Correctional officers and other line staff spend the majority of their time with inmates/clients. Nonclinical staff often have the best opportunity to randomly observe a client’s behavior during times of the day in which most clinical staff do not. Some of the behaviors witnessed by nonclinical staff may be the key to identifying inmates who are abusing substances or need to be referred to treatment due to past use. Without a basic education of what behaviors to look for and how to identify substance abuse and/or addiction, valuable information is lost. Inmates may exhibit erratic behavior, which may be symptomatic of substance use or withdrawal from addictive drugs. Some illegal drugs show obvious physical signs, such as changes in the size of pupils, increase in appetite and/or a change in mood and temperament.

Clinicians rely heavily on behavioral observations to decide the appropriate next step. Some clinicians feel that an uneducated line staff could more easily be manipulated by an inmate who has a desire to use or has a desire to hide their use. It often takes team observations to see if a real problem exists. Inmates are very savvy in trying to hide addictions and/or abuse. Careful documentation by nonclinical staff may reveal a substance abuse issue that desperately needs to be addressed.

Understanding Basic Medical Terminology

Teaching nonclinical staff to understand basic medical terminology may be a bridge to getting an inmate into treatment or to get the inmate evaluated by a clinician. Each term may include scientific words and may seem complicated. However, each can be broken down into easily understood concepts.

**Substance use and induced disorders.** The newly-released *Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition (DSM-V)* has divided substance-related disorders into substance use disorders and substance induced disorders. Substance use disorders include types of improper, uncontrollable use of illegal substances. These are based on pathological patterns of behaviors related to use of the substance. Substance use disorders occur in a range of severity from mild to severe based on the number of symptoms observed. Symptoms of a substance use disorder include impaired control, social impairment, risky use and pharmacological problems as major categories in the *DSM-V*. Tolerance signaled by requiring an increased dose of the substance to achieve the desired effect and withdrawal signaled by physical symptoms when the drug is withdrawn compromise pharmacological criteria. Symptoms of tolerance and withdrawal are still criteria for substance use.

By Randy Shively and Rob Jones
disorders, according to the DSM-V, but are no longer necessary for a diagnosis of a substance use disorder as they were in the fourth edition of the DSM. Symptoms of tolerance and withdrawal occurring during appropriate medical treatment with prescribed medications are specifically not counted when diagnosing a substance use disorder, according to the DSM-V.

**Addiction.** This is described as a chronic disease of brain reward, motivation, memory and related circuitry. Addiction is characterized by a person pathologically pursuing reward and/or relief by substance use and other behaviors. Addiction is a powerful force, as the substance to which inmates are addicted occupies their thoughts and continues to give them very unpleasant symptoms in the event that they don’t have access to the substance. The destructive pattern mounts as the inmate uses more of the substance to try and feel normal — only to feel more helpless and out of control.

**Recovery.** As part of the recovery definition, it is critical to understand the importance of abstaining from alcohol and other drugs; and the longer one abstains, the better the chance of recovering brain function as well as regaining a more functional lifestyle. It is imperative that the person stop using the substance to allow the brain to heal and recover normal functioning, such as memory and comprehension skills, which have been compromised.

**Relapse and relapse prevention.** Relapse occurs when an addict returns to drug use or drinking after a period of abstinence, often accompanied by reinstatement of dependent symptoms. Relapse prevention is defined as a set of therapeutic procedures to help individuals cope and to avoid lapses or relapses of uncontrolled substance use. Coping strategies can be used by the individual to avoid high-risk situations that place them in danger of relapse. Individuals can also rehearse strategies and techniques that will help prevent relapse. One component of relapse prevention is teaching individuals to avoid people, places and things that can trigger use, and working with them to develop the skills necessary to stay away from the illegal substances. Someone in remission is abstaining from the destructive use of the substance. An individual in remission no longer meets the diagnostic criteria for substance use but may benefit from relapse prevention services so that he or she will not reenter an abusive and/or addictive pattern.

Relapses to substances are problematic but are also very predictable and expected. Substance abuse relapses are no more prevalent than patient relapses with other chronic disease disorders such as diabetes, hypertension and asthma. Planning for relapse is critical in the long-term management of offenders with addictions. Relapses can be educational tools rather than events for “throwing in the towel” if the individual returns to their sobriety and learns about what triggered their use. Recovery is possible if the inmate abstains from the addictive substance(s), and this is the time an inmate can benefit the most from counseling and 12-step groups.

Planning for relapse starts at the beginning of treatment and is woven into all phases of treatment and aftercare. Inmates are asked what has worked to maintain sobriety in the past and how they can build on those successes. It is important for nonclinical staff to examine the failures and learn what could have been more helpful in those situations or what could have gotten the inmate back into a treatment mindset quicker. It is very important that nonclinical staff do not chastise or belittle an inmate in relapse but rather try to get the inmate back into treatment. Inmates often deny problems because they are tired of failing to stay sober. They can quickly fall into a negative mindset — which is extremely defeating and needs to be addressed by all nonclinical staff.

**Treatment needs.** Treatment is a formal array of services and interventions that range from outpatient services to inpatient services. Treatment programs can be funded by both public and private agencies. It is helpful for nonclinical staff to understand that inmates should be referred to therapists to get help learning new coping strategies and learning to abstain from addictive substances. Generally, whether an inmate is put in treatment is dependent on a biopsychosocial assessment, which is a thorough set of questions outlining past use, family history, work history, social influences and other factors related to alcohol and/or drug problems.

A cognitive-behavioral approach has been found as the most promising way to address substance use disorders with inmates, according to a 2011 evidence-based curriculum by the University of Cincinnati. The approach covers areas such as problem solving, relapse prevention, regulating emotions, enhancing motivation and cognitive restructuring. This approach is the most commonly used curriculum among treatment providers. The cognitive-behavioral approach keys into the thoughts behind substance abuse. With the cognitive-behavioral approach, thoughts and behaviors are learned and rewarded to compete with the triggers to use. For example, an individual might say, “I need this beer to help my anxiety go down.”

**Common Types of Addictive Substances**

It is important for nonclinical staff to understand some of the simple effects of various classes of illegal drugs or abused drugs. This may help when communicating with inmates about their problems and/or being aware when someone might be using while incarcerated. For example, in corrections, K2 or “spice” (synthetic marijuana) and bath salts are more commonly becoming a problem, as they are increasingly being used in correctional facilities and interfering with inmate programs. It is also important for nonclinical staff to realize if someone is withdrawing from an addictive substance, he or she may experience very negative side effects and may need medical treatment. Nonclinical staff need to be good observers and provide documentation so that information can be passed on to medical professionals and treatment professionals who can address any problems.
Evidence of an inmate abusing substances could be in the form of a physical sign, a behavioral sign and/or a psychological sign. Physical signs include dilated pupils, excessive talking and slurred speech. Behavioral signs can be a drop in attendance from work or programs; an unexplained need for money or a financial problem; frequently getting into trouble; sudden changes in friends or hobbies; and engaging in secretive and suspicious behaviors. Psychological warning signs can be unexplained changes in attitude or personality; sudden irritability and mood swings; periods of unusual hyperactivity, agitation or giddiness; acting fearful or paranoid for no apparent reason; and a lack of motivation or appearing dazed.5

**Depressants.** Depressant medications are prescribed by doctors to relieve anxiety, irritability and tension. They have a high potential for abuse and development of tolerance. Drugs in this category include barbiturates and tranquilizers such as Valium or Xanax. One of the most commonly abused depressants is alcohol. Alcohol has a high correlation rate with suicide/homicide rates as well as with motor vehicle injuries and death. When mixed with pain pills and/or barbiturates, alcohol can lead to death. Symptoms of depressant use include contracted pupils; a drunken-like state with difficulty concentrating; clumsiness; poor judgment; and slurred speech.

**Hallucinogens.** These types of drugs — which include LSD and PCP — can cause profound distortions in one’s perceptions of reality and often cause sensory experiences in the body that seem real but do not exist. Some hallucinogens produce rapid, intense emotional swings. Common symptoms of hallucinogen use include dilated pupils; bizarre and irrational behavior which can include paranoia, aggression, auditory and/or visual hallucinations; detachment from others; slurred speech; and confusion. Marijuana is a commonly-used hallucinogen. Known as a “gateway drug,” its use can lead to the use of more destructive and addictive drugs. Some research suggests long-term Marijuana use can lead to mental health and physical symptoms.6

**Inhalants.** Inhalants are drugs that are inhaled to get high, such as household cleaners. Other examples include paint products and glue, and are often separated into solvents and gases. Breathable chemical vapors produce mind-altering effects. Inhalants are inexpensive, easily obtained and their effects resemble alcohol inebriation. A user may experience stimulation, loss of inhibition and distorted perception. Indicators of inhalant use include stains on the body or clothes; red eyes and nose; a chemical odor; a dazed appearance; loss of appetite; and excitability. Staff should look for an excessive number of aerosol cans in the trash. Rashers around the eyes and nose; impaired vision; headaches and nausea; irritability; and drowsiness are other symptoms.

**Opioids or pain killers.** These drugs are highly addictive. They are called “narcotic analgesics,” and their use has dramatically risen in the U.S. From 1999-2010, deaths from opioid pain relievers increased five times for women and 3.6 times for men.7 Common types of opioids include codeine, Dilaudid, heroin, morphine, Oxycontin and Percocet. Opioid diagnosis is based on an individual’s history and observations of the individual’s behavior. Signs of opioid use include repeatedly cancelling doctor’s appointments; frequently requesting refills of medication; multiple prescriptions from physicians; accidents; appearing intoxicated; asking for night medication; and/or selling prescriptions. Heroin, a Schedule I drug, is one of the more addictive opioids. Heroin users may need to be on a methadone program or other controlled substance — until they are weened off, or possibly for life — to stay stable and have a manageable life. Symptoms of heroin use include contracted pupils; no response of pupils to light; needle marks; sleeping at unusual times; sweating; vomiting; coughing; twitching; and loss of appetite. Heroin use is often associated with HIV and AIDS due to sharing of needles among users.

**Stimulants.** Stimulants are drugs that elevate mood, increase feelings of well-being and increase energy and alertness. These drugs produce euphoria and are perceived as powerfully rewarding due to the drugs’ stimulation of pleasure centers in the brain. Some commonly abused stimulants are cocaine, methamphetamine and Ritalin. Common symptoms of stimulant use include dilated pupils; hyperactivity; irritability; anxiety; excessive talking followed by depression; and sleeping at odd times. The user may go long periods of time without eating or sleeping, lose substantial weight and have a dry mouth and nose.

Two of the increasingly abused drugs in correctional populations are K2 and bath salts, also known as designer drugs. K2’s effects mimic effects of tetrahydrocannabinol, or “THC,” found in marijuana. It is difficult and expensive to test for as part of a urine panel, and very cheap to purchase. The drug is highly addictive, with symptoms of acute anxiety; panic attacks; hallucinations; coughing; tremors; irregular heartbeat; and nausea. Bath salts are white crystals which resemble bath products. The effects of bath salts are similar to amphetamines and cocaine. Bath salts are often packaged with a label that states, “Not for human consumption,” which helps dealers avoid legal challenges. The bath salts are swallowed or snorted and cause extremely dangerous health symptoms including headache; paranoia; heart attack; liver failure; kidney failure; and increased risk for violence and suicide.
Treatment Environments

When an inmate in the corrections system has serious substance abuse issues, they can be treated in a variety of settings. One of the most intensive places to receive treatment is in a therapeutic community. This is a structured environment where individuals with substance use disorders live together in order to achieve rehabilitation. The community operates under strict rules and procedures, and is often directed by people who have recovered from dependence. It is characterized by a combination of confrontation and support for recovery between both staff and peers.

Residential substance abuse treatment (RSAT) is usually a commitment of six months or longer and is considered to be a best practice. This is a type of therapeutic community that operates using a structured program. An RSAT program does not need to be directed by people in recovery and can operate under the umbrella of substance abuse professionals. A community residential program is a place of residence that serves as an intermediate stage between an inpatient therapeutic program and a person living independently in the community. The community residential program is usually three to six months in length as the individual attempts to maintain sobriety while trying to reenter the community.

A mutual help group is an approach such as Alcoholics Anonymous where participants support each other in recovery while maintaining recovery from alcohol or other drug dependence without professional therapy or guidance. These 12-step groups are based on a non-denominational, spiritual approach. Some of these groups allow for semi-professional guidance. Some recovery homes or community residential programs might be seen as residential mutual help groups.

Motivational Interviewing

One of the biggest challenges in working effectively with corrections populations who have abused substances is “proper engagement.” Health care professionals know substance abuse treatment is effective in reducing risk of relapse, and a failure to stay sober often makes it very likely that offenders will return to the criminal justice system. It is important to inform inmates of rules and expectations in treatment, and how professionals go about informing inmates is extremely important. Motivational interviewing (MI) is the process of developing and strengthening motivation for change in offenders. Nonclinical staff can learn techniques and approaches that move inmates toward change without forcing change. Forcing change merely encourages resistance, and moving an inmate toward change using MI breaks down resistance. Resistance is natural and expected in any change process. MI trains corrections professionals to “roll with resistance” rather than becoming defensive or arguing.

MI is an evidence-based practice that is increasingly being taught and applied across many different types of professional roles. This technique is as important for non-clinical staff to use in day-to-day interaction with inmates as it is in a structured treatment setting. MI strategies are usually nonauthoritative and involve active listening and guiding, and directing an offender only when necessary. The MI approach strives for negotiation between staff and offender whenever possible, and allows offenders to better understand and utilize their strengths and abilities. In part, this involves recognizing past successes, but also affirming small and meaningful “wins” in the present. For example, an inmate may be asked to compare the pros and cons of their continued use. Hopefully, the inmate will come to some real conclusions about how his or her substance use has gotten in the way of his or her life goals and relationships. In the process, MI helps inmates enhance their self-confidence, manage change and increase self-reliance.

Certain parameters must be met for MI to be successful. First, a clear target behavior or goal must be identified, such as abstinence. The offender must have some level of ambivalence surrounding changing a behavior. MI should not be used in a situation where public safety is a major concern — such as an inmate preparing to commit a crime or when there is an immediate risk for violence or aggression with an inmate. Foundational principals of MI include expressing empathy, developing discrepancy, rolling with resistance and supporting self-advocacy. Empathy is created by staff putting themselves in the inmate’s shoes. When staff do so, they successfully gain the inmate’s trust and better understand his or her current situation. Motivation is enhanced when the inmate understands the gap between his or her desired goals and values and his or her present behavior. This process helps clarify and articulate discrepancies and assists the inmate in finding an appropriate and effective means to “close their gaps” between these goals and present behaviors. The inmate is now motivated to find his or her own path because he or she was not forced into changes but empowered to find his or her own answers.

The ultimate goal is to help offenders better themselves. This is accomplished through efforts to develop and support self-advocacy. Inmates need to believe in the possibility of change and have clear achievable targets for the change process. Staff who routinely practice MI find their work less stressful. Inmates with substance abuse issues are often defensive and in denial. MI techniques help cut through some of these layers and give the inmates more control over their options.

The Importance of Nonclinical Staff Input

It is critical that nonclinical staff understand that abuse and addiction becomes a lifestyle that affects every area and every minute of an inmate’s life. There are many ways that addiction can be addressed throughout an inmate’s day. It is also important for nonclinical staff to realize that their observations, progress notes and communication with substance abuse professionals are valued. Without clear communication between clinical and nonclinical staff, inmates may try to divide and/or manipulate the staff — creating a major obstacle in the recovery process. Inmates only succeed at dividing staff when staff stop communicating and start to blame each other. Bridges have to be built between clinical and nonclinical staff to continue holding inmates accountable for their recovery.
Addiction needs to be understood as something that can be addressed by every staff member who works with an inmate through informed daily interaction and an intentional plan. Nonclinical staff can use MI techniques as well as the cognitive behavioral approach in helping inmates address their addiction.\textsuperscript{12} Creating a common language for all staff regarding substance use and addiction is critical.

\textbf{ENDNOTES}


\textsuperscript{3} Urschel, H. 2009. \textit{Healing the addicted brain}. Naperville, Ill.: Sourcebooks Inc.


\textit{Randy Shively, Ph.D., is vice president of clinical services for Alvis Inc., in Columbus, Ohio. Rob Jones, M.D., is medical director of the Arizona Department of Corrections.}