

Explain that this is a model that can help understand the context of addiction. It can help us make more sense of addiction. This model can provide a useful context to both how a person starts in addiction and what might be involved in recovery and reducing use. Looking at their addiction within the context of family, background experiences, gender, sexuality, culture, abilities and disabilities, trauma and health can all be part of understanding and part of working out how to change things.

When explaining the biopsychosocial model it is important to emphasise:

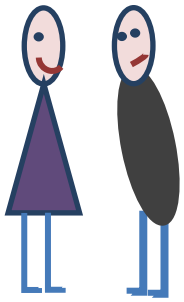
- Everybody can have different ideas about addiction – there is no right or wrong, and there is room for all ideas
- Our understanding about addiction probably comes from our own experience and everybody's experiences will be different
- Being open to looking at how different factors can have an impact on us can be helpful when we are trying to change

Ask the group what they understand about:

1. Biological / medical understanding of addiction
2. Psychological
3. Social / cultural

Add brief clear explanations for each.

You might want to refer to 'Dave and Davina' to illustrate your explanations



Your discussions may (briefly) encompass the following points:

<u>Biological/Medical issues</u>

- Genes/Hereditary
- Disease
- Addiction as a physical and/or mental illness

<u>Psychological issues</u>

- Learned behaviour
- Trauma
- Self esteem
- Addictive personality

<u>Social issues</u>

- Family
- Peers
- Cultural values
- Economic status

5. Personal Drug and Alcohol Inventory

- H ❷4

Explain that as a start to the Reduce the Use course all participants are being asked to fill in their current drug situation on this sheet. This information is confidential and will be seen only by the facilitator.

Explain the importance that they are as honest as they feel they can be. If they under state what they use, then it will be more difficult for them to see any progress they might make over the next few weeks.
Explain that these sheets will be held safely in their folders.

6. Supports and Safety

- Explain to group members that each module will end with the participants taking a few moments to reflect on how they will commit to keeping themselves safe until they next meet. This could range from harm reduction techniques to drug avoidance techniques and each person will have different aims. Give everyone a copy of an example Safe Plan H ❷5 and ask them to take a moment to go through it. Answer any questions that might arise.

H ❷6 Safe Plan
Ask participants to try to come up with several ideas for their safe plan.

7. Group Check-Out

- Ask each person to read out <u>one</u> item from their safe plan this week.

Aims

- To introduce the main concept of Cognitive Behavioural Therapy (CBT) – how thoughts turn to actions
- To increase an understanding of the components of Triggers – Thoughts and Beliefs – Cravings - Behaviours - Consequences
- To discuss triggers in more detail, to increase understanding of how they can operate

Learning Outcomes

At the end of Module 3, participants will be able to:

- Outline an understanding of the Cognitive Behavioural Therapy (CBT) model – Triggers – Thoughts and Beliefs - Behaviours - Consequences
- Describe a variety of triggers

Materials Needed

- Folders for each participant
- Flip chart paper and marker for noting discussions.
- Copies of Handouts H❸1, H❸2, H❸3, H❸4, H❸5, H❸6 for each participant
- Copy of Module ❸ Attendance Sheet
- *Copy of your groups 'Dave and Davina' story (if you have decided to use your own)*

		Approximate guide (minutes)
1.	Check-in	10
2.	The process of decision making	30
3.	Examples of decision making	10
4.	Your example	10
Tea / Coffee Break		15
5.	Triggers	20
6.	Triggers Exercise	10
7.	Safety Planning	10
8.	Check out	5

M3

FACILITATOR GUIDELINES

1. Check-in

- Ask the participants to name an emotion that they are feeling at the start of this group.

- Send around the signing in sheet

2. The Process of Decision Making

Explain to the group that the Reduce the Use programme uses the ideas of Cognitive Behavioural Therapy (CBT) to help explore the processes that are involved in actions we might take.

Cognitive Behavioural Therapy helps participants to learn specific skills that are applicable not just for addiction issues but also for the rest of their lives.
These skills centre on identifying unhelpful thinking patterns, changing beliefs, relating to the world in different ways and modifying behaviours. It is grounded in the understanding that the way we perceive a situation will influence how we feel emotionally; that if we are in distress, our perceptions are likely to be distorted and our thoughts will probably be unrealistic. As a result, our behaviour is likely to be unhelpful in achieving our goals. CBT attempts to help us change our thinking so that we feel differently and we can focus attention on our stated goals, so as to bring about positive behaviour change,

Explain and discuss with the group each part of the diagram, H ❸1 by raising the following points:

Trigger
A trigger is something that sets off the desire to use.
Get the group to list some common triggers; these are often described under the categories of people, places and things. Tell the group that you will be looking at these in more detail later in this session.

Automatic Thoughts
This is the first thought that comes into someone's mind in response to a trigger. Ask the group to call out what drug using thoughts they may have when faced with a trigger. For example, when you see an ad on television for a delicious chocolate bar, often the first thought that jumps into your head is that you want one. This is what can be described as an automatic thought.
Automatic thoughts will often be based on something that is not real but is a learned response to a situation. With a bit of practice this response can be changed and this is what the participants will learn in the next few modules.

Craving
This is an intense desire to use.
Get the group to discuss the compulsions behind their cravings. Is there a physical reaction, is there a psychological reaction?
Tell the group that the programme will cover ways of dealing with cravings other than using drugs.

Permissive beliefs – Giving Yourself Permission to Use
This is the voice in someone's head that says: "It's alright to use" "I deserve it" "It's alright I can handle it" etc.
Get the group to give some examples of beliefs that they think give them permission to use.

Consequence
There are both long term and short term consequences of the decision to use. Get the group to give some examples of both.

Tell the group that over the next few sessions you will be looking at each of these components in more detail.

3. Examples of decision making

H ❸2 and H ❸3

Give each participant a copy of the handouts. Read these out loud, asking for volunteers to read if appropriate, as a way of stimulating discussion.

4. Your own example

Give each participant a copy of H ❸4.

Ask them to complete their own examples of their decision making processes.

Ask if anyone is willing to share any part of their example with the rest of the group.

5. Triggers

With the help of a flipchart facilitate a discussion about triggers. It may take a little time to get the group to start identifying their own triggers. Encourage participants to be as specific as possible. For example, a common answer might be 'people, places and things', but this discussion will work better the more detailed participants can be.
Include as many senses as possible:

- Sight
- Sound
- Touch
- Smell
- Taste

Include emotions too.

Examples from previous groups have included, TV theme tunes (as the time when the children goes to bed and the person then feels like using; the sound of seagulls (as the time they step off the train in Dublin when they have come up for the day); the sight of silver foil on a chocolate bar etc.

Write up every idea on the flipchart.

6. Triggers Exercise

Give each participant a copy of H ❸5. Explain that this contains a list of situations and that you want them to mark each situation from 1 – 3

1 = no temptation to use

2 = slight temptation to use

3 = strong temptation to use)

After participants have completed this, check how they found doing the exercise.

7. Supports and Safety

- Explain to group members that the safety plan today directly relates to the topic of triggers. Having identified a situation of higher risk (from the previous exercise, H❸5), try to work out a plan that will reduce the risk for you from this particular trigger.

  H❸6

  Tell the group that at the start of next week you will check out with them whether the plan was effective, so encourage them to remember to try to put it into action and note whether it was successful.

7. Group Check-Out

- Ask each person to name an emotion that they are feeling now at the end of the group.

Aims

- To gain an understanding of how beliefs and thought patterns influence our decision making and our actions
- To increase understanding of how negative beliefs and thinking can lead to drug or alcohol use

Learning Outcomes

At the end of Module 4, participants will be able to:

- Describe what is meant by automatic thinking and be able to give an example to demonstrate their understanding
- Outline how thinking can influence our actions
- Demonstrate an understanding of how negative thinking can be connected to drug or alcohol use

Materials Needed

- Folders for each participant
- Flip chart paper and marker for noting discussions.
- Copies of Handouts H❹1, H❹2, H❹3, H❹4 for each participant
- Copy of Module ❹ Attendance Sheet
- Spare copies of H❸1 – in case participants have misplaced from last session

		Approximate guide (minutes)
1.	Check-in	20
2.	Automatic Thinking	10
3.	Automatic Thinking Exercise	20
4.	70,000 Thoughts	10
Tea / Coffee Break		15
5.	The Role of Negative Thoughts	20
6.	Own Negative Thoughts and Beliefs Exercise	10
7.	Safety Planning	10
8.	Check out	5

M4

FACILITATOR GUIDELINES

1. Check-in

- Ask the participants to report back on how their Safety Plan from Module 3 worked out for them. Did they remember to try it out? Were they able to keep to their plan? Did it work in the way they expected? Did it work out in any other way?

  Even if very few participants remembered to try the plan, or are able to report back on it, this check in can still be a valuable exercise.

  Discuss with the group why their plans might not have worked.

  Make sure that this discussion does not lead to conclusions that they have failed; instead look at it as an opportunity that might be suggesting they need better or different plans – ones that might work better for them.

- Send around the signing in sheet

2. Automatic Thinking

Explain that this Module is about how we make decisions and how negative beliefs and thought patterns can underpin their drug or alcohol taking.

Refer back to H❸1 to show how and where this Module's topic of Automatic Thinking fits into the Cognitive Behavioural Therapy model.
(Participants should have a copy of this in their folders, but make sure you have some spares for anyone who may need one).

Decision making can happen automatically without us being aware of all the steps involved. Changing gears in the car, making a call on your mobile phone or lighting a cigarette are good examples of this. Most people who smoke will have, at times, found themselves half way through a cigarette without consciously being aware of taking it out of the packet, finding their lighter and lighting up. The more often you do something, the less conscious awareness you have of the action. It becomes a sort of 'second nature' to us. This is what can happen with patterns of behaviour in addiction.

Role-play the action of making a call on a mobile phone with the group. This is an action that most of us don't actually think about. If it's someone we are used to calling it becomes a series of unconscious automatic actions leading to the call being made.

However if this were a new mobile phone or you were doing it for the first time you would need to pay attention to the steps involved. Get the group to come up with all of the steps involved in dialling a number from their mobile phone and write these up on a flip char
Example of steps in making a call from a mobile phone

- Think that you want/need to make that call
- Decide that you will make it
- Find your mobile phone
- Find the button for your contacts
- Scroll through your contacts for the name of the person to call
- Select their number
- Press dial button and connect

3. Automatic Thinking Exercise

Get everyone to work with the person next to them to come up with a few tasks/situations of their own where an action is so familiar it can almost be done on auto pilot. Possible examples could include lighting a cigarette, making a cup of tea, getting money out of an ATM machine.

Ask each pair to break down the steps involved in their chosen task and write a list of the steps in the order in which they need to be done. When this is done ask them mark those steps as either Thoughts or Actions.

Bring the group back together and ask how they found the exercise. Explain that one of the key elements of the programme is paying attention to the steps involved in drug taking and then learning how to interrupt those steps before they become actions.

4. 70,000 Thoughts

Ask the group to try to guess how many thoughts each person has every day. Write up each guess on the flipchart until every participant has guessed. Hand out H❹1 and see how near their guesses were. Tell the group that you will be talking about how important our thoughts are, and how much they can influence how we feel and what we do. Discuss how they feel about having 70,000 thoughts a day; about what proportion of those thoughts are helpful; what proportion might be focussed on addiction, using, substances etc.

5. The Role of Negative Thoughts

Give each participant a copy of Handout H❹2

By using H❹2 as an example, explain the role of a person's negative thoughts and beliefs and how they can lead to feelings of inadequacy which can in turn lead to automatic thoughts and permissive beliefs. Permissive beliefs can be described simply as a pattern of thinking that gives a person 'permission' to take an action, e.g. "I can handle taking drugs this once' or 'I deserve to be happy'.

Discuss with the group if they can identify with any of the thoughts/beliefs in the example. Through discussion and recognising the association between the initial thoughts/beliefs and the ultimate action, the group will learn that by changing their initial negative thoughts and beliefs into more positive ones, they can have an impact on their drug or alcohol use.

Exercise

Personal beliefs

- Ask the group to come up with some examples of negative thoughts and beliefs that they have felt. These can be negative emotions about oneself, one's situation or one's future. Write the responses on a flip chart.
- Remember to explain that beliefs can be true or untrue. We can very often believe things about ourselves simply because we have endured unfair criticism in the past or have been victims in an emotionally abusive situation. Perhaps we have never really looked at our beliefs and asked ourselves if they are really true. Are they really deserved? Get the class to look at the examples on the flip chart. Are they true or untrue? Discuss each belief.
- As the facilitator, you may need to play a supportive and motivating role with the participants when discussing whether negative thoughts are untrue or true. Strong held beliefs can be difficult to shift and if we have believed something about ourselves for most of our lives, then it is hard to believe that

these may in fact be untrue. For instance nobody is ever worthless or unlovable. No environment is ever 100% negative and people's future can be positive or negative depending on the choices that they make, the supports they have or the outlook they have.

- Some thoughts and beliefs may actually be true. For example 'My friends won't hang out with me if I don't drink or use drugs' If this is the case, they will need to look at the pros and cons of the situation and make decisions as to whether they want to change this situation and the implications for these changes. Perhaps they may want to reflect on these changes before the next module.

6. Own Personal Beliefs and Thoughts

Give each person a copy of H❹3 and ask them to fill in the flowchart with examples of their own personal beliefs. This is completed individually and should be a quiet time for the group. Some members may need help with this. The facilitator should check with participants that they understand the difference between their thoughts and beliefs.

Bring the group back together and ask how people felt about writing their own personal 'flowchart'. Did it make sense? At this point it would be good to highlight that by understanding their negative thoughts and beliefs, they are in a position to challenge themselves, and, with practice, change the way they think and feel about themselves.

7. Supports and Safety

- Explain to group members that the Safety Plan today directly relates to the topic of personal thoughts and beliefs.
  Having identified a negative though or belief (from the previous exercise, H❹3), try to work out an alternative way of thinking or a way of challenging this thought or belief.

  H❹4 Ask participants to complete the handout exercise.

7. Group Check-Out

- Ask each person to name one thing that they like about themselves. This might be something they are good at, or something they are. Try to keep participants statements to one clear sentence (i.e. without tagging on negative parts).

Aims

- To explore how changes can be made to old patterns of thinking
- To increase understanding of how negative beliefs and thinking can lead to drug or alcohol use

Learning Outcomes

At the end of Module 5, participants will be able to:

- Identify a negative thought or belief they might hold, or have held
- Describe a process to challenge negative thinking patterns
- Demonstrate an understanding of how negative thinking can be connected to drug or alcohol use

Materials Needed

- Folders for each participant
- Flip chart paper and marker for noting discussions.
- Copies of Handouts H ❺1, H ❺2, H ❺3 for each participant
- Copy of Module ❺ Attendance Sheet
- Balloons
- Felt tip markers
- Safety Pin (or something sharp to burst balloons)

		Approximate guide (minutes)
1.	Check-in	10
2.	Recap and Introduction	10
3.	Positive / Negative Exercise	15
4.	Sources of Negative Thinking	5
5.	The Balloon Exercise	20
Tea / Coffee Break		15
6.	Our Internal Dialogue	5
7.	Changing Negative Thought Patterns / Dave's Story	20
8.	Changing Thinking Tips/Safety Planning	15
9.	Check out	5

M5

FACILITATOR GUIDELINES

1. Check-in

- Ask each participant to answer 'If you could have one super-power, what would it be, and why?

- Send around the signing in sheet

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2. Recap from last session

Go through some of the key points from the last three sessions to remind participants about the components of decision making – such as triggers, automatic thoughts and beliefs, cravings, permissive beliefs and consequences.

3. The Importance of Positive Thinking

This exercise is about getting the participants to explore how positive or negative thinking can lead to different feelings and different outcomes, such as a decision to use drugs.

The two facilitators (or a facilitator and a volunteer) illustrate the role play as described below. They sit facing each other on two chairs. One facilitator is named as the negative person and the other positive. The two people conduct a conversation on any given topic, for example; their favourite movie, a summer day, their favourite TV show. Person A constantly says positive things and person B can only say negative things.

Example:

A – *It's a great day today, isn't it?*

B – What's so good about it?

A – *Really? Mornings are my favourite time of the day*

B – I hate getting up in the morning

A – *But the sun is shining, the sky is a beautiful blue*

B – I hate the sun – can't see a thing without my sunglasses

Now get the participants into pairs to do a similar exercise. Ask them to swap roles, giving them a different topic.

Bring the group back together and get feedback on what it was like being in the different roles.

Prompt questions:

What was it like in their role? How did it feel to be the negative/positive person?
Can they identify with the roles?
Can they see a link between negative thoughts and self-beliefs?

The facilitator should ensure that the following points are covered in the group discussion.

Negative thoughts can lead to negative personal beliefs

Negative personal beliefs can lead to automatic thoughts and permissive beliefs
Permissive beliefs give us the 'reason' we need to use

4. Sources of Negative Thinking

Introduce and facilitate a discussion on 'where do our negative beliefs come from?' Write all ideas on to the flipchart.

Prompt questions:

How long have you had these beliefs?
Who can you hear saying the belief?

5. Letting go of Negative Beliefs

The Balloon Exercise

Explain to the group that negative beliefs can be very powerful when we have inherited them. In other words, they can be carried from our childhoods and incorporated into our own adult belief systems. Some examples of these could be having been told 'you'll never amount to anything' or 'you're stupid', etc.

This exercise will help the participants to let go of some of those negative thoughts and replace them with more positive ones.

Give each participant a marker and a balloon that has been blown up. Ask each person to write on the balloon a negative belief about themselves that they want to let go.

The facilitator starts by asking for a volunteer who is ready to let go of their negative belief by bursting their balloon. The facilitator will check if the person is sure they are ready to let go of their negative belief. If so, they are then asked to state something positive to replace the negative belief. For example the negative belief 'I am stupid' can be changed to 'I am smart and can do anything if I put my mind to it'. At this point, the Facilitator gives a pin to the participant and they are invited to burst their balloon. The tutor should go from person to person guiding them through this part of the exercise.

If a participant does not wish to burst the balloon, it is important to emphasise that letting go of negative beliefs can be difficult. They can be given the opportunity to burst their balloon at a later date.
If a participant cannot state a positive replacement, then others in the group may be able to help by adding some of their positive observations about the participant. It is important to check whether the participant can own any of these statements. They might be able to select one that fits best.

6. Our Internal Dialogue

Explain to the group that we all have what is called an internal dialogue or conversations going on inside our heads. We are constantly talking with ourselves. Day and night our lives are kept busy deliberating, evaluation, judging, contemplating, considering, denying, etc. and it can be hard to stop it. Most people, in fact, aren't even aware of their internal conversations.

Its normal to have these internal dialogues going on but problems occur if these 'conversations' are full of negative thoughts and negative self-belief. We are then in danger of listening to only hearing negative thoughts about ourselves and these will influence what we think, what we believe and how we act as a result of those beliefs.

For example, it's difficult to imagine feeling confident if there is a voice in your head constantly shouting 'you're a waste of space, you can do nothing right, you're only a drug user, you're a failure'.

7. Changing Negative Thought Patterns

Facilitate a group discussion by asking members to reflect on some of the negative thoughts they have already discussed in the group in the previous modules. Do they have these thoughts often? Do these thoughts prevent them from doing things? Do these thoughts justify them doing things? Do they believe these thoughts or deserve these thoughts?

The next exercise will look at how to change these negative thoughts and beliefs.

Give out H❺1– Dave's Story. Read down through the handout with the group. Ask the group if they can:

- Identify with all or part of the story
- Discuss their views on Dave's thought patterns

In order for Dave to manage the urge to use better, he will need to change how he thinks in high risk situations. This can be described as changing his addictive thinking. We can think of this as if he is changing the end of his own movie. In order to do this, ask the group the following questions:

- Is there any truth to the thoughts that Dave is having?
- Is this way of thinking helping him?

Write up the group feedback on the flipchart if appropriate.

8. Changing Thinking Tips / Safety Planning

Explain to group members that today's Safe Plan will focus on changing thoughts. Read through H❺2 with the group, then ask each person to complete their own Safe Plan H❺3.

9. Group Check-Out

- Ask each person if they could change the ending to one movie or one book, what would that film or book be and how would they change the ending.

Identifying Goals

M6

Aims

- To identify problems caused by drug or alcohol use
- To identify advantages and disadvantages of drug or alcohol use
- To enable participants decide whether they wish to
    - Reduce their use
    - Stop using a particular drug altogether **(bearing in mind the cautions advised with abrupt cessation of some drugs)**
    - Continue on with their current level of drug or alcohol use

Learning Outcomes

At the end of Module 6, participants will be able to:

- Identify both positive and negative consequences in their substance use
- Outline an understanding of the SMART model in making goals
- Articulate a SMART goal for themselves in relation to drug or alcohol use

Materials Needed

- Folders for each participant
- Flip chart paper and marker for noting discussions.
- Copies of Handouts H ❻1, H ❻2, H ❻3, H ❻4, H ❻5 for each participant
- Copy of Module ❻ Attendance Sheet

		Approximate guide (minutes)
1.	Check-in	10
2.	Introduction	5
3.	Good and Bad Things about Using	15
	Good and Bad things about Reducing / Stopping	15
4.	SMART goals	15
Tea / Coffee Break		15
4.	SAMRT goals (continued)	15
5.	Name your goal	20
6.	The Goldilocks Test	5
7.	Check out	5

M6

FACILITATOR GUIDELINES

1. Check-in

- Ask each participant how they are feeling coming into the group today
- Send around the signing in sheet

2. Introduction

This Module marks the half way point through the Reduce the Use course. This is an important module as it asks participants to think very clearly about their overall goal in relation to their drug or alcohol use.

The questions they will face are:

- Do they want to **continue** with their drug or alcohol use as it is for the moment?
- Do they want to **reduce** their drug or alcohol use?
- Do they want to **stop** their drug or alcohol use?
- **Which drug** they want to prioritise? (for the goal setting exercise).

In our experience most poly-drug users will have one drug which is causing them most problems and which they want to reduce or stop first. We find that it is best to put the main focus on one substance at a time although there are no hard and fast rules about this.

During today's session, each participant will be asked to work out at least one goal that can be worked on over the next 6 sessions, and they will get an opportunity to review this goal in the final session.

In order for the participants in your group to be able to make clear, informed decisions about the drugs that they are having problems with, they need to be aware of all aspects of their drug or alcohol use, both positive and negative.

3. Good and Bad Things

Exercise

Give out copy of H❻1 to each group member 'Good and Bad Things about using Drugs or Alcohol'

Ask each member to complete the worksheet and once completed, ask each member to read out one good and one bad thing about their drug or alcohol use.

Encourage and facilitate group discussion on the good and bad sides of using drugs and alcohol. Are there any similarities? Are there more good or bad sides?

Exercise

Give out copy of Worksheet H❻2 to each group member 'Good and Bad Things about Reducing/Stopping Drug or Alcohol Use'

Ask each member to fill in the worksheet and once completed, ask each member to read out one good and one bad thing about reducing or stopping their drug or alcohol use.

Encourage and facilitate group discussion on the good and bad sides of reducing or stopping. Are there any similarities? Are there more good or bad sides?

Note to Facilitator
It is our experience that some participants find it difficult to recognise any bad aspects to reducing/stopping their drug or alcohol use. This may be because of their determination to change, the positive attitude of the group setting or their belief that they can do so 'easily'. Looking at the bad aspects to stopping or reducing drug or alcohol use can be a frightening thing to do and as the facilitator you may need to help the group to acknowledge the difficulties in the road ahead. This will help each member to be more prepared and aware of the dangers of relapse.

Use the following examples if necessary:

- Will you have too much spare time on your hands if your day is not spent trying to access drugs or using?
- Will you have to consider dropping certain friends and/or establishing new friends or social networks?
- Will you feel lonely, bored or isolated?

4. Decision Time – Goal Setting

Give each participant a copy of H❻3 **Goal Setting Guidelines**. Read through these guidelines with the group, ensuring that each member understands them.

Note to Facilitator
At all times throughout this decision making process, emphasise that the participants are making their own choices i.e. that they are free to decide themselves if they want to continue, reduce or stop their drug or alcohol use.

5. Name your Goal

Exercise

Give each participant a copy of H❻4 **- My Goals.**
Ask each member to complete this worksheet, using the learning of the previous discussion. Start by encouraging short term goals – targeting the time left over the next six sessions.

Exercise
When participants have completed this worksheet, ask them to work in twos to check that their goals meet the guidelines already discussed. Are they SMART?

6. The Goldilocks Principle

H❻5 Explain the simple idea of checking whether the goals pass the Goldilocks Principle – not too big, not too small – but just right
Ask whether any participant would like to share one of their goals with the group, and get feedback on whether the goal seems workable.
Are there any ways in which it could be improved, to make it more likely to succeed?

Participants can decide not to share their goals with the group although it is important to bear in mind that it can be beneficial to 'go public' about goals as it helps to reinforce them if other people are aware of them. Be flexible in this.

7. Group Check-Out

Get the participants to think of someone who they know or admire (child or adult) who has achieved a goal in their life. In turn, ask each person to share this with the group.

Note to facilitators:

As Facilitator, it may be useful to review participant's goals after the module to ensure that the participant understood the exercise fully. It is our experience that all members will have at least one goal for change and it is up to you to decide if the programme can continue to facilitate that goal. In the unlikely event that a member has expressed no desire for change, their ongoing participation on the programme will need to be reviewed so that the best way forward for them can be agreed.

It may also be useful to take a copy of completed H❻4 so that you will be able to provide this to participants on the final session (in case this mislay it). Make sure you get the groups permission if you want to copy this Handout.

Aims

- To introduce Personal Action Plans
- To introduce Drug Diaries

Learning Outcomes

At the end of Module 7, participants will be able to:

- Demonstrate an understanding in breaking down a goal into logical steps
- Complete an entry in their personal drug diary, identifying triggers, feelings, behaviours and consequences with respect to drug or alcohol use

Materials Needed

- Folders for each participant
- Flip chart paper and marker for noting discussions.
- Copies of Handouts H ❼1, H ❼2, H ❼3 for each participant
- Spare copies of H ❼3 for participants to take home with them to complete before next session
- Copy of Module ❼ Attendance Sheet

		Approximate guide (minutes)
1.	Check-in	10
2.	Goal Review	10
3.	Personal Action Plans	10
	Davina's Plan	10
4.	Stop and Think	10
5.	Immediate Responses	15
Tea / Coffee Break		15
6.	Long Term Alternatives	10
7.	Rewards	10
8.	Drug Diaries	20
9.	Check out	5

M7

FACILITATOR GUIDELINES

1. Check-in

- Ask each participant to name one activity they like to do that does not involve using drugs. Write these up on the flipchart.

- Send around the signing in sheet

2. Goal Review

Give each participant a copy of their completed 'My Goals' H❻4 from the previous module. Ask them to read over and reflect on their goals and make sure that they are confident and happy about them.

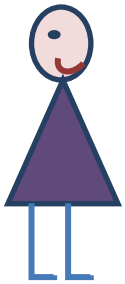
Tell the group that they are now going to learn how to put an Action Plan in place that will help them achieve their goals.

3. Personal Action Plan

Lead the discussion by explaining that people are much more likely to succeed in achieving goals if they have done some planning beforehand. This is because they will have thought about how realistic their goals are, what kind of problems they might come across, the ways they can get round these problems, the supports they might need in times of crisis or cravings, etc.

The more thought put into this planning stage, the more they are likely to be prepared when they hit a problem. We find that using an analogy often helps. For example, if you want to go a city on the other side of Ireland, it makes sense to first work out how you are going to get there before just jumping up and setting off. For example, will you get a bus, a train or drive? What time is the bus? Where does it leave from? When does it leave? How much does it cost? You need to know all this in advance to make the trip easier and more likely to be successful.

Exercise



Give each member a copy of H❼1.

Ask the group to read the instructions and complete the exercise i.e. to list the steps that 'Davina' will need to think of and work out to help make her detox goal realistic.

After 5 minutes get feedback from the group and put all suggestions up on a flipchart.

Explain that when putting together their Personal Action Plan there are FOUR steps to follow and the module today will go through all of these steps and will give them the opportunity to write up their own Personal Action Plan.

4. Personal Action Plans

Give each member a copy of H❼2 and read through it with the group.

Step One - Stop and Think

Explain to the group that it's important to give themselves a moment to reflect and think if they are faced with a thought that could lead to them 'using'. Explain that it is normal to have thoughts of using. They **will** happen and these thoughts don't just 'switch off' automatically. The important thing is to **expect** them and to be ready and prepared to change them before they put you in danger of using.

Exercise

Give each member a copy of H❼3

Explain that this is a visual aid to remind them to STOP and think.

Ask the participants to think about a common negative thought that they have about themselves. The facilitator might like to recall some of the previous statements made by participants about their negative thoughts.

Ask the participants to look at their handout – STOP SIGN! Ask them to interrupt this thought by calling out, in their head, the word STOP! They can repeat this as often as they like. In our experience some participants may want to share their negative thoughts and shout the word STOP out loud. That's fine and should be facilitated.

The group can be encouraged to use more than one example. The important thing about this exercise is to get the participant used to associating the word STOP with the negative thoughts.

Ask the group for feedback on this technique. Does it help? Do they think they can use it in real life? How did it feel?

5. Step Two: 'Immediate Responses'

When someone is tempted to use or finds themselves in an unexpected risk situation, it is very useful to have a mental list of 'immediate responses' that they can tap into. Ask the group to think of some common triggers and some possible responses to these, i.e.

- "*When the thoughts or cravings are very strong, I need to go to a meeting'*
- *'If I'm tempted to score, I need to talk to my brother. He'll sort me out and I know I won't score then'*

You may wish to write these on a flipchart. Make sure that each participant has their own mental list of 'Immediate Responses'

6. Step Three: Long Term Alternatives

It is important, when trying to reduce or stop drug or alcohol use, to find something else interesting to do to distract yourself. Feeling bored, isolated and lonely can be powerful triggers and can lead back to old behaviours and habits.

Being aware that these feelings are natural and happen to everybody will help each person to understand and prepare for them.

Exercise

Ask the group to name as many possible alternative activities that they could do to either deflect these feelings or to deal with them when they come over them. Refer to flipchart you wrote up at the very beginning of the session and add to this.

Type up this feedback and give each participant a copy at the next module.

7. Step Four: 'Rewards'

Explain to the group that it is very natural to feel that they deserve a reward for doing so well at reducing or stopping their drug or alcohol use. Rightly so! However there is a danger that the reward

could end up being the drug itself and this is a very common reason for relapse. Explain that what they are going to do is to write some alternative rewards that would work for them.

Exercise

Ask the group to call out ideas for the kind of rewards that might work for them. Write these up on the flipchart and encourage the group to write them into their notebook.

Type up this feedback and give each participant a copy at the next module.

8. Drug Diaries

Explaining the Drug Diary H❼4

Hand out H❼4 to each participant. This is their own personal record and will be useful as time goes by to help identify triggers and patterns to their drug or alcohol use.

Explain that you have been working on the component parts of the diary for the last few weeks. For example, you have looked at triggers; automatic thinking; good and bad things about using or not using. The diary is just a way of putting all this together. It makes it easier then to look at the patterns that each person might have.

For example, the first column is the day and time that they felt an urge to use. Maybe this is the same day and time every week? By keeping a record, we might notice things like this.

Or, for example, the third column asks for thoughts or feelings. Maybe a person will notice that they use more often if they are feeling angry or sad or lonely.

When we understand our patterns, it is easier then to make plans that will address the higher risk situations.

Ask everybody to fill in at least one complete line across the drug diary. Check that everybody has a good understanding of what is being asked.

A common question is what does a person do if they haven't used. Let people know that they are to fill it in, for any time they felt the urge to use – whether they did or not.

Explain to the group that you will be asking them to take a copy of **the Drug Diary** H❼4 home, so that they can fill it in during the week.

Check that everybody is ok with being asked to do this. If a participant does not have a safe environment at home, and/or they do not want family to know they are participating in Reduce the Use, then suggest that you could arrange a time to meet them in between sessions to work on the Drug Diary. (This will only take about 30 minutes).

Explain to the group that you will be working on Drug Diaries in every session from now on.

9. Group Check-Out

Ask the participants to name the most helpful thing they learned from this module

Note to facilitators:

Make sure each participant has spare copies of H❼4 *for participants to take home with them to complete before next session.*

If any participant needs help with this, arrange a suitable time and place to meet up with them in between group modules.

Cravings

M8

Aims

- To understand the experience of craving and to convey the nature of craving as a normal, time limited experience.
- To identify craving triggers
- To give practical techniques on how to move through a craving

Learning Outcomes

At the end of Module 8, participants will be able to:

- Outline an understanding of cravings
- Identify 3 ways in which to move through a craving

Materials Needed

- Folders for each participant
- Flip chart paper and marker for noting discussions.
- Credit card sized piece of cardboard for each participant
- Coloured markers, pens, pencils etc. for decorating
- Copies of Handouts H 8 1, H 8 2, H 8 3 for each participant
- Spare copies of H 7 4 for participants to take home with them to complete before next session
- Copy of Module 8 Attendance Sheet
- Copies of typed 'Long Term Alternatives' list from Module 7 flipchart for each participant
- Copies of typed 'Rewards' list from Module 7 flipchart for each participant

		Approximate guide (minutes)
1.	Check-in	10
2.	Drug Diary Review	15
3.	What are Cravings?	35
Tea / Coffee Break		15
4.	How to Recognise a Craving	10
5.	Managing Cravings	10
6.	Affirmation Exercise	15
7.	Drug Diary	5
8.	Safe Plan / Check Out	5

M8

FACILITATOR GUIDELINES

1. Check-in

- Send around the signing in sheet
- Give each participant copies of the typed up 'Long Term Alternatives' list from Module 7 flipchart and the 'Rewards' list from Module 7 flipchart.
- Ask each participant one 'nice' or 'good' thing that they did, or that happened since the last session.

2. Drug Diary Review

Ask each participant to look at their completed 'Drug Diary' H❼4 from the previous module.

Ask participants to reflect on their Drug Diary. We have found that the following 'guiding' questions are useful to prompt discussion.

- Have they noticed any pattern to their trigger situations?
- Have they noticed any pattern to their automatic thoughts?
- Have they noticed any pattern to their feelings?

If any group member is comfortable enough to share their insight, this should be encouraged by the Facilitator as it may help others who are having difficulty identifying patterns. Encourage each member to continue with their Drug Diary throughout the duration of the programme.

3. What are Cravings?

Explain to the group that the word 'craving' is used a lot by people without much thinking as to what it actually is. For some members of your group, the term craving will mean one thing and for others it will mean something completely different.

As a way of starting the discussion, ask the group to think of what words they could use to describe a craving. Write all suggestions up on the flipchart.

While cravings for different drugs might produce different physical effects on the body, the impact tends to be the same – they produce an intense longing or need to use the drug. In our experience many of our participants say that they sometimes take a certain drug or drugs because of habit or boredom or simply because it was available. They didn't experience an intense 'craving' in that sense – but they did experience the urge or 'need' to take the drug. Sometimes they will take the drug to avoid the craving.

Cravings are a completely normal part of the process of reducing or stopping drug or alcohol use. They should be expected and there is no need to fear them. They can happen at any time and will be different from person to person. The important thing to get across to your group is that they will pass. They can learn how to cope with cravings.

Cravings tend to happen in two ways.

1. Sudden onset

One can experience sudden onset cravings which can be brought about by being in a high risk trigger situation. These can be intense moments of wanting to use the drug or drugs which can put the person at risk of using. With practice, you can learn how to avoid these situations in the first place but in the early days they can sometimes catch you unaware. Sudden onset cravings or urges can be triggered by things around you that remind you of using drugs. It may be a song you hear on the radio, a smell, an object you see or a feeling that you are having. These cravings can appear long after you have ceased to use the drug and may take you by surprise.

2. Ongoing urges

Other types of cravings can be best described as an ongoing gnawing feeling in the pit of your stomach that you believe can only be satisfied by using the drug. These urges or cravings will be stronger during the early stages of reducing their drug or alcohol use and will lessen over time.

What do cravings feel like?

Depending on the type of drug, cravings can cause different reactions. They can have a physical and psychological effect.

Most drugs can produce physical and well as psychological cravings. Drugs such as opiates, benzodiazepines and alcohol will cause physical withdrawal symptoms and should be reduced slowly and, depending on history of previous use, with medical supervision. Other drugs such as cocaine, crack cocaine and other stimulants will cause strong psychological cravings.

Exercise

Give each participant a copy of H 8️⃣1 Symptoms of Withdrawals

Using this handout, go through the list of withdrawals from the various drug groups. If your group members have been chronic poly-drug using for some time, they will need to know what to expect if they start reducing their use. Withdrawal symptoms can be minimised by slow reduction.

Ask your group to comment on the list and if they can identify with these descriptions. Ask if they have any other experiences. Record any additions on the flipchart.

Exercise

Give each participant a copy of H 8️⃣2 Understanding Cravings

Using this handout, go through it with the group. We have found that it is useful to ask each person to read out one statement from the list. When they have finished ask the group if they recognise any of the signs. Are there other ones they want to add? Use the flipchart to record discussion and ask them to write any additional ones on their handout.

4. How to Recognise a Craving

Ask participants to think of the last time they experienced a strong craving or an urge to use. While thinking of this situation ask them to think about what triggered off this craving. Encourage them to write any notes in their notebook.

Here are some prompting questions which you might like to pose:

- Was it someone they saw?
- Was it something they smelled?
- Was it something they heard?
- Was it something they felt?

When they have finished, remind them that cravings can be managed and the next thing they are going to do is to look at ways of managing them. Lots of people have cravings and get through them. It can be done. They will most likely have gotten through many cravings in their time.

5. Managing Cravings

Give each participant a copy of H❽3 **Six Steps to managing Cravings** Read through the steps and discuss with the group, checking understanding. (Step Number 6 will be explained next)

6 Affirmation Card Exercise

Using notebooks / paper from their folders, ask each participant to write down some ideas for an affirmation statement that will help them stay motivated, especially if they are experiencing a craving or a desire to use. When they have finished writing down their ideas, help each participant to put together a strong statement that they are happy with and that means something special to them. The following are some possible affirmation statements to help the facilitator prompt participants if needed:

My family will be so proud of me

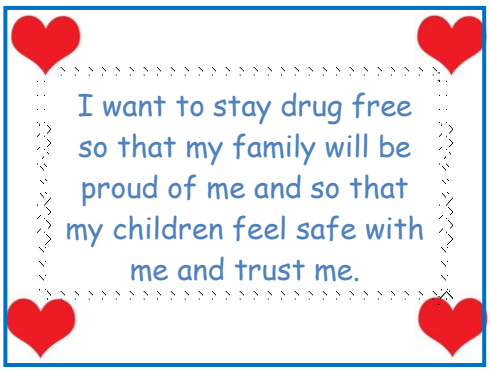
I feel stronger every day

I am very proud of myself

I am much stronger than I thought

When each person is happy that they have written the statement they like best, ask them to transfer this to their credit card sized card so that they can carry it around in their wallet or purse as a reminder of why they have reduced or stopped their drug use. Participants often like to decorate this card, so have pens available.

The card could look something like this:



7 Drug Diary

Participants need to continue to keep their Drug Diary H❼4, up to date until the next module. If you have time you may want to use this space to let members complete their diary if they haven't already done so.

Make sure each participant has spare copies of H ❼4 *for participants to take home with them to complete before next session.*

If any participant needs help with this, arrange a suitable time and place to meet up with them in between group modules.

8 Check Out

Ask the participants to read out their Affirmation Card statement to the rest of the group. If they prefer to keep this personal, then ask them to say one positive thing about themselves.

Tell the group that being able to hold onto positive thoughts can be part of their Safe Plan and may help to reduce the harm to themselves or stay drug safe until the next meeting.

Aims

- To impart skills to participants for safe refusal skills

Learning Outcomes

At the end of Module 9, participants will be able to:

- Describe situations in which refusal skills may be needed
- Identify a range of techniques for refusing drugs / alcohol
- Role play a situation using refusal techniques

Materials Needed

- Folders for each participant
- Flip chart paper and marker for noting discussions.
- Copies of Handouts H ❾1, H ❾2, H ❾3 for each participant
- Spare copies of H ❼4 for participants to take home with them to complete before next session
- Copy of Module ❾ Attendance Sheet

		Approximate guide (minutes)
1.	Check-in	5
2.	Drug Diary Review	10
3.	Identify Trigger Situations	15
4.	Learning Refusal Skills	20
5.	Refusal Techniques Exercise	10
Tea / Coffee Break		15
6.	Role Play	35
7.	Drug Diary	5
8.	Safe Plan / Check Out	5

FACILITATOR GUIDELINES

1. Check-in

- Send around the signing in sheet

- Ask one person to start off by extending an invitation to the person on their left to go somewhere or do something. The person must refuse by starting with the words 'Thanks very much but.....' The rules are they must be polite, clear and aim not to offend, and must come up with a reason why they are refusing.

  Then that person invites the next person to somewhere, or to do something. Repeat until all have had a chance to refuse. We find that it is useful for the Facilitator to be the first one to refuse so that they can help set the tone of the exercise.

2. Drug Diary Review

Ask each participant to look at their completed 'Drug Diary' H❼4 from the previous module.

Ask participants to reflect on their Drug Diary. We have found that the following 'guiding' questions are useful to prompt discussion.

- Have they noticed any pattern to their trigger situations?
- Have they noticed any pattern to their automatic thoughts?
- Have they noticed any pattern to their feelings?

If any group member is comfortable enough to share their insight, this should be encouraged by the Facilitator as it may help others who are having difficulty identifying patterns. Encourage each member to continue with their Drug Diary throughout the duration of the programme.

3. Identify Trigger Situations

Ask the members to break up into pairs and identify one example each of a trigger situation which could happen unexpectedly i.e. where they would need to use their refusal skills. Get them to think about:

- Where it would happen?
- Who would be there?
- Any other things which would make the situation difficult, i.e. your best friend is offering you drugs.

Bring the group back together and get feedback. Write these up on a flipchart and display as these will be needed further on in this module.

4. Learning Refusal Skills

Explain to the group that many drug taking behaviours or habits have been learned by being practiced over and over again. Ask the group to consider how long they have been involved in using drugs and reflect on how deep those habits will have become. We are all comfortable with

familiarity. We have learned how to respond in the environment we know and this is our comfort zone.

If one is determined to change these behaviours or habits, it is necessary to practice new ways of relating to people and situations. This module is about starting to practise new ways to respond to trigger situations.

Exercise

If there are members in your group who have had 'drug-free time' ask them to share with others how they found the experience of refusing drugs.

Prompt questions

- What did it feel like?
- Were they nervous, anxious?
- Did they fear rejection?

If there are no members in your group who have experienced 'drug-free time' prompt the discussion to ask them if they have used drugs ***every time*** they have been in a trigger situation?

In our experience it would be most unusual, if not impossible, for someone to use drugs every single time they were confronted with a trigger or negative thought or craving.

What stopped them from using at these times?

- Lack of money?
- Fear of consequences?
- Worried for their health?
- Non -availability of the drug?

Most people will have decided at some point not to use drugs but don't often see it as a refusal. As the facilitator it is important that they identify what worked for them and how they can capitalise on this in the future. For example, if lack of money was the motivation for not using, then how can they make sure that they do not hold spare cash on them or have easy access to spare cash?

Give each participant a copy of H❾1 - **Tips for Refusing**. Ask participants to read through the list out loud in the group.

5. Refusal Techniques

Exercise

Give each participant a copy of H❾2. Ask them to think of an example when they refused drugs successfully. There is room for two examples on this worksheet and they may like to include a second.

(If a participant cannot immediately think of a time they have refused drugs or walked away from a high risk situation, help them by asking them if there was any time when they took a break from drugs. How did they do this? What were they thinking at the time? Who were they with? What stopped them?)

Next ask them to think about what they did to avoid using the drugs. Did they simply refuse and say no? Did they say they were in trouble with some authority, i.e. courts, social workers, doctor, and couldn't take the risk? Did they come up with another excuse? Ask them to write down what they did on H❾2.

6. Role Play/Group Feedback

Exercise

Ask if someone would like to share a refusal tip that they described in H❾2.

Ask them to share how it felt for them. Was it difficult? Did they feel uncomfortable? Did they feel good? See if others will also share their tips.

Record these Refusal Tips on the flipchart.

Type these up later and print them out as a handout for the next module.

From the flipchart list ask the group to select a Refusal Tip that they would like to role play in the group.

The role play can involve as many people as is needed for the situation. Ask for volunteers to play the two main parts – i.e. the person refusing drugs and the person(s) offering drugs. Remind them that this is a role play and they will be taking on character parts.

Those who are not playing characters will act as observers and will give feedback.

The steps for managing the Role Play are as follows;

a. Decide on the situation and the Refusal Tip
b. The person practicing their refusal skills assumes the role of the director
c. They are going to direct the other characters by telling them what to do and say
d. They may get the actors to say a few practice lines in character
e. The director can give them a few pointers to help them to act more like the character/s
f. The facilitator should prompt the director by asking questions such as 'is that how the character sounds and acts'? The more realistic it is for the director, the more they will learn from the experience
g. The role play begins once the director is happy with how the characters are playing the roles. The director assumes their own role in the situation.
h. The facilitator needs to instruct the actors to make the role play as real as possible
i. The facilitator should end the module when the main character has had an opportunity to use their refusal skills and walk away.

The Facilitator asks the actors to come out of character and 'back into the room'. The actors should be given an opportunity to feedback how the role play was for them.

Next, ask the observers for their feedback. You might find the following guidelines useful:

- Could they identify with the situation?
- What was positive about the role play?
- Could they suggest any improvements on the refusal techniques?

The facilitator should use the 'tips' covered in H❾1 to feedback on the role plays, i.e. did they make direct eye contact? Did they close the door on future offers?

Repeat the role play as many times as possible within the time, using different situations that the group have identified on the flipchart.

7 Drug Diary

Participants need to continue to keep their Drug Diary H❼4, up to date until the next module. If you have time you may want to use this space to let members complete their diary if they haven't already done so.

Make sure each participant has spare copies of H❼4 *for participants to take home with them to complete before next session.*

If any participant needs help with this, arrange a suitable time and place to meet up with them in between group modules.

8 Check Out / Safe Plan

Give each participant a copy of H❾3. Ask them to write down at least three sentences they could say, to refuse drugs or alcohol. These sentences could include new ones that they have heard in the group today and that they think might work, or the sentences could be ones that they have used already at some time.
For the check out ask each participant to share their favourite sentence from this Handout.

Aims

- To understand relapse as a process and an event
- To look at relapse prevention in the overall context of reducing harm
- To understand personal relapse warning signs
- To construct a personal Relapse Prevention Plan

Learning Outcomes

At the end of Module 10, participants will be able to:

- Describe a range of relapse warning signs
- Identify actions they could take to prevent relapse

Materials Needed

- Folders for each participant
- Flip chart paper and marker for noting discussions.
- Copies of Handouts H ❿1, H ❿2, H ❿3, H ❿4 for each participant
- Spare copies of H ❼4 for participants to take home with them to complete before next session
- Copy of Module ❿ Attendance Sheet

		Approximate guide (minutes)
1.	Check-in	5
2.	Drug Diary Review	10
3.	Defining Relapse	15
4.	Relapse Warning Signs	15
5.	Relapse Prevention Plan	15
Tea / Coffee Break		15
6.	Reducing Harm	25
7.	Drug Diary	15
8.	Safe Plan / Check Out	5

FACILITATOR GUIDELINES

1. Check-in

- Send around the signing in sheet

- Ask participants to name one piece of advice they were given, or one tip they have learned that has helped them to avoid slipping.

  (They might have later slipped or relapsed but the advice /tip helped for a particular moment.)

2. Drug Diary Review

Ask each participant to look at their completed 'Drug Diary' H ❼4 from the previous module.

Ask participants to reflect on their Drug Diary. We have found that the following 'guiding' questions are useful to prompt discussion.

- Have they noticed any pattern to their trigger situations?
- Have they noticed any pattern to their automatic thoughts?
- Have they noticed any pattern to their feelings?

If any group member is comfortable enough to share their insight, this should be encouraged by the Facilitator as it may help others who are having difficulty identifying patterns. Encourage each member to continue with their Drug Diary throughout the duration of the programme.

3. Defining Relapse

Ask the group to tell you what they understand by the word relapse. Write all ideas up on the flipchart.

In our experience, most people see a relapse as the point at which they are using uncontrollably after a period of not using. Many participants use the word 'slip' to describe intermittent use and don't necessarily class this as a 'relapse'.

The truth of course is that relapse is a slow process that usually begins long before the person actually uses again. The steps to a relapse are actually changes in attitudes, feelings and behaviours that gradually lead to the final step, picking up a drink or a drug.

Drug or alcohol relapse, while not inevitable, is very common. The better prepared the participant is, the better chance they will have of staving off a relapse or preventing it altogether. People sometimes make the mistake of believing that now that they can control their drug use, they are in no danger by being around others who are using. Eventually they may convince themselves that they can use the drug sparingly because they now have the tools to quit using it. Returning to old habits is the easiest way to relapse back into using drugs. Places, friends and situations that previously encouraged your drug or alcohol use should be avoided at all costs.

For most people there will be warning signs over a period of days or weeks before they actually resume their drug or alcohol taking. It is crucial that participants understand that they can stop the process of relapse before they reach the stage of taking a drug by becoming aware of their relapsing thoughts i.e. negative thinking or fantasising about a particular drug or alcohol. In other words, relapse can be seen as a process that begins when a person's thinking pattern changes.

4. Relapse Warning Signs

Exercise

Give the group a copy of H ⑩ 1**– Relapse Warning Signs.**

Discuss the four relapse warning areas –

- Changes in Behaviour
- Changes in Attitude
- Reverting to Addictive Thinking
- Changes in Feelings or Moods

Ask the group to add their own examples.

Once you have covered all the points on the chart, get the group to elaborate on why ignoring these warning signs can lead to relapse. Some examples we have found useful are:

a. If someone is feeling negative for a long period of time, then self destructive behaviour such as drug or alcohol using may be a practiced response to this.

b. If someone has not wanted to talk to their usual support people for a period of time, then this may lead to them feeling more isolated, which in turn increases their desire to use.

5. Personal Relapse Prevention Plan

Give each participant a copy of H ⑩ 2**– My Relapse Prevention Plan**

Ask them to complete Part 1 of this worksheet, using the previous discussion and Dave's example as a guide. When they have completed the worksheet, ask for feedback and write this up on a flipchart.

Using the examples of warning signs H ⑩ 1 and the flipchart page ask the group to suggest interventions that they can put into action to help prevent relapsing. Remember that these need to be practical and achievable. Now ask participants to complete Part 2 of H ⑩ 2**– My Relapse Prevention Plan**.

When the group has had enough time to complete their Relapse Plan bring the group back together and ask how they felt about the exercise.

6. Reducing Harm

Introduce the topic of Reducing Harm by saying that the Reduce the Use programme is a programme of harm reduction. All this means is that recovery in addiction can take many forms, from total abstinence to minimising the harms caused by the use of drugs and alcohol. The new National Strategy in Ireland promotes this approach too: 'Reducing Harm, Supporting Recovery, 2017 – 2025' aims to provide an integrated public health approach to drug and alcohol use, focused on promoting healthier lifestyles within society.

Give each participant a copy of H ⑩ 3**– Reducing Harm**

This handout has eight statements, all connected in some ways to the principles of Reducing Harm.

Exercise

Depending on the size of your group, you could ask people to work in pairs and give each pair one of the statements to discuss – and report back to the group. Or you could lead a full group discussion working through the statements in turn.

The aim of this exercise is to encourage participants to think about their own journey through recovery.

It is our experience that people may often be stuck in thinking that detoxification, for example, is the only way forward. And when this seems unachievable at the present time, then this can be used as a way of putting off any changes. Reducing harm provides options for multiple tiny steps.

7 Drug Diary

Participants need to continue to keep their Drug Diary H ❼4, up to date until the next module. If you have time you may want to use this space to let members complete their diary if they haven't already done so.

Make sure each participant has spare copies of H ❼4 *for participants to take home with them to complete before next session.*

If any participant needs help with this, arrange a suitable time and place to meet up with them in between group modules.

8 Check Out / Safe Plan

Ask each participant to pick out their most common warning sign (from Part 1 of their Personal Relapse Prevention Plan) and to pick out their 'best' intervention (from Part 2 of their Personal Relapse Prevention Plan). Get them to write these down in their Safe Plan H ❿4.

Ask each participant to share with the rest of the group. Sharing these insights with each other will help all participants with the prevention of relapse.

Aims

- To emphasise the importance of self-care to participants
- To identify appropriate support systems
- To impart a range of techniques / skills to participants for self-care and support

Learning Outcomes

At the end of Module 11, participants will be able to:

- Identify a range of techniques for self care
- Devise an appropriate self-care plan

Materials Needed

- Folders for each participant
- Flip chart paper and marker for noting discussions.
- Copies of Handouts H 11 1, H 11 2, H 11 3, H 11 4, H 11 5 for each participant
- List of relevant Social Support Agencies and phone numbers (e.g. Samaritans, Drug Help lines, etc)
- Spare copies of H 7 4 for participants to take home with them to complete before next session
- Copy of Module 11 Attendance Sheet

		Approximate guide (minutes)
1.	Check-in- 'There's a Hole in my Path'	10
2.	Drug Diary Review	15
3.	Why Self Care is so Important	15
4.	Self Care Inventory	20
Tea / Coffee Break		15
5.	Social Support Systems	35
6.	Drug Diary	5
7.	Safe Plan / Check Out	5

FACILITATOR GUIDELINES

1. Check-in

- Send around the signing in sheet

- Give participants a copy of H 11.1 - **There's a hole in my path**

  Ask for five volunteers to read each step out loud.

  Ask the group for feedback on the Handout.

2. Drug Diary Review / H 11.2

Give participants a copy of H 11.2. Read the quote from Viktor Frankl out loud: '*Between stimulus and response there is a space. In that space is our power to choose our response. In our response lies our growth and freedom'.*

Ask each participant to look at their latest completed 'Drug Diary' H 7.4.

Ask participants to reflect on their Drug Diary thinking about their power to choose a response.

Useful 'guiding' questions might help prompt discussion:

- Is there a chance to choose between trigger and thought?
- Is there a chance to choose between a trigger and feeling?
- Is there a chance to choose between thinking and using?

3. The Importance of Self-Care

Facilitate a discussion about self-care.
In our experience, people in addiction often struggle both in understanding the importance of self-care and in practicing self-care techniques. Therefore, you may need to direct the discussion to help participants engage.
Prompt questions might include:

- What do you currently do to look after yourself?- give examples
- Do you think you do a good job at looking after yourself? - give examples
- Is it easier to look after others or to look after yourself? – give examples
- Do you think people in addiction in general, are good at looking after themselves?
- Why might it be different / difficult for people in addiction?
- Why is self-care important?

Write all comments up on the flipchart.

4. A Self-Care Rating Scale

Give each participant a copy of H 11.3 – Self Care Rating Scale
Explain that you are now going to look at a Self-Care Rating Scale. This particular one is taken from Virginia Satir. She has defined 8 categories that need care. (Other rating scales might look at different areas).

Read through each category with the group to ensure everybody understands the area of self-care that it relates to. The examples will help.
Then ask each participant to rate themselves for each category by circling the number
e.g. 1 ② 3 4 5

5 = Excellent Form
1 = Needs Work

When each person has completed the form ask for some feedback from the group on how it felt to do this exercise.

5. Social Support Systems

A social support system is a network of people or organisations that you can turn to when you need help or support. It can consist of family, friends, loved ones, professionals and agencies that you turn to when you just need a 'chat' or when you are feeling lonely or experiencing cravings, etc.

Using drugs can have a negative effect on a person's support system i.e. the people around them that are normally willing to support them through difficult times. Family members, partners and friends can often be annoyed and frustrated with the person for wasting their life using drugs and all the trouble that resulted. This can reduce down the amount of positive supportive people that participants feel they have in their lives. It is surprisingly easy and common for people in addiction to be socially isolated.

Some people in the group may have more people in their network than others but its important to stress that its quality and not quantity that counts. Also using their supports wisely will enhance the support benefits.

Exercise
Write the phrase 'Social Support System' on the flip chart. Ask the group to brainstorm the type of people and agencies that could be a support to someone. Make sure to include:

- Immediate family members
- Extended family members
- Partners / friends
- NA sponsors/members
- Doctors, counsellors, support agencies and organisations
- Key workers or drug workers

Explain to the group that you are going to ask them to identify their own Personal Social Support System. Encourage them to consider carefully the appropriateness of the individuals that they wish to include in their personal support system. Naming someone who is not in a good position to support them at this time will defeat the purpose of the exercise.

Give each participant a copy of H 11 4 and ask the group to complete the sheet. If anyone is having difficulties identifying supports, encourage them by making some suggestions. Can you or your agency be a support for them?

Have a sheet prepared for each participant that outlines some local helpline numbers available e.g. AA, NA, Samaritans, etc.

The group should be encouraged to share their list of agencies as others might benefit from that knowledge.

6 Drug Diary

Participants need to continue to keep their Drug Diary H❼4, up to date. If you have time you may want to use this space to let members complete their diary if they haven't already done so.

Make sure each participant has spare copies of H❼4 *for participants to take home with them to complete before next session.*

If any participant needs help with this, arrange a suitable time and place to meet up with them in between group modules.

8 Check Out / Safe Plan

Give each participant a copy of H⓫5. .
Read through the information about Davina. Ask each participant to identify **3** self-care activities for that Davina might do to look after herself better – for social, nutritional and physical categories.
Then ask participants to identify **1 thing** they could do for themselves for each of these categories.

For the check out, as everybody to share one of their self-care plans with the rest of the group.

Aims

- To review all parts of the programme
- To evaluate and reinforce the learning
- To celebrate and certify attendance and learning

Learning Outcomes

At the end of Module 12, participants will be able to:

- Evaluate their learning by completing a questionnaire
- Identify a key point of learning for themselves

Materials Needed

- Folders for each participant
- Flip chart paper and marker for noting discussions.
- Copies of Handouts H12 1, H12 2 for each participant
- Copies of participants completed H6 4 – My Goals, for review
- Spare copies of H7 4 for participants to take home with them
- Copy of Module 12 Attendance Sheet
- Certificates of Completion and Attendance

		Approximate guide (minutes)
1.	Check-in	10
2.	Course Evaluation and Reflection	35
3.	Play it Forward	15
Tea / Coffee Break		15
4.	Course Closure Ceremony and Certificates	30
5.	Final Check Out	10

FACILITATOR GUIDELINES

1. Check-in

- Send around the signing in sheet

- Ask participants to describe in one word what they are feeling coming into the final group of Reduce the Use.

2 Evaluation of Course Programme

Facilitator asks each group member to gather their folders together for a reflection on the programme. It might be useful to ask the group to look through their folders as oftentimes details of the topics covered can be forgotten.

Specifically ask participants to look at their copy of H6 4 – My Goals. (*Have a copy of this available if possible).* Have they achieved this goal?

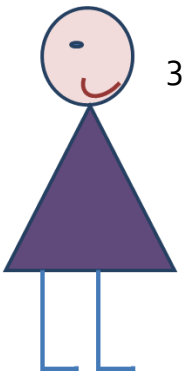
H12 1 - **Review and Evaluation**

Explain that you are asking each participant to individually complete H12 1 - **Review and Evaluation.** This will be a useful way for participants to be reminded of how much work they have completed over the last 12 sessions and a way for them to evaluate their learning. It will also be useful for you as a Facilitator to see what has worked well in this group.

When everybody has finished, ask them to come back together as a group and encourage them to share their findings with the rest of the group.

For example, what part of the course did they find least beneficial, what part did they find most beneficial?

Write the key points up on the flipchart for evaluation purposes. Reinforce the learning by encouraging group discussion. If there are any participants who feel they would benefit from another opportunity to re-do the course, take their details and arrange a follow up appointment with them. Retain H12 1 for your own review and evaluations.



3. Thinking Ahead

H12 2 – Play it Forward

Give each participant a copy of H12 2. Read through the instruction together: 'If I met you on O'Connell Street in three years' time, and said ***'How are you? What are you up to these days?'*** what would you say?'. Read through Davina's example.

Tell the group that you want them to think creatively. Rather than just 'I'm fine' as an answer, what might they be doing during the day? Working? What as? In college? Studying what? Where would they be living? What about relationships? Children? Holidays?

When everybody has filled in something, bring the group back together. Ask participants to share <u>one</u> of their answers to what they will be doing in 3 years time.

4. Course Closure Ceremony and Certificates

Finish by affirming the group for their participation in the programme. Remind them that they are all unique individuals with free will and that they can do anything they put their mind to with the right knowledge and supports. Let the group know that your agency will be there for them if they need to clarify anything or need some help and guidance and let them know how they can access this.

Finally finish off by awarding Programme Completion Certificates to those who covered the full programme. Record of Attendance Certificates may be given to those who did not manage to complete the entire programme but who, nonetheless, attended several sessions. Copies of these are attached to this pack and can be photocopied directly onto certificate style blank paper.

5. Final Check-out

Ask each participant to name one thing above all else that stands out for them during the course of the programme – perhaps a new insight or learning, perhaps a new support they have identified, perhaps a new strength they have found.

Then ask them to make a strong, positive statement about themselves – something that they like or admire about themselves or something that will inspire them during their recovery.

The Facilitator should finish the session by affirming everyone for their participation and, once again, reminding them of the supports available to them from the project or agency.

Participants are encouraged to take their folders home with them.
If they do not want to do this, you may be able to store them in your agency / organisation. Note that personal information contained in individual folders is confidential, and so should be stored carefully.

Participants are also encouraged to take home spare copies of the Drug Diary H ❼4 *to continue and maintain their progress in reducing use.*

Reduce the Use

Attendance Sheets

M

Please photocopy and retain in original manual

MODULE SIGNING IN ATTENDANCE SHEET

Date: _____ Facilitator(s) _____

MODULE SIGNING IN ATTENDANCE SHEET

Date: _____ Facilitator(s) _____

MODULE SIGNING IN ATTENDANCE SHEET

Date: _____ Facilitator(s) _____

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MODULE SIGNING IN ATTENDANCE SHEET

Date: _____ Facilitator(s) _____

MODULE SIGNING IN ATTENDANCE SHEET

Date: _____ Facilitator(s) _____

Record of Attendance

This is to certify that:

_____

has attended _____ modules in the

Reduce the Use

Addiction Programme facilitated by:

_____

Signed: _____

Date: _____

Certificate of Completion

This is to certify that:

_____

has successfully completed the

Reduce the Use

Addiction Programme facilitated by:

_____

Signed: _____

Date: _____

Reduce the Use

Participant Handouts

H

Please photocopy and retain in original manual

Commitment Contract

I agree to attend this course and to complete work assigned to me.

I agree that if I do not want to complete the course I will let the facilitator know and I will be welcome to re-engage in any future courses.

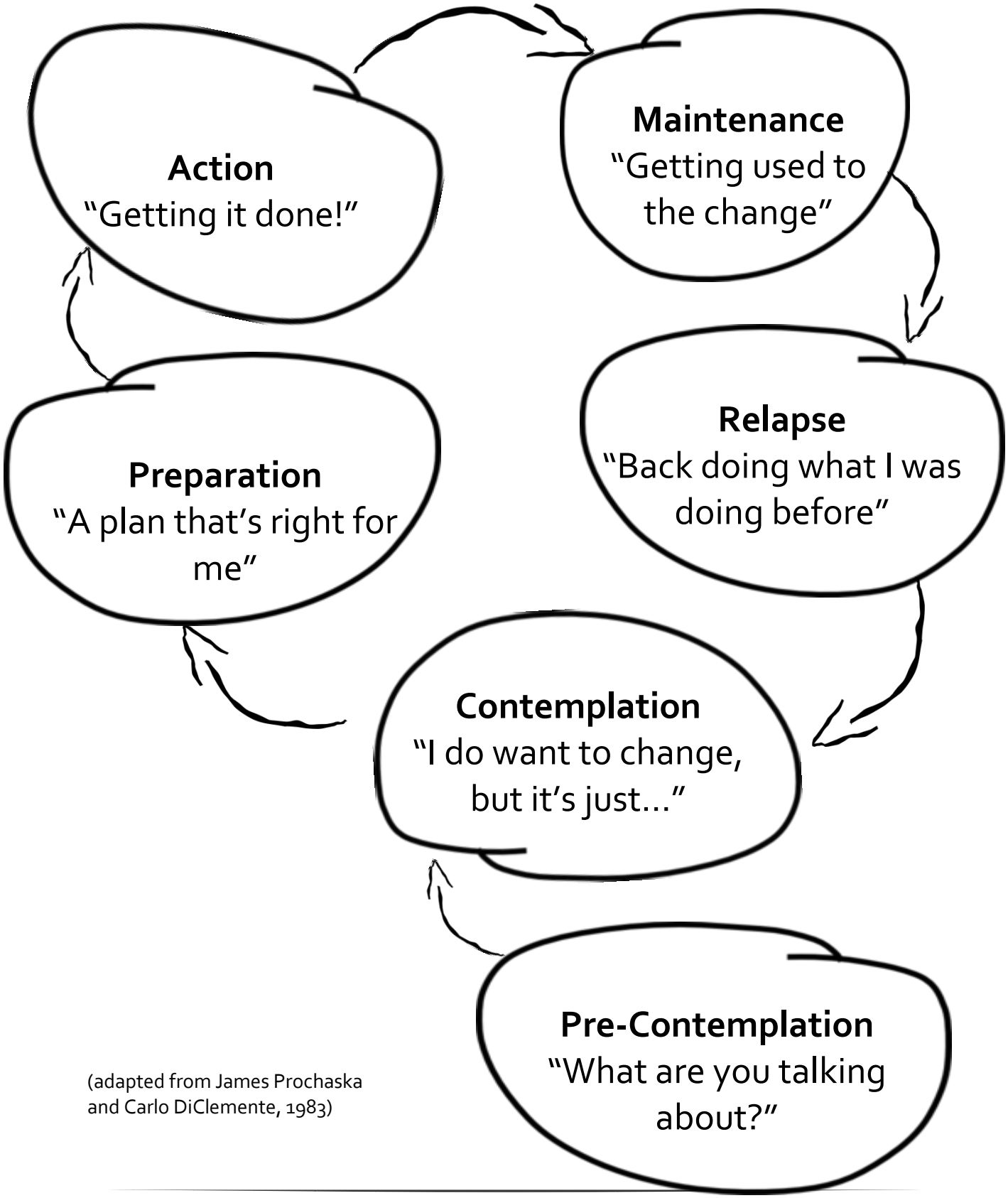
Signed: _____ Participant

Signed: _____ Course Facilitator

Date: _____

A copy should be kept by the participant and facilitator

The Wheel of Change



(adapted from James Prochaska and Carlo DiClemente, 1983)

The Wheel of Change Explained

Pre Contemplation - Happy User

This would describe the client who is not thinking about change at the moment. They may be unaware that they have a problem with drug or alcohol use or they may have simply given no thought to the possibility of a change of behaviour. Their addiction is 'working' for them and the benefits of their drug or alcohol use far outweigh the difficulties it might be causing. They have no interest or inclination to change behaviour patterns.

Contemplation - In two minds

This is the point where the client begins to recognise that there may be a problem with their behaviour and are thinking about the possibility of change. Sometimes this stage can be forced upon them by a crisis such as a fight with a partner or friend, a problem at work which has arisen because of a drug issue, childcare concerns, ill health, etc. These moments of insight can come and go very quickly so it is important to seize the opportunity and make the most of it when it arises.

Preparation - Get ready, get set

This is when the client decides to do something to change their drug or alcohol use and starts to put plans in place. Sometimes they might be determined to do something about their drug or alcohol use but can get scared or knocked back based on past experiences or if the reality of changing behaviour patterns is very difficult to contemplate. This planning stage can lead to action if the goals set here are realistic and attainable. For some people it might be impossible for them to see their way to achieving complete abstinence from their drug and alcohol use and therefore reducing their use can be a more realistic goal.

Action - Go! Action time

This is when the client has started to put their plans into action and have either stopped or reduced their drug or alcohol use to a less harmful state. This is a difficult time in the process of change. Often a client can feel like they have lost their best friend or that life is never going to be the same again. At this stage it is critically important that the client will have gained the insights and tools to help them stay on track and this is where Reduce the Use has the greatest impact.

Maintenance - Keep going!

This is the stage when it is most likely that you can make a permanent exit from the wheel and become a Happy Changer! As a general rule a person is said to have moved from the action stage to this stage after a period of about six months though this can vary from person to person. It is most important though that they continue to practice the new skills learned during Reduce the Use to ensure that they remain safe from high risk situations.

Relapse - Slips and Lapses

Slips and Relapses are not quite the same thing. It is possible for someone to have a 'slip', i.e. to return to using the drug or alcohol on a one off basis. If this happens and a client gets back onto the wheel of change immediately afterwards, then they can begin the work again. However frequent 'slips' can lead to a relapse and the client must be aware of the danger of allowing themselves to slip back. If the 'slips' become frequent and the client starts reverting to old behaviours and patterns of drug and alcohol use they can then be defined as suffering from a full relapse. Relapse can happen at any time during the change process but it is possible to recover from it and get back into the Action stage at any time.

Safe Plan

Between now and my next meeting I will keep myself safe from harm by:

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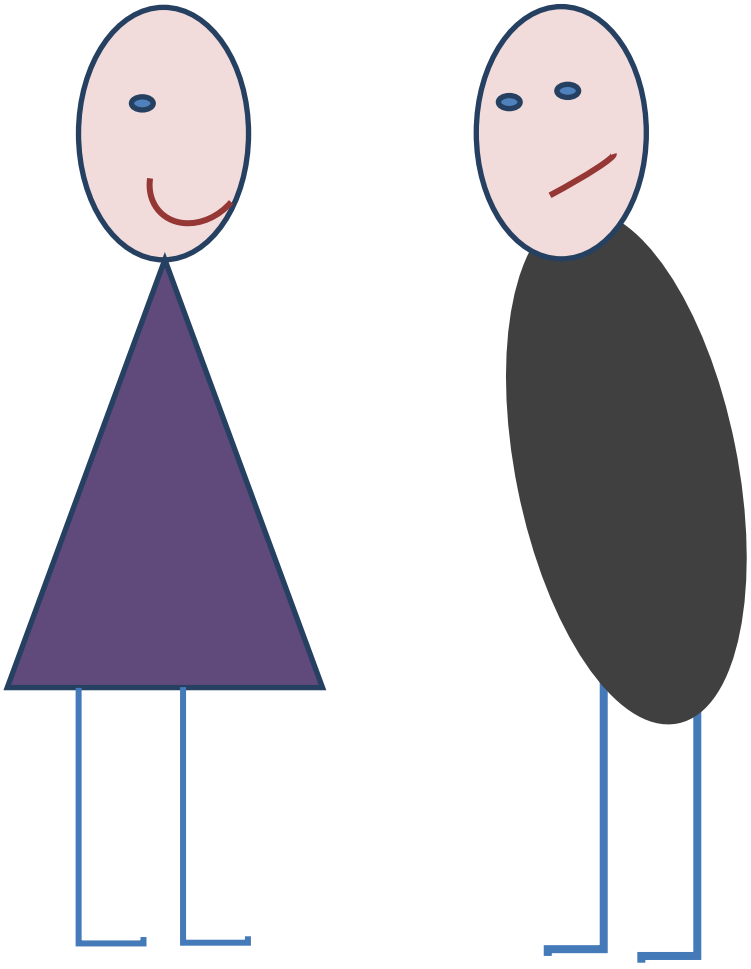
Name at least one way in which you could reduce the harm to yourself from drug / alcohol use; or avoid high risk situations; or can find supports.

You don't have to stick with one – you can name as many as you like.

Introducing Dave and Davina



Sample Story

Davina

Age 28
3 children 12year-old twin boys (with ADHD); 3 year-old daughter
Left school at 15 – just before Junior Cert
Substance use history:

- Alcohol (alcopops) at 11, and then vodka
- E's at 12
- Started smoking hash at about 12 / 13 years of age
- Doesn't smoke cigarettes – never has and never will

Medication – anti depressants, topping up with street drugs – zimovaine (to help her sleep)
Family – can be supportive sometimes.

Dave

Age 34
Father with Davina to their 3 year-old girl
Doesn't always come home every night
Works in construction
Substance use history:

- Cocaine
- Occasional steroids
- Pain killers (for back)
- Alcohol

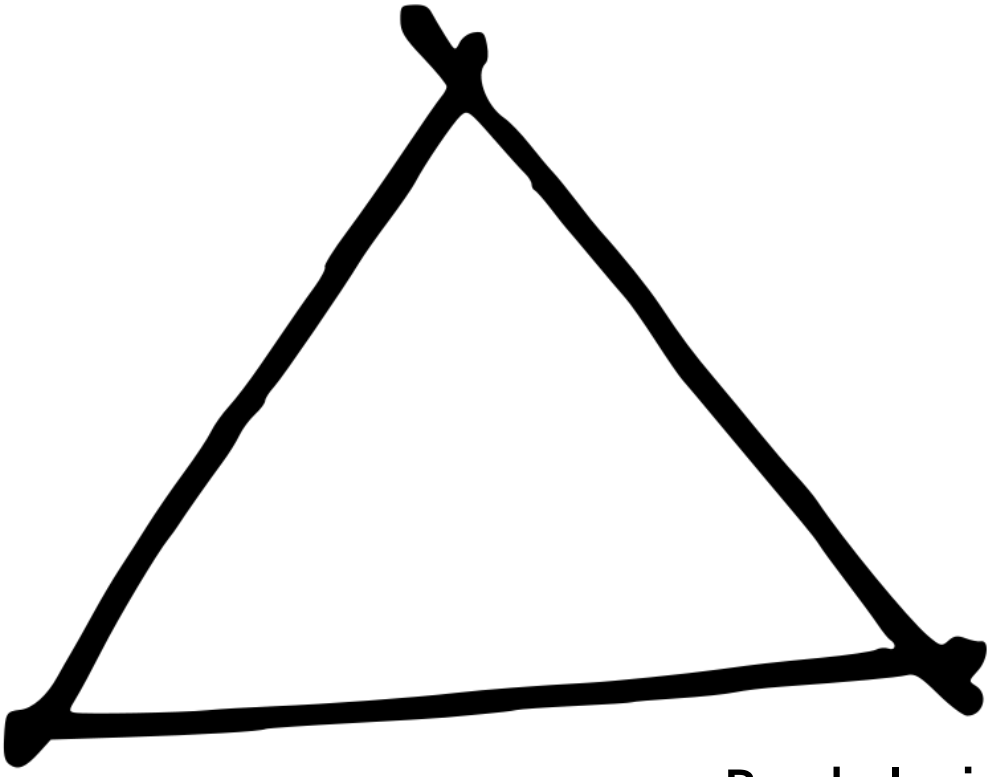
Has 'anger issues' and 'paranoia'.

Dave and Davina have a corporation house together. They are behind with the rent.

The Bio Psycho Social Model of Addiction

To do with the substance and the body

Biological



Social Cultural

To do with the world

Psychological

To do with the mind and the personality

Current Drug and Alcohol Use Inventory

Write down your current drug or alcohol use as honestly as you can remember. If a particular drug does not apply to you just leave the boxes blank. The first two lines are examples to get you started.

Substance	How much / many each time	How often (per week)	Cost per week
Alcohol	*Every day*	*About 4 cans a day*	*€42*
Tablets *Sleepers*	*Every day if I can get them*	*Some days 2 – other days 10*	*Can be up to €70 some weeks*

Substance	How much / many each time	How often (per week)	Cost per week
Alcohol			
Hash			
'Head shop'			
Cocaine			
Crack cocaine			
Tablets			
Type			
Type			
Type			
Heroin			
Extra methadone			
Other			
			Total cost per week

Example Safe Plan

Between now and my next meeting I will keep myself safe from harm by:

1. *Making sure I don't leave the house with much money in my pocket*

2. *Coming straight back from the school and not hanging around*

3. *Deleting certain phone numbers from my mobile*

4. *Calling a good friend if I feel the urge to use*

Name at least one way in which you will reduce the harm to yourself from drug/alcohol use or avoid high risk situations. You don't have to stick with one – you can name as many as you want.

Safe Plan

Between now and my next meeting I will keep myself safe from harm by:

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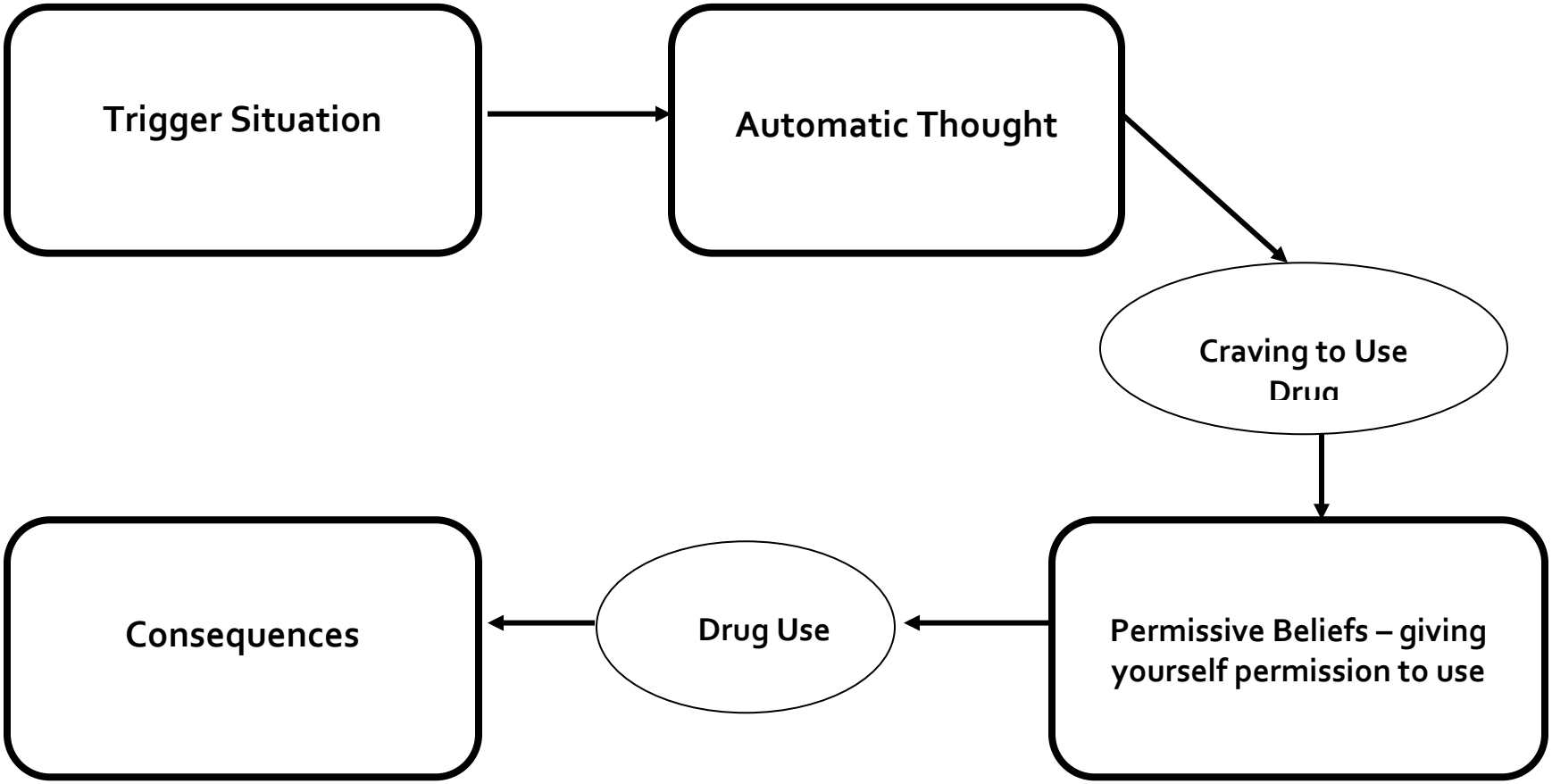
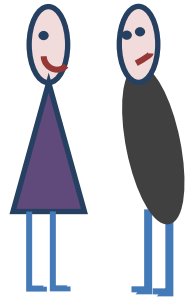
Name at least one way in which you could reduce the harm to yourself from drug / alcohol use; or avoid high risk situations; or can find supports.

You don't have to stick with one – you can name as many as you like.


Trigger Situation
Automatic Thought
Craving to Use Drug
Permissive Beliefs – giving yourself permission to use
Drug Use
Consequences



Trigger Situation

Dave sees his friends drinking at a party.

Automatic Thought

Having a drink is the only way I will enjoy this party.'

Craving to Use Drug

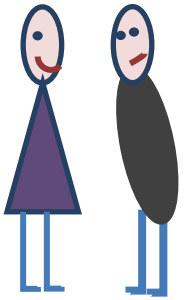
Permissive Beliefs – giving yourself permission to use

'It's only this once.' 'I deserve it with all the grief I get at home'

Drug Use

Consequences

Dave continues to drink heavily for the weekend. He meets up with friends and Dave stays in their home. Dave doesn't go home that weekend.



Trigger Situation

Davina has heard that her friend has got 20 'trays' of tablets.

Automatic Thought

'I haven't been sleeping well and a few might take the edge of me'

Craving to Use Drug

Permissive Beliefs – giving yourself permission to use

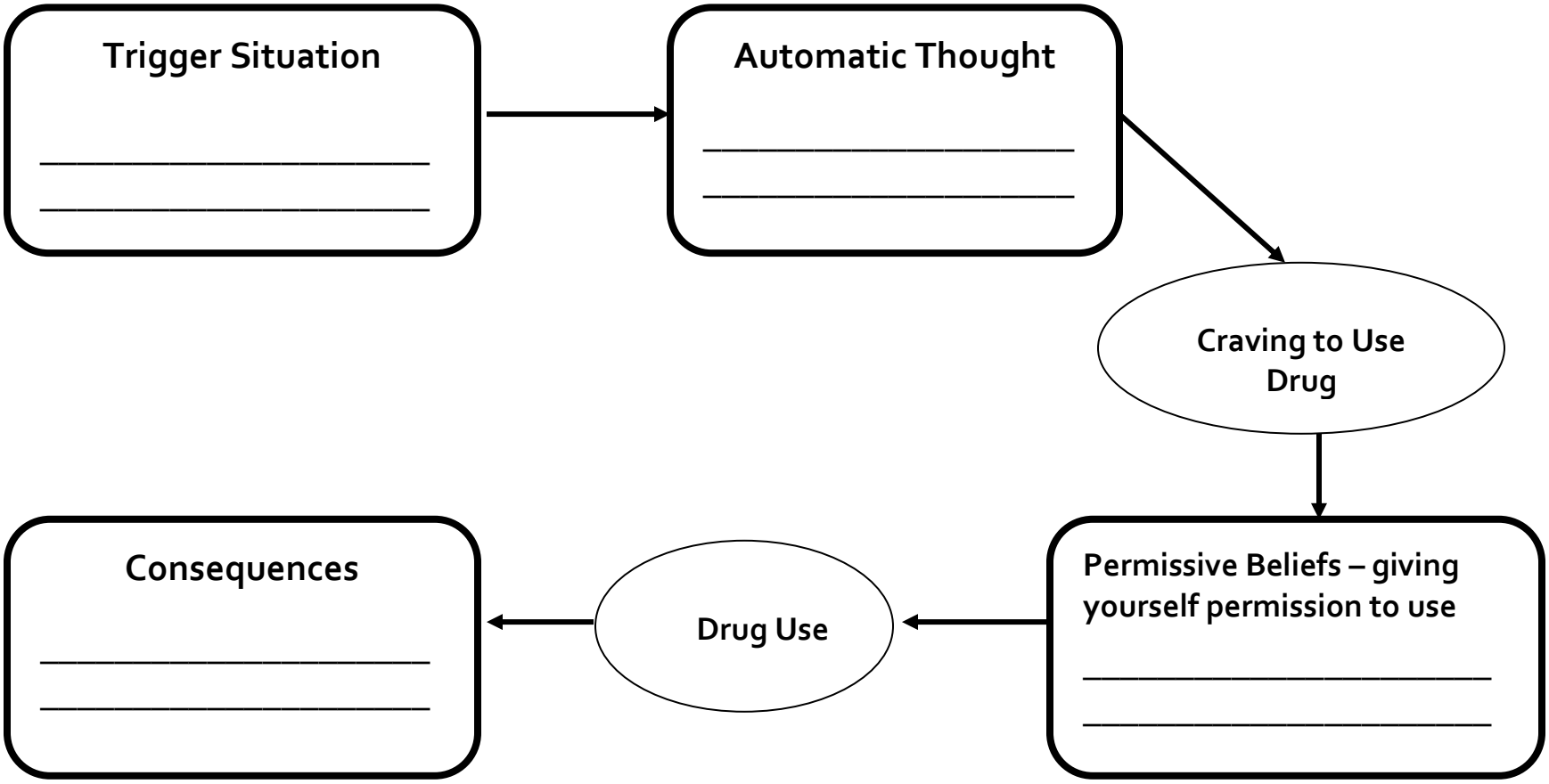
'It's only a few tablets to help me sleep. I'm wrecked with the twins. It's not like I will be taking them every day'

Drug Use

Consequences

Davina buys another tray and is short of money at the end of the week. She doesn't know what to tell Dave

Your Example



Triggers

Here are some situations. Mark them from 1 – 3 as you see fit
(1 = no temptation to use);
2 = slight temptation to use;
3 = strong temptation to use)

Risky situation	1	2	3
When I am angry			
When I feel sad			
When I'm around others who are using			
When I have money worries			
When I feel happy			
When I feel good about myself			
When I feel bored			
When I feel lonely			
When I feel guilty			
When I don't feel good about myself			
When I am offered other drugs			
When I have money to spend			

Safe Plan (for triggers)

Having identified a situation of higher risk (from the previous exercise H ❸5), try to work out a plan that will reduce the risk for you from this particular trigger.

First name the higher risk and the trigger, then outline your plan in detail.

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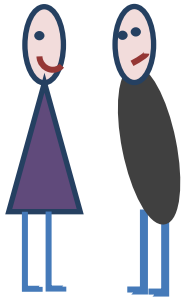
Name at least one way in which you could reduce the harm to yourself from drug / alcohol use; or avoid high risk situations; or can find supports.

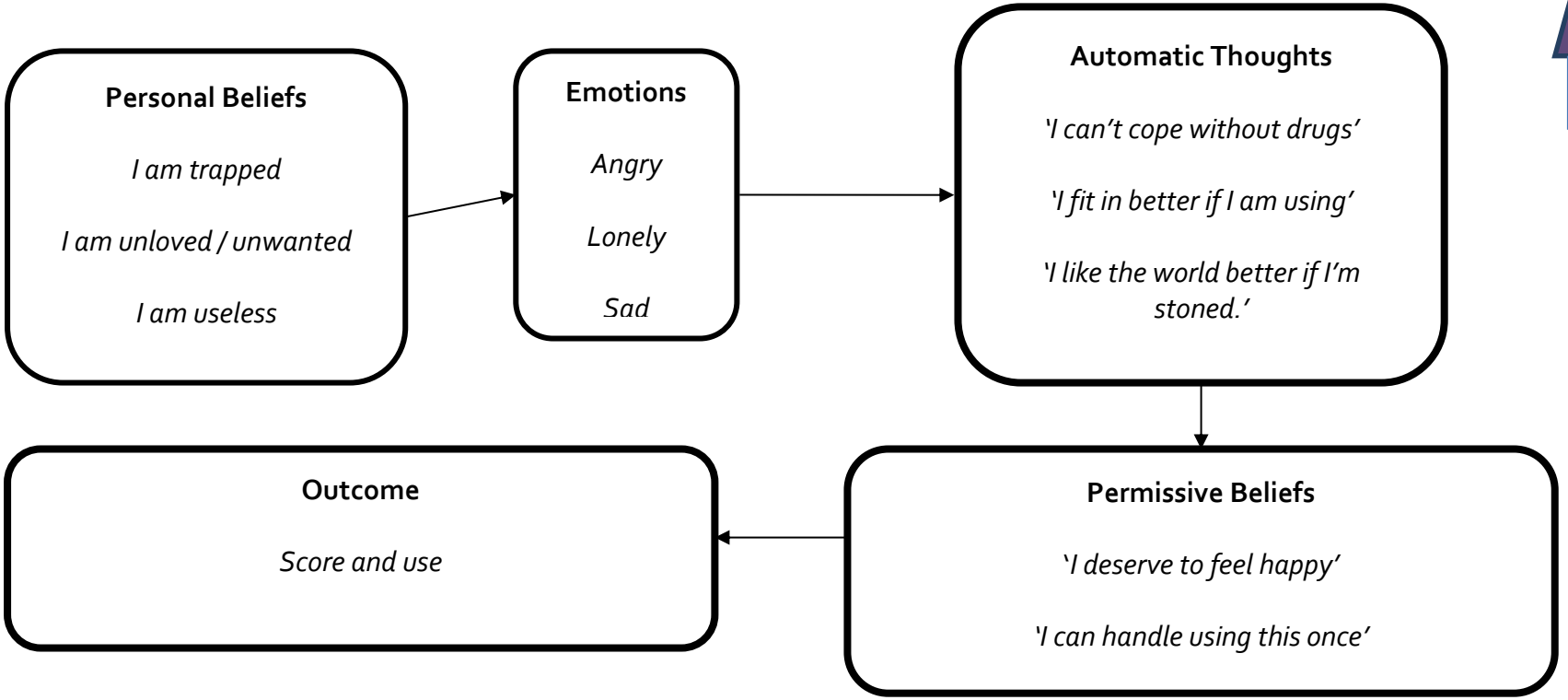
You don't have to stick with one – you can name as many as you like.

70,000

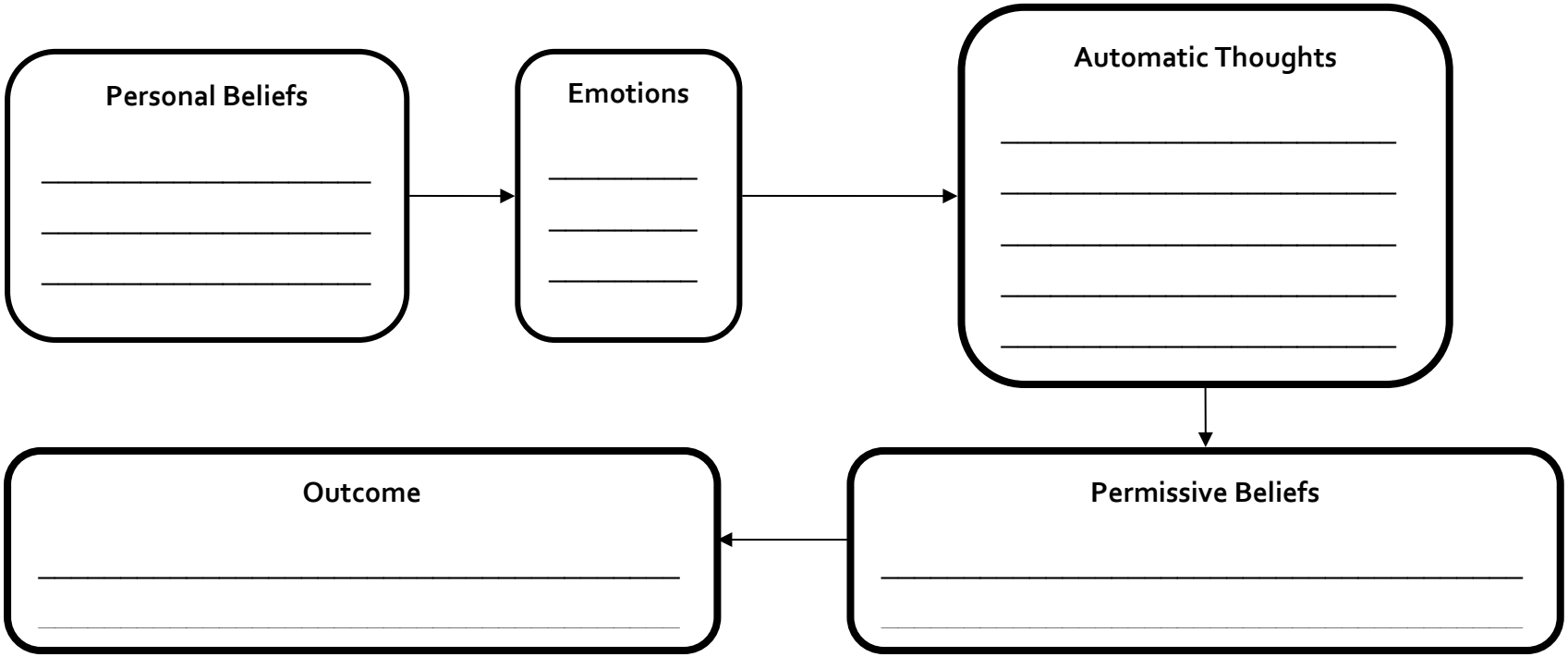
Seventy thousand thoughts a day

Personal Thoughts and Beliefs Diagram - sample





Personal Thoughts and Beliefs Diagram - Your Example



Safe Plan (for negative thoughts and beliefs)

Having identified a negative thought or belief (from the previous exercise H ❹3), try to work out an alternative thought or a challenge to the belief.

First name the thought or belief, then outline your alternative thought or challenge. Davina's example might help:

Her negative belief is 'I am stupid'

The challenge to her belief might be ' There are lots of times when I am definitely not stupid, when I am smart about what I do, for example I am good at cooking dinners for my kids'

_____

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Name at least one way in which you could reduce the harm to yourself from drug / alcohol use; or avoid high risk situations; or can find supports.

You don't have to stick with one – you can name as many as you like.

Dave's Story

Background

Dave has wanted to give up mixing coke and alcohol for a while and has been on and off it for a few months. He has also started to take some sleeping tablets that a friend introduced him to because he wasn't sleeping well. The last time he used coke or tablets was about a week ago and he is feeling really good about himself and starts to make some plans for the future. He hasn't had a drink in the past week either and if you ask him, he will say there is no way he wants to go back using coke and alcohol together again and that he feels proud of himself. He even feels he has been sleeping a bit better these past few days.

Situation/Incident

Dave decides to go down to his local pub where there is a party on for a friend of his. Dave has a few drinks and he starts to feel a bit tired.

Thoughts- Internal Conversation

Dave starts to think that if he had just a small bit of coke, then he could stay drinking longer and enjoy the party better. He knows who to approach in the pub to get coke. He thinks, 'There'd be no harm in taking just one bag' 'Sure, I've got a handle on this now and I am able to stop using when I want'. 'If I have the one bag it will liven me up and I can stay longer.'

Feeling

Dave feels excited at the thought of having the coke. He feels a rush of energy through his body. He is feeling reckless from the alcohol and he's only thinking of the here and now. At this point Dave has started to forget all the positive things he was thinking about just a short while ago.

Behaviour

Dave buys the bag of coke and uses it, quickly feeling high and powerful. Soon after, he buys another two bags – just to finish off the night. He doesn't have enough money on him but the guy gives it to him on credit til tomorrow.

Consequences

Dave was out most of that first night and hardly slept. He felt awful when he woke up. He noticed two missed calls from the 'coke guy' on his mobile and he remembered that he owes him money. He doesn't have it and has been avoiding him for a few days. Dave feels like he needs a drink to think about what he should do. He can't sleep because of the worry and has bought a few sleeping tablets to help him.

He is avoiding calls and messages from Davina.

Changing Your Thoughts

When learning to change your thoughts follow these instructions:

1. **STOP for a MOMENT**

When you're having negative thoughts, you need to simply STOP for a moment. Give your body a chance to catch up with your thoughts. By giving yourself a moment to really think about your thoughts, you will be better able to make an informed decision about what action you are going to take. Without taking this moment you will still be following your old thoughts and we now know what the dangers of negative thoughts are.

2. **In that Moment:**

- Ask yourself if your thoughts are really true?
- Where have these thoughts led me before?
- Are you fooling yourself?

3. **Practise Changing your Thoughts**

The more you practice, the easier it becomes. You know you have the power to change the way this situation ends. You don't have to use. You can take control over your situation.

Safe Plan

Between now and my next meeting I will keep myself safe from harm by practicing changing my thoughts.

The thoughts I want to change the most are:

_____

_____

_____

_____

_____

_____

Instead of these thoughts, I would like to think of:

_____

_____

_____

_____

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_____

Name at least one way in which you could reduce the harm to yourself from drug / alcohol use; or avoid high risk situations; or can find supports.

You don't have to stick with one – you can name as many as you like.

Good and Bad things about Drug or Alcohol Use

For this exercise you need to write down as many good and bad things about your drug or alcohol use as you can. Be as clear as possible.
Only answer for the substances that you relate to.

Like the previous exercise you will need to write as many good and bad things about reducing/stopping your drug or alcohol use as you can. Aim for a minimum of three for each.

Drug	Bad things about using	Good things about using
Cocaine		
Alcohol		
Heroin		
Crack Cocaine		
Tablets *Name* *Name* *Name*		
Head shop		
Methadone top up		
Hash		
Other		

Good and Bad things about Reducing / Stopping Drug or Alcohol Use

Like the previous exercise you will need to write as many good and bad things about reducing/stopping your drug or alcohol use as you can.

Drug	Bad things about Reducing / Stopping	Good things about Reducing / Stopping
Cocaine		
Alcohol		
Heroin		
Crack Cocaine		
Tablets *Name* *Name* *Name*		
Head shop		
Methadone top up		
Hash		
Other		

Goal Guidelines to Goal Setting

Being SMART

Specific

Be as clear and as focused as possible. Unclear goals will only frustrate you. For example, 'I am going to get my life together' is too vague. This makes it hard to work out what you are going to do and how you would go about achieving it.

Make clearer statements such as, 'I am going to stop my cocaine use' or 'I am going to detox from benzos'. By having clear goals, the steps to achieving them will be easier to name.

Measurable

Identify exactly what it is that will be different when you reach your goal. For example, 'I am going to cut down from 8 cans to 4 cans' each time I drink'.

Achievable

Set goals that are realistic! For some people it may be an unrealistic goal to stop using completely at this time. For others, reducing may be an unrealistic goal as past experience may have shown them that they are an 'all or nothing' kind of person. Only you know what is realistic for you. Do not set goals that you haven't a hope of achieving. You will only set yourself up to fail.

Relevant

Only make goals that are really relevant to you. Do you actually want to achieve this goal at this time? Is this the most important goal for you at the moment?

Timed

Set yourself a deadline or a target date to reach your goal. If your goals have a target date, there are easier to measure. Also by having a target date, you can put a step by step plan in place to achieve them. For example, it is better to say that I will stop using cocaine from Friday onwards rather than leaving it open-ended i.e. 'I'm going to stop using coke'

My Goal Worksheet Date:_____

Its time to set some goals and make decisions about your current drug or alcohol use.
What goals do you want to achieve?
Do you want to stop using a certain drug or drugs?
Do you want to reduce your use of a certain drug or drugs?
Are you happy enough to continue with your current drug or alcohol use?

The goal(s) I want to achieve over the next six sessions are:

_____

_____

_____

The most important goal of all is:

The most important reasons why I want to achieve this goal is:

_____

_____

The steps I plan to take in achieving this goal is:

_____

_____

_____

_____

The ways other people can help me are:

_____

_____

_____

_____

Some things that might interfere with my plan are:

_____

_____

_____

_____

Goldilocks Principle - for goal setting

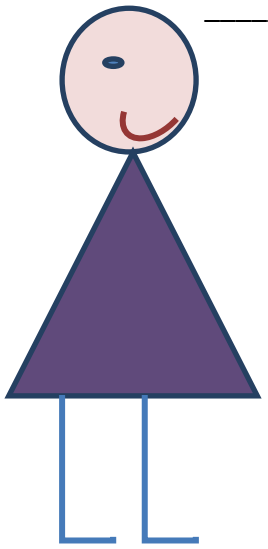
'not too big, not too small, just right'

Davina and a Plan of Action

Davina has decided that she wants to do a detox to address her tablet use.

What are some of the steps that she will need to think of and work out to help make this goal realistic?

List below:



Personal Action Plan

Step One: Think Stop!

- Picture a STOP sign in your head.
- Interrupt that thought and change it to a positive one
- Think of yourself in a positive place or situation
- Think of the consequences if you use.

Step Two: Immediate Responses

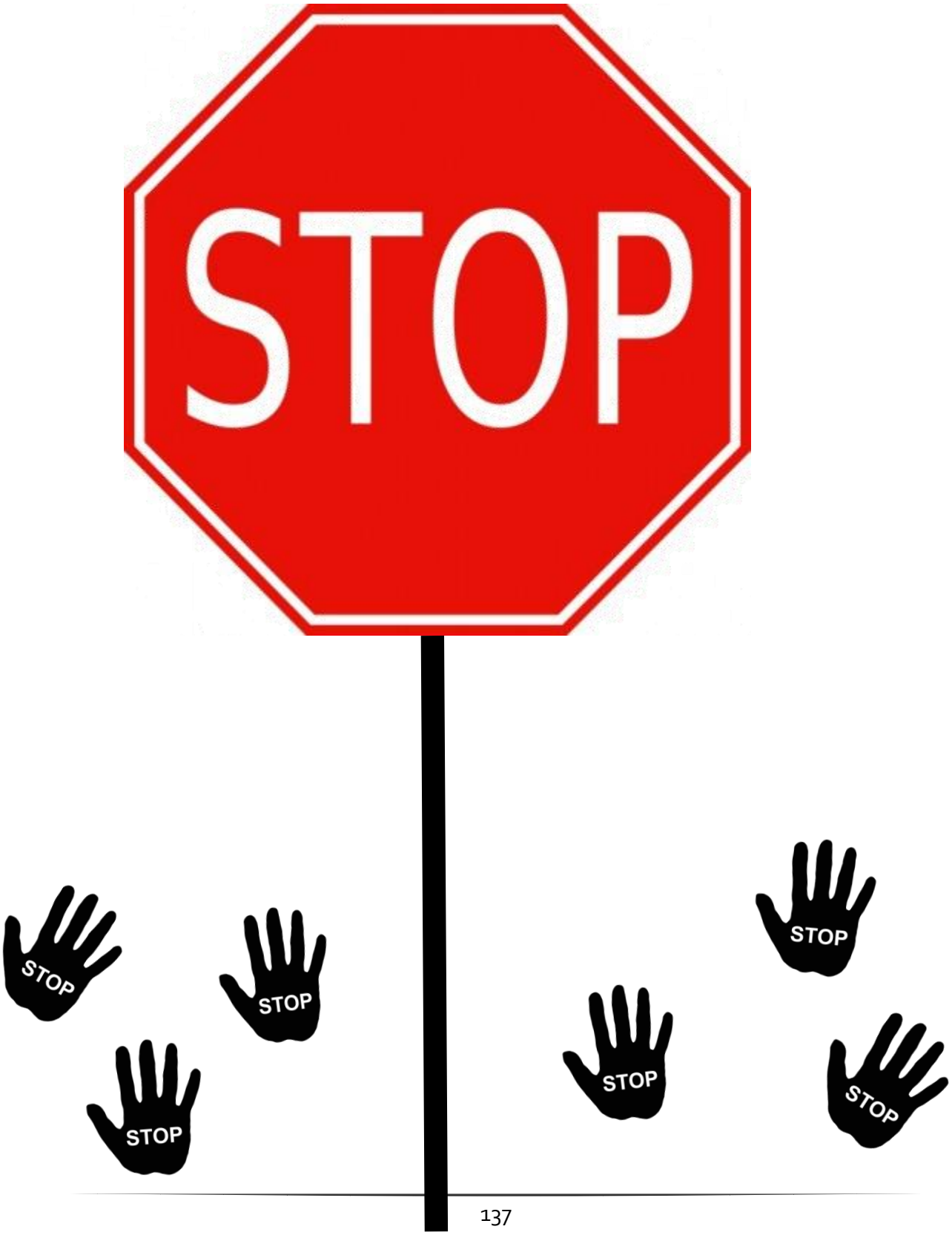
- Think of other things you can do immediately to deflect these thoughts or to get you out of this high risk situation.

Step Three: Long Term Alternatives

- Think of some other things you can do. Pick something from your list. Go do it!

Step Four: Rewards

- What rewards can you give yourself? Pick something from your list. Go do it!


STOP
STOP
STOP
STOP
STOP
STOP
STOP

DRUG DIARY/JOURNAL

By filling out this diary sheet you will begin to see patterns to your drug or alcohol use, what triggered it, the feelings associated with those triggers, the actions you took and the consequences of those actions. You should record every trigger regardless of whether you ended up using drugs or not. This information will help you to become more self aware around your drug or alcohol use. Record as many situations as possible in between each module of the course and bring this Drug Diary with you to each module.

Day	**Trigger** What made me want to use?	**Thoughts & Feelings** What was I thinking? What was I feeling?	**Behaviours** Did I use? If so, what did I take? If I didn't use what did I do instead?	**Good Consequences** Did anything good happen?	**Bad Consequences** Did anything bad happen?

Symptoms of Cravings / Withdrawals

If you are in the early stages of reducing your drug or alcohol use, you should understand that your body will be going through a period of withdrawals which will intensify the cravings. Withdrawal symptoms cause cravings for the drug. Written below is a comprehensive list of possible withdrawal symptoms that you might experience. You may experience some or all of these symptoms - depending on the amount of the drug you use and the length of time using.

Please remember that stopping alcohol or benzodiazepines suddenly can be very dangerous and sometimes fatal, so if you have been using these drugs for a considerable period of time you will need medical advice and guidance.

Opiates

Physical withdrawal symptoms	Emotional withdrawal symptoms
○ nausea ○ vomiting ○ diarrhoea ○ chills ○ runny nose ○ sweating ○ insomnia ○ aches and pains in muscles and joints ○ stomach cramps	○ Increase in dangerous and self destructive behaviours ○ anxiety ○ restlessness ○ irritability ○ Insomnia ○ headaches ○ poor concentration ○ depression ○ social isolation

Cocaine, Crack Cocaine and Stimulant Drugs

Physical withdrawal symptoms	Emotional withdrawal symptoms
○ diarrhoea ○ sweats ○ insomnia ○ stomach cramps ○ fatigue ○ hunger ○ loss of sex drive ○ shaking ○ increased heart rate ○ sensation of being able to smell or	○ anxiety ○ restlessness and agitation ○ irritability ○ insomnia ○ headaches ○ depression ○ paranoia ○ aggression ○ suicidal thoughts ○ psychosis

taste the drug ○ tightness in the chest ○ difficulty breathing ○ headaches	○ poor concentration ○ social isolation

Alcohol

Physical withdrawal symptoms	Emotional withdrawal symptoms
○ increased body temperature ○ unstable blood pressure ○ strokes ○ heart attack ○ high pulse rate ○ hand shakes ○ insomnia ○ nausea or vomiting ○ delirium tremens (DT's) ○ seizures	○ hallucinations ○ anxiety ○ restlessness ○ irritability ○ insomnia ○ headaches ○ poor concentration ○ depression ○ social isolation

Benzodiazepines

Physical withdrawal symptoms	Emotional withdrawal symptoms
○ seizures ○ sweating ○ racing heart ○ palpitations ○ muscle tension ○ tightness in the chest ○ difficulty breathing ○ tremor ○ nausea, vomiting, or diarrhoea	○ anxiety ○ irritability ○ suicidal thoughts ○ restlessness ○ insomnia ○ headaches ○ poor concentration ○ depression ○ social isolation

Cannabis/ Hash

Physical withdrawal symptoms	Emotional withdrawal symptoms
○ Insomnia ○ Vivid dreams/nightmares ○ Fatigue ○ Poor appetite	○ anxiety ○ restlessness ○ depression ○ irritability

Understanding Cravings

1. Cravings are a normal part of reducing or stopping your drug or alcohol use and are to be expected.

2. Cravings will come and go and will lessen in intensity over time

3. They are most often experienced early in recovery but can persist longer

4. Cravings can be triggered in many ways:
   - Seeing someone that you associate with your drug or alcohol use
   - Feeling emotions such as frustration, stress, boredom, depression, excitement, happiness, etc
   - Familiar objects, smells and sounds

5. Physical signs of Cravings can include:
   - Feeling nervous and agitated
   - Heart pounding
   - Sensation of being able to smell or taste the drug
   - Sweaty palms
   - Feeling of wanting to go to the toilet / diarrhoea

6. Psychological signs can include:
   - Fantasies about using
   - Convincing yourself that you'll feel great if you use
   - Fooling yourself that it'll be ok to use just the once

6 Steps to Manage Cravings

1. Recognise your Cravings

Half the battle is learning how to recognise your cravings and the effect they have on you. What does it feel like? Is it really a craving or something else? Get to know your body and what it is telling you

2. Swing into Action

Get up and do something. Don't just sit there! There are lots of ways that you can cope with cravings.

- Distract yourself – go do something different to take your mind off it.
- Make a list of possible things to do in the event of a crisis.
- Talk about it with someone who understands. Do you know someone you can trust? Can you get to a meeting? Can you phone someone? Do you have a support worker?

3. Write, write, write…

Writing is a powerful way of processing thoughts and feelings and helping you move through the moment. Do you still have your Drug Diary, notebook and folder? Review your goals. Write down the feelings you are going through.

4. Be Aware of your Triggers

Being aware of your risk triggers will help you avoid and overcome them. Make sure you get rid of all drug paraphernalia around you. Don't make contact with people who are not good for your recovery. Delete numbers from your mobile phone. Don't go to places where you will be at risk. Don't call around to friends who are not good for your recovery.

5. Think Positively

Think to yourself, 'I had a similar craving before. I didn't use then and it went away'. This craving will pass. Promise yourself a positive reward for getting through this craving without using. You deserve better. It will get better.

6. Check your Affirmation Card

Take out your Affirmation Card. Remind yourself of the strong message you wrote. You are that person. You can get through this.

Tips for Refusing

There are many ways you can refuse the offer of drugs. It is obviously best if you are clear and firm and say **NO**.
Remember that your FIRST objective is to refuse or turn down the offer.
Your SECOND objective is to reinforce your commitment to not use and to feel good about not using

The following are suggested responses you can make. Think about the best one for you in the situation you are in. Add your own suggestions to this list if you like.

- Respond quickly – prepare yourself beforehand
- If you meet someone who is offering you drugs, make direct eye contact with that person
- Respond with a clear and firm 'no' that does not leave the door open to future offers
- Use strong, confident body language
- Ask the person to stop tempting you (e.g. 'look I've decided to stop and I don't want you to ask me to use anymore…If you can't do that you will have to stop coming to my house').
- Leave the situation
- Make an excuse that you have to be somewhere else urgently
- Give an excuse why you can't take drugs (courts, social workers, doctors, etc)
- Repeat yourself if necessary
- Say thanks, but no thanks.
- Use humour (e.g. that stuff makes me fat, that stuff makes me stupid)
- If you are in a situation where you can't avoid the person (clinic waiting room for example) then change the subject to something else – having something prepared!
- Suggest something else you can do together that doesn't involve using, e.g. taking the kids out to play

My Refusal Techniques

For this exercise you are asked to write about TWO situations where you refused drugs or alcohol

Situation One

Describe a situation where you refused drugs or alcohol. Who were you with? Where was it?

What did you say and do to refuse the drugs or alcohol?

Situation Two

Describe a situation where you refused drugs or alcohol. Who were you with? Where was it?

What did you say and do to refuse the drugs or alcohol?

Safe Plan – Refusing Sentences

Between now and my next meeting I will keep myself safe from harm by practicing a few ways in which I could refuse drugs or alcohol.

My **three** sentences are:

1. _____

   _____

2. _____

   _____

3. _____

   _____

Put a star by your favourite sentence

Common Warning Relapse Signs

Changes in Behaviour

- Hanging out with people who use
- Not going to rehabilitation programmes or support groups (such as NA / AA)
- Taking other drugs including alcohol
- Arguing with others for no apparent reason
- Not being honest with those around you
- Doing things that are self destructive, i.e. shoplifting, hanging out with people that make you feel bad
- Not filling your days and spending a lot of time feeling bored

Changes in Attitude

- Not caring about yourself
- Becoming really negative about life and how things are going.

Reverting to Addictive Thinking

- Thinking that you deserve a reward for being clean for a period of time
- Thinking that you could just have a small bit and that it would be alright
- Thinking back to how good drugs made you feel without thinking about all the bad parts of drug or alcohol use
- Thinking that you are 'cured' and you no longer need to be careful of your triggers

Changes in Feelings or Moods

- Feeling unusually stressed
- Feeling depressed or angry
- Feeling invincible and unusually happy

My Relapse Prevention Plan

Part 1 - Your Relapse Warning Signs
Dave's examples:

Stopped going to NA/AA meetings

Was feeling really angry with everyone around me

Was thinking negative thoughts a lot of the time

Starting avoiding my family

Fantasised about using as a reward

You:

1. _____
2. _____
3. _____
4. _____
5. _____

Part 2 What I will do if I notice these warning signs
Dave's examples:

Force myself to speak to my sponsor

Talk to a counsellor about my feelings of anger

Write down all the good things about my life / take some time out to do something for me

Open up to someone I trust about my feelings

Pick a different reward from my Reward List

You:

1. _____
2. _____
3. _____
4. _____
5. _____

Reducing Harm: 8 Statements

1. The majority of people who use drugs do not need treatment

2. With regard to reducing substance use, small gains for many people have more benefit for a community than heroic gains achieved for a select few

3. People are much more likely to take multiple tiny steps rather than one or two huge steps

4. Keeping people who use drugs alive and preventing irreparable damage is regarded as the most urgent priority

5. Human rights apply to everyone. People who use drugs do not forfeit their human rights.

6. Many policies and practices intentionally or unintentionally create and exacerbate risks and harms for drug users

7. People who use drugs should be involved in decisions that affect them

8. Many people who use drugs are unable or unwilling to stop using drugs at any given time

Safe Plan

Between now and my next meeting I will keep myself safe from harm by being alert to any warning signs I might notice.

My most common warning sign is:

_____

_____

When I notice this warning sign, my best plan will be to:

_____

_____

_____

There's a Hole in My Path

Chapter One
I walk down a street and there's a big hole. I don't see it and fall into it. It's dark and hopeless and it takes me a long time to find my way out. It's not my fault.

Chapter Two
I walk down the same street. There's a big hole and I can see it, but I still fall in. It's dark and hopeless and it takes me a long time to get out. It's not all my fault.

Chapter Three
I walk down a street. There's a big hole. I can see it, but I still fall in. It's become a habit. But I keep my eyes open and get out immediately. It is my fault.

Chapter Four
I walk down a street. There's a big hole. And I walk around it.

Chapter Five
I walk down a different street.

'Between stimulus and response there is a space. In that space is our power to choose our response. In our response lies our growth and freedom'.

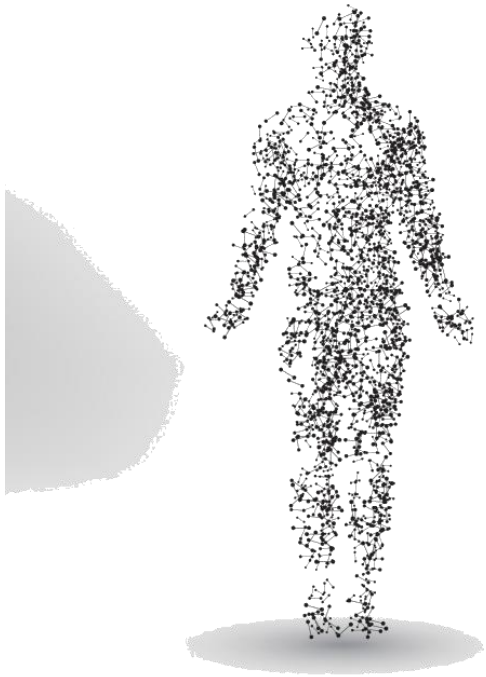
Viktor Frankl

Self-Care Rating Scale

According to Virginia Satir, there are 8 categories that need care. Rate yourself for each category by circling the number e.g. 1 ② 3 4 5

5 = Excellent Form
1 = Needs Work

Anything less than a 3 needs attention.



Intellectual
Stimulate the brain, e.g. read, games, learn, talk, debate
1 2 3 4 5

Social
Social networks, visit see friends, family, go out together
1 2 3 4 5

Emotional
Explore and experience a range of emotions e.g. watch films, comedy
1 2 3 4 5

Nutritional
Improve diet, e.g. eat new things, reduce sugar
1 2 3 4 5

Sensual
Be in touch with senses and sexuality, e.g. music, massage, orgasm
1 2 3 4 5

Spiritual
Feed your soul (not necessarily religious), e.g. nature, creative, meditate
1 2 3 4 5

Physical
Challenge and care for your body, e.g. exercise, sleep, dance
1 2 3 4 5

Contextual
Improve or change your environment, e.g. clean, repair, visit new places
1 2 3 4 5

Identifying my Own Support System

List three **people** you can turn to when you need some help and support.
Write down the contact details for each of these people.

Name	This could be an address or a phone number,
1.	
2.	
3.	

List three **Organisations / Agencies** that you can turn to when you need some help or support.
Write down the contact details for each of these organisations and also the hours when you can contact them.

Agency	Contact Details – address, phone number, email, name of the person you know at this agency	Hours open
1.		
2.		
3.		

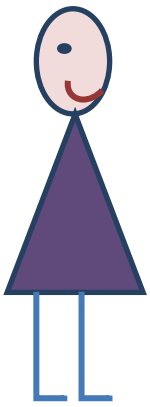
Are there any other useful contacts you have?
This could be websites, Facebook pages etc.
Write them down below:

_____

_____

_____

Safe Plan



Davina

Age 28
3 children 12year-old twin boys (with ADHD); 3 year-old daughter
Left school at 15 – just before Junior Cert
Substance use: Alcohol, hash
Medication – anti depressants, topping up with street drugs
Family – can be supportive sometimes
Lives with partner Dave

Identify **3** things for each of the following categories that Davina might do to look after herself better:
Then identify **1** thing for you.

Social

1.
2.
3.

You: ----------

Nutritional

1.
2.
3.

You: ----------

Physical

1.
2.
3.

You: ----------

Review and Evaluation

You have now completed the **Reduce the Use** course and we would like you to take a few moments to reflect on the learning and to give us some feedback.

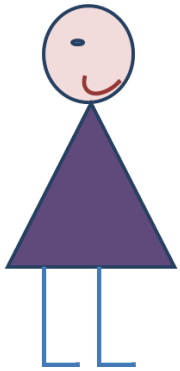
Please circle the statement that suits best.

I am more aware of my drug/alcohol use than before	True	False	Neither true nor false
I am more aware of my triggers to drug/alcohol use than before	True	False	Neither true nor false
I understand what automatic thoughts and personal beliefs are and how they can lead to drug/alcohol use	True	False	Neither true nor false
I understand that I can control and change my thoughts	True	False	Neither true nor false
I know how to set realistic goals for myself	True	False	Neither true nor false
I have learned new refusal skills	True	False	Neither true nor false
I have learned more about recognising my cravings and how to deal with them	True	False	Neither true nor false
I have learned to recognise the early stages of relapse	True	False	Neither true nor false
I have learned what I need to do to avoid relapse	True	False	Neither true nor false
I have identified supports for myself to help me in my recovery	True	False	Neither true nor false
I feel confident that I have learned the skills to reduce or stop my drug/alcohol use	True	False	Neither true nor false

Play it Forward

If I met you on O'Connell Street in three years' time, and said ***'How are you? What are you up to these days?'*** what would you say:

Davina's examples:



I've gone back to college

I'm studying childcare

I go two mornings a week

I'm not with Dave anymore

My kids are all doing well in school

I've started swimming again

You:

_____

_____

_____

_____

_____

_____

_____

_____

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