

UNIVERSIDAD SAN FRANCISCO DE QUITO USFQ
Colegio de Ciencias Sociales y Humanidades

**SMART Recovery implementation for individuals with substance
use disorder in Ecuador.**
Proyecto de Investigación.

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DEDICATORIA

Quiero dedicar esta investigación primeramente a mis papás que siempre me han apoyado en todo momento a lo largo de mi carrera. Ellos siempre han sido mi fuerza y las personas en las que más confío porque me enseñaron a nunca darme por vencida. Igualmente, quiero agradecer a mis hermanos Lula, Juan y Oscar, que siempre apoyan todas mis decisiones y me motivan a ser mejor, son los mejores amigos que puedo tener y siempre alegran mis días. Quiero agradecer también a mi novio Sebastián, porque siempre escucha todas mis ideas, me ha acompañado en este proceso y me da el mejor apoyo que un novio te puede dar. Quiero igualmente reconocer a Richard West no solo como mi profesor y un excelente director de tesis, sino como un mentor que me ha enseñado gran parte de lo que se sobre psicología. Quiero mencionar a mi abuelita que siempre estuvo pendiente sobre los avances de esta investigación y finalmente, quiero dedicar este texto a mi abuelito, que siempre fue mi motor y la persona que me enseñó que uno siempre debe perseguir sus sueños.

RESUMEN

Smart Recovery es un programa sustentado científicamente y basado en terapia cognitivo conductual que se utiliza para el tratamiento de los comportamientos adictivos. La intervención se basa en 4 puntos principales que son: construcción y mantenimiento de la motivación, manejo de la necesidad de consumo, entendimiento de los pensamientos, emociones y comportamientos y finalmente, vivir una vida balanceada. El propósito de este trabajo se basó en investigar la efectividad de implementar el programa Smart Recovery por primera vez en poblaciones ecuatorianas con abuso y dependencia de sustancias. Se utilizó una muestra que fue reclutada en hospitales, universidades, clínicas y farmacias. Las intervenciones se realizaron 1 vez por semana durante 1 año. Además, para medir la efectividad del tratamiento se empleó el cuestionario The Alcohol, Smoking and Substance Involving Screening Test (ASSIST), para analizar la sintomatología y la gravedad del consumo de drogas de los individuos. Las mediciones respectivas se realizaron 3 veces durante 12 meses las cuales fueron: previo a la implementación del programa, al sexto mes y al año. Finalmente, se espera que el estudio tenga como resultado una reducción significativa de uso de sustancias en poblaciones con las siguientes características: estatus socioeconómico medio-alto, baja espiritualidad, locus de control interno y alto nivel de educación.

Palabras clave: adicciones, Smart recovery, terapia cognitivo conductual, abuso de sustancias, locus de control.

ABSTRACT

Smart Recovery is a research-based program grounded on cognitive behavioral therapy that is used to treat addictive disorders. The intervention is based on 4 points that consist in: building and maintaining motivation, coping with urges, managing thoughts, feelings and behaviors and living a balanced life. The purpose of this study was to analyze the effectiveness of implementing the Smart Recovery program, for the first time, in the Ecuadorian population with substance abuse and addictions. The participants were recruited from hospitals, universities, clinics and pharmacies. The interventions are ought to be made once a week for 1 years. Furthermore, to measure the effectiveness of the program the questionnaire *The Alcohol, Smoking and Substance Involving Screening Test (ASSIST)*, was implemented to analyze the symptoms and problems related to substance use. The test was taken 3 times for 12 months which were: before the intervention, at 6 months and on the 12th month. Finally, it is expected that the investigation will have significant results in the reduction of substance use in populations with the following characteristics: high socioeconomic status, low spirituality and religiosity, internal locus of control and high educational levels.

Keywords: addiction, Smart recovery, cognitive behavioral therapy, substance use disorder, locus of control.

TABLE OF CONTENTS

Introduction	8
Background	10
The Problem	
Substance Abuse Disorder	10
Drug use, abuse and dependence	12
The Problem	13
Research Question	14
Study Purpose	14
Study Significance	14
Literature Review	15
Methodology and Research Design	27
Methodology Design and Justification	27
Participants	28
Research Tools	29
Ethical Considerations	30
Probable Results	31
Discussion	33
Limitations	34
Future Recommendations	35
References	36
Appendixes	41
Assist Questionnaire	52
Informed Consent	59

INTRODUCTION:

Substance abuse and addiction are diseases that change the behavior and the brain of individuals. With the constant use of a substance, a person becomes unable to control whether to stop or continue its use. Nowadays, addiction has become one of the main public health concerns worldwide. According to the United Nations Office on Drugs and Crime (UNODC), 31 million people suffer from drug abuse and addiction and 275 million tried drugs or used them at least once in 2016. Additionally, global deaths directly caused by drug usage have increased up to 60% from 2000 to 2015 (United Nations Office on Drugs and Crime, 2018).

Statistics indicate that Ecuador has a high prevalence of drug consumption. Recent research that studied drug use across Latin America, determined that Ecuador is the second country with the highest rates of substance use in the Andean region after Colombia (PRADICAN, 2012). One of the main aggravating factors of this situation is that not only the country has become an important drug transit route between substances produced in Colombia, Peru and Bolivia, but it is also a well-known cocaine and base cocaine producer. As a result, the availability and low cost of substances have increased drug use and abuse over the years.

According to the Consejo Nacional de Sustancias Estupefacientes y Psicotrópicas (CONSEP), between 1998 and 2005 the prevalence of alcohol and cigarette use among high school teenagers has increased from 44.3% to 54.4%. Furthermore, the age of first consumption has decreased from 14.4 to 13.1 years old (CONSEP, 2007). Data also shows that illicit drug use—marijuana, opioids, inhalants, and cocaine—and prescribed painkillers consumption has significantly increased over the years (CONSEP, 2007).

Another important problem is that addiction treatment facilities usually function under illegal and unethical standards and provide treatment with no research background. According to the list of legal and regulated facilities available in the country, there are only 37 private and three public rehabilitation facilities that are mainly based on the twelve-step model (Paucar, 2019). Therefore, there is not enough free, available, and fair treatment for people with drug-related issues.

The unavailability of treatment facilities and the increasing prevalence of drug use and abuse in the country has created a problem that is impacting both our society and the treatment efficacy of addicted individuals. The proposed alternative to confronting this problem is the implementation of the Self-Management and Recovery Training (SMART) program in Ecuador. SMART Recovery is based on a 4-point program that provides tools, techniques, and strategies that help individuals on their journey to recovery. These are: 1. building and maintaining motivation; 2. coping with urges; 3. managing thoughts, feelings, and behaviors; and 4. living a balanced life (SMART Recovery, 2013).

The SMART Recovery program emphasizes that although the treatment focuses on abstinence, individuals that cannot achieve it are welcomed and encouraged by the group (Horvath & Yeterian, 2012). SMART Recovery is a research-based program that uses techniques from Cognitive Behavioral Therapy (CBT). CBT is a model developed by Aaron Beck in the 1960s that states that the emotions and behaviors of individuals are greatly influenced by their perception of events and their thinking patterns (Fenn & Byrne, 2013).

Additionally, the SMART Recovery program was designed for people who do not identify with the higher power principle associated with twelve-step groups (Horvath & Yeterian, 2012). Members do not need to seek a recovery approach of powerlessness, use labels such as “addict”

and “alcoholic”, or believe in addiction as a disease (Horvath & Sokoloff, 2011). SMART Recovery focuses on the development of personal, didactic, and interpersonal skills that give individuals the capacity to foster their own recovery, not only by providing the treatment skills available for them to choose, but also allowing them to explore and develop important and effective techniques to cope with their addictive behaviors. Taking this into consideration, the SMART Recovery program might be a viable option for addicts in Ecuador.

The objective of this study is to evaluate if the implementation of the SMART Recovery program in people with addiction in Ecuador could reduce the rates of substance abuse dependence and relapse in the population.

BACKGROUND:

Substance Abuse Disorder

Substance abuse is a problem that causes a series of negative consequences on individuals, families, communities, and society. According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), the main characteristics of a substance abuse disorder are a pattern of cognitive, behavioral, and physiological symptoms that indicate that a person cannot refrain from using substances, in spite of the negative consequences and problems related to the drug consumption (American Psychiatric Association [APA], 2013).

An important feature of individuals with a severe substance abuse and addiction problem is a change in brain functioning that leads to continuous relapses and drug cravings when they are exposed to a drug-related situation or stimuli (APA, 2013). The American Psychiatric Association has recognized a series of patterns of behaviors and actions that are commonly seen in individuals with substance abuse and addiction problems.

Criterion A refers mainly to impaired control, social impairment, risky use, and pharmacological criteria.

Impaired control (Criteria 1-4) means that the person may take the drug in higher quantities or for a longer period than intended (Criterion 1). There is a persistent desire to reduce or stop consuming the substance but, in spite of the efforts, the individual may be unsuccessful to discontinue the use or abuse (Criterion 2). The person may invest a great amount of time obtaining the drug, using it, and recovering from its effects (Criterion 3). Finally, there may be an intense desire to use the substance when the individual is exposed to an environment where the drug was obtained or consumed previously (Criterion 4) (APA, 2013).

Social impairment encompasses criteria 5 to 7. It includes: failure to accomplish academic, home, and work obligations (Criterion 5); the individual may continue using the substance regardless of the social consequences and interpersonal problems that the usage has brought (Criterion 6); the person may withdraw from recreational, family, social, and occupational activities due to the substance use and abuse (Criterion 7) (APA, 2013).

Risky use includes criteria 8 and 9. It is important to state that these criteria are based on evaluating if the person is unable to abstain from the drug use in spite of the consequences it produces. Criterion 8 indicates a sustained use of the substance in situations where it is physically dangerous. Criterion 9 states that the individual may continue using the drug regardless of the physical and psychological problems likely caused by the substance (APA, 2013).

Pharmacological criteria (10 and 11) include tolerance that can be defined as a marked need to increase drug doses in order to obtain the desired effect or intoxication state (Criterion

10). The degree of tolerance depends on the physiological characteristics of the individual and the substance that is being consumed. Withdrawal syndrome (Criterion 11) occurs when the individual has stopped the consumption of the drug and the amount of substance concentration in the blood has declined. It consists of a variety of symptoms that differ depending on the substance. The different symptoms that can be identified are nausea, vomiting, trembling, delirium, insomnia, feeling cold, and sweating, among others (APA, 2013).

Drug use, abuse, and dependence

It is important to differentiate between substance use, abuse, and addiction. According to the DSM-5, substance use has different severity specifiers, from mild to severe. These specifiers depend on the number of symptoms reported by the individual. “*Mild* substance use disorder is suggested by the presence of two to three symptoms, *moderate* by four to five symptoms, and *severe* by six or more symptoms” (APA, 2013, p. 484). According to Barra and Diazconti (2013), substance use occurs when the individual consumes a drug in occasional situations, without having physical, social, or health problems. It may be related to recreational, experimental, or habitual factors. Substance abuse occurs when the drug use turns into a compulsion; the person might develop problems on recreational, social, occupational, and familiar activities due to substance abuse. The main motivation of the abusive consumption is to avoid the physical and psychological effects that the lack of the drug in the system may produce. Drug addiction or dependence occurs when the life of the individual revolves around obtaining and consuming the drug. There is a mental and physiological desire to consume the substance that will not allow the individual to abstain from it and may likely turn into a physical and psychological dependence (Barra & Diazconti, 2013).

The problem

Ecuador has a high prevalence of drug consumption. Statistics show that it is the second country with the highest reported drug use in the Andean region. Prevalence values related to the use of different substances among the Ecuadorian population from ages 18-25 indicate that: 70.43% consume alcohol, 21.3% marijuana, 4.33% cocaine, 2.11% base cocaine (the highest percentage in Latin America), 2.3% amphetamines, and 2.90% inhalants (PRADICAN, 2012). The Ecuadorian government spent 214.029.337 million dollars in 2015 to manage the drug crisis in the country; however, only 4% was destined to treatment facilities and health care services (Naranjo & Jaramillo, 2015). Additionally, risk perception has decreased, and drug availability has become a significant issue in the country. Research indicates that marijuana, cocaine, base cocaine, ecstasy, and heroin are the easiest to find (CONSEP, 2007).

In most cases, treatment facilities in Ecuador are illegal and use unethical practices. There are only 37 rehabilitation facilities that are regulated and legal in the country, 91% of which are private. These facilities can treat approximately 820 users (Paucar E. , 2019). As a result, people have opted for illegal recovery services that have no research background, are cheaper and, in many cases, function in hazardous infrastructures.

At the same time, many individuals do not seek treatment due to the irregularities and possible abuse that can occur in these facilities. The model implemented in public and private centers tends to be the twelve-step model. This model has been criticized for teaching patients that they can only recover through the intervention of a higher power. This idea might be harmful to the treatment process because it preserves the idea that the person is helpless and powerless, and will always remain that way (Ellis & Schoenfeld, 1990).

Research question:

To what extent could the implementation of the SMART Recovery Program for addicts in Ecuador decrease substance abuse and dependence rates in the country.

Study purpose:

This study proposes the program Self-Management and Recovery Training (SMART), based on Cognitive Behavioral Therapy principles, for people with substance abuse and dependence problems that have no other treatment alternatives. The expected results should prove that the techniques and tools taught in the program will reduce relapse rates in the country. The study purpose is to improve the lives of individuals with drug addiction.

Study significance

The SMART Recovery program could improve or generate ways and alternatives to the actual treatment practices available in Ecuador. Since drug addiction is an arising problem in the country and there are not enough prevention programs, treatment facilities, or research available, SMART Recovery could develop a new and different way of seeing and treating addiction. Its structured and research-based approach might improve the recovery and abstinence rates in a population with several risk factors. The application of the 4-point program will offer individuals different alternatives and strategies to deal with their addiction. Therefore, the SMART Recovery program could reduce addiction and relapse rates in the country.

LITERATURE REVIEW

Format of the Literature Review

The Literature Review includes four topics: an explanation of the disease and choice models of addiction; the risk and protective factors that have been identified worldwide and in Ecuador; twelve-step group treatment modality and its criticism; and an explanation of the 4-point modules of SMART Recovery.

1. Disease and choice models of addiction

The disease model consists of seeing addiction as a treatable disease that has physical, emotional, and behavioral aspects. According to the Hazelden Foundation (2008), addiction is perceived as an issue that can be solved when patients accept responsibility for their problem and seek behavioral treatments for help. The American Psychiatric and Medical Association, as well as the World Health Organization, consider the disease model of addiction as the most accurate one. Due to its biological components, alcoholism and addiction have genetic features that may disrupt the critical and main pathways of the brain that control behavior (Hazelden Foundation, 2008).

There are three main factors that support the idea of addiction as a disease: addiction has identifiable symptoms, such as tolerance, withdrawal, and an inability to discontinue the use of a substance in spite of the consequences; addiction has a predictable course, for example, the different processes that occur when an individual abstains and relapses; and finally, the disease condition is not caused by choice because there is a genetic and biological predisposition that leads individuals to make substance consumption their priority (Hazelden Foundation, 2008).

Additionally, several neuroimaging studies have identified different brain circuits and areas that change once an individual develops an addiction, for example, substance abusers have

less D2 (dopamine) receptors in the motivational areas of the brain (Garavan & Hester, 2007). Finally, research has found that the genetic heritability of addiction can be compared to diseases like diabetes, hypertension, and cancer, among others; therefore, addiction treatment should be as important as the treatment of other diseases (Hazeldeen Foundation, 2008).

On the other hand, the choice model dictates that the individual has the skills and resources to decide whether or not to stop using the substance. Due to the person's initial decision to consume drugs, the same individual should have the ability to discontinue the substance seeking and consuming behavior. Additionally, the choice model states that addiction is not a disease due to the significant recovery rates of individuals who reached sobriety without any kind of treatment (Heyman, 2013). Unfortunately, the choice model might be stigmatizing and critical towards individuals that suffer from alcoholism or substance abuse and that are unable to quit.

2. Risk and protective factors

Drug addiction is not usually caused by one isolated problem or circumstance. It generally develops by the influence of various situations and factors that lead the individual to this pathology. The three main areas that contribute to the development of a substance use disorder are: biological predispositions, environmental factors and influences, and drug choice and delivery method (Mordey, 2015).

Risk factors can increase or enhance the propensity of an individual to develop an addiction. Biological and genetical predisposition has been described as one of the most important factors for developing a substance addiction. For example, research has shown that "children of alcoholic parents have approximately four times greater risk of becoming alcoholics themselves" (West & Prinz, 1987, p. 212). Furthermore, studies have shown that there are

heritable components transmitted from one generation to another that provide evidence that genetic factors play a major role in the etiology of alcoholism (Reich, 1997). Impulsive behavior has also been linked to drug use, not only as a cause but also as a consequence; therefore, impulsivity may increase the tendency and predisposition to use drugs (Wit, 2008).

Environmental factors include age, family, parental involvement and relationship, substance use in the family environment, school-related factors, peer group, and neighborhood influences. Age is a very influential factor because the younger an individual is exposed to a drug, the greater the risk of having a substance use disorder later in life. Parental involvement and relationship are determinant risk factors. According to Trutz (2010), parental concern and involvement have a very protective effect in reducing the likelihood of drug consumption in school attending individuals. Substance use by family members is another important risk factor, “[t]he possible reasons for a strong and direct relationship are many: the presence of a role model, access to the substance, a relaxation of disapproval, or, possibly, a reduction in parenting skills as a result of substance use” (Trutz, 2010, p. 85).

Among the school-related factors, non-attendance and negative school-related experiences can increase the risk of substance use. Peer effect and influence may also raise the likelihood of drug consumption if the group is exposed to substances. On the other hand, the peer group can also be a protective factor if the friends do not use substances and are involved in positive interactions where the group disapproval of drug consumption may play a crucial role (Trutz, 2010). Finally, neighborhood factors like poverty and crime may increase the likelihood of substance use. “Neighborhoods that are perceived as chaotic, unpredictable, or merely unwelcoming and alienating can increase stress and shaping patterns of anti-social behaviors and

attitudes that are viewed as necessary to cope with a tough environment” (Kulis, Marsiglia, Sicotte, & Nieri, 2007, p.275).

In Ecuador, the main risk factors associated with drug abuse and addiction, according to a 2007 national survey on drug consumption, are: living with friends, having a fragmented family or divorced parents, lack of communication in the family, physical and psychological abuse in the domestic environment, abandonment in childhood and adolescence, poverty, low educational level, and insecurity and delinquency in the neighborhood (Corella, 2007). Another study among the Andean community states that additional risk factors in young people are a low-risk perception of substance use and drug availability (PRADICAN, 2012).

On the other hand, protective factors are associated with a reduced potential for drug use and abuse. Among these, parental monitoring and control, academic competence, and drug policies and safety in the neighborhood are considered important (U.S Department of Health and Human Services, 2003). As it was mentioned previously, parental monitoring has a positive effect on children and may be effective in protecting young individuals from early substance use and abuse. Academic competence and student motivation can be helpful to reduce the rates of school dropouts, decreasing the prevalence of substance users in the school environment (Trutz, 2010). Drug policies can reduce the availability of substances, preventing young individuals from using drugs and delaying the age of first consumption. Additionally, prevention programs that address drug abuse in the community or region, target risk factors, and increase protective factors can reduce early substance use rates and strengthen drug resistance skills (U.S Department of Health and Human Services, 2003). Finally, safe neighborhoods with low crime and poverty rates and a sense of disapproval of drug consumption are also identified as an important protective factor.

According to the SETED, the main protective factors in Ecuador are: positive communication in the domestic environment, cohesive family, parental monitoring and control, school attendance, and healthy peer group relationships (Secretaría Técnica de la Prevención Integral de Drogas, 2017).

3. Twelve-step program modality and criticism

Twelve-step program groups are organizations of mutual help, like Alcoholics or Narcotics Anonymous, that are available worldwide. Several research studies have found a positive correlation between twelve-step group participation, addiction recovery, and better interpersonal functioning (Zemore, Lui, Mericle, Hemberg, & Kaskutas, 2018). The central philosophy of Alcoholic and Narcotic Anonymous is based on the concept of a divine or higher power that plays a major role in sobriety and recovery. According to Eric, Fefer, and Strohm (2000), seven of the 12 steps in the program make reference to the notion of religious or spiritually based concepts, such as prayers or spiritual awakening. Individuals who participate in this type of program should be spiritually oriented and accept powerlessness; therefore, the only way to succeed in the twelve-step program is to trust and surrender to a higher power.

Many of the twelve-step techniques have been criticized for encouraging their members to depend on an external source for their recovery. It has been argued that “teaching patients that they can only recover through the intervention of a Higher Power is often destructive to the treatment process because it perpetuates the idea that the person is helpless and will always remain that way” (Ellis & Schoenfeld, 1990, p.462). According to Horvath, the social support that is provided by the twelve-step groups is similar to the one given by any recovery group for

people with common problems; therefore, individuals may benefit most from the social support element of the group discussion rather than from the twelve-step principles (Horvath, 2004).

4. SMART Recovery 4-Point Program

Self-Management and Recovery Training (SMART) is an international non-profit organization that does not focus specifically on substance abuse, but in any sort of addictive behavior. It was founded in 1994 as a peer support program that can be used as an alternative to twelve-step groups. The meetings commonly last 90 minutes and are led by volunteers that have support from health professionals (Horvath & Velten, 2000). The program is research-based and uses techniques from Cognitive Behavioral Therapy (CBT). Cognitive Behavioral Therapy is a model developed by Aaron Beck in the 1960s. It states that the emotions and behaviors of people are influenced by their thoughts and perception of events (Fenn & Byrne, 2013). Many studies have shown that CBT is an effective treatment for substance abuse and addiction.

According to Rangé and Bernard (2008), the SMART Recovery Program was the first intervention attempt of using CBT for addiction treatment. The Cognitive Model for substance abuse was developed under the assumption that the cognitive components of automatic thoughts, schemes, and dysfunctional thinking patterns come from early life experiences. Moreover, treatment approaches like exposure, directed activities, changing beliefs about substance use, and plans, among others, are CBT tools and models that play a major role in therapy (Rangé & Marlatt, 2008). Research has shown that the tools used by the SMART Recovery program are effective in treating addictions (Horvath & Yeterian, 2012).

SMART Recovery is based on a 4-Point Program that provides tools, techniques, and strategies to help individuals on their journey to recovery. These are: 1. Building and maintaining motivation, 2. Coping with urges, 3. Managing thoughts, feelings, and behaviors, and 4. Living a

balanced life (SMART Recovery, 2013). The four points do not have to follow a specific order as some strategies might be more important to develop in different situations or times (Horvath & Yeterian, 2012).

Building and maintaining motivation is the first point of the program. Individuals are expected to understand their main goals and motives for overcoming the addiction. According to the *SMART Recovery 3rd Edition Handbook*, motivation is the key to recovery and the force that allows individuals to meet their goals. On this module, there are several assessment tools and questionnaires that evaluate and foster motivation; for example, the *CAGE questionnaire*, which is based on a series of questions to assess whether or not participants have an addictive behavior (Appendix 1). *The Cost Benefit Analysis of Using* (Appendix 2) identifies the long- and short-term benefits of abstinence. *The Change Plan Worksheet* (Appendix 3) is a guide to recognize the main reasons for change and motivation. The application of the different activities and worksheets helps individuals to build a specific and structured plan for their recovery (SMART Recovery, 2013).

The SMART Recovery program divides the different stages on the recovery journey as:

Precontemplation stage, where individuals are not seeing their behaviors as problematic and, consequently, they are not willing to change. Usually, they blame and place responsibility on external sources. On the contemplation stage, participants start to analyze the benefits and consequences of their behaviors. On the preparation stage, the person is convinced that change is needed and starts analyzing what changes should be made, and finally, the action stage is where participants actively work on changing their behaviors by having a greater commitment to the program. Here changes are more visible, and a support system is determinant (SMART Recovery, 2013).

Coping with urges is the second point of the program. According to the SMART Recovery program (2013), coping with urges makes the difference between using and abstaining; therefore, emotional, mental, and physical commitments must be made. The main objective of the module is to understand the beliefs that promote urges. This module states that some beliefs might be irrational and unrealistic; consequently, some individuals are not able to deal with urges. One important tool taught is to *identify the triggers* (Appendix 4). According to the *SMART Recovery Handbook* (2013), “triggers are things that lead to cravings, which can lead to urges. They might be your emotions, something you are doing or have done, a day of the week, a period of time, something you touch, hear, smell, see or taste, or anything that leads to urges” (pg. 26). This stage allows individuals to identify their riskiest triggers and teaches them strategies on how to prevent them. One important worksheet is the *Urge Log* (Appendix 5), which helps program attendants identify patterns of urges, situations, times of the day, and people, among others, that are most likely to activate drug-seeking behaviors.

The SMART Recovery program offers some alternatives for coping with urges: avoiding situations, sensations, or events that may intensify urges; escaping, which means that the individual is expected to leave from provoking situations; distraction, that involves engaging in other activities or actions to change the focus of attention; reviewing motivation and goals of treatment; recalling negative consequences and moments of clarity; and picturing the future, which means that individuals are expected to develop a mental picture of themselves recovered, among other strategies (SMART Recovery, 2013).

Some important strategies are taught in this module. One of them is to defeat urges with the DEADS approach: Delay, Escape, Avoid, Attack, Accept, and Distract. This strategy helps the individual to deal with urges in a cognitive way and to identify strategies to avoid the urge.

Another well-researched and investigated strategy is the ABC model of Rational Emotive Behavioral Therapy (Ellis & Schofield, 1990). This model explains how urges and beliefs are activated and how to cope with them.

The third point of the program consists of managing thoughts, feelings, and behaviors. The first step in this module focuses on helping attendants to adopt unconditional acceptance to overcome the emotional problems that addictions may have brought to their lives (SMART Recovery, 2013). In this section, the key components of CBT are used and explained to the participants.

According to the CBT model, cognitions are divided into three levels: core beliefs or schemas, dysfunctional assumptions, and automatic thoughts (Beck, 1976). Fenn and Byrne (2013), explained that core beliefs, also known as schemas, are strong and deep beliefs about oneself, others, and the world that are mainly developed through early life experiences. Dysfunctional assumptions are rigid rules that individuals adopt for their lives. Most of them are unrealistic, hence dysfunctional. Negative automatic thoughts are involuntarily activated cognitions that occur in specific situations; most of them are negative and catastrophic (Fenn & Byrne, 2013). These thoughts or cognitions activate negative emotions that consequently make individuals act in a certain way, for example, displaying avoidant or impulsive behaviors.

One of the main activities presented in this module is the identification of rational and irrational beliefs. Common types of cognitive distortions and irrational beliefs are mentioned to enhance the individual's understanding of the CBT model. Some of the worksheets to work on this task are the *Dispute of Irrational Beliefs Worksheet* (Appendix 6) and *Change Your Vocabulary Change Your Feelings* exercise (appendix 7).

The following step in the module consists of understanding the ABC model. Participants are asked to identify some triggering event that activated an irrational belief, understand and identify the consequences of their irrational belief, and finally, dispute or discourage it. One of the tools that can be used for this stage is *My ABC for Dealing With Emotional Upset Worksheet* (Appendix 8). Once the thinking patterns are disputed and start to change, the irrational beliefs will not be activated as often by triggering events.

Other important tools and techniques taught in this module consist of relapse prevention strategies. They involve identifying dangerous situations where relapse can occur and different coping strategies that could be used to manage urges, for example: getting psychological help, find substitute activities, distractions, stimulus control, abstinence, and violation effect, among others (SMART Recovery, 2013).

The fourth point of the SMART Recovery program is living a balanced life. It is a module centered on the promotion of healthy activities and decisions that may enhance the individual's possibility to prevent relapse. Understanding and respecting each area of the person's life and changing the perspective on areas in which the person feels stuck are the main actions that lead to a balanced life. In order for the SMART program to be effective, participants should be honest about their values and beliefs and, according to it, plan and engage in activities that might help them live a balanced life.

One of the main strategies taught in this module is called *Lifestyle Balance Pie* (Appendix 9). Individuals need to identify different aspects of their lives and rate how satisfied they are with each one of them; therefore, they will be aware of some areas in their lifestyle that need more attention and work. Another important tool is called *Vital Absorbing Creating Interest* (VACI) (Appendix 10), which can help participants to identify some of the activities that they

enjoyed in the past but quit doing because of their addiction (SMART Recovery, 2013). The tool is used to find new activities and hobbies that can be helpful to develop a healthy and balanced lifestyle.

Goal-setting is an important technique in this section. Goals should be specific, measurable, agreeable, realistic, and time-bound (SMART) in order to be accomplished. Additionally, some activities are recommended in order to improve the lifestyle of the participants and maintain sobriety; for example, the practice of relaxation techniques like progressive muscle relaxation (PMR), visualization of the future, meditation, and mindfulness; eating healthy; exercising; getting enough sleep, and taking medication when necessary (SMART Recovery, 2013).

The meeting rules involve maintaining confidentiality, showing respect and acceptance towards other members, active participation, listening and learning from the experiences of others, focusing on how to abstain, and donating what the individual can afford. Family meetings are also encouraged in order to involve the system in the recovery journey of the individual. The systemic meetings are based on the Community Reinforcement Approach and Family Training (CRAFT) that enhances and promotes positive interaction and communication skills for friends and family of addicted individuals (Smart Recovery, 2014).

The SMART Recovery program was designed for people that are not able to identify with the higher power principle of the twelve-step groups. In twelve-step groups, members seek a recovery approach of powerlessness, use the labels “addict” or “alcoholic,” consider addiction a disease, and are willing to engage on lifetime attendance (Horvath & Sokoloff, 2011). Research on SMART Recovery has determined that individuals who will mainly benefit from this 4-step program should have an internal locus of control, as well as higher education and income rates

(Zemore, et al., 2018). “This mutual self-help program may be especially appealing to secular, highly educated individuals because these alternatives emphasize cognitive-behavioral (scientifically informed) strategies rather than religious or spiritual change” (Zemore, et al., 2018, p.22).

According to Horvath and Yeterian (2012), evidence has shown that the SMART Recovery program is successful in treating individuals who have an internal locus of control, which means that they perceive their addictive behavior as manageable; therefore, they believe that it can be controlled by learning the appropriate tools and techniques to overcome addiction. On the other hand, people with an external locus of control feel incapable and unable to change their substance using behavior and, consequently, need to accept powerlessness, which makes twelve-step approaches well suited for them (Horvath & Yeterian, 2012).

Studies have shown positive associations between length/intensity of involvement and length of sobriety as well as other beneficial outcomes from alternatives to twelve-step programs, like the SMART Recovery program. Research has shown that people attending the SMART Recovery program have more abstinent days and a reduction in substance-related issues and drinks per day (Hester, Lenberg, Campbell, & Delaney, 2013). Additionally, individuals with co-occurring mental health diagnoses and substance use disorder have better outcomes and results when attending the SMART Recovery program (Brooks & Penn, 2003).

METHODOLOGY AND RESEARCH DESIGN

This research study is based on the question: To what extent could the implementation of the SMART Recovery program for addicts in Ecuador decrease substance abuse and dependence rates in the country. The methodology will consist of a quantitative design with a statistical ANOVA for repeated measures.

Methodology Design and Justification

This study aims to evaluate the possibility of reducing substance abuse and addiction rates in Ecuador with the application of the SMART Recovery program. A quantitative design is appropriate for this study because “it explains the phenomena by collecting numerical data that are analyzed using mathematically based methods” (Mujis, 2004, p. 13). The Alcohol, Smoking, and Substance Involving Screening Test (ASSIST) is a questionnaire developed by the World Health Organization (WHO) that provides information about substances people currently use, have used in the past three months or in their lifetime, problems related to substance abuse, actual risk, future harm, dependence, and injecting behavior (World Health Organization [WHO], 2003).

Participants will receive three questionnaires on a time frame of 12 months. The first questionnaire will be applied before the SMART Recovery intervention, the second will be given six months after the beginning of the treatment, and the last questionnaire will be applied 12 months after starting the program. This method will be useful to analyze the results at different time points. The dependent variable of the study is the application of the SMART Recovery program, while the independent variables are age, sex, and substance abuse diagnosis. A quantitative design with an ANOVA with repeated measures is used because it measures and

reveals any type of difference between related means and it is useful to detect changes in mean scores over three or more points in time (Lund Research, 2018). An ANOVA with repeated measures helps to determine statistical significance; therefore, it will be useful to analyze whether the SMART Recovery intervention has a significant effect in reducing consuming and addictive behaviors and evaluate the validity of the hypothesis.

Participants

Participants will be recruited from different places. Brochures and advertisements will be placed in hospitals, universities, clinics, and pharmacies, among other places, in order to select a random sample of subjects. Individuals will be assessed with the ASSIST questionnaire and the DSM-5 diagnostic criteria for substance use disorder in order to evaluate if they have a substance addiction problem.

Inclusion criteria include:

1. Participants with a substance abuse disorder
2. Participants older than 16 years old
3. Participants that have at least seven years of formal education
4. Agreement of the informed consent

Exclusion criteria include:

1. Attending other treatment modalities for substance use disorder
2. Inability to read
3. Individuals with cognitive impairments

4. Individuals with a dual diagnosis

Research Tools

For this study, the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) will be used. This assessment tool is useful to identify substance use problems in health care settings that offer addiction treatment and prevention alternatives. Participants will need approximately 5 to 10 minutes to complete the test. This screening tool has strong reliability; therefore, the results obtained are statistically significant. It is also useful to identify differences among participants and classify them into three groups: people with low risk of substance use, risk factors of individuals with drug abuse problems, and differences between substance users and abusers (WHO, 2003).

The questionnaire consists of eight questions. The first seven questions assess consuming patterns and problems associated with using substances. Drug categories are specified, and if there is an additional drug that is consumed, it can be placed in the “other” distinction option.

Question 1 asks about the drugs individuals have used on their lifetime. Question 2 assesses the frequency of drug usage and substance preference. Question 3 evaluates the level of desire for drug use and substance urge. Question 4 analyzes the social, financial, and occupational problems associated with drug use. Question 5 assesses the consuming frequency of a specific drug and how it interferes with the patient’s daily life. Question 6 appraises family and social concern regarding the substance abuse problem. Question 7 explores the failed attempts of abstinence and their frequency (WHO, 2003).

The last question is about drug injecting behavior. This behavior has several severity associations, like blood-borne viruses and stronger drug-related issues therefore, it is studied separately (WHO, 2013).

There will be availability for 50 participants, 25 for group A and 25 for group B meetings. Individuals will be informed about the research study and its purpose, and they will be given an informed consent form previously approved by the ethics committee of Universidad San Francisco de Quito (USFQ). Participants will meet weekly; sessions will be guided by a voluntary facilitator previously trained on the SMART Recovery program.

The first ASSIST questionnaire will be administered before the initial SMART Recovery intervention. The screening results will be documented in order to analyze the ANOVA repeated measures and to obtain statistically significant results about the efficacy of the interventions. The application of this program is expected to offer long-term outcomes that can make it a reliable treatment option for people with a substance addiction problem. This treatment is also expected to reduce relapse rates.

Ethical Considerations

Due to the stigma and discrimination that most substance abusers face, the study will maintain complete anonymity. Participants will be given a code or number to identify them during the length of the research study. In the group meetings, individuals will use an alias or their participant number. Documents and tests in which the participant's identification information is revealed will be kept on secured files, and the documents that will be used during the research process will only have an identification number. Therefore, if something happens to the documents during the study, confidentiality will be maintained. If participants relapse or are

incapable of remaining abstinent, they can continue in the study. Additionally, if they feel overwhelmed or want to leave the program, they are free to do so at any stage of the treatment process. Finally, participants will be given their results at the end of the study or at any given time if they decide to terminate their participation before the study is completed.

PROBABLE RESULTS

At the initial stage of the program, it is expected that participants question the functionality and reliability of the SMART Recovery interventions. There are a few features that can predict possible treatment outcomes. Factors such as the setting where the meetings are held; religious beliefs, cognitive abilities, and socioeconomic status of the participants; and the efficacy of the meeting mediators might influence the outcomes of the research study (Eric, Feifer, & Strohm, 2000). It is likely that during the first three months of intervention, participants accomplish the first step of the SMART Recovery program, which is building and maintaining motivation. It can also be predicted that some individuals may not reduce the drug use frequency during the initial phase of the program. On the other hand, it can be foreseen that most of the participants that follow and continue with the program as established may be able to fulfill the abstinence goal by the end of the 12-month treatment period.

According to Eric, Feifer, and Strohm (2000), previous research on SMART Recovery interventions has shown that individuals with an internal locus of control have better outcomes with the application of this program. Therefore, it is expected that participants who assume responsibility for their recovery will benefit the most from this treatment approach. Additionally, individuals with a higher socioeconomic status and education level, and low religiosity may report greater benefits from the interventions (Zemore et al., 2018). Consequently, participants who share these features among the Ecuadorian population may have a more positive outcome at

the end of the program. It is important to take into account that the Ecuadorian population usually exhibits a strong sense of religiosity. This characteristic is often present in individuals from every socio-economic stratum; therefore, it is important to assess the impact of this variable on the results of the study as the SMART Recovery interventions tend to have more positive outcomes in populations with lower religiosity.

It can be predicted that by the 6th-month evaluation, most of the participants who are from a lower socioeconomic status, have fewer years of education, or high religiosity may have abandoned the program due to the difficulty of the tasks and their need of spiritual orientation. Therefore, participants that continue in the program should show better responses to the interventions and may have reduced the frequency of substance consumption or be already abstinent. By this stage, it is expected that participants reach the second point of SMART Recovery: coping with urges.

It is predicted that most participants may reach total abstinence by the 8th month of the SMART Recovery implementation and that they will be able to effectively manage the third point of the program: identifying and managing thoughts, emotions, and behaviors. The cognitive-behavioral model will be majorly taught and implemented during this stage of treatment. Most spiritually oriented and uneducated individuals may have dropped the program at this point.

By the 12th month of the implementation, all remaining individuals should be abstinent and following the fourth point of the program, which consists of living a balanced life. At this stage, participants should start disengaging from the program using the techniques and methods learned; therefore, the management of urges and impulses, an understanding of the cognitive

model, the difference between thoughts, emotions, and behaviors, and the adoption of healthier activities should be achieved.

DISCUSSION

To conclude the investigation, the researched question: *To what extent could the implementation of the SMART Recovery program for addicts in Ecuador decrease substance abuse and dependence rates in the country?* will be analyzed.

The purpose throughout this study was to examine in which ways could the implementation of the SMART Recovery program with individuals who have a substance use disorder, reduce dependence and abuse rates in the country. It is important to emphasize that the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) is a good screening measure to assess and understand the level of substance abuse and addiction that the individual is experiencing. Taking this into account, individuals suffering from substance abuse and addiction problems may be the ones that will most benefit from this program. This proposal aims to develop a clear understanding of a new treatment for addictive disorders that has never been implemented in the country. Therefore, screening measures regarding socioeconomic, educational, and spiritual factors should be analyzed.

It is important to take into consideration that individuals with the following characteristics may not benefit from the intervention: low socioeconomic status, low educational attainment, or high spirituality or religiosity. (Zamore et al., 2018). Therefore, the SMART Recovery program can decrease substance abuse and dependence rates in certain social strata from the Ecuadorian population with singular characteristics. Consequently, prior to a SMART

Recovery program implementation, a socioeconomic, spiritual, and educational evaluation should be held in order to give participants the best alternative for recovery.

The implementation of the program should be carefully monitored and conducted by a moderator that will teach and train individuals how to complete the 4-point program; therefore, the availability of an experienced facilitator is a determinant condition for recovery. It is important to mention that SMART Recovery members generally report greater involvement and satisfaction with the program as compared to other mutual help groups (Zamore et al., 2018). For this reason, moderators and members should try to maintain fidelity and be involved with the program in order to have a positive outcome.

Finally, it is important to consider that SMART Recovery could considerably decrease substance abuse and dependence rates in the country due to the gratuity and easy implementation of the program. Furthermore, it is a research-based treatment that could provide positive results in a certain stratum of the population. This could be an important contribution to the field of addiction treatment in the country, which, as was mentioned before, is in many cases unethical, improvised, and unavailable.

LIMITATIONS

There are some limitations that could impact the validity of the results of this investigation. First, there should be a distinction between the gender and age of individuals. This factor might influence the results of the SMART Recovery implementation, as previous research has shown that the program has better outcomes with male adults in comparison with other demographic populations (Hester et al., 2013). Secondly, the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) has not been implemented nor validated in the

Ecuadorian population before. Therefore, the results may show some inconsistencies due to the demographical differences. Thirdly, results cannot be generalized due to the small sample that will be used on this investigation. Future investigations should evaluate the results with a greater number of participants. Finally, a limitation concerning the methodology of this research is that it does not include more screening evaluations to assess demographic, socioeconomic, and spiritual factors that can significantly influence the results and the effectiveness of the SMART Recovery program.

FUTURE RECOMMENDATIONS

It is recommended that prior socioeconomic, educational, and religiosity assessment is made before the implementation of the program in the future. Better outcomes could be predicted in addicted individuals with an internal locus of control, higher socioeconomic status, and better educational attainment.

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Appendix 1



Start at SMART NE

SMART New England: www.smartne.org
 SMART Worldwide: www.smartrecovery.org

The CAGE assessment tool

When you first read this handout, you may wonder if you even have a problem. There are several assessment tools used in the addiction field to help assess whether you might have a problem. An easy one is the CAGE questionnaire below that has you answer 4 simple yes/no questions.



THE TOOL: The CAGE Questionnaire EFFECTIVELY
 USED FOR WHICH OF THE 4 POINTS?

Building Motivation Coping with Urges Problem Solving Lifestyle Balance

1. Have you ever felt you should Cut down on your drinking?
2. Have people Annoyed you by criticizing your drinking?
3. Have you ever felt bad or Guilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (Eye-opener)?

If you answered yes to even one of these, you may have a problem. With two or more, it's even more likely that you have a problem and you might like to come to a meeting and learn more. There is no commitment to anything, and a 90-minute investment in a SMART meeting now might save your life.

Appendix 2

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Figure 3.4. **Cost-Benefit Analysis.**

Using or Doing	
Label each item short-term (ST) or long-term (LT)	
Benefits (rewards and advantages)	Costs (risks and disadvantages)
NOT Using or Doing	
Label each item short-term (ST) or long-term (LT)	
Benefits (rewards and advantages)	Costs (risks and disadvantages)

Appendix 3

Appendix B: Worksheets

Figure 3.3. **Change-Plan worksheet.**

Changes I want to make:	
How important is it to me to make these changes? (1-10 scale)	
How confident am I that I can make these changes? (1-10 scale)	
The most important reasons I want to make these changes are:	
The steps I plan to take in changing are:	
How other people can help me:	
Person	Kind of help
I will know my plan is working when:	
Some things that could interfere with my plan are:	

Appendix 4

Chapter 4: Point 2 – Coping with Urges

Figure 4.2. **Trigger risks.**

Trigger	Rate risk on 1-10 scale
Unpleasant emotions: Anger, frustration, grief, etc. Others:	
Pleasant emotions: Joy, peace, anticipation, etc. Others:	
Unpleasant physical sensations: Pain, cold, heat, etc. Others:	
Stress: Peer pressure, work issues, general fear, financial concerns, etc. Others:	
Conflict with others: Spouse, co-worker, boss, children, parents, etc. Others:	
Physical place or time: Restaurant, park, with friends, car, work, summer, evening, etc. Others:	
Other:	
Other:	

Now that you rated the risk of each trigger in Figure 4.2, apply the triggers to your addictive behavior. For each addictive behavior, list every situation you can think of that triggers your urge to use. Start with the riskiest (10) to the least risky (1). Follow this example:

Figure 4.3. **Trigger worksheet** (example).

My addictive behavior: Cocaine	
Trigger:	Risk: 1-10
Fighting with my spouse	10
Hanging out with Robert	10
Driving by the corner where I used to buy	8
Dancing at a nightclub	3
Holidays	10

My trigger worksheets

My addictive behavior:	
Trigger:	Risk: 1-10

My addictive behavior:	
Trigger:	Risk: 1-10

Urges

Identifying your triggers is an important part of your recovery. Awareness gives you the power to understand and deal with urges; however, even with awareness and planning, you will experience urges. It's a normal and natural part of recovery.

An awareness and understanding of urges is crucial to recovery. You identified what triggers them, but do you know how long they last? How intense they are? How frequent? Most people with addictive behaviors don't realize that urges usually last only seconds to minutes and then pass.

One way to understand your urges is by recording them in an urge log.

EXERCISE: Urge log

An urge log (Figure 4.4) is a table in which you record specific information about your urges. After a few entries, you may notice patterns and similarities about your urges. The log then becomes a road map that will help you anticipate situations and emotions that may trigger

Appendix 6

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Figure 5.1. **Disputing Irrational Beliefs** (example).

Irrational belief	Question IB	Rational belief
I always fail.	Do I always fail?	I have done some useful things in the past so I don't and won't always fail.
I'm totally worthless.	Have I never done anything worthwhile?	I have done some worthless and useless things BUT because I have had success at things, I cannot judge myself as a totally worthless person.
My partner treats me unfairly. He is a bad person.	Does my partner treat me unfairly? Is he a bad person?	He has done unfair things BUT he also has done many things to help me so I can't judge him as a totally bad person. No one is perfect.
Nothing good ever happens to me and never will.	Does nothing good ever happen to me?	The love and support of my family and friends are all good things that continue to happen to me.
I must always do whatever it takes to be comfortable.	Is it realistic to expect to always feel comfortable?	Comfort ebbs and flows. It may be better to stay uncomfortable temporarily if it will help me achieve my long-term goals.
When I mess something up, it proves what I have always thought: I am a complete failure.	Am I a complete failure?	I don't judge others as harshly as I judge myself. Everyone makes mistakes. I can make mistakes and learn from them; it makes me human, not a failure.
I have to be better and do better than the people around me or I am nothing.	Am I really nothing?	I don't need to prove I'm better than others to be OK. I can be happy just as I am, and deserve to accept myself.
Because my addictive behavior has proven that I'm a loser, I should never trust myself and my instincts, and will always need the advice of others.	Do I need others' advice?	I've made mistakes and will continue to make them. BUT I can trust my thoughts and feelings, and I don't need to rely on others' opinions to validate my self-worth.
Others are responsible for my unhappiness. I hate them, I want to punish them, or I complain bitterly when they disappoint me.	Are other people in charge of my happiness?	I'm responsible for my happiness. Holding others responsible is unrealistic, unfair to them, and doesn't lead to my long-term happiness.
I must find the one person or belief that will make my life stable.	Is there one person or belief that will make me happy?	Life is an ongoing process of learning many things and relating to many people. It's a journey on which I will change and grow.
I'm bored, and that makes me uncomfortable. The only thing I can do is engage in my addictive behavior.	Is using the only option I have?	I can do other things to relieve the boredom. If I do one, I will be less bored and it will get my mind off my addictive behavior.

Appendix 7

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Figure 5.3. **Statement exchange.**

Instead of saying or thinking:	Say or think:
I must be perfect	I really want to do well
You should not do that	I prefer you not do that
You ought to help	I would appreciate your help
I can't stand this feeling	I don't like feeling this way
You are a bad person	I don't like your behavior
This urge is awful	This urge is unpleasant
This situation is unbearable	This is not the best way
Everything is terrible	Things are not the way I want them to be
This happens every time	This frequently happens
I need your love	I want your love
I'm a bad person	I behaved badly
I am a failure	I made a mistake / I failed at

Figure 5.4. **Emotion vocabulary exchange.**

Instead of saying or thinking:	Say or think:
I am terribly anxious	I feel concerned
I am so depressed	I feel sad
I am really angry	I feel annoyed
I am guilty	I feel remorse / I feel regret
I am so ashamed	I feel disappointment
I'm really hurt	I feel sorry
I'm jealous	I feel concern for my relationship
I'm envious	I feel unhappy

Managing feelings

Strong emotions are an inevitable part of the human condition. You can learn to reduce unhealthy negative emotions (unhealthy because these make us want to behave in self-defeating ways) and even change them to healthy negative emotions (healthy because they can help us get what we want for ourselves in the long run).

Let's use anger as an example. Some low-level annoyance or aggravation — healthy anger — can lead to positive and assertive action: standing up for yourself or others in the face of injustice. Rage — unhealthy anger — can be dangerous and destructive, leading to negative and aggressive behavior. While annoyance is balanced by logic, extreme anger — as with

Appendix 8

Chapter 5: Point 3 – Managing Thoughts, Feelings, and Behaviors

My ABC for dealing with emotional upset worksheet

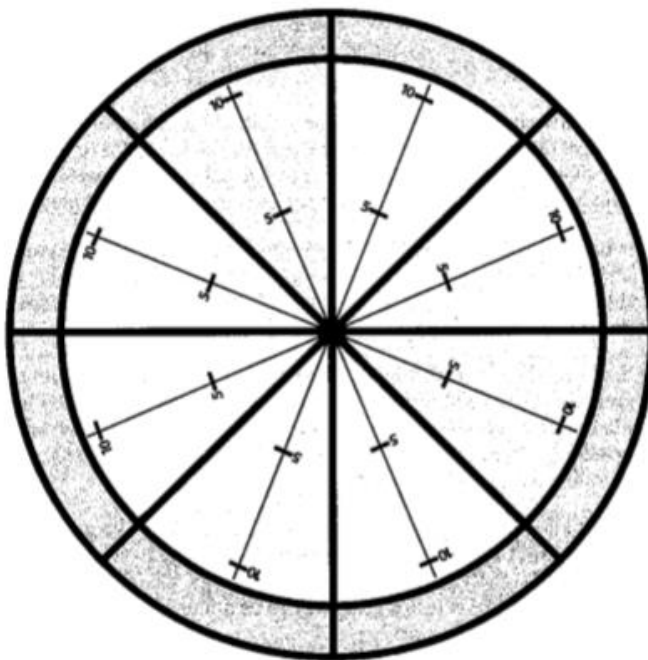
A ctivating event What happened?	B elief about event — Irrational What am I telling myself about the event? Example: Demand, awfulizing, downing, frustration intolerance, etc.	C onsequence of my irrational belief How does my irrational belief make me feel? Example: Rage, depression, anxiety, shame, avoidance, aggression, etc.	D ispute my irrational belief Turn B into a question (DIBs). Example: <i>Am I really a...? Do I have proof of...?; etc.</i>	E ffective change in my thinking Rational thoughts, moderate emotions. Example: Annoyance, disappointment, assertiveness, sadness, etc.

Appendix 9

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My Lifestyle Balance Pie

Date _____



Lowest scores	
Life category	Score
1.	
2.	
3.	
4.	
Highest scores	
4.	
3.	
2.	
1.	
Plan	

Appendix 10

Chapter 6: Point 4 – Living a Balanced Life

TOOL: Vital absorbing creative interest (VACI)

Before your life was overtaken by addictive behavior, there were probably hobbies and activities you enjoyed and others you wanted to try. Now you can bring them back into your life, and explore the new ones. Hobbies and interests help balance your life.

A vital absorbing creative interest can help bring the simple pleasure of living back into your life. When we get overly involved in any one activity, be it helpful or not so helpful, we cut a lot out of our lives that we used to enjoy. Finding a balance can restore the fun and enjoyment that life has to offer. So, how can we get back to those simple pleasures of life?

First, look at the benefits list on your CBA. What were some of the benefits you were getting from your addictive behavior before the costs became too high? Did you enjoy the buzz? Did you like being able to just check out for a bit? Was it the taste or the social aspect? Believe it or not, each of these benefits is a key to finding a VACI.

If you enjoyed the buzz, then look at things you could do to get a real buzz out of life. The reward will be greater and you will remember it in the morning and for years to come. Maybe you decide to ride a roller coaster you have never ridden before. Maybe it's taking up running or race walking. Perhaps you have always wanted to sky dive or ride a motorcycle. Figure out what would give you a buzz and take it on.

If using or acting out allowed you to "check out" for a bit, maybe looking at some ways of being away from the world for a while might give you the chance to restore your energy. Take a walk by yourself. Go to the ocean and watch the waves. Go on a day trip and be alone with yourself in your car. A bike ride is a great way to be alone with nature. What about gardening, crafts, and artistic endeavors?

Be careful to do your VACI in moderation so that you don't replace one addictive behavior with another.

If you leaned on alcohol or drugs to help you feel comfortable in social situations, you might challenge yourself to go to a social event and act as fun and as friendly as you were when you were using.

What did you like to do as a kid? What hobbies did you have? What dreams were never realized? Now is the time to take your life back and make some of those things happen.

Variety is the spice of life. Find many VACIs and keep looking for more. Life is full of amazing and new things to learn and do.

VACI list

Use the table in Figure 6.2 to make a list of the VACIs that interest you. Write it down then rate it, 1-10, on how much it interests you. After you try it, come back to the list and rate it again to see how closely your "before and after" ratings are.

ASSIST Questionnaire

OMS - ASSIST V3.0



OMS - ASSIST V3.0

ENTREVISTADOR	<input type="text"/>	PAÍS	<input type="text"/>	CLÍNICA	<input type="text"/>
N° PARTICIPANTE	<input type="text"/>	FECHA	<input type="text"/>	<input type="text"/>	<input type="text"/>

INTRODUCCIÓN (Léalo por favor al participante)

Gracias por aceptar a participar en esta breve entrevista sobre el alcohol, tabaco y otras drogas. Le voy hacer algunas preguntas sobre su experiencia de consumo de sustancias a lo largo de su vida, así como en los últimos tres meses. Estas sustancias pueden ser fumadas, ingeridas, inhaladas, inyectadas o consumidas en forma de pastillas (muestre la tarjeta de drogas).

Algunas de las sustancias incluidas pueden haber sido recetadas por un médico (p.ej. pastillas adelgazantes, tranquilizantes, o determinados medicamentos para el dolor). Para esta entrevista, no vamos a anotar fármacos que hayan sido consumidos tal como han sido prescritos por su médico. Sin embargo, si ha tomado alguno de estos medicamentos por motivos distintos a los que fueron prescritos o los toma más frecuentemente o a dosis más altas a las prescritas, entonces díganoslo. Si bien estamos interesados en conocer su consumo de diversas drogas, por favor tenga por seguro que esta información será tratada con absoluta confidencialidad.

NOTA: ANTES DE FORMULAR LAS PREGUNTAS, ENTREGUE LAS TARJETAS DE RESPUESTA A LOS PARTICIPANTES

Pregunta 1

(al completar el seguimiento compare por favor las respuestas del participante con las que dio a la P1 del cuestionario basal. Cualquier diferencia en esta pregunta deben ser exploradas)

A lo largo de su vida, ¿cual de las siguientes sustancias ha consumido alguna vez? (SOLO PARA USOS NO-MÉDICOS)	No	Si
a. Tabaco (cigarrillos, cigarros habanos, tabaco de mascar, pipa, etc.)	0	3
b. Bebidas alcohólicas (cerveza, vino, licores, destilados, etc.)	0	3
c. Cannabis (marihuana, costo, hierba, hashish, etc.)	0	3
d. Cocaína (coca, farlopa, crack, base, etc.)	0	3
e. Anfetaminas u otro tipo de estimulantes (speed, éxtasis, píldoras adelgazantes, etc.)	0	3
f. Inhalantes (colas, gasolina/nafta, pegamento, etc.)	0	3
g. Tranquilizantes o pastillas para dormir (valium/diazepam, Trankimazin/Alprazolam/Xanax, Orfidal/Lorazepam, Rohipnol, etc.)	0	3
h. Alucinógenos (LSD, ácidos, ketamina, PCP, etc.)	0	3
i. Opiáceos (heroína, metadona, codeína, morfina, dolantina/petidina, etc.)	0	3
j. Otros - especifique:	0	3

Compruebe si todas las respuestas son negativas:
"¿Tampoco incluso cuando iba al colegio?"

Si contestó "No" a todos los ítems, pare la entrevista.

Si contestó "Si" a alguno de estos ítems, siga a la Pregunta 2 para cada sustancia que ha consumido alguna vez.



Pregunta 2

¿Con qué frecuencia ha consumido las sustancias que ha mencionado en los <u>últimos tres meses</u> , (PRIMERA DROGA, SEGUNDA DROGA, ETC)?	Nunca	1 ó 2 veces	Cada mes	Cada semana	A diario o casi a diario
a. Tabaco (cigarrillos, cigarros habanos, tabaco de mascar, pipa, etc.)	0	2	3	4	6
b. Bebidas alcohólicas (cerveza, vino, licores, destilados, etc.)	0	2	3	4	6
c. Cannabis (marihuana, costo, hierba, hashish, etc.)	0	2	3	4	6
d. Cocaína (coca, farlopa, crack, etc.)	0	2	3	4	6
e. Anfetaminas u otro tipo de estimulantes (speed, éxtasis, píldoras adelgazantes, etc.)	0	2	3	4	6
f. Inhalantes (colas, gasolina/nafta, pegamento, etc.)	0	2	3	4	6
g. Tranquilizantes o pastillas para dormir (valium/diazepam, Trankimazin/Alprazolam/Xanax, Orfidal/Lorazepam, Rohipnol, etc.)	0	2	3	4	6
h. Alucinógenos (LSD, ácidos, ketamina, PCP, etc.)	0	2	3	4	6
i. Opiáceos (heroína, metadona, codeína, morfina, dolantina/petidina, etc.)	0	2	3	4	6
j. Otros - especifique:	0	2	3	4	6

Si ha respondido "Nunca" a todos los items en la Pregunta 2, salte a la Pregunta 6.

Si ha consumido alguna de las sustancias de la Pregunta 2 en los últimos tres meses, continúe con las preguntas 3, 4 & 5 para cada una de las sustancias que ha consumido.

Pregunta 3

En los <u>últimos tres meses</u> , ¿con qué frecuencia ha tenido deseos fuertes o ansias de consumir (PRIMERA DROGA, SEGUNDA DROGA, ETC)?	Nunca	1 ó 2 veces	Cada mes	Cada semana	A diario o casi a diario
a. Tabaco (cigarrillos, cigarros habanos, tabaco de mascar, pipa, etc.)	0	3	4	5	6
b. Bebidas alcohólicas (cerveza, vino, licores, destilados, etc.)	0	3	4	5	6
c. Cannabis (marihuana, costo, hierba, hashish, etc.)	0	3	4	5	6
d. Cocaína (coca, farlopa, crack, etc.)	0	3	4	5	6
e. Anfetaminas u otro tipo de estimulantes (speed, éxtasis, píldoras adelgazantes, etc.)	0	3	4	5	6
f. Inhalantes (colas, gasolina/nafta, pegamento, etc.)	0	3	4	5	6
g. Tranquilizantes o pastillas para dormir (valium/diazepam, Trankimazin/Alprazolam/Xanax, Orfidal/Lorazepam, Rohipnol, etc.)	0	3	4	5	6
h. Alucinógenos (LSD, ácidos, ketamina, PCP, etc.)	0	3	4	5	6
i. Opiáceos (heroína, metadona, codeína, morfina, dolantina/petidina, etc.)	0	3	4	5	6
j. Otros - especifique:	0	3	4	5	6



Pregunta 4

En los últimos tres meses , ¿con qué frecuencia le ha llevado su consumo de (<i>PRIMERA DROGA, SEGUNDA DROGA, ETC</i>) a problemas de salud, sociales, legales o económicos?	Nunca	1 ó 2 veces	Cada mes	Cada semana	A diario o casi a diario
a. Tabaco (cigarrillos, cigarros habanos, tabaco de mascar, pipa, etc.)	0	4	5	6	7
b. Bebidas alcohólicas (cerveza, vino, licores, destilados, etc.)	0	4	5	6	7
c. Cannabis (marihuana, costo, hierba, hashish, etc.)	0	4	5	6	7
d. Cocaína (coca, farlopa, crack, etc.)	0	4	5	6	7
e. Anfetaminas u otro tipo de estimulantes (speed, éxtasis, píldoras adelgazantes, etc.)	0	4	5	6	7
f. Inhalantes (colas, gasolina/nafta, pegamento, etc.)	0	4	5	6	7
g. Tranquilizantes o pastillas para dormir (valium/diazepam, Trankimazin/Alprazolam/Xanax, Orfidal/Lorazepam, Rohipnol, etc.)	0	4	5	6	7
h. Alucinógenos (LSD, ácidos, ketamina, PCP, etc.)	0	4	5	6	7
i. Opiáceos (heroína, metadona, codeína, morfina, dolantina/petidina, etc.)	0	4	5	6	7
j. Otros - especifique:	0	4	5	6	7

Pregunta 5

En los últimos tres meses , ¿con qué frecuencia dejó de hacer lo que se esperaba de usted habitualmente por el consumo de (<i>PRIMERA DROGA, SEGUNDA DROGA, ETC</i>)?	Nunca	1 ó 2 veces	Cada mes	Cada semana	A diario o casi a diario
a. Tabaco					
b. Bebidas alcohólicas (cerveza, vino, licores, destilados, etc.)	0	5	6	7	8
c. Cannabis (marihuana, costo, hierba, hashish, etc.)	0	5	6	7	8
d. Cocaína (coca, farlopa, crack, etc.)	0	5	6	7	8
e. Anfetaminas u otro tipo de estimulantes (speed, éxtasis, píldoras adelgazantes, etc.)	0	5	6	7	8
f. Inhalantes (colas, gasolina/nafta, pegamento, etc.)	0	5	6	7	8
g. Tranquilizantes o pastillas para dormir (valium/diazepam, Trankimazin/Alprazolam/Xanax, Orfidal/Lorazepam, Rohipnol, etc.)	0	5	6	7	8
h. Alucinógenos (LSD, ácidos, ketamina, PCP, etc.)	0	5	6	7	8
i. Opiáceos (heroína, metadona, codeína, morfina, dolantina/petidina, etc.)	0	5	6	7	8
j. Otros - especifique:	0	5	6	7	8



Haga las preguntas 6 y 7 para todas las sustancias que ha consumido alguna vez (es decir, aquellas abordadas en la Pregunta 1)

Pregunta 6

¿Un amigo, un familiar o alguien más <u>alguna vez</u> ha mostrado preocupación por su consumo de (PRIMERA DROGA, SEGUNDA DROGA, ETC)?	No, Nunca	Si, en los últimos 3 meses	Si, pero no en los últimos 3 meses
a. Tabaco (cigarrillos, cigarros habanos, tabaco de mascar, pipa, etc.)	0	6	3
b. Bebidas alcohólicas (cerveza, vino, licores, destilados, etc.)	0	6	3
c. Cannabis (marihuana, costo, hierba, hashish, etc.)	0	6	3
d. Cocaína (coca, farlopa, crack, etc.)	0	6	3
e. Anfetaminas u otro tipo de estimulantes (speed, éxtasis, píldoras adelgazantes, etc.)	0	6	3
f. Inhalantes (colas, gasolina/nafta, pegamento, etc.)	0	6	3
g. Tranquilizantes o pastillas para dormir (valium/diazepam, Trankimazin/Alprazolam/Xanax, Orfidal/Lorazepam, Rohipnol, etc.)	0	6	3
h. Alucinógenos (LSD, ácidos, ketamina, PCP, etc.)	0	6	3
i. Opiáceos (heroína, metadona, codeína, morfina, dolantina/petidina, etc.)	0	6	3
j. Otros - especifique:	0	6	3

Pregunta 7

¿Ha intentado <u>alguna vez</u> controlar, reducir o dejar de consumir (PRIMERA DROGA, SEGUNDA DROGA, ETC) y no lo ha logrado?	No, Nunca	Si, en los últimos 3 meses	Si, pero no en los últimos 3 meses
a. Tabaco (cigarrillos, cigarros habanos, tabaco de mascar, pipa, etc.)	0	6	3
b. Bebidas alcohólicas (cerveza, vino, licores, destilados, etc.)	0	6	3
c. Cannabis (marihuana, costo, hierba, hashish, etc.)	0	6	3
d. Cocaína (coca, farlopa, crack, etc.)	0	6	3
e. Anfetaminas u otro tipo de estimulantes (speed, éxtasis, píldoras adelgazantes, etc.)	0	6	3
f. Inhalantes (colas, gasolina/nafta, pegamento, etc.)	0	6	3
g. Tranquilizantes o pastillas para dormir (valium/diazepam, Trankimazin/Alprazolam/Xanax, Orfidal/Lorazepam, Rohipnol, etc.)	0	6	3
h. Alucinógenos (LSD, ácidos, ketamina, PCP, etc.)	0	6	3
i. Opiáceos (heroína, metadona, codeína, morfina, dolantina/petidina, etc.)	0	6	3
j. Otros - especifique:	0	6	3



Pregunta 8

	No, Nunca	Si, en los últimos 3 meses	Si, pero no en los últimos 3 meses
¿Ha consumido <u>alguna vez</u> alguna droga por vía inyectada? (ÚNICAMENTE PARA USOS NO MÉDICOS)	0	2	1

NOTA IMPORTANTE:

A los pacientes que se han inyectado drogas en los últimos 3 meses se les debe preguntar sobre su patrón de inyección en este período, para determinar los niveles de riesgo y el mejor tipo de intervención.

PATRÓN DE INYECCIÓN

Una vez a la semana o menos
o
Menos de 3 días seguidos

Más de una vez a la semana o
3 o más días seguidos

GUÍAS DE INTERVENCIÓN

Intervención Breve, incluyendo la tarjeta "riesgos asociados con inyectarse"

Requiere mayor evaluación y tratamiento más intensivo *

CÓMO CALCULAR UNA PUNTUACIÓN ESPECÍFICA PARA CADA SUSTANCIA.

Para cada sustancia (etiquetadas de la a. la j.) sume las puntuaciones de las preguntas 2 a la 7, ambas inclusive. No incluya los resultados ni de la pregunta 1 ni de la 8 en esta puntuación. Por ejemplo, la puntuación para el cannabis se calcula como: P2c + P3c + P4c + P5c + P6c + P7c

Note que la P5 para el tabaco no está codificada, y se calcula como: P2a + P3a + P4a + P6a + P7a

EL TIPO DE INTERVENCIÓN SE DETERMINA POR LA PUNTUACIÓN ESPECÍFICA DEL PACIENTE PARA CADA SUSTANCIA

	Registre la puntuación para sustancia específica	Sin intervención	Intervención Breve	Tratamiento más intensivo *
a. tabaco		0 – 3	4 – 26	27+
b. alcohol		0 – 10	11 – 26	27+
c. cannabis		0 – 3	4 – 26	27+
d. cocaína		0 – 3	4 – 26	27+
e. anfetaminas		0 – 3	4 – 26	27+
f. inhalantes		0 – 3	4 – 26	27+
g. sedantes		0 – 3	4 – 26	27+
h. alucinógenos		0 – 3	4 – 26	27+
i. opiáceos		0 – 3	4 – 26	27+
j. otras drogas		0 – 3	4 – 26	27+

NOTA: *UNA MAYOR EVALUACIÓN Y TRATAMIENTO MÁS INTENSIVO puede ser proporcionado por profesionales sanitarios dentro del ámbito de Atención Primaria, o por un servicio especializado para las adicciones cuando esté disponible.

Informed consent



Comité de Ética de Investigación en Seres Humanos

Universidad San Francisco de Quito

El Comité de Revisión Institucional de la USFQ
The Institutional Review Board of the USFQ

Formulario Consentimiento Informado

Título de la investigación: Smart Recovery Implementation for Individuals with substance use disorder

Organización del investigador Universidad San Francisco de Quito

Nombre del investigador principal Daniela Isabel Uría Vallejo

Datos de localización del investigador principal 0958851008/318120

E-mail: dani_isabel95@hotmail.com

Co-investigadores no aplica

DESCRIPCIÓN DEL ESTUDIO	
Introducción	Usted ha sido invitado a participar en una investigación sobre la aplicación del programa Smart Recovery para personas con uso problemático de sustancias. El propósito de esta investigación es analizar la efectividad de este tipo de intervención en individuos con uso, abuso y dependencia de drogas. Los participantes de la investigación son personas que cumplen con el diagnóstico de abuso o dependencia de sustancias, son mayores a 16 años, tienen al menos 7 años de educación formal, no asisten a otros tipos de tratamiento y no han sido diagnosticados con enfermedades mentales graves. Usted puede hacer todas las preguntas que quiera para entender claramente su participación y despejar sus dudas. Para participar puede tomarse el tiempo que necesite para consultar con su familia y/o amigos si desea participar o no.
Propósito del estudio	El propósito de esta investigación es analizar la efectividad de este tipo de intervención en individuos con uso, abuso y dependencia de drogas en Ecuador. A los participantes se les proporcionará todas las pautas y enseñanzas del programa, con el fin de reducir el consumo de sustancias y llegar a la abstinencia. Las intervenciones se manejarán en 2 grupos, cada uno de 25 personas. Las reuniones grupales y de intervención se realizarán una vez por semana.
Descripción de los procedimientos	

En la etapa inicial se tomará un test para medir y analizar el tipo de consumo, frecuencia, problemas relacionados con la utilización de sustancias y diferenciar si el caso consiste en uso, abuso o dependencia.

La segunda fase consiste en iniciar la intervención por 6 meses y volver a tomar el test para analizar resultados esperados.

La tercera etapa se realiza al culminar el programa a los 12 meses del tratamiento, nuevamente se aplica el test para evidenciar los resultados finales.

Riesgos y beneficios

Los riesgos que se podrían presenciar son problemas emocionales y dificultades al narrar y relacionarse con los demás participantes del grupo, sin embargo, esto es parte fundamental del tratamiento donde el grupo en sí y los moderadores, analizan las problemáticas emocionales asociadas al consumo.

Confidencialidad de los datos

Para nosotros es muy importante mantener su privacidad, por lo cual aplicaremos las medidas necesarias para que nadie conozca su identidad ni tenga acceso a sus datos personales:

- 1) La información que nos proporcione se identificará con un código que reemplazará su nombre y se guardará en la residencia del investigador donde solo esa persona tendrá acceso.
- 2) Si usted está de acuerdo, los resultados que se obtengan de su persona serán utilizadas para esta investigación y luego se las guardarán para futuras investigaciones removiendo cualquier información que pueda identificarlo
- 3) Su nombre no será mencionado en los reportes o publicaciones.
- 4) El Comité de Bioética de la USFQ podrá tener acceso a sus datos en caso de que surgieran problemas en cuando a la seguridad y confidencialidad de la información o de la ética en el estudio.

Derechos y opciones del participante

Usted puede decidir no participar y si decide no participar solo debe decírselo al investigador principal o a la persona que le explica este documento. Además aunque decida participar puede retirarse del estudio cuando lo desee, sin que ello afecte los beneficios de los que goza en este momento.

Usted no recibirá ningún pago ni tendrá que pagar absolutamente nada por participar en este estudio.

Información de contacto

Si usted tiene alguna pregunta sobre el estudio por favor llame al siguiente teléfono 0958851008 que pertenece a Daniela Isabel Uría Vallejo, o envíe un correo electrónico a dan_isabel95@hotmail.com

Si usted tiene preguntas sobre este formulario puede contactar al Dr. Iván Sisa, Presidente del Comité de Ética de Investigación en Seres Humanos de la USFQ, al siguiente correo electrónico: comitebioetica@usfq.edu.ec

Consentimiento informado	
<p>Comprendo mi participación en este estudio. Me han explicado los riesgos y beneficios de participar en un lenguaje claro y sencillo. Todas mis preguntas fueron contestadas. Me permitieron contar con tiempo suficiente para tomar la decisión de participar y me entregaron una copia de este formulario de consentimiento informado. Acepto voluntariamente participar en esta investigación.</p>	
Firma del participante	Fecha
Firma del testigo <i>(si aplica)</i>	Fecha
Nombre del investigador que obtiene el consentimiento informado	
Firma del investigador	Fecha