Treating Substance Misuse and Dependence: A Facilitator’s Manual

by

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The procedures in the facilitator’s manual are meant to be used by agency staff, as part of the broader services they provide, or under supervision of agency staff.
Dedication

To my family—thank you for always supporting me, encouraging me to achieve my goals and picking me up when I fall down. Without you, I would not be where I am today.
Abstract
Substance misuse and dependence is a widespread issue that can lead to significant physical, mental and interpersonal dysfunction for the individual. Although studies have highlighted the prevalence of Substance Use Disorders (SUD’s) and polysubstance use among people who use substances and have demonstrated the need for effective, timely and accessible intervention, support and treatment for substance misuse and dependence remains limited. The goal of this thesis was to develop an evidence-based treatment manual to assist staff at Addiction & Mental Health Services (AMHS) KFL&A in facilitating a drop-in group to address substance misuse and dependence, as well as to address skill deficits related to substance use. The facilitator’s manual is designed to be delivered by agency staff with clients who are experiencing dysfunction as a result of substance use, and provides detailed instructions for weekly group sessions, as well as reviews evidence-based practice in terms of teaching skills and providing psycho-education within a harm reduction framework. However, due to time constraints, the author was not able to formally evaluate the effectiveness of the manual. As such, future research should aim to evaluate the efficacy of the facilitator’s manual, as well as the treatment protocol included, in addressing substance misuse and dependence within a community setting.
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Chapter I: Introduction

Substance Misuse and Dependence

Though individuals may engage in substance use without meeting criteria for misuse or dependence, studies have suggested not only a high prevalence of substance use among adults in primary care settings, but also a high incidence of Substance Use Disorder (SUD) among individuals who engage in substance use (Wu et al., 2017; Hayley et al., 2017; Fleury et al., 2016). In addition to poor health, the perceived social and internalized stigma associated with substance use is correlated to lower self-esteem, higher rates of depression and anxiety, and poor sleep (Birtel et al., 2017). There are also a number of social, economic and healthcare burdens associated with substance misuse and dependence (Morin et al., 2017; Runyan et al., 2017). At this time, support and treatment for individuals who engage in substance misuse remain limited—a gap that has possibly contributed to recent increases in substance-related deaths (Morin et al., 2017). Despite the fact that several studies have demonstrated the importance of aligning treatment with evidence-based findings, the development and implementation of successful policies and programs to address substance misuse and dependence remain limited and are somewhat restricted by public opinion, and political agenda (Morin et al., 2017).

Recently, addressing substance misuse and dependence has become a priority on a national level due to an increase in individuals reporting substance use and seeking treatment for SUD’s, as well as increased reports of poly-substance use (Wu et al., 2017; Hayley et al., 2017). In Ontario, Opioid Use Disorder (OUD) has been declared a provincial health concern, and has been termed the “opioid academic” or “opioid crisis” (Morin et al., 2017). At this time, substance-related deaths are at an all-time high in major cities, as well as some rural communities, due to an increase of an illegally produced version of fentanyl, which is either cut into heroin or sold on its own (Morin et al., 2017; Runyan et al., 2017). Although substance use treatment has historically been underfunded in many cities, some researchers argue that the recent crisis has increased the need for accessible and effective treatment of OUD, as well as SUDs in general (Morin et al., 2017; Runyan et al., 2017).

According to The Canadian Community Health Survey conducted by Statistics Canada, rates of substance use in Kingston surpass those of provincial norms. In 2013 and 2014, 11.4% of men and 6.6% of women over the age of 19 in the KFL&A area admitted to drinking more than one drink per day in the previous 12 months. Approximately 20% of adults over the age of 19 self-identified as a heavy drinker, which was higher than the provincial average at 17.7%. Perhaps unsurprisingly, men reported drinking more often than women, on average, and there were a higher proportion of regular, binge and heavy drinkers among respondents in the 19-29 age group than any other. Regarding illicit drug use, approximately 36% of KFL&A residents have used an illicit drug in their lifetime, excluding one-time use of marijuana. Of that sample, 12.7% reported using an illicit drug at least once in the previous year, not including one-time marijuana use. Overall, results indicated that cocaine/crack was the most frequently used illicit substance among KFL&A residents (9.1%), followed by hallucinogens, PCP or LSD (4.6%).
Rationale

The present thesis involved the development of a treatment manual to be used by agency staff in facilitating a drop-in group to target substance misuse and dependence. The manual was also developed by the author in partial fulfillment of the requirements for an applied thesis in the Honours Bachelor of Behavioural Psychology degree program at St. Lawrence College. Although studies have demonstrated the need for effective, timely and accessible intervention, as well as the prevalence of SUD’s and polysubstance use among people who use substances, support and treatment for substance misuse and dependence remains limited (Wu et al., 2017; Hayley et al., 2017; Fleury et al., 2016; Prendergast et al., 2002; Burlingame et al., 2016). At the time of this thesis, the agency was in the process of designing several skill-based drop-in groups to meet the needs of clients, as well as to increase client contact with staff and accessibility to treatment. Therefore, the evidence-based treatment manual included in this thesis was designed to assist staff in facilitating consistent group treatment, to address skill deficits related to substance misuse and dependence and to increase client accessibility to services.

Hypothesis/Goals

Given the prevalence of substance use in Kingston, and among service users at AMHS, it was hypothesized that providing the agency with a treatment manual focusing on the implementation of evidence-based best practices would assist in the development of group treatment for substance misuse and dependence. Moreover, it was hypothesized that a manual that includes current and thorough information about substance misuse and dependence would provide staff with the means to effectively address the unique needs of their clients. As discussed later in the literature review, studies have demonstrated the effectiveness of group-based intervention in the treatment of SUDs. As such, it was hypothesized that a group designed to address substance misuse and dependence would not only improve treatment outcomes, but also assist clients in meeting their goals related to substance use. Lastly, it was hypothesized that including strategies to build self-management, mindfulness, communication and problem solving skills, in addition to enhancing motivation and reducing harm, would empower service users to manage their substance use and develop healthy coping strategies. Unfortunately, due to time constraints, hypotheses could not be tested.

Thesis Overview

To begin, this thesis provides a thorough review of the literature as it relates to substance misuse and dependence. Topics discussed include the prevalence of SUDs and polysubstance use, the short-term and long-term implications of substance use and rates of polysubstance use, as well as several theoretical considerations in the treatment of substance misuse and dependence. Next, the method used for manual development is described, and includes a description of the intended participants, setting, materials and design for implementation of the facilitator manual. The results section will present and summarize the final product of this thesis, as well as feedback received by the researcher by agency staff. Lastly, the discussion chapter will examine potential strengths and limitations of the facilitator manual, as well as challenges to implementation, recommendations for future research and contributions to the field of Behavioural Psychology.
Substance Misuse and Dependence

Recent literature has demonstrated the association between lifetime substance use, polysubstance use and drug use disorders, such as SUD. In a recent study by Wu et al. (2017), which examined substance use among 2000 adults in five primary care settings in the United States, 27.9% of participants reported drug use and 62% endorsed alcohol use in the last year. Of this sample, 13.9% and 14% of participants met DSM-5 criteria for SUD and Drug Use Disorder (DUD), respectively. Of those who reported using illicit substances, such as marijuana, cocaine and heroin, 50% of individuals met criteria for any DUD. These findings suggest not only a high prevalence of substance use among adults in primary care settings, but also a high incidence of SUD and DUD among individuals who engage in substance use.

Hayley, Stough and Downey (2017) found similar results while studying the relationship between Cannabis Use Disorder (CUD) and co-occurring substance use. By conducting computerized semi-structured face-to-face interviews, data were collected regarding participant’s substance use, as well as psychiatric and physical health, to provide insight into the prevalence of substance use. In their study, CUD was found to be strongly associated with greater incidence of life time drug use, specifically stimulant-type drugs, such as cocaine, prescription stimulants and club drugs, including LSD and MDMA. Moreover, Hayley et al. (2017) found that a greater proportion of individuals diagnosed with CUD were young males aged 18-34 years, who had used cannabis early in life, and that cannabis use early in life was associated with comorbid use of other illicit substances later in life. As a result of their findings, the authors asserted that the observed association between CUD and lifetime substance use might reflect a natural progression of maladaptive patterns of behaviour, which, for many, may result in poly-substance use.

In accordance with findings by Hayley et al. (2017), research by Copersino (2017) suggested that negative reinforcement—that is, the escape or avoidance of stressors—may provide additional insight in regards to the role of learning in the development and maintenance of SUD’s. In his work, Copersino (2017) argued that over time, an individual’s urge to engage in substance use is strengthened as a result of predisposing factors and neurobehavioral adaptations that result from the escape or avoidance of stressors. Eventually, this escape or avoidance weakens willpower, interfering with an individual’s ability to think rationally about the benefits and risks associated with continued substance use (Copersino, 2017). However, at this time, evidence on the role of learning in the development and maintenance of substance misuse and dependence remains limited.

Recently, Birtel, Wood and Kempa (2017) examined the negative impact of substance use for individuals diagnosed with SUD. By conducting an online survey among 64 participants receiving treatment for substance abuse, they found that higher levels of perceived stigma associated with substance use was correlated with low self-esteem, higher levels of internalized shame, and poorer sleep. Individuals who perceived more stigma towards their diagnosis of SUD also reported higher levels of internalized public stigma, which had a negative effect on their mental and physical health (Birtel et al., 2017). However, results from the study also suggested that social support may, to some extent, mediate this relationship. As such, the authors argued the importance of treatment modalities that encourage participants to develop their social network, thereby...
reducing internalized stigma associated with substance abuse.

Earlier this year, Cafferky, Mendez, Anderson and Stith (2018) conducted a meta-analytic review of 285 studies to examine the relationship between Intimate Partner Violence (IPV) and substance use. Overall, findings suggested a high incidence of IPV among those who engage in substance use. However, findings also suggested that the relationship between substance use and being a victim of IPV is stronger for those who use illicit substances, as compared to those who use alcohol (Cafferky et al., 2018). Moreover, individuals who met diagnostic criteria for SUD, as compared to those who engaged in substance use relatively infrequently, were more likely to be victims of IPV (Cafferky et al., 2018). Results also indicated significant gender differences in terms of IPV victimization. In terms of overall substance use, there was a significantly stronger association between male substance use and IPV perpetration than female substance use, meaning that females were more likely to be victims of IPV than males (Cafferky et al., 2018). Additionally, Cafferky et al. (2018) found that rates of both IPV perpetration and victimization were statistically similar among individuals who used amphetamines, cocaine, marijuana and ‘other’ drugs, including pills and tranquilizers. While it remains unclear whether substance use results in IPV, the co-occurrence of IPV among individuals who use substances is important to note.

According to Fleury et al. (2016), relatively few studies have documented the course and duration of SUD remission, despite evidence suggesting that patterns of substance misuse and dependence are chronic for many. By examining the results of 21 studies published worldwide in a meta-analytic review, Fleury et al. (2016) found a wide variation in remission rates among individuals with SUD. Overall, 54% of individuals were in remission from SUD’s after an average of 18 years of substance use (Fleury et al., 2016). Unlike research by Hayley et al. (2017) that suggested age and gender to be associated with substance misuse and dependence, no differences were found in remission rates based on comparisons of legal and illicit substance use among participants (Fleury et al., 2016). A comparison of study-level characteristics revealed that remission rates for SUDs tended to rise with the overall number of follow-up years, and that early interventions after SUD onset may be highly effective (Fleury et al., 2016). These findings not only support the need for long-term follow-up, but also early intervention and continuity of care, in treating individuals with substance misuse and dependence.

**Treatment Design & Implementation**

Several researchers have examined the role of evidence-based treatment design, implementation and content in effective interventions for SUD’s (Prendergast et al., 2002; Burlingame et al., 2016).

For example, Prendergast et al. (2002) identified consistent implementation, level of theoretical content, and researcher allegiance as positive moderators of treatment effects. Studies that were rated as well implemented, that included standardized treatment protocols and were monitored in terms of treatment delivery, produced better outcomes (Prendergast et al., 2002). However, Prendergast et al. (2002) also suggested that interventions that focused on the practical application of evidence-based skills were more effective than those that relied heavily on theoretical content, which they noted may reflect a disconnect between theory and practical application. Although not associated with substance use outcomes, age was correlated with crime outcomes, which suggested
not only that treatment was more effective at reducing crime in those of a younger age, but also that early intervention may be a key feature of treatment for substance misuse and dependence (Prendergast et al., 2002).

In a more recent study, Burlingame et al. (2016) compared the effects of professionally delivered face-to-face group treatment to individual psychotherapeutic intervention. In doing so, they conducted a meta-analysis of 67 peer-reviewed studies that were published over a 25-year period. Although participant characteristics varied, due to the inclusion of studies that ranged in terms of participant age and diagnoses, Burlingame et al. (2016) found statistically indistinguishable outcomes when individual and group formats were compared. Overall, results indicated that there is no difference in treatment outcomes when individual and group treatments are compared across a range of participant populations (Burlingame et al., 2016). Given that group treatments can typically service more clients in less time, and increase client service access by utilizing clinicians’ time effectively, Burlingame et al. (2016) argued that indistinguishable treatment outcomes may be a more persuasive reason to encourage group treatment formats. Data from Burlingame et al. (2016) also suggested that acceptance and dropout rates did not differ regardless of whether a group or individual format was delivered to participants. Similar to data obtained by Prendergast et al. (2002), these findings yielded a positive correlation between a researcher’s allegiance to a particular treatment format and overall effect size, suggesting that a researcher bias may have the potential to impact the effectiveness of intervention (Burlingame et al., 2016). Given these findings, it is imperative that moderator preferences be considered in designing effective interventions, regardless of whether an individual or group format is used.

Effective Treatment Approaches in Treating Substance Misuse and Dependence

The previous discussion examined the prevalence of SUD among individuals who use substances, as well as the prevalence of polysubstance use and comorbid psychiatric disorders (Wu et al., 2017; Hayley et al., 2017; Fleury et al., 2016). As such, it is important to examine the appropriateness of evidence-based treatment approaches and theoretical orientations in designing an intervention for substance misuse and dependence.

Motivational Interviewing (MI). According to Bertrand et al. (2015), MI is an approach designed to enhance intrinsic motivation by eliciting and strengthening internal commitment to change. Bertrand et al. (2015) demonstrated the effectiveness of MI as in reducing risk behaviour among a sample of intravenous drug users, or people who inject drugs (PWID). Using a sample of 219 participants, Bertrand et al. (2015) compared the effectiveness of a single session of MI with that of a brief educational intervention (EI) at reducing risk behaviour, including sharing drug use equipment such as syringes, filters and water. Overall, results indicated that MI was more effective at decreasing risk behaviour among participants, despite similar session length and setting to EI (Bertrand et al., 2015). At follow-up, participants who received MI were 50% less likely to report any risk behaviour than those who had received EI, and 53% less likely to share drug use equipment (Bertrand et al., 2015). Though both treatment modalities produced reductions in risk behaviour, the effects of MI were more pronounced at follow-up, demonstrating its ability to produce and maintain behavioural change (Bertrand et al., 2015). Bertrand et al. (2015) argued that MI was effective at producing behaviour change due to its ability to enhance client motivation and increase participants’ awareness by developing
discrepancies between the person’s values, their goals, and the risks associated with substance use.

More recently, Sayegh et al. (2017) conducted a meta-analysis of 84 studies to compare the effectiveness of MI and Contingency Management (CM) in the treatment of substance misuse and dependence. Overall, results demonstrated that both MI and CM were effective at promoting reductions in substance use, even months after treatment had concluded (Sayegh et al., 2017). However, each approach produced a substantial difference in outcome during follow-up. Results from the study suggested that CM produced significant follow-up effects in the first 3 months after intervention, but that these changes were not maintained in the following 3 months. While MI did not produce significant treatment effects during the first 3 months following treatment, significant follow-up effects were observed between 3-6 months after intervention (Sayegh et al., 2017). Similar to Bertrand et al. (2015), Sayegh et al. (2017) asserted that MI was effective due to its’ ability to enhance intrinsic motivation, unlike CM, which may promote extrinsic motivation.

**Harm Reduction.** According to Marlatt, Blume and Parks (2001), harm reduction therapy is a compassionate and respectful approach that emphasizes “meeting individuals where they are at” in terms of motivation to change. One major difference between harm reduction and abstinence-based programs is the definition of therapeutic progress (Marlatt and Logan, 2010). Although abstinence may be the ultimate goal for some clients, harm reduction is a client-directed approach that involves supporting and encouraging self-efficacy, practicing refusal skills, identifying triggers and developing alternative behaviours (Marlatt et al., 2001; Logan and Marlatt, 2010). Several researchers have argued that harm reduction may be effective in reducing risk behaviour and producing behavioural change among individuals who normally do not seek treatment, due largely to the abstinence-based inclusion criteria of most interventions for substance misuse and dependence (Marlatt et al., 2001; Logan and Marlatt, 2010; Elzerbi et al., 2015).

Recently, a study by Boucher et al. (2017) explored the perceived efficacy of harm reduction strategies among People Who Inject Drugs (PWID) through a series of semi-structured interviews. Despite a small sample size, most participants in the study reported using harm reduction strategies in their everyday life, including using community supports and services (Boucher et al., 2017). According to Boucher et al. (2017), several participants reported the importance of having moral support or positive social interaction with staff members, and feeling a sense of belonging to the community. In terms of strategies for managing substance use, the most common harm reduction strategies reported by participants included using in moderation, including replacing one substance with another or taking medication as prescribed, as well as increasing engagement in the community (Boucher et al., 2017). A large portion of participants reported that they used marijuana, alcohol and cigarettes as common substitutions for their drug of choice (Boucher et al., 2017). Lastly, the majority of participants reported at least some instances of using increased awareness or self-reflection to manage their substance use (Boucher et al., 2017). Other strategies included reflecting on difficult or traumatic events, reflecting on substance use, and recognizing progress over time (Boucher et al., 2017). Some participants also mentioned the importance of maintaining a positive attitude or sense of humor to cope (Boucher et al., 2017). In terms of behavioural
strategies, several participants reported the benefits of distraction, and suggested that community-based harm reduction services incorporate more opportunities for peer discussion and community involvement as a means to reduce harm, break isolation and provide individuals with adaptive coping strategies (Boucher et al., 2017).

**Treatment Content**

Research on the best practice in terms of treating individuals within community settings and without official DSM-5 diagnoses remains limited, especially regarding specific treatment content (Hayley et al., 2017; Wu et al., 2017; Fleury et al., 2016). However, a review of the previous and current literature revealed several theoretical considerations that may be particularly effective reducing substance misuse and dependence across a variety of settings and client demographics, as described below.

**Mindfulness.** According to Shorey et al. (2014), mindfulness is “being attentive to whatever is occurring in the present moment (e.g., emotions, thoughts) without needing to judge or change anything about the experience”. In Shorey et al. (2014), researchers collected data from 125 patients housed at a residential treatment facility for substance misuse and dependence, and found a strong association between mindfulness and all mental health disorders, especially depression. As hypothesized by the authors, lower levels of the trait mindfulness were associated with increased levels of substance use, depression and Post-traumatic Stress Disorder (PTSD). Moreover, individuals who were identified as most likely meeting criteria for comorbid depression or PTSD, in addition to SUD, reported the lowest levels of mindfulness, as compared to individuals diagnosed with SUD only (Shorey et al., 2014). Results from Shorey et al. (2014) not only demonstrate an association between lower mindfulness and mental health disorders, in general, but also implicate mindfulness in the development and maintenance of SUD’s, depression and PTSD. As such, Shorey et al. (2014) concluded that integrating mindfulness training may be helpful in targeting the vulnerabilities or maintaining factors of various mental health disorders.

According to Kirby, Tellegen and Steindl (2017), compassion-based interventions, such as self-compassion training and mindfulness may be particularly effective at producing reductions in depression, anxiety and psychological distress associated with substance misuse and dependence. Although Kirby et al. (2017) noted that the current evidence base for compassion-based interventions is limited, meta-analysis revealed a statistically significant moderate effect size was observed for well-being and mindfulness. These results not only demonstrate the potential of mindfulness as an evidence-based and effective approach for treating SUDs, but may also provide insight into the mechanisms that maintain substance misuse and dependence (Kirby et al., 2017).

In a meta-analytic review of 39 studies, Karyadi, VanderVeen and Cyders (2014) examined the relationship between mindfulness and substance use behaviour. Overall, they found a negative relationship between increased mindfulness and substance use behaviour, especially regarding alcohol and tobacco use, as compared to marijuana (Karyadi et al., 2014). According to Karyadi et al. (2014) further analysis of results indicated that acting with awareness, non-judgment and non-reactivity were the facets of mindfulness that were significantly and negatively related to substance use behaviour.

In a literature review conducted by Chiesa and Serretti (2014), Mindfulness Based Interventions (MBI’s) were associated with reduced consumption of a variety of
substances, including alcohol, cocaine, amphetamines, marijuana, cigarettes and opiates, as compared to waitlist controls, as well as non-specific educational support groups included in the analysis. Additionally, results from Chiesa and Serretti (2014) demonstrated that MBIs were associated with a reduction in self-reported craving, which suggested MBIs may be effective at improving psychological outcomes (i.e. psychological distress) for individuals who misuse or depend on substances.

Enkema and Bowen (2017) examined the effectiveness of mindfulness-based approaches and the importance of formal mindfulness practice in the treatment of SUD’s by delivering Mindfulness-Based Relapse Prevention (MBRP) to a sample of participants who met criteria for SUD. Overall, data suggested that time spent engaging in formal mindfulness practice was correlated with a reduction in the relationship between craving and substance use (Enkema & Bowen, 2017). However, Enkema and Bowen (2017) also noted that mindfulness practice did not appear to reduce craving directly; rather, they asserted that mindfulness may be effective as it enhances an individual’s ability to distinguish between cognitive, affective and/or physical experiences from behaviour. Based on these results, Enkema and Bowen (2017) suggested that group facilitators inform participants of the benefits and importance of formal mindfulness practice, and encourage participants to incorporate practice into their everyday life. Like Enkema and Bowen (2017) a literature review conducted by Brewer, Elwafi and Davis (2014) argued that mindfulness may be effective at treating substance misuse and dependence due to its ability to change one’s relationship to core addictive elements, such as the experience of craving. However, Brewer et al., (2014) also suggested that individuals who are able to separate the experience of craving from substance use behaviour, through the practice of mindfulness, will ultimately make more adaptive choices, thereby leading to a decrease in substance use.

Positive Social Interaction and Effective Communication. In a study by Herrick and Elliott (2001), researchers demonstrated the importance of self-appraised social problem solving abilities in the treatment of SUDs. By examining data collected from participants receiving inpatient treatment, Herrick and Elliot (2001) found that greater confidence in social problem solving abilities was associated with greater willingness to adhere to program expectations. Given that a number of studies have demonstrated the importance of program adherence, as well as continued practice of skills learned in treatment and follow-up, enhancing individual’s perceived social problem solving abilities, thereby encouraging program adherence, may promote a reduction in substance misuse and dependence (Herrick & Elliot, 2001). Additionally, Herrick and Elliot (2001) argued that self-appraised social problem solving abilities may be important indicators of treatment success and outcome among individuals diagnosed with SUD.

Self-compassion. Research by Germer and Neff (2013) demonstrated that self-compassion positively contributes to psychological well-being and self-reported life satisfaction for adolescents and adults. Self-compassion is an important part of psychotherapy and can be conceptualized as containing three core components: self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus over identification (Germer and Neff, 2013). Following Self-compassion Training (SCT), Germer and Neff (2013) demonstrated an increase in participant self-compassion, mindfulness, compassion for others and life satisfaction, as well as a decrease in
depression, anxiety, stress and emotional avoidance for participants.

**Problem Solving.** A study by Marquez-Arrico, Benaiges and Adan (2015) demonstrated that individuals diagnosed with SUD may use maladaptive coping strategies more often and active problem solving strategies less than those without the disorder. By comparing those diagnosed with SUD with participants who diagnosed with both SUD and Schizophrenia (SZ+), Marquez-Arrico et al., (2015) discovered similarities and differences in problem solving ability and engagement. Overall, high severity of SUD was strongly associated with increased use of disengagement strategies in the SUD group of participants, while the daily amount of medication was related with general engagement and disengagement coping strategies in the SZ+ group of participants (Marquez-Arrico et al., 2015). Given that deficits in problem solving were associated with later onset of SUD, Marquez-Arrico et al. (2015) argued that problem solving could play a role in the development and maintenance of SUDs. Although both groups of participant’s demonstrated deficits in their ability to problem solve stressful situations, SZ+ participants used fewer behavioural and cognitive strategies, had lower rates of self-perceived efficacy, and used wishful thinking more frequently than those diagnosed with SUD alone (Marquez-Arrico et al., 2015).

In a more recent study, Adan, Atunez and Navarro (2017) examined substance use behaviour and problem solving among men diagnosed with SUD and found similar results. Like Marquez-Arrico et al. (2015), Adan et al. (2017) compared individuals diagnosed with SUD to those who were diagnosed with a comorbid diagnosis of SUD and Major Depressive Disorder (MDD), and found deficits in problem solving for both groups of participants. As compared to SUD-MDD participants, individuals diagnosed exclusively with SUD reported more frequent use of problem solving, cognitive restructuring and social support (Adan et al., 2017). As such, Adan et al. (2017) argued the importance of engagement strategies to increase participation and the teaching of adaptive coping strategies, such as problem solving, in the treatment of substance misuse and dependence. However, depending on the clinical characteristics of participants, they noted that increasing participant’s self-perceived capacity to cope with stressful events may also be particularly important (Adan et al., 2017). These findings suggest that integrating problem solving skills training into treatment may be beneficial for those diagnosed with SUD, especially for those with a comorbid mental health disorder (Adan et al., 2017).

**Behavioural Activation.** According to Dimmagio and Shahar (2017), Behavioural Activation (BA) may be an effective treatment modality in addressing a variety of disorders, due its emphasis on enhancing positive affect and distracting from negative emotional states, as well as its ability to initiate and enhance an individual's motivation to fulfill goals.

In a study by Fernandez and Mairal (2017), researchers found evidence to suggest that BA may an effective treatment in terms of reducing negative symptomology and automatic negative thoughts. Pre and post treatment measures revealed that both Behavioural Activation (BT) and Cognitive Therapy (CT) were effective at reducing the intensity of symptoms of anxiety and increasing participants automatic thoughts (Fernandez & Mairal, 2017). However, Fernandez and Mairal (2017) also suggested that BA may be superior to CT in terms of reducing automatic thoughts and modifying maladaptive behaviour.
A similar study by Chan et al. (2017) found evidence to suggest that group-based BA is also effective in terms of treating symptoms of depression. In a meta-analytic review of 7 RCT’s, Chan et al. (2017) demonstrated that not only was BA clinically effective at reducing symptoms of depression, but also that it was more effective than treatment as usual and waitlist conditions. Additionally, Chan et al. (2017) that BA contained flexible treatment methods that can be implemented in a variety of settings, which may be particularly important in treating individuals displaying negative affect.

In Norway, Bergly, Grawe and Hagen (2014) conducted a survey among individuals receiving inpatient treatment for substance use to compare the perceived benefits of various types of treatment. Among interventions included, the most common involved improving relationships with family/important others (91.8%), applied relaxation (77.6%), psychodynamic therapy (57.6%), cognitive behavioural therapy (45.9%) and motivational interviewing (41.2%). Overall, participants reported that they had found increasing physical activity helpful, as well as learning strategies to improve relationships with other people (Bergly et al., 2014). Furthermore, participants reported that they had benefited from the support of co-patients, group therapy and from help in coping with stressful situations (Bergly et al., 2014). Although research on the efficacy of BA in treating substance misuse and dependence remains limited, Bergly et al. (2014) argued that BA is an effective means of distraction and reinforcement for managed substance use.
Chapter III: Method

Target Population
In accordance with the policies and inclusion criteria for services at Addiction and Mental Health Services (AMHS) KFL&A, the facilitator’s manual is intended to be used among individuals above the age of 16, who either self-report experiencing issues related to substance use, or are identified by staff as requiring additional support related to substance misuse and/or dependence. Additionally, participants should demonstrate a need to develop skills in at least one of the following areas: self-management, mindfulness, communication, problem solving and/or motivation. However, since the techniques included in the manual are applicable and effective for a variety of symptoms and diagnoses, a formal diagnosis of SUD is not necessary for inclusion in group treatment.

Selection procedures and consent. Six to eight service users should be referred to the group treatment program by their Transitional Case Manager (TCM) or Emergency Room Service Diversion Case Manager (ERDCM), based on their engagement with agency services and need for additional support regarding substance misuse and/or dependence. It is also recommended, but not necessary, that participants have a history of substance misuse and dependence and demonstrate literacy skills at, or above, a grade 6 reading level to ensure relevance and comprehension of material. Before beginning the program, the facilitators should obtain verbal consent from each participant. Consent procedures should include a thorough explanation of the purpose of the program, including the potential risks and benefits associated with participation. The facilitator should also clarify that participation in the program is voluntary, and inclusion in the program will not impact or influence any other services provided to the client by the agency. Lastly, the facilitator should explain that abstinence is not required for participation in treatment. Although it is not recommended that participants attend treatment modules under the influence of substances, there is no need for participants to commit to sobriety before attending treatment. Note that written consent is not required for participation in the program, due to the fact that it is obtained as part of the TCM/ERDCM intake process.

Program Facilitators
The manual is intended to be delivered by one or two agency staff, who are part of either the TCM or ERDCM team and possess a Bachelor’s degree in a field related to psychology, at minimum. Experience in the field of psychology, especially in working with substance use and/or vulnerable populations, may be an asset in the implementation of the program, but is not required. It is also recommended that facilitators are familiar with harm reduction principles and strategies, as well as Motivational Interviewing (MI), as they are evidence-based and provide the theoretical basis for the program. Lastly, facilitators should possess the ability to develop and maintain rapport with service users, encourage meaningful discussion of program content and practical application of skills, and anticipate potential barriers to individual and program success.

Design
The facilitator’s manual was created by the author during a 14-week field placement as part of an applied thesis in the Honours of Behavioural Psychology program.
at St. Lawrence College. The manual focuses on skill building, as well as the identification and adaptive resolution of negative thoughts and emotion-based states. The manual is intended for facilitators to use with individuals experiencing dysfunction as a result of substance misuse and dependence in a group-based setting at a community agency, and is meant to provide staff with additional insight into the unique needs of their clients. Further, the manual provides detailed descriptions of how to implement weekly group sessions, including instructions on leading group discussions, as well as outlines evidence-based practice in terms of teaching skills and providing psycho-education within a harm reduction framework. Participants are given the opportunity to rehearse the skill when appropriate, and verbal feedback is provided by the facilitator.

In terms of implementation, the manual is designed to compliment existing services provided. Therefore, it is recommended that TCM/ERDCM staff continue to schedule client contact appointment as required by program mandates, regardless of whether or not their client is participating in the program.

Ideally, each program session should last approximately two hours and should include oral instruction, demonstrations, group exercises, rehearsal and verbal feedback. However, it should be noted that implementation of the manual should be highly individualized, depending on specific client needs. If necessary, the number, frequency and content of each program session can be altered to meet the needs and/or limitations of a particular client based on the facilitators clinical judgment and expertise.

**Setting/Apparatus**

The facilitator’s manual is designed to be delivered in a quiet office setting, or similar location, that can accommodate approximately 10 people in total. The program is intended for delivery in a workspace that allows for the completion of skill-building exercises, including demonstrations and role-plays. At times, the facilitator and/or the participant will require access to a pen or pencil to complete worksheets, as well as a photocopier.

**Materials**

For implementation, each group facilitator will require a copy of the facilitator manual, which was developed by the Behavioural Psychology placement student. The facilitator’s manual contains an overview of current evidence-based literature regarding substance misuse and dependence, as well as detailed instructions for implementing the treatment modules. Within each treatment module, the facilitator’s manual provides an overview of skill-based exercises for each group session, including recommendations for group discussions and role-plays, as well as required worksheets. It should be noted that, unless otherwise specified, the Behavioural Psychology placement student designed all included worksheets. Other required materials include a notepad and pen for each facilitator to record any notes from the session, or important information, as identified by the facilitator. At times, both the facilitators and participants require a pen or pencil, which should be provided by the facilitator and collected at the end of the session.

**Measures**

Although testing the efficacy is not within the scope of the current thesis, feedback was requested from staff to help ensure the language of the manual is appropriate for the target population, and the exercises included are easy to implement.
and as helpful as possible. Revisions were made following this feedback and as a result of discussions with the college supervisor.

**Procedures**

The facilitators’ manual consists of four main parts. Part I is the Introduction, which explains the purpose for the manual, provides a rationale for its use, and gives a brief description of content. Part II provides an overview of the evidence-based literature in regards to substance misuse and dependence, as well as psycho-education and training on Motivational Interviewing (MI) and Harm Reduction strategies that may be beneficial for the facilitator, depending on his/her experience and training.

Part III of the manual consists of five treatment modules. Each module emphasizes the development of a different skill that has been identified in the literature as pertinent to substance misuse and/or dependence. Each module outlines its intended purpose and objectives, as well as provides some brief psycho-education about the usefulness or importance of the skill. For each skill, a list of recommended discussion questions and skill building exercises are also included, as well as optional worksheets to be provided to participants if requested. The following are brief descriptions of each treatment module:

**Module A: Mindfulness & Self-Management:** Participants are introduced to mindfulness through a series of exercises, and taught the benefit of incorporating mindfulness into everyday life. Participants are encouraged to identify and manage cravings, triggers for substance use and use positive self-talk.

**Module B: Positive Social Interaction & Effective Communication:** Participants are taught the importance of effective communication, and provided with information about conflict resolution. Participants are also introduced to the importance of setting healthy boundaries, and encouraged to identify potential social/professional supports.

**Module C: Self-compassion:** Participants are introduced to self-compassion, as well as the importance of self-care. Participants are encouraged to identify adaptive coping techniques.

**Module D: Problem Solving:** Participants are taught strategies for problem solving, and encouraged to work through a variety of scenarios as a group. Participants are taught about considering alternatives, as well as relaxation strategies.

**Module E: Behavioural Activation:** Participants learn about the concept of behavioural activation and are encouraged to develop skills related to goal-setting. Participants are also encouraged to self-manage their behaviour using behavioural scheduling and taught the importance of distraction.
Chapter IV: Results

The final version of the facilitator’s manual can be found in Appendix C. The facilitator’s manual was created for agency staff to aid in the facilitation of a skills-based group for individuals experiencing dysfunction as a result of substance misuse and/or dependence. The manual contains an overview of current evidence-based best practices in treating substance use and dependence, and focuses on teaching skills aimed at reducing harm associated with substance use. Such skills include: mindfulness, positive social interaction, self-compassion, problem solving, behavioural activation and goal setting.
Chapter V: Discussion

Summary
Substance misuse and dependence is a prevalent and problematic issue. Without effective treatment, substance misuse and dependence often becomes chronic, which may result in a myriad of social, physical and interpersonal issues for the individual. Although several studies have demonstrated the effectiveness of MI in treating SUDs, a gap in the literature was identified in terms of treating those without formal diagnoses of SUD. For these reasons, continued research on effective treatment for substance misuse and dependence is of importance. Based on support from the literature, using MI to teach skills related to substance use within a Harm Reduction framework may lead to improved outcomes for service users. Such skills include: mindfulness, communication, self-compassion, problem solving, behavioural activation and goal setting.

The goal of this thesis was to develop a facilitator’s manual that would aid professionals in the implementation of a skill-based drop-in group to address substance misuse and dependence. This manual was requested and intended for use by agency staff and includes a review of current evidence-based best practices in treating substance misuse and dependence, as well as specific guidelines and recommendations for group sessions.

Strengths
This thesis was created based on empirical evidence, as outlined in the literature review, to ensure the compilation of best practices in the development of the facilitator’s manual. The literature review guided not only the creation of this thesis, but also provided support for the inclusion of specific skills, as well as the structure and content of group sessions.

Another strength of this thesis is the readability and formatting of the facilitator’s manual. Designed to be used by agency staff, the manual includes a review of evidence-based best practices in addressing substance misuse and dependence, as well as session-by-session guidelines and recommendations. Each treatment module contains several activities and exercises aimed at teaching skills, as well as all necessary worksheets and additional resources.

There are also several strengths related to the specific treatment plan outlined in the facilitator manual. First, the session guidelines include a wide range of activities, such as group discussions, exercises and games, which may help to increase participants’ interest and engagement throughout treatment. Second, the skills and strategies included in the intervention are socially significant, which may increase the potential generalizability of skills, as well as the likelihood that skills will be reinforced in a variety of natural environments. Lastly, despite the fact that each treatment module contains a clear structure for group sessions, the manual is particularly adaptable and could be tailored in a variety of ways to meet the needs of participants. The protocol included is a client-centered approach that offers an alternative to traditional abstinence-based intervention methods, which may be particularly efficacious for individuals who have not benefited from treatment in the past.

Limitations and Challenges
Despite its strengths, there are several limitations to this thesis. Perhaps the most
significant limitation is the lack of empirical research on the effectiveness and usability of the strategies suggested within the facilitator manual. Due to time constraints, no formal data were collected to evaluate the effectiveness of the intervention with the target population (specifically AMHS service users). Although a thorough review of current empirical literature was conducted and identified several skills and strategies of importance in treating substance misuse and/or dependence, there remains limited research on the applicability and effectiveness of delivering treatment protocols simultaneously. Without this information, it is difficult to assess the effectiveness of the facilitator manual, or to make improvements to the strategies included.

There are also some limitations in the treatment protocol outlined in the facilitator manual. First, the protocol does not include strategies for evaluating participant’s comprehension of material or the effectiveness of strategies at addressing dysfunction associated with substance use. Although participants’ understanding may be assessed during group discussion and by review of completed homework, neither is necessary for participation in the group. Second, due to the drop-in nature of the group, it is possible that participants may not attend all sessions and therefore receive minimal benefit from treatment. Lastly, another limitation can be found in the lack of service user involvement in the creation of the facilitator manual. While steps were taken to ensure comprehension of material, primarily by seeking feedback from agency staff, service users themselves were not included in this process.

**Multilevel Challenges to Service Implementation**

**Client level.** A significant client-level challenge in community-based settings is client motivation and participation. Regardless of treatment modality, intervention is unlikely to be effective without client involvement and participation. Although participants are referred by staff, who are likely to have a therapeutic rapport with their prospective clients, based on a history of dysfunction resulting from substance use, it is also possible that some participants may not see a reason to change their behaviour or view their substance use as problematic. Despite the inclusion of strategies aimed at increasing client motivation, some participants may remain resistant to treatment. Lastly, due to the fact that the treatment protocol is to be implemented in a group setting, it may be difficult for facilitators to tailor treatment to meet the needs of each participant, which may increase potential for dropout.

**Program level.** At the program level, staffing and infrastructure in order to adequately facilitate the treatment protocol may be a significant challenge. While sessions are designed to be two hours in length, it is recommended that some skills and specific participant groups may benefit from session being extended or reduced. However, doing so may be impractical for group facilitators, depending on their current workload. Additionally, the agency would require the ability to hold segregated group therapy sessions. Lastly, the nature of the skills and strategies included in the treatment protocol require participants to use and practice skills both in session and outside of the group. If participants do not actively practice the skills and strategies, it is less likely that the skills learned will be generalized to the natural environment.

**Organization level.** At the organizational level, it may be challenging for staff to gain approval or permission to implement the proposed treatment protocol, as well as to dedicate time and resources for facilitation of the group. Given that agency resources are largely dependent on third party funds, the services delivered by front-line staff must
align with the priorities and mission of the agency as a whole. However, it is likely that the research supporting the use of strategies and the efficacy of treatment outlined in this thesis and in the facilitator’s manual will provide sufficient rationale to support implementation of the protocol.

**Societal level.** Stigma is a significant challenge faced by clients at this agency. Moreover, substance misuse and dependence, in particular, continues to be highly stigmatized within society as a whole. Given that the majority of treatments designed to address substance use are abstinence based—that is, require participants abstain from substance use—and empirical evidence on the efficacy of harm reduction strategies remain limited, some people may question the impact of the proposed treatment protocol.

**Contribution to the Behavioural Psychology Field**

Overall, the goal of this thesis was to develop a resource of empirically based techniques and strategies for agency staff to address substance misuse and/or dependence among service users. Ultimately, the skills included in the treatment protocol may improve outcomes related to substance use, as well as well being for participants.

Additionally, this thesis contributes to research on the effectiveness and applicability of the included techniques and strategies in addressing substance misuse and/or dependence among a population that has been identified as vulnerable and highly stigmatized. As such, this thesis is likely to promote further research on the effectiveness and applicability of this treatment protocol, as well as the efficacy of combining treatment modalities to treat clients within a community setting.

**Practical Applications and Recommendations for Future Research**

Due to time constraints, the present thesis could not be directly evaluated. However, the facilitator’s manual, as it exists in its hypothetical state, is in itself a possible future research opportunity as it would be of value for the agency to conduct a pilot study to evaluate the effectiveness of the treatment protocol. In doing so, a between-group experimental research design could be used and would likely produce the most accurate results. Ideally, the study would compare outcomes of a group of participants receiving treatment with outcomes of those receiving treatment as usual, or no treatment for their substance misuse and/or dependence.

Furthermore, it is recommended that future research include the collection of both facilitator and participant feedback, which may provide direction for adjusting the treatment protocol. In addition to determining how many treatment sessions are required or produce the best outcomes for participants, participant feedback may provide some insight as to what skills are most beneficial for participants.
References


doi:10.1111/add.12960


Fernandez, E. N., & Mairal, J. B. (2017). Behavioural activation versus cognitive restructuring to reduce automatic negative thoughts in anxiety generating situations. Psicothema, 29(2)172-177


Psychology Research, 228(3), 752-759. doi:10.1016/j.psychres.2015.05.028


Appendix A
Consent For Use of Agency Name

Date: February 22, 2018

Consent for Use of Agency Name

I, Kristiana Clemens, consent to the use of the name of AMHS-KFLA's name in Meaghan Desautels' applied thesis for the Honours Bachelor of Behavioural Psychology program at St. Lawrence College.

Agency Staff Signature

Student Signature

Kristiana Clemens
Printed Name

Meaghan Desautels
Printed Name

Appendix B
Consent for Use of Agency Logo

St. Lawrence College
www.sl.on.ca

Date: February 22, 2018

CONSENT FOR USE OF AGENCY LOGO

I Kristiana Clemens consent to the use of the logo of AMHS-KFLA in Meaghan Desautels’ applied thesis poster for the Honours Bachelor of Behavioural Psychology program at St. Lawrence College.

Agency Staff Signature
Kristiana Clemens

Student Signature
Meaghan Desautels

Printed Name
Printed Name

LOGO

[REPLACE ST.LAWRENCE LOGO WITH YOUR AGENCY’S LOGO]

AMHS-KFLA
Addiction & Mental Health Services | services de lutte contre les dépendances et de santé mentale
Kingston Frontenac: Lennox & Addington
Treating Substance Misuse & Dependence

Photo retrieved from http://openphoto.net/

Facilitator’s Manual

Created by Meaghan Desautels
Honours Bachelor of Behavioural Psychology
St. Lawrence College
This manual was developed by the author in partial fulfillment of the requirements for an applied thesis in the Honors Bachelor of Behavioural Psychology degree program at St. Lawrence College. This manual was also developed at the request of staff at Addiction and Mental Health Services KFLA. At the time, the agency was in the process of designing several skill-based groups to meet the needs of clients, as well as to increase client contact with staff and accessibility to treatment.

**Description of Contents**

**Part I: Introduction**
Includes an overview of the facilitator’s manual, as well as treatment protocol.

**Part II: Current Literature & Psycho Education**
Provides an overview of current evidence-based literature in treating substance misuse and/or dependence. Facilitators are encouraged to access these resources to familiarize themselves with manual topics and skills introduced throughout treatment.

**Part III: Treatment Modules**
Provides session-by-session guidelines for group sessions, including activities, psycho-education, skills training and optional homework assignments.

- **Module A: Mindfulness & Self-management**
- **Module B: Positive Social Interaction & Communication**
- **Module C: Self-compassion**
- **Module D: Problem Solving**
- **Module E: Behavioural Activation**

**Using This Manual Effectively**
- **Read this manual in its entirety.**
- Implementation of the manual should be *individualized*, depending on group-specific needs. If necessary, the number, frequency and content of each module can be altered to meet the needs and/or limitations of participants based on the facilitators clinical judgment and expertise.
- It is recommended that facilitators review the contents of each module before implementing with participants.

**For More Information, Please Contact:**
Meaghan Desautels
Email: mdesautels16@student.sl.on.ca
Part I
Purpose & Rationale

I. To improve treatment outcomes, assist clients in meeting their goals related to substance use, and empower service users to manage their substance use and develop healthy coping strategies.

II. To provide agency staff with current evidence-based research and additional insight into the unique needs of their clients.

III. To provide a framework for facilitating drop-in group sessions, including detailed instructions for teaching skills and leading group discussions.

IV. To provide clients with psycho-education about substance use, thereby reducing harm.

V. To increase accessibility to agency services and provide clients with an alternative to abstinence-based treatment.

Participants

- 6-8 service users above the age of 16 who either:
  - A) Self-report experiencing issues related to substance use, or
  - B) Are identified by staff as requiring additional support related to substance misuse and/or dependence

- Referred to group treatment by Transitional Case Manager (TCM) or Emergency Room Service Diversion Case Manager (ERDCM).

- It is recommended, but not necessary, that participants demonstrate literacy skills at, or above, a grade 6 reading level to ensure relevance and comprehension of material.

Participants should also demonstrate a need to develop skills in at least one of the following areas:

- Self-management
- Mindfulness
- Communication
- Problem Solving
- Motivation

Note: Given that the techniques and skills included in the manual are applicable and effective in treating a variety of symptoms and diagnoses, a formal diagnosis of Substance Use Disorder (SUD) is not necessary for participation.
**Consent Procedures**

Before beginning the program, it is **recommended** that facilitators obtain verbal consent from each participant. **Consent procedures should include:**

- A thorough explanation of the purpose and content of the program, including the potential risks/benefits associated with participation
- Clarification that participation in the program is voluntary

**Note:** Written consent is **not required** for participation in the program, as it is obtained as part of the TCM/ERDCM intake process.

**Facilitators**

- 1-2 agency staff, who are part of the TCM/ERDCM staff, and possess a Bachelor’s degree in a field related to psychology (minimum).

  - **Recommended:**
    - Experience in the field of psychology, especially in working with substance misuse and/or dependence
    - Experience facilitating group treatment
    - Ability to develop and maintain rapport with service users, encourage meaningful discussion of program content and practical application of skills
    - Familiar and comfortable with Harm Reduction and Motivational Interviewing (MI) approaches to treatment

**Materials**

- Facilitator manual (one per facilitator)
- Notepad & pen/pencil
- Chairs (10 or more)

**Setting & Delivery**

- Deliver in quiet office setting, or similar location, that can accommodate approximately 10 people in total.
- Workspace should be large enough to allow for the completion of skill-building exercises, including demonstrations and role-plays.
- Although each session is designed to be approximately **two hours** long, the treatment protocol may be adapted at the facilitator’s discretion to meet group-specific needs.
Recommendations & Considerations

- This manual is designed to **compliment** existing services provided. Therefore, it is recommended that TCM/ERDCM staff continue to schedule client appointments as required by program mandates.
- Ideally, each program module should last approximately **two hours** in length and should include oral instruction, demonstrations, group exercises, rehearsal, discussion and feedback.
- Implementation of the manual should be **highly individualized**, depending on group-specific needs.
- Although it is **not necessary** to deliver treatment modules in order or in succession, each module should be offered to participants before offering a module again.
- **Note:** Unless otherwise specified, the worksheets provided in Part III of the facilitator’s manual were made by this author.

Preparation

- Read each section of the facilitator’s manual carefully. Familiarize yourself with any material or additional information that you wish to incorporate into the module.
- Prepare your introduction to the group, including a personal story if you wish.
- Take note of any materials required for the session. Photocopy the module resources required for the upcoming session—ensuring that you have a copy for each member of the group.
- Review and select discussion questions for the session. If you’d like, brainstorm a few discussion questions of your own to ask the group—keeping in mind the objective of the session.

Setting Up The Room

- Ensure that there is a chair for each participant and facilitator. If possible, provide participants with cushioned chairs or couches to facilitate relaxation.
- Arrange the chairs to form a circle. If using a whiteboard or projector to deliver the module, ensure that each participant will have an unobstructed view from the screen.
- If possible, group sessions should be held in a quiet room with **little or no distraction** (i.e. foot traffic).

**Remember:** Each group of participants and session is going to be different! Try to keep an open mind and be flexible in order to create a positive and therapeutic environment.
Module A: *Mindfulness & Self-Management*
Participants are introduced to mindfulness through a series of exercises, and taught the benefit of incorporating mindfulness into everyday life. Participants are also encouraged to identify and manage cravings, triggers for substance use and use positive self-talk.

Module B: *Positive Social Interaction & Communication*
Participants are taught the importance of effective communication, and provided with information about conflict resolution. Participants are introduced to the importance of setting healthy boundaries, and encouraged to identify potential social/professional resources.

Module C: *Self-compassion*
Participants are introduced to self-compassion, as well as the importance of self-care. Participants are encouraged to identify adaptive coping techniques.

Module D: *Problem Solving*
Participants are taught strategies for problem solving, and encouraged to work through a variety of scenarios. Participants are encouraged to consider alternatives, as well as use relaxation strategies.

Module E: *Behavioural Activation*
Participants learn about the concept of behavioural activation and are encouraged to develop skills related to goal setting. Participants are also encouraged to self-manage behaviour using behavioural scheduling, and are taught the importance of distraction.

Don't let yesterday take up too much of today.
- Will Rogers
Part II
This section provides a thorough review of current evidence-based literature as it relates to substance misuse and dependence. As a facilitator, it is important that you are knowledgeable about the topics discussed and feel comfortable delivering treatment as it is recommended.

**Topics Discussed Include:**
- Prevalence of Substance Use Disorder (SUD) and polysubstance use among individuals who engage in substance use
- Short & Long-term implications of substance use
- The role of learning and development in the development and maintenance of substance misuse & dependence
- Motivational Interviewing (MI) and Harm Reduction
- Evidence-based treatment design, implementation & content in treating SUD’s

**Objectives**
- Provide a thorough review of current literature as it relates to substance misuse and dependence.
- Explain the principles of Motivational Interviewing (MI) and Harm Reduction.
- Provide staff with the means to educate clients on substance misuse and dependence, as well as evidence-based best practice in terms of treatment.

Knowing is not enough; we must apply. Wishing is not enough; we must do.

- Johann Wolfgang
According to The Canadian Community Health Survey, rates of substance use in Kingston surpass those of provincial norms.

- 11.4% of men and 6.6% of women 19+ reported drinking more than 1 drink per day in the previous 12 months
- Approximately 20% of adults self-identified as “heavy drinkers” (17.7% provincial average)
- Highest rates of drinking among men aged 19-29
- 36% of residents reported using an illicit drug in their lifetime, excluding one-time use of marijuana
- 12.7% reported using an illicit drug at least once in the previous year, not including marijuana
- Cocaine/crack was the most frequently used illicit substance (9.1%), followed by hallucinogens, PCP or LSD (4.6%)

Recent literature has demonstrated the association between lifetime substance use, polysubstance use, and Substance Use Disorders (SUD’s).

Wu et al. (2017) examined substance use among 2000 adults in five primary care settings in the U.S. and found…

- Approximately 28% of participants reported ‘drug’ use and 62% reported alcohol use in the last year
- 13.9% and 14% of participants met DSM-5 criteria for Substance Use Disorder (SUD) and Drug Use Disorder (DUD), respectively.
- Of those who reported using illicit substances (i.e. marijuana, cocaine, heroin), 50% of individuals met criteria for any DUD.

These findings suggest not only a high prevalence of substance use among adults in primary care settings, but also a high incidence of SUD and DUD among those who engage in substance use.

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1 Wu et al., 2017
2 Copersino (2017)
Hayley, Stough & Downey (2017) found similar results while studying the relationship between Cannabis Use Disorder (CUD) and co-occurring substance use. By examining data collected from the 2012-2013 National Epidemiological Survey on Alcohol and Related Conditions (NESARC-III), which consists of a nationally representative sample of approximately 36,000 adults in the United States researchers found...

- CUD was strongly associated with greater incidence of lifetime drug use, specifically stimulant-type drugs (i.e. cocaine, prescription stimulants, and club drugs, including MDMA and LSD)
- Cannabis use early in life was associated with comorbid use of other illicit substances later in life
- The observed association between CUD and lifetime substance use might reflect a natural progression of maladaptive patterns of behaviour, which, for many, may result in polysubstance use.

The Role of Learning

Studies suggest that negative reinforcement—that is, the escape or avoidance of stressors—may provide additional insight in regards to the role of learning in the development and maintenance of SUD’s. ²

- Over time, an individual’s urge to engage in substance use may be strengthened as a result of predisposing factors and neurobehavioural adaptations that result from the escape or avoidance of stressors.
- Eventually, this escape or avoidance weakens willpower, interfering with an individual’s ability to think rationally about the benefits and risks associated with continued substance use.

SUD Remission

According to Fleury et al. (2016), relatively few studies have documented the course and duration of SUD remission, despite evidence suggesting that patterns of substance misuse and dependence are chronic for many. Using conservative remission rates to examine the results of 21 studies published worldwide in a meta-analytic review, researchers found a wide variation in remission rates among individuals with various SUD’s.

- Overall, 54% of individuals were in remission from SUD’s after an average of 18 years of substance use.
- No differences were found in remission rates based on comparisons of legal and illicit substance use among participants.
- Remission rates for SUD’s tended to rise with the overall number of follow-up years and early intervention.

² Copersino (2017)
Negative Impact of Substance Use

Stigma & Shame
- Higher levels of perceived stigma associated with substance use was correlated with lower self-esteem, higher levels of internalized shame, and poorer sleep.\(^3\)
- Individuals who perceive more stigma towards their diagnosis of SUD report higher levels of internalized public stigma, which has a negative effect on both mental and physical health.

Intimate Partner Violence
- Overall, findings suggest a high incidence of Intimate Partner Violence (IPV) among those who engage in substance use.\(^4\)
- Findings suggest that those who engage in illicit substance use are more likely to be victims of IPV, as compared to those who engage in alcohol use, for example.
- Individuals who met criteria for SUD, as compared to those who engaged in substance use relatively infrequently, were more likely to be victims of IPV.
- There was a significantly stronger association between male substance use and IPV perpetration, as compared to female perpetration.
- Rates of IPV were statistically similar among individuals who used amphetamines, cocaine, marijuana and ‘other’ drugs, including pills and tranquilizers.

Summary
Although studies have demonstrated the need for effective, timely and accessible intervention, as well as the prevalence of Substance Use Disorder (SUD) and polysubstance use among people who use substances, support and treatment remain limited.\(^5\)

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\(^3\) Birtel, Wood and Kempa (2017)
\(^4\) Cafferky et al. (2018)
\(^5\) Wu et al., 2017; Hayley et al., 2017; Fleury et al., 2016; Prendergast et al., 2002; Burlingame et al., 2016
Several researchers have examined the role of evidence-based treatment design, implementation and content in effective interventions for SUD’s.

**Data Suggests...**

- Overall, data suggested a statistically significant and clinically meaningful relationship between treatment and substance use outcomes, as well as crime outcomes. ⁶
- Studies that are rated as *well-implemented*, that included *standardized treatment protocols* and were *monitored* in terms of treatment delivery produce better outcomes. ⁷
- Interventions that focused on the *practical application of skills* were more effective than those that relied heavily on theoretical content. ⁸
- Overall, results indicated that there is *no difference* in treatment outcomes when individual and group treatments are compared across a range of participant populations.⁹
- Data also suggests that, in general, acceptance and dropout rates do not differ, regardless of whether a group or individual format is delivered to participants.¹⁰
- Positive correlation between a researcher’s allegiance to a particular treatment format and overall effect size, suggesting that researcher bias may have the potential to impact the effectiveness of intervention.¹¹
- Group treatments typically service more clients in less time, and increase service access by utilizing clinician’s time effectively.¹²

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⁶ Prendergast et al. (2002)
⁷ Prendergast et al. (2002)
⁸ Prendergast et al. (2002)
⁹ Burlingame et al. (2016)
¹⁰ Burlingame et al. (2016)
¹¹ Burlingame et al. (2016)
¹² Burlingame et al. (2016)
Research on the best practice in terms of treating individuals within **community settings** and **without official DSM-5 diagnoses remain limited**, especially regarding specific treatment content.\(^{13}\) However, a review of previous and current literature revealed several theoretical considerations that may be particularly effective in reducing substance misuse and dependence across a variety of settings and client demographics.

**Topics Discussed Include:**
- Motivational Interviewing (MI)
- Harm Reduction

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\(^{13}\) Hayley et al., 2017; Wu et al., 2017; Fleury et al., 2016
Motivational Interviewing (MI) is a psychosocial intervention aimed at enhancing intrinsic motivation by eliciting and strengthening an individual's internal commitment to change. Information only given if particular participants agree, and after they have explained what they already know about a given topic.

What does MI involve?
1. Encourage participants to voice their desires, needs and reasons to change behaviors
2. Increase motivation to change behavior
3. Support the person in the plan he or she chooses, when they are ready, with an emphasis on reducing risk behaviour.

Sayegh et al. (2017) conducted a meta-analysis of 84 studies to compare the effectiveness of Motivational Interviewing (MI) and Contingency Management (CM) in the treatment of substance misuse and dependence. Although both MI and CM were effective at reducing substance use in the majority of studies, each approach produced a substantial difference in outcome during follow-up.

- CM produced significant follow-up effects in the first 3 months following intervention, but these changes were not maintained in the following 3 months.
- While MI did not produce significant treatment effects during the first 3 months following treatment, significant follow-up effects were observed between 3-6 months after intervention.

NOTE: The authors assert that MI may be more effective at reducing substance use because it may enhance participants’ intrinsic motivation and internal commitment to change, unlike CM, which may promote extrinsic motivation due to the promise of reward or fear of punishment.

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14 Sayegh et al. (2017)
15 Bertrand et al. (2015)
16 Bertrand et al. (2015)
Bertrand et al. (2015) demonstrated the effectiveness of MI in reducing risk behaviour among a sample of intravenous drug users, or people who inject drugs (PWID), in Montreal. Researchers compared the effectiveness of a single session of MI with a brief educational intervention (EI) aimed at reducing risk behaviour (i.e. sharing drug use equipment such as syringes, filters and water). Overall, results indicated that MI was more effective at decreasing risk behaviour among participants, despite similar session length and setting.

Both interventions used a *harm reduction* approach, which emphasized individualized goal-setting and participant-led behavioural change.

- However, MI sessions were designed to encourage participants to change their behaviour based on their desires and needs, as well as motivate and support individuals in behaviour change when they were ready, rather than to provide information about substance use to the client.
- Using an MI approach, information was only provided to participants if requested, and after they had explained what they already knew about the topic. Then, participants’ reactions and opinions were explored, with assistance from the facilitator.
- At follow-up, participants who had received MI were 50% less likely to report any risk behaviour than those who had received EI, and 53% less likely to share drug use equipment.

**Note:** Researchers argued that MI has a greater effect than EI at increasing participants’ awareness by developing discrepancies between the person’s values, their goals, and the risks associated with substance use.
What is Harm Reduction?

Harm reduction therapy is a compassionate and respectful approach that emphasizes “meeting individuals where they are at” in terms of motivation to change.\(^{17}\) One major difference between harm reduction and abstinence-based programs is the definition of therapeutic progress.\(^{18}\)

Although abstinence may be the ultimate goal for some clients, harm reduction is a client-directed approach that involves supporting and encouraging self-efficacy, practicing refusal skills, identifying triggers and developing alternative behaviours.\(^{19}\) Several researchers have argued that harm reduction may be effective in reducing risk behaviour and producing behavioural change among individuals who normally do not seek treatment, due largely to the abstinence-based inclusion criteria of most interventions for substance misuse and dependence.\(^{20}\)

Boucher et al. (2017) explored the efficacy of harm reduction strategies among people who inject drugs (PWID) in Ottawa through a series of semi-structured interviews.

- Most participants reported using harm reduction strategies in their everyday life, including using community supports and services.
- Common reasons for using these services included access to drop-in services and sterile equipment for substance use. Several participants also noted the importance of having moral support or positive social interaction with staff members, and feeling a sense of belonging to the community.
- In terms of strategies for managing substance use, the most common harm reduction strategies reported by participants included using in moderation and increasing engagement in the community.
- A large portion of participants reported that they used marijuana, alcohol and cigarettes as common substitutions for their drug of choice.
- The majority of participants reported at least some instance of using increased awareness or self-reflection to manage their substance use. Other strategies included reflecting on difficult or traumatic events, reflecting on substance use, and recognizing progress over time.
- Some participants mentioned the importance of maintaining a positive attitude or sense of humor to cope.
- In terms of behavioural strategies, several participants reported the benefits of distraction, and suggested that community-based harm reduction services incorporate more opportunities for peer discussion and community involvement as a means to reduce harm, break isolation and provide individuals with adaptive coping strategies.

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\(^{17}\) Marlatt, Blume & Parks (2001)

\(^{18}\) Logan & Marlatt (2010)

\(^{19}\) Marlatt et al., 2001; Logan & Marlatt, 2010

\(^{20}\) Marlatt et al., 2001; Logan & Marlatt, 2010; Elzerbi et al., 2015
Harm Reduction Strategies

✓ Managing substance use behaviours
  o Reducing substance consumption little by little each day/week/month
  o Planning not to use substances until a certain time of day, or a day of abstinence per week/month/etc.
  o Changing route of substance administration—for example, smoking instead of injecting
  o “Swapping” one substance for another—for example, using cigarettes or marijuana to reduce cocaine cravings

✓ Reducing risk behaviour
  o Preventing the contraction of HIV, and other blood borne conditions by minimizing shared drug use equipment, preventing needle stick injuries, etc.
  o Carrying condoms to reduce the transmission of Sexually Transmitted Infections (STI’s), as well as HIV and other blood borne conditions.
  o Taking public transportation while under the influence of substances
  o Increasing communication with a positive social support network
  o Arranging childcare, if needed.

✓ Treatment for substance misuse and/or dependence
  o Support in learning skills related to substance use

✓ Medication-assisted treatment (MAT) for opioid misuse and/or dependence
  o Such as methadone, buprenorphine, and naltrexone

✓ Opioid overdose prevention
  o Commonly known as naloxone, which can be given as a metered nasal spray or an injection.
Part III
The following section provides a **session-by-session outline** of the treatment modules, including suggested topics for discussion, group exercises and recommended worksheets. Each module is designed to be approximately **two hours** in length; however, it should be noted that this is a recommendation and facilitator’s can extend or reduce module length, if they so choose.

**Topics Discussed Include:**
- Mindfulness
- Positive Communication & Social Interaction
- Self-compassion
- Problem Solving
- Behavioural Activation

**Objectives**
- Provide staff with the means to educate clients on substance misuse and dependence, as well as evidence-based best practice in terms of treatment.
- Provide a thorough review of current literature as it relates to substance misuse and dependence.
- Provide staff with the means to facilitate group sessions, including group discussions and activities.
- Provide participants with optional exercises to complete after session to facilitate the generalization of skills learned.
- Provide participants with a non-judgmental, safe, and inclusive atmosphere to learn skills and change behaviour.

*There are no limits to what you can accomplish, except the limits you place on your own thinking.*

- Brian Tracy
Module A: Mindfulness
**What is Mindfulness?**

Mindfulness is “being attentive to whatever is occurring in the present moment (e.g. emotions, thoughts) without needing to judge or change anything about the experience”.21

**Rationale**

- Research suggests not only an association between mindfulness and mental health disorders, in general, but also implicates mindfulness in the development and maintenance of SUD’s, depression and PTSD.22
- Research has shown that Mindfulness-based interventions (MBI’s) may be just as, if not more, effective than Cognitive-behavioural therapy (CBT) in the treatment of substance misuse and dependence.23
- MBI’s have been associated with reduced consumption of a variety of substances, including alcohol, cocaine, amphetamines, marijuana, cigarettes, and opiates.24
- MBI’s have also been associated with a reduction in self-reported craving, which suggests that MBI’s may be effective at improving psychological outcomes (i.e. psychological distress) for individuals.25
- Time spent practicing mindfulness has been correlated with a reduction in craving and substance use.26 These results highlight home-based practice as a key component in the ongoing recovery from substance misuse and/or dependence.
- MBI’s may be particularly effective for more severe clients, specifically those with co-occurring high SUD symptom severity and high levels of depression and/or anxiety symptoms, as well as clients with high SUD symptom severity only.27

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21 Shorey et al. (2014)
22 Shorey et al. (2014)
23 Chiesa & Serretti, 2014; Garland et al., 2017
24 Chiesa & Serretti, 2014; VanderVeen & Cyders, 2014
25 Chiesa & Serretti, 2014; Kirby, Tellegen & Steindl, 2017; Brewer, Elwafi & Davis, 2014
26 Enkema & Bowen, 2017; Grow et al., 2015
27 Roos, Bowen & Witkiewitz (2017)
**Objectives**

✓ Assist participants in developing the skill of mindfulness, and explain the benefits of doing so.

✓ Teach participants how to identify and manage cravings and triggers for substance use and use positive self-talk.

✓ Lead participants in exercises to introduce ways of experiencing triggers, cravings and thoughts of using without “automatically” reacting.

✓ Decrease stress and stress reactivity.

✓ Encourage participant’s to practice mindfulness at home and in their everyday life.

**Materials**

- Chairs
- Photocopied worksheets (see module resources)
- Pens

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The moment that judgment stops through acceptance of what is, you are free of the mind. You have made room for love, for joy, for peace.

—Eckhart Tolle
1. **Introductions (5 mins)**

*Introduce yourself*— start by saying your name. This might also be a good opportunity to let participants know a little bit about yourself or your professional background! Include an interesting fact or story about yourself.

*Note:* This is part of building therapeutic rapport with your group—participants may be more likely to open up with you if you share something with them.

*Participant introductions*— have the participants introduce themselves to the group. This can be done by going around the circle, or by having participants jump in as they feel comfortable until everyone has taken a turn.

2. **Group Guidelines (15 Mins)**

*Overview of group*— explain the purpose of the group to participants. It may be important to note to participants that the skills and strategies introduced during sessions:

A. Are supported in current evidence-based research as being effective, or helpful, in the treatment of substance misuse and/or dependence.

B. Are adaptive coping strategies that can be used by anyone.

C. Are skills that should be practiced in-between session.

*Important:* Remind participants that abstinence is not required for participation, but encourage participants to refrain from or decrease substance use prior to session, if possible.

*Participant suggestions*— ask participants to brainstorm a list of suggested guidelines for the group. Guidelines may include behaviors to refrain from (i.e. “no talking over one another”) or behaviors for participants to engage in (i.e. “honest disclosures only”). For future reference, make note of any suggested guidelines below:

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**Identify possible barriers**—ask participants to identify any possible barriers to treatment, or practice of skills at home. For future reference, make note of any potential barriers below:

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**Important:** Remind participants that while modules are flexible and can be adapted to meet their needs and preferences, it is their responsibility to get along with their group members and practice the skills they have learned in-between modules.

3. **Social Activity (10 Mins)**
Choose one of the following activities and engage the participants *(see module resources)*.

*Option A:* Two Truths, One Lie
*Option B:* Interview

**Note:** Social activities can be a fun way for participants and facilitators to get to know one another, and will contribute to the rapport of the group. This is also your first opportunity to make observations regarding the characteristics of group members, and to watch how they interact with one another.

4. **What is Mindfulness? (10 Mins)**

*Instructions:* Describe mindfulness in your own words, using the information below as well as your personal knowledge. If possible, incorporate personal stories or facts about mindfulness, or how you practice mindfulness in everyday life.

*Mindfulness* is “being attentive to whatever is occurring in the present moment (e.g. emotions, thoughts) without needing to judge or change anything about the experience”.  
- **Contains 2 core components:**
  1. Maintaining awareness of the immediate experience and,
  2. Maintaining an attitude of non-judgment and acceptance towards this experience

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28 Shorey et al. (2014)
5. Mindfulness Exercise (15 Mins)

**Instructions:** Using the exercise provided, engage participants in a mindfulness activity (see module resources).

**Group Discussion (15 Mins)**

**Instructions:** Facilitate a discussion with the group about substance use and the importance of mindfulness. Find some possible discussion questions below:

- How could mindfulness be helpful in changing substance use behaviour?
- How do you think mindfulness might help you in your life?
- What is the opposite of mindfulness?
- How might mindfulness be helpful in identifying triggers or cravings?
- What do you think happens when we’re not thinking or behaving mindfully?

**Note:** Clients are encouraged to notice how triggers are experienced in thoughts, emotions and physical sensations. Also, how the automatic tendency to interpret and judge experience can prevent us from being “fully present” and aware of helpful options.

6. Activity: Mindfulness in High-Risk Situations (20 Mins)

**Instructions:** Encourage participants to identify past triggering situations and factors associated with substance use, using the worksheet provided (see module resources).

7. Group Discussion (15 Mins)

**Instructions:** Ask participants to brainstorm ways that they could incorporate mindfulness into their everyday life. Find some possible discussion questions below:

- Can you think of some ways that you already use mindfulness?
- What helps you feel calm?
- How could you perform daily activities (i.e. chores) mindfully?
- What does it mean to set an intention?
- How could mindfulness help in dealing with cravings?

**Homework (Optional)**

**Instructions:** Provide participants with the continuing mindfulness practice worksheet (see ‘additional resources’).

*Nothing brings down walls as surely as acceptance.*

-Deepak Chopra
Social Activities

Instructions: Choose one of the following activities and engage the participants

Option A: Two Truths, One Lie
Instructions: Hand each participant a card (see next page) and a pen. Ask the participants to write down two true facts about themselves, and one lie. When everyone is finished writing, ask members to volunteer to share what they have written. Afterwards, ask other group members to vote on which statement they believe to be a lie. Keep track of which statement each participant thinks is a lie (i.e. record the number) on a whiteboard or piece of paper. After everyone has voted—including facilitators—ask the participant to disclose which statement was a lie. Continue on until each person has shared their statements.
Note: To make things even more interesting, give each participant who guesses the right answer (i.e. the lie) a point throughout the activity. If nobody guesses the right answer, the person who shared their statements gets a point. At the end of the activity, tally up the points and declare a winner!

Option B: Interview
Instructions: Divide the group into pairs. In two minutes or less, ask the pair to interview each other and find out 3 interesting facts about their partner. Bring everyone back together and ask each participant to present one interesting fact about their partner to the rest of the group.
Two Truths, One Lie

**Instructions:** Before the session, photocopy the following page and cut out the boxes. During the exercise, hand a paper and a pen to each participant. For a complete list of instructions to complete the activity, see the previous page.

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Five Senses Mindfulness Exercise

Sometimes we feel like we’re caught up in a whirlwind of thoughts and emotions. The following exercise is a quick and easy technique that can be used to feel more centered and bring yourself back to the present moment when you’re caught up worried or thinking about something, having trouble focusing, or feeling upset about something. It’s also great to practice at times when you’re not feeling as stressed, so that you know exactly how to use it when you need it the most.

If you begin to notice thoughts coming into your mind, that is completely normal. Take this as an opportunity to be kind to yourself and try not to judge. Just notice that you are having these thoughts, then, redirect your attention back to the here and now.

1. **Sit in a comfortable upright position with your feet flat on the ground.** Rest your hands on your legs and, if you feel comfortable, close your eyes.

2. **Notice your breathe.** No need to breathe in any particular way. Bring your attention to each part of the breathe—the inhale, exhale, and space in between.

3. **Bring your awareness to each of your 5 senses**—we will go through them one at a time.

   **Sound:** Begin to notice all of the sounds around you. Again, try not to judge the sounds, just notice them. They are not good or bad, they just are. Some sounds might be internal, like breathing or the sound of your stomach rumbling. Sounds might also be close by or more distant, like the sound of traffic. You may begin to notice subtle sounds you did not hear before.

   **Smell:** Now, shift your attention to notice the smells in this room. Maybe you smell food, or maybe you can smell the shampoo of the person next to you.

   **Taste:** Next, focus your attention on what you taste. You may notice an aftertaste of a previous drink or meal—maybe your morning coffee. You can just notice your tongue in your mouth, your saliva, and you breathe as you exhale. Run your tongue over your teeth and cheeks.

   **Touch:** Bring your focus to the sensation of your body in contact with your chair, clothing, and feet on the floor. You may notice the pressure between your feet and the floor, or you body and the chair. You may also notice temperature, like the warmth or coolness or your hands or feet. You might take time to focus your attention on your hands on your lap.

   **Sight:** If your eyes are closed, you can now open them and focus your attention on what you see in front of you. As you observe your surroundings, notice the colors, shapes and textures. If you really look, you may notice things you haven’t noticed before.

Now that we’ve almost finished, pause to notice how your body feels in this moment. Compare how you feel now with how you felt 5 minutes ago—what has changed?
**Mindfulness In High-Risk Situations**

What *emotions* do you experience before you use substances? How do you feel when you are in crisis? (Circle all that apply).

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<td>Jealous</td>
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<td>Frustrated</td>
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<td>Panicked</td>
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<td>Self pity</td>
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Overall, which 3 emotions would you say you experience the **most** before you use substances? List and rate each emotion from 0-10, based on the intensity you experience them.

1. ____________________________
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3. ____________________________

**Thoughts & Images**

Think about a time recently that you engaged in substance use and were feeling especially emotional. What thoughts were going through your head? What caused you to feel the way you were feeling?

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**Physical Sensations**

At the time, what did you notice in your body? What did you feel and where did you feel it? (e.g., difficulty breathing, increased heart beat).

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**Behaviour**
What could you have done differently? How would the outcome have changed?

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**Using Mindfulness**
Now that you’ve learned about the skill of mindfulness, how do you think you could use it next time you are experiencing a craving to use substances? How might you try to stay in the present moment? Do you think that would change the outcome of the situation?

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Continuing Mindfulness Practice

Instructions: Below are several ways that you can incorporate mindfulness practice into your daily life. Practicing mindfulness regularly not only makes it easier to use in times of distress, it can also help you become more aware and help you pay attention.

1. Deep breathing techniques— there are many different ways to practice deep breathing. Some common deep breathing techniques include belly breathing, box breathing, and 4-7-8 breathing, as described below. Try it for yourself!

   Step One: Get into a comfortable position—either sitting with your feet on the floor, or lying down. Place one hand on your stomach and one hand on your chest.
   Step Two: Breathe in slowly, but deeply. Take 4 seconds to breathe in, feeling your stomach move in the process.
   Step Three: Hold your breath for 7 seconds.
   Step Four: Breathe out for 8 seconds, as softly as you can. Once you reach a count of 8, you should have completely emptied your lungs of air.
   Step Five: Repeat as many times as you need!

2. Setting daily intentions— intentions are like guiding principles for how you want to live, be and interact with others. But intentions shouldn’t be confused with goals—they are not something that you attach an expectation or evaluation to. It’s an aim, a purpose or an attitude that you live by.

   To set a daily intention: Think carefully about what intention you’d like to set for your day, and either write it down or commit it to memory. Throughout the day (especially when you’re feeling stressed or out of the present moment), remind yourself of your intention, using the moment as an opportunity to realign your behaviour and your purpose.

3. Performing everyday activities mindfully— even everyday activities can be used to practice mindfulness! The more we practice being in the present moment, the easier it will be to get there. Try a few of the suggestions below!

   Doing dishes: focus your senses on the sound of the running water, the warmth on your hands, the smell of the soap, the sound of the bubbles popping, etc.
   Showering: focus your senses on the warmth of the water, the running water against your skin, the smell of soap, the sound of running water, etc.
Module B: Positive Social Interaction & Communication
**What is Positive Communication & Social Interaction?**

Positive and effective communication includes the ability to express feelings or ideas, as well as listen to the feelings and ideas of others. It includes our ability to resolve conflict in an assertive, but respectful way that encourages collaboration.

**Rationale**

- Data suggests that greater confidence in problem solving abilities is associated with greater willingness to adhere to program expectations.²⁹
- Self-appraised social problem solving abilities may be important indicators of treatment successes and outcome among individuals diagnosed with SUD.³⁰

**Objectives**

- Teach participants about the importance and benefits of effective communication.
- Inform participants about adaptive conflict resolution strategies, as well as the importance of setting healthy boundaries.
- Assist participants in identifying potential social and professional resources.

**Materials**

- Photocopied worksheets (see additional resources)
- Pens
- Chairs

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“One can choose to go back toward safety or forward toward growth. Growth must be chosen again and again; fear must be overcome again and again.”

- Abraham Maslow

²⁹ Herrick & Elliot (2001)
³⁰ Herrick & Elliot (2001)
1. **Introductions (5 mins)**

*Introduce yourself*— start by saying your name. This might also be a good opportunity to let participants know a little bit about yourself or your professional background! Include an interesting fact or story about yourself.

**Note:** This is part of building therapeutic rapport with your group—participants may be more likely to open up with you if you share something with them.

*Participant introductions*— have the participants introduce themselves to the group. This can be done by going around the circle, or by having participants jump in as they feel comfortable until everyone has taken a turn.

2. **Group Guidelines (15 mins)**

*Overview of group*— explain the purpose of the group to participants. It may be important to note to participants that the skills and strategies introduced during sessions:

A. Are supported in current evidence-based research as being effective, or helpful, in the treatment of substance misuse and/or dependence.

B. Are adaptive coping strategies that can be used by anyone.

C. Are skills that should be practice in-between session.

**Important:** Remind participants that abstinence is not required for participation, but encourage participants to refrain from or decrease substance use prior to session, if possible.

*Participant suggestions*— ask participants to brainstorm a list of suggested guidelines for the group. Guidelines may include behaviours to refrain from (i.e. “no talking over one another”) or behaviours for participants to engage in (i.e. “honest disclosures only”). For future reference, make note of any suggested guidelines below:

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Identify possible barriers—ask participants to identify any possible barriers to treatment, or practice of skills at home. For future reference, make note of any potential barriers below:

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Important: Remind participants that while modules are flexible and can be adapted to meet their needs and preferences, it is their responsibility to get along with their group members and practice the skills they have learned in-between modules.

3. Social Activity (10 Mins)
Choose one of the following activities and engage the participants (see module resources).

Option A: Two Truths, One Lie
Option B: Interview

Note: Social activities can be a fun way for participants and facilitators to get to know one another, and will contribute to the rapport of the group. This is also your first opportunity to make observations regarding the characteristics of group members, and to watch how they interact with one another.

4. Group Discussion (20 mins)
Instructions: Facilitate a group discussion about communication, and the importance of communicating effectively. For sample discussion questions, see below:

- What does it mean to communicate effectively?
- What happens when you don’t communicate effectively?
- Why is communicating effectively hard?
- Why does it matter to communicate effectively?
- How can communicating effectively help to solve problems?
- How do you feel when you don’t communicate effectively?
- What do you think/feel when others don’t communicate effectively with you?
5. **What is Effective Communication? (5 mins)**

*Instructions:* Describe effective communication, and explain the importance of communicating effectively. Provide participants with the effective communication worksheet (see *module resources*).

6. **Setting Healthy Boundaries (10 mins)**

*Instructions:* Explain the importance of setting healthy boundaries to participants, using your own words. If possible, recount a personal story about setting healthy boundaries. Discuss strategies for setting healthy boundaries (i.e. assertiveness, distancing, problem solving, etc.).

7. **Conflict Resolution (15 mins)**

*Instructions:* Provide participant with the conflict resolution worksheet (see *module resources*) and explain the importance of resolving conflict effectively, in your own words. Read the worksheet aloud to participants, including personal accounts of successful conflict resolution, if possible.

8. **Role Play (20 mins)**

*Instructions:* Encourage participants to choose a partner to complete the role-play using the scenarios provided (see *module resources*).

9. **Activity: Identifying Positive Supports (20 mins)**

*Instructions:* Encourage participants to identify several positive social and professional supports/resources, using the identifying positive supports worksheet (see *module resources*).

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*The secret of change is to focus all of your energy—not on fighting the old, but on building the new.*

- Socrates
Social Activities

Instructions: Choose one of the following activities and engage the participants

Option A: Two Truths, One Lie
Instructions: Hand each participant a card (see next page) and a pen. Ask the participants to write down two true facts about themselves, and one lie. When everyone is finished writing, ask members to volunteer to share what they have written. Afterwards, ask other group members to vote on which statement they believe to be a lie. Keep track of which statement each participant thinks is a lie (i.e. record the number) on a whiteboard or piece of paper. After everyone has voted—including facilitators—ask the participant to disclose which statement was a lie. Continue on until each person has shared their statements.

Note: To make things even more interesting, give each participant who guesses the right answer (i.e. the lie) a point throughout the activity. If nobody guesses the right answer, the person who shared their statements gets a point. At the end of the activity, tally up the points and declare a winner!

Option B: Interview
Instructions: Divide the group into pairs. In two minutes or less, ask the pair to interview each other and find out 3 interesting facts about their partner. Bring everyone back together and ask each participant to present one interesting fact about their partner to the rest of the group.
**Two Truths, One Lie**

**Instructions:** Before the session, photocopy the following page and cut out the boxes. During the exercise, hand a paper and a pen to each participant. For a complete list of instructions to complete the activity, see the previous page.

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39
## Effective Communication

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<th>Skill</th>
<th>Steps</th>
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| **Asking for Help**           | ✓ Look at the person.  
                                 | ✓ Ask the person politely if they have time to help you, or would mind doing so.  
                                 | ✓ Describe the problem or situation.  
                                 | ✓ Thank the person for their help. |
| **Controlling Emotions**      | ✓ Identify & monitor your feelings.  
                                 | ✓ Breathe deeply.  
                                 | ✓ Use appropriate words and a calm voice tone when expressing how you feel. |
| **Raising a Concern/Issue**   | ✓ Look at the person.  
                                 | ✓ Say, “May I raise a concern?” or “I’d like to bring something up”.  
                                 | ✓ State your concern using an appropriate voice tone and express how you are feeling.  
                                 | ✓ If you don’t agree, try restating your concern or re-approach the person later. |
| **Accepting Authority/Consequences** | ✓ Look at the person.  
                                 | ✓ Remain calm and use a pleasant tone.  
                                 | ✓ Say, “Okay” or “I understand”.  
                                 | ✓ Do not argue, sigh or pout.  
                                 | ✓ If you don’t agree, re-approach the person at a later time. |
| **Saying No**                 | ✓ Look at the person.  
                                 | ✓ Say, “No” or “I’m not able to do that”.  
                                 | ✓ Answer questions honestly.  
                                 | ✓ Remain calm. |
| **Accepting Feedback**        | ✓ Look at the person.  
                                 | ✓ Say, “Okay”.  
                                 | ✓ Stay calm.  
                                 | ✓ If you disagree, ask the person to explain or re-approach them at a later time. |
| **Giving Feedback**           | ✓ Look at the person.  
                                 | ✓ Try to stay away from overgeneralizations, like “I feel like you never do anything”.  
                                 | ✓ Use a respectful tone of voice.  
                                 | ✓ Remain calm.  
                                 | ✓ Be genuine and honest. |
Conflict Resolution Worksheet

<table>
<thead>
<tr>
<th>Step</th>
<th>What To Say</th>
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<tbody>
<tr>
<td>1. Be specific in identifying emotions</td>
<td>✓ Try to be specific about what you are feeling—avoid using general terms like “bad” or “upset”, instead use words like “guilty” or “disappointed”.</td>
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<td>✓ Mixed feelings are common—state each feeling that you are experiencing.</td>
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<tr>
<td>2. Specify the degree to which you are feeling the emotion</td>
<td>✓ It can be difficult for others to interpret our emotions—this will reduce miscommunication.</td>
</tr>
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<td></td>
<td>✓ For example, if you are feeling very angry about a situation then say, “I am furious”, or if you are only a little annoyed say, “I am annoyed about what just happened”.</td>
</tr>
<tr>
<td>3. Describe the behaviour that you did not appreciate, or the situation, and how it relates to your feelings.</td>
<td>✓ This will prevent the other person from getting defensive, and help them understand what you’re feeling.</td>
</tr>
<tr>
<td></td>
<td>✓ Be specific and honest about what you’re feeling.</td>
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<td></td>
<td>✓ For example, say “I did not like how he turned the TV off instead of telling me it was too loud. It made me angry”, instead of saying “I am so mad at him”.</td>
</tr>
<tr>
<td>4. Offer to be part of the solution</td>
<td>✓ Make an honest and genuine effort to find solutions that work for everyone, if you can.</td>
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<td></td>
<td>✓ Discuss the pros and cons to possible solutions as a team.</td>
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</table>
Conflict Resolution Role-play

Instructions: Choose one of the following scenarios to act out with your partner, using the conflict resolution strategies you have learned.

Scenario #1
First person: You’ve asked your friend for a ride to a very important job interview. Even though they assure you that you will be on time, they don’t show up when it is time for your interview.
Second person: You’ve been asked to give your friend a ride to a very important job interview, and agree. However, they don’t tell you what time the interview is. On the day of the interview, you get a very angry phone call from your friend.

Scenario #2
First person: Over the last few weeks, you’ve been trying to reduce your drinking and have made it a goal to only have one drink when you go out with friends for dinner. However, tonight when you go out, your friend urges you to order a second drink.
Second person: You’re out having dinner with some friends, but notice that one of your friends has only had one drink. You wonder whether or not they are having fun, or would like to go home instead. Hoping to make your friend feel included, you urge them to order another drink.

What have you learned?
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

What types of conflict do you typically face? Now that you’ve learned ways to effectively deal with conflict, brainstorm some possible solutions below:
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
Identifying Positive Social Supports

Instructions: Brainstorm a list of positive social supports to reach out to when you’re not doing well, need to vent, or need someone to talk to. We all go through tough times, and it’s important to remember we are never alone!

Social Supports— e.g. family members, friends, or partners.

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Information</th>
<th>How They Help Me</th>
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</table>

Professional Supports— e.g. community agencies or workers

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Information</th>
<th>Organization</th>
<th>How They Help Me</th>
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Signs I Should Reach Out

Instructions: Below, list several signs that typically mean you should reach out to your social supports. These could include signs you’re not doing well, are overwhelmed, or are experiencing cravings, for example.

1. _________________________________________
2. _________________________________________
3. _________________________________________
4. _________________________________________
5. _________________________________________
Module C: Self-compassion
**Module Overview**

**What is Self-compassion?**

Self-compassion is the act of being compassionate towards oneself during perceived occurrences of failure, or states of general discomfort.\(^{31}\)

It involves…

1. Practicing self-kindness vs. self-criticism
2. Being mindful by accepting reality as it is, instead of avoiding or escaping them
3. Recognizing that suffering and failure are aspects of common humanity, not abnormal or isolated events

**Rationale**

- Research suggests that self-compassion positively contributes to psychological well-being and self-reported life satisfaction for adolescents and adults.\(^{32}\)
- Significantly improved self-compassion, compassion for others, mindfulness, and maladaptive avoidance behaviours.

**Objectives**

- Explain the importance and benefits of self-compassion, and how it relates to substance use.
- Assist participants in identifying adaptive coping strategies and ways of managing distress.

**Materials**

- Photocopied worksheets (see ‘additional resources’)
- Pens
- Chairs

---

31 Germer & Neff (2013)
32 Germer & Neff (2013)

*Of all of the judgments we pass in life, none is more important than the judgment we pass on ourselves.*

— Nathaniel Branden
1. **Introductions (5 mins)**

*Introduce yourself*— start by saying your name. This might also be a good opportunity to let participants know a little bit about yourself or your professional background! Include an interesting fact or story about yourself.

**Note:** This is part of building therapeutic rapport with your group—participants may be more likely to open up with you if you share something with them.

*Participant introductions*— have the participants introduce themselves to the group. This can be done by going around the circle, or by having participants jump in as they feel comfortable until everyone has taken a turn.

2. **Group Guidelines (15 Mins)**

*Overview of group*— explain the purpose of the group to participants. It may be important to note to participants that the skills and strategies introduced during sessions:

A. Are supported in current evidence-based research as being effective, or helpful, in the treatment of substance misuse and/or dependence.
B. Are adaptive coping strategies that can be used by anyone.
C. Are skills that should be practice in-between session.

**Important:** Remind participants that abstinence is not required for participation, but encourage participants to refrain from or decrease substance use prior to session, if possible.

*Participant suggestions*— ask participants to brainstorm a list of suggested guidelines for the group. Guidelines may include behaviours to refrain from (i.e. “no talking over one another”) or behaviours for participants to engage in (i.e. “honest disclosures only”). For future reference, make note of any suggested guidelines below:

___________________________________________________________________________________

___________________________________________________________________________________

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Identify possible barriers—ask participants to identify any possible barriers to treatment, or practice of skills at home. For future reference, make note of any potential barriers below:

__________________________________________________________________________________
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**Important:** Remind participants that while modules are flexible and can be adapted to meet their needs and preferences, it is their responsibility to get along with their group members and practice the skills they have learned in-between modules.

3. Social Activity (10 Mins)
Choose one of the following activities and engage the participants (see module resources).

**Option A:** Two Truths, One Lie
**Option B:** Interview

**Note:** Social activities can be a fun way for participants and facilitators to get to know one another, and will contribute to the rapport of the group. This is also your first opportunity to make observations regarding the characteristics of group members, and to watch how they interact with one another.

4. Group Discussion (20 mins)
**Instructions:** Facilitate a group discussion about compassion, and encourage participants to discuss their experience being compassionate to others compared to their experience being compassionate towards themselves. For possible discussion questions, see below:

- What does it mean to be compassionate?
- How do you show compassion to others?
- Why is compassion so important?
- What does it mean to be self-compassionate?
- Why is it important to be self-compassionate?
- How do you show yourself compassion?
- How can you start showing yourself more compassion?
- How does being compassionate towards someone else differ from self-compassion?
- How are compassion and self-compassion similar?
- Why is it important to be self-compassionate about substance use?
5. **Self-Compassion (15 mins)**  
**Instructions:** Define self-compassion using your own words, if possible, and the information below. Explain the difference between self-correction and self-criticism. Next, encourage participants to complete the self-compassion exercise as a group (see module resources).

- Self-compassion is being kind to yourself, accepting your mistakes, and knowing that you can do and be better.
- Self-compassion also involves the realization that mistakes are what make us human, and are how we learn to do better.

6. **Activity: Unhelpful Thinking (15 mins)**  
**Instructions:** Provide participants with the unhelpful thinking (see module resources) and read the material aloud. Throughout the activity, encourage participants to provide examples of unhelpful thinking to the group.

7. **Positive Self-Talk (20 mins)**  
**Instructions:** Explain the concept of positive self-talk to participants, in your own words, using the information below, if needed.

- Self-talk are comments that we say to ourselves out loud and/or in our head.
- Everyone does self-talk—sometimes, without even realizing it.
- There are both positive and negative ways we can talk to ourselves—and the ways that we self-talk can affect how we feel and how we react to stress.
- Making positive comments to yourself can sometimes be helpful, while making negative comments can make you feel worse or react poorly.
- Positive self-talk can increase motivation, confidence and help you stay calm when you are experiencing stress.

<table>
<thead>
<tr>
<th><strong>Examples of Positive Self-Talk</strong></th>
<th><strong>Examples of Negative Self-Talk</strong></th>
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<tbody>
<tr>
<td>“I can do this”</td>
<td>“There’s no way I can do this”</td>
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<tr>
<td>“I may make a mistake, but that is part of learning”</td>
<td>“If I make a mistake that means that I have failed”</td>
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<td>“I am trying to be better”</td>
<td>“I can never do anything right”</td>
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8. **Activity: Positive Affirmations (20 mins)**  
**Instructions:** Provide participants with the positive affirmation worksheet (see module resources). Using your own words, explain the concept of positive affirmations to participants and provide personal examples, if possible.

**Homework (Optional)**  
**Instructions:** Provide participants with the self care tracker (see module resources). Encourage participants to identify adaptive self-care strategies, set goals and record their behaviour throughout the week.
**Social Activities**

*Instructions:* Choose one of the following activities and engage the participants

**Option A:** Two Truths, One Lie

*Instructions:* Hand each participant a card (see next page) and a pen. Ask the participants to write down two true facts about themselves, and one lie. When everyone is finished writing, ask members to volunteer to share what they have written. Afterwards, ask other group members to vote on which statement they believe to be a lie. Keep track of which statement each participant thinks is a lie (i.e. record the number) on a whiteboard or piece of paper. After everyone has voted—including facilitators—ask the participant to disclose which statement was a lie. Continue on until each person has shared their statements.

*Note:* To make things even more interesting, give each participant who guesses the right answer (i.e. the lie) a point throughout the activity. If nobody guesses the right answer, the person who shared their statements gets a point. At the end of the activity, tally up the points and declare a winner!

**Option B:** Interview

*Instructions:* Divide the group into pairs. In two minutes or less, ask the pair to interview each other and find out 3 interesting facts about their partner. Bring everyone back together and ask each participant to present one interesting fact about their partner to the rest of the group.
**Two Truths, One Lie**

*Instructions:* Before the session, photocopy the following page and cut out the boxes. During the exercise, hand a paper and a pen to each participant. For a complete list of instructions to complete the activity, see the previous page.

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**Self-Compassion Exercise**

**Instructions:** Before beginning the activity, encourage participants to sit in a comfortable position and minimize any possible distractions. Encourage participants to take a few deep breaths before reading the following exercise aloud for the group.

Begin by imagining someone who cares deeply about you. If there is no one who comes to mind, you can think of a pet or someone who has been kind to you in the past. Notice what it is like to be here with this person. Notice your thoughts and take note of any physical sensations that emerge as you’re thinking about this person.

Now, think of something that you have experienced that was stressful or upsetting in some way. Imagine that this person begins to tell you that the same event that has made you sad or uncomfortable has happened to them. What would you do or say to them in response to what they are telling you? Come up with words or gestures that might make them feel better. Allow yourself to get a sense of what it is like to extend kindness and compassion to them.

Now, imagine that your friend tells you that he or she feels much better and has to leave. As you watch them depart, you recall that you have also had this experience. See if you can allow yourself to continue to extend kindness to yourself. Try saying the same words to yourself or making the small gestures that you gave to your friend, such as giving yourself a soothing touch. Notice how this makes you feel.

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Below are a list of common unhelpful thinking styles, or cognitive distortions.

<table>
<thead>
<tr>
<th>Unhelpful Thinking</th>
<th>Description</th>
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</table>
| **All or Nothing Thinking** | Sometimes called ‘black and white’ thinking or ‘splitting’; failing to consider the positive and negative qualities of something at the same time.  
“*If I’m not perfect, I have failed*”  
“I have to do it perfect or not at all” |
| **Mental Filter** | Only paying attention to certain types of evidence. For example, noticing our failures but not our successes. |
| **Overgeneralization** | Seeing a pattern based on a single event, or being broad in the conclusions we draw about something.  
“*Nothing good ever happens to me*”  
“I always screw everything up” |
| **Jumping to Conclusions** | There are 2 main types we jump to conclusions:  
A) *Mind reading*—imagining we know what others are thinking/feeling  
B) *Fortune telling*—predicting the future |
| **Disqualifying the Positive** | Discounting the good things that have happened or that you have done.  
“That doesn’t count” |
| **Magnification or Minimization** | Blowing things out or proportion (magnification), or making something seem less important than it is (minimization). |
| **Emotional Reasoning** | Assuming that because we feel a certain way, what we think must be true.  
“I feel embarrassed so I must be an idiot” |
| **Should or Must Thinking** | Using critical words like ‘should’ and ‘must’ can make us feel guilty, or like we have already failed.  
“I must do this perfectly”  
“I should know how to do this” |
| **Labeling** | Assigning labels to ourselves or other people.  
“I’m a loser”  
“I’m completely useless” |
| **Personalization** | Blaming yourself or taking responsibility for something that wasn’t your fault. Or, blaming other people for something that was your fault. |

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Adapted from [www.psychologytools.org](http://www.psychologytools.org)
Can You Identify the Thinking Error?

**Instructions:** Each of the following maladaptive thoughts contains an unhelpful thinking style. Can you guess the thinking error(s) for each thought?

1. Something bad is going to happen.

2. I'm not good at anything.

3. I feel overwhelmed, therefore my problems are impossible to solve.

4. I did well because it was an easy test.

5. I'm a failure.

6. I'm not in the mood to do anything, so I might as well just lie in bed all day.

7. If my partner breaks up with me, I will never be happy and my life will be empty.

8. If my friend was a better liar, we wouldn’t have been caught.

9. My worker only said she liked my drawing out of pity.

10. I'm the reason my family doesn't get along.
**Positive Affirmation Worksheet**

*Instructions:* Below are several positive statements, otherwise known as ‘positive affirmations’. Positive affirmations are powerful statements that, when heard or repeated (even in your own head) can make you feel more capable or empowered.

<table>
<thead>
<tr>
<th>I am strong and wise.</th>
<th>I am my best source of motivation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>My actions are intentional and they bring me closer to my goals.</td>
<td>I am capable of accomplishing my goals and responsibilities.</td>
</tr>
<tr>
<td>I deserve what I want because I am motivated and I am ready to improve.</td>
<td>There are no blocks I cannot overcome</td>
</tr>
<tr>
<td>I will be a better person today than I was yesterday.</td>
<td>I am grateful for another day to try.</td>
</tr>
<tr>
<td>Today is full of possibilities.</td>
<td>I am worthy of love and compassion.</td>
</tr>
<tr>
<td>I trust myself.</td>
<td>I have power over my path</td>
</tr>
<tr>
<td>I am stronger than my negative thoughts.</td>
<td>I am safe.</td>
</tr>
<tr>
<td>Today I will speak with kindness.</td>
<td>I face my future with an open mind.</td>
</tr>
<tr>
<td>I am strong enough to make a change.</td>
<td>I am never alone in my struggles.</td>
</tr>
</tbody>
</table>

**Now, make your own!**

1. _____________________________________________________________
2. _____________________________________________________________________
3. _____________________________________________________________________
4. _____________________________________________________________________
Self-care is any activity that you do to try and improve your physical or mental health. Practicing self-care regularly can help you deal with stress or cravings, and can improve quality of life overall. Below are several common activities that you might try to help manage stress in a healthy way.

**Exercising:** Working out, or exercising, can be helpful in working through stress, taking your mind off things, or improving yourself physically. Exercise can also help improve our cardiovascular system, and reduce the likelihood of diseases like diabetes. Keep in mind—you don’t have to have a gym membership to exercise. Try going for a walk, or doing some light stretching.

**Eating Healthy:** Like exercising, there are several known benefits to eating healthy. Healthy eating helps your body create more energy, which can help fuel you when you are managing stress. Healthy eating can also help to improve mood, and cooking can be a great way to take your mind off things!

**Sleeping:** For many people, getting the right amount of sleep can be difficult. With the right amount of sleep, we are more well rested and better able to deal with stress. It is recommended that people get approximately 8 hours of sleep. However, everyone is different and should aim for the right amount of sleep that works for them.

**Leisure Activities or Hobbies:** When you’re dealing with stress, it can be helpful to take breaks and do things that you find enjoyable. Taking a break can help you “recharge”, and is important in trying to balance the stress of managing responsibilities. Examples of hobbies may include watching TV, taking a walk, drawing, cooking, or gardening.

**Social Relationships:** A strong supportive family or group of friends can be helpful when you’re dealing with stress, need advice, or feel overwhelmed. Sometimes it can be important to feel like someone is “on your side” and to vent about how you’re feeling. However, it is important to build healthy relationships with people who treat you with respect.

**Instructions:** Using the list above, choose 3 self-care activities to make part of your daily routine. If you’d like, you can also add your own ideas. Over the next week, use the self-care tracker (see next page) to record your daily self-care activities.
**Self-Care Tracker**

**Instructions:** Using the list provided, choose at least 3 self-care activities to try to make a part of your daily routine and record your progress throughout the next week. If you’d like, include ideas of your own!

<table>
<thead>
<tr>
<th>Self-care activity</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
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Module D: Problem Solving
What is Problem Solving?

RATIONALE

- Several studies have shown that people diagnosed with SUD are likely to have deficits in their ability to problem solve that may be exacerbated by comorbid diagnosis.\(^{35}\)
- Data suggests that individuals diagnosed with SUD use maladaptive coping strategies more often and active problem solving strategies less than those without the disorder.\(^{36}\)
- Individuals diagnosed with SUD and a comorbid mental health diagnosis (i.e. Major Depressive Disorder) report frequent use of maladaptive coping strategies, including wishful thinking, social withdrawal and self-criticism, which some researchers argue constitute risk in terms of relapse and recovery.\(^{37}\)
- Research suggests that integrating problem solving skills training into treatment for substance misuse and/or dependence may be beneficial, especially for those diagnosed with comorbid mental health disorders.\(^{36}\)

OBJECTIVES

- Assist participants in developing skills related to adaptive problem solving and conflict resolution.
- Encourage participants to apply problem solving strategies to everyday situations.
- Teach participants the importance and benefits of considering alternative thoughts, as well as the likely consequences of their behaviour, in problem solving.
- Explain the importance of relaxation strategies, and assist clients in practicing the skill of relaxation.

MATERIALS

- Photocopied worksheets (see ‘additional resources’)
- Pens
- Chairs

The pessimist complains about the wind; the optimist expects it to change; the realist adjusts the sails.

-William Arthur Ward

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\(^{35}\) Marquez-Arrico et al., 2015; Adan et al., 2017
\(^{36}\) Marquez-Arrico et al. (2015)
\(^{37}\) Adan, Atunez, & Navarro (2017)
\(^{38}\) Marquez-Arrico et al., 2015; Adan et al., 2017
1. Introductions (5 mins)

*Introduce yourself*— start by saying your name. This might also be a good opportunity to let participants know a little bit about yourself or your professional background! Include an interesting fact or story about yourself.

**Note:** This is part of building therapeutic rapport with your group—participants may be more likely to open up with you if you share something with them.

*Participant introductions*— have the participants introduce themselves to the group. This can be done by going around the circle, or by having participants jump in as they feel comfortable until everyone has taken a turn.

2. Group Guidelines (15 Mins)

*Overview of group*— explain the purpose of the group to participants. It may be important to note to participants that the skills and strategies introduced during sessions:

A. Are supported in current evidence-based research as being effective, or helpful, in the treatment of substance misuse and/or dependence.
B. Are adaptive coping strategies that can be used by anyone.
C. Are skills that should be practiced in-between session.

**Important:** Remind participants that abstinence is not required for participation, but encourage participants to refrain from or decrease substance use prior to session, if possible.

*Participant suggestions*— ask participants to brainstorm a list of suggested guidelines for the group. Guidelines may include behaviors to refrain from (i.e. “no talking over one another”) or behaviors for participants to engage in (i.e. “honest disclosures only”). For future reference, make note of any suggested guidelines below:

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Identify possible barriers—ask participants to identify any possible barriers to treatment, or practice of skills at home. For future reference, make note of any potential barriers below:

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**Important:** Remind participants that while modules are flexible and can be adapted to meet their needs and preferences, it is their responsibility to get along with their group members and practice the skills they have learned in-between modules.

3. Social Activity (10 Mins)
Choose one of the following activities and engage the participants (see module resources).

**Option A:** Two Truths, One Lie
**Option B:** Interview

**Note:** Social activities can be a fun way for participants and facilitators to get to know one another, and will contribute to the rapport of the group. This is also your first opportunity to make observations regarding the characteristics of group members, and to watch how they interact with one another.

4. Group Discussion (15 mins)
**Instructions:** Facilitate a group discussion about problem solving. For sample questions, see below:
- Why is problem solving important?
- What kinds of problems cause you the most distress?
- How do you solve problems?
- What are the most important things to consider when you’re solving a problem?
- Who else do you consider when you’re making a decision?
- How do you know if you’ve made a good decision?
- What are the risks associated with problem solving?

5. Problem Solving Strategies (15 mins)
**Instructions:** Provide participants with the problem solving worksheet (see module resources) and describe, in your own words, the steps of adaptive problem solving. When finished, ask participants if they have any questions or comments.
6. Activity: Problem Solving Scenarios (20 mins)

Instructions: Choose one of the scenarios provided (see module resources) and read aloud to participants. Afterwards, encourage the participants to discuss the scenario and apply the problem solving strategies they have learned.

Note: This activity might be a great opportunity to hear from some of the quieter members of the group—try to encourage participation from everyone if possible!

7. Relaxation Strategies (20 mins)

Instructions: Explain the importance of using relaxation strategies in times of distress, to cope with problems, etc., using the information below as a guide. Provide participants with a copy of the relaxation strategies worksheet (see module resources).

- We all face difficult things in life, but some people face these things more often than others. While none of us can fully control what happens to us or when, we are in control of how we react to these difficult things.
- Stress management works best when it is integrated into your daily life—that way it becomes a routine.
- By developing healthy coping strategies, you can learn how to identify what makes you stressed and ways to manage your stress better.
- How we think about the things we experience plays a big part in shaping the stress we will experience.

8. Activity: Relaxation Strategies (20 mins)

Using the guide provided (see module resources) choose one of the following relaxation strategies to facilitate with the group:

Option A: Progressive Muscle Relaxation
Option B: Deep breathing

Homework (Optional)

Instructions: Provide participants with the practicing problem solving worksheet and encourage them to complete it before the next session (see module resources).
Social Activities

**Instructions:** Choose one of the following activities and engage the participants

**Option A:** Two Truths, One Lie

**Instructions:** Hand each participant a card (see next page) and a pen. Ask the participants to write down two true facts about themselves, and one lie. When everyone is finished writing, ask members to volunteer to share what they have written. Afterwards, ask other group members to vote on which statement they believe to be a lie. Keep track of which statement each participant thinks is a lie (i.e. record the number) on a whiteboard or piece of paper. After everyone has voted—including facilitators—ask the participant to disclose which statement was a lie. Continue on until each person has shared their statements.

**Note:** To make things even more interesting, give each participant who guesses the right answer (i.e. the lie) a point throughout the activity. If nobody guesses the right answer, the person who shared their statements gets a point. At the end of the activity, tally up the points and declare a winner!

**Option B:** Interview

**Instructions:** Divide the group into pairs. In two minutes or less, ask the pair to interview each other and find out 3 interesting facts about their partner. Bring everyone back together and ask each participant to present one interesting fact about their partner to the rest of the group.
Two Truths, One Lie

**Instructions:** Before the session, photocopy the following page and cut out the boxes. During the exercise, hand a paper and a pen to each participant. For a complete list of instructions to complete the activity, see the previous page.

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Problem Solving Worksheet

Tom was offered a job interview for next Tuesday at 4pm, but he had to pick up his son from the babysitter at the same time. He started worrying about this and became very anxious, but tried to using a problem solving approach to help with the situation.

1. Identify the problem—I have to pick up my son, but I’ve already agreed to the interview and am really hoping I get the job.

2. Identify all possible solutions
   - I could ask my wife to pickup our son
   - I could ask if any of my friends are free
   - I could call the employer and ask if the interview time could be changed

3. Evaluate pros and cons
   - My wife might get angry, but she might also be free and available
   - There’s a good chance that someone I know will be free, but they might also feel like they have to say yes.
   - It might be possible to change the interview time, but I don’t know if that looks good to a prospective employer.

4. Select a solution—after thinking about the pros and cons, Tom ranked his solutions in the following order:
   1. I could ask my wife to pick up our son
   2. I could ask if any of my friends are free
   3. I could call the employer and ask if the interview time could be changed

5. Plan—I will wait for my wife to get home from work and ask her if she’ll be available next Tuesday to pick up our son.

6. Do—Tom asked his wife if she could pick up their son next week.

7. Review—Unfortunately, Tom’s wife was not available to pick up their son next week. She said that she may have been able to if she had been given more notice. Tom learnt that he may have to give people more notice in the future. He decided to try his next solution, and called a few friends to see if they were free. One of them was, and agreed to pick up his son. Tom attended the job interview and got the job.
Problem Solving Scenarios

Scenario #1
You live with your roommate, Gus, who has a bad habit of stealing your food. Although you’ve asked him several times not to steal your food, you’ve recently noticed that lately he ate your cereal. You’re feeling very frustrated, but you don’t want to cause a big fight with Gus.

- What would you say to Gus?
- How could you approach Gus?
- What would you do if Gus ate your cereal again?

Scenario #2
You are spending time with your friend, Carol, when you hear someone across the room making fun of her. Carol has recently been trying to change her substance use behaviour, and has keeping to herself more often than usual lately. You overhear someone calling her a “quitter” and predicting her failure. Carol has been working very hard, and you can tell she is starting to become discouraged by the comments made about her.

- How could you address the situation?
- How might you encourage Carol to address the situation?

Scenario #3
You are riding on the bus. At the next stop, someone gets on and sits next to you. You start to get frustrated because the person is playing music loudly over the speakerphone on his phone and singing along. You have a headache and would like to ride in quiet, but aren’t sure how to address the situation without making a big scene.

- How would you approach the person?
- What could you say to make them understand your perspective?
- What tone of voice would you use?
- What would you do if they started singing loudly again, after you’ve asked them to stop?
Relaxation Strategies

1. Deep Breathing
   ✓ Deep breathing has been identified as a simple and effective relaxation technique that can be helpful in times of distress.
   ✓ Deep breathing is very easy to use, can be used anywhere, and doesn’t take long to do!

   **Step 1:** Before you begin, notice your current level of stress. Become aware of the stress you are feeling in your mind and your body.

   **Step 2:** Get in a comfortable position, clear your mind, and if you feel comfortable, close your eyes.

   **Step 3:** Gently, put one hand on your chest and one hand on your belly.

   **Step 4:** As you breathe in through your nose, count to three. 1…2…3… Notice that as you breathe in, the hand on your belly will rise as your belly becomes full. The hand on your chest will stay where it is.

   **Step 5:** Count to three again as you softly let your breathe go out of your mouth. 1… 2… 3… Notice the hand on your belly go down. Allow all the air to exit your belly as you breathe out.

   **Step 6:** Repeat these steps for 2 minutes by yourself. Breathing in your nose, 1…2…3… and out of your mouth, 1…2…3… Becoming more and more relaxed with every breath you take.

   **Step 7:** (After 2 minutes) Now, open your eyes and notice your stress level. Notice the feeling of relaxation and, if you can, compare how you’re feeling now to how you felt before this activity.

2. Progressive Muscle Relaxation
   ✓ Progressive muscle relaxation has been identified as one of the most effective relaxation techniques.40
   ✓ The main idea behind the technique is that our body responds to stress by tensing the muscles, which can actually work to increase the distress we are feeling. By relaxing the muscles one by one, the body relaxes sending a different signal to the brain—you are ok.
   ✓ Progressive muscle relaxation can reduce heart rate, blood pressure and the “fight-or-flight” response.

   **Step 1:** Before you begin, notice your current level of stress. Become aware of the stress you are feeling in your mind, and in your body by practicing mindfulness and by focusing on your breath. Get in a position that is as comfortable as possible and close your eyes, if you feel comfortable.

   **Step 2:** We will begin with your right arm. Tense the muscles in your right hand, lower arm, upper arm and shoulder. Make a tight fist and bring it up to your shoulder. Squeeze your hand, tricep and bicep,

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39 Adapted from Bernstein, Brokovec, & Hazlett-Stevens, 2000
40 Vancampfort et al. (2011)
noticing the tension in your hand and arm as you do this. Squeeze and hold it for 3…2…1… Now, let go and feel how the muscles are now relaxed. (Pause)

**Step 3:** Now, we will move onto the left arm. Make a fist with your left hand and bring it up to your left shoulder. Squeeze all of the muscles in your hand and arm. Hold this for 3…2…1… Then, let go of the tension and relax. This might be a good time to check in with your breathing, and to make sure your breath is still steady, slow and deep. (Pause)

**Step 4:** Next, we will move onto the face and head. Start by squeezing your forehead muscles by furrowing your brows as if you were angry. Close your eyes tight, wrinkle your nose, clench your teeth, and smile with your mouth closed. Feel the tension in your forehead, scalp, center of your face and around your mouth, before releasing it in 3…2…1… Notice the feeling of relaxation in your forehead now, compared to before. (Pause)

**Step 5:** Next, we will work on relaxing the muscles in the neck. Bend your neck forward so that your chin is almost touching your chest. Feel the tension in the back and front of your neck and hold it for 3…2…1… and then relax. Try to be aware of the difference between how your neck felt when it was tense, and how it feels now that it’s relaxed. (Pause)

**Step 6:** Now, we will focus on the muscles in your chest, shoulders, back and stomach. Take a deep breath in and hold it as you pull your shoulder blades together. As you do this, engage your stomach muscles by hardening them. Feel the tension in your chest, shoulders, back and stomach. Let it go in 3…2…1… and relax. Do your muscles feel more relaxed now then they did a minute ago? (Pause)

**Step 7:** To tense the muscles in the right leg, straighten your leg out in front of you and tighten your thigh and calf muscles by pointing your feet for 3…2…1… and by pulling your toes towards you for 3…2…1… Notice the feeling of relaxation has now spread to your leg, and think about the difference between the tension you just experienced and the relaxation you feel now. (Pause)

**Step 8:** To tense the muscles in your left leg, straighten your left leg out in front of you and tighten your thigh and calf muscles by pointing your feet for 3…2…1… and by pulling your toes towards you for 3…2…1… Now that you’ve released the muscles, notice the feeling of relaxation you feel now and how it is different from the tension you just experienced. (Pause)

**Step 9:** Now that we’ve almost finished, scan your body from the tips of your fingertips, up to your forearms, your upper arms and your shoulders. Notice how relaxed your neck, face and face feels. Bring your attention to your stomach, your thighs, your calves and your feet. Take a moment to enjoy this relaxation before opening your eyes and returning to the session.
**Practicing Problem Solving**

**Instructions:** Use the following worksheet to apply the problem solving strategy to an issue that you have recently encountered.

1. **Identify the problem**—describe the situation. What was going on? Why was it a problem?
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2. **Identify all possible solutions**— First, what did you end up doing to try to solve the problem? Next, list a few other potential solutions.
   What I did: ______________________________________________
   **Possible Solutions:**
   A) _____________________________________________
   B) _____________________________________________
   C) _____________________________________________

3. **Evaluate pros and cons**— list the pros and cons of each possible solution.
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4. **Select a solution**— after thinking about the pros and cons, would you still choose to do the same thing? If not, what would you do now?
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   __________________________________________________________

7. **Review**— now that you’ve completed the exercise, how do you feel about the problem you encountered? Write down one thing you have learned below.
Module E: Behavioural Activation
What is Behavioural Activation?

_Behavioural activation_ is an action-oriented approach that is designed to activate clients in ways that increase rewarding experiences in their lives.\(^{41}\)

**Rationale**
- Research suggests that Behavioural Activation (BA) may be an effective treatment modality in addressing a variety of disorders, due to its emphasis on enhancing positive affect and distracting from negative emotional states, as well as its ability to initiate and enhance an individual’s motivation to fulfill goals.\(^{42}\)
- Data suggests that BA may be superior to Cognitive Therapy (CT) in terms of reducing negative automatic thoughts and modifying maladaptive behaviour.\(^{43}\)
- BA contains flexible treatment methods that can be implemented in a variety of settings, which may be particularly important in treating individuals displaying negative affect.\(^{44}\)

**Objectives**
- Assist clients in identifying and modifying nurturing and draining activities/tasks.
- Explain the importance and benefits of goal-setting, and assist participants in setting SMART goals.
- Teach participants the importance of self-managing behaviour, including substance use.
- Assist participants in brainstorming a list of possible distraction techniques.

**Materials**
- Photocopied worksheets (see ‘additional resources’)
- Pens
- Chairs

When you recover or discover something that nourishes your soul and brings joy, care enough about yourself to make room for it in your life.

– Jean Shinoda Bolen

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\(^{41}\) Ross et al. (2016)

\(^{42}\) Dimmagio & Shahar (2017)

\(^{43}\) Fernandez & Mairal (2017)

\(^{44}\) Chan et al. (2017)
1. Introductions (5 mins)

**Introduce yourself**— start by saying your name. This might also be a good opportunity to let participants know a little bit about yourself or your professional background! Include an interesting fact or story about yourself.

**Note:** This is part of building therapeutic rapport with your group—participants may be more likely to open up with you if you share something with them.

**Participant introductions**—have the participants introduce themselves to the group. This can be done by going around the circle, or by having participants jump in as they feel comfortable until everyone has taken a turn.

2. Group Guidelines (15 Mins)

**Overview of group**— explain the purpose of the group to participants. It may be important to note to participants that the skills and strategies introduced during sessions:

A. Are supported in current evidence-based research as being effective, or helpful, in the treatment of substance misuse and/or dependence.
B. Are adaptive coping strategies that can be used by anyone.
C. Are skills that should be practiced in-between session.

**Important:** Remind participants that abstinence is not required for participation, but encourage participants to refrain from or decrease substance use prior to session, if possible.

**Participant suggestions**— ask participants to brainstorm a list of suggested guidelines for the group. Guidelines may include behaviours to refrain from (i.e. “no talking over one another”) or behaviours for participants to engage in (i.e. “honest disclosures only”). For future reference, make note of any suggested guidelines below:

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Important: Remind participants that while modules are flexible and can be adapted to meet their needs and preferences, it is their responsibility to get along with their group members and practice the skills they have learned in-between modules.

3. Social Activity (10 Mins)
Choose one of the following activities and engage the participants (see module resources).

Option A: Two Truths, One Lie
Option B: Interview

Note: Social activities can be a fun way for participants and facilitators to get to know one another, and will contribute to the rapport of the group. This is also your first opportunity to make observations regarding the characteristics of group members, and to watch how they interact with one another.

4. What is Behavioural Activation? (15 mins)
Instructions: Using your own words, as well as the information provided below, explain behavioural activation and the importance of ‘keeping busy’.

- Behaviour activation is an action-oriented approach designed to increase motivation, and activate clients in ways that increase the rewarding experiences in their lives.
- Avoidance is central to behavioural activation—when we avoid things, we reduce the amount of enjoyment we can experience.
- Although avoidance can feel good in the moment, avoidance can actually make you feel worse in the long run.
5. **Activity (25 mins)**

**Instructions:** Provide participants with the behavioural activation worksheet (see module resources). Encourage participants to record a list of their typical daily activities and identify ones that are draining, nurturing, or both. As a group, discuss ways to increase nurturing activities and modify draining activities, wherever possible.

6. **Goal Setting (20 mins)**

**Instructions:** Provide participants with the goal setting worksheet (see module resources). Define SMART goals and describe, in your own words, the importance of setting goals.

7. **Self-Management (10 mins)**

**Instructions:** Define and discuss the importance of self-managing behaviour, using the information provided below, if needed.

- Self-managing can be a great way of holding yourself accountable.
- We can use self-managing to keep track of our progress towards a goal, or to be aware of our current behaviour.

8. **Group Discussion (25 mins)**

**Instructions:** Facilitate a group discussion and encourage participants to discuss ways of self-managing behaviour and substance use. For sample discussion questions, see below:

- Why is it important to manage your own behaviour?
- What are some ways that you already manage your behaviour?
- What do you find helpful in managing your behaviour?
- Why is it hard to self-manage behaviour?
- What happens when you don’t self-manage your behaviour?

**Homework (Optional)**

**Instructions:** Provide participants with the activity scheduling worksheet and encourage them to use the tool throughout the next week (see module resources).

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> When we are no longer able to change a situation, we are challenged to change ourselves.

> -Viktor E. Frankl
Social Activities

Instructions: Choose one of the following activities and engage the participants

Option A: Two Truths, One Lie
Instructions: Hand each participant a card (see next page) and a pen. Ask the participants to write down two true facts about themselves, and one lie. When everyone is finished writing, ask members to volunteer to share what they have written. Afterwards, ask other group members to vote on which statement they believe to be a lie. Keep track of which statement each participant thinks is a lie (i.e. record the number) on a whiteboard or piece of paper. After everyone has voted—including facilitators—ask the participant to disclose which statement was a lie. Continue on until each person has shared their statements.

Note: To make things even more interesting, give each participant who guesses the right answer (i.e. the lie) a point throughout the activity. If nobody guesses the right answer, the person who shared their statements gets a point. At the end of the activity, tally up the points and declare a winner!

Option B: Interview
Instructions: Divide the group into pairs. In two minutes or less, ask the pair to interview each other and find out 3 interesting facts about their partner. Bring everyone back together and ask each participant to present one interesting fact about their partner to the rest of the group.
**Two Truths, One Lie**

**Instructions:** Before the session, photocopy the following page and cut out the boxes. During the exercise, hand a paper and a pen to each participant. For a complete list of instructions to complete the activity, see the previous page.

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**Behavioural Activation Worksheet**

*Instructions:* Record a list of your typical daily activities. Put a box around activities that you find draining; circle activities that you find nurturing; lastly, put a star next to activities that you find *both* nurturing and draining.

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**SMART Goal Setting**

Once you have decided what behaviour you want to change, the first step is to develop goals. Goals help to clarify what exactly it is you want to achieve, and the steps that you plan to get there. However, it is important to set SMART goals.

**SMART Goals** are…
- **S** — specific
- **M** — measurable
- **A** — achievable
- **R** — realistic
- **T** — trackable

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<thead>
<tr>
<th>Specific</th>
<th>✓ Well defined</th>
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<td></td>
<td>✓ Clear to anyone</td>
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<tr>
<td>Measurable</td>
<td>✓ How to know when the goal has achieved</td>
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<td>✓ How to know how far away completion is</td>
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<td>Achievable</td>
<td>✓ Is the goal too big? Are there too many moving parts?</td>
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<td>Realistic</td>
<td>✓ Given your behaviour now, is it realistic?</td>
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<td>✓ Do you have everything you need to reach your goal?</td>
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<tr>
<td>Trackable</td>
<td>✓ Give yourself a time limit to achieve the goal</td>
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What’s your goal? How could someone else tell that you had achieved your goal?
__________________________________________________________________________________
__________________________________________________________________________________

How will you measure your goal? How will you know when you have achieved your goal?
__________________________________________________________________________________
__________________________________________________________________________________

Is this goal realistic? Do you have the skills and resources to accomplish your goal?
__________________________________________________________________________________
__________________________________________________________________________________

When will you accomplish this goal?
__________________________________________________________________________________
__________________________________________________________________________________
**Activity Scheduling Worksheet**

*Instructions:* After completing the group exercise, modify your weekly activities wherever possible so that you’re maximizing pleasure and enjoyment, and limiting activities that are draining.

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Addiction and Mental Health Services (AMHS) KFLA
552 Princess Street
Kingston, Ontario
Phone number: 613 544 1297
Hours: Monday to Friday 8:30am- 4:30pm

24/7 Crisis Phone Line
613 544 4229 or 1 866 616 6005 (toll free)

Drop-in Support Groups
- *Making Connections*— open to anyone with no registration required. Well-suited for anyone who is considering connecting, or have recently connected, with AMHS services. Weekly, rotating modules offer resources on coping with stress, self-managing emotions, etc.
- *Problem Solving & Support*— weekly drop-in group that offers non-judgmental support for anyone with substance use concerns.
- *Umbrella Group*— a drop-in group that explores various topics and builds skills such as relapse management, grief & loss, problem solving, coping, budgeting, etc.

Day Treatment
- Provides daily contact for individuals requiring more intensive support than individual or group counseling can offer, and who may be seeking an alternative to residential treatment.
- Participants are required to achieve some abstinence in the community prior to the program, and commit to attending 5 half days per week for 4 weeks.
- Guides participants through the process of change, offering strategies for self-stress management, emotional regulation, communication and relapse prevention.
Back on Track
- AMHS-KFLA is a provider of Back on Track, the Ontario Ministry of Transportation’s program for individuals who have been convicted of impaired driving or have had 2 or more administrative suspensions.
- Individuals must complete this program before their licenses can be reinstated.
- Assessments, courses and follow-up provided.

Motherwise
- A free, confidential service for individuals who are pregnant or have children aged 6 and under to address concerns about substance use.
- Offers individual assessments, client-centered treatment plans, confidential support, parenting information, and referrals to other community agencies and treatment facilities.

Family Resource Centre
- Provides educational material and information about local resources for family members, professionals and individuals living with mental illness or addiction.
- The FRC features a library of educational materials on loan for a $5 refundable deposit.
- All services are free.
- Peer-led support groups, including one for individuals diagnosed with mood disorders and other mental illnesses, and one for family members of someone with mental illness or substance use issues.

Providence Care (*physician referred)
752 King Street West
Kingston, Ontario
Phone number: 613 546 1101

Collaborative Mental Health Services
- Inclusion criteria: Adults (18 years of age or older) with stable to moderate severe mental illness of at least two years in duration. Last psychiatric admission must be greater than 6 months prior to referral and client must have an established family physician.
- Provides an intake assessment, supportive counseling, occupational therapy and social work support.
Mood Disorder Outpatient Services
• Adults with a primary diagnosis of severe and/or persistent mood disorder with treatment resistance or comorbidities.
• A specialized, non-urgent service for individuals diagnosed with a mood disorder.

Street Health Centre
115 Barrack Street
Kingston, Ontario
Phone number: 613 549 1440
Hours: Monday to Friday 8am-12pm/ 1pm-4pm

Harm Reduction Supplies
• Free, clean, sterile equipment for people using injection and inhalant drugs.
• Used needle pick-up in the community.
• Drop-in space

Opioid Overdose Prevention
• Free naloxone kits, training and outreach to prevent opioid overdose in our community.

Methadone Maintenance Treatment

Hepatitis C Treatment and Education
• Hepatitis C testing, treatment and support (individual and group).
• Community outreach.

Other
• Food and clothing cupboard
• Housing and job board
• Internet and phone access
• Acupuncture

Canadian Mental Health Association (CAMH)
1473 John Counter Blvd., Suite 402
Kingston, Ontario
Phone number: 613 546 4266
Hours: Monday to Friday 8:30am- 4:30pm
**Advocacy**
- Advocacy and monitoring on behalf of individuals living with mental illnesses, as well as their families.

**Living Life to the Full**
- An interactive course that introduces the five principle areas of Cognitive Behaviour Therapy (CBT) to help individuals understand their feelings and what to do about them.

**Women & Building Resilience Around the Table**
- A 10-hour long program designed to change personal perceptions of mental health and increase social connectivity.

**Mental Health Services**
- Various CAMH services require a referral from a physician or nurse practitioner.
- CAMH referral forms are available on the agency website. Clearly indicating the reason for your referral and attaching any relevant materials will help CAMH process your request.

**Detoxification Centre**
- 240 Brock Street
- Kingston, Ontario
- Phone number: 613 549 6461

- Short-term, non-medical treatment service for individuals who want to detoxify from alcohol and/or other substances, or who are waiting for intake into a treatment program.
- Offers supportive counseling and referrals to community services, self-help groups and ongoing treatment programs.
- No fees.

**Peers of the Round Table**
- 60 Queen Street
- Kingston, Ontario
- Phone number: 613 549 4964
- Hours: Monday to Saturday 10am- 3pm
For individuals 16 years or older who self-identify with addictions and/or mental health challenges.

Includes social and recreational activities, peer support, community outreach and referrals.

**The Centre for Trauma and Abuse**

234 Concession Street, Suite 200
Kingston, Ontario
Phone: 613 507 2288

Provides therapeutic counseling to survivors of all forms of abuse and trauma, as well as aims to improve public knowledge in our community regarding all aspects of abuse and trauma (advocacy).

Services are income-based. In some cases, ODSP or OW will pay for a select amount of sessions.

**Alcoholics Anonymous**

12 step, faith-based program for individuals who are seeking help in recovering from alcohol.

Meetings are open to anyone, free and confidential.

*Meeting schedule can be found online at http://www.kingstonaa.org/meetings*

**Limestone Area Narcotics Anonymous**

136 Princess Street
Kingston, Ontario
Phone: 1-888-811-3887 (toll free)

12 step, faith-based program for individuals who are seeking help in recovering from narcotics and/or alcohol.

Meetings are open to anyone, free and confidential.

*Meeting schedule can be found online at http://www.limestonena.com/meetings.php*

**Kingston Community Health Centre (KCHC)**

263 Weller Avenue
Kingston, Ontario
Phone: 613 542 2949

Hours: Monday, Thursday and Friday 8am- 4:30pm
Tuesday and Wednesday 8am- 8pm
Thrive
• A program for women who are pregnant and/or parenting children under the age of 6, and have been experiencing problems with opioids or receiving methadone treatment.
• Offers counseling, supportive visits (both in hospital and at home) and parenting support and education.
• Assist with transportation, food and childcare to reduce barriers in participating in the program.

HIV/AIDS Regional Services (HARS)
844a Princess Street
Kingston, Ontario
Phone: 613 545 3698
Hours: Monday to Friday 9am-12pm/ 1pm-5pm

Harm Reduction Supplies
• Free, clean, sterile equipment for people using injection and inhalant drugs.
• Used needle pick-up in the community.
• Drop-in space
• Confidential and non-judgmental.

Hepatitis C Treatment and Education
• Hepatitis C testing and treatment.
• Individual and group support.
• Community outreach.

City and Regional Support and Counselling
• Support and individualized counseling for individuals living with HIV or AIDS.

Other:
• Drop-in space including phone access.
• Free coffee and snacks offered daily. Occasionally, hot meals are provided by volunteers.
• Food and clothing cupboard.