Time to Change:
A Proposal for a Substance Abuse Relapse Prevention Manual for Group Facilitators who Counsel Legally-involved Clients

BY
MARIA E. PARTON

A Final Project submitted to the Campus Alberta Applied Psychology Counselling Initiative in partial fulfillment of the requirements for the degree of

MASTER OF COUNSELLING

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The undersigned certifies that she or he has read and recommends to the Faculty of Graduate Studies and Research for acceptance, a final project entitled TIME TO CHANGE: A PROPOSAL FOR A SUBSTANCE ABUSE RELAPSE PREVENTION MANUAL FOR GROUP FACILITATORS WHO COUNSEL LEGALLY-INVOLVED CLIENTS submitted by MARIA E. PARTON in partial fulfillment of the requirements for the degree of Master of Counselling.

Dr. B. Hiebert  
Project Supervisor  
2007-01-09  
Date
CAMPUS ALBERTA APPLIED PSYCHOLOGY:
COUNSELLING INITIATIVE

SECOND READER SIGNATURE PAGE

Faculty of Graduate Studies and Research

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[Signature]
Dr. G. Wong-Wallie  
Second Reader

[Signature]  
December 18, 2006  
Date
ABSTRACT

This project document draws together information from the academic literature on substance abuse and antisocial behaviour to provide the foundation for a substance abuse relapse prevention manual for those who counsel mandated clients. Several themes emerged from the literature review: (a) personal cognitions may exert the strongest influence on the maintenance of substance abuse and criminal behaviour, (b) lack of coping skills or emotional control may lead to a relapse to substance abuse, (c) reluctant clients may require motivational counselling approaches, and (d) adjunctive social services may reduce drug abuse. Ten psychoeducational sessions were developed integrating the work of Ellis and Marlatt and incorporating the constructs of Stages of Change and Motivational Interviewing. Strengths and limitations of the project and future approaches to the treatment of offender substance abuse are provided.
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Chapter I
Introduction

Purpose of the Final Project

This final project will bring together information from the fields of psychology and substance abuse counselling to provide the theoretical basis for a proposed outpatient substance abuse relapse prevention manual for adult male and female clients who are legally required to attend treatment. The manual would provide counsellors and paraprofessionals with a facilitation guide based on the work of established theorists such as Samenow, Ellis, Marlatt, Miller, Prochaska, DiClemente, and Norcross.

Research Questions

A literature review will be conducted using electronic databases, university library holdings, and government publications to seek answers to the following questions:
1. What are the issues in substance abuse behaviour?
2. How is substance abuse treated?
3. What are the issues in antisocial behaviour?
4. What are the issues in counselling involuntary clients?

The Importance of this Final Project

Substance abuse is considered to be a chronically relapsing condition (Annis & Davis, 1994) regardless of clients' social or legal status. However, if appropriate treatment services are not provided, clients who abuse intoxicants and exhibit antisocial traits may become caught up in the revolving door of drug use, crime, and
incarceration (Hughey & Klemke, 1996). Counsellors and paraprofessionals who provide effective counselling services to legally involved clients not only make a contribution to their clients’ mental health, but also make a contribution to the safety of the Canadian public by reducing the probability of recidivism (Hughey & Klemke). Yet, to achieve effectiveness, group facilitators need psychoeducational materials that have been developed with an understanding of the sociocultural background of offender-clients, their common traits, and effective treatment practices.

In spite of agreement that efforts must be made to provide offenders with treatment appropriate to their needs (Standing Committee on Justice and Human Rights, 2000) historically, there have been questions about the efficacy of treatment for this population. For example, Martinson (as cited in Springer, McNeece, & Arnold, 2003) claimed that most rehabilitative efforts with offenders do not work. Nonetheless, recent research suggests that offenders may reduce or eliminate their use of intoxicating substances and have a reduced post-treatment arrest rate, when treatment programs (a) use motivational techniques, (b) match treatment to risk and need, and (c) use effective after-care services (Crowley, 1999; Hughey, & Klemke, 1996; Quinsey, Harris, Rice, & Cormier, 1998; Springer, McNeece, & Arnold, 2003).

Attendance at outpatient substance abuse counselling may be imposed as a probation or bail condition, or as part of an arrangement through a Drug Treatment Court (Department of Justice Canada, 2005). Usually, such sanctions are reserved for offenders who would not pose an undue risk to public safety by remaining in the community. Nevertheless, it is important that adequate intervention occurs as early as possible to avoid an escalation in chemical dependency and criminal activity.
Yet, people who abuse intoxicants and who are required to come into treatment because they have come into conflict with the law are considered by many professional counsellors to be among the least desirable of client groups due to the seemingly intractable nature of their problems, and their resistance to treatment (Martin & Inciardi, 1993). It is apparent that counsellors and paraprofessionals who are required to work with involuntary clients would benefit from information on the psychosocial needs of this particular client population, as well as information on helpful treatment elements and practices. It is hoped that this project will lead to the development of an effective facilitation manual and ultimately to improved treatment for offender-clients.

The Structure of this Final Project

This final project document consists of four parts: (a) the introduction, (b) a literature review on the topic of substance abusing behaviour, the theoretical basis for treatment, and the issues in treating clients who display antisocial behaviour, (c) a rationale and outline for a proposed relapse prevention manual based on the information gathered through the literature review, and (d) a final discussion summarizing the final project document and providing suggestions for further treatment interventions based on current research. The hope is that this document will help counsellors and paraprofessionals deal more effectively with the major issues encountered when working with involuntary clients who abuse substances.
Chapter II

Literature Review

In order to design effective treatment interventions it is necessary to understand why people continue to abuse substances, in spite of incurring deleterious health effects and social sanctions. Assisting clients to abstain or reduce their reliance on intoxicants not only helps improve their quality of life, but also reduces allied medical and criminal justice costs. In this chapter, I review four topics: (a) issues in substance abuse behaviour, (b) treating substance abuse, (c) antisocial behaviour, and (d) issues in counselling involuntary clients. This literature review provides the foundation for a proposed relapse prevention facilitation guide designed for use by counsellors and paraprofessionals employed in outpatient clinics.

Issues in Substance Abuse Behaviour

Some theorists have attempted to explain chemical abuse as the result of lax morals, or brain malfunction, but in contemporary North American society, academics and treatment providers consider also information from the fields of sociology, psychology, medicine, and criminology. For example, in 1990, the National Council on Alcoholism and Drug Dependence Incorporated, and the American Society of Addiction Medicine acknowledged that genetic, environmental, and psychosocial factors influence the development of alcoholism (Benshoff & Janikowski, 2000).

Using substances has not always been considered a personal or social problem. For example, substance abuse, including drunkenness, has been variously considered a moral lapse and a medical condition (McMurran, 1994). In
contemporary Canadian society, substance use is considered to be problematic when it interferes with users' ability to carry out personal responsibilities, such as family care. Incurring legal sanctions or losing employment for behaviour committed when under the influence of an intoxicant is considered problem behaviour. Thus, defining the use of substances as a "problem" has been a function of culture and public attitude as specific times in history (McMurran).

Genetic, environmental, and psychosocial factors influence the development of alcoholism and the abuse of other drugs (Benshoff & Janikowski, 2000). Therefore, no single medical, sociological, or psychological theory provides a comprehensive explanation for the phenomenon of substance abusing behaviour. In the following section, some of the major theories of substance abuse are reviewed. These brief descriptions will illustrate the challenges faced when trying to design effective treatment strategies.

*Moral Lapse versus the Disease Model.* Hartnoll (2004) described the moral lapse concept as an idea “founded in the Protestant work ethic or puritanical disapproval of ‘undeserved’ or ‘unearned pleasure’…” (p. 33). The moral lapse viewpoint led to the nineteenth century temperance movements, and the development of interventions such as “inebriate asylums.” The moral lapse model views substance abuse as a problem that resides within the person, and not due to a convergence of factors.

Adherents of the moral lapse model view the use of alcohol or other drugs as a deviancy deserving of punishment. Followers of the moral lapse model would view
needles exchange facilities as condoning immoral behaviour, rather than encouraging harm reduction.

In 1952, Jellinek (as cited in Doweiko, 1996) described alcoholism as a "disease." Defining substance abuse as a medical condition, rather than a moral lapse, has led to the examination of the brain structures and neural pathways affected by drug use. Researchers hope to discover the physiological reasons behind cravings and the subjective feelings induced by drug and alcohol use (McGue, 1999).

The disease model has led to the development of pharmacological interventions, counselling, and behaviour modification to treat substance abuse (Hartnoll, 2004). An important by-product of the disease model is the status accorded alcoholics and addicts; they are defined as "patients" or "clients," rather than criminals or moral bankrupts.

The Canadian movement towards a biomedical and clinical understanding of substance abuse is exemplified by the development of Drug Treatment Courts staffed by judges chosen for their knowledge of substance abuse issues. Likewise, administrators of Canadian provincial, territorial, and federal correctional systems have introduced substance abuse treatment in community settings and in prisons as an adjunct to interdiction and punishment.

Social Learning. The social learning theory of alcohol abuse was described by Bandura in 1969 (Maisto, Carey, & Bradizza, 1999). Bandura theorized that stress reduction was the major pharmacological effect of drinking alcohol, and therefore, alcohol consumption could be described as a negative reinforcer (Maisto et al.).
Bandura suggested that cultural and subcultural mores shaped drinking behaviour from youth onwards, and that parents modeled the use of alcohol as a stress-reducing measure. Through use, the stress-reducing qualities of alcohol become more evident, and may lead to continued use and dependency. At the same time, the unpleasant physical and mental effects of discontinuing drinking (withdrawal) result in some individuals drinking to avoid withdrawal symptoms.

Bandura later developed the idea of “triadic reciprocality,” which referred to the inter-relatedness of the individual, his or her behaviour, and the environment. The concept of triadic reciprocality has implications for the development of treatment interventions, as it acknowledges the mediating effects of cognitions in the decision to drink or use other drugs (Maisto et al., 1999).

Bandura’s application of social learning theory to alcohol abuse resulted in a “coping deficits” model, which suggested that substance abuse stems, in part, from an inability to cope with everyday stressors. Bandura’s coping deficits model has led to the inclusion of assertiveness training, emotions management training, and other types of self-management training within substance abuse treatment interventions.

Genetics. Traditional research into alcohol abuse examined environmental influences or genetic markers (McGue, 1999). However, current collaborative research examines the reciprocal influence of biological and environmental factors in alcoholism. Although contemporary behavioural genetics has not yet formulated a comprehensive theory of alcoholism, “it account[s] for one of the most fundamental aspects of alcoholism etiology-its familial basis” (McGue, p. 372).
Cognitions associated with drinking behaviour, sensitivity to ethanol, metabolic activity, and the frequency and quantity of alcohol consumption, have all been found to be heritable factors. This finding led to research to identify the actual mechanisms that contribute to the development of alcoholism. The results of heritability studies may lead to a review of traditional theories, for example, the moral lapse model of alcoholism.

The genetic influence on the development of alcoholism does not eliminate the effects of the environment or personality characteristics. There are many intervening steps between genetic makeup and expressed behaviour (McGue, 1999). In Swedish adoption studies spanning 3 decades, Bohman (1996) studied the inter-relatedness of genetics, alcohol abuse, and criminality. He found that there was a high correlation between crime and alcohol abuse in biological fathers and their sons who had been adopted-out. Bohman noted that there is a “marked heterogeneity” among alcoholics and criminals in their biological and social backgrounds and behaviour.

Bohman’s (1996) finding that environmental factors, rather than genetics, influence the severity of alcoholism and symptomatic crime, seems to strengthen McGue’s (1999) finding that although quantity and frequency of drinking are heritable characteristics, environmental and personality characteristics play their part in the expression of behaviour. To develop a fuller understanding of the development of alcoholism and the nature of its connection to criminality, it will be necessary to conduct further studies of twins reared together and apart, as well as studies of adopted children.
The Phenomenon of Relapse

Mental health providers hope their clients will maintain the gains made in treatment. This is especially true in the criminal justice field where a client’s relapse to drug use can signal an imminent return to criminal activity, and the victimization of others. Even clients who successfully complete substance abuse treatment are “at risk to relapse when the structure afforded by the intervention is removed,” (Enos & Southern, 1996, p. 175).

Marlatt (1985) studied relapse among dieters, smokers, drug addicts, compulsive gamblers, and others, and found that interpersonal determinants, such as conflicts with family members, and intrapersonal determinants, such as depression and anxiety, could lead to relapse. It is noteworthy that pleasant emotions and pleasant social events can also lead to relapse through peer pressure and temptations. Overall, using alcohol or drugs to remove unpleasant emotions was the most commonly cited reason for relapse after a period of sobriety.

Clients who lack coping skills are at a much greater risk of relapse than clients who know their high-risk factors, and have a ready repertoire of responses (Enos & Southern, 1996). Clients who have identified their high-risk situations can draw up a self-management plan incorporating Marlatt’s (1985) strategies. A more detailed review of factors that may lead to relapse is provided below.

Biochemical Factors. Ingesting narcotics, stimulants and other commonly abused drugs affects the chemical balance of the brain; when a client stops using intoxicants, he or she may experience depression, anxiety, restlessness, or other mental and physical symptoms. Clients report that withdrawing from heroin causes
depression, while withdrawing from cocaine causes insomnia and restlessness (Doweiko, 1996). As some substance abusers use more than one drug, for example, cocaine and heroin, withdrawal can lead to a variety of unpleasant physical and emotional effects. To avoid these unpleasant effects, the client may resume drug use and return to the cycle of drug use, sobriety and relapse.

**Environmental Factors.** Clients learn to associate sights, sounds, places and people with the good feelings they got from ingesting alcohol or drugs. If they do not consistently practice relapse prevention strategies they may be unable to combat the temptations that result from returning to old drug haunts, or being at family gatherings where alcohol is available (Doweiko, 1996).

Substance abuse clients state that meeting a drug-using associate from prison can put into place a series of events that may end in relapse, and perhaps lead to crime. The sight of flour may cue drug-seeking behaviour in cocaine users. Hearing particular pieces of music that were being played while clients were using drugs can also be a cue to use.

Each person who uses drugs and alcohol has a unique history, so it is necessary for clients to determine the circumstances that were at play when they were actively drinking or using drugs. This will enable them to prepare strategies to deal with future risk situations.

**Psychological Factors.** Setting aside a lifestyle of drug-seeking and drug-using behaviour leads to boredom, anxiety, and a sense of loss for clients whose daily activities revolved around the drug culture, and whose major source of social contact was drug-using friends (Enos & Southern, 1996). In some case, clients
grieve the loss of their drug. In other cases, clients who are afraid of relapse may engage in hypervigilant behaviour, such as attending several peer-support meetings each day (Enos & Southern). Clients may report that they enjoyed the emotion-numbing quality of substance use, and find it difficult to cope with the flood of emotions that accompanies withdrawal and sobriety.

Unfortunately, when clients are unable to cope with their emotions, they will feel pulled back into their old, comfortable habit of drug or alcohol use. Learning to acknowledge and cope with emotions is one of the major factors in gaining sobriety.

*Treating Substance Abuse*

Clients attending substance abuse treatment may be there of their own volition, or may have been coerced by family members or employers. In some cases, clients will be there at the direction of the court system. Substance abuse treatment is available in many forms such as inpatient residential treatment, outpatient clinics, and detoxification centres. Methadone maintenance treatment and other pharmacological treatments are provided in medical practice settings or, in the case of Methadone, at specially designated clinics.

Inpatient and outpatient treatment may be Twelve-Step spirituality-based programs, culturally-based programs, or the more recently developed biopsychosocial programs. The following section reviews the variety of approaches used in treating substance abuse and is adapted from Doweiko (1996).

*Residential Treatment.* Residential treatment caters to clients who have severe substance abuse problems, and who would benefit from residing in a
structured environment for a set period of time. Clients who have not had success with outpatient approaches may benefit from residential treatment.

Some inpatient facilities will not accept a client who has recently used drugs or alcohol. This can hamper the admission of clients who urgently require treatment, but are unable to stop using drugs or alcohol for the requisite period prior to admission. Inpatient treatment facilities may have a detoxification unit to help clients safely withdraw from drugs or alcohol before they settle into the daily treatment sessions.

The disadvantages of residential treatment include the cost and the disruption to family life. However, residential treatment has great potential for helping severely addicted clients make major changes in their lives.

In a specialized form of residential treatment, called "therapeutic communities," clients may be expected to remain in treatment from 6 months to 3 years. The lengthiness of the program is based on the idea that to change drug or alcohol-using behaviour requires a complete revision of clients' usual lifestyle, and this can only be accomplished by sustained effort (Doweiko, 1996).

Outpatient Treatment. Among outpatient clients are those mandated to attend treatment in lieu of incarceration, or those attending sessions as required by the stipulations of parole or probation conditions. Outpatient treatment may include adjunctive family or individual counselling. In some case, non-substance-using spouses may attend open sessions with their partners. Certified chemical dependency counsellors, or counsellors with graduate degrees in psychology usually
fulfill supervisory functions, with paraprofessional counsellors providing individual and group treatment.

The treatment philosophy may follow the Alcoholics Anonymous model, or it may be biopsychosocial. Outpatient psychoeducational treatment is usually provided in weekly sessions. It may have continuous intake or a set number of sessions. Outpatient treatment of 1 year's duration, with adjunctive urine testing, is the ideal (Nate, as cited in Doweiko, 1996).

There are several advantages to outpatient treatment: clients can continue with their regular employment, there is no disruption to the family structure, and it costs much less than residential treatment. However, clients may still be faced with the daily problems and temptations that they had before they entered treatment.

**Adjunctive Chemical Treatments.** Chemical treatments are prescribed drugs and are usually provided in conjunction with counselling. The physical effects of chemical treatments can be as severe and lethal as the problem drug, itself, and must be used with caution and continuous medical supervision.

The use of chemicals to treat chemical dependency may seem contrary to the spirit of substance abuse treatment, and in fact, those who abuse substances are often against using prescription drugs to combat their addiction, fearing that they are only substituting one crutch for another. Yet, the use of chemical replacements can potentially wean drug users off drugs in a safe manner.

Common chemical treatments are Methadone, which is a synthetic opiate used to replace heroin, and Antabuse, which is used to combat alcoholism. Antabuse works on the principle of aversive conditioning by causing patients to
become physically ill if they ingest alcohol while taking the medication. Residential treatment centres may refuse to admit clients who are currently prescribed Methadone, fearing that the client may divert the medication to another client.

**Harm Reduction Versus Abstinence.** Harm reduction is a strategy implemented to reduce the harmful effects of chemical abuse, for example, providing educational opportunities to marginalized groups, or providing injection drug users (IDUs) with clean needles and a safe place to inject to reduce the transmission of the Human Immunodeficiency Virus (HIV). Harm reduction is sometimes viewed as society’s surrender to the problem of chemical abuse and as an admission of failure on the part of drug users and treatment providers. However, in some cases, such as the co-occurrence of serious mental illness or Fetal Alcohol Effects (FAE) with chemical dependency, clients find it difficult to eliminate chemical use for a variety of reasons. Clients may report that using marijuana or other drugs relieve the symptoms of their mental illness. Clients suffering from brain damage may have difficulty understanding the seriousness of sharing needles, or using street drugs of questionable purity. In other cases, chronic drug users who have contracted Hepatitis or HIV, have no intention of curbing their drug use. In cases such as these, a harm reduction protocol may be the wisest course of action to reduce the harmful effects.

**Antisocial Behaviour**

The American Psychological Association’s Diagnostic and Statistical Manual of Mental Disorders (4th. ed., 2000) (DSM-IV) differentiates between Antisocial Personality Disorder and Antisocial Behaviour, with the former being a more serious
manifestation of antisocial conduct. The *DSM-IV* also differentiates between Childhood Conduct Disorder, Oppositional Defiant Disorder and Childhood Antisocial Behaviour.

Categorizing particular behaviours as antisocial is a function of culture and historical context. Shoham and Seis (1993) commented that “almost all behaviours that are presently prohibited by law were at some time in history permitted by various cultures” (p. 5). Nevertheless, within North American society, antisocial behaviour, as exemplified by the traits described later, takes its toll on individuals and communities through victimization and the cost of law enforcement.

Antisocial behaviour is believed to comprise two parts: the presence of negative behaviour, and the absence of prosocial behaviour. Lying, cheating, aggressive acting-out, substance abuse, irresponsibility, sexual promiscuity, and lack of respect for authority are common antisocial traits (Samenow, 1998). Adults and children who demonstrate characteristics of antisocial behaviour reportedly lack remorse for their actions. They also fail to exhibit positive emotions, such as warmth and empathy, but do exhibit anger and hostility.

*Issues in Antisocial Behaviour.* Psychoanalytic explanations of criminality are “vanishing” because of problems operationalizing Freudian concepts such as the “superego” (Shoham & Seis, 1993) Nevertheless, Aichorn (as cited in Shoham & Seis) concluded that parental neglect and lack of guidance resulted in under-development of the superego, and consequently, lack of regulation of the id. Aichorn believed that a strong home-like environment would help develop the superego, and help rehabilitate delinquents.

Parenting programs and family therapy were thought to be the most promising interventions. Unfortunately, high-risk families have high drop-out rates. This has led to the development of “family preservation” interventions delivered in the family’s home.

Bandura’s Social Learning theory has been influential in helping to understand criminal behaviour. Bandura acknowledged that there are biological factors predisposing some persons towards aggressive conduct. He claimed that the type of aggressive behaviour displayed and "its frequency, the specific situation, and the locations for attack, are products of socially learned behaviour" (Shoham & Seis, p. 78).

Bandura and Walters (1959) argued that aggressive behaviour was under cognitive control, and pointed out the "...futility of punishment as a means of correcting many antisocial patterns" (p. 359). Importantly, they suggested "the environment provides the content of the value system...however, the conditions necessary for internalization of values are to be found in the psychological development of the child" (p. 358). They pointed out that there were three ways children learned to be aggressive, (a) parental modeling, (b) the immediate environment, such as neighbourhood gangs, and (c) the mass media. Nevertheless,
children and adults learn to associate their aggressive behaviour with certain outcomes, and can decide to change their behaviour (Shoham & Seis, 1993).

Samenow (1998) suggested that criminality resides within individuals, not the environment, although the environment "provides a greater or lesser opportunity for it to be expressed" (p. 265). Samenow acknowledged there is evidence that genetic or biological factors can contribute to criminality, but he believed that children are not pre-ordained to become criminals, and can be taught to make responsible choices.

Samenow (1998) rejected traditional sociological and psychological theories of antisocial behaviour. He cited considerable financial waste in providing rehabilitation programs for offenders that do not target their specific needs. Samenow placed great emphasis on "criminal thinking". He suggested that changing "criminal thinking" to prosocial thinking is a long, arduous process for the client and the counsellor and in some cases will not be successful.

In contrast to Samenow's opinions, the literature reviewed suggests that parental behaviour strongly influences the development of antisocial tendencies. Parenting programs are more effective in reducing childhood antisocial behaviour than interventions aimed specifically at the child, such as Outward Bound programs. Quinsey et al. (2004) cited Leitenberg's comment that the actions most likely to be undertaken to curb juvenile delinquency were the least likely to be effective, for example, counselling, recreational activities, and vocational programs were ineffective.
Glasser (1966) argued that antisocial behaviour is a product of irresponsibility. He suggested that spending counselling time exploring why a client behaved in an irresponsible manner only legitimized the irresponsible behaviour. Glasser, like Samenow, believed that finding good foster homes, providing recreation, and other necessaries, did not change the delinquent's behaviour, because it did not change the client's thinking.

Sociocultural Profile of Canadian Offenders. In 1999, adult females incurred 17% of all adult criminal charges, and were more likely to have committed property offences than violent crimes. During the same year, the number of juvenile females charged with violent offences increased by 81%. In 1999 violent crime increased by 30% for juvenile males. Overall, adult females committed one sixth of violent crimes; juvenile females committed one third of violent offences (Statistics Canada, 2001).

In comparison to males, adult and juvenile females were less likely to be convicted and less likely to be sent to prison on conviction. Female offenders were more likely to be awarded probation or sentenced to alternative measures, for example, community service. Males had more serious criminal histories, and committed more serious crimes. This may account for the differences in conviction rate and sanctions. Female offenders are more likely to be single, Aboriginal, less educated, and unemployed than the general public (Statistics Canada, 2001).

Offenders admitted to the Canadian federal correctional services are assessed against seven domains believed to be correlated to criminal behaviour: marital and family relationships, substance abuse, associates, education and employment, attitude, community functioning, and personal and emotional
orientation. In a 2003 study of male federal offenders, it was noted that 73% of offenders had substance abuse problems, 92% had personal or emotional problems, and 64% had problematic associates (Grant, Kunic, MacPherson, McKeown, & Hansen, 2003). Examining the most prevalent criminogenic factors helps focus treatment on the most promising targets.

In spite of the societal sanctions levied against those who abuse substances and engage in criminal behaviour, involuntary clients may express resistance or lack of motivation for treatment. The last section of this literature review examines (a) client resistance, (b) client readiness for change, (c) motivational interviewing techniques, and (d) cognitive behavioural therapy. Firstly, a discussion of coerced treatment is provided.

Counselling Involuntary Clients

Coerced treatment for drug-using criminal justice clients is based on three assumptions: reducing substance abuse will reduce crime, clients can benefit from mandatory treatment, and clients who do not perceive their drug use as a problem can benefit from coerced treatment (Longshore, Prendergast, & Farabee, 2004). From their review of the empirical literature Longshore et al. found that all three assumptions were correct, and that coerced treatment moderately reduced both criminal and drug-using behaviour.

Several factors may moderate the success of coerced treatment: the client's "demographic characteristics, life history, drug of choice, or prior experience in treatment" (Longshore et. al., 2004, p. 114).
offered, and the availability of adjunctive services also has an impact on treatment outcome.

Longshore et al. (2004) suggested that engaging involuntary clients in treatment may be accomplished by employing one or more of the following techniques: (a) Miller and Rollnick’s (1991) motivational interviewing techniques in concert with the client’s readiness for change (see Prochaska, DiClemente, & Norcross, 1992), (b) contingency management, that is, positive reinforcement, and (c) criminal justice options such as restorative justice or drug treatment court sanctions. According to Longshore et al., the latter criminal justice options allow the client’s viewpoint to be heard, and may reduce resistance.

Resistance. Harris and Watkins (1987) examined the phenomenon of reluctant involuntary clients, and suggested that the involuntary client is like "an uninterested customer, [who] sees no value in the product being sold" (p. 7). Client resistance may have many reasons. For example, some involuntary clients may view the counsellor as a representative of "the system," or they may deny that they have any problems. Other clients have never engaged in self-reflection, and are unable to imagine any benefit from counselling (Harris & Watkins).

Client resistance can be exhibited by hostility, silence, defensiveness, avoidance, and silliness (Harris & Watkins, 1987). Strategies for dealing with resistant clients include (a) acknowledging clients’ right to self-determination, (b) allowing clients to formulate their own goals for treatment, and (c) being clear on subjects such as limits of confidentiality.
Involuntary clients who have a history of aggressive behaviour may express resistance by using tactics such as staring at the counsellor, raising their voices, invading the counsellor's personal space, or making veiled or direct threats. Reviewing client histories, assessing which clients have the potential to be aggressive, and under what circumstances, can help counsellors prepare for such contingencies.

Clients who have been coerced into treatment may resist, as described above, or silently acquiesce while maintaining their own beliefs. Gauging clients' readiness to change and motivating clients to engage in treatment are ongoing components of counselling involuntary clients. They are described below.

**Stages of Change.** Prochaska et al. (1992) developed the idea that changing behaviour involved movement through phases: precontemplation, contemplation, preparation, action, and maintenance. In the precontemplation stage clients will not have given any thought to changing their behaviour. They do not recognize that there is a problem. When they reach the contemplation stage, clients weigh the costs and benefits of change, but may be ambivalent about changing. During the third stage, preparation, clients make a decision to change their behaviour. In the fourth stage, action, clients embark on treatment or some other activity to address the problem behaviour. The fifth stage, maintenance, entails maintaining the gains made in treatment.

The stages of change model as described by Prochaska et al. (1992) is commonly used by treatment providers in the Canadian federal correctional system, so that stage-appropriate counselling techniques can be used. Bean and Neimitz
(2004) stated that during the precontemplation phase, clients should be encouraged to develop an awareness of their problems related to using drugs or drinking. When the client moves into the contemplation phase, educational and self-monitoring strategies can be implemented. At the action stage, the client requires specific behaviour-change techniques and skills training.

*Motivational Interviewing.* How can counsellors motivate involuntary clients to fully engage in treatment? Confrontation and threats usually do not work with clients who display antisocial traits. In fact, these approaches may further alienate the client. Miller's (1989) Motivational Interviewing (MI) approach has been found effective with drug users who have not fully committed to changing their behaviour. An important distinction between MI and other approaches is that the counsellor does not persuade or otherwise influence clients into changing their behaviour. The counsellor using MI simply helps clients make a decision. Contrary to other opinions on the nature of client resistance, Miller argued that client denial and resistance is a product of counsellors' behaviour.

Counsellors using MI help clients (a) identify the problem(s) they are having, and (b) examine the costs and benefits of continuing to abuse substances or terminating the behaviour (Bean & Nemitz, 2004). MI is based on the premise that a reasonable client will realize that the cost of continuing substance use far outweighs the benefits.

However, antisocial clients may not ascribe to common beliefs. Samenow (1998) argued that offenders have their own reality. Nonetheless, he also indicated that "the change agent must begin by capitalizing on periods in which the criminal is
vulnerable…owing to an arrest or confinement” (p. 293). Longshore et al., (2004), as stated earlier, suggested that drug treatment court sanctions and restorative justice helped accomplish offender treatment by allowing clients to voice their opinions. However, it may well be as Samenow suggested—these events bring the offender-client’s life into focus, and may propel the client towards change.

Counsellors providing treatment to mandated clients on an outpatient basis have the opportunity to motivate them by exploring the benefits of changing, and the possible outcome of continuing with their usual behaviour. At this time in Canadian federal corrections, Cognitive Behavioural Therapy is the preferred treatment approach.

*Cognitive Behavioural Therapy.* Cognitive Behavioural Therapy (CBT) has replaced other forms of psychological treatment in Canadian federal corrections. Psychodynamic approaches, which were used in group settings, are no longer sanctioned. The use of CBT with offenders is based on the rationale that offenders are poor problem-solvers, rigid in their thinking, and cope poorly with everyday stressors. Using CBT helps offenders identify their problematic thinking. One of the benefits of the general use of CBT with offenders is that the core principles can be used in treating sexual offenders, substance abusers, and violent offenders. As well, an offender may take a treatment program in prison then take a follow-up component in the community, without any need to learn new concepts or terminology.

A core part of offender treatment includes (a) learning to identify personal high-risk situations, that is, the risk to ingest substances and/or commit crime, (b)
learning to identify emotions and control them is, and (c) developing a personal relapse prevention plan. It is believed that by identifying emotions and the attendant cognitions, offenders will be able to avoid relapsing to substance abuse or recidivism.

Summary

Research suggests that genetic and environmental factors exert some influence on the development and maintenance of criminal and substance abuse behaviour. Nevertheless, individuals can decide to exert control over their thought patterns, emotions, and behaviours to eliminate substance abuse and criminal activity. The following chapter provides a brief description of a relapse prevention manual, which implements Marlatt's model of relapse prevention and Ellis's Rational Emotive Behaviour Therapy (REBT) within a 10 session psychoeducational program format. Miller's (1989) motivational interviewing techniques and the stages of change model (Prochaska et al., 1992) are foundational to the program, and their implementation is discussed in Chapter III.
CHAPTER III

Outline of the Proposed Relapse Prevention Manual

Contextual issues

This psychoeducational program is designed to teach substance abuse relapse prevention techniques to criminal justice clients in a time-limited, closed-group format. The program is a “low-intensity” program and is not designed to treat personality disorders or severe mental health issues. Clients currently abusing drugs would be required to complete detoxification prior to attending the group.

Co-facilitation is the preferred method of delivery, as one facilitator can observe the group, while the other facilitator delivers the material. Group facilitators would require knowledge of (a) Miller’s (1989) motivational interviewing techniques, (b) the transtheoretical model of “Stages of Change” (Prochaska et al., 1992), (c) the social needs of criminal justice clients, and (d) substance abuse treatment strategies. It would be important for group facilitators to display acceptance and empathy, while maintaining professional boundaries.

Referral process. It is expected that this relapse prevention program would be delivered in a community outpatient clinic under the auspices of a regional health authority. It could be delivered as part of a Drug Treatment Court initiative. It is anticipated that the majority of the clients would be mandated to attend treatment and would be referred by Probation Officers. As well, it is anticipated that clients would be in various stages of commitment to change.
Admission Criteria. Participants would be expected to attend all sessions, as each session builds on previously presented material. Participants should be able to read, write, and speak English at a grade 8 level or higher. Participants should have attended some form of substance abuse treatment in the past. Participants would be required to consent to the group facilitators sharing information with Probation Officers and others who are legally entitled to have the information.

Exclusionary Criteria. Applicants who were actively psychotic would not be accepted into the group. Applicants going through withdrawal, and those with a history of aggressive acting-out in treatment settings would not be accepted.

Rationale for the Group Session Content

The program sessions have been designed to incorporate the theories of several authors who have written on chemical dependency and/or crime, and whose work has been reviewed in previous chapters of this project document. For example, Samenow (1998) suggested that offenders have a common way of thinking about themselves, others, and the world. That style of thinking is often replete with distortions, such placing blame on others. Similarly, people who abuse substances often hold unhelpful beliefs that perpetuate their substance abuse. For example, some alcoholics cling to the idea that they can drink in moderation, although their personal experience has demonstrated this to be untrue.

In a closed-group, time-limited format, few issues can be addressed in depth. My review of the literature indicates that important treatment topics for court-involved people who use substances include challenging beliefs, identification of high-risk situations, improving coping abilities, and providing access to adjunctive services.
As indicated earlier, coerced clients may be reluctant to engage in treatment. Their interest and motivation may vary from session to session, and even within a session. Thus, it is recommended that treatment providers utilize the stages of change model (Prochaska et al., 1992) along with Miller's (1989) motivational interviewing techniques as the underlying framework for each session. For example, the receptivity of clients who are in the precontemplation or contemplation stage may be increased through employing Miller's (1989) motivational interviewing techniques during the sessions to help them re-consider the costs and benefits of not engaging in treatment.

**Group Sessions**

**Session 1 Introduction:** Behavioural expectations, limits of confidentiality, informed consent, personal goals. The content of Session 1 is based partly on Harris and Watkins' (1987) work, which is mentioned in Chapter II of this document in the section on counselling involuntary clients. In Session 1, facilitators explain the behavioural expectations regarding punctuality, level of participation, and in-group etiquette; the potential risks and benefits of participating in the group are explained; facilitators explain the limits of confidentiality, and participants are asked to sign an "Informed Consent" declaration. Participants introduce themselves and state the goals they have set for themselves for the program. The advantages and disadvantages of using alcohol and drugs are discussed. Each participant states the benefits and losses he or she incurred through substance abuse.
Session 2 The Inventories of Drug Taking and Alcohol Taking Situations:

Identification of personal high risk situations. The content of Session 2 is based on Marlatt's (1985) work on the phenomenon of relapse as described in the section of the same name in Chapter II of this document. There is evidence that poorly handled situations can lead to a relapse to drug or alcohol use (Marlatt). By identifying their personal high-risk factors, clients can begin to look at the situations where these factors arise. Session 2 provides the foundation for later sessions on coping skills. In this session, clients complete the Inventory of Drug Taking Situations (IDTS) (Annis & Martin, 1985) and/or the Inventory of Alcohol Taking Situations (IATS) (Annis, 1982) questionnaires along with the companion graph sheets; facilitators help participants complete the questionnaires and graphs; group members examine their own most common reasons for using drugs and/or alcohol; each client develops a list of his or her high risk situations based on the results of the graphing.

Session 3 Self-monitoring: Introduction to keeping a daily journal of high-risk situations. In Session 3, clients are introduced to the idea of keeping a daily journal to keep track of high-risk situations and how they coped with them. Journaling continues for the rest of the program. Clients are shown how to journal and asked to write out the “what, where, when and why” of daily situations that they found difficult to cope with. Session 3 is used as a stepping-stone to Ellis’s (2000) Rational Emotive Behaviour Therapy (REBT) which is formally introduced in the next session.

Session 4 Introduction to Ellis’s Rational Emotive Behaviour Therapy: How thinking can affect behaviour. Session 4 is based on the work of Ellis (2000) and Samenow (1998) who suggested that thinking styles lie at the root of personal
problems, as indicated in the second chapter of this project document. Criminal justice and chemically dependent clients may not see a link between their thinking, their emotions, and their actions. They may engage in blaming others, that is, “someone else” “made” them feel a certain way. For example, a client may blame his wife for "making" him angry, which (he claims) forced him to drink or use drugs to deal with the feelings.

In Session 4, clients are introduced to Ellis’s (2000) ideas on “straight” thinking versus irrational thinking and how our irrational thinking, if unchecked, can led to self-defeating behaviours. In this session, group members use examples from their journals to illustrate how they handled high-risk situations since the last meeting. Facilitators explain Rational Emotive Behaviour Therapy (REBT) and use examples from the group’s journals to illustrate the principles. Clients are shown how changing thinking can change their feelings, and lead to an altered outcome.

Session 5 Coping Skills: Awareness of our typical responses to high-risk situations. Session 5 is based on the work of Enos and Southern (1996) which is mentioned in the section on the phenomenon of relapse in Chapter II. In Session 5, clients give examples of their typical coping responses taken from entries in their daily journals. The group discusses the impact of no coping, poor coping, and effective coping strategies on the outcome of high-risk situations. Clients are encouraged to generate a list of effective coping strategies for their previously identified high-risk situations.
Session 6 Introduction to Marlatt’s Model of Relapse: The outcome of poor versus effective coping skills. Session 6 continues to explore coping skills, and introduces Marlatt’s (1985) model of relapse as mentioned in the section on the environmental and psychological factors of relapse in the second chapter of this document. As in previous sessions, the examples are drawn from the group members’ journals. The clients are introduced to the idea that when they find themselves in a high-risk situation they can choose to cope well and have a successful outcome, which means they will not slip back into using drugs or alcohol, or they can choose not to cope, or use poor coping strategies, which will possibly lead to a relapse.

Session 7 Review of program concepts and personal goals: Using the theories to accomplish personal goals. Session 7 brings together Ellis’s (2000) and Samenow’s (1998) theories on distorted thinking, and reviews Marlatt’s (1985) model of relapse, as discussed in Chapter II in this document. In Session 7, facilitators review REBT and the phenomenon of relapse. Group members reiterate the goals they mentioned during the first session. Facilitators and group members discuss the barriers to achieving goals. The group discusses how the theories can help achieve goals, for example, challenging negative beliefs and using effective coping strategies.

It is important that clients develop the ability to notice their harmful and distorted beliefs. Unchallenged cognitive distortions, such as, “Everyone should always agree with me,” may lead to annoyance (an unpleasant emotion) followed by drinking (ineffective coping) to reduce the unpleasant emotion.
Session 8 Community resources: Support groups, healthcare, social assistance, and employment. Session 8 is an attempt to assist clients to draw together elements that will help them put in place their own structure, in the form of support groups, financial help, medical care, and employment. Session 8 is based on Enos and Southern's (1996) acknowledgement of the importance of structure to prevent relapse, as mentioned in the section on the phenomenon of relapse in Chapter II of this document.

The facilitators provide the group members with the addresses of support groups, healthcare centres, applications for social assistance, and the names of employment agencies. The group discusses methods of accessing housing, healthcare, and employment. The facilitators explain the impact of stress on the ability to maintain sobriety.

Session 9 Drawing up a Personal Relapse Prevention Plan: Using the program material to prepare a viable plan. Session 9 is based on Marlatt’s (1985) work on relapse prevention, as well as the work of Enos and Southern (1996), and Doweiko (1996). The reader is referred to the sections in Chapter II on the environmental and psychological factors involved in relapse. In brief, it is most helpful if clients have a good understanding of their high-risk factors, and have a plan in place to counteract those high-risk factors when they arise. Session 9 allows clients to think about, and put in writing, the way they plan to cope with their high-risk factors and situations.

Group members are provided with a template to draw up a personal relapse prevention plan. Participants list their high-risk situations, and effective methods for
coping with each situation. They document the places and times of support group meetings. Names, addresses and phone numbers of crisis lines and community resources such as foodbanks are documented, along with the names of friends and family members who are willing to help in an emergency. A clear and detailed plan of action is written out addressing those occasions when the client expects to experience strong urges and temptations to drink or use drugs.

*Session 10 Termination: Discussion of plans, fears, and hopes.* Group participants discuss their future plans and hopes, and any fears they may have about remaining sober. Facilitators challenge any examples of distorted thinking, and encourage planning and effective coping skills. Group members are reminded to use their new skills and resources. Termination activities.
CHAPTER IV

Summary of the Final Project

The purpose of this project was to develop an outline for a proposed substance abuse relapse prevention manual for counsellors and paraprofessionals who treat criminal justice clients in outpatient settings. Reviewing the academic literature exposed several core issues including: (a) attempting to understand the genetic, environmental, and psychological factors underlying substance abuse and antisocial behaviour, (b) motivating coerced clients to participate in treatment, and (c) on-going development of treatment to reduce substance abuse-related crime. It is indicated in the literature that there is a gradual move, in Canada, towards integrating the criminal justice and healthcare systems to reduce drug-related crime and illness, which should be reflected in any treatment approaches. Observations related to these elements are provided below.

Factors Underlying Substance Abuse and Antisocial Behaviour

The role of genetics and the environment in the development of substance abuse and criminal behaviour has been widely researched. Overall, the predominating conclusion from this research is that criminal behaviour and substance abuse are under conscious control, regardless of other factors. Given the conclusion that substance abuse and criminal behaviour are under conscious control, thinking patterns became the target of intervention for clients with substance abuse and criminal behaviour problems. Many of these clients are mandated to receive treatment and such coerced clients may resist treatment necessitating the
use of motivational counselling approaches to get these clients engaged in treatment.

**Motivating Reluctant Clients**

Clients who are legally required to attend substance abuse treatment may be reluctant to participate fully in counselling. The literature on substance abuse treatment frequently mentioned Motivational Interviewing (Miller, 1989) and the transtheoretical stages of change model developed by Prochaska et al. (1992) as being promising components of any treatment approach.

Motivational Interviewing, as described by Miller (1989) is one procedure that allows clients to explore the benefits and costs of their behaviour, and helps them decide for themselves whether to change their behaviour or accept the consequences of their current course of action. Allowing coerced clients some self-determination is believed to be helpful in encouraging compliance with treatment orders.

The transtheoretical model of change (Prochaska et al., 1992) suggests that clients move through five stages of change, from not thinking about changing their behaviour, the precontemplation stage, to contemplation, preparation, action, and the maintenance stage. However, relapse is widely acknowledged as part of the overall recovery process in criminal behaviour and substance abuse and must be given consideration (Annis & Davis, 1994; Marlatt, 1985).

By utilizing approaches such as stages of change model (Prochaska et al., 1992) and Miller’s (1989) motivational interviewing techniques, counsellors may be able to encourage coerced clients to engage in treatment and to sustain that
engagement for a long enough period of time for change to take place. The following section provides a brief overview of treatment methods.

_Treating Substance Abuse_

Traditional methods of treating substance abuse include peer-support groups, detoxification centres, and psychoeducational treatment. Treatment is offered in outpatient and residential treatment centres, and may vary from a few sessions to several months' residence in a therapeutic community. Treatment may be based on cultural practices, spirituality, and/or cognitive behavioural techniques. Some treatment practices draw from various domains to provide biopsychosocial treatment for substance abuse.

Nevertheless, some substance abusers may be reluctant to enter these types of treatment or may be marginalized and unaware of treatment options. In those cases, harm reduction practices may be helpful. Such practices are examples of the benefits that can be derived from closer coordination between the healthcare and law enforcement systems.

_The Integration of Healthcare and Law Enforcement_

The view that substance abuse is a moral failing deserving of punishment continues to have some support among the Canadian public. Nonetheless, those who work in the Canadian healthcare and justice systems prefer to view excessive use of intoxicants as a health issue, which has broad societal implications. Viewed this way, reducing substance abuse can be expected to lead to a reduction in criminal activity. Yet, the ineffectiveness of social and legal sanctions against drug
use has resulted in the introduction of harm reduction measures in some Canadian cities, for example, safe injection sites for heroin users.

Drug treatment courts can also be considered a form of harm reduction as this model allows substance-abusing criminal justice clients the opportunity to attend treatment rather than be incarcerated. This model provides law enforcement, psychoeducational treatment, healthcare, and social services as required. It is an important component within substance abuse treatment as it diverts less criminally-oriented clients away from prison, and reduces their chances of becoming further entrenched in the criminal subculture.

Overall, the literature reviewed suggests replacing the old belief that “nothing works” when treating antisocial clients who abuse substances, with a more optimistic perspective. There are many treatment options open to offender-clients and the probation officers who supervise them. The last part of this chapter describes some potential future directions in substance abuse treatment for criminal justice clients, followed by a brief discussion of the development of the manual outlined in chapter three and its potential for further development.

**Future Directions in the Treatment of Criminal Justice Clients who Abuse Substances**

One of the great problems facing the criminal justice system is its historic “demonization” of drug use, and its inability to eliminate drug use, regardless of the amount of money spent on the process. One example of this is the insistence of the Canadian federal correctional system that it has a “zero tolerance policy” with respect to drug use in prisons. Yet, in order to reduce the transmission of HIV/AIDS
through needle sharing, inmates are allowed to possess bleach kits to clean their syringes, which is a clear acknowledgement that zero tolerance is a myth.

In the future, administrators of Canadian correctional systems may decide to provide clean needles and safe injection sites within prisons to further reduce the transmission of HIV and hepatitis among offenders. Hopefully, if such action occurs, it would be accompanied by a formal revision of the “zero tolerance” policy. However, such a policy revision would need to take into account the community impact likely to result. It is sometimes overlooked that few inmates are permanently incarcerated, and those who are released may spread diseases to the community.

There are many chemical alternatives to methadone currently available for treating narcotics addictions. Providing chemical alternatives may encourage wary heroin-addicted offenders to engage in a medical regimen that does not have Methadone’s serious side effects. Limited clinical trials of heroin may be seen as a useful way to gradually wean offenders off heroin and reduce heroin trafficking within institutions and in communities. However, ultimately, most offenders will be released into the community and relapse would be a likely occurrence. Hence there is a need to develop effect ways for dealing with relapse when it occurs.

Development of the Proposed Manual for Relapse Prevention

The content for the relapse prevention manual outlined in chapter three was based on the literature review. The substance abuse literature and the criminal justice literature have many common themes. In short, cognitive distortions, poor coping skills, emotional problems, and lack of adjunctive medical and social services have been found to be prevalent among criminal justice clients and substance
abusers. Consequently, each session in the manual was designed to move clients through a process during which they might: (a) begin to recognize that they had developed problematic behaviour, (b) identify their high-risk situations, (c) develop alternative cognitions to help control emotions and behaviour, and (d) develop a personal plan to avoid or treat a drug relapse. The penultimate session encourages clients to link to available community resources.

Several problems arose in developing the content for the manual. Firstly, most of the research that has taken place on treating offender substance abuse has occurred within prison populations. There is little Canadian material on community-based treatment for probationers. Secondly, in Canada, females constitute a very small number of offenders. Again, there was little information on treating female offenders in prison or in the community. In fact, most of the documents reviewed did not mention whether the offenders under study were male or female. This resulted in the development of a generic approach to relapse prevention, which may need to be tailored to specific client groups to insure its relevance.

It was difficult to decide how many sessions would be appropriate in a time-limited outpatient program. It is often said that a person who wishes to maintain sobriety should attend “90 meetings in 90 days,” and that the length of time the client remains in treatment is positively correlated to the length of time the client will maintain sobriety (Martin & Inciardi, 1993). The literature reviewed suggested that 3 months is the minimum acceptable duration of treatment. Nevertheless, for the purpose of this project, the 10 sessions gave a brief introduction to the material.
Further Development of the Relapse Prevention Manual

Currently, it is possible to purchase self-help books on addictions, but there is a shortage of material directed towards the needs of criminal justice clients. This final project has provided the kernel of a relapse prevention program. It would be possible for treatment providers to formalize the sessions and prepare background material based on the literature review. Written assignments could be designed for participants, as well as a self-help manual to accompany the program.

It may be possible to build a continuous-intake program by re-working and augmenting the material presented in the 10 sessions. This may result in a more appropriate program for clients who have a more extensive history of substance abuse.

This final project attempted to bring together relevant material from the fields of substance abuse counselling and criminal justice to provide the foundation for a relapse prevention manual for criminal justice clients. Offender-clients may not be willing to examine their chemical abuse and antisocial behaviour. Hence, the manual's content is designed to gradually demonstrate to clients that they can change their lives by changing the way they think. Additionally, the manual integrates material on linking clients to community resources as a way of delaying or reducing their relapse to drug use.

This manual is appropriate for use in outpatient clinics that offer time-limited, psychoeducational group counselling to probationers. It is recommended that program facilitators customize the session on community resources to make it relevant to their clients. Lastly, it is hoped that this project will encourage counsellors
to work with marginalized criminal justice clients, and that those clients will be encouraged to reduce their chemical dependence.
References


Research in contingency management interventions (pp. 345-370).


