An International Literature Review on the Needs of People who have Offending Behaviours and/or Substance Use Issues

Niamh Condron

CARL Research Project
in collaboration with
Churchfield Community Trust

CARL
COMMUNITY - ACADEMIC
RESEARCH LINKS
University College Cork, Ireland

Name of student(s):	Niamh Condron
Name of civil society organisation/community group:	Churchfield Community Trust
Name of community group liaison person:	Kevin Mooney
Academic supervisor(s):	Dr. Fiachra O'Suilleabhain
Name and year of course:	Masters of Social Work, Year 2
Date completed:	16th April 2018

What is Community-Academic Research Links?
Community Academic Research Links (CARL) is a community engagement initiative provided by University College Cork to support the research needs of community and voluntary groups/ Civil Society Organisations (CSOs). These groups can be grass roots groups, single issue temporary groups, but also structured community organisations. Research for the CSO is carried out free of financial cost by student researchers.

CARL seeks to:

- provide civil society with knowledge and skills through research and education;
- provide their services on an affordable basis;
- promote and support public access to and influence on science and technology;
- create equitable and supportive partnerships with civil society organisations;
- enhance understanding among policymakers and education and research institutions of the research and education needs of civil society, and
- enhance the transferrable skills and knowledge of students, community representatives and researchers (www.livingknowledge.org).

What is a CSO?
We define CSOs as groups who are non-governmental, non-profit, not representing commercial interests, and/or pursuing a common purpose in the public interest. These groups include: trade unions, NGOs, professional associations, charities, grass-roots organisations, organisations that involve citizens in local and municipal life, churches and religious committees, and so on.

Why is this report on the UCC website?
The research agreement between the CSO, student and CARL/University states that the results of the study must be made public through the publication of the final research report on the CARL (UCC) website. CARL is committed to open access, and the free and public dissemination of research results.

How do I reference this report?
Author (year) *Dissertation/Project Title*, [online], Community-Academic Research Links/University College Cork, Ireland, Available from: http://www.ucc.ie/en/scishop/completed/ [Accessed on: date].

How can I find out more about the Community-Academic Research Links and the Living Knowledge Network?
The UCC CARL website has further information on the background and operation of Community-Academic Research Links at University College Cork, Ireland.

http://carl.ucc.ie. You can follow CARL on Twitter at @UCC_CARL. All of our research reports are accessible free online here: http://www.ucc.ie/en/scishop/rr/.

CARL is part of an international network of Science Shops called the Living Knowledge Network. You can read more about this vibrant community and its activities on this website: http://www.scienceshops.org and on Twitter @ScienceShops. CARL is also a contributor to Campus Engage, which is the Irish Universities Association engagement initiative to promote community-based research, community-based learning and volunteering amongst Higher Education students and staff.

Are you a member of a community project and have an idea for a research project?
We would love to hear from you! Read the background information here http://www.ucc.ie/en/scishop/ap/c&vo/ and contact us by email at carl@ucc.ie.

Disclaimer
Notwithstanding the contributions by the University and its staff, the University gives no warranty as to the accuracy of the project report or the suitability of any material contained in it for either general or specific purposes. It will be for the Client Group, or users, to ensure that any outcome from the project meets safety and other requirements. The Client Group agrees not to hold the University responsible in respect of any use of the project results. Notwithstanding this disclaimer, it is a matter of record that many student projects have been completed to a very high standard and to the satisfaction of the Client Group.

Declaration of Originality

This is to certify that the dissertation titled: "An International Literature Review on the Needs of People who have Offending Behaviours and/or Substance Use Issues" submitted to the School of Applied Social Studies, University College Cork, in partial fulfilment of the requirements for the award of "Masters of Social Work", is my own work.

Where the work of others has been utilised within this research, it has been cited and referenced accordingly using recognised academic conventions. This dissertation has been submitted through TurnItIn and any changes necessitated by the originality report generated, have been addressed.

Name: _____

Date: _____

Acknowledgements:

This research project would not have been possible without the support and dedication of a number of people. Foremost, I wish to express my sincere thanks to my tutor, Dr. Fiachra O'Suilleabhain, for his valuable guidance and never ending support throughout the two year course.

To Dr. Kenneth Burns, Dr. Anna Kingston and the CARL team for allowing me to undertake this research and mentoring me throughout the project.

I would like to thank most importantly all in the Churchfield Community Trust, particularly my community liaison partner, Kevin Mooney, for your collaboration on this project with me. It is deeply appreciated and I can only hope I have done justice for the agency.

Finally, I would like to thank my parents, my brother and my partner for their endless love, encouragement, support and attention throughout the two years.

Abstract:

This project researched the concept of the Community Reinforcement Approach (CRA) and Cognitive Behavioural Therapy (CBT) and used secondary research in the form of an international literature review, to explore its links to the re-integration of those who have offending behaviours and/or substance use issues. To achieve this, the researcher researched the best practice guidelines internationally when working with those who have offending behaviours and/or substance use issues and the positive impact that engaging in CBT and CRA can have on their rehabilitation and re-integration into the community. Based on this, a number of recommendations have been made which hope to inform both policy and social work practice going forward.

Table of Contents

Chapter One: Introduction and Methodology

1.1 Introduction:

This chapter will introduce the research by providing an overview of the background and the value of undertaking this research to social work. The research rationale and the aims and objectives of the research and key research questions will be outlined. Subsequently, the theoretical perspective and methodology underpinning the research will be discussed. The researcher's reflexivity and ethical considerations will also be acknowledged, along with the limitations of the project. The chapter will then conclude with an outline of the succeeding chapters.

1.2 Title:

"An International Literature Review on the Needs of People who have Offending Behaviours and/or Substance Use Issues"

1.3 Background to Research and its Value to Social Work:

According to the Department of Justice and Equality (2011) and McNeill et al (2012), one of the objectives of the Irish criminal justice system is to reduce the level of crime, hence it is important to gain an in-depth understanding of why individuals engage in offending behaviours and also to understand what interventions support the process of desistance from crime. Statistics reveal the number of prisoners held in Irish prisons with a history of substance misuse issues greatly outnumber those without (Drummond et al, 2014).This project endeavours to provide an insight in to the contributions Cognitive Behavioural Therapy (CBT) and Community Reinforcement Approach (CRA) have on an individual's rehabilitation and re-integration back into society.

It is a community-based research project undertaken in collaboration with Churchfield Community Trust (CCT) through the Community Academic Research Links (CARL) initiative.

Churchfield Community Trust is a community-based re-integration initiative primarily funded by the Irish Probation Service that works with individuals towards reducing their risk of re-offending through social and educational development and by addressing an individual's criminogenic needs such as substance use.

There are many benefits to both the researcher and the profession of social work in engaging in the research process. Social workers work with individuals on a daily basis who may have offending behaviours and/or substance use issues. Engaging in research will better equip social workers to identify the needs of their clients and the most effective and appropriate method in response to their needs. It also allows researchers to develop links with experts in the field of social work and contributes to the professionalisation of social work as it is an evidence-based profession.

1.4 Research Rationale:

This study has been carried out in collaboration with Community Academic Research Links (CARL) and Churchfield Community Trust (CCT). CARL is a community engagement initiative that supports the research needs of community groups and organisations. CARL invites Civil Society Organisations (CSO) to submit a research topic of interest to be pursued by students on their behalf (University College Cork, 2018). The CSO that proposed this study is Churchfield Community Trust. CCT wanted to gain a better understanding of whether the interventions they offer are appropriately meeting the needs of the client group they support in re-integrating back into society. This project is an example of community-based research (CBR) as it involves a community organisation proposing a research topic that has emerged as a direct result of their day-to-day practice (Munck et al, 2014). As social workers in training, we are encouraged to promote empowerment, collaboration and participation in our work, all of which are core components of CBR (Shaw and Holland, 2014).

CBR requires various parties working together for the purpose of developing an action plan that will benefit the CSO involved (McIlrath et al, 2014).

I was interested in undertaking a CARL project as I liked the idea of my research potentially contributing to some level of social change in one's work with individuals who have offending behaviours and/or substance use issues. The prospect of working in partnership with a community organisation, undertaking secondary research and developing my research skills were also advantages to me undertaking CBR. My motivation for choosing this particular project stemmed from a keen interest in substance misuse and addiction. My interest in this particular topic stemmed from my employment experience and my first social work placement. I am currently employed with the Peter McVerry Trust where I have worked with offenders and substance users on a regular basis for the past two and a half years. I completed my first 14 week social work placement with the Probation Service where I met offenders daily and became aware of the many issues facing offenders who want to lead a life away from crime such as substance use, mental health, homelessness and poor educational attainment. The Probation Service is the lead agency in the assessment and management of offenders in our community. There are currently 10,208 individuals on the caseload of the Probation Service (The Probation Service, 2015). A national report published in 2012 revealed that 89% of the adult offender population on probation supervision had misused drugs and/or alcohol at some point in their life (The Probation Service, 2012). Throughout my time in the Probation Service, I engaged with a number of agencies within the community who provided interventions to those with offending behaviours and/or substance use issues. I always reflected on the work these agencies carried out with my clients and always questioned the effectiveness of such interventions in supporting re-integration.

1.5 Aim of Research:

To explore the effectiveness of Cognitive Behavioural Therapy and the Community Reinforcement Approach in supporting individuals who have offending behaviours and/or substance use issues in re-integrating back into society.

1.6 Research Objectives:

1. To examine the effectiveness of two interventions i.e. Cognitive Behavioural Therapy and the Community Reinforcement Approach in supporting the process of desistance and re-integration of those with offending behaviours and/or substance use issues back into their communities.

2. To provide Churchfield Community Trust with an analysis report that will allow them to assess the effectiveness of the services they provide by informing them of best practice guidelines and to determine whether the interventions they offer are responsive to the needs of their clientele.

3. To act as a resource for Churchfield Community Trust and have the potential be used to assist funding applications in the future.

1.7 Research Questions:

1. What is meant by Community Reinforcement Approach (CRA) in the context of professional work with those who have offending behaviours and how effective are these approaches in supporting re-integration?

2. How can a Cognitive Behavioural Therapy (CBT) approach assist in desistance work and re-integration with those who have offending behaviours and/or who have alcohol and/or drug issues?

3. What role can CBT play in CRA to work with individuals who have offending behaviours who have alcohol and drug issues also?

1.8 Glossary of Terms:

Crime is defined as “an activity that is prohibited, prosecuted and punishable by criminal law” (Henry and Lanier, 2001, p. 6). Offending is the behaviour associated with crime. According to the Irish Crime Classification System (ICCS), there are sixteen categories of crime offences (Central Statistics Office, 2008).

These are:

1. Homicide
2. Sexual
3. Attempts/Threats to Murder, Assaults, Harassment and Related Offences
4. Dangerous or Negligent Acts
5. Kidnapping and Related Offences
6. Robbery, Extortion and Hijacking
7. Burglary and Related Offences
8. Theft and Related Offences
9. Fraud, Deception and Related Offences
10. Controlled Drugs
11. Weapons and Explosives
12. Damage to Property and/or the Environment
13. Public Order and Other Social Code Offences such as begging
14. Road and Traffic
15. Offences against the Government, Justice Procedures and Organisation of Crime
16. Offences not classified elsewhere such as animal and maritime offences, data protection, employment and immigration.

Substance misuse is defined as "the illegal or illicit drug taking or alcohol consumption which leads a person to experience social, psychological, physical or legal problems related to intoxication or regular excessive consumption and/or dependence. Drug misuse is therefore drug taking which causes harm to the individual, their significant others or the wider community" (National Drug Treatment Centre, 2018).

The DSM-V, the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (2013), no longer uses the terms substance abuse and substance dependence, but rather it refers to substance use disorders, which are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems and failure to meet major responsibilities at work, school, or home (American Psychiatric Association, 2013).

According to the DSM-V, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria. The criteria used to diagnose an individual with a substance use disorder are:

1. Taking the drug in larger amounts and for longer than intended
2. Wanting to cut down or quit but not being able to do it
3. Spending a lot of time obtaining the drug
4. Craving or a strong desire to use drugs
5. Repeatedly unable to carry out major obligations at work, school, or home due to drug use
6. Continued use despite persistent or recurring social or interpersonal problems caused or made worse by drug use
7. Stopping or reducing important social, occupational, or recreational activities due to drug use
8. Recurrent use of drugs in physically hazardous situations
9. Consistent use of drugs despite acknowledgment of persistent or recurrent physical or psychological difficulties from using drugs
10. Tolerance - defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount.
11. Withdrawal - manifesting as either characteristic syndrome or the substance is used to avoid withdrawal.

In relation to the above criteria, meeting 2-3 of the above list is required for a mild substance use disorder diagnosis, while 4-5 is a moderate substance use disorder diagnosis, and above 6 is classified as a severe substance use disorder (American Psychiatric Association, 2013).

Community-based research (CBR) is defined as "the systemic creation of knowledge that is done with and for the community for the purpose of addressing a community-identified need" (Strand et al, 2003, p. 8).

Desistance is defined as the "long term abstinence from criminal behaviour among those for who offending had become a pattern of behaviour" (McNeill et al, 2012, p. 3).

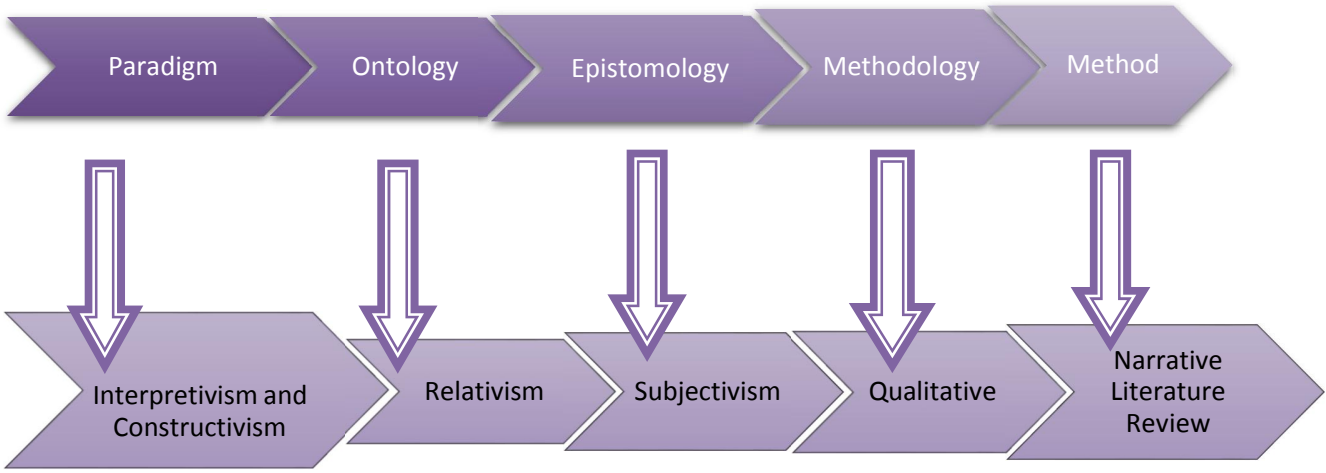
1.9 Researcher Reflexivity:

Reflexivity is "a process of looking inward and thinking about how our own life experiences or significant events may impact on our thinking, or on the research process" (Shaw and Gould, 2001, p. 101). I am making these biases clear at the outset of my research in order to enhance the credibility of the project findings (Carey, 2009; Mays and Pope, 2000). According to Fox (2007), it is imperative that the researcher understands how the process and outcomes of research are affected by their own personal position in addition to the methodology. My reflexive positioning as a researcher has been influenced by my life experiences to date, my experience of working as a social care worker and my two practice placements on the Master of Social Work programme at University College Cork (UCC) which has inevitably influenced my worldview (Gergen and Davis, 1985). I completed my first fourteen week placement with the Probation Service and this has influenced my reflexivity and positionality. I feel strongly about the shift towards more community based services and sanctions for people with offending behaviours. Therefore, it is likely that these values will have influenced my research and the lens through which I view the research. However, I aimed to maintain a degree of self-awareness throughout this research in order to remain objective, not letting personal bias compromise my work. I am currently employed with the Peter McVerry Trust where I have worked with offenders and substance users on a regular basis for the past two and a half years. I believe my reflexivity and positionality became influenced by my attained knowledge and values which are that although individuals engage in crime as a result of personal issues such as homelessness and substance use there are also many structural issues in society that cause individuals to become involved in crime such as a lack of homeless accommodation services and the difficulty in claiming social welfare without an address results in individuals resorting to crime to fund their substance use.

Padgett (1998) maintains that researchers are not required to eliminate their personal beliefs and biases but instead must develop a greater awareness around them in order to understand the potential impact they could have on the research process. In an attempt to address my reflexivity, I kept a learning journal throughout the research journey. This has allowed me to explore my thoughts and views and to ensure that they did not interfere with the research process.

1.10 Philosophical and Theoretical Underpinnings:

Figure 1: Outline of Research Design



A paradigm is defined as "the entire constellation of beliefs, values, techniques and so on shared by members of a given community" (McLaughlin, 2012, p. 39). Simply, paradigms are "the theories which define legitimate areas for research questions, methods and solutions for a scientific community" (McLaughlin, 2012, p. 39). The term paradigm includes the researcher's epistemological, ontological and methodological perspective (Guba and Lincoln, 2005). As a CARL project, the research questions were designed collaboratively by the researcher and the community group, Churchfield Community Trust. The research paradigm for this research is interpretivism and constructivism. According to Gergen (1999), constructivism is about realities and relationships. It focuses on the core belief that there is no objective reality or objective truth. Meanings are not fixed, they arise out of an individual's motivation and interaction within the structures and the world. According to Cooper (1998), there is no meaning without the mind. Lueger (2000) states that constructing reality is based on personal experiences and culturally defined and historically situated interpretations. Interpretivisim focuses on understanding human behaviour and actions (Sarantakos, 1998). The researcher will attempt to understand the effectiveness of CBT and CRA in reducing offending behaviours and/or substance use while re-integrating individuals back into society.

The main theoretical framework that will underpin this research project is Bronfenbrenner's ecological theory (see figure 2) (Santrock, 2003). This theory discusses how individuals such as offenders do not operate in isolation but rather operate in a system. As can be seen below, the individual is affected and influenced by their family, community and political and cultural structures. The individual is impacted by each system level. For example, children who grow up in an environment where their father has a criminal conviction(s) have twice a higher chance of having a criminal conviction than those with non-criminal fathers, while if a child's father is imprisoned they have a 32%-53% chance of having a criminal conviction in later life compared to non-imprisoned parents (Hjalmarsson and Lindquist, 2012).

This suggests that if an individual grows up in a family environment where crime is a part of their life, they are more likely to commit crimes as they grow older. Duncan et al (1998) states that it is strongly correlated that if an individual grows up in a disadvantaged and poverty stricken family and neighbourhood environment, they are more likely to experience difficulties in terms of sourcing employment and proceeding to higher education if their parent is either an early school leaver and/or unemployed for longer than eighteen months. All of these systems impact on the needs of offenders.

Figure 2: Bronfenbrenner's Ecological Model

1.11 Ontology:

Ontology can be understood as 'the science or study of being' or ‘the nature of reality’ (Sarantakos, 2005, p. 430). the ontological perspective is the set of beliefs the researcher has about the nature of reality (Schwandt, 2007). The ontology for this research is relativism as there is no one meaning, but rather a collection of meanings as to why individuals engage in offending behaviour and/or substance use and is relative to one's perception of this. Relativism denies the possibility of objective knowledge independent of the individual, of the social environment and of ethical/values that impinge upon the individual (Foster, 2007). Ontology is directly linked to epistemology as it allows us as researchers to construct a research methodology and therefore generates research questions (Holloway, 1997).

1.12 Epistemology:

The epistemology for this research is subjectivism. Epistemology is the theory of knowledge. It is also concerned with how knowledge is created and formed and how the knowledge changes and develops over time (Carey, 2009). Epistemology "addresses the question of what counts as legitimate knowledge" (Whittaker, 2012, p .3). Subjectivism examines the individual meanings and actions i.e. why individuals engage in offending behaviours and/or substance use.

Ontology and epistemology influence methodology and this directs the choice of the research design and research instrument (Sarantakos, 2005).

1.13 Methodology:

Methodology is the way one goes about obtaining the knowledge that we desire as researchers (Shaw and Gould, 2001). This research will be secondary desk-based. This study will attempt to understand the most effective models when working with individuals who have offending behaviours and/or substance use issues through analysing these models and the theory used. It will also attempt to understand, through statistics, the effectiveness of the CRA and CBT in re-integration with those engaging in offending behaviours and/or substance use. The research will be completed in the form of an international narrative literature review.

The narrative literature review allows the researcher to analyse the data, establish any patterns that emerge and then critically evaluate the research findings by exploring existing literature (Gray, 2004). Secondary desk-based research was chosen for this study as CCT were particularly interested in gaining an in-depth understanding of the effectiveness of the CRA and CBT in promoting re-integration among those who have offending behaviours and/or substance use issues internationally.

1.14 Research Methods:

A research method is set of techniques that are used to identify and explore your research questions and a procedure by which to “collect and analyse data, and present findings” (Payne and Payne, 2004, p.149).

The research method that will be used in this research will be a narrative literature review. Narrative reviews "pull together the existing work on a ...describes how the issue is conceptualised within the literature, how research methods and theories have shaped the outcomes of scholarship, and what strengths and weaknesses of the literature are" (Onwuebbuzie and Frels, 2016, p. 29). The strengths of this method are that it combines empirical and theoretical literature and draws upon studies that use qualitative and quantiative approaches.

Date of Search:	**Search Location:**	**Time-Frame of Search:**	**Search Terms Used:**	**Number of Sources Retrieved:**	**Any Other Restrictions Placed on Search:**
6th March 2018	UCC One Search	1975-Present	Community Reinforcement Approach	188,596	N/A
6th March 2018	UCC One Search	1975-Present	Community Reinforcement Approach, Offending and Re-integration	221	N/A
6th March 2018	UCC One Search	1975-Present	Community Reinforcement Approach, Substance Use	81,679	N/A
6th March 2018	UCC One Search	1975-Present	Community Reinforcement Approach, Offending, Substance Use and Re-integration	193	N/A
22nd March 2018	UCC One Search	1975-Present	Cognitive Behavioural Therapy	423,748	N/A
22nd March 2018	UCC One Search	1975-Present	Cognitive Behavioural Therapy, Offending and Re-integration	188	N/A

22nd March 2018	UCC One Search	1975-Present	Cognitive Behavioural Therapy, Offending, Substance Use and Re-integration	152	N/A
4th April 2018	UCC One Search	1975-Present	Cognitive Behavioural Therapy and Community Reinforcement Approach	21,022	N/A

1.15 Ethical Considerations:

Ethics can be defined as "ensuring the dignity, rights, safety and well-being of research participants" (McLaughlin, 2012, p. 57). This research will be ethical as I am bound by the research ethics of University College Cork and CORU. The idea for this project was proposed by CCT and, therefore, was already approved by the organisation's management team before appearing on the CARL website. The researcher was also required to submit an ethical review form, outlining the main ethical considerations of the research, to UCC's Ethics Committee.

The only ethical issues I foresee at the moment are the inclusion and exclusion criteria for the study.

The inclusion criteria will be as follows:

1. Must be a male
2. Must have a conviction.

The exclusion criteria will be as follows:

1. Sexual Offenders
2. Juveniles (Clark, 2000).

The inclusion and exclusion criteria has been agreed in partnership with the CARL agency, Churchfield Community Trust, as the agency primarily work with adult men who have a criminal conviction. CCT does not work sexual offenders or juveniles.

1.16 Limitations:

The two main limitations to this project was the restrictive nature of the time frame and the word count. Due to these restrictions, more in depth research of the effects different interventions such as Motivational Interviewing (MI) could not be explored and had to be limited to Cognitive Behavioural Therapy and the Community Reinforcement Approach. Even within this search filter, restraint had to be exercised as numerous interesting topics arose such as the effect of offending behaviours and substance use on wider family relationships but could not be included. Due to time constraints, it was only viable to complete a small-scale international study. While initially the researcher had hoped to conduct an international systematic review, this was not possible due to time constraints.

1.17 Conclusion:

To conclude, this chapter provided the reader with a thorough understanding of the research process that was followed in order to achieve the research aims and objectives. It provided a comprehensive description of both community-based research and secondary research i.e. a narrative literature review and discussed their relevance in the design of this study. It outlined the interpretivism and constructivism paradigm that informed the research methods. The chapter concluded by examining the ethical considerations and limitations of conducting a community-based research project within a limited time-frame. The following chapter will explore existing literature relevant to the research topic.

1.18 Chapter Outline:

Chapter One

Chapter one introduces the topic to be studied and explains why this research is being conducted outlining the aim and objectives of the research as well as the overarching research questions. It will also acknowledge and discuss the theoretical perspective and methodology underpinning the research. The researcher's reflexivity and ethical considerations will also be acknowledged, along with the limitations of the project.

Chapter Two

Chapter two consists of a literature review which explores best practice guidelines and best practice interventions internationally.

Chapter Three

This chapter lays out in detail what Cognitive Behavioural Therapy (CBT) is and its effectiveness in working with individuals who have offending behaviours and/or substance use issues in re-integrating them back into their communities and supporting the process of desistance.

Chapter Four

Chapter four outlines what the Community Reinforcement Approach (CRA) is and its effectiveness in working with individuals who have offending behaviours and/or substance use issues in re-integrating them back into their communities and supporting the process of desistance. This chapter will also discuss what role CBT can play in CRA to work with individuals who have offending behaviours who also have alcohol and drug issues.

Chapter Five

The final chapter draws an overall conclusion based on all the previous chapters and puts forward a number of recommendations for both the community group and social work practice as well as for further research and policy. This chapter concludes with a reflective piece on the research process.

Chapter Two: Background

2.1 Introduction:

This chapter aims to provide the reader with a background summary of some of the available literature surrounding my research topic. This chapter will conceptualise the needs of those who have a history of offending and/or those who have substance use issues over the course of their re-integration into the community by examining models underpinned by best practice guidelines and used by various jurisdictions. Over the last 25 years, there has been a growing body of research which has enabled a more structured approach based on actuarial models, which can predict re-offending and identify the issues and challenges faced by those who have offended which need to be addressed if they are to be given the best chance possible of successful re-integration back into society (Penal Reform International, 2016).

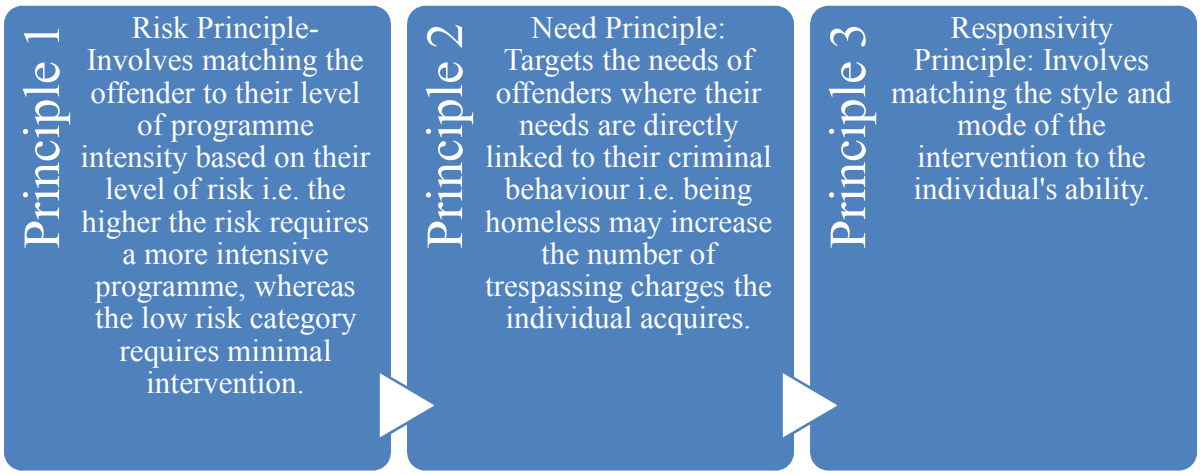
2.2 International Best Practice Re-Integration Models:

The re-integration of prisoners back into society poses a significant challenge to all nations of the world (Wartna and Nijssen, 2006). As of the 1st March 2018, there were 9,663 individuals on the probation caseload (The Probation Service, 2018). Of this figure, 8,155 individuals were on probation in the community while the remaining 1,508 individuals were on probation while in custody. Of the individuals on probation in the community, 1,213 of these were on supervision. In essence, all of the individuals who have engaged in offending behaviours have some need for re-integration back into their communities and families. This section will explore three international best practice re-integration models; the Risk, Need, Responsivity Model, the Good Lives Model and the Restorative Justice Model.

2.2.1 The Risk, Need, Responsivity Model (RNR):

The Risk, Need, Responsivity Model (RNR) is widely recognised as the primary model in offender assessment and treatment in the United Kingdom, Canada, Australia and New Zealand (Ward and Brown, 2004). Components of this model are used by the Probation Service in Ireland, however it is not officially recognised as the primary model. The RNR model is based on three key principles (see figure 3 below) (Andrews et al, 1990).

Figure 3: Principles of the RNR Model



The RNR model systematically assesses the offender's risk, their criminogenic needs and their responsivity factors (Andrews et al, 2008). Criminogenic needs are needs such as substance use and homelessness that increase an individual's probability of engaging in criminal behaviour. The basic assumption underlying the responsivity principle is that offenders are not all the same, for example, people have individual intelligences, communication styles and emotionalities. These characteristics also influence how offenders respond to efforts to change their behaviour, thoughts and attitudes. Responsivity factors are simply individual attributes that affect the achievement of treatment goals (Andrews and Bonta, 1994). Interventions designed for offenders and that adhere to the RNR principles correlate with large reductions in recidivism rates. Bonta et al (2000) conducted a study and concluded that high risk offenders who did not receive any intensive treatment services had a recidivism rate of 51% but the high risk offenders who did receive intensive RNR services had almost half the recidivism rate at 32%. Interventions that do not adhere to the RNR principles result in minimal changes in recidivism rates and at times can even increase recidivism rates (Andrews and Bonta, 2010).

The RNR Model has had a huge influence on offender theory, policy and practice (Ward et al, 2007). Ward and Stewart (2003, p.142) criticized the concept of criminogenic needs for ignoring more basic human needs that underlie optimal personal fulfilment. They argued that attaining the basic goods of "friendship, enjoyable work, loving relationships, creative pursuits, sexual satisfaction, positive self-regard, and an intellectually challenging environment" should be the primary goals for offender rehabilitation. They believed that if these basic goods were achieved, a reduction in criminogenic needs would follow.

Overall, the overarching principles of RNR Model are respect for the client and crime prevention work with the client, their family and their community. This respect for the client is derived from Carl Roger's (1961) person-centred theory. Meta-evaluation studies have considered the quality of the relationship between the worker and client as a factor relevant to psychologically informed treatment (Dowden and Andrews, 2004). Recent research is very favourable to the RNR approach, wherein multiwave longitudinal studies have concluded that a bonus of desistance from crime is the subsequent enhancement of success in other areas of life (Farrington et al, 2006). The national average recidivism rate in the United Kingdom is 60%. A pilot programme conducted in Hull, UK and based on the RNR model proves that it is very successful when individuals engage with the programme and address their criminogenic needs (Davies et al, 2010). This pilot programme specifically addresses the need for employment, accommodation and education. The participants met their key worker based on the risk they posed to the community. Of the participants that successfully completed the programme the recidivism rate was only 17% and 29% for all clients who engaged with the programme. Of the 36% who were assisted with education and employment, only 24% reoffended (Davies et al, 2010). This is a significant reduction given the national re-offending rate is 60%. A criticism of the RNR model is that it conveys that it has an attitude that "offenders are outsiders, moral strangers who do not merit any empathy or concern and therefore whose interests are of peripheral concern when designing intervention programs" (Ward, 2007, p. 12). According to Ward and Willis (2010, p. 405), another criticism is that the RNR model holds a certain level of "ethical blindness" in ignoring the treatment of low-risk offenders.

The Good Lives Model (discussed below) criticises the RNR model as it states that the RNR model:

- pays insufficient attention to human agency (Ward et al, 2007, p. 210);
- minimizes the role of behaviour motivation (Ward et al, 2006, p. 270);
- provides "a narrow view of human nature" (Ward and Marshall, 2007, p. 283);
- "downplays the relevance of contextual or ecological factors" (Ward et al, 2007, p. 210) and;
- favours "one size fits all" (Ward and Maruna, 2007, p. 23).

2.2.2 The Good Lives Model (GLM):

The Good Lives Model (GLM) was published by Tony Ward in 2002 is considered an enhancement to the Risk, Need, Responsivity Model (Ward and Gannon, 2006). This model is not used in Ireland, however it is used in Canada, Australia, New Zealand and the United Kingdom. The GLM is a strengths-based model with a particular emphasis on a restorative model of rehabilitation (Andrews et al, 2011). The GLM places great emphasis on personal fulfilment as it believes that this will lead to a natural and gradual reduction in criminogenic needs. GLM owes much to strain theory (Merton, 1957). Strain theories state that certain strains or stressors increase the likelihood of crime, for example unemployment. These strains lead to negative emotions, such as anger. These emotions create pressure for corrective action, and crime is one possible response. Strain theory describes the particular strains most likely to lead to crime, why strains increase crime, and the factors that lead a person to or dissuade a person from responding to strains with crime (Joon Jang and Agnew, 2015). The GLM has been critiqued for weakness in theory (Ward et al, 2006). This model address four conceptual areas:

1. the question of whether to adopt a positive or negative (i.e. risk reduction) approach to treatment
2. the relationship between managing risk and promoting human goods
3. the question of causal preconditions for effective therapy or treatment readiness
4. and the impact of therapists' attitudes toward offenders on therapeutic engagement

According to Ward and Brown (2004) the list of nine primary human goods in the Good Lives Model are:

1. Life including healthy living, optimal physical functioning and sexual satisfaction
2. Knowledge
3. Excellence in play and work including mastery experiences
4. Excellence in agency i.e. autonomy and self-directedness
5. Inner peace i.e. freedom from emotional turmoil and stress
6. Relatedness including intimate, romantic and family relationships and community
7. Spirituality in the broad sense of finding meaning and purpose in life
8. Happiness
9. Creativity

GLM has now evolved to also include self-regulation (Yates and Ward, 2008). Research conducted by Emmons (1996) and Cummins (1996) concludes that primary goods are essential ingredients in good lives and as such result in higher levels of well-being. Deci and Ryan (2000), have produced research on the three psychological needs of autonomy, mastery, and relatedness and their importance for happiness and well-being.

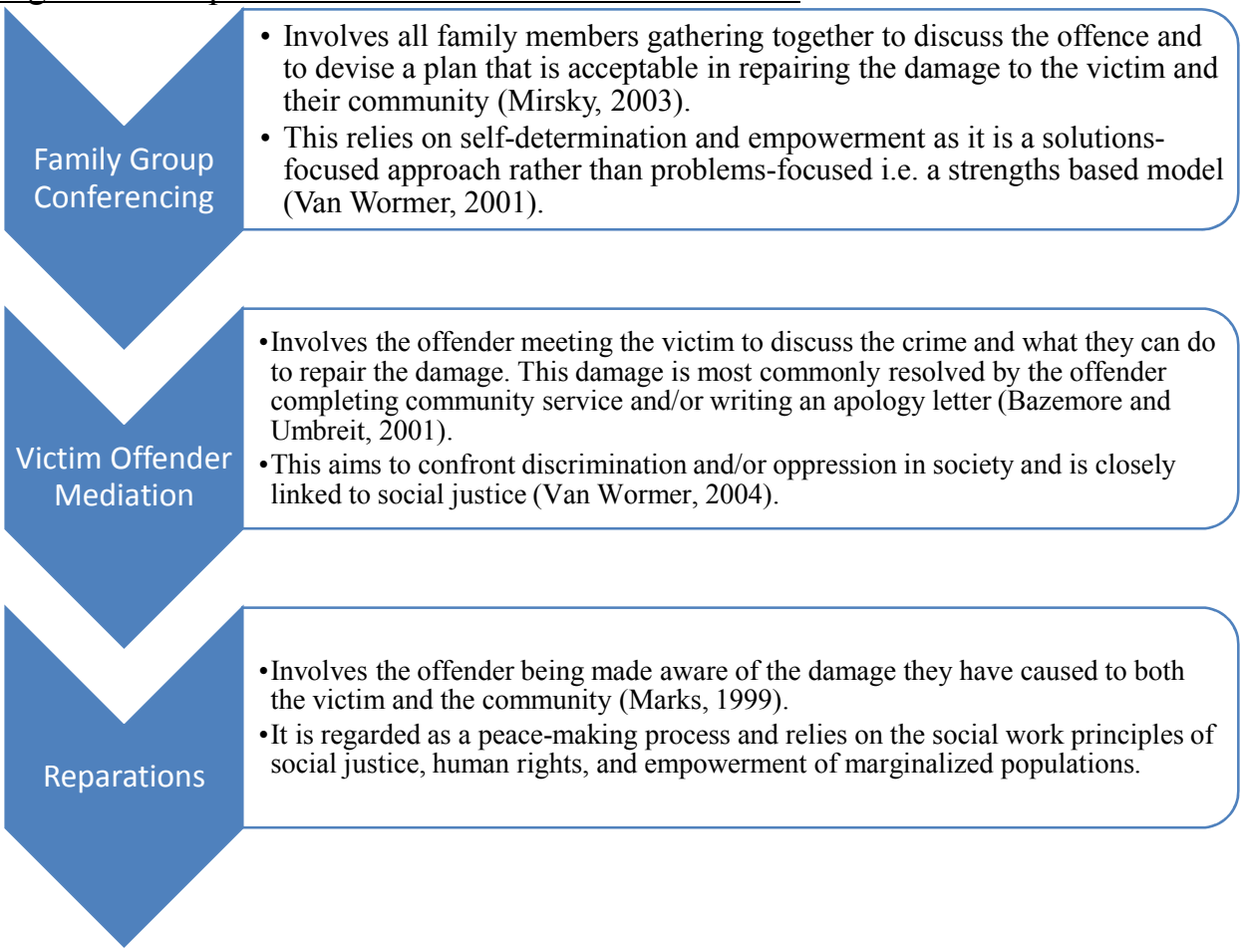
The Risk, Need, Responsivity Model is said to emphasize deficits (i.e. criminogenic needs) and the Good Lives Model emphasizes strengths (i.e. primary goods). The GLM underestimates the serious possibility of criminogenic effects while the pursuit of well-being does not address an individualized understanding of the major causes of crime.

2.2.3 The Restorative Justice Model (RJM):

The Restorative Justice Model (RJM) is a model for personal and societal empowerment and is also a strengths-based approach (Saleebey, 2002). It is widely used in Scandinavian countries such as Norway. Norway has one of the lowest recidivism rates at just 14% and research proves that offenders normally desist from crime after their first offence (Fazel and Wolf, 2015). It focuses on the crime committed and what can be done to repair the damage caused to the community as a result of the crime rather than focusing on punishment (Van Wormer, 2004).

At the core of restorative justice is communication, honesty, personal empowerment, and healing by all parties to the wrong doing. Restorative justice condemns the criminal act but not the offender rather holds the offender accountable to the community (Umbreit, 2000). There are three components to the Restorative Justice Model, as outlined in figure 4.

Figure 4: Components of the Restorative Justice Model



Research conducted by Bazemore and Umbreit (1998) in Vermont, USA concludes that over 80% of the offenders who have participated in the mediation process have completed it successfully and that they are less likely to reoffend, resulting in a reduction in recidivism rates. Morris (2000) and Zehr (2001) conducted interviews with victims and offenders in Canada on victim satisfaction and these interviews proved that restorative justice is extremely effective for both the victim and offender.

2.3 Conclusion:

To conclude, this chapter examined three international models underpinned by best practice guidelines and used by various jurisdictions to promote the re-integration of individuals who engage in offending behaviours. The next chapter, chapter three, will explore what is meant by Community Reinforcement Approach (CRA) in the context of professional work with those who have offending behaviours.

Chapter Three: Community Reinforcement Approach

3.1 Introduction:

This chapter will present and analyse the secondary research findings gathered from undertaking a narrative literature review on the Community Reinforcement Approach (CRA). Firstly, it will discuss in detail the CRA in the context of professional work with those who have offending behaviours and/or substance use issues. The chapter will then examine how effective this approach is in supporting individuals re-integrating back into their communities after engaging in offending behaviour and/or substance use, in particular alcohol, opiate and cocaine use. To conclude, the chapter will examine both the benefits and limitations of the CRA.

3.2 What is the Community Reinforcement Approach:

The Community Reinforcement Approach (CRA) is a biopsychosocial approach and a behavioural programme for treating substance use issues (Roozen et al, 2004). It is based on the idea that an individual's environment can and does play a powerful role in encouraging or discouraging substance use. As a result, CRA utilises social, recreational, familial, and vocational re-enforcers to assist clients in the recovery process. Its goal is to make a drug and alcohol free lifestyle more rewarding than a substance use lifestyle (Schottenfield et al, 2000). There are eight components in the CRA, of which the assessment and treatment planning components are essential, as outlined in figure 5.

Figure 5: Features of the CRA

3.2.1 Functional Analysis:

Functional analysis is an assessment method for identifying the framework in which substance using behaviour occurs. It involves the client listing their triggers i.e. the external (people, places, times) and internal (thoughts, feelings), that they associate with substance use. Next, the client lists the positive and negative consequences of engaging in drug use. The overall objective of the functional analysis is to lay the foundation for a plan that will eventually help the client access psychological and environmental conditions which reinforce sobriety and discourage substance use (Azrin, 1976; Hunt and Azrin, 1973).

3.2.2 Sobriety Sampling:

This occurs when the worker and client engage in a gentle negotiation process for a time-limited period of sobriety i.e. the client will not use any substances for the next three days (Azrin et al., 1982).

During this period of abstinence, the necessary behavioural skills are taught and the reinforcing aspects of a drug-free lifestyle are emphasized to the client (Azrin, 1976; Meyers and Smith, 1995). At the conclusion of the agreed-upon substance free period, the benefits of extending the period are discussed (Smith and Meyers, 2001).

3.2.3 CRA Treatment Plan:

The treatment plan is structured using The Happiness Scale and The Goals of Counselling Framework. The Happiness Scale is a brief evaluation of satisfaction in 10 areas of a person's life (e.g. job, personal habits, relationships). Based on the results of this assessment, the client and worker work together to select areas on which to focus (Meyers and Smith, 1995). The Goals of Counselling sets out the plans of the areas to focus on and the plans for accomplishing them ensuring they are brief, realistic, specific, and measurable (Smith and Meyers, 2001).

3.2.4 Behavioural Skills Training:

Behavioural skills training includes problem solving, communication and drink and/or drug refusal training. The problem solving skills training is D'Zurilla and Goldfried's (1971) seven-step structured approach to solving problems. The objective is to teach clients to break down a problem into manageable pieces, to systematically arrive at a reasonable plan, and to evaluate the outcome. Communication skills training is a simplified approach taught to assertively enable clients to discuss difficult issues without them becoming overly defensive. It involves teaching the client how to discuss thoughts and feelings, for example, be specific, label your feelings, give an understanding statement, accept partial responsibility. The drink and/or drug refusal training involves providing role-plays of assertive refusals to use substances. The situations selected for practice are often based on information about triggers from the client's functional analysis (Meyers and Smith, 1995, pp. 102–120).

3.2.5 Job Skills:

This aspect of CRA does not apply to all clients. Job skills focuses on helping clients to obtain and keep jobs but also focuses on assessing if the jobs are meeting the client's needs i.e. intellectually, socially and financially (Azrin and Besalel, 1980).

3.2.6 Social/Recreational Counselling:

Social and recreational counselling assists clients in identifying and trying new social activities while also addressing the common concerns about socialising while sober, and in dealing with the problem of having a social life that is dominated by individuals who drink or use drugs. Most of the CRA studies also have a Social Club, which is an alcohol-free place to meet recreationally that was available at high-risk times (e.g. at weekends and in the evenings). The objective was twofold: to help clients discover that life could be fun without substances, and to provide increased opportunities for clients to practice new social skills in a non-threatening, low-risk atmosphere (Hunt and Azrin, 1973; Mallams, et al, 1982).

3.2.7 Relapse Prevention:

Relapse prevention is a process that begins when the client undertakes the functional analysis assessment. It incorporates various behavioural skills that are practiced as needed, such as substance refusal and problem solving (Meyers and Smith, 1995, pp. 180–197).

3.2.8 Relationship Counselling:

Given the CRA goal of making a client's "community" more reinforcing, it is of huge importance to include the families of clients in at least several therapy sessions so that the relationship can be enhanced (Meyers and Smith, 1995). The Community Reinforcement Approach has also branched off and developed a new approach Community Reinforcement Approach and Family Training, CRAFT, designed to work with the loved ones of a treatment-refusing substance user. CRAFT is an intervention that works through a non-using individual i.e. a family member to affect the behaviour of a substance user (Sisson and Azrin, 1986).

3.3 Effectiveness of Community Reinforcement Approach Interventions:

There have been a number of randomised controlled trials to support the effectiveness of the Community Reinforcement Approach.

3.3.1 CRA Alcohol Interventions:

Hunt and Azrin (1973) conducted the first control study with inpatients who had issues with alcohol. They concluded that individuals randomly assigned to the CRA condition did significantly better than did the standard treatment group individuals during the first month after hospital discharge. Specifically, at the six month follow-up the CRA group individuals reported drinking only 14% of the follow-up days while the control group drank 79% of those days. A study conducted by Azrin et al (1982) on outpatients with alcohol issues also validated the effectiveness of the CRA. In this study, individuals were randomly assigned to one of three treatment conditions: traditional treatment (12-step counselling and a disulfiram prescription), antabuse assurance (12-step counselling and disulfiram compliance training) or CRA and antabuse assurance (CRA + disulfiram compliance training). Their findings indicated that there was an overall significant group difference in terms of days abstinent. The CRA and antabuse assurance group was abstinent an average of 97% of the 30 days, the antabuse assurance condition was abstinent 74% of the days, and traditional treatment averaged 45% of the days abstinent. An interesting finding of this study was that married participants had significantly higher abstinence rates than did single individuals, therefore emphasising the importance of "community" in remaining substance free.

3.3.2 CRA Opiate Interventions:

A randomised controlled trial was conducted by Bickel et al (1997). Individuals were randomly assigned to one of two groups: a group who received no CRA input and a group who were treated using the CRA. The results showed that after four weeks 55% of the individuals who received no CRA input were opiate free compared to 68% of the group who received the CRA input. When followed up at four months 5% of the individuals who received no CRA input were opiate free compared to 26% of the CRA group who were opiate free. A further follow up at six months indicated that 0% of the individuals who received no CRA input were opiate free compared to 11% of those in the CRA group who were opiate free. Abbot et al (1998) also conducted research on individuals with opiate use issues. They concluded that individuals in the CRA groups had an 89% probability of remaining three consecutive weeks free from opiates vs. individuals in the standard control group who had a probability of 78%.

3.3.3 CRA Cocaine Interventions:

Higgins et al (1991) are the only researchers to research the effectiveness of CRA cocaine interventions. They randomly assigned individuals to one of the following groups: usual care group i.e. with no CRA input and a group where the focus was on CRA. After four weeks, 77% in the CRA group remained cocaine free compared to 25% in the usual care group. A further follow up at 4 months showed that 46% of individuals in the CRA group remained cocaine free compared to 0% in the usual care group.

3.4 Strengths of the Community Reinforcement Approach:

There are many strengths of the CRA. One such strength is the universality of the approach. CRA can be used to treat clients with mild substance use disorders to those who have severe and chaotic substance use disorders, where the goal is to reduce one's substance use i.e. harm reduction or to stop using substances completely i.e. abstinence. It also works well in a range of treatment settings, for example inpatient, outpatients and day centre settings as well as both in urban and rural settings (Azrin, 1976; Azrin et al, 1982; Hunt and Azrin, 1973; Smith et al, 1998). Another strength is the flexibility of the approach. The various components of the CRA can be tailored to meet the needs of the individual clients i.e. the job seeking skills component may immediately benefit one who is seeking employment whereas the relationship counselling may benefit an individual who is attempting to address broken familial relationships as a result of substance use (Meyers et al, 2005).

3.5 Limitations of the Community Reinforcement Approach:

The Community Reinforcement Approach is a consistently highly ranked cognitive-behavioural substance use treatment that has been in existence for over 30 years and has a treatment manual available, yet it remains a largely underutilised treatment modality (Finney and Monahan, 1996; Meyers and Smith, 1995). As outlined in Miller and Meyers (2001), it is probably due to a combination of factors i.e. the limited CRA training opportunities and the belief of some clinicians that since they are already using a few cognitive or behavioural techniques they already are doing CRA.

Additionally, many substance use programs in the United States are unaccustomed to attributing much importance to the social context in which a substance use problem occurs, and consequently CRA's emphasis on social reinforcement contingencies is often not well regarded internationally. Since this is not the norm internationally, it is not surprising then that practitioners in countries such as Sweden, Germany and England often appear the most enthusiastic about CRA (Miller and Meyers, 2001).

3.6 Conclusion:

To conclude, this chapter examined in detail the Community Reinforcement Approach and its various components. The chapter then analysed the effectiveness of the CRA in treating substance use issues, with particular reference to alcohol, opiate and cocaine use.

It then detailed the benefits and the limitations of engaging with the CRA. The next chapter, chapter four, will explore Cognitive Behavioural Therapy (CBT) and the role that this plays in the Community Reinforcement Approach.

Chapter Four: Cognitive Behavioural Therapy

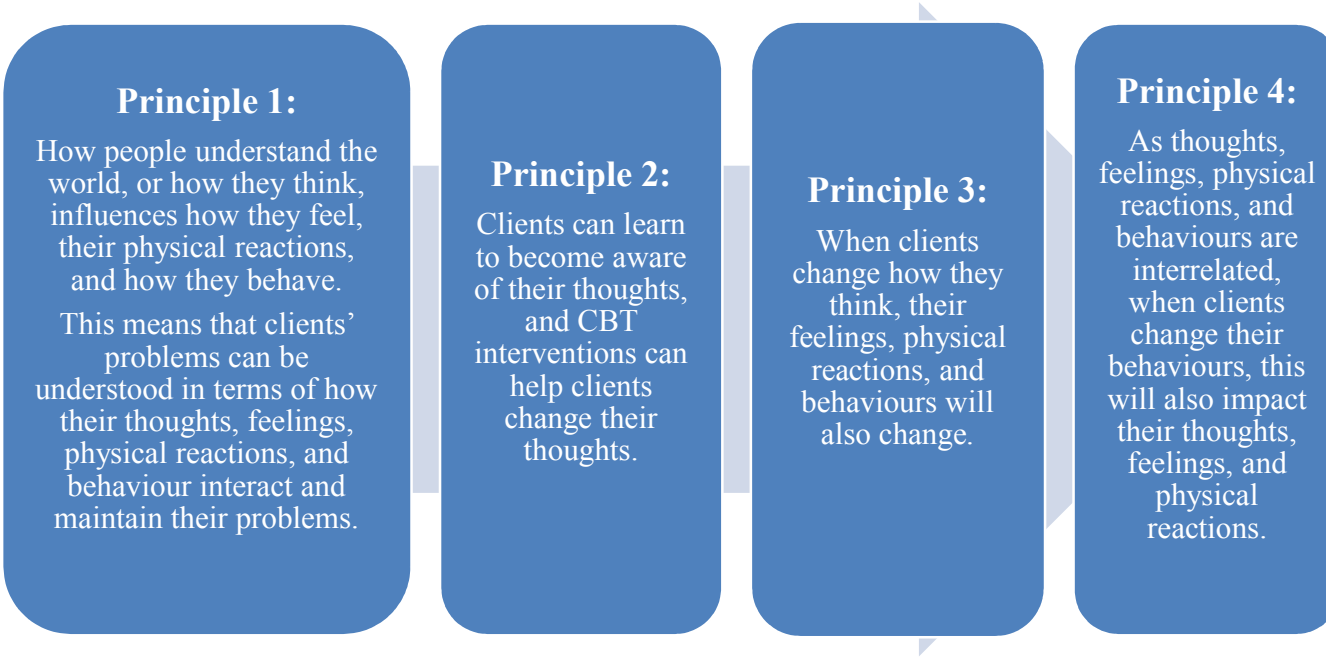
4.1 Introduction:

This chapter will present and analyse the secondary research findings gathered from undertaking a narrative literature review on Cognitive Behavioural Therapy (CBT). Firstly, it will discuss in detail CBT in the context of professional work with those who have offending behaviours and/or substance use issues. The chapter will then examine how effective this approach is in supporting individuals re-integrating back into their communities after engaging in offending behaviour and/or substance use. It will then examine both the benefits and limitations of CBT. To conclude, the chapter will discuss the role CBT plays in the Community Reinforcement Approach.

4.2 What is Cognitive Behavioural Therapy:

Cognitive Behavioural Therapy (CBT) is an evidence-based cognitive and behavioural approach to understanding and treating psychological problems, such as offending behaviours and substance use issues (Martin, 2015). It is a structured problem-focused and goal oriented therapy in which the client's goals are set in the beginning and addressed through a specified number of therapy sessions, with the active participation of the client throughout the counselling process (Josefowitz and Myran, 2017). An important goal of CBT is self-efficacy (Thomas and Drake, 2012). Self-efficacy is the belief in one's ability to master a situation and produce positive outcomes (Kowalski and Westen, 2008). CBT is based on four fundamental principles, as outlined in figure 6 (Beck, 2011).

Figure 6: CBT Principles



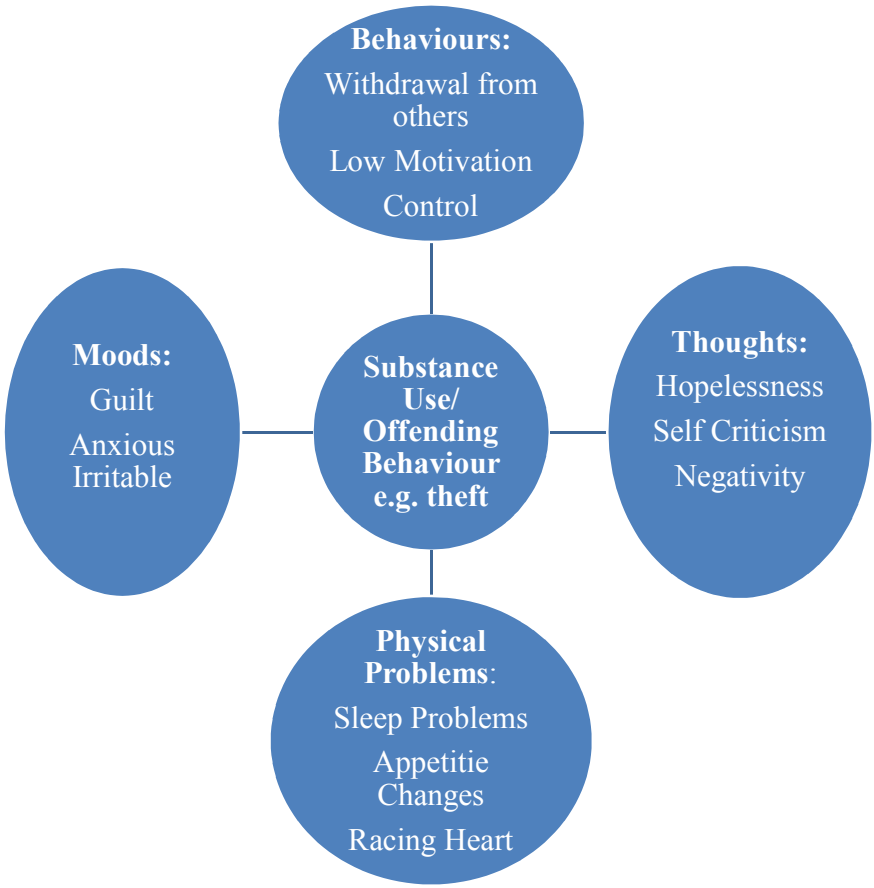
4.2.1 Five Part Model:

Figure 7: CBT Five Part Model

Padesky and Mooney (1990).

CBT examines the relationship between thoughts, behaviour, emotion, physiology and environment to understand the origin and nature of a client's problems. All five areas are interconnected, each influencing each other as shown above in figure 7 (Kennerley et al, 2011). The goal of CBT is to recognise and challenge automatic negative thoughts and self-defeating thoughts such as I cannot stop offending (see figure 8). This is achieved through record keeping i.e. the client records his/her thoughts during the week and homework is then assigned by the therapist in an attempt to address these negative thoughts and to activate and sustain a change in behaviour i.e. for the individual to reduce the number of times they use a substance within the week. CBT is based on the assumption that cognitive deficits and distortions characteristic of offenders are learned rather than genetic, therefore, programmes for offenders emphasize individual accountability and attempt to teach offenders to understand the thinking processes and choices that immediately preceded their criminal behaviour.

Figure 8: CBT Five Part Model Practice Example



4.3 Effectiveness of Cognitive Behavioural Therapy Interventions:

In the past fifty years, hundreds of studies have examined both the underlying theory as well as the effectiveness of CBT for adults (Beck and Dozois, 2011). Hofmann et al (2012) examined meta-analyses of the effectiveness of CBT. They found that while the research is stronger for some disorders than others, generally CBT has been found to be an effective therapy compared with a placebo or waiting list control group for a great variety of problems, including the use of alcohol and drugs.

4.3.1 CBT, Offending Behaviour and Recidivism:

A number of meta-analyses have been undertaken and have identified CBT as a particularly effective intervention for reducing the recidivism rate for adult offenders. Pearson et al (2002) for conducted a meta-analysis of 69 research studies covering both behavioural (e.g. contingency contracting and token economy) and cognitive-behavioural programmes. They found that the cognitive-behavioural programs were more effective in reducing the recidivism rate than the behavioural ones, with a mean recidivism reduction for treated groups of approximately thirty per cent. Another meta-analysis conducted by Wilson et al (2005) examined 20 studies of group-oriented cognitive behavioural programmes for offenders and found that CBT was very effective for reducing their criminal behaviour. They concluded that representative CBT programmes showed recidivism reductions of 20-30% compared to control groups. Lipsey et al (2001) conducted a meta analysis that examined 14 experimental and quasi-experimental studies that emphasised cognitive change as the defining condition of CBT and considered only effects for general offender samples while focusing on the recidivism rate as the treatment outcome. The results showed that offenders engaging in CBT were less likely to re-offend by 55% when compared with the control group. Landenberger and Lipsey (2005) then re-conducted the research and concluded again that the mean recidivism rate for the treatment groups was significantly lower than that of the control groups. Lipsey et al (2007) conducted a systematic review of the effectiveness of CBT on recidivism rates and their results correlated with the above findings. Their results concluded that those who received CBT were one and a half times less likely to re-offend in the post-intervention period of twelve months when compared to individuals in the control group who received no CBT input.

4.3.2 CBT and Substance Use:

CBT for substance use disorders has demonstrated efficacy as both a single therapy and as part of a combination of treatment strategies (Magill and Ray, 2009). McHugh et al (2010) conducted a meta-analytic review of CBT for drug abuse and dependence which included 34 randomised controlled trials and 2,340 participants. The study found that larger treatment effect sizes were found for treatment of cannabis, followed by treatments for cocaine, opioids, and with the smallest effect sizes, poly-substance dependence. This implies that CBT is effective for treating substance use disorders, however its effectiveness is reduced when treating poly-substance use disorders i.e. one or more drug issues. Magill and Ray (2009) also conducted a meta analyses and yielded the same results. CBT has been proven to have long term effects in relation to substance use. Rawson et al (2002) conducted a study and they reported that 60% of individuals in the CBT group provided clean toxicology screens at a 52-week follow-up.

4.3.3 CBT, Substance Use and Offending Behaviour:

Easton et al (2017) conducted a study to examine if CBT is effective in reducing substance use and offending behaviour as a joint intervention. There were sixty-three male participants, all of whom were arrested for partner violence within the past year. They were randomly assigned to one of two groups: a cognitive behavioural substance abuse-domestic violence programme or a drug counselling condition. Seventy percent of offenders completed eight core sessions with no differences between either groups in the amount of substance use or aggression at pre-treatment. The participants in the CBT group had fewer cocaine-positive toxicology results and breathalyser results during treatment, were less likely to engage in aggressive behaviour in close proximity to a drinking episode, and reported fewer episodes of violence than the participants in the drug counselling group at post-treatment follow-up. This study indicates that offenders with substance use issues who received CBT as a joint intervention were less likely to re-offend and relapse into substance use when compared to individuals in the drug counselling group.

4.4 Strengths of Cognitive Behavioural Therapy:

There are a number of strengths in CBT. The efficacy of CBT has been validated empirically which has concluded that the results for CBT in treating difficult issues such as panic and phobias are superior when compared to other forms of therapy i.e. psychotherapy. Hollon et al (2005) and Marlatt and Gordon (1994) state that CBT can be as effective as medication in treating some mental health disorders and that those who engaged in CBT were less likely to relapse. CBT is transparent and works in partnership with the client. The client is informed of the theoretical concepts and actively participates in identifying the problems, modifying their belief systems and changing their behaviours. The client's changes are noted, recorded and measured and this provides a sense of empowerment for the individual (Lehmann and Coady 2001).

4.5 Limitations of Cognitive Behavioural Therapy:

CBT, like any other form of therapy, is dependent on the therapist providing the therapy and/or their training. For example, a novice therapist may adhere to strictly following the CBT techniques with the result that he/she ignores the importance of establishing a therapeutic relationship with the client (Kendall and Hollon, 1979). Another limitation of CBT is that it is a time-limited intervention, with an average of six to eight sessions. This amount of time may not be sufficient to adequately address the long history that many clients of offending behaviours and/or substance use may experience, therefore resulting in only short-term success (Martin, 1993).

4.6 The Role of Cognitive Behavioural Therapy in the Community Reinforcement Approach:

The Community Reinforcement Approach is based on the principles of Cognitive Behavioural Therapy. One of the components of the CRA is behavioural skills training and this is based on CBT. CRA is model for treating substance use issues. Its behavioural skills component is based on the CBT Model as it begins with the client defining the problem and brainstorming a number of possible solutions.

The client then selects one potential solution, outlines the manner in which they will undertake it and how they plan to addresses anticipated obstacles and barriers. Finally, the client commits to attempting the solution during the week, referred to as homework in CBT, and the therapist reviews their work and outcome at the next session. As can be seen from the above, CBT is a key component in the CRA.

4.7 Conclusion:

To conclude, this chapter examined in detail Cognitive Behavioural Therapy and its key principles. The chapter then analysed the effectiveness of CBT with particular reference to offending behaviour and recidivism, substance use while also examining offending behaviour and substance use as a joint intervention. It then detailed the benefits and the limitations of CBT. The next chapter, chapter five, will be the concluding chapter and will examine the conclusions and recommendations of this study.

Chapter Five: Conclusions and Recommendations

5.1 Introduction:

Using the data acquired through secondary research, this closing chapter draws on the research questions set out in the introduction chapter. This chapter will briefly outline a number of recommendations for the Churchfield Community Trust. The implications for social work practice will then be discussed with particular reference to criminal justice and substance use practice. This chapter concludes with a reflective piece, detailing my reflections on the process of engaging in a community-based research project in collaboration with CARL and the Churchfield Community Trust.

5.2 Concluding Comments:

This study set out to explore two models i.e. the Community Reinforcement Approach and Cognitive Behavioural Therapy that are used when working with those who have offending behaviours and/or substance use issues. Having conducted the research and completed an extensive review of the literature, there were a number of key findings.

5.2.1 Research Question 1- What is meant by Community Reinforcement Approach (CRA) in the context of professional work with those who have offending behaviours and how effective are these approaches in supporting re-integration?

The Community Reinforcement Approach (CRA) is a biopsychosocial approach and a behavioural programme for treating substance use issues (Roozen et al, 2004). CRA utilises social, recreational, familial, and vocational re-enforcers to assist clients in the recovery process. Its goal is to make a drug and alcohol free lifestyle more rewarding than a substance use lifestyle (Schottenfield et al, 2000). There are eight components in the CRA; functional analysis, sobriety sampling, treatment plan, behavioural skills training, job skills, social and/or recreational counselling, relapse prevention and relationship counselling.

There have been a number of randomised controlled trials to support the effectiveness of the Community Reinforcement Approach in supporting abstinence and re-integration of substance users back into their communities. A study conducted by Azrin et al (1982) on outpatients with alcohol issues validated the effectiveness of the CRA in supporting re-integration with the CRA and antabuse assurance group remaining abstinent an average of 97% of the 30 days. Abbot et al (1998) conducted research on individuals with opiate use issues. They concluded that individuals in the CRA groups had an 89% probability of remaining three consecutive weeks free from opiates versus individuals in the standard control group who had a probability of 78%. Higgins et al (1991) researched the effectiveness of CRA cocaine interventions. After four weeks, 77% in the CRA group remained cocaine free compared to 25% in the usual care group. A further follow up at 4 months showed that 46% of individuals in the CRA group remained cocaine free compared to 0% in the usual care group. These randomised controlled trials provide evidence that the Community Reinforcement Approach is an effective intervention in supporting the re-integration of those who have substance use issues and/or offending issues.

5.2.2 Research Question 2- How can a Cognitive Behavioural Therapy (CBT) approach assist in desistance work and re-integration with those who have offending behaviours and/or who have alcohol and/or drug issues?

Cognitive Behavioural Therapy is a structured problem-focused and goal oriented therapy in which the client's goals are set in the beginning and addressed through a specified number of therapy sessions, with the active participation of the client throughout the counselling process (Josefowitz and Myran, 2017). CBT is based on four fundamental principles (Beck, 2011). The first principle involves understanding that how people understand the world, or how they think, influences how they feel, their physical reactions, and how they behave. This means that clients' problems can be understood in terms of how their thoughts, feelings, physical reactions, and behaviour interact and maintain their problems. The next principle involves clients learning to become aware of their thoughts, and CBT interventions can help clients change their thoughts. The third principle states that when clients change how they think, their feelings, physical reactions, and behaviours will also change.

The final principle discusses that as thoughts, feelings, physical reactions, and behaviours are interrelated, when clients change their behaviours, this will also impact their thoughts, feelings, and physical reactions.

In the past fifty years, hundreds of studies have examined both the underlying theory as well as the effectiveness of CBT for adults (Beck and Dozois, 2011). Wilson et al (2005) examined 20 studies of group-oriented cognitive behavioural programmes for offenders and found that CBT was very effective for reducing their criminal behaviour. They concluded that representative CBT programmes showed recidivism reductions of 20-30% compared to control groups. Rawson et al (2002) conducted a study on those who had substance use issues and they reported that 60% of individuals in the CBT group provided clean toxicology screens at a 52-week follow-up. Easton et al (2017) conducted a study to examine if CBT is effective in reducing substance use and offending behaviour as a joint intervention. The results showed that participants in the CBT group had fewer cocaine-positive toxicology results and breathalyser results during treatment, were less likely to engage in aggressive behaviour in close proximity to a drinking episode, and reported fewer episodes of violence than the participants in the drug counselling group at post-treatment follow-up. This study indicates that offenders with substance use issues who received CBT as a joint intervention were less likely to re-offend and relapse into substance use when compared to individuals in the drug counselling group. The above meta analyses indicate that CBT is an effective intervention in supporting re-integration with those who have offending issues, substance use issues and offending issues as well as substance use issues.

5.2.3 Research Question 3- What role can CBT play in CRA to work with individuals who have offending behaviours who have alcohol and drug issues also?

The Community Reinforcement Approach is based on the principles of Cognitive Behavioural Therapy. One of the components of the CRA is behavioural skills training and this is based on CBT.

5.3 Research Recommendations:

5.3.1 Researcher's Recommendations:

This was a follow on research study from the CARL group research study that was conducted last year. A finding of the study last year stated that a number of participants spoke about the positive influence their peers had on both their recovery and their ability to desist from crime. This finding is very much in keeping with the Community Reinforcement Approach as it utilises social, recreational, familial, and vocational re-enforcers to assist clients in the recovery and re-integration process. As such, it is recommended that all staff in the Churchfield Community Trust receive training in the CRA as it has been highlighted as an important factor by the CCT participants and the international literature review.

There appears to be a direct correlation between substance use and offending behaviour. As outlined in chapter four, Cognitive Behavioural Therapy is an effective intervention in supporting re-integration with those who have offending issues, substance use issues and offending issues as well as substance use issues. The researcher therefore recommends that CCT select a staff member to undertake CBT training and for this staff member to be designated as the CBT therapist who will manage a caseload of clients. An alternative would be that the CCT employ a CBT therapist from outside the agency to provide an external specialised CBT service to the CCT clients.

Lastly, it is evident from the research findings that the relationship between the client and worker is a fundamental asset in initiating positive change. Therefore it is vital that all staff receive training in the Servol philosophy which sets out CCT's mission statement and values and underpins their daily practice.

5.3.2 Implications for Social Work Practice:

This research serves as a source of information on the CRA and CBT, as well as an overview of international criminal justice models. This research is significant to social work practice as it provides an overview of the CRA and CBT, as well as identifying gaps in the service delivery for social workers and other professionals who work on behalf of individuals who have offending behaviours and/or substance use issues in CCT.

Finally, this research exemplified the positive outcomes of continuous professional development within the social work profession and the importance of relationship building, all of which are of fundamental importance to professional development in social work practice.

5.3.3 Further Research Opportunities:

The findings of this research study suggest that many family members play a key role in supporting an individual's recovery and re-integration back into their community. Further research on this would be beneficial to influence evidence based practice when offering family support to CCT clients.

5.4 Research Limitations:

The two main limitations to this project was the restrictive nature of the time frame and the word count. Due to these restrictions, more in depth research of the effects of different interventions such as Motivational Interviewing (MI) and Family Therapy could not be explored and had to be limited to Cognitive Behavioural Therapy and the Community Reinforcement Approach. Even within this search filter, restraint had to be exercised as numerous interesting topics arose such as the effect of offending behaviours and substance use on wider family relationships but could not be included. Due to time constraints, it was only viable to complete a small-scale international study. While initially the researcher had hoped to conduct an international systematic review, this was not possible due to time constraints and instead a narrative review was undertaken.

5.5 Reflective Piece:

This research process begun with me wanting to broaden my understanding of criminal justice practice in social work after completing my first year placement with the Probation Service. The experience of undertaking the research has influenced my personal and professional understanding of criminal justice and substance use social work and the importance of the worker-client relationship and continuous professional development. This is something I will take with me as I enter the social work profession and throughout my personal life experiences; the importance of unconditional positive regard for all individuals.

I initially felt great excitement coupled with anxiety towards undertaking a research dissertation, however I now feel an enormous sense of achievement upon completion of this research project. This research was an important learning experience for me. I have gained invaluable experience in the process of secondary research and undertaking database searches. In particular, my skills in identifying high quality research have immensely improved such as utilising randomised controlled trials, systematic reviews and meta analyses over un-reputable research. As with any research, there were challenges associated with this research project. I am extremely grateful to have undertaken my research with a community organisation, however, that led to feelings of pressure to undertake research in a way that the CCT would be happy with. However, through communication with the CCT designated liaison person, he was aware of the time restrictions in which this research had to be conducted. If I was to undertake this research again, I would designate more time to the completion of searching the literature. I had the opportunity to work in partnership with CCT and I was given insight into the valuable work they complete with vulnerable clients which will be of huge value to me in my future social work career.

Having carried out the research as part of the CARL initiative, I was given the opportunity to carry out social research in partnership with a community organisation working in the field of substance use and criminal justice practice. My work with the CCT has highlighted the worker's aspirations to improve on their skills, to ultimately deliver the best service they can to the clients they work with. I hope that I will carry forward these social justice principles to my future social work practice. I hope that the research carried out is an informative read for the CCT, and can assist them in continuing to expand and develop their service in line with best practice international guidelines.

5.6 Conclusion:

This CARL research study set out to explore international criminal justice models and two treatment models; Community Reinforcement Approach and Cognitive Behavioural Therapy. The subsequent findings highlighted the factors that contributed to the effectiveness of these interventions when working with individuals who have offending behaviours and/or substance use issues. It is hoped that this research study will assist Churchfield Community Trust in informing their future practice.

Reference List

Abbott, P. J., Weller, S. B., Delaney, H. D. and Moore, B. A. (1998). Community Reinforcement Approach in the Treatment of Opiate Addicts. *American Journal of Drug and Alcohol Abuse*, 24 (1), pp. 17–30.

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders.* 5th Edition. Washington: American Psychiatric Association.

Andrews, D. A. and Bonta, J. (2010). Rehabilitating Criminal Justice Policy and Practice. *Psychology, Public Policy and Law*, 16 (3), pp. 39-55.

Andrews, D. A. and Bonta, I. (1994). *The Psychology of Criminal Conduct*. Cincinnati: Anderson.

Andrews, D. A., Bonta, J. and Hoge, R. D. (1990). Classification for Effective Rehabilitation: Rediscovering Psychology. *Criminal Justice and Behaviour*, 17 (2), pp. 19-52.

Andrews, D. A., Bonta, J. and Wormith, J. S. (2011). The Risk, Need, Responsivity (RNR) Model: Does Adding the Good Lives Model Contribute to Effective Crime Prevention? *Criminal Justice and Behaviour,* 38 (7), pp. 735-755.

Andrews, D. A., Bonta, J. and Wormith, S. J. (2008). The Level of Service/Risk-Need-Responsivity (LS/RNR). Canada: Multi-Health Systems.

Azrin, N. H. (1976). Improvements in the Community Reinforcement Approach to Alcoholism. *Behaviour Research and Therapy.* 14 (5), pp. 339–348.

Azrin, N. and Besalel, V. (1980). *Job Club Counsellor's Manual.* Baltimore: University Press.

Azrin, N. H., Sisson, R. W., Meyers, R. and Godley, M. (1982). Alcoholism Treatment by Disulfiram and Community Reinforcement Therapy. *Journal of Behaviour Therapy and Experimental Psychiatry,* 13 (2), pp. 105–112.

Bazemore, G. and Umbreit, M. (1998). Balancing the Response to Youth Crime: Prospects for a Restorative Juvenile Justice in the Twenty-First Century. In A. Roberts (Ed.), Juvenile justice: Policies, Programs, and Service, pp. 371-408. Belmont: Wadsworth.

Bazemore, G. and Umbreit, M. (2001). A Comparison of Four Restorative Conferencing Models- Juvenile Justice Bulletin. Washington: U.S. Department of Justice.

Beck, A. T. and Dozois, A. J. (2011). Cognitive Therapy: Current Status and Future Directions. *Annual Review of Medicine,* 62 (1), pp. 397-409.

Beck, J. S. (2011). *Cognitive Behaviour Therapy: Basics and Beyond.* 2nd Edition. New York: The Guilford Press.

Bickel, W. K., Amass, L., Higgins, S. T., Badger, G. J. and Esch, R. A. (1997). Effects of Adding Behavioural Treatment to Opioid Detoxification with Buprenorphine. *Journal of Consulting and Clinical Psychology*, 65 (1), pp. 803–810.

Bonta, J., Wallace-Capretta, S. and Rooney, R. (2000). A Quasi-Experimental Evaluation of an Intensive Rehabilitation Supervision Program. Criminal Justice and Behaviour, 27 (1), pp. 312-329.

Carey, M. (2009). *The Social Work Dissertation: Using Small Scale Qualitative Methodology*. New York: Open University Press.

Central Statistics Office. (2008). *Irish Crime Classification System (ICCS)*. Dublin: Central Statistics Office.

Clark, C. L. (2000). *Social Work Ethics: Politics, Principles and Practice.* London: Macmillan Press.

Cooper, H. M. (1998). *Synthesising Research: A Guide for Literature Reviews.* London: Sage Publications.

Cummins, R. A. (1996). The Domains of Life Satisfaction: An Attempt to Order Chaos. *Social Indicators Research* , 38, pp. 303- 328.

Davies, B., Green, S. and Johnston, H. (2010). Report on the Goodwin Development Trust's-Preventing Re-Offending through Employment. Hull: University of Hull.

Deci, E. L., and Ryan, R. M. (2000). The "What" and "Why" of Goal Pursuits: Human Needs and the Self-Determination of Behaviour. *Psychological Inquiry*, 11, pp. 227-268.

Department of Justice and Equality. (2011). *White Paper on Crime: The Community and the Criminal Justice System.* Dublin: Department of Justice and Equality.

Dowden, C. and Andrews, D. A. (2004). The Importance of Staff Practices in Delivering Effective Correctional Treatment: A Meta-Analysis of Core Correctional Practices. *International Journal of Offender Therapy and Comparative Criminology,* 48, pp. 203-214.

Drummond, A., Codd, M., Donnelly, N., McCausland, D., Mehegan, J., Daly, L. and Kellehar, C. (2014). *Study on the Prevalence of Drug Use, Including Intravenous Drug Use, and Blood-Borne Viruses among the Irish Prisoner Population*. Dublin: National Advisory Committee on Drugs and Alcohol.

Duncan, G. J., Yeung, W. J., Brooks-Gunn, J. and Smith, J. R. (1998). How Much Does Poverty Affect the Life Chances of Children? *American Sociological Review,* 63 (3), pp. 406-423.

D'Zurilla, T. J. and Goldfried, M. R. (1971). Problem Solving and Behaviour Modification. *Journal of Abnormal Psychology*, 78 (1), pp. 107–126.

Easton, C. J., Crane, C. A. and Mandel, D. (2017). A Randomized Controlled Trial Assessing the Efficacy of Cognitive Behavioural Therapy for Substance-Dependent Domestic Violence Offenders: An Integrated Substance Abuse-Domestic Violence Treatment Approach (SADV). *Drug and Alcohol Review,* 36 (1), pp. 24-33.

Emmons, R. A. (1996). Striving and Feeling: Personal Goals and Subjective Well-Being. In P. M. Gollwitzer and J. A. Bargh (Eds.). The Psychology of Action: Linking Cognition and Motivation to Behaviour. New York: Guilford Press.

Farrington, D. P., Coid, J. W., Harnett, L., Jollife, D., Soteriou, N., Turner, R. and West, D. J. (2006). *Criminal Careers up to age 50 and Life Success up to age 48: New findings from the Cambridge Study in Delinquent Development (Home Office Research Study 299)*. London: HMSO.

Fazel, S. and Wolf, A. (2015). A Systematic Review of Criminal Recidivism Rates Worldwide: Current Difficulties and Recommendations for Best Practice. *PLos One*, 10 (6).

Finney, J. W. and Monahan, S. C. (1996). The Cost-Effectiveness of Treatment for Alcoholism: A Second Approximation. *Journal of Studies on Alcohol*, 57 (1), pp. 229–243.

Fox, S. (2007). *Relating to Clients: The Therapeutic Relationship for Complementary Therapists*. London: Jessica Kingsley Publishers.

Foster, V. L. (2007). The Art of Empathy: Employing the Arts in Social Inquiry with Poor Working-Class Women. *Social Justice,* 34 (1), pp. 12-27.

Gergen, K. J. (1999). *An Invitation to Social Construction.* London: Sage Publications.

Gergen, K.J. and Davis, K.E. (1985). *The Social Construction of the Person*. New York: Springer-Verlag.

Gray, D. E. (2004). *Doing Research in the Real World.* London: Sage Publications.

Guba, E. and Lincoln, Y. (2005). Paradigmatic Controversies, Contradictions and Emerging Confluences. In: N. Denzin and Y. Lincoln, ed., *The Sage Handbook of Qualitative Research*, 3rd ed. California: Sage Publications.

Henry, S. and Lanier, M. M. (2001). *What is Crime? Controversies over the Nature of Crime and What to do About It.* New York: Rowman and Littlefield Publishers.

Higgins, S. T., Delaney, D. D., Budney, A. J., Bickel, W. K., Hughes, J. R. and Foerg, F. (1991). A Behavioural Approach to Achieving Initial Cocaine Abstinence. *American Journal of Psychiatry*, 148 (1), pp. 1218–1224.

Hjalmarsson, R. and Lindquist, M. J. (2012). Like Godfather, Like Son- Exploring the Intergenerational Nature of Crime. *The Journal of Human Resources,* 47 (2), pp. 550-582.

Hofmann, S.G., Asnaani, A., Vonk, I.J.J., Sawyer, A.T. and Fang, A. (2012). The Efficacy of Cognitive Behavioural Therapy: A Review of the Meta-Analyses. *Cognitive Therapy and Research,* 36 (5), pp. 427-440.

Hollon, S. D., DeRubeis, R. J., Shelton, R. C., Amsterdam, J. D. and Salomon, R. M. (2005). Prevention of Relapse following Cognitive Therapy Versus Medications in Moderate to Severe Depression. Archives of General Psychiatry, 62 (1), pp. 417– 22.

Holloway, I. (1997). *Basic Concepts for Qualitative Research.* Oxford: Blackwell Science.

Hunt, G. M., Azrin, N. H. (1973). A Community Reinforcement Approach to Alcoholism. *Behaviour Research and Therapy*, 11 (1), pp. 91–104.

Joon Jang, S. and Agnew, R. (2015). *International Encyclopaedia of The Social and Behavioural Sciences*. 2nd Edition. The Netherlands: Elsevier.

Josefowitz, N. and Myran, D. (2017). *CBT Made Simple: A Practical Guide to Learning Cognitive Behavioural Therapy.* Canada: New Harbinger Publications.

Kendall, P. and Hollon, S. (1979). *Cognitive Behavioural Interventions: Theory, Research and Procedures.* San Francisco: Academic Press.

Kennerley, H., Kirk, J. and Westbrook, D. (2011). An Introduction to Cognitive Behaviour Therapy: Skills and Applications. 2nd Edition. London: Sage Publications.

Kowalski, R. and Westen, D. (2008). *Psychology.* 5th Edition. New Jersey: Wiley.

Landenberger, N. A. and Lipsey, M. W. (2005). The Positive Effects of Cognitive-Behavioural Programs for Offenders: A Meta-Analysis of Factors associated with Effective Treatment. *Journal of Experimental Criminology*, 1, pp. 451-476.

Langdridge, D. (2004). *Introduction to Research Methods and Data Analysis in Psychology.* England: Pearse Education.

Lehmann, P., and Coady, N. (2001). *Theoretical Perspectives for Direct Social Work Practice: A Generalist-Eclectic Approach.* New York: Springer Publishing.

Lipsey, M. W., Chapman, G. and Landenberger, N. A. (2001). Cognitive-Behavioural Programs for Offenders. *The Annals of the American Academy of Political and Social Science*, 578 (1), pp. 144- 157.

Lipsey, M. W., Landenberger, N. A. and Wilson, S. J. (2007). Effects of Cognitive-Behavioural Programs for Criminal Offenders. *Campbell Systematic Reviews,* 6 (1), pp. 1-27.

Lueger, M. (2000). *Grundlagen Qualitativer Feldforchung.* Wien: Universitatsverlag Wien.

Magill, M. and Ray, L. A. (2009). Cognitive-Behavioural Treatment with Adult Alcohol and Illicit Drug Users: A Meta-Analysis of Randomized Controlled Trials. *Journal of Studies on Alcohol and Drugs,* 70 (4), pp. 516–527.

Mallams, J. H., Godley, M. D., Hall, G. M. and Meyers, R. J. (1982). A Social-Systems Approach to Resocialising Alcoholics in the Community. *Journal of Studies on Alcohol*, 43 (1), pp. 1115–1123.

Marks, A. (1999). Instead of Jail, Criminals face Victims. *Christian Science Monitor*, 1, p. 4.

Marlatt, G. A. and Gordon, J. (1985). *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviours.* New York: The Guilford Press.

Martin, E. (2015). *Concise Medical Dictionary.* 8th Edition. Oxford: Oxford University Press.

Martin, J. (1993). Self-Psychology and Cognitive Treatment: An Integration. *Clinical Social Work Journal,* 21 (1), pp. 385-394.

Mays, N. and Pope, C. (2000) 'Qualitative Research in Healthcare: Assessing Quality in Qualitative Research', *BMJ*, 50 (2), p. 320.

McHugh, R. K., Hearon, B. A. and Otto, M. W. (2010). Cognitive Behavioural Therapy for Substance Use Disorders. *Psychiatric Clinics of North America*, 33 (3), pp. 511-525.

McIlrath, L., Bates, C., Burns, K., Lyons, A., McKenna, E. and Murphy, P. (2014). Emerging Policy and Practices on Community-Based Research-Perspectives from the Island of Ireland. In: R. Munck, L. McIlrath, B. Hall and R. Tandon, ed., *Higher Education and Community-Based Research: Creating a Global Vision*. New York: Palgrave Macmillan.

McLaughlin, H. (2012). *Understanding Social Work Research.* 2nd Edition. Los Angeles: Sage Publications.

McNeill, F., Farrall, S., Lightowler, C. and Maruna, S. (2012). *How and Why People Stop Offending: Discovering Desistance*, [online], available at: https://www.iriss.org.uk/sites/default/files/iriss-insight-15.pdf [Accessed 12 February 2018].

Merton, R. K. (1957). Social Theory and Social Structure. New York: Free Press.

Meyers, R. J. and Smith, J. E. (1995). *Clinical Guide to Alcohol Treatment: The Community Reinforcement Approach.* New York: Guilford Press.

Miller, W. R. and Meyers, R. J. (2001). Summary and Reflections. In R. J. Meyers & W. R. Miller (Eds.), *A Community Reinforcement Approach to the Treatment of Addiction*. Cambridge: University Press.

Mirsky, L. (2003). Hampshire County, UK: A Place of Innovation for Family Group Conferencing. International Institute for Restorative Practices, [online], available at: www.iirp.org [accessed 27 July 2017].

Morris, R. (2000). *Stories of Transformative Justice.* Toronto: Canadian Scholars Press.

Munck, R., McIlrath, L., Hall, B. and Tandon, R. (2014). *Higher Education and Community-Based Research: Creating a Global Vision*. New York: Palgrave Macmillan.

National Drug Treatment Centre. (2018). *Definition of Drug Misuse,* [online], available: http://www.dtcb.ie/faq/article.asp?FID=58&T=F [accessed 02 February 2018].

Onwuegbuzie, A. J. and Frels, R. (2016). *Seven Steps to a Comprehensive Literature Review: A Multimodal and Cultural Approach*. London: Sage Publications.

Padesky, C. A., and Mooney, K. A. (1990). Presenting the Cognitive Model to Clients. *International Cognitive Therapy Newsletter*, 6 (1), pp. 13–14.

Padgett, D. (1998). *Qualitative Methods in Social Work Research*. California: Sage Publications.

Payne, G. and Payne, J. (2004). *Key Concepts in Social Research*. London: Sage Publications.

Pearson, F. S., Lipton, D. S., Cleland, C. M., and Yee, D. S. (2002). The Effects of Behavioural/Cognitive-Behavioural Programs on Recidivism. *Crime and Delinquency*, 48 (3), pp. 476- 496.

Penal Reform International. (2016). *On Probation: Models of Good Practice for Alternatives to Prison*. Middle East: Penal Reform International.

Punch, K. (1998). *Introduction to Social Research: Quantitative and Qualitative Approaches*. London: Sage Publications.

Rawson, R. A., Huber, A., McCann, M., Shoptaw, S., Farabee, D., Reiber, C. and Ling, W. (2002). A Comparison of Contingency Management and Cognitive-Behavioural Approaches during Methadone Maintenance Treatment for Cocaine Dependence. *Archives of General Psychiatry*, 59 (9), pp. 817-824.

Rogers, C. (1961). *On Becoming a Person*. Boston: Houghton Mifflin.

Roozen, H. G., Boulogne, J. J., van Tulder, M. W., van den Brink, W., De. Long, C. J. and Kerhof, A. J. (2004). A Systematic Review of the Effectiveness of the Community Reinforcement Approach in Alcohol, Cocaine and Opioid Addiction. *Drug and Alcohol Dependence,* 74 (1), pp. 1-13.

Saleebey, D. (2002). *The Strengths Perspective in Social Work Practice.* 3rd Edition. Boston: Allyn and Bacon.

Santrock, J. W. (2003). *Psychology.* 7th Edition. Boston: McGraw Hill.

Sarantakos, S. (2005). *Social Research.* 3rd Edition. New York: Palgrave Macmillan.

Sarantakos, S. (1998). *Social Research.* New York: Palgrave Macmillan.

Schottenfeld, R. S., Pantalon, M. V., Chawarski, M. C. and Pakes, J. (2000). Community Reinforcement Approach for Combined Opioid and Cocaine Dependence: Patterns of Engagement in Alternate Activities. *Journal of Substance Abuse Treatment*, 18 (1), pp. 255–261.

Schwandt, T. (2007). *The Sage Dictionary of Qualitative Inquiry*. 3rd Edition. California: Sage Publications.

Shaw, I. and Gould, N. (2001). *Qualitative Research in Social Work*. London: Sage Publications.

Shaw, I. and Holland, S. (2014). *Doing Qualitative Research in Social Work*. London: Sage Publications.

Sisson, R. W. and Azrin, N. H. (1986). Family-Member Involvement to Initiate and Promote Treatment of Problem Drinkers. *Journal of Behaviour Therapy and Experimental Psychiatry*, 17 (1), pp. 15–21.

Smith, J. E., and Meyers, R. J. (2001). The Treatment. In R. J. Meyers and W. R. Miller (Eds*.), A Community Reinforcement Approach to Addiction Treatment.* England: University Press.

Smith, J. E., Meyers, R. J. and Delaney, H. (1998). The Community Reinforcement Approach with Homeless Alcohol-Dependent Individuals. *Journal of Consulting and Clinical Psychology,* 66 (1), pp. 541–548.

Steinhaus, N. (2014). "With or Without You" - The Development of Science Shops and Their Relationship to Higher Education Institutions in Europe. In: R. Munck, L. McIlrath, B. Hall and R. Tandon, ed., *Higher Education and Community-Based Research: A Global Vision*. New York: Palgrave Macmillan.

Stewart, W. J. (2006). *Dictionary of Law.* Glasgow: Collins.

Strand, K., Marullo, S., Cutforth, N., Stoecker, R., and Donohue, P. (2003). *Community-Based Research and Higher Education*. San Francisco: Jossey-Bass.

The Probation Service. (2018). *Web Report Caseload End February 2018*, [online], available: http://www.probation.ie/EN/PB/0/C136EF5C22E23C5F8025824F003F669E/$File/Web%20Report%20Caseload%20End%20February%202018.pdf [accessed 09 March 2018].

The Probation Service. (2015). *Information Centre,* [online], available: http://www.probation.ie/ [accessed 01 June 2017].

The Probation Service, (2012). *Drug and Alcohol Misuse Among Adult Offenders on Probation Supervision in Ireland; Findings From Drugs and Alcohol Survey 2011*, [online], Available at: http://www.drugs.ie/resourcesfiles/research/2012/Drug+and+Alcohol+Misuse+among+Adult+Offenders+on+Probation+Supervision+in+Ireland.pdf [Accessed 08 July 2017].

Thomas, M. and Drake, M. (2012). *Cognitive Behaviour Therapy Case Studies.* London: Sage Publications.

Umbreit, M. (2000). *Family Group Conferencing: Implications for Crime Victims*. Washington: U.S. Department of Justice.

Van Wormer, K. (2004). *Confronting Oppression, Restoring Justice: From Policy Analysis to Social Action*. Alexandria: Council on Social Work Education.

Van Wormer, K. (2004). Restorative Justice. *Journal of Religion & Spirituality in Social Work: Social Thought*, 23 (4), pp. 103-120.

Van Wormer, K. (2001). *Counselling Female Offenders and Victims: A Strengths-Restorative Approach.* New York: Springer Publishing Company.

Ward, T. (2007). Promoting Human Goods and Reducing Risk: Part 1. *Correctional Psychologist*, 30, pp. 11-13.

Ward, T. and Brown, M. (2004). The Good Lives Model and Conceptual Issues in Offender Rehabilitation. *Psychology, Crime & Law*, 10 (3), pp. 243-257.

Ward, T. and Gannon, T. (2006). Rehabilitation, Etiology, and Self-Regulation: The Good Lives Model of Rehabilitation for Sexual Offenders. *Aggression and Violent Behaviour*, 11 (1), pp. 77−94.

Ward, T., Melser, J. and Yates, P. M. (2007). Reconstructing the Risk-Need-Responsivity Model: A Theoretical Elaboration and Evaluation. *Aggression and Violent Behaviour*, 12, pp. 208-228.

Ward, T. and Stewart, C. (2003). Criminogenic Needs and Human Needs: A Theoretical Model. *Psychology, Crime and Law,* 9, pp. 125-143.

Ward, T. and Willis, G. (2010). Ethical Issues in Forensic and Correctional Research. *Aggression and Violent Behaviour*, 15 (1), pp. 399-409.

Wartna, B. S. J. and Nijssen, L. T. J. (2006). *National Studies on Recidivism: An Inventory of Large Scale Recidivism Research in 33 European Countries*. The Hague: WODC.

Whittaker, A. (2012). *Research Skills for Social Work.* 2nd Edition. California: Sage Publications.

Wilson, D. B., Bouffard, L. A. and MacKenzie, D. L. (2005). A Quantitative Review of Structured, Group-Oriented, Cognitive-Behavioural Programs for Offenders. *Journal of Criminal Justice and Behaviour*. 32 (2), pp. 172-204.

University College Cork. (2018). *About CARL: Community-Academic Research Links UCC*. [online] Available at: http://www.ucc.ie/en/scishop/ac/ [Accessed 15 January 2018].

Yates, P. M. and Ward, T. (2008). Good Lives Model, Self-Regulation, and Risk Management: An Integrated Model of Sexual Offender Assessment and Treatment. *Sexual Abuse in Australia and New Zealand*, 1, pp. 3-20.

Zehr, H. (2001). *Transcending: Reflections of Crime Victims*. Intercourse: Good Books.