Effective Treatment of Substance Addiction: An Information Resource for Staff on Best Practices Amongst Offenders

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Dedication

To all who have shown me that nothing is impossible, and that dedication and passion can change the world. To those who have provided me guidance and support, listened unconditionally, and never doubted my abilities. Thank you.
Abstract

Approximately 70% of offenders incarcerated in a federal institution demonstrate symptoms of a substance use disorder fluctuating in severity between use and dependency. Furthermore, substance use is one of the top three factors contributing to increased recidivism rates. Therefore, effective intervention is essential in order to successfully reduce and manage the risks and needs of this population. However, correctional programs staff identified effective treatment for decreasing substance abuse amongst offenders to be a gap in service. Therefore, it was hypothesized that increasing staff awareness and knowledge regarding best practice approaches proven effective at treating substance abuse within the offender population will enable correctional programs staff to be better equipped to understand substance abuse in offenders. Conceivably, this will enable staff to work more effectively with offenders who display symptoms of substance abuse. This thesis sought to develop a comprehensive treatment manual for correctional programs staff to use in the supervision and treatment of offenders incarcerated in a federal institution who display symptoms of substance abuse. The contents of this manual were selected following an in-depth literature review and feedback from correctional staff. Based on the research, best practice approaches amongst offenders include motivational interviewing, pharmacotherapy, the Risk Need Responsivity Model, and the Transtheoretical Model. Best practices that should be given consideration to improve treatment efficacy include solution-focused therapy and cognitive behavioural therapy. The resource manual provides an overview, rationale for use, and instructions on how to effectively implement each best practice approach within a correctional environment. Due to time constraints, the effectiveness of the manual was not formally evaluated. Therefore, the focus of this thesis pertains to the development of the resource manual, directed primarily by current research. In conclusion, strengths and limitations of this thesis in addition to multilevel challenges to service implementation and recommendations for future research are discussed.

Keywords: best practice approaches, evidence-based practices, offenders, substance abuse, treatment, motivational interviewing, pharmacotherapy, risk, need, and responsivity model, transtheoretical model.
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Chapter I: Introduction

Substance Addiction

An addiction is defined as repetitively engaging in a rewarding behaviour resulting in pleasure and the satisfaction of a desire, despite the behaviour producing negative consequences that outweigh the positive effects (Herie & Skinner, 2014). Addiction can be characterized by an inability to abstain, cravings, a reduced level of awareness surrounding substantial problems regarding one’s behaviour and interpersonal relationships, and inhibited emotional responses (American Society of Addiction Medicine, 2018). Substance addiction can result in negative health consequences, triggered or exacerbated mental illnesses, increased transmission of infectious diseases (National Institute on Drug Abuse, 2018), isolation from family, financial strain (Kaufman & Yoshioka, 2005), and an increased risk of engaging in criminal behaviour (Weekes, Thomas, & Graves, 2004).

Substance Abuse and Crime

The relationship between substance abuse and crime is inextricable (Nurco, Hanlon, & Kinlock 1991). Fifty-four percent of federal offenders report that they were under the influence of a psychoactive substance at the time of their offence (Pernanen, Cousineau, Brochu, & Sun, 2002), and an estimated 70% of the incarcerated population demonstrate symptoms of a substance use disorder fluctuating in severity between use and dependency (Glaze & Bonczar as cited in Taxman, Perdoni, & Caudy, 2013). National Institute of Health (2010) noted that offenders are four times more likely to be diagnosed with a substance use disorder (SUD) than the general population. Furthermore, 53% of federal offenders admit to engaging in illicit substance use in the six months prior to their most recent arrest (Pernanen et al., 2002). Of offenders who reported substance use in the six months prior to their incarceration, 85% report using marijuana, 80% alcohol and drugs, 60% cocaine, 35% tranquilizers, 30% opioids, 25% hallucinogens, 25% sedatives, 15% heroin, and 5% inhalants (Weekes, Thomas, & Graves, 2004). Moreover, Weekes, Thomas, and Graves (2004) noted that of crimes committed, for 94% of offenders the abuse of drugs and/or alcohol were strongly associated to the following crimes: driving under influence – 94%; assault – 69%; theft – 66%; murder – 58%; break and enter – 56%; robbery – 56%; sexual assault – 45%; drug-related offences – 28%; and fraud – 22%. There are three identified ways in which crime and substance abuse can be correlated: 1) crime for gain to support the cost of drug use (e.g., armed robbery), 2) crime caused by the psychopharmacological effect of a substance (e.g., violent or aggressive behaviour as a result of the disinhibiting effects of substances), and 3) criminal behaviour incorporated into drug transacting business (Weekes et al., 2004).

Substance Abuse and Recidivism

Belenko, Foltz, Lang, and Sung (2004) noted that chronic substance abuse is associated with an increased risk of recidivism. Additionally, the Government of Western Australia (2014) concluded that substance use is one of the top three factors contributing to recidivism rates. Upon being released from a correctional institution, offenders diagnosed with a substance use disorder are likely to encounter a number of stressors that challenge their substance reduction or abstinence and elevate the risk of relapse (National Center for Biotechnology Information, 2009). Stressors may include but are not limited to: the stigma associated with having been incarcerated, finding employment, reuniting with family, finding housing, and meeting the requirements surrounding criminal justice supervision (National Center for Biotechnology Information, 2009).
Unless offenders abstain from substance use or engage in treatment programs during their incarceration, reoffending rates are likely to remain elevated (Belenko et al., 2004).

**Best Practice Approaches**

Despite the high prevalence of substance abuse within federal institutions, effective treatment interventions are established. According to Friendman, Taxman, and Henderson (2007), an effective substance abuse program is comprised of a standardized assessment measure to determine severity of substance use, a standardized risk-assessment to assess the intensity of treatment required (e.g., high risk offenders receive high intensity treatment; Taxman & Marlowe, 2007), a method to motivate and engage offenders in the treatment program offered (Simpson, 2004) and consistent drug testing to observe progress (Sherman, 1997). Best practice approaches incorporate multiple or all factors that comprise an effective treatment intervention. Following an extensive literature review, it was concluded that best practice approaches to treat offenders who display symptoms of substance abuse include motivational interviewing (MI), pharmacotherapy, the Risk-Need-Responsivity Model (RNR), and the Transtheoretical Model (TTM).

Therefore, it is proposed that increasing staff awareness and knowledge regarding best practice approaches proven effective at treating substance abuse within the offender population will enable employees of correctional programs staff to be better equipped to understand substance abuse in offenders. Conceivably, staff would be enabled to work more effectively with offenders who display symptoms of substance abuse.

**Thesis Overview**

This applied thesis entails five components: (1) introduction; (2) literature review; (3) methodology; (4) results; and (5) discussion. The introduction provides readers with information pertaining to the addiction, the relationship between substance abuse and crime and substance abuse and recidivism, and indicates the need for treatment of substance abuse amongst offenders. The literature review provides additional information regarding substance abuse within the correctional environment, current programming provided within correctional facilities (i.e. the Integrated Correctional Programs Model (ICPM) program), and best practice approaches to reduce substance abuse (i.e. solution-focused therapy, narrative therapy, and psychoeducational, cognitive behavioural, skill development, and support groups). Additionally, the literature review discusses best practice approaches to treat substance abuse amongst offenders (i.e. MI, pharmacotherapy, the RNR model, and the TTM) and demonstrates the need for a resource manual for staff containing best practice approaches to reduce substance abuse amongst offenders. The methodology section provides a description of the process involved in the development of the facilitator’s manual. The results section entails a description of the resource manual as well as a summary and analysis of the data collected from the informal feedback survey administered to potential facilitators. Lastly, the discussion section contains a summary of the key components of this thesis as well as an interpretation of the results. Additionally, the discussion section outlines the strengths and limitations of the manual, the multilevel challenges to program implementations, contributions to the field of behavioural psychology, and recommendations for future research.
Chapter II: Literature Review

Substance Abuse

Substance use within the correctional environment is a significant and growing concern (Correctional Service Canada, 2015). The Canadian Centre on Substance Abuse (2016) noted that approximately 80% of offenders incarcerated in a federal institution reported problematic substance use patterns, 54% of federal offenders reported that they were intoxicated by a psychoactive substance at the time they committed their crime (Pernanen et al., 2002), and approximately 25% of offenders disclosed being pressured to bring substances into the institution upon incarceration (McVie, 2015). Correctional facilities implement numerous preventative measures to reduce the availability of substances including random and reasonable ground cell and facility searches, reasonable ground exceptional cell searches, visitor and staff screening, drug detection technology such as x-ray machines and ion scanners, security intelligence officers, and a random urinalysis program (Weekes et al., 2004). However, Weekes et al. (2004) noted that many correctional facilities have deemed a drug-free institution to be unrealistic, even with preventative measures in place. Furthermore, once released from an institution, offenders no longer have restricted access to substances. Therefore, it is essential that effective, evidence-based treatment programs are implemented while offenders are incarcerated to provide them with the skills and techniques required to avoid engaging in substance abuse during their incarceration and following their release.

The American Psychological Association (2006) defines evidence-based practices (EBP) as treatments that integrate the most recent and supported research available with clinical expertise regarding patient culture, characteristics, and preferences. EBP’s utilize empirically supported assessments and intervention principles as well as therapeutic rapport to provide effective treatments (American Psychological Association, 2006). Bahr, Masters, and Taylor (2012) note that such programs often: (a) include an incentive for participating in the treatment, (b) are provided to high-risk offenders, (c) integrate multiple intervention types simultaneously, (d) are high intensity, and (e) provide an element of aftercare.

Integrated Correctional Programs Model

Correctional Service Canada (CSC) provides offenders with the Integrated Correctional Program Model (ICPM) program; a holistic rehabilitation treatment program that targets offenders criminogenic risk factors and provides offenders with the coping strategies required to manage and reduce risky thinking and harmful behaviours (Correctional Service Canada, 2014). Offenders are taught how to set goals, problem solve, manage their thoughts and behaviours, and develop communication, interpersonal, and coping skills (Correctional Service Canada, 2014). ICPM programs are offered at both moderate and high intensity levels (Correctional Service Canada, 2014). A moderate intensity program entails 50 individual and group sessions, while a high intensity program is comprised of 97 individual and group sessions (Correctional Service Canada, 2014). Each session is between 2 to 2.5 hours in duration (Correctional Service Canada, 2014). However, not all offenders are required to complete an ICPM program as part of their correctional plan.

Given a large percentage of offenders require intervention in multiple domains, the integrated essence of the ICPM programs allows offenders to simultaneously receive treatment for multiple targets while enhancing their understanding of the relationship between various personal risk factors (Correctional Service Canada, n.d.). Furthermore, the integrated nature allows offenders to better understand how the same skill can be applied to effectively manage
multiple risk factors (Correctional Service Canada, n.d.). However, given ICPM programs address multiple risk factors, including substance abuse, the efficacy of the program is questioned. Due to the high rates of substance abuse amongst offenders, consideration should be given to providing offenders with additional EBP’s to ensure they are receiving the most effective treatment possible to reduce symptoms of substance abuse.

Best Practice Approaches

Solution-focus therapy. Solution-focused therapy is a competence-based approach in which a clinician focuses on a client’s accomplishments and strengths (McCollum, Trepper, & Smock, 2004). The helper works with the individual to create goals and determine a solution to their problem as opposed to introducing ‘appropriate’ treatment targets (Berg & Miller, 1992). A key element of solution-focused therapy is holding the technique accountable as opposed to the client should a treatment not be effective (Berg & Miller, 1992). Additionally, Berg and Miller (1992) stated that if an intervention is not producing the desired results, a new approach is adopted. Solution-focused therapy strives to determine a distinct solution for every individual, utilize previous successes to encourage confidence, and view the client as the expert (Messina, 2018). During solution-focused therapy, a clinician adopts a variety of techniques such as amplifying change, scaling questions, relapse assessment and prevention, and exception-finding questions (McCollum et al., 2004). Solution-focused therapy is often implemented during brief therapy, however, McCollum, Trepper and Smock (2004) noted that the treatment approach can be effectively implemented in group therapy.

Solution-focused therapy demonstrates growing evidence regarding its efficacy, and was deemed a promising treatment for individuals who display symptoms of substance abuse (McCollum et al., 2004). Additionally, O’Connell (2005) noted that solution-focused therapy has been found to be an effective treatment method for challenging psychological cases such as substance abuse. In contrast, Lee, Sebold, and Uken (2003) noted that though solution-focused therapy is an effective treatment for domestic violence amongst offenders, no studies have been conducted regarding the efficacy of the treatment at reducing substance abuse with this population. However, McCollum and Trepper (2001) described the approach as being effective when working with individuals who abuse drugs and alcohol, and Linton (2017) conducted a study in which an individual with presenting symptoms of a co-occurring substance abuse and anxiety disorder received solution-focused therapy. Specifically, the clinician utilized solution-focused questions including coping, scaling, exception and miracle questions (Linton, 2017). Linton (2017) noted that following the implementation of solution-focused therapy, the client was able to cope with his presenting substance cravings in a healthy and effective manner. Furthermore, Lindforss and Magnusson (1997) conducted a study in which solution-focused therapy was implemented with offenders, and recidivism rates were assessed 12 and 16 months following the study. Offenders in the experimental group received between one and 12 solution-focused therapy sessions (M = 5), with each session lasting one to two hours in duration (Lindforss & Magnusson, 1997). The results of the study concluded that offenders in the experimental group who received solution-focused therapy reported reduced rates of recidivism compared to the offenders who comprised the control group and did not receive solution-focused therapy (Lindforss & Magnusson, 1997). However, a small sample size (i.e. a control group comprised of 29 participants and an experimental group containing 30 participants) may serve as a limitation for this study (Lindforss & Magnusson, 1997). Overall, though the study did not focus on substance abuse specifically, given offenders are a difficult population to implement
treatment amongst the positive results of the study imply that solution-focused therapy would have a positive impact on alternative problem behaviours such as substance abuse amongst offenders.

Ultimately, no research has been conducted on implementing solution-focused therapy as a treatment approach for substance abuse amongst offenders. In contrast, considering the intervention has been found to be an effective treatment with challenging populations such as offenders, as well as at reducing substance abuse in the general population, it can be assumed that the implementation of solution-focused therapy would be an effective means at reducing substance abuse amongst offenders incarcerated in a federal institution. However, further research is required.

**Narrative therapy.** Narrative therapy is defined as a collaborative, non-confrontational approach in which the client is viewed as the expert of his or her life (Brown & Augusta-Scott, 2007). This allows a client to be viewed as separate from the problems in their life, and consequently develop the realization that one must not be defined by the problems in their life (Clark, 2014). Furthermore, Clark (2014) noted that narrative therapy allows a client to reflect on the relationship they experience with challenges in their life, and therefore alter the relationship to a healthier state. Narrative therapy assumes that clients possesses multiple beliefs, capabilities, competencies, skills, and values that allows them to change the way in which they view and manage problems in their lives (Morgan, 2000). Moreover, Clark (2014) noted that the approach allows a client to provide meaning to the various challenges they are encountering, and Thurston (2006) concluded that key factors of narratives include that each narrative is discoursed in chronological order, social, and meaningful.

Narrative therapy has been determined to be a beneficial treatment for various populations and presenting issues including decreasing self-harm behaviours and substance abuse in individuals diagnosed with Post Traumatic Stress Disorder (Cloitre, 2013) and decreasing self-harm behaviours in adolescents (Hannen & Woods, 2012). Furthermore, Chan, Ngai, and Wong (2012) noted narrative therapy to be a potentially effective treatment for individuals who display symptoms of substance abuse. Likewise, Brown and Augusta-Scott (2007) concluded that narrative therapy in an individual setting has proven to be effective at decreasing substance use. Clark (2014) described the implementation of narrative therapy through two case illustrations, the first being a young mother who had her children removed from her custody due to her substance abuse and the second being a mother who is seeking to reform the relationship with her children and grandchildren following a life of substance abuse. Via creating pictures and writing a letter, narrative therapy allowed both women to reflect on their past and create a positive future for themselves free of substances (Clark, 2014). Clark (2014) went on to state that the integration of narrative therapy principles into group therapy demonstrated promising results regarding reducing symptoms of substance abuse. Moreover, Szabo, Toth, and Pakai (2014) conducted a study in which individuals receiving treatment for alcohol abuse rewrote their autobiography, ensuring their linguistic expressions were reflective of an individual in recovery as opposed to someone who still abused alcohol. Szabo et al. (2014) concluded that individuals who participated in narrative therapy reported decreased feelings of hopelessness and improved problem solving skills, which are essential techniques for recovery from substance abuse. However, it should be noted that a limitation of the study conducted by Szabo et al. (2014) included a finite target population, which consequently may decrease generalization of the study’s results.
Though narrative therapy has demonstrated promising results regarding decreasing substance use, no studies have been completed regarding the efficacy of the intervention within a correctional environment. Therefore, further research is required to determine whether the implementation of narrative therapy would be an effective treatment at reducing symptoms of substance abuse amongst offenders.

**Group therapy.** The Center for Substance Abuse Treatment (2005) noted that any group has the potential to have therapeutic effects. Given humans are born with an innate propensity to congregate, group therapy has been found to be an effective treatment for numerous psychological disorders including decreasing symptoms of substance abuse (Center for Substance Abuse, 2005). Group therapy has a number of advantages including: positive peer pressure and support to refrain from engaging in substance use; decreased feelings of isolation frequently associated with substance abuse; the opportunity for group members to witness successful recovery of other individuals; the opportunity to allow group members to discover new, healthy methods of coping with substance abuse by discussing and observing how other group members manage similar problems; encouragement, support and reinforcement to group members as they undertake a challenging or anxiety-provoking task; the opportunity for a single clinician to simultaneously provide treatment to multiple clients; and added discipline and structure to the lives of people seeking treatment for substance abuse (Center for Substance Abuse Treatment, 2005). Group therapy models include but are not limited to psychoeducational groups, cognitive-behavioural groups, skills development groups, and support groups (Center for Substance Abuse Treatment, 2005).

**Psychoeducational group.** Psychoeducation is the process of informing clients of key information while adopting a cognitive-behavioural approach (Bäuml, Froböse, Kraemer, Rentrop, & Pitschel-Walz, 2006). O’Neil (2015) concluded that psychoeducation is an effective manner of empowering clients during group counselling while providing education and Brown (2011) stated that psychoeducation can have a significant contribution to group counselling and be a highly effective method of educating clients. Furthermore, O’Neil (2015) noted that psychoeducation promotes a client’s emotional, personal, and intellectual development. Davis, Corrin-Pendry, Savill, and Doherty (2011) conducted a study in which 57 participants received eight psychoeducational classes over a 36-month period, with session topics including an opening and closing session as well as sessions providing information on communication styles, loss and disappointment, mood and motivation, anxiety, panic and phobia, perfectionism, chaos and control, and frustration, anger, and resentment. Davis et al. (2011) concluded that clients who participated in the program experienced a more significant decrease in psychological distress compared to clients who did not receive the program. Likewise, Jusoh and Halim (2015) analyzed the effectiveness of Psychoeducation Group Therapy (PGT) at increasing readiness to change, decisional balance, and self-efficacy in individuals who were experiencing symptoms of substance abuse. Participants received 15 sessions of PGT, and the results determined that PGT was an effective means of enhancing client’s motivation to alter their behaviour patterns surrounding substance use (Jusoh & Halim, 2015). Furthermore, the authors concluded that PGT resulted in individuals progressing through the stages of change model at a quicker rate, and had increased levels of decisional balance and self-efficacy. In contrast, Kaminer, Burleson, and Goldberger (2002) completed a study to compare the effectiveness of psychoeducational therapy (PET) versus cognitive behavioural therapy (CBT) at reducing substance abuse. Kamier et al. (2002) concluded that though PET did result in fewer positive urinalysis tests, CBT was a more effective treatment for substance abuse. However, it should be noted that participants of this
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study were adolescents, and the results may not generalize to the adult population. Therefore, though studies demonstrate that psychoeducation is effective at increasing motivation to change and reducing substance abuse, research recommends that the treatment be implemented in combination with additional interventions as opposed to as a monotherapy.

**Cognitive behavioural groups.** CBT is amongst the most frequently researched and utilized treatment approaches in both group and individual settings for clients diagnosed with a substance use disorder (Magill & Ray, 2009). The treatment is derived from the premise that the learning process plays a key role in maladaptive, unhealthy behaviour patterns (National Institute on Drug Abuse, 2018), and has three primary underlying factors; behaviour is largely learned, not inherited through genetic facts, the learning process by which problems behaviours are created is the same process required to alter the behaviours, and majority of behaviour is governed by the environment (Fenn & Byrne, 2013). A review of the literature by McHugh, Hearon, and Otto (2010) concluded that CBT is an effective treatment for substance abuse, and can be effectively implemented as a monotherapy or as a component of a combination treatment approach. Similarly, Longabaugh and Morgenstern (1999) conducted a literature review and concluded that cognitive behavioural coping skills therapy (CBST) is amongst the most effective interventions when treating alcohol abuse, and can be implemented as a stand-alone treatment, as part of a comprehensive intervention, or as aftercare. Furthermore, CBT has been consistently proven effective at identifying coping strategies and triggers in addition to increasing motivation to participate in activities related to decreasing substance use (Magill & Ray, 2009). A research synthesis conducted by Morgan and Flora (2002) reiterated the efficacy of cognitive-behavioural approaches with offenders, and Gendreau (1996) stated that effective interventions should include CBT. However, a meta-analysis conducted by Hofmann, Asnaani, Vonk, Sawyer, and Fang (2012) reported mixed findings surrounding the efficacy of CBT at reducing symptoms of substance abuse compared to alternative approaches. Hofmann et al. (2012) noted that though CBT was found to be a more effective intervention for substance abuse than generic drug counselling, it was less effective than the implementation of pharmacological treatments. Ultimately, though some studies note that CBT is not the most effective treatment in the addictions field, extensive research has been conducted and it can be concluded that the intervention is a highly effective best practice approach for reducing substance abuse amongst offenders (Harrison, Cappella, Alaszewski, Appleton, & Cooke, 2003).

**Skills development groups.** Skills development groups frequently combine cognitive-behavioural techniques and psychoeducation elements to teach various life skills (Center for Substance Abuse Treatment, 2005). The primary goal of a skills development group is to develop or strengthen cognitive and behavioural resources in order to allow individuals to more effectively cope with environmental stimuli (Center for Substance Abuse, 2005). The Center for Substance Abuse (2005) noted that substance abuse is a common coping strategy for individuals who lack required life skills. Therefore, skills development is an effective method at reducing symptoms of substance abuse as clients are taught healthy, alternative coping skills (Center for Substance Abuse Treatment, 2005). The most common skill development group for individuals who abuse substances is a coping skills training group, which focuses on teaching the necessary skills to obtain and maintain abstinence (Center for Substance Abuse Treatment, 2005). Examples of skills taught may include but are not limited to emotional regulation and refusal skills (Center for Substance Abuse Treatment, 2005). Other skill development groups may focus on teaching skills that would raise social competency such as self-efficacy, communication, and assertiveness (National Institute on Drug Abuse, 2016). According to a meta-analysis completed
by Miller and Wilbourne (2002), behavioural skills training, which includes social skills training, is one of the top ten most effective treatments for reducing symptoms of substance abuse. However, limited research has been conducted regarding the efficacy of skill development groups with substance abuse and no research regarding the treatment efficacy amongst offenders. Therefore, further research should be completed prior to implementing social skills training as a method of reducing substance abuse within a correctional facility.

Support groups. Support groups are designed to increase an individual’s motivation and efforts to manage their thoughts and emotions regarding substance abuse more effectively (Center for Substance Abuse Treatment, 2005). The focus of a support group can range from achieving and sustaining abstinence to increasing a client’s self-confidence and self-esteem (Center for Substance Abuse Treatment, 2005). Given a key element of support groups entail promoting a safe environment, they are often appealing to individuals who are apprehensive about or new to abstinence (Center for Substance Abuse Treatment, 2005).

The Center for Substance Abuse Treatment (2005) noted that support groups can be an effective method of decreasing symptoms of substance abuse. A literature review including 10 studies conducted by Tracy and Wallace (2016) determined that support groups can demonstrate positive results in addictions treatment. However, Vederhus and Kristensen (2006) recommended support groups as a supplementary treatment for substance abuse, or following a treatment. Furthermore, the majority of support groups are derived from 12-step methods utilized by Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) self-help groups (Harrison et al., 2003). Such approaches view addiction as a biopsychosocial and spiritual disease, and focus on the spirituality associated with the 12-step philosophy (Nowinsky, Baker, & Carroll, 1992). However, the National Institute on Drug Abuse (2018) notes that addiction is defined as a disease of the brain. Therefore, the efficacy of the treatment is questionable and a potential limitation of the treatment is that it is culturally specific, with two thirds of the steps referencing God. Furthermore, a meta-analysis completed by Miller and Wilbourne (2002) concluded out of the 46 treatment modalities evaluated, self-help groups such as AA were ranked in the bottom 10 concerning evidence for efficacy at decreasing substance use.

Given no data was found analyzing the efficacy of support groups within a correctional environment, in addition to the mixed results regarding the effectiveness of support groups for substance abuse treatment, there is insufficient research to support the implementation of support groups as a best practices treatment for substance abuse amongst offenders.

Best Practice Approaches Amongst Offenders

Motivational interviewing. Motivational interviewing (MI) has been described as a client centered form of therapy that assists clients to explore and rectify ambivalences to evoke behaviour change (Miller & Rollnick as cited in Mendel & Hipkins, 2002). It is designed to help clients assume responsibility for behaviour modification and avoid confrontation via empowerment (Mendel & Hipkins, 2002). An MI style often includes listening reflectively, asking open-ended questions, managing resistance while avoiding direct confrontation, and encouraging self-motivational affirmations using directive methods and strategies such as providing feedback, providing choice, practicing empathy, eliminating barriers, and clarifying goals (Carroll et al., 2006). Walters, Clark, Gringerich, and Meltzer (as cited in Spohr, Taxman, Rodriquez, & Walters, 2016) noted that a frequent challenge within the correctional environment is motivating offenders to participate in actions that would reduce the likelihood of committing another offence such as participating in treatment programs.
MI has continued to develop recognition within literature as an effective approach when working with individuals who display symptoms of substance abuse (Clark, 2012), and specifically with offenders who are resistant to change (Harrison et al., 2003). A systematic review conducted by McMurran (2009) concluded that within a correctional environment, MI is implemented most frequently with offenders who abuse substances, proceeded by offenders incarcerated for domestic violence and general offending. According to Carroll et al. (2006), MI can instigate an increase in an offender’s motivation to participate in treatment programs. Partaking in treatment programs frequently results in a higher retention rate of materials learned, and therefore results in a more effective treatment (Carroll et al., 2006). Easton, Swan, and Sinha (2000) conducted a study to determine the efficacy of motivational enhancement therapy (MET), a type of MI, on reducing substance abuse amongst offenders charged with domestic violence. Two groups of offenders participating in an anger management program were selected to evaluate the effectiveness of MI at increasing an offender’s motivation to alter their substance use behaviours (Easton, Swan, & Sinha, 2000). The authors noted that participates in the experimental group received MET sessions while the comparison group were provided with conventional anger management classes. The MET utilized in this study consisted of using a style that avoided confrontation, was empathetic, promoted self-efficacy, utilized double-sided reflections, rolled with resistance, promoted positive self-statements of change, and noted discrepancies (Easton et al., 2000). Easton et al. (2000) concluded that the use of MET was a practical and effective means of increasing motivation and readiness to alter substance use in offenders charged with domestic violence. However, limitations of the study included an insufficient sample size, data collection via self-report as opposed to a clinical interview, and potential participant misportrayal of information to appear in a positive manner for upcoming court cases (Easton et al., 2000). Similarly to Easton et al, Mednel and Hipkins (2002) determined that the implementation of MI was an effective method of increasing offenders’ motivation to decrease their substance use behaviour in offenders diagnosed with a learning disability. Moreover, Harper and Hardy (2000) conducted a study to evaluate the effectiveness of MI as a way of improving effective practice in offenders who have a substance use problem. Specifically, the authors assessed whether or not the use of MI impacted an offender’s attitude regarding their substance use as well as their offending behaviours. Results demonstrated that MI techniques were effective at increasing an offender’s desire to change behaviours regarding substance use.

Overall, it can be concluded that MI leads to an increase in an offender’s motivation to participate in substance abuse treatments provided within the institutional environment. This in turn leads to a decrease in the number of offenders who meet the criteria for a substance abuse disorder. Therefore, given extensive research demonstrates MI is an effective treatment for decreasing symptoms of substance abuse in offenders with various learning styles, motivation levels, and criminal convictions, MI can be considered a best practice approach amongst offenders.

Pharmacotherapy. Pharmacotherapy refers to the administration of medication as a form of treatment for substance abuse (Peters & Wexler, 2005). Multiple pharmacological drugs exist that are effective treatments for substance abuse including methadone, naltrexone (Sharma et al., 2016), disulfiram, and buprenorphine (Douaihy, Kelly, & Sullivan, 2013). According to Harrison et al. (2003), the Methadone Maintenance Treatment (MMT) is the most frequently used pharmacological treatment and Correctional Service Canada (2009) noted MMT is the most
effective treatment for an individual displaying symptoms of opioid abuse, specifically within a correctional facility. Therefore, this literature review will focus on MMT.

**Methadone maintenance treatment program.** According to Brands, Marsh, Hart, and Jamieson (2002), MMT is a key component to effectively prevent and treat opioid dependence. Methadone, an opioid agonist, reduces or removes symptoms associated with opioid withdrawal including vomiting and nausea, anxiety, tearing, and restlessness (Brands, Marsh, Hart, & Jamieson, 2002). Individuals participating in MMT take the medication orally one to two times daily (Brands et al., 2002).

According to Dolan, Hall, and Wodak (1996), a larger percent of individuals who inject substances are willing to participate in MMT than any other form of treatment. Furthermore, offenders who participated in MMT displayed significantly reduced rates of syringe sharing and substance injection (Dolan, Hall & Wodak, 1996). Jamison, Beals, and Lalonde (2002) concluded that the implementation of the MMT in the general population resulted in a decrease in the use and abuse of opioids and other substances and a reduction in criminal behaviours; in addition to an improvement of both physical and mental health, social functioning, and quality of life. Furthermore, Brands et al. (2002) noted that MMT is a best practice approach to treating opioid dependency in offenders incarcerated in a correctional facility. Correctional Service Canada (2014) conducted a study regarding the efficacy of the MMT program within a federal institution for opioid dependent offenders. The study concluded that the implementation of MMT resulted in reduced opioid and other substance use, a significant decrease in positive urinalysis tests, a decrease in disciplinary charges and an increase in the display of positive institutional behaviour and offender participation in correctional programs. Likewise, Correctional Service Canada (2009) reported that offenders who participated in MMT had reduced recidivism rates. However, Harrison et al. (2003) noted that offenders who receive MMT while incarcerated should simultaneously receive psychological treatment as well as ongoing care upon their release for the most effective treatment. Therefore, though offenders receiving analgesic drugs while incarcerated may raise a number of questions, ultimately the implementation of MMT has been found to be an effective method of reducing substance abuse amongst offenders.

**Risk, needs, and responsivity model.** Pearce and Holbrook (2002) noted that the RNR Model is an evidence-based approach to treating substance abuse within a correctional environment. The treatment is established on three primary principles: risk, needs and responsivity (Pearce & Holbrook, 2002). The risk principle states that the level of treatment an offender receives should be matched their risk of reoffending (Government of Canada, 2018). Therefore, a high risk offender should receive a high intensity treatment and a low risk offender should not participate in a treatment program. The need principle states that the likelihood an offender re-offending can be reduced if their criminogenic needs are identified and treated (Pearce & Holbrook, 2002). Critical criminogenic needs include antisocial associates, antisocial cognitions, a history of antisocial behaviours, an antisocial personality pattern, satisfaction with school or work, leisure activities, family and marital relations, and substance use (Andrews, Bonta, & Wormith, 2006). Lastly, the responsivity principle states that the treatment style should be tailored to offender characteristics (Bonta, 1995). Bonta (1995) noted that all offenders are different, and thus have differing characteristics such as emotionality or communication style which may impact the way in which an offender responds to a treatment designed to change thoughts, attitudes, and behaviours. Pearce and Holbrook (2002) noted that there are two distinct components that comprise the responsivity principle: specific and general
responsivity. Specific responsivity considers factors such as personality, strengths, learning style, bio-social characteristics, and motivation (Pearce & Holbrook, 2002). Hanson, Bourgon, Helmus, and Hodgeson (2009) noted that the more RNR principles an intervention adheres to, the more effective the treatment will be. General responsivity suggests influencing behaviour with the use of a cognitive social learning approach while specific responsivity refers to tailoring the cognitive behavioural approach to the offenders (Pearce & Holbrook, 2002). Furthermore, a study conducted by Timko et al. (2017) concluded that administration of substance abuse treatment amongst offenders that adhered to the RNR principles was more effective at decreasing substance abuse than treatment that did not follow the RNR principles. Similarly, Corabian, Dennett, and Harstall (2011) concluded that programs that did not adhere to these principles reported lower treatment effects as opposed to treatments that did adhere to the RNR principles. Therefore, any treatment implemented within a correctional environment should adhere to as many RNR principles as possible.

Transtheoretical model. The TTM, often referred to as the Stages of Change, is a theory that suggests that behaviour change does not occur instantaneously in one step (Kern, 2008). Rather, individuals work through six different stages at their own rate when engaging in successful change (Kern, 2008). This model allows clinicians to tailor and adapt the intervention to the offender; an approach Norcross, Krebs, and Prochaska (2011) noted to be highly effective. The six stages of the TTM include precontemplation, contemplation, preparation, action, maintenance, and relapse (Kern, 2008).

Precontemplation. An individual in the precontemplative stage of change does not recognize that his behaviour is problematic and sees no need for change (Herie & Skinner, 2014). McConnaughy, Prochaska, and Velicer (1983) noted that clients displaying symptoms of the precontemplation stage of change are resistant, may be seeking treatment due to the pressure of others, have no desire or motivation to change, and may be either ignoring or unaware that their behaviour is problematic. When working with an individual in the precontemplative stage of change, the goal is to encourage thoughts and discussion surrounding their problem behaviours to create discrepancy (DiClemente & Prochaska, 1998).

Contemplation. A client in the contemplation stage of change is aware that his behaviour is problematic, however may not be aware of specifically what to change (McConnaughy, Prochaska, & Velicer, 1983) noted that clients displaying symptoms of the precontemplation stage of change are resistant, may be seeking treatment due to the pressure of others, have no desire or motivation to change, and may be either ignoring or unaware that their behaviour is problematic. When working with an individual in the precontemplative stage of change, the goal is to encourage thoughts and discussion surrounding their problem behaviours to create discrepancy (DiClemente & Prochaska, 1998).

Preparation. An individual in the preparation stage of change is preparing to make the necessary changes (Herie & Skinner, 2014) and has committed to changing their behaviour (McConnaughy et al., 1983). They are willing to experience the consequences of change (e.g., discomfort and effort), have started to accept responsibility for their actions (McConnaughy et al., 1983), and are starting to assess the changes that will need to be made to people, places and things in their life (Herie & Skinner, 2014). However, the client has not yet implemented any behaviour changes (McConnaughy et al., 1983). During the preparation stage of change, the goal is to assist the client to develop a plan for change (DiClemente & Prochaska, 1998).
Action. A client in the action stage of change has started to engage in behaviours associated with changing their substance abuse behaviour, but may be experiencing challenges (McConnaughy et al., 1983). The client will have ceased previous, negative behaviour patterns and have replaced them with new, positive ones (Herie & Skinner, 2014). Herie and Skinner (2014) noted that client’s goals often have to be adapted or changed during this stage. When working with a client in the action stage of change, the goal is to reinforce successful behaviour changes while addressing any barriers to change that may have arisen (DiClemente & Prochaska, 1998).

Maintenance. An individual in the maintenance stage of change has implemented the required behaviour changes, has made long-term positive behaviour changes and has generalized the new, positive behaviours (Herie & Skinner, 2014). However, the client may have difficulty maintaining long-term change (McConnaughy et al., 1983). During the maintenance stage of change, the goal is to support the client in determining a coping plan, managing relapse triggers, and maintain behaviour change long term (DiClemente & Prochaska, 1998).

Relapse. Though not all professionals consider relapse to be a stage of change, Herie and Skinner (2014) noted that relapse is a common and potentially beneficial aspect of lasting change. A client is considered to have relapsed when he returns to previous behaviour patterns (Herie & Skinner, 2014). Herie and Skinner (2014) emphasize that relapse is not a failure, but rather just a component of lasting behaviour change. DiClemente and Prochaska (1998) noted that the goal of the relapse stage of change is to assist the client to cope with the consequences of their behaviour in a healthy manner and develop a plan for next steps. (DiClemente & Prochaska, 1998).

Summary. In order to determine an effective intervention that allows an offender to move through the various stages of change, it is crucial to determine their current stage of change. Although individuals in the early stages of change do not want to begin behaviour change, Prochaska, DiClemente, and Norcross (1992) determined that the implementation of specific interventions increases the chance of advancing through the different stages. Yong, Williams, Provan, Clarke, and Sinclair (2013) completed a study in which 371 medium-risk offenders participated in a Short Motivational Program (SMP), and a pre-and-post assessment was completed to determine the offender’s stages of change prior to and following the program. The authors reported mixed results, noting that following the SMP some offenders regressed to a previous stage while others skipped a stage. It was hypothesized that offenders who skipped a stage following SMP may have gone through an intermediary stage while the intervention was taking place, while offenders who regressed to a previous stage may have obtained improved awareness regarding their problem behaviour (Yong, Williams, Provan, Clarke, & Sinclair, 2013). In contrast, an article written by Casey, Day, and Howells (2005) outlined potential critical issues when applying the TTM in a federal institution. A primary issue noted was that clinicians ultimately use clinical judgement to determine which stage of change they believe their client is in (Casey, Day, & Provan, 2005). However, differing procedures of stage allocation may result in varying outcomes and therefore different stage-matched interventions (Casey et al., 2005). Additionally, the authors noted that a key factor of the TTM is the proper integration of the models constructs (Casey et al., 2005). However, limited research has been conducted on the implementation of the TTM within a correctional environment. Therefore, Casey et al. noted that ultimately, though the TTM may assist offenders with behaviour change, this model alone is unlikely to result in permanent behaviour change. However, Ward, Day, Howells, and Birgden, 2003 noted that a frequent challenge when implementing programs in a
correctional environment is offender denial, specifically denial that their substance use is problematic and engagement in confrontational behaviours. Therefore, using the TTM to identify which stage of change an offender is currently in and consequently developing an intervention that matches behaviours the offender is displaying is an effective method of addressing substance abuse amongst offenders.

Ultimately, each offender progresses through the stages of change differently. Therefore, it is beneficial to assess which stage of change an offender is in order to develop and implement an intervention that will be most effective for their respective stage of change.

Conclusion

Literature supports the implementation of the ICPM program as an effective treatment program for offenders across multiple domains. However, given the high prominence of substance abuse within the correctional environment and the relationship between substance abuse and criminal behaviour, further evidence-based treatment is recommended. Additionally, the lack of an employee resource designed to guide staff on the most effective methods to manage and reduce the risks and needs of offenders who abuse substances was identified as a gap by the agency.

Following an extensive review of the literature, it can be concluded that best practice approaches to substance abuse amongst offenders include utilizing MI, pharmacotherapy, specifically the MMT program, adhering to principles of the RNR model and individualizing treatment based upon the stage of change the offender is in. Additionally, to improve intervention efficacy consideration should be given to implementing best practice approaches that have proven effective at decreasing substance abuse amongst various population, however have not yet been deemed a best practice approach with offenders. Such treatments include solution-focused therapy and CBT. Though solution-focused therapy has not been implemented with offenders strictly for substance abuse, the approach has been proven effective at decreasing substance abuse amongst the general population in addition to being successfully implemented within a correctional environment. Therefore, it is speculated that the approach would be an effective manner at reducing symptoms of substance abuse amongst offenders. Similarly to studies conducted regarding solution-focused therapy, a number of studies have been conducted regarding the efficacy of CBT at reducing substance abuse as well as with the offender population. However, limited research has been conducted regarding the efficacy of CBT at decreasing substance abuse amongst offenders. Ultimately, given results from extensive research regarding the efficacy of CBT at reducing substance use and the implementation of CBT in a correctional environment conclude the treatment has a reliable record regarding effectiveness, it can be presumed that CBT would be an effective means of reducing symptoms of substance abuse amongst offenders.

The purpose of this thesis is to provide correctional programs employees with an information resource of best practice approaches to assess and provide treatment for offenders who display symptoms of substance abuse. It is proposed that this resource manual will provide correctional programs staff with information, strategies, and techniques required to effectively manage the potential risks and needs of this population.
Chapter III: Methodology

Participants
An information resource manual was developed for correctional programs staff who work with and deliver treatment programs to offenders who display symptoms of substance abuse. This manual, comprised of relevant and recent research regarding best practice approaches to treating addictions, is designed to be used with all offenders who demonstrate issues with substance abuse. Additional inclusion criteria for offender participation includes: Offenders who are incarcerated in the minimum, medium, or maximum security unit of Collins Bay Institution, who had ‘manage thinking that justifies and supports substance use’ noted as a primary or notable target for the Integrated Correctional Program Model (ICPM) program, and who correctional programs staff identify as being resistant to treatment for substance abuse. Additionally, as individual needs arise, facilitators are encouraged to select offenders at their discernment. Offenders are not required to be waitlisted for or currently participating in a stream of the ICPM program to receive treatments outlined in this manual. These interventions would not be relevant if the offender does not display any symptoms of substance abuse. All participation is voluntary.

Facilitators are not required to receive specialized training to utilize this manual as it is designed to be used as a guide and a resource to increase knowledge surrounding substance abuse amongst offenders. However, experience working with offenders who display symptoms of substance abuse or who meet the DSM-5 criteria for a SUD is recommended to ensure the offenders risk and needs are adequately assessed, and thus the intended population is benefiting from the implementation of the manual. Additionally, facilitators would benefit from the ability to develop a therapeutic rapport with offenders to ensure a safe environment in which the offender feels comfortable disclosing and discussing personal information is fostered. Furthermore, collaboration between the facilitator and additional professionals working with the offender (e.g., a parole officer and mental health services) is strongly encouraged. Integrated approaches can increase offender motivation and participation, and support across multiple domains increases success rates.

Consent Procedures
A formal consent form was not administered for the purpose of this thesis as no client data was collected. However, should the treatments outlined in the resource manual be implemented, written consent must be obtained. A formal consent form (Appendix A) will be reviewed by the facilitator with each client prior to the implementation of any treatments outlined in the resource manual. Once the consent form is reviewed, it is to be signed by the client and witnessed and dated by the staff member. This signed and dated document must be kept with the client’s file.

Design
This information resource manual was developed by the Behavioural Psychology student during a 14-week field placement in partial fulfillment of the requirements for the honours Bachelor of Behavioural Psychology. The manual was created following an in-depth literature review regarding effective treatments for substance abuse. Specifically, the review of the literature focused on treatments found to be effective within a correctional environment. Key words included best practice approaches, offenders, substance abuse, treatment, motivational interviewing, pharmacotherapy, Risk Need Responsivity principle and Stages of Change. The
manual explores best practice approaches for substance abuse amongst various populations, focusing on the offender population. The purpose of the designed manual is to enhance treatments available to offenders within a federal institution who display symptoms of substance abuse, and consequently enhance rehabilitation.

The design of the manual was created based on the expectation that increasing staff awareness and knowledge regarding best practice treatment approaches proven effective at decreasing substance abuse within the offender population would enable correctional programs employees to be better equipped to understand substance abuse in offenders. Conceivably, this would enable staff to work more effectively with offenders who display symptoms of substance abuse.

As no conditions were manipulated during the project, the manual is a non-experimental research design. However, should the manual be implemented, the independent variable (i.e., the implemented treatment in the manual) and dependent variable (i.e., increased staff awareness of addressing the substance needs of offenders) would be identified and correlations between both variables would be analyzed.

Setting and Apparatus
This manual was designed to be utilized by correctional programs staff in a Federal Institution. An individual will be sentenced to a Federal Institution for a minimum of two years plus a day as a disciplinary action resulting from a perpetrated crime. Employees of this agency include correctional staff in a variety of positions who provide treatment to and ensure the safety of the offenders. Given the treatments outlined in this resource manual are designed to be implemented by correctional programs employees, it can be presumed that the interventions will be implemented in a similar setting as the ICPM program. The ICPM program is delivered in a classroom within the programs building. Tables and chairs are positioned in a U shape to ensure all participants are able to view the facilitator, and offenders work alongside each other to promote social interaction.

Measures
An informal feedback process was utilized to determine the efficacy of the manual at enhancing the treatments provided to offenders who display symptoms of substance abuse. A satisfaction survey (Appendix B) assessing the content, presentation and practicality of the manual was administered to potential facilitators (e.g., Correctional Programs Officers). The Likert scale survey ranged from strongly disagree (1) to strongly agree (5) and was utilized to ascertain qualitative data regarding the manual. The survey included a blank section for potential facilitators to provide any additional comments or recommendations, which allowed for qualitative feedback pertaining to the manuals non-experimental design. Survey questions were categorized into two groups based on whether a high or low response correlated to a positive response. Results were calculated and interpreted by computing the percentage equivalent to the average response for each question. Conducting an assessment of the manual allowed for improvements where required, which in turn should increase the efficacy of the manual.

The Manual
Part I: Introduction.
The introductory section of this manual was designed to provide an overview of substance abuse and familiarize users with prevalence rates, relevant terms, and information
pertaining to substance abuse amongst offenders. Additionally, this portion provides details surrounding the foundation and rational of the ICPM program provided by CSC.

**Part II: Assessment measures.**

The assessment measures section of this manual provides readers with information and rationales for use regarding the actuarial risk assessments used to assess substance use risk amongst offenders. The Computerized Assessment of Abuse (CASA) utilized by CSC is a self-administered test comprised of five standardized assessment measures including the Alcohol Dependence Scale (ADS), the Problems Related to Drinking Scale (PRD), the Michigan Alcoholism Screening Test (MAST), the Drug Abuse Screening Test (DAST), and the Severity of Dependence Scale (SDS). The ADS, PRD, and MAST are utilized to assess the severity of alcohol abuse while the DAST and SDS assess the severity of drug abuse. Though the results from all five assessments establish the severity of substance abuse, only the results from the ADS, PRD, and DAST are examined when determining the referral criteria.

**Part III: Best practice approaches.**

The best practice approaches component of this manual entails a compilation of treatment approaches that have been deemed best practice amongst offenders who display symptoms of substance abuse, in addition to two approaches proven effective at decreasing substance abuse amongst various population, however have not yet been deemed a best practice approach with offenders. Best practice approaches amongst offenders include MI, pharmacotherapy, the RNR model and the TTM. Best practices that should be given consideration to improve treatment efficacy include solution-focused therapy and CBT. Furthermore, the manual provides an overview, rational for use, and instructions on how to effectively implement each best practice intervention within a correctional environment.

**Procedures**

Following an extensive literature review, a resource manual regarding best practice approaches to reduce substance abuse amongst offenders was developed. Potential facilitators interested in providing additional support to offenders who display symptoms of substance abuse were then provided with the manual. Upon reviewing the manual, the behavioural psychology student discussed any questions or concerns potential facilitators had. Each potential facilitator was then asked to complete the evaluation form regarding the contents of the manual, and alterations based on the feedback received were completed as necessary.
Chapter IV: Results

The Facilitator’s Manual for Effective Intervention regarding Best Practice Approaches for Substance Abuse Amongst Offenders (Appendix C) was developed for correctional programs staff. This manual is intended to enable correctional programs employees to be better equipped to understand substance abuse in offenders. Conceivably, this will allow staff to more effectively manage the potential risks and needs of this population. The manual contains information pertaining to substance abuse amongst offenders, the assessment measures utilized by CSC to assess the severity of an offender’s substance use, and evidence-based treatment approaches proven effective at reducing substance abuse amongst offenders.

Feedback Questionnaire

Results from the feedback questionnaire provided to potential facilitators are presented in Appendix D. The Likert scale questionnaire ranged from 1 (strongly disagree) to 5 (strongly agree). A summary of the results is as follows: 100% of participants felt as though the information the manual contained was useful; 75% indicated the manual represented needs of the agency staff; 75% thought the approaches and techniques outlined in the manual were relevant and applicable; 100% found the manual was easy to follow; 75% felt as though the manual contained easy-to-read language and was well organized; 100% found the manual to be visually appealing; 100% indicated that no changes should be made to the manual regarding information pertaining to assessment measures or substance abuse; and 50% learned information and/or approaches they were not previously aware of. Additionally, 100% of participants indicated that their overall impression of the manual was ‘very good’.

In summary, the results of the feedback questionnaire distributed to potential facilitators within a correctional facility indicate correctional programs staff would find a resource manual for best practice approaches to reduce substance abuse amongst offenders to be highly beneficial. Additionally, the questionnaire presented the opportunity to provide recommendations to increase the efficacy of the manual. This information was utilized to reaffirm that the proposed thesis would be utilized by the agency.
Chapter V: Discussion

Summary

A gap was identified by correctional programs staff regarding the most effective method to reduce substance abuse amongst offenders incarcerated in a federal institution. In response to this need, this thesis was developed to provide staff with an information resource manual of best practice approaches to assess and provide treatment for offenders who display symptoms of substance abuse. This manual was developed following an extensive literature review conducted based on the following key words: best practice approaches, evidence-based practices, offenders, substance abuse, treatment, motivational interviewing, pharmacotherapy, risk-need-responsivity model, and transtheoretical model. The review of the literature was conducted utilizing journal articles, books, and manuals collected primarily from online databases and focused on providing information pertaining to substance addiction, current programming provided within correctional facilities (i.e. the ICPM program), and best practice approaches to reduce substance abuse including solution-focused therapy, narrative therapy, and psychoeducational, cognitive behavioural, skill development, and support groups. The literature review then proceeded to focus on best practice approaches to reduce substance abuse amongst offenders including MI, pharmacotherapy, pharmacotherapy, the RNR model, and the TTM. It was concluded that access to information pertaining to treatment strategies and protocols for offenders who display symptoms of substance abuse is essential to ensure staff respond in the most effective manner possible. Therefore, upon analysis of the literature, this thesis supports the use of MI, pharmacotherapy, pharmacotherapy, specifically the MMT program, adhering to principles of the RNR model, and individualizing treatment based upon the stage of change the offender is in to reducing symptoms of substance abuse. Additionally, based on the research, it is recommended that solution-focused therapy and CBT be implemented as they have been proven effective at decrease substance abuse amongst various populations.

Moreover, an informal feedback questionnaire was provided to potential facilitators interested in providing additional support to offenders who display symptoms of substance following the distribution of the resource manual. The results of the questionnaire demonstrated that the manual was well written, easy to follow, and contained useful information. Given correctional programs staff identified that a resource manual containing best practice approaches to reduce substance abuse amongst offenders would be highly beneficial, this resource manual sought to provide employees with information, strategies, and techniques to implement the best practice approaches and more effectively manage the needs and potential risks of these offenders. Consequently, this should result in an increase in successful rehabilitation and reintegration in to society.

Strengths

This thesis has numerous strengths. Firstly, the resource manual was developed based on empirical evidence obtained from an extensive review of the literature to ensure strictly best practice approaches are utilized. The literature review allowed for the support of specific techniques, approaches, and information regarding the delivery of treatment for offenders who display symptoms of substance abuse.

An additional strengths is that the resource manual developed is a permanent product available to all staff employed within the correctional institution. A need for a resource manual providing information pertaining to best practice methods to effectively manage the risks and needs of offenders who display symptoms of substance abuse, in addition to effective
interventions to decrease symptoms of substance abuse, was indicated by staff. Furthermore, following the completion of the resource manual, multiple correctional programs staff reviewed the manual and were consulted with in order to determine potential efficacy and areas of improvement to increase manual effectiveness. This is considered a strength as it increases the likelihood that the manual will have positive results when implemented with the intended population.

Lastly, the resource manual follows a logical progression (i.e. information overview, assessment measures, best practice approaches) that is outlined in the table of contents. Additionally, the manual was designed to be read with ease at a moderate academic reading level and in unambiguous, clear language. The manual does not require high levels of decoding or extensive knowledge of psychological concepts, yet entails enough detail that an individual with experience in a correctional environment could effectively implement the outlined treatments.

Limitations
As with all studies, limitations are present that create parameters for ability, expectations, and improvement. Firstly, due to the time constraint of a 14 week field practicum, the manual was unable to be implemented and therefore no formal clinical data could be collected. In the future, in order to determine the efficacy and impact of the resource manual, a formal evaluation should be completed.

A second limitation to this thesis is the language barrier associated with this resource manual as it is only available in English. Therefore, facilitators and clients must be fluent in English. This may result in a small percentage of offenders who are unable to receive the treatment due to not speaking or comprehending the English language.

Moreover, there was no offender input or involvement in the development of this manual. Therefore, though this manual was created based on an extensive review of the literature and empirically supported interventions, the manual may not be as effective as it would have been had offender’s opinions been taken into consideration.

An ethical issue that may arise when implementing the material outlined in the resource manual includes research on a captive and dependent population. As previously noted, if implemented, the independent and dependent variable will be identified and the correlation will be analyzed. In order to manage sensitivity, the research design implemented will be an AB design. Therefore, baseline data will have been collected via the CASA, the intervention will be implemented, and a debrief session will be conducted with each client to discuss their results. The protocols for confidentiality include all data and identifying documentation (i.e., informed consent form) being stored in a secure office. Additionally, the facilitator will stress that the treatment is voluntary and consent may be drawn at any point in time.

Lastly, should treatments outlined in the resource manual be implemented in the future, a potential limitation that may arise is offender resistance. Given there are no incentives (e.g., financial, certificate, etc.) other than self-development, offenders may not be motivated to participate in the additional treatments discussed in this manual.

Multilevel Challenges to Service Implementation

Client level. A challenge encountered at the client level of service implementation is a lack of client motivation. Offenders often participate in correctional programs because these are listed as a part of their correctional plan rather than because they want to change their behaviour and improve themselves. Therefore, it is essential that facilitators utilize motivational
interviewing to educate offenders on the benefits of actively participating in various correctional programs and/or treatments to increase offender motivation. This in turn should reduce attrition rates and increase offender attendance and participation rates for program. The techniques described in the resource manual provides facilitators with the skills necessary to effectively work with offenders who display low levels of motivation.

**Program level.** Treatments aim to provide the most effective intervention possible for each client, however, responsivity barriers often impede an offender’s progress when participating in correctional programs. Intellectual abilities, readiness to change, and learning styles are some of the factors that can have a significant influence an offender’s success in a treatment program. This resource manual provides facilitators with multiple treatment options that can be tailored to offenders who have varying intellectual abilities and learning styles. Additionally, it provides strategies for offenders who demonstrate low levels of motivation in order to provide an effective treatment approach to decrease substance abuse amongst offenders despite responsivity barriers being present.

**Organizational level.** A barrier encountered at the organizational level within a correctional facility was completing the research required while maintaining communication with the required individuals exterior to the institution. For security purposes, staff have limited Internet access while in the institution (i.e. unable to access school email accounts) and do not have access to certain CSC information (i.e. CSC email, the CSC hub, etc.) while outside of the institution. Therefore, efficient time management and organization was required from the placement student to effectively manage this barrier. An additional barrier at the organization level is a lack of individualized interventions due to the structured nature of the ICPM program and a lack of staff resources.

**Societal level.** A challenge frequently encountered when working in the mental health field is the societal stigma surrounding individuals who abuse substances. Specifically within a correctional environment, a challenge encountered at the societal level was the stigma associated with offender’s who abuse substances. Offenders may receive judgment from other offenders, staff, family, or themselves and are often viewed by society as helpless or unable to be rehabilitated. However, providing a treatment that is empirically supported at reducing symptoms of substance abuse, a key factor in recidivism rates, is likely to result in reduced rates of reoffending. This in turn will result in an increase in the security and safety of society.

**Contribution to the Field of Behavioural Psychology**

In the field of behavioural psychology, research is ongoing and therefore the most current information is constantly changing. This thesis provides employees of CSC with the most up-to-date information regarding the treatment of substance abuse amongst offenders. Therefore, this thesis contributes to the field of behavioural psychology as providing correctional programs staff with a resource manual should result in a more effective treatment of this population, which may, in future, assist with effective societal reintegration and decrease recidivism.

**Recommendations for Future Research**

As demonstrated by the limitations of this thesis, recommendations for future research have been identified. In the future, the efficacy of this resource manual should be assessed to determine which methods were most effective and contribute to future best practice interventions of offenders who display symptoms of substance abuse. This may include offender feedback as well as a pre-and-post test to determine if the manual resulted in a decrease in substance abuse.
amongst offenders. If the manual were to be tested, the independent variable (i.e., the implemented intervention in the manual) and dependent variable (i.e., increased employee awareness of addressing the substance needs of offenders) would be identified and correlations between both variables would be analyzed and utilized to determine the efficacy of the manual. Identifying the effectiveness of the manual may contribute to the field of best practice approaches for substance abuse amongst offenders.
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Appendix A
Consent Form

To Whom It May Concern,

You are being invited to take part in an additional treatments designed to target symptoms of substance abuse, as outlined in a resource manual for correctional programs staff. The manual was designed as part of a research project (called an applied thesis) by a 4th year Honours Behavioural Psychology program student at St. Lawrence College. The treatment may include motivational interviewing, pharmacotherapy, following the Risk Need Responsivity model, the transtheroetical model, Cognitive Behavioural Therapy, and solution-focused therapy.

We are legally obligated to release information without your consent under certain circumstances. These are: 1) If you are at imminent risk to your own safety and/or the safety of others; 2) If you disclose that a child under 16 is suspected of being abused or neglected or; 3) If you were sexually abused by a regulated health care professional in Ontario.

Taking part is voluntary. It is up to you to decide whether or not to take part in this treatment. Taking part in this study will not increase your chance of parole or decrease your sentence time, and it cannot be completed in place of a required program. If you decide to take part in this, you will be asked to sign this consent form. If you do decide to take part in this treatment, you are still free to stop at any time, without giving any reason, and without it having any negative consequences on your sentence. If you choose not to take part in this study, you can still continue to participate in the programs offered at Collins Bay Institution.

If you agree to participate in this treatment, please complete the form at the bottom of this letter and return it as soon as possible.
If you agree to take part in this treatment, please complete the following form and return it to me as possible.
By signing this form, I agree that:

☐ The study has been explained to me.

☐ All my questions were answered.

☐ I understand that I have the right not to participate and the right to stop at any time.

☐ I am free now, and in the future, to ask any questions I have about the study.

☐ I have been told that my personal information will be kept confidential.

☐ I understand that no information that would identify me will be released or printed without asking me first.

I hereby consent to take part:

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Dear Agency Staff,
This survey is designed to collect information regarding the Best Practice Approaches treatment manual. Any feedback you provide is confidential and will be used to improve the manual. Your time and feedback are greatly appreciated, thank you!

Sincerely,
Jori Bird

Directions: Please select the responses that most accurately reflect your opinion of the manual.

(1) – Strongly Disagree, (2) – Disagree, (3) – Neutral, (4) Agree, (5) – Strongly agree

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Additional Comments or Recommendations:

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Appendix D
Responses to the Feedback Questionnaire

Q1. The information in this manual was useful.

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Q2. The manual represented needs of agency staff.

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Q3. The approaches and techniques outlined in the manual were relevant and applicable.

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Q4. The manual was easy to follow.

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Q5. The manual contained easy-to-read language and was well organized.

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Q6. The manual was visually appealing.

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Q7. Changes should be made to the information regarding assessment measures in the manual.

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Q9. Changes should be made to the information regarding substance abuse in the manual.

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Q10. Learned information and/or approaches previously not aware of.

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Q11. Overall manual impression

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Q12. Please leave any additional comments or recommendations:
   1. Stats from substance use in the institution are staggering. Yikes! I like that you included this.
   2. I love the addition of substance misuse; also how you break down and explain addiction, abuse, and misuse.
   3. I really like how you broke down MI into common symptoms, the goal, and how you can help. Great work!
   4. I like the different worksheet resources you included.
Appendix C
Information Resource Manual

Best Practice Approaches for Substance Abuse Amongst Offenders

A Facilitator’s Manual for Effective Intervention

Developed by Jori Bird
Honours Bachelor of Behavioural Psychology
St. Lawrence College

2019
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Part I: Introduction

Purpose of the Manual
This manual was developed to provide Correctional Service Canada (CSC) programs staff with an information resource of best practice approaches to assess and provide treatment for offenders displaying symptoms of substance abuse. This resource manual will provide correctional programs staff with information, strategies, techniques and worksheets to more effectively manage the needs, and potential risks of these offenders. This format was selected based on the assumption that increasing staff awareness and knowledge of best practice approaches that have been proven effective at treating substance abuse within the offender population would enable staff to be better equipped to understand substance abuse amongst offenders. Conceivably, this would enable them to work more effectively with this population.

Manual Overview
Part II: Substance Abuse
The introductory section includes an overview of substance abuse and familiarizes users with prevalence rates, relevant terms and information pertaining to substance abuse amongst offenders.

Part III: Assessment Measures
The assessment measures portion includes information and the rationale for use regarding the actuarial risk assessments used to assess substance use risk amongst offenders. The assessments included are not exhaustive, but rather those already implemented by CSC and therefore included to enhance understanding.

Part IV: Best Practice Approaches
The best practice approaches component of this manual entails a compilation of interventions that have been deemed best practice amongst offenders who display symptoms of substance abuse. Additionally, this manual outlines two treatment approaches that have been proven effective at decreasing substance abuse amongst various populations, however have not yet been deemed a best practice approach with offenders. This section includes an overview, rationale for use and instructions on how to effectively implement each best practice approach within a correctional environment. Similar to the assessment measures detailed in this manual, the treatment approaches included are not exhaustive. Rather, they are interventions that have high levels of research and validity supporting the use with an offender population, or have high levels of research supporting the introduction of the treatments in an offender population.
**Participant Characteristics**

This manual is designed for offenders incarcerated in a federal institution who:

- Display symptoms of a substance abuse or addiction.
- Were charged with and consequently incarcerated due to substance related crimes.
- Noted ‘manage thinking that justifies and supports substance use’ as a primary or notable target for the Integrated Correctional Program Model (ICPM) program.
- Are resistant to treatment for substance abuse.

**Using the Manual Effectively**

- This manual should be implemented individually with offenders, in addition to any treatment currently being received (i.e. ICPM programming, mental health programs or services, etc.).
- It is advised that facilitators review treatment material prior to implementation to allow familiarity with the content and to ensure they feel comfortable when delivering the treatment.
- It is recommended that facilitators have experience working with offenders prior to implementation of this manual.
- Facilitators should allow client input when determining the pace at which treatment is implemented based on individual needs.
Part II: Substance Abuse

What is a Substance Addiction?
➢ An addiction is defined as repetitively engaging in a rewarding behaviour (i.e. using a drug) resulting in pleasure (i.e. a high) and the satisfaction of a desire (i.e. no more craving), despite the behaviour producing negative consequences that outweigh the positive effects.
➢ Addiction can be characterized by an inability to abstain, cravings, a reduced level of awareness surrounding substantial problems regarding one’s behaviour and interpersonal relationships, and inhibited emotional responses.
➢ The repeated use of a substance causes changes in the way an individual’s brain functions. Persistent substance use over-activates the brains reward center which causes the individual to continue to engage in substance use despite the negative consequences of using.
➢ Similar to other chronic diseases (i.e. epilepsy or diabetes), addiction frequently includes cycles of remission and relapse. The road to recovery is not a straight path.
➢ Addiction does not discriminate: it can affect anyone regardless of their age, gender, education, race or socioeconomic status.

What is the Difference Between Substance Addiction, Substance Abuse and Substance Misuse?
➢ Substance misuse, abuse and addiction are not the same diagnosis.

➢ Symptoms of substance addiction include:
  o Withdrawal symptoms when not using the drug of choice
  o Reduced interest in hobbies or school/career pursuits
  o Using increased amounts of a substance to get the same feeling initially experienced (i.e. tolerance)
  o Withdrawing from family and/or friends
  o Numerous unsuccessful attempts to reduce or stop substance use
  o Continuing to use substance regardless of continuous and growing problems caused by substance use

➢ Substance abuse refers to continuing to use a substance even though the individual is aware that it is having negative consequences on their health, finances and social life. Symptoms include:
  o Legal issues caused by an individual’s substance use or their behaviour while under the influence
  o Physical harm to self or others as a result of an individual’s substance use or their behaviour while under the influence
  o Inability to fulfill home, school, work or other responsibilities
Continued substance use despite ongoing interpersonal and/or social problems caused or exacerbated by substance use

- Ongoing substance abuse can lead to an addiction.

- **Substance misuse** refers to the use of a substance in a frequency, manner, situation or amount other than they were intended. For example, if someone is prescribed to take a medication once daily but takes the medication three times per day, they would be misusing the medication.

**Symptoms of Substance Abuse**

**Physical Symptoms**
- Bloodshot eyes
- Pupils either smaller or larger than usual
- Changes in sleep patterns
- Changes in appetite
- Sudden weight gain or weight loss
- Unusual odors on body, breath or clothing
- Slurred speech
- Tremors

**Behavioural Symptoms**
- Neglecting responsibilities (i.e. not showing up to school, work, programs, etc.)
- Change in friends
- Unexplained and urgent need for money
- No longer engaging in enjoyable activities

**Psychological Symptoms**
- Loss of motivation
- Appearing paranoid, fearful or anxious for no apparent reason
- Sudden mood swings
- Increased irritability

**Symptoms of Commonly Abused Substances**

**Depressants**

*Examples:* Valium, Xanax, Seroquil, Amytal

- Difficulty concentrating
- Shrunken pupils
- Slurred speech
- Tiredness
- Difficulty concentrating
**Hallucinogens**

*Examples:* PCP, LCD
- Dilated pupils
- Slurred speech
- Mood swings and/or aggression
- Paranoia and/or hallucinations
- Confusion
- Anxiety
- Detachment from people
- Absorption with self or others

**Inhalants**

*Examples:* Aerosols, vapors, glues
- Impaired vision
- Drowsiness
- Headache and/or nausea
- Watery eyes
- Rash surrounding the mouth and nose
- Change in appetite
- Irritability
- Poor muscle control

**Stimulants**

Examples: Cocaine, amphetamines, crystal meth
- Dilated pupils
- Euphoria
- Anxiety
- Weight loss
- Dry mouth and nose
- Hyperactivity
- Euphoria

**Marijuana**
- Red, glassy eyes
- Loud tone of voice
- Loss of motivation and/or interest
- Weight loss or gain
- Inappropriate laughter followed by tiredness

**Heroin**
- Small pupils
- Needle marks on arms
- Sweating
➢ Coughing
➢ Vomiting
➢ Loss of appetite
➢ Sleeping at unusual times
➢ Twitching

**Fentanyl**
➢ Lethargic
➢ Withdrawing from friends and/or family
➢ Nausea
➢ Drowsiness
➢ Slowed heart rate
➢ Laboured or shallow breathing
➢ Confusion/disorientation
➢ Inability to concentrate
➢ Anxiety
➢ Paranoia

**Consequences of Substance Abuse.**
Substance abuse can have a number of physical health, mental health, legal, social, and financial consequences on an offender. Common consequences include:

➢ **Physical health consequences:** Stroke, lung disease, heart disease, kidney and/or liver damage, gastrointestinal disease, cancer, an increased transmission of infectious diseases such as HIV or Hepatitis.

➢ **Mental health consequences:** Triggered or exacerbated mental illnesses. Some of the most common mental health issues associated with substance abuse include depression, anxiety, paranoia and hallucinations. Long-term substance use can impair with an individual’s judgement, memory, stress levels, learning and decision-making.

➢ **Legal consequences:** Fines, probation, jail sentences, a criminal record, suspended driver’s license, community service requirements or living restrictions. Additionally, substance abuse has been proven to result in an increased risk of engaging in criminal behaviour.

➢ **Social consequences:** Job loss, divorce, aggressive behaviours towards friends or family members, distancing self from friends and family members.

➢ **Financial consequences:** Financial strain, debt.

**Why Do People Abuse Substances?**
Initially, someone may use a substance to feel good, to make a bad feeling go away, out of curiosity or due to peer pressure.
➢ **To feel good**: Substances can create strong feelings of pleasure (i.e. feelings of self-confidence and power, increased energy or relaxation).

➢ **To make a bad feeling go away**: Some people may use substances to numb unpleasant feelings such as stress, anxiety, or depression.

➢ **Curiosity and/or peer pressure**: Teenagers are at an increased risk of using drugs due to curiosity or social pressure. Peer pressure is often very strong during teenage years and teenagers are more likely to participate in risky behaviours to impress friends and demonstrate independence.

However, over time, changes will occur in the brain which control and interfere with a person’s ability to say no to using drugs. Long-term substance use can impact brain functioning including:

- Learning
- Decision-making
- Memory
- Judgement

Even if someone is aware of the harmful consequences of substance misuse or abuse, they may continue to use drugs. This phenomenon is the nature of addiction.

**What is the Relationship Between Substance Abuse and Crime?**

There is a strong correlation between substance abuse and crime.

- 54% of federal offenders’ report that they were under the influence of a psychoactive substance at the time of their offence.
- An estimated 70% of the incarcerated population demonstrate symptoms of a substance use disorder fluctuating in severity between use and dependency.
- Offenders are four times more likely to be diagnosed with a substance use disorder (SUD) than the general population.
- 53% of federal offenders admit to engaging in illicit substance use in the six months prior to their most recent arrest.

Of crimes committed, the abuse of drugs and/or alcohol were strongly associated with the following crimes:

- Driving under influence – 94%
- Assault – 69%
- Theft – 66%
- Murder – 58%
- Break and enter – 56%
- Robbery – 56%
- Sexual assault – 45%
- Drug-related offences – 28%
- Fraud – 22%
There are three primary ways in which crime and substance abuse can be correlated:

1) Crime for gain to support the cost of drug use (i.e. armed robbery).
2) Crime caused by the psychopharmacological effect of a substance (e.g. violent or aggressive behaviour as a result of the disinhibiting effects of substances).
3) Criminal behaviour incorporated into drug transacting business.

**What Role Does Substance Abuse Play in Recidivism?**

Substance use is one of the top three factors contributing to recidivism rates. Upon being released from a correctional institution, offenders diagnosed with a substance use disorder are likely to encounter a number of stressors that challenge their substance reduction or abstinence and elevate the risk of relapse. Stressors may include but are not limited to:

- The stigma associated with having been incarcerated
- Finding employment
- Reuniting with family
- Finding housing
- Meeting the requirements surrounding criminal justice supervision

Unless offenders abstain from substance use or engage in treatment programs during their incarceration, reoffending rates are likely to remain elevated.

**Substance Abuse Within an Institution**

Correctional facilities have the greatest per-capita proportion of individuals who have a substance abuse problem in society:

- Approximately 80% of offenders incarcerated in a federal institution reported problematic substance use patterns.
- 25% of offenders disclosed being pressured to bring substances into the institution upon incarceration.
- Almost 51% of offenders incarcerated in a federal institution display symptoms of alcohol abuse.
- Nearly 48% of federal offenders in Canada engage in problematic drug use.

Cannabis and THC-based substances are most frequently used in an institution, followed by a variety of opiates, benzodiazepines, and cocaine.
What is Addiction?

Addiction: a disease involving continued use of a substance despite serious substance-related problems, such as loss of control over use, health problems, or negative social consequences.

⚠️ Signs of Addiction

- **Loss of Control Over Substance Use**
  - Using more of the substance than intended
  - Difficulty reducing substance use
  - Significant time spent obtaining, using, or recovering from substance
  - Having cravings: strong desire to use substance

- **Social / Occupational Problems**
  - Not fulfilling major obligations at work, school, or home
  - Social problems caused by continued use of substance
  - Decreasing or giving up important social or occupational activities

- **Risky Use**
  - Using the substance in situations where it is physically dangerous
  - Physical or psychological problems caused by continued use of the substance

- **Physical Effects**
  - Building tolerance: needing more of the substance to achieve desired effect
  - Experiencing withdrawal: physical or psychological symptoms when not using the substance

📝 Addiction Facts

- Addiction is a disease. Addiction causes changes in the brain's structure and functioning. It is not caused by poor willpower or character flaws.

- Addiction can grow slowly and isn't always easy to see. Many people with addiction continue to function in some parts of their life, but have problems in other areas.

- Relapse means returning to regular substance use after a period of sobriety. A lapse, on the other hand, is an isolated incident of use without returning to old patterns of substance use.

- Relapses can happen at any point during recovery, which is a lifelong process. Those who are in recovery are at heightened risk during periods of stress.
Part III: Assessment Measures

Computerized Assessment of Substance Abuse (CASA)

The CASA is a standardized substance abuse assessment administered as a supplementary assessment to the Offender Intake Assessment (IOA) by CSC. The assessment is a 288-item self-administered test designed to assess the nature and severity of an offender’s substance use. All assessments in the CASA look at the 12-month period prior to an offender’s arrest. The assessment is comprised of the Alcohol Dependence Scale (ADS), the Problems Related to Drinking Scale (PRD), the Michigan Alcoholism Screening Test (MAST), the Drug Abuse Screening Test (DAST), and the Severity of Dependence Scale (SDS). The ADS, PRD, and MAST are utilized to assess the severity of alcohol abuse while the DAST and SDS the severity of drug abuse. Though the results from all five assessments establish the severity of an offender’s substance abuse, only the results from the ADS, PRD, and DAST are examined when determining the referral criteria and treatment intensity required.

The CASA is broken down into 15 drug related content areas:

- Patterns of alcohol consumption
- Consequences of consuming alcohol
- Severity of alcohol use
- Problems associated with alcohol use
- The connection between alcohol and previous or current criminal behaviour
- History of drug use
- Problems associated with drug use
- The connection between drugs and previous or current criminal behaviour
- The severity of psychological dependence
- Abusing multiple substances, engaging in drug use via injection
- Previous treatment
- Motivation to participate in treatments
- Substance use while in-custody and a history of family-related drug use

The CASA is designed to match an offender’s needs with the suitable treatment intensity. If an offender receives a score of either “substantial” or “severe” severity, it is indicative that they should be referred to a high-intensity program. “Moderate” severity is indicative of a moderate intensity program while a score of “low” severity does not require treatment.

Alcohol Dependence Scale (ADS)

The ADS is a 25-item questionnaire that is designed to assess the severity of problems associated with alcohol consumption and the extent of physiological dependence. Offenders select which statement best describes their current situation based on either two or three options provided for each of the 25 questions. The numbers
associated with each statement the offender selected are added together. The maximum score an offender can receive is 47. A total score between 1 to 13 refers to a low level of alcohol dependence, 14 to 21 is indicative of a moderate level of alcohol dependence, 22 to 30 suggests a high level of alcohol dependence and 31 to 47 refers to a severe level of alcohol dependence.

*See Appendix A for Alcohol Dependence Scale.

**Problems Related to Drinking Scale (PRD)**

The PRD is an assessment developed by CSC comprised of 15 yes or no questions designed to assess the severity of problems caused by a client’s alcohol consumption. The PRD classifies an offender’s score as either “none”, “some”, “quite a few” or “a lot” as a description of the extent of an offender’s alcohol-related problems.

*See Appendix B for the Problems Related to Drinking Scale.

**Drug Abuse Screening Test (DAST)**

The DAST is a 20-item assessment in which clients answer yes or no to the questions provided to assess their level of problematic substance use. The assessment is designed to determine the extent of psycho-social interference regarding an offender’s substance use. The highest score an offender can report is 20, with a score ranging between 1 to 5 being indicative of a low severity, 6 to 10 referring to moderate severity, 11 to 15 suggesting substantial severity and 16 to 20 indicating a high severity of substance use.

*See Appendix C for the Drug Abuse Screening Test.

**Severity of Dependence Scale (SDS)**

The SDS is a 5-item assessment designed to analyze the extent of an offender’s psychological dependence to a substance. Specifically, the SDS assesses an individual’s preoccupation regarding drug taking in addition to any anxieties they may have regarding drug use. SDS scores indicate factors including the dose, frequency and duration of use and the extent to which the individual interacts with other drug users.

*See Appendix D for the Severity of Dependence Scale.

**Michigan Alcoholism Screening Test (MAST)**

The MAST is a 25-item assessment measure included in the CASA in order to determine the measures clinical utility within a correctional environment. The assessment focuses on an offender’s previous drinking and alcohol-related incidents. In the future, the PRD will replace the MAST.

*See Appendix E for the Michigan Alcoholism Screening Test.
What Are Best Practice Approaches?

➢ Best practice approaches are defined as evidence-based treatments that integrate the most recent and best research available with clinical expertise regarding patient culture, characteristics and preferences.
➢ Evidence-based treatments utilize empirically supported assessments and intervention principles as well as therapeutic rapport to provide effective treatments.
➢ The purpose of evidence-based practices are to promote effective psychological practice and enhance public health by applying empirically supported (research-based) principles of psychological assessment, case formulation, therapeutic rapport, and intervention.
➢ Evidence-based programs often:
  (a) Include an incentive for participating in the treatment
  (b) Are provided to high-risk offenders
  (c) Integrate multiple intervention types simultaneously
  (d) Are high intensity
  (e) Provide an element of aftercare

Why Use Best Practice Approaches?

➢ The approaches are created using scientific research and have been proven to be effective.
➢ Treatments that are not empirically validated (supported by research) may be ineffective or potentially harmful to a client.
Motivational Interviewing

Motivational interviewing (MI) is a client centered form of therapy that helps clients to explore and resolve ambivalence to evoke behaviour change. It is designed to help clients take responsibility for their behaviour change in a non-confrontational manner. It should be noted that a helper should never force an offender to change his behaviour, but rather direct or guide him. MI often includes listening reflectively (using reflective statements or paraphrasing what your client is saying to ensure you understand their thoughts, feelings and needs), asking open-ended questions (questions that cannot be answered with yes or no), managing resistance while avoiding direct confrontation and encouraging self-motivational affirmations using directive methods and strategies including providing feedback, providing choice, practicing empathy, eliminating barriers, and clarifying goals. The overall role of the clinician is to elicit motivation and self-efficacy in the client to generate positive behaviour change.

Four Processes of MI

The four processes of MI are a logical sequence MI follows, with each process building on the previous one. However, a helper may switch between the processes or return to a previous process when working with an offender.

1. **Engaging:** Offender engagement is a critical component of a helping relationship. The engaging process focuses on the helper developing a rapport with an offender. Offender engagement must continue to be used during all processes of MI.

2. **Focusing:** The focus process is ongoing and entails helping the offender to develop an agenda of priorities and goals. Offender autonomy must be respected during this stage – it must be their decision as to what goals they choose to work towards during treatment.

3. **Evoking:** During the evoking stage, the goal of the helper is to prompt the offender to develop motivation in order to maintain the behaviour changes set in the focusing stage.

4. **Planning:** The planning process entails the helper assisting an offender to create a specific change plan which the offender is willing to implement.

Key Principles of MI

1. **Express Empathy**
   As a helper, the goal of this principle is to display empathy to the offender by attempting to understand their point of view regarding all aspects of their life. This helps to normalize any ambivalences the offender may have.
Support Self-Efficacy

As a helper, it is important to emphasize the importance of offenders developing the belief that change is possible, and that you as the helper believe they can change. Doing so helps an offender develop self-efficacy, which in turn increases an offender’s motivation to change their behaviour.

Roll with Resistance

Rolling with resistance refers to accepting any resistance an offender may display and use it as a sign to shift the direction of the session. A key factor to successfully rolling with resistance is to not argue with an offender when they are displaying resistance.

Develop Discrepancy

A helper can develop discrepancy by gradually pointing out the differences between an offender’s goals and the behaviour they display. This allows the offender to see the difference between the behaviours they currently display and those they want to display following their behaviour change.

Avoid Arguments

Avoiding arguments when working with an offender can help to minimize resistance and alleviate the appearance of a power struggle. One of the most common arguments between a helper and a client is the client’s unwillingness to acknowledge or accept a label such as ‘drug addict’ or ‘alcoholic’.

Though ultimately it is the offender’s responsibility to make the decision and commitment to changing their behaviour, you as a helper should be supportive and believe in the offender’s ability to change. Increasing an offender’s self-efficacy is the most important component of motivational interviewing to ensure lasting behaviour change.
Substance Use Motivation Ruler

Are you motivated to end your substance use? Rank your motivation on the ruler from 1 to 10. A “1” means that you have absolutely no motivation to end your use. A “10” means that you are completely ready to be sober, and have no doubt about the decision.

1 2 3 4 5 6 7 8 9 10

Why is your motivation where it is? Why not lower? Even if you marked only a “2” or a “3,” there must be a reason you didn’t write “1”. List some of your motivators.

1

2

3

4

5

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# Building Discrepancy

How will your life change if you choose to either continue or quit using drugs and alcohol?

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<th>My relationships with my family and other loved ones will be affected...</th>
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Pharmacotherapy

Pharmacotherapy, also referred to as Opioid Agonist Therapy or Medication-Assisted Treatment of Opioid Dependence, refers to the administration of medication as a form of treatment for drug abuse. The treatment can be an effective method to manage withdrawal symptoms and prevent relapse amongst offenders. The methadone maintenance treatment program and Suboxone program are the pharmacological treatments implemented within a correctional environment. Both medications are designed for individuals who abuse opioids. Frequently abused opioids include opium, codeine, morphine, oxycodone, methadone, fentanyl and heroin.

Methadone

Methadone, an opioid agonist, reduces or works by removing symptoms associated with opioid withdrawal such as vomiting and nausea, anxiety, tearing and restlessness. Individuals participating in the methadone maintenance treatment program take the medication orally one to two times daily. Individuals who have participated in the methadone maintenance treatment program for a long period of time have been determined to reduce the use of opioids, illnesses or deaths related to drug use, and criminal behaviour.

Suboxone

Suboxone, a combination of naloxone and buprenorphine, has the same effect as methadone; reducing symptoms of opioid withdrawal. Suboxone is taken orally and comes in tablet form, which is dissolved under an offender’s tongue. Suboxone can be taken one to two times daily, as prescribed.

A common concern with pharmacological treatments are the addictive properties of methadone and Suboxone. Though both opioids do have addictive properties, the substances do not produce the same amount of euphoria compared to alternative opioids and the effects of methadone and Suboxone are longer in duration. Some offenders will utilize pharmacological treatment for the duration of their life, whereas others will choose to slowly lessen their use until they are no longer dependent on the substance. Methadone and Suboxone can result in withdrawal, and though the withdrawal process lasts longer that of other opioids the symptoms are less intense. However, given both methadone and Suboxone are opioids, if misused there is the potential that an offender would become addicted. Therefore, it is crucial to ensure offenders are taking opioid replacement drugs as prescribed. To ensure offenders do not misuse the pharmacological treatment, they must attend health care in order to receive each dose of medication. Additionally, both methadone and Suboxone are Direct Observation Therapy (DOT) medications. Therefore, offenders must be observed at all times when consuming the medications to ensure they are taking the right dose and are consuming the medication themselves as opposed to hiding it to either misuse or sell at a later point in time.
Risk Need Responsivity Model

The Risk Need Responsivity Model treatment is established on three primary principles: Risk, needs, and responsivity of an individual.

Risk Principle

The risk principle focuses on who it is the intervention is targeting. The level of treatment an offender receives (i.e. time, intensity and resources) should be matched to an offender’s risk of reoffending. Therefore, an offender who has a higher risk of reoffending should receive a high intensity treatment while a low risk offender should receive minimal to no program. Evidence shows that a low to moderate risk offender participating in a high intensity program can increase their risk of reoffending.

Need Principle

The need principle focuses on the concept that the likelihood of an offender reoffending can be reduced if certain factors are identified and treated. These factors are often addressed during correctional programming, and logically programs are most effective when targeting specific factors related to an offender’s crime process. Superficially, there are two categories of needs that should be assessed: criminogenic and non-criminogenic. Criminogenic needs are factors that are directly related to an offender’s likelihood of reoffending. The main eight criminogenic needs often targeted are antisocial associates, antisocial cognitions, a history of antisocial behaviours, an antisocial personality pattern, satisfaction with school or work, leisure activities, family and marital relations, and substance use. Furthermore, there are two types of criminogenic needs: static and dynamic. Static factors are aspects that cannot be changed through programs such as age at first arrest, criminal history, or a history being abused. Dynamic factors are those that can be addressed through intervention and if addressed, may influence an offender’s likelihood of reoffending. The main eight criminogenic previously mentioned are examples of dynamic criminogenic needs. Non-criminogenic needs are attributes that have no impact on an offender’s likelihood of reoffending. Examples of non-criminogenic needs include physical health, depression, anxiety, self-esteem, fear of punishment and victimization. Dynamic criminogenic needs should be addressed as an offender’s personal targets during correctional programming to reduce his likelihood of reoffending.

Responsivity Principle

The responsivity principle states that the treatment style should be tailored to an offender’s characteristics. All offenders are different, and thus have differing characteristics such as emotionality or communication style which may impact the way in which an offender responds to a treatment designed to change thoughts, attitudes and behaviours. There are two distinct components that comprise the responsivity principle: general and specific responsivity. General responsivity refers to influencing an offender’s behaviour with the use of cognitive behavioural therapy techniques including
positive and negative reinforcement, problem solving and prosocial modelling. Ultimately, general responsivity alludes that powerful cognitive social and behavioural learning strategies must be utilized for successful behaviour change. Specific responsivity focuses more on individualized and tailored treatments and suggests that intervention modes should be matched to personality, strengths, learning style, bio-social characteristics and motivation.
Transtheoretical Model

Overview
The transtheoretical model, often referred to as the Stages of Change, is a theory that suggests that behaviour change does not occur instantaneous in one step. Rather, individuals work through six different stages at their own rate when successfully changing their behaviour. This model allows clinicians to tailor or adapt the intervention to the offender. The six stages include precontemplation, contemplation, preparation, action, maintenance and relapse.

Precontemplation
An individual in the precontemplative stage of change does not recognize that his behaviour is problematic, and sees no need for change. Clients displaying symptoms of the precontemplation stage of change are resistant, may be seeking treatment due to the pressure of others, have no desire or motivation to change and may be either ignoring or unaware that their behaviour is problematic. If an offender is stuck in the precontemplation stage they may exhibit various forms of denial including defensiveness, minimizing their actions, avoidance, blaming others or appearing uncommitted to participating in correctional programming. An individual in the precontemplation stage may be unconvinced that their behaviour patterns are risky or problematic as they may have never experienced adverse consequences as a result of their negative behaviour.

Common Indicators:
- Denial
- Blaming
- Defensiveness
- Hostility
- Uncommitted to change
- Minimization
- Resistant to the proposition that their behaviour is problematic
- Seeking help due to pressure from others

Goal: When working with an individual in the precontemplative stage of change, the goal is to encourage thoughts and discussion surrounding the problem behaviours to create discrepancy.

How Can You Help?
- Validate the offenders lack of readiness; let them know it is okay that they are not ready to change their behaviour yet.
- Develop rapport.
- Explain and personalize the risks of their substance use.
Contemplation

A client in the contemplation stage of change is aware that his behaviour is problematic, however may not be aware of specifically what to change. The stage is often referred to as the “yeah…but…” stage of change. The client often recognizes that there is a problem and a need for change and are interested in treatment, however, they do not yet consider changing their behaviour and are not ready for the commitment of behaviour change. They will often weigh the pros and cons of changing their behaviour, however ultimately they will be unable to decide on a definite answer. Offenders in the contemplative stage of change are seriously contemplating changing their behaviours they have begun to realize the negative consequences on themselves and others should they continue their risky behaviour.

Common Indicators:
➢ Distress
➢ Contemplating changing their behaviour
➢ Trying to understand their behaviour
➢ Looking at the positives and negatives to their current behaviour
➢ Not making any changes to their behaviour and are not committed to doing so yet

Goal: The goal of the contemplative stage of change is to utilize MI to assist the client to resolve ambivalences and guide them to the decision to take action and change their behaviours.

How Can You Help?
➢ Elicit talk about behaviour change.
➢ Continue to build rapport.
➢ Explain the different stages of change and have a discussion surrounding which stage the offender thinks they may be in.
➢ Discuss the pros and cons of changing their behaviour as well as of not changing their behavior.
➢ Keep the offender engaged.

Preparation

An individual in the preparation stage of change is preparing to make the necessary changes and has committed to changing their behaviour. Furthermore, they are able to envision the changes they want to implement regarding their behaviour. They are willing to experience the consequences of change (i.e. discomfort, effort), have started to accept responsibility for their actions and are starting to assess changes that will need to be made to people, places and things in their life. However, the client has not yet implemented any behaviour changes. An offender in the preparation stage of change may have previously attempted to alter their behaviour and have learned from their previous failed attempts which they can utilize to improve their current attempt. During this stage
of change offenders are mentally preparing to implement change in the action stage of change.

**Common Indicators:**
- Has decided to change their behaviour
- Has a positive attitude regarding changing their behaviour
- Ready to take action
- Ready to commit to following the action plan previously determined

**Goal:** During the preparation stage of change, the goal is to assist the client to develop a plan for change.

**How Can You Help?**
- Help the offender set comfortable and reasonable goals (i.e. SMART goals).
- Encourage self-monitoring.
- Elicit the offender’s ideas for behaviour change.

**Action**

A client in the action stage of change has started to engage in behaviours associated with changing their substance abuse behaviour, but may be experience challenges. The client will have begun to stop previous, negative behaviour patterns and have replace them with new, positive ones. An offender may be modifying their environment, thought patterns, experiences and behaviours during this stage. A client’s goals often have to be adapted or changed during this stage.

**Common Indicators:**
- Decided to make a change
- Motivated and actively engaging in the change process
- Demonstrating and/or verbalizing their commitment to changing their behaviour
- Open to strategies to change and maintain behaviour change

**Goal:** When working with a client in the action stage of change, the goal is to reinforce successful behaviour changes while addressing any barriers to change that may have arisen.

**How Can You Help?**
- Revisit goals.
- Monitor the offenders progress.
- Teach and have offender practice new coping skills.
- Explore why change is important to the offender.
- Explore the offender’s level of confidence regarding changing their behaviour.
Maintenance

An individual in the maintenance stage of change has implemented the required behaviour changes, has made long-term positive behaviour changes and has generalized the new, positive. This stage is designed to prevent relapse, and offenders in the maintenance stage of change will display a level of change resulting from successful actions during the action stage. However, the client may have difficulty maintaining long-term change.

Common Indicators:
- Avoids high risk situations
- Actively working towards sustaining behaviour changes
- May experience anxiety about encountering high risk situations
- May experience temptations to test themselves (i.e. place themselves in high-risk situations or engage in high-risk activities)

Goal: During the maintenance stage of change, the goal is to support the client in determining a coping plan, managing relapse triggers, and maintain behaviour long term.

How Can You Help?
- Have the offender engage in the new behaviour in different places, at different times and around different people to generalize the behaviour.
- Focus on preventing relapse.
- Continue to help the offender build confidence.
- Prepare the offender on high-risk situations and how to cope with them.

Relapse

Though not all professionals consider relapse to be a stage of change, relapse is a common and potentially beneficial aspect of lasting change. A client is considered to have relapsed when he returns to previous behaviour patterns. However, relapse is not a failure, but rather just a component of lasting behaviour change.

Goal: The goal of the relapse stage of change is to assist the client to cope with the consequences of their behaviour in a healthy manner and develop a plan for next steps.

How Can You Help?
- Encourage the offender to learn from the relapse.
- Re-evaluate the offender’s strategies and goals.
Stages of Change

Precontemplation

1. The costs of the problem behavior (such as drug use) are not yet recognized. The individual is in denial and is not seriously considering changing their behavior. They may have made previous attempts to change, but have since given up.

Contemplation

2. The individual is experiencing ambivalence about change. They can see reasons to change their behavior, but they are still hesitant. The problem behavior continues.

Preparation

3. The individual has decided to change their behavior, and they begin to think about how to do so. During this stage they will begin to make minor changes to support their goal, but they might not have completely ended the unwanted behavior.

Action

4. Significant steps are taken to end the problem behavior. The individual might be avoiding triggers, reaching out for help, or taking other steps to avoid temptation.

Maintenance

5. The changes made during the action stage are maintained. The individual may continue to face challenges, but at this point they have successfully changed their behavior for a significant period of time.

Relapse

After making changes, some individuals will return to their previous problem behavior. This can happen at any time during the previous stages. Not everyone will experience relapse, but it is always a risk.
Solution-Focused Therapy

Solution-focused therapy is a competence-based approach in which a clinician focuses on a client’s accomplishments, strengths and places a greater importance on discussing solutions as opposed to problems. The helper works with the individual to create goals and determine a solution to their problem as opposed to introducing ‘appropriate’ treatment targets. A key element of solution-focused therapy is holding the technique accountable as opposed to the client should a treatment not be effective. Additionally, if an intervention is not producing the desired results, a new approach is adopted. Solution-focused therapy strives to determine a distinct solution for every individual, utilize previous successes to encourage confidence, and view the client as the expert. During solution-focused therapy, a clinician adopts a variety of techniques such as amplifying change, scaling questions, relapse assessment and prevention and exception-finding questions. Solution-focused therapy is often implemented during brief therapy; however, the treatment approach can be effectively implemented in group therapy.

Key Concepts and Tools

Looking for Previous Solutions
Most people have previously solved many problems in their life in an effective manner, and likely have an idea of how to solve their current problem even if they are not aware that they do. As a clinician, you may ask questions along the lines of “Have there been times when this was less of a problem? If so, what did you do then to make it less of a problem?” or “What have you or others done in past that you found helpful?” to help a client see potential solutions to the problem.

Looking for Exceptions
Though a client may not always have a previous solution to the problem or a different problem than can be repeated, most clients will be able to think of recent examples of exceptions to their problem. Such instances are times in which a problem could have occurred, but it did not. Though similar to previous solutions, a previous solution is a solution the offender used for a period of time but then stopped. Whereas an exception is a situation that happens instead of the problem. As a clinician, you may ask the client to identify exceptions by asking questions along the lines of “what sort of things were different when this was less of a problem?”

Present and Future Focused Questions
Questions asked by the clinician during solution-focused therapy should be present or future oriented. Doing so reflects the belief that a solution can be solved by continuing to do what is already working. Additionally, this allows a client to focus on what they want their life to look like in the future as opposed to focusing on the past and the origin of their problem. An example of a present oriented question would be “what are you doing right now that would let you know you are continuing to make progress” while a
future oriented question would be “what will you do in the next week that would let you know you are continuing to make progress.”

**Compliments**

Compliments are a key component of solution-focused therapy. An offender should be validated on what they have been succeeding at while the difficult problems they are experiencing should be acknowledged so they are aware that you care and are listening to what they have to say. Often, compliments can be conveyed in the form of a question such as “How did you accomplish that?”, which allows the offender to self-compliment upon answering the question.

**Suggesting the Offender Does More of What Works**

As a helper, once you have validated and acknowledged the offender and established previous exceptions and solutions to the problem, you may gently invite the offender to try to incorporate more of what has previously worked into their routine.

**Miracle Questions**

Miracle questions are designed to help a client determine realistic, small, doable steps they can implement immediately in order to work towards achieving their goal. As a helper, have the offender envision and describe what their life would look like if all of their problems no longer exist. Based on what they describe as their ideal life, work with the offender to create SMART (specific, measurable, achievable, realistic, time-based) goals to work towards the life they described.

**Coping Questions**

Coping questions are powerful reminders that the client is currently using many coping skills when situations become difficult or overwhelming. Even in the most difficult situations, offenders often have skills they use to get out of bed, attend passes, get food or go to recreation. Coping questions along the lines of “How have you managed when things have been tough?” or “How have you prevented the situation from becoming worse” is an effective method of analyzing an offender’s determination and resiliency.

**Golden Rules**

1. If it is not broken, then do not fix it.
2. Once you have determined what is effective, do more of it!
3. If something does not work, then do not do it again. Instead, try something different!
Cognitive Behavioral Therapy

Cognitive Behavioural Therapy (CBT) is a treatment that was developed based on the idea that the learning process plays a key role in maladaptive, unhealthy behaviour patterns (such as substance abuse). The treatment has three primary underlying factors; (1) behaviour is largely learned, not inherited through genetic facts, (2) the learning process by which problems behaviours are created is the same process required to alter the behaviours and (3) majority of behaviour is controlled by the environment. CBT is a structured, problem-focused, goal-directed form of treatment designed to educate, motivate and support individuals on how they can decrease or stop their harmful substance use. The treatment provides information surrounding what an addiction is, ways someone cannot use substances and focuses on the development of alternative behaviours to substance use. Additional components include exploring and addressing an offender’s cognitive distortions surrounding their use, exploring and addressing triggers to an offender’s substance use behaviour, developing healthy coping strategies and relapse prevention.

Benefits of CBT include that the treatment is adaptable, can be individualized to each client, can be implanted in a variety of different settings and can be implemented in addition to other treatments an offender may be receiving such as pharmacotherapy.

Early Stages of CBT

When first implementing CBT, it is important learn the various details of an offender’s drug use. To know that an offender uses a particular type of drug is not sufficient. Knowing as much information as possible will allow you to connect an offenders drug use with various aspects of their life and in turn will allow you to create the most effective treatment plan possible. Questions you can ask include:

**When:** What time periods did the offender use drugs?
**Where:** Which places did the offender both buy and use drugs?
**Why:** What external cues or emotions triggered a craving?
**With/from whom:** Who did the offender buy drugs from or use drugs with?
**What happened:** What psychological or physical effects did the offender experience from using the drug?

Later Stages of CBT

Once a framework of where, when, why and with whom an offender uses drugs has been established, offenders can be taught what an addiction is as well as about triggers and cravings, various cognitive skills to manage these urges, and relapse prevention.
Example: Bob

Situation: Bob had a long and frustrating day at work.

Thoughts: “I had a really stressful day at work I deserve to relax a little and have a few drinks.”

Emotions: Frustrated, overwhelmed, discouraged.

Behaviours: Bob has a few drinks, which turns into a few more. He wakes up hung over the next morning and is late for work.

As humans, we all have irrational thoughts like these. Unfortunately, irrational or not, these thoughts still affect how we feel and how we behave. Consider how Bob might have responded to the same situation if he had a different thought:

Thoughts: “I had a really stressful day at work, I deserve to relax and blow off some steam.”

Emotions: Frustrated, motivated.

Behaviours: Bob goes to the gym to exercise, goes home to his family and gets a good night’s sleep so he is able to have a productive day at work the following day.

Using the cognitive model, you will learn to identify your own patterns of thoughts, emotions, and behaviors. You’ll come to understand how your thoughts shape how you feel, and how they impact your life in significant ways.

Once you become aware of your own irrational thoughts, you will learn to change them. The thoughts that once led to depression, anxiety, and anger will be replaced with new, healthy alternatives. Finally, you will be in control of how you feel.
Cognitive Distortions

Cognitive distortions are irrational thoughts that can influence your emotions. Everyone experiences cognitive distortions to some degree, but in their more extreme forms they can be harmful.

**Magnification and Minimization:** Exaggerating or minimizing the importance of events. One might believe their own achievements are unimportant, or that their mistakes are excessively important.

**Catastrophizing:** Seeing only the worst possible outcomes of a situation.

**Overgeneralization:** Making broad interpretations from a single or few events. “I felt awkward during my job interview. I am always so awkward.”

**Magical Thinking:** The belief that acts will influence unrelated situations. “I am a good person—bad things shouldn’t happen to me.”

**Personalization:** The belief that one is responsible for events outside of their own control. “My mom is always upset. She would be fine if I did more to help her.”

**Jumping to Conclusions:** Interpreting the meaning of a situation with little or no evidence.

**Mind Reading:** Interpreting the thoughts and beliefs of others without adequate evidence. “She would not go on a date with me. She probably thinks I’m ugly.”

**Fortune Telling:** The expectation that a situation will turn out badly without adequate evidence.

**Emotional Reasoning:** The assumption that emotions reflect the way things really are. “I feel like a bad friend, therefore I must be a bad friend.”

**Disqualifying the Positive:** Recognizing only the negative aspects of a situation while ignoring the positive. One might receive many compliments on an evaluation, but focus on the single piece of negative feedback.

**“Should” Statements:** The belief that things should be a certain way. “I should always be friendly.”

**All-or-Nothing Thinking:** Thinking in absolutes such as “always”, “never”, or “every”. “I never do a good enough job on anything.”
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**Magical Thinking:** The belief that acts will influence unrelated situations. “I am a good person—bad things shouldn’t happen to me.”

**Personalization:** The belief that one is responsible for events outside of their own control. “My mom is always upset. She would be fine if I did more to help her.”

**Jumping to Conclusions:** Interpreting the meaning of a situation with little or no evidence.

**Mind Reading:** Interpreting the thoughts and beliefs of others without adequate evidence. “She would not go on a date with me. She probably thinks I’m ugly.”

**Fortune Telling:** The expectation that a situation will turn out badly without adequate evidence.

**Emotional Reasoning:** The assumption that emotions reflect the way things really are. “I feel like a bad friend, therefore I must be a bad friend.”

**Disqualifying the Positive:** Recognizing only the negative aspects of a situation while ignoring the positive. One might receive many compliments on an evaluation, but focus on the single piece of negative feedback.

**“Should” Statements:** The belief that things should be a certain way. “I should always be friendly.”

**All-or-Nothing Thinking:** Thinking in absolutes such as “always”, “never”, or “every”. “I never do a good enough job on anything.”
STOPP

➢ Stop and Step Back
  o Don’t act immediately. Pause.

➢ Take a Breath
  o Notice your breath as you breathe in and out.

➢ Observe
  o What am I thinking and feeling? What are the words that my mind is saying? Is this fact or opinion? Descriptions or evaluations? Accurate or inaccurate? Helpful or unhelpful? What unhelpful thinking habit am I using (e.g. mind-reading, negative filter, thinking the worst)? Where is my focus of attention? What metaphor could I use (mountain, tunnel, playground bully, thought train, beach ball, passengers on the bus)?

➢ Pull Back: Put in some Perspective
  o See the situation as an outside observer. What would a fly on the wall see? Is there another way of looking at it? What would someone else see and make of it? What advice would I give to someone else? What’s 'the helicopter view'? What meaning am I giving this event for me to react in this way? How important is it right now, and will it be in 6 months? Is my reaction in proportion to the actual event?

➢ Practise what works
  o Do what works, what is most helpful. Play to your Principles and Values. Will it be effective and appropriate? Is it in proportion to the event? Is it in keeping with my values and principles? What will be the consequences of my action? What is best for me and most helpful for this situation?
Triggers and Coping Skills

Specific people, places, and things can remind us of past drug use. Avoiding these triggers can be an effective way to reduce the likelihood of relapse. List five people, places, or things that might make you more likely to relapse.

People, places, and things:

1.

2.

3.

4.

5.

What if you’re unable to avoid these people, places, and things? What if you come into contact with them accidentally? Briefly describe how you can deal with each of the people, places, and things listed above.

How I can deal with dangerous people, places, and things:

1.

2.

3.

4.

5.
People, Places, and Things

People, places, and things that remind us of our past drug use can trigger relapse. Driving past an old bar, hanging out with certain friends, or listening to an old song can bring back memories of using. List the people, places, and things you should avoid to reduce your risk of relapse.

People


Places


Things


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When I am Tempted to Use

Check off the situations in which you would be most tempted to use drugs or alcohol. Write in your own situations if you don’t see them listed.

___ When I am having withdrawals
___ When I want to have just one drink
___ When I want to see if I can handle using in moderation
___ When I have a headache
___ When I am worrying about something
___ When I have a dream about drugs
___ When I am tired
___ When I’m in pain
___ When I’m depressed
___ When I’m angry
___ When I want to relax
___ When I’m at a party
___ When I see drugs and alcohol on TV
___ When I’m happy
___ When my friends are using
___ When I am on vacation
___ When I am bored
Triggers

**Trigger:** A stimulus—such as a person, place, situation, or thing—that contributes to an unwanted emotional or behavioral response.

**The Problem**
Describe the problem your triggers are contributing to. What's the worst-case scenario, if you are exposed to your triggers?

---

**Trigger Categories**
Just about anything can be a trigger. To begin exploring your own triggers, think about each of the categories listed below. Is there a specific emotion that acts as a trigger for you? How about a person or place? List your responses in the provided spaces.

<table>
<thead>
<tr>
<th>Emotional State</th>
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<tr>
<td>People</td>
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<td>Places</td>
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<td>Things</td>
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<td>Thoughts</td>
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<td>Activities / Situations</td>
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**Tips for Dealing with Triggers**

- Oftentimes, the best way to deal with a trigger is to avoid it. This might mean making changes to your lifestyle, relationships, or daily routine.

- Create a strategy to deal with your triggers head on, just in case. Your strategy might include coping skills, a list of trusted people you can talk to, or rehearsed phrases to help you get out of a troublesome situation.

- Don’t wait until the heat of the moment to test your coping strategy. *Practice!*
In this section, you will develop a plan for dealing with your three biggest triggers. Review your plan regularly, and practice each of the strategies.

Describe your three biggest triggers, in detail.

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<th>Trigger</th>
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Describe your strategy for avoiding or reducing exposure to each trigger.

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<th>Trigger</th>
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</table>

Describe your strategy for dealing with each trigger head on, when they cannot be avoided.

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<th>Trigger</th>
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Coping Skills
Addictions

Social Support
Few things are as powerful as having a supportive person in your corner. Just knowing that friends, family, or even a fellow group member or sponsor are pulling for you can make all the difference.

Daily Social Support
There's more to social support than having someone to call during moments of crisis. People who have strong relationships are more resilient when facing life's obstacles, and more likely to beat addiction. Make a point to strengthen your relationships, attend support groups, and build new friendships.

Crisis Social Support
When in crisis, it's helpful to have a person you can count on for support—someone who you can call, who will help to talk you through the situation. Make a list of people who you can contact during these situations, and how you can reach them.

Diversions
Cravings are brutal. They grow and grow, gnawing at your willpower, demanding that you relapse. In the middle of a craving, it might feel as if there's no escape but to use. But then, if you resist, the craving starts to fade. Eventually, it disappears. Most cravings end within one hour of starting.

The goal of diversions is to buy yourself time during a craving. If you can distract yourself for just one hour, you will have a much better chance of avoiding relapse. Come up with a list of activities you genuinely enjoy that will keep you at a distance from your temptation.

Diversion Ideas

<table>
<thead>
<tr>
<th>go for a walk</th>
<th>read a book</th>
<th>play a sport</th>
<th>listen to music</th>
</tr>
</thead>
<tbody>
<tr>
<td>watch a movie</td>
<td>practice a hobby</td>
<td>go for a run</td>
<td>clean or organize</td>
</tr>
<tr>
<td>do yard work</td>
<td>draw or paint</td>
<td>do a craft</td>
<td>cook or bake</td>
</tr>
<tr>
<td>play a game</td>
<td>go for a bicycle ride</td>
<td>write or journal</td>
<td>take a long bath</td>
</tr>
<tr>
<td>play an instrument</td>
<td>call a friend</td>
<td>lift weights</td>
<td>go swimming</td>
</tr>
<tr>
<td>go hiking in nature</td>
<td>take photographs</td>
<td>play with a pet</td>
<td>rearrange a room</td>
</tr>
</tbody>
</table>
Building New Habits

Most addictions require a lot of time. Thinking about, acquiring, and indulging an addiction can fill most of a day. When you quit, one of your greatest new resources is time. However, if your newfound time isn’t filled with healthy activities, it will pose a risk for falling back into old habits.

Building new habits is different than diversion because of the focus on long-term or permanent life changes. This isn’t about riding out a craving—this is about building a better life for yourself.

- Join a casual sports league.
- Attend a local meetup for one of your interests or hobbies.
- Get involved in your community by volunteering or supporting a cause you care about.

Develop New Professional Skills

- Return to school to pursue a subject you are interested in.
- Find a full-time job, or seek a new career that you enjoy.
- Build new skills on your own using free online resources, or practice your existing skills.

Refocus on Existing Relationships

- Build a routine around socializing with friends and family. For example, have Sunday dinners with family, and evening walks with a friend.
- Be proactive—don’t wait for others to reach out to you.
- Say "yes" to every social invitation that will not put you at risk of relapse.

Prevention

Avoid Triggers / Risky Situations

Don’t wait until you’re in a bad situation to figure out how to escape it. Instead, avoid those situations altogether. Create a list of the people, places, and things that will likely lead to relapse, and come up with a plan to avoid them in the future. Sometimes this is as simple as taking a different route home from work, and other times it might mean a significant lifestyle change.

Healthy Lifestyle

A healthy lifestyle will make you more resilient when faced with obstacles. Many unhealthy habits, such as insufficient sleep and exercise, have been closely linked to many forms of mental illness. Focus on creating a routine that accounts for the following aspects of a healthy lifestyle:

- Sleep
- Exercise
- Medical Compliance (e.g. taking medications as prescribed and attending appointments)
- Healthy Diet
Managing Emotions / Relaxation

Most addictions serve as an escape from uncomfortable emotions such as stress, anxiety, and anger. When the crutch of addiction is taken away, you may need to re-learn how to manage your emotions. If you don't learn how to relax, tension will build and build, until it leads to relapse. These techniques, when practiced regularly, will help you manage your emotions in a healthy way.

Deep Breathing
Deep breathing is a simple technique that's excellent for managing emotions. Sit comfortably and place one hand on your abdomen. Breath in deeply enough that your hand begins to rise and fall. Imagine you are trying to completely fill your lungs with air. Time the inhalation (4s), pause (4s), and exhalation (6s) during every breath. Practice for 3 to 5 minutes at a time.

Journaling
Writing about personal experiences gives your brain the opportunity to process information and organize it into manageable chunks. Some of the many benefits of journaling include improved mental wellbeing, and the reduction of uncomfortable emotions. As you journal, be sure to describe your feelings alongside the facts of your experiences.

Feel free to journal however you like. However, if you feel stuck, try these prompts:

- **Daily Log:** Jot a few notes about each day. Whatever comes to mind is fine.
- **Letter:** Write a letter to someone with whom you would like to tell something. Remember to describe your feelings. *Do not send the letter!*
- **Gratitude:** Describe three good things from your day, no matter how minor they seem.

Imagery
Your brain has the power to turn thoughts into real emotions, and physical responses. Think about it: Your mouth waters at the thought of your favorite food, and a happy memory can make you laugh. With the imagery technique, you will use this power to your advantage.

Take a moment to think of a relaxing location or situation. This could be a memory, or something entirely made up. Maybe you're on a warm beach, alone at the top of a mountain, or at dinner with close friends. Next, imagine this scene through each of your senses. Don't just think about each detail for a second and move on—really imagine them. What do you see? What sounds do you hear? What do you feel? What smells are around you?

Use imagery for at least 5 minutes whenever you need a quick escape.
Grounding Techniques

After a trauma, it’s normal to experience flashbacks, anxiety, and other uncomfortable symptoms. **Grounding techniques** help control these symptoms by turning attention away from thoughts, memories, or worries, and refocusing on the present moment.

**5-4-3-2-1 Technique**

Using the 5-4-3-2-1 technique, you will purposefully take in the details of your surroundings using each of your senses. Strive to notice small details that your mind would usually tune out, such as distant sounds, or the texture of an ordinary object.

<table>
<thead>
<tr>
<th><strong>What are 5 things you can see?</strong></th>
<th>Look for small details such as a pattern on the ceiling, the way light reflects off a surface, or an object you never noticed.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What are 4 things you can feel?</strong></td>
<td>Notice the sensation of clothing on your body, the sun on your skin, or the feeling of the chair you are sitting in. Pick up an object and examine its weight, texture, and other physical qualities.</td>
</tr>
<tr>
<td><strong>What are 3 things you can hear?</strong></td>
<td>Pay special attention to the sounds your mind has tuned out, such as a ticking clock, distant traffic, or trees blowing in the wind.</td>
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<tr>
<td><strong>What are 2 things you can smell?</strong></td>
<td>Try to notice smells in the air around you, like an air freshener or freshly mowed grass. You may also look around for something that has a scent, such as a flower or an unlit candle.</td>
</tr>
<tr>
<td><strong>What is 1 thing you can taste?</strong></td>
<td>Carry gum, candy, or small snacks for this step. Pop one in your mouth and focus your attention closely on the flavors.</td>
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</table>

**Categories**

Choose at least three of the categories below and name as many items as you can in each one. Spend a few minutes on each category to come up with as many items as possible.

<table>
<thead>
<tr>
<th>Movies</th>
<th>Countries</th>
<th>Books</th>
<th>Cereals</th>
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<tbody>
<tr>
<td>Sports Teams</td>
<td>Colors</td>
<td>Cars</td>
<td>Fruits &amp; Vegetables</td>
</tr>
<tr>
<td>Animals</td>
<td>Cities</td>
<td>TV Shows</td>
<td>Famous People</td>
</tr>
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</table>

*For a variation on this activity, try naming items in a category alphabetically. For example, for the fruits & vegetables category, say “apple, banana, carrot,” and so on.*
Grounding Techniques

Body Awareness
The body awareness technique will bring you into the here-and-now by directing your focus to sensations in the body. Pay special attention to the physical sensations created by each step.

1. Take 5 long, deep breaths through your nose, and exhale through puckered lips.
2. Place both feet flat on the floor. Wiggle your toes. Curl and uncurl your toes several times. Spend a moment noticing the sensations in your feet.
3. Stomp your feet on the ground several times. Pay attention to the sensations in your feet and legs as you make contact with the ground.
4. Clench your hands into fists, then release the tension. Repeat this 10 times.
5. Press your palms together. Press them harder and hold this pose for 15 seconds. Pay attention to the feeling of tension in your hands and arms.
6. Rub your palms together briskly. Notice and sound and the feeling of warmth.
7. Reach your hands over your head like you’re trying to reach the sky. Stretch like this for 5 seconds. Bring your arms down and let them relax at your sides.
8. Take 5 more deep breaths and notice the feeling of calm in your body.

Mental Exercises
Use mental exercises to take your mind off uncomfortable thoughts and feelings. They are discreet and easy to use at nearly any time or place. Experiment to see which work best for you.

- Name all the objects you see.
- Describe the steps in performing an activity you know how to do well. For example, how to shoot a basketball, prepare your favorite meal, or tie a knot.
- Count backwards from 100 by 7.
- Pick up an object and describe it in detail. Describe its color, texture, size, weight, scent, and any other qualities you notice.
- Spell your full name, and the names of three other people, backwards.
- Name all your family members, their ages, and one of their favorite activities.
- Read something backwards, letter-by-letter. Practice for at least a few minutes.
- Think of an object and “draw” it in your mind, or in the air with your finger. Try drawing your home, a vehicle, or an animal.
Deep Breathing

Deep Breathing: a relaxation technique performed by purposefully taking slow, deep breaths. When practiced regularly, deep breathing provides both immediate and long-term relief from stress and anxiety.

How Deep Breathing Works

During periods of anxiety, the body triggers a set of symptoms called the stress response. Breathing becomes shallow and rapid, heart rate increases, and muscles become tense. In opposition to the stress response is the relaxation response. Breathing becomes deeper and slower, and the symptoms of anxiety fade away. Deep breathing triggers this response.

Instructions

Sit back or lie down in a comfortable position. Close your eyes, if you would like to do so. When you’re learning, try placing a hand on your stomach. If you breathe deeply enough, you should notice it rising and falling with each inhalation and exhalation.

1. **Inhale.** Breathe in slowly through your nose for 4 seconds.
2. **Pause.** Hold the air in your lungs for 4 seconds.
3. **Exhale.** Breathe out slowly through your mouth for 6 seconds.
   Tip: Pucker your lips, as if you are blowing through a straw, to slow your exhalation.
4. **Repeat.** Practice for at least 2 minutes, but preferably 5 to 10 minutes.

Tips

- If it isn’t working, slow down! The most common mistake is breathing too fast. Time each step in your head, counting slowly as you do so.
- Counting out your breaths serves a second purpose. It takes your mind off the source of your anxiety. Whenever you catch your mind wandering, simply return your focus to counting.
- The times we use for each step are suggestions, and can be lengthened or decreased. Lengthen the time if it feels natural to do so, or decrease the time if you feel discomfort.

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Relapse Prevention Plan

**Coping Skills:** List activities or skills you enjoy that can get your mind off of using.

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**Social Support:** Who are three people you can talk to if you are thinking about using?

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**Consequences:** How will your life change if you relapse? How about if you stay sober?

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<tr>
<th>Outcomes of Relapse</th>
<th>Outcomes of Sobriety</th>
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**Tips to avoid relapse:**

- Cravings will eventually pass. Do your best to distract yourself and ride it out.
- Don’t become complacent. Relapse can happen years after you’ve quit using. It probably won’t ever be safe to "just have one".
- Avoid situations that you know will put you at risk of relapse, such as spending time with friends who use drugs or going places that remind you of your past use.
- The decision to relapse is made when you put yourself in risky situations, long before you actually use.
- Don’t view relapse as a failure. Falling back into old patterns because of a slip will only make the situation worse.
Tips for Avoiding Relapse

The most important moment before relapse isn’t the final decision to use a drug. It’s when you decide to expose yourself to triggers. For example, a trigger could be going to a party or walking through the liquor section at the store. Before encountering your triggers, you still have most of the control. Not your craving.

If you’re feeling the urge to use, try to wait it out. If you distract yourself for even 30 minutes, it’s likely your craving will lessen in intensity. It might not totally disappear, but it will become easier to resist.

Focus on replacing your past drug use with new positive activities. If you used to go home after work and drink, you’ll need to make a new plan to occupy yourself. Going home and staring at a wall will eventually lead to staring at a wall with a drink in your hand.

Don’t try to do this alone. Sharing your goals for sobriety with a friend makes all the difference. They can hold you accountable when you’re making questionable decisions (“I’m just going to the bar to hang out, I won’t drink!”) and they can offer a kind ear when you’re struggling.

Remind yourself that cravings will pass. Have you ever had that experience when you’re sick where you can’t remember what it feels like to not be sick? The same thing happens with cravings. Give it time, and believe it or not, the feeling will go away.

You’ll have to make sacrifices beyond giving up the drug. If you previously used during specific activities (for example: watching a game on TV, going to concerts, or spending time with friends), you may need to make changes. This might mean not watching the game, or making new friends who are sober. This can be really hard, but that’s what makes it a sacrifice.

Have a plan for when things get bad, because at some point, they will. People get fired, hearts get broken, and sometimes people leave us forever. Develop a plan to get through these major life challenges—without the use of drugs—before they happen.

Don’t become complacent with your sobriety. If you someday consider having “just a glass of wine with dinner”, don’t make the decision lightly. If you’ve struggled with addiction in the past, you are much more likely to develop an addiction again.

If you do relapse, don’t give up. A lot of people find it helpful to keep track of how long they’ve been sober, but don’t confuse this count with the true goal of leading a good life. If you’re at day 100 of sobriety, that’s great. However, if you make a mistake and end up back at day 0, know that you are not starting over (you gained knowledge, experience, and confidence). In other words: Slipping up is not a license to go on a binge.

Come up with new rituals. How do you celebrate holidays, promotions, or any other happy occasion? If your answer includes any sort of drug, you’ll want to get creative and figure out something new. Go wild with a hobby for the day, treat yourself to a nice dinner, or take a weekend trip. Make sure it’s something you can get excited about.
References


Appendix A

ALCOHOL DEPENDENCE SCALE (ADS)

1. Look back to the 12 months before your arrest for this current offence(s). How much did you drink the last time you drank?
   0. a) Enough to get high or less [The last time you drank, you drank enough to get high.]
   1. b) Enough to get drunk [The last time you drank, you drank enough to get drunk.]
   2. c) Enough to pass out [The last time you drank, you drank enough to pass out.]

2. Look back to the 12 months before your arrest for this current offence(s). Did you often have hangovers on Sunday or Monday mornings?
   0. a) No
   1. b) Yes [you often had hangovers on Sunday or Monday mornings.]

3. Look back to the 12 months before your arrest for this current offence(s). Did you have the "shakes" when sobering up (hands tremble, shake inside)?
   0. a) No
   1. b) Sometimes [you sometimes had the shakes when sobering up.]
   2. c) Almost every time I drank [you almost always had the shakes when sobering up.]

4. Look back to the 12 months before your arrest for this current offence(s). Did you get physically sick (e.g., vomit, stomach cramps) as a result of drinking?
   0. a) No
   1. b) Sometimes [you got sick sometimes.]
   2. c) Almost every time I drank [you got sick almost every time you drank.]

5. Look back to the 12 months before your arrest for this current offence(s). Did you have the "DTs" (delirium tremens) - that is, seen felt or heard things not really there; felt very anxious, restless, and over excited?
   0. a) No
   1. b) Once [you suffered on time the DTs and experienced auditory and visual hallucinations.]
   2. c) Several times [you suffered several times the DTs and experienced auditory and visual hallucinations.]

6. Look back to the 12 months before your arrest for this current offence(s). When you drank, did you stumble about, stagger, and weave?
   0. a) No
   1. b) Sometimes [you sometimes stumbled or staggered about when you drank.]
   2. c) Often [you often stumbled or staggered about when you drank.]
7. Look back to the 12 months before your arrest for this current offence(s). As a result of drinking, did you feel overly hot and sweaty (feverish)?
   0. a) No
   1. b) Once [you once felt feverish as a result of drinking.]
   2. c) Several times [you felt feverish several times as a result of drinking.]

8. Look back to the 12 months before your arrest for this current offence(s). As a result of drinking, did you see things that were not really there?
   0. a) No
   1. b) Once [you experienced visual hallucinations on one occasion.]
   2. c) Several times [you experienced visual hallucinations several times.]

9. Look back to the 12 months before your arrest for this current offence(s). Did you panic because you feared you might not have a drink when you needed it?
   0. a) No
   1. b) Yes [you reported panic attacks when you feared you might not get a drink.]

10. Look back to the 12 months before your arrest for this current offence(s). Did you have blackouts ("loss of memory" without passing out) as a result of drinking?
    0. a) No, never
    1. b) Sometimes [you experienced blackouts sometimes.]
    2. c) Often [you often experienced blackouts.]
    3. d) Almost every time I drank [you experienced blackouts almost every time you drank.]

11. Look back to the 12 months before your arrest for this current offence(s). Did you carry a bottle with you or keep one close at hand?
    0. a) No
    1. b) Some of the time [you kept a bottle close at hand some of the time.]
    2. c) Most of the time [you kept a bottle close at hand most of the time.]

12. Look back to the 12 months before your arrest for this current offence(s). After a period of abstinence (not drinking) did you end up drinking heavily again?
    0. a) No
    1. b) Sometimes [you sometimes drank heavily again after a period of abstinence.]
    2. c) Almost Every Time [Most of the time, you drank heavily after a period of abstinence.]

13. Look back to the 12 months before your arrest for this current offence(s). Did you pass out as a result of drinking?
    0. a) No
    1. b) Once [you passed-out on one occasion as a result of drinking.]
    2. c) More than once [you passed-out several times as a result of drinking.]

14. Look back to the 12 months before your arrest for this current offence(s). Did you have a convulsion (fit) following a period of drinking?
0. a) No
1. b) Once [you experienced an alcohol induced convulsion on one occasion.]
2. c) Several times [you experienced an alcohol induced convulsion on several occasions.]

15. Look back to the 12 months before your arrest for this current offence(s). Did you drink throughout the day?
0. a) No
1. b) Yes [you typically drank throughout the day.]

16. Look back to the 12 months before your arrest for this current offence(s). After drinking heavily, did your thinking get fuzzy or unclear?
0. a) No
1. b) Yes, but only for a few hours [After heavy drinking, you experienced cognitive impairment, but only for a few hours.]
2. c) Yes, for one or two days [After heavy drinking, you experienced cognitive impairment for one or two days.]
3. d) Yes, for many days [After heavy drinking, you experienced cognitive impairment for many days.]

17. Look back to the 12 months before your arrest for this current offence(s). As a result of drinking, did you feel your heart beating rapidly?
0. a) No
1. b) Once [As a result of heavy drinking, you experienced a rapid heartbeat on one occasion.]
2. c) Several times [As a result of heavy drinking, you experienced a rapid heartbeat on several occasions.]

18. Look back to the 12 months before your arrest for this current offence(s). Did you almost constantly think about drinking and alcohol?
0. a) No
1. b) Yes [you almost constantly thought about drinking and alcohol.]

19. Look back to the 12 months before your arrest for this current offence(s). As a result of drinking, did you hear "things" that were not really there?
0. a) No
1. b) Once [As a result of drinking, you experienced auditory hallucinations on one occasion.]
2. c) Several times [As a result of drinking, you experienced auditory hallucinations on several occasions.]

20. Look back to the 12 months before your arrest for this current offence(s). Did you have weird and frightening sensations when drinking?
0. a) No
1. b) Once or twice [you experienced weird and frightening sensations when drinking at least once or twice.]
2. c) Often [you often experienced weird and frightening sensations when drinking.]
21. Look back to the 12 months before your arrest for this current offence(s). As a result of drinking, did you "feel things" crawling on you that were not really there (e.g., bugs, spiders)?
0. a) No
1. b) Once [As a result of drinking, you experienced the sensation of things crawling on him on one occasion.]
2. c) Several times [As a result of drinking, you experienced the sensation of things crawling on him on several occasions.]

22. Look back to the 12 months before your arrest for this current offence(s). With respect to blackouts:
0. a) Never had a blackout [you never experienced a blackout.]
1. b) Had blackouts that lasted less than an hour [you experienced blackouts that lasted for less than an hour.]
2. c) Had blackouts that lasted for several hours [you experienced blackouts that lasted for several hours.]
3. d) Had blackouts that lasted for a day or more [you experienced blackouts that lasted for a day or more.]

23. Look back to the 12 months before your arrest for this current offence(s). Have you tried to cut down on your drinking and failed?
0. a) No
1. b) Once [On one occasion, you attempted to cut down but failed.]
2. c) Several times [Several times, you attempted to cut down but failed.]

24. Look back to the 12 months before your arrest for this current offence(s). Did you gulp drinks (drink quickly)?
0. a) No
1. b) Yes [you reported gulping drinks.]

25. Look back to the 12 months before your arrest for this current offence(s). After taking one or two drinks, could you usually stop?
0. a) Yes
1. b) No [After taking one or two drinks you usually had difficulty stopping.]
Appendix B

PROBLEMS RELATED TO DRINK (PRD)

1. Look back to the 12 months before your arrest for this current offence(s). Were you in a fight while using alcohol where you hit someone?
   0. No
   1. Yes [you acknowledged physically fighting while using substance.]

2. Look back to the 12 months before your arrest for this current offence(s). Were there major arguments in your family because of your using alcohol?
   0. No
   1. Yes [you acknowledged that your using substance led to major arguments in your family.]

3. Look back to the 12 months before your arrest for this current offence(s). Did your using alcohol result in marital or family separation?
   0. No
   1. Yes [you admitted that your using substance resulted in marital or family separation.]

4. Look back to the 12 months before your arrest for this current offence(s). Did you lose friends because of your using alcohol?
   0. No
   1. Yes [you lost friends because of using substance.]

5. Look back to the 12 months before your arrest for this current offence(s). Were you in trouble at work or at school because of your using alcohol?
   0. No
   1. Yes [you experienced difficulties at work or school because of your using substance.]

6. Look back to the 12 months before your arrest for this current offence(s). Did you miss 2 or more days of work or school because of your using alcohol?
   0. No
   1. Yes [you acknowledged that your using substance resulted in work or school related absences.]

7. Look back to the 12 months before your arrest for this current offence(s). Were you arrested for using alcohol?
   0. No
   1. Yes [you were arrested for using substance and driving.]
8. Look back to the 12 months before your arrest for this current offence(s). Were you in trouble with the law because of your using alcohol (Do not include driving offences)?
   0. No
   1. Yes [you committed law violations as result of your using substance.]

9. Look back to the 12 months before your arrest for this current offence(s). Did your using alcohol result in your getting hurt in an accident?
   0. No
   1. Yes [you suffered accident related injuries as a result of your using substance.]

10. Look back to the 12 months before your arrest for this current offence(s). Did your using alcohol lead to an accident where others got hurt or where property was damaged?
    0. No
    1. Yes [you were using substance led to accidents where others got hurt or where property was damaged.]

11. Look back to the 12 months before your arrest for this current offence(s). Were you hospitalized for an illness connected to your using alcohol?
    0. No
    1. Yes [you were hospitalized for an illness related to your using substance.]

12. Look back to the 12 months before your arrest for this current offence(s). Did your using alcohol result in an illness that kept you from regular activities for 2 or more days?
    0. No
    1. Yes [you using substance resulted in illness that interfered with activities of daily living for 2 or more days.]

13. Look back to the 12 months before your arrest for this current offence(s). Did you spend too much money while using alcohol?
    0. No
    1. Yes [you spent too much money while using substance.]

14. Look back to the 12 months before your arrest for this current offence(s). Did you spend money on using alcohol that was needed for essentials (such as food, clothing and payments)?
    0. No
    1. Yes [you spent money on using substance that was needed for essentials.]

15. Look back to the 12 months before your arrest for this current offence(s). Did you seek professional help or go to a group such as A.A. / N.A for help with your using alcohol?
    0. No
    1. Yes [you sought professional help for your using substance.]
Appendix C

DRUG ABUSE SCREENING TEST (DAST)

1. Look back to the 12 months before your arrest for this current offence(s). Did you use drugs other than those for medical reasons?
   0. No
   1. Yes [you used drugs for reasons other than medical.]

2. Look back to the 12 months before your arrest for this current offence(s). Did you abuse prescription drugs?
   0. No
   1. Yes [you abused prescription drugs.]

3. Look back to the 12 months before your arrest for this current offence(s). Did you abuse more than one drug at a time?
   0. No
   1. Yes [you abused more than one drug at a time.]

4. Look back to the 12 months before your arrest for this current offence(s). Could you get through the week without using drugs?
   1. No [you could not get through the week without using drugs.]
   0. Yes

5. Look back to the 12 months before your arrest for this current offence(s). Were you always able to stop using drugs when you wanted to?
   1. No [you experienced difficulties curbing your drug use.]
   0. Yes

6. Look back to the 12 months before your arrest for this current offence(s). Did you have "blackouts" or "flashbacks" as a result of drug use?
   0. No
   1. Yes [you experienced blackouts/flashbacks as result of drug use.]

7. Look back to the 12 months before your arrest for this current offence(s). Did you ever feel bad or guilty about your drug use?
   0. No
   1. Yes [you felt guilty about your drug use.]

8. Look back to the 12 months before your arrest for this current offence(s). Did your spouse (or parents) ever complain about your involvement with drugs?
   0. No
1. Yes [family members complained about your involvement in drugs.]

9. Look back to the 12 months before your arrest for this current offence(s). Did your drug abuse create problems between you and your spouse or your parents?
   0. No
   1. Yes [you experienced problems with your spouse/parents because of your drug use].

10. Look back to the 12 months before your arrest for this current offence(s). Did you lose friends because of your use of drugs?
    0. No
    1. Yes [you lost friends because of your drug use].

11. Look back to the 12 months before your arrest for this current offence(s). Did you neglect your family because of your use of drugs?
    0. No
    1. Yes [you neglected your family because of drugs].

12. Look back to the 12 months before your arrest for this current offence(s). Were you in trouble at work because of drug abuse?
    0. No
    1. Yes [you experienced difficulties at work because of drug use].

13. Look back to the 12 months before your arrest for this current offence(s). Did you lose a job because of drug abuse?
    0. No
    1. Yes [you lost at least one job because of drug use].

14. Look back to the 12 months before your arrest for this current offence(s). Did you get into fights when under the influence of drugs?
    0. No
    1. Yes [you physically fought while under the influence of drugs].

15. Look back to the 12 months before your arrest for this current offence(s). Did you engage in illegal activities in order to obtain drugs?
    0. No
    1. Yes [you engaged in illegal activities to obtain drugs].

16. Look back to the 12 months before your arrest for this current offence(s). Were you ever arrested for possession of illegal drugs?
    0. No
    1. Yes [you were arrested for possession of illegal drugs].
17. Look back to the 12 months before your arrest for this current offence(s). Did you ever experience withdrawal symptoms (felt sick) when you stopped taking drugs?
0. No
1. Yes [you experienced withdrawal symptoms.]

18. Look back to the 12 months before your arrest for this current offence(s). Did you have medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?
0. No
1. Yes [you suffered medical problems as a result of your drug use.]

19. Look back to the 12 months before your arrest for this current offence(s). Did you go to anyone for help for a drug problem?
0. No
2. Yes [you sought professional help because of your drug problem.]

20. Look back to the 12 months before your arrest for this current offence(s). Have you been involved in a treatment program specifically related to drug use?
0. No
1. Yes [you has been involved in a drug abuse treatment program.]
Appendix D

Severity of Dependence Scales (SDS)

1. Did you ever think your use of cannabis was out of control?
   Never or almost never  0
   Sometimes  1
   Often  2
   Always or nearly always  3

2. Did the prospect of missing a smoke make you very anxious or worried?
   Never or almost never  0
   Sometimes  1
   Often  2
   Always or nearly always  3

3. Did you worry about your use of cannabis?
   Not at all  0
   A little  1
   Quite a lot  2
   A great deal  3

4. Did you wish you could stop?
   Never or almost never  0
   Sometimes  1
   Often  2
   Always or nearly always  3

5. How difficult would you find it to stop or go without?
   Not difficult  0
   Quite difficult  1
   Very difficult  2
   Impossible  3
## Appendix E

### Michigan Alcohol Screening Test (MAST)

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Do you feel you are a normal drinker? (By normal we mean you drink less</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>than or as much as most other people.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Have you ever awakened the morning after some drinking the night before</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>and found that you could not remember a part of the evening?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Does your wife, husband, a parent, or other near relative ever worry or</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>complain about your drinking?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Can you stop drinking without a struggle after one or two drinks?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>5</td>
<td>Do you ever feel guilty about your drinking?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>6</td>
<td>Do friends or relatives think you are a normal drinker?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>7</td>
<td>Are you able to stop drinking when you want to?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>8</td>
<td>Have you ever attended a meeting of Alcoholics Anonymous (AA)?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>9</td>
<td>Have you gotten into physical fights when drinking?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>10</td>
<td>Has your drinking ever created problems between you and your wife,</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>husband, a parent, or other relative?</td>
<td></td>
<td></td>
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<tr>
<td>11</td>
<td>Has your wife, husband (or other family members) ever gone to anyone for</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>help about your drinking?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Have you ever lost friends because of drinking?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>13</td>
<td>Have you ever gotten into trouble at work or school because of drinking?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>14</td>
<td>Have you ever lost a job because of drinking?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>15</td>
<td>Have you ever neglected your obligations, your family or your work for two</td>
<td>Yes</td>
<td>No</td>
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<td></td>
<td>or more days in a row because you were drinking?</td>
<td></td>
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<tr>
<td>16</td>
<td>Do you drink before noon fairly often?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>17</td>
<td>Have you ever been told you have liver trouble? Cirrhosis?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>18</td>
<td>After heavy drinking have you ever had Delirium Tremens (D.T.s) or severe</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td></td>
<td>shaking, or heard voices or seen things that really were not there?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Have you ever gone to anyone for help about your drinking?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>20</td>
<td>Have you ever been in a hospital because of drinking?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>21</td>
<td>Have you ever been a patient in a psychiatric hospital or on a psychiatric</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td></td>
<td>ward of a general hospital where drinking was part of the problem that</td>
<td></td>
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<tr>
<td></td>
<td>resulted in hospitalization?</td>
<td></td>
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<tr>
<td>22</td>
<td>Have you ever been seen at a psychiatric or mental health clinic, or gone</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>to any doctor, social worker, or clergyman for help with an emotional</td>
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<td></td>
<td>problem, where drinking was part of the problem?</td>
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<td>23</td>
<td>Have you ever been arrested for drunk driving, driving while intoxicated,</td>
<td>Yes</td>
<td>No</td>
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<td></td>
<td>or driving under the influence of alcoholic beverages? (If YES, how many</td>
<td></td>
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<td></td>
<td>times? _______ )</td>
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<tr>
<td>24</td>
<td>Have you ever been arrested, or taken into custody even for a few hours,</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>because of other drunk behavior?</td>
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<tr>
<td></td>
<td>If YES, how many times? _______ )</td>
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<td></td>
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</tbody>
</table>