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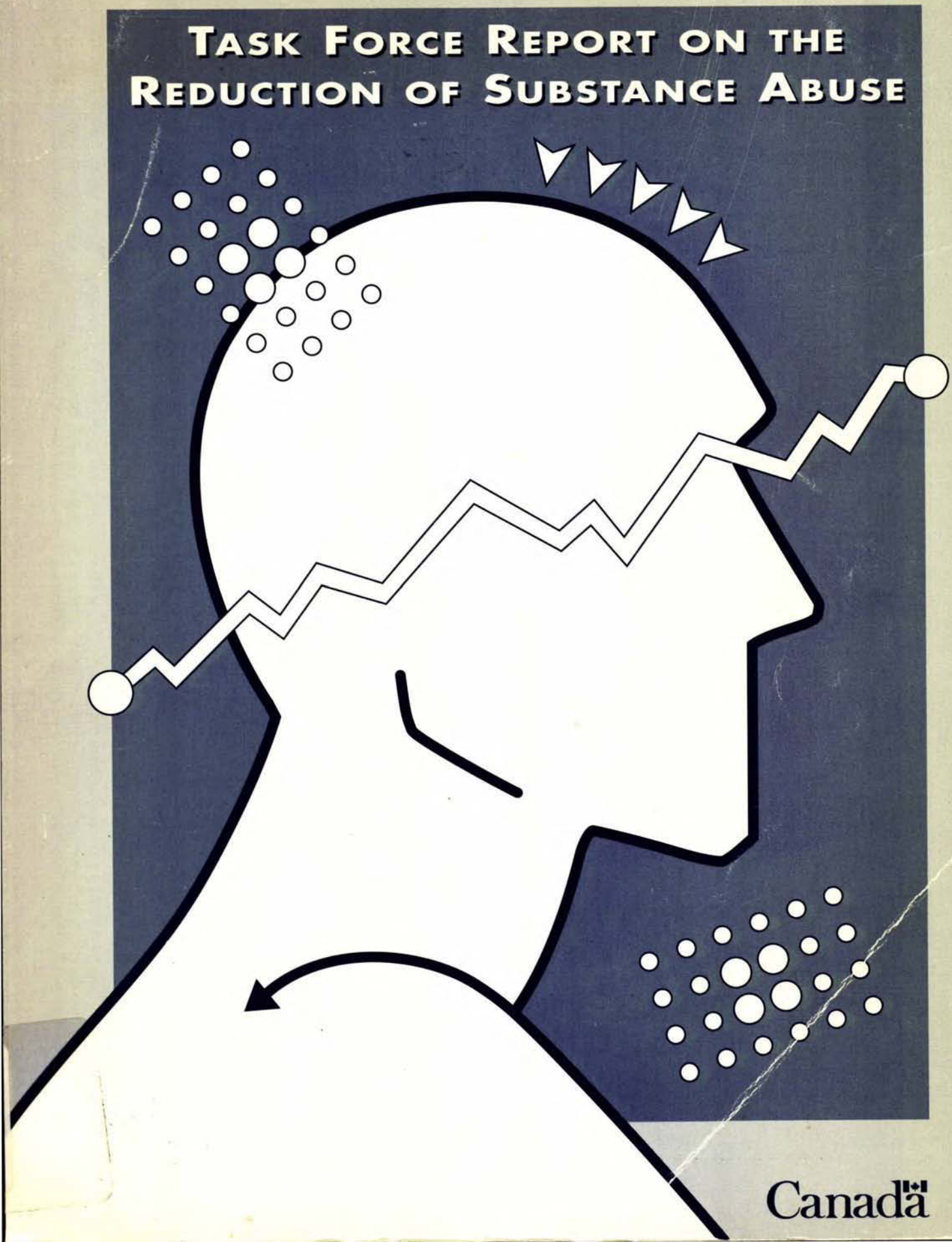
Task Force Report on the Reduction of Substance Abuse



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FOREWORD

In August of 1989, the Commissioner of the Correctional Service of Canada commissioned a Task Force on the Reduction of Substance Abuse. This three-volume report presents the Task Force's findings and recommendations. Volume one proposes a strategic framework for the reduction of substance abuse, which govems the planning and delivery of a continuum of substance-abuse services and programs to federal offenders, from reception to warrant expiry. The supporting documents are contained in Volume Two - Background Papers. These documents expand on specific parts of the report. Volume Three contains the review of the literature as well as the evaluation of substance abuse programs used by the CSC.

The first step in fostering and promoting a healthy lifestyle is to create positive interactions between the offender, the Correctional Service of Canada staff, the environment and the community. To achieve this end, the Task Force proposes a Health Promotion Model consistent with the Mission of the Service and with prevailing community and professional standards. The Task Force believes implementing the proposed recommendations is a necessary step towards fulfilling our Mission: to actively encourage and assist offenders to become law-abiding citizens while exercising reasonable, safe and humane control.

The report is the result of collaborative efforts of the Steering Committee members, the Working Group, and external consultants, specifically those from the community addiction agencies. I would like to thank the Addiction Research Foundation of Ontario and the Alcoholism Foundation of Manitoba for their generous support of staff members. In particular, I would like to thank Dr. Serge Brochu, Dr. Paul Gendreau and Ms. Colleen Allan for their significant contribution.

The Task Force wishes also to thank the representatives of the Union of Solicitor General Employees, the Professional Institute of Public Servants, the Ministry of the Solicitor General Secretariat, the National Parole Board, Addiction Research Foundation (ARF), Health and Welfare Canada and the Department of National Defence.

Particular reference should also be made to the Regional Substance Abuse Co-ordinators from the Correctional Service of Canada. Without their input and advice, the regional consultations would not have been possible. Other CSC employees, individuals and organizations have also contributed; hopefully, their contributions are faithfully reflected in this report.

The Task Force considers this report as the beginning of a process that will lead to improved treatment and management of substance-abusing offenders, as well as leading to improved linkages with the community addiction agencies upon whom we will have to rely so heavily in future years for information, programming and expertise.

Jacques H. Roy, M.D.
Director General
Health Care Services.
Chairman of the Steering Group

EXECUTIVE SUMMARY

Substance abuse in Canadian society is a serious problem. There are many factors that may contribute to an individual abusing substances; and there are demonstrated treatment approaches, particulary in the community addiction agencies, that are useful in addressing these factors. No one approach can offer total success, however, various approaches, most often used in combination, have shown considerable success. The practitioners in this field do not claim to "cure"; their treatment strategy is to assess the need, match it to the most appropriate form of treatment and manage the risk of reoffending.

Alcohol and other drug use among offenders has been the subject of considerable interest. It is now more clearly established that the rate of substance abuse by offenders is closely related to the rate of substance use in the community and the selective process leading to imprisonment. Prisons have not been established to be an independent risk factor in the epidemiology of alcoholism. While there remains some controversy regarding the manner in which drug abuse may result in criminal behaviour, recent studies indicate that criminal behaviour, recent studies indicate that criminal behaviour serves as a multiplier of crime: in spite of the fact that criminal behaviour frequently occurs prior to the addictive behaviour, addictive behaviour leads to greater criminal behaviour.

While substance abuse is a major influence on the lives of persons having contact with the criminal justice system, debate continues as to whether it causes much of the behaviour leading to criminal actions, or is a symptom of other personality disorders. Psychological, psychiatric and biomedical researchers have often sought explanations of abuse "inside" the individual, in personality or biological constitution. Recent sociological and epidemiological research now suggests important factors may be found in the drinker's social relations and that "drinking careers" should be the subject of more scrutiny.

Substance abuse, whether chemical (physiological) dependence or abuse of alcohol or drugs that results in impairment of major areas of functioning, is seen primarily as a health problem. It is, nevertheless, unique among health problems in the extent to which it affects behaviour.

Substance abusers are often unwilling to admit their addiction and are often reluctant to participate in treatment. An onus lies with the treatment providers and designers to make treatment attractive as well as meaningful and a responsibility on the system to establish a continuum of care that includes incentives to participate in treatment.

Continuity of treatment from the institution to the community is critical, and currently problematic. Programs tend to operate in isolation. Greater co-ordination is needed among the various institutional and community agencies involved in the provision of substance abuse treatment. As well, these services need to be linked to ensure the offender does not fall between the cracks.

The Task Force has not specifically addressed control and demand strategies, although they are an integral part of the Health Promotion Model for the delivery of substance abuse services. However, the Task Force endorses the recommendations of the Contraband Control Study, and in particular,

those recommendations concerning incentives and disincentives as they relate to the overall strategy. Clearly, treatment programs must operate within the delicate balance between supply and demand strategies.

There is a different way to influence this sizable faction of those with alcohol-related problems; it is through prevention or health promotion initiatives that seek to prevent such problems before they occur. Such initiatives differ fundamentally from treatment programs. They are impersonal actions that apply uniformly to large groups of people, thus reaching many people for whom treatment would be inappropriate; and to be effective, they should be light and unburdensome rather than powerful and controlling.

As the Task Force was initiated with the assistance of outside agencies such as the Alcoholism Foundation of Manitoba, AADAC, Addiction Research Foundation of Ontario and Health and Welfare Canada, a new conception of program delivery – that of health promotion and prevention – grew from the first meetings of the Steering Committee. Rather than assuming a uni-dimensional model or conception of program delivery (focused only on the offender), a more comprehensive model involving the person, the environment and social relationships developed.

Prevention is oriented towards the future, not the past. Its success is measured not in terms of immediate accomplishments but long-term results. It requires a long-term vision of the future.

The concept of prevention can suffer from a lack of definition unless an integrative approach clearly specifies that prevention, by its very natures, cuts across categories and boundaries. It is a comprehensive concept, not a casualty area. The absence of a specific casualty component can act as an obstacle politically. Although prevention efforts may be seen as humane and cost-effective, they have had trouble moving to the forefront of national, provincial and local health and human services policy.

The Health Promotion Model being proposed by the Task Force is an integrative one which is based upon a **Biopsychosocial** model which provides a framework within which the biological, psychological, and sociocultural approaches to health can be integrated.

This approach implies that problems are determined by multiple factors and recognizes the heterogeneity of causes and courses involved. Problem etiology and the maintenance of harmful patterns of drinking and drug-taking behaviour are seen as a complex interaction among the biological, psychological and sociological risk factors. This model recognizes that, for each individual, all three sets of factors are potentially involved but that in any one individual, one set may predominate.

This model has two major orientations implicit in it. First, it implies a **Transtheoretical** orientation, implicit in the relapse prevention process, that provides a direct approach for studying and organizing the treatment of alcohol and other drug problems. This orientation posits that individuals experience a common sequence of changes in developing a problem behaviour, and in either maintaining the cessation of the behaviour or relapsing. Second, it implies a **normalization** orientation which shifts the emphasis from a search for alcoholic and offender traits to a search for intervention procedures that increase treatment compliance and motivation for change and success.

In practice there appear to be programs and practitioners that offer a single treatment type or modality, or a wide range of modalities that can be selectively pursued (e.g. multidisciplinary, multimodality milieu therapy in a freestanding or institutional-based alcohol rehabilitation unit).

Often, treatments are combined with psychologically oriented treatment programs using medications as adjuncts and drug treatments being offered together with psychological, sociocultural and prevention strategies.

There are not enough staff trained in substance-abuse treatment and not adequate training opportunities to allow individuals to develop the expertise required to manage and treat substance abusers. Greater linkages to expertise in the community need to be established. The advent of Unit Management provides the opportunity to involve all staff in a core philosophy and approach. The adoption of a health promotion strategy provides the vehicle for staff to become involved in ways previously not possible.

The Task Force recognizes the realities of the correctional environment and difficulties of establishing a treatment regime within such a setting. Yet a great deal can be done through the combined efforts of the offender, the staff, volunteers and the community. It is recognized, however, that our staff is our greatest strength. It is through the education and training of our staff that these initiatives will be fully introduced.

TABLE OF CONTENTS

Chapter 1

Introduction

Chapter 1

INTRODUCTION

1. OBJECTIVE

The purpose of this document is to present a framework by which the Correctional Service of Canada can establish a policy and strategic plan to reduce substance abuse by federal offenders.

2. CANADIAN SOCIETY IN GENERAL

A. The Prevalence of Substance Abuse

Substance abuse in Canada is a long-standing and complex problem. It includes illegal drug abuse as well as the abuse of alcohol, prescription drugs and solvents.

The **social costs** of substance abuse are considerable. Substance abuse harms individuals, families and communities, threatens workplace safety, and results in highway and other accidental injuries and deaths.

The **economic costs** are also substantial. They involve lost productivity and potential, as well as the more concrete costs borne by the enforcement, criminal justice, social and health care systems, for which we all pay through our taxes.

For the **health care system** alone, it is estimated that over one million days of care per year in hospitals, psychiatric units and residential care facilities can be attributed directly to drug treatment and rehabilitation activities.

B. Trends

Patterns are shifting. While use is down, young people are experimenting with alcohol and drugs at earlier ages. The **1987 Ontario Student Survey** indicated that "...although the overall rate of alcohol use was down substantially from 1977, the frequency of becoming drunk increased while there were few changes in the rates of reported alcohol-related problems." According to Adlaf, "There may be a larger group who exhibit a problematic pattern of consumption." By the time of the 1989 survey, the use of alcohol remained unchanged between 1987 and 1989 but was significantly lower in comparison to surveys prior to 1987.
The 1989 survey also mentions the following:

- Cannabis use has been on a steady but weak decline since 1979.

- Use of barbiturates and stimulants without the direction of a physician declined from 3.3% to 2.2% in 1989, while stimulant use posted declines from 7.9% to 6.5%. Both barbiturates and stimulants have been on a strong downward trend since their peak in the early 1980s. Tranquillizer use, on the other hand, has shown a weak but consistent downward pattern since 1977.

- Inhalant is the only substance to show greater use among younger students. In 1989 this pattern is especially prominent for solvent use, where rates among Grade 7s and 9s are significantly higher than all other grade levels. One significant trend between 1987 and 1989 shows an increase in solvent use from 0.4% to 1.1% among Grade 13 students.

- Despite declines in drug use and self-reported problems among the total sample, the percentage reporting drug problems among drug users has increased.

According to the 1990 Health and Welfare document, *National Alcohol and Other Drugs Survey* which reported the results of a major survey carried out by Statistics Canada:

- Comparisons with other studies suggest a trend toward moderation in drinking: fewer adult Canadians are drinking, more have stopped drinking, and those who are drinking are drinking less.

- Men consume alcohol more frequently and in greater quantity than do women.

- A higher percentage of younger Canadians tend to drink. However, they tend to consume more alcohol per drinking occasion.

- Trends since 1985 suggest the greatest decrease in alcohol consumption among adult Canadians took place among the youngest and oldest segments of the population.

- In general, there is an inverse relationship between age and the prevalence of alcohol consumption. With the exception of a 14 point increase (from 74% to 88%) between the 15 to 19 and 20 to 24 year categories, the percentage of people who reported drinking in the year prior to the survey decreases with age.

- Separated, divorced and single current drinkers consumed the most alcohol the week prior to the survey.

- Alcohol consumption is more prevalent among Canadians with some post-secondary education. This group tends to consume more drinks per week.

- Alcohol use is more prevalent among adult Canadians with higher household incomes. They tend to drink more frequently, and their average weekly consumption is higher.

- On the occasions when people in lower-income groups do drink, they tend to consume more than those in other income groups. Blue-collar workers have the highest weekly consumption levels.

- In general, the percentage of current drinkers increases from east to west. Estimates of the average number of drinks consumed in the week preceding the survey indicate drinkers from Ontario and Quebec consume the highest levels of alcohol followed by British Columbia.

- Of current drinkers, 12% report having experienced a physical health problem at some time in their life due to their drinking, and 7% report problems occurring in the 12 months prior to the survey.

- At some time in their lives, 4% of current and former drinkers, approximately 615,000 Canadians, have used a formal agency or service to help deal with problems caused by their own alcohol use. The most widely used service is AA: 3% of the respondents have used AA or a similar support group.

- Almost one-half (47%) of all current drinkers had not consumed a drink in the week prior to the survey. An additional 38% consumed between one and seven. Nine percent reported drinking between 8 and 14 drinks, while 6% consumed 15 drinks or more. The average current drinker consumes 3.7 drinks per week.

- In general, as alcohol use increases a higher incidence of problems result. For example, 22% of current drinkers who consumed 15 drinks or more in the week preceding the survey reported experiencing a problem with their physical health during the year preceding the survey, as compared with only 5% of those who did not drink in the week preceding the survey. Similarly, Canadians who consumed 15 drinks or more in the week preceding the survey are four times more likely (13%) than those who did not drink during this period (3%) to have problems with friendships related to their alcohol use.

- Cannabis (marijuana or hashish) is the most commonly used illicit drug in Canada: 23.2% of Canadians have used it at some time in their lives, and 6.5% are current users.

- The highest rate of current usage is among respondents 20 to 24 years of age (23.2%) followed by those 25 to 34 years (15.2%).

- More than twice as many men as women (8.9% vs. 4.1%) report having used cannabis during the year preceding the survey.

- Cocaine or crack have been used by 3.5% of adult Canadians at some time in their lives, and 1.4% (280,000 adult Canadians) are current users.

- Cocaine use is apparently much less prevalent in Canada than in the United States. In 1988, 12% of Americans aged 18 to 25 reported using in the year prior to being surveyed (U.S. Department of Health and Human Resources, 1989). In Canada, the rate of cocaine use is 3% in this age group.

- Comparison with other studies suggests that patterns of drug use in Canada have remained quite stable over the past four years.

- The use of prescription narcotics such as codeine, morphine or demerol in the 30-day period prior to the survey was reported by 5% of adult Canadians.

- Rates for use did not vary dramatically with age, but in each age group more women than men reported use of these medications.

- The highest rates of sleeping pill use were reported by women, particularly senior women and widows. Rates of use were higher among respondents with low incomes and limited education than among higher-income respondents with higher educational attainments.

- Tranquillizer usage during the 30-day period preceding the survey was reported by 3.1% of the respondents. The highest rates of use were reported by women, particularly senior women and widows, adult Canadians with low incomes or limited education, and Francophone respondents.

- 21.9% of adult Canadians indicated they had a friend with a drug problem; 13.7% had a family member or relative with a drug problem; 11.3% knew a co-worker with a drug problem; and slightly less than 1.0% indicated that a spouse or partner had a drug problem.

C. Defining Health

The Constitution of the World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." This definition opened new vistas, bringing the mental and social dimensions of health into focus along with the physical and it recognized that all three were intertwined. The World Health Organization's insistence that health was much more than simply the absence of illness opened the way for much reflection and discussion of health and its implications on public policy.

Health and Welfare Canada, in a 1986 document entitled *Achieving Health For All*, extended this definition even further. It speaks of health as a resource, a dynamic energy influenced by our culture, our social, economic and physical environment, which endows people with the ability to control and alter their environment. This new definition compels us to consider health as a state not solely experienced individually, but also collectively.

Substance abuse, whether chemical (physiological) dependence or abuse of alcohol or other drugs is seen primarily as a health problem. It is, nevertheless, unique among health problems in the extent to which it affects behaviour.

While substance abuse is a major influence in the lives of persons having contact with the criminal justice system, debate continues as to whether it is the cause of much of the behaviour leading to criminal actions, or whether it is a symptom of other personality disorders. Psychological, psychiatric and biomedical researchers have often sought explanations of abuse "inside" the individual, in personality or biological constitution. Recent sociological and epidemiological research suggests important factors may be found in the drinker's social relations and that "drinking careers" should be the subject of more scrutiny.

No one position needs to be taken on this debate by the CSC. It is clear that if, as a health-care problem, substance abuse causes some antisocial behaviour, addressing the health problem will alleviate this. This more modern approach is becoming recognized, most recently by Rosenbaum (1989) who states "Given that illegal drug use has a deleterious physiological effect, it should be defined primarily as a health-related problem that should reside in the public health domain. In so doing, we might obtain better epidemiological data to estimate the true extent of the problem and re-allocate our resources from criminal justice to treatment, prevention and education."

If substance abuse is a component of a personality disorder, it must be addressed for a change in behaviour to occur. The cycle of substance abuse, criminal behaviour and the enormous cost to Canadian society must be broken.

D. Perspectives on Substance Abuse

A major problem in the field of treatment of substance abusers, in particular, alcohol abuse, has been the difficulty in defining when someone who uses alcohol may be said to have a problem with alcohol. What behaviours and what consequences distinguish the "alcoholic" or alcohol abuser from the "normal" social drinker?

It is essential to have a clear-cut definition of substance abuse to initially identify and then later, help alleviate the problem. Such a definition would help shape effective policies and programs in the field. In particular, it would clarify the objectives of substance abuse health promotion and substance abuse treatment services. Furthermore, it would delineate more accurately the roles of various agents in educating and treating substance abusers.

There is no general agreement on the nature of substance abuse, and in particular, alcoholism. Neither researchers nor treatment professionals utilize anything even approaching a consensus definition. According to Glaser (1988), this lack of agreement has contributed to the weaknesses in structure, cohesiveness and direction in the field.

The terms "alcoholic," "chronic alcoholic," "alcohol addict" and even "problem drinker" are bandied about, often with little attention to their implications. According to Miller (1980), all alcoholics are problem drinkers, but not all problem drinkers are alcoholics. All of these terms have been used interchangeably in reference to an imperfectly conceptualized malady that is either a cause, an effect, or a correlate of excessive use of alcohol.

For much of the first half of this century, problems resulting from alcohol use were regarded as complications of a unitary disease "alcoholism" which was considered to have a predominantly genetic basis and a predictable natural history. This disease concept reached its apogee with the description by Jellinek (1952) of his topology of alcoholism in which he recognized five distinct subspecies. This disease concept had a strong influence on the development of treatment programs in Anglo-Saxon countries, with the concentration on specialized units, a goal of total abstinence from alcohol and close links with AA.

Former views of "alcoholism" as a dichotomous disease entity have been replaced by the concept of "problem drinking behaviour." There is a growing acceptance of the multi-dimensional nature of substance abuse. Thus, drinking that results in problems is viewed as a behaviour lying on a continuum from light to moderate to almost continuous heavy drinking. Drinking behaviour, in turn, often leads to problems in other aspects of social, vocational, psychological or health functioning.

The concept of a unitary disorder was criticized by many workers in Europe and in developing countries who saw it as an unnecessary attempt to force a constellation of very diverse problems into a disease entity. Many European workers favoured the concept of alcohol-related disabilities that were associated with a certain level of alcohol consumption. This has developed into the "desegregation approach" proposed by many epidemiologists and sociologists (Saunders and Aasland, 1987).

Medical practitioners, especially in North America, were pre-occupied with devising more scientifically acceptable definitions of alcoholism. The National Council on Alcoholism proposed one in 1972 which was based on the disease concept. In 1980, the American Psychiatric Association, in their Diagnostic and Statistical Manual of Mental Disorder (DSM) made the distinction between "alcohol

abuse" and "alcohol dependence."

The criteria for alcohol abuse were threefold:

1. Continuous or episodic heavy use of alcohol for at least one month;
2. Social complications of alcohol abuse; and
3. Psychological dependence (e.g., compulsion to drink), or pathological patterns of alcohol use or both.

For the diagnosis of alcohol dependence, the additional criterion of either tolerance or experience of withdrawal symptoms was required.

Another approach was provided by Edwards and Gross (1976) in their description of the alcohol dependence syndrome. This was conceived as a psycho-biological state characterized by a reorientation of life around alcohol and awareness of a compulsion to drink, and drinking to avoid the discomfort of its absence. A distinction was made between this syndrome and the broader range of problems that results from harmful drinking, which was termed "alcohol-related disabilities" (Edwards et al., 1977). The crucial point is that both the alcohol-dependant syndrome and alcohol-related disabilities were considered to exist in a continuum of severity. Both, nonetheless, are seen as dimensions of behaviour rather than all-or-none states.

The difficulties in defining substance abuse have resulted in a moving away from an all or nothing definition toward a concept of harmful alcohol consumption and hazardous consumption. Both, although relatively new, are included in the provisional recommendations for classification in the Tenth Revision of the International Classification of Diseases. Harmful alcohol consumption is denoted as the consumption of alcohol that is causing harm to the psychological or physical well-being of the individual. Hazardous alcohol consumption is defined as a level of alcohol consumption or a pattern of drinking likely to result in harm should present drinking habits persist.

E. The Concept of a "Continuum of Risk" for Alcohol Problems

The concept of hazardous consumption of alcohol has been well-developed in the U.K. where alcohol is viewed as a risk factor for ill health in much the same way that serum cholesterol is a risk factor for coronary heart disease and high blood pressure a risk factor for cerebrovascular disease. By and large, the more alcohol is consumed the greater the risk to the individual in terms of social, psychological and physical well-being (Watson 1989).

In Canada, a similar "risk continuum" was developed by the Ontario Ministry of Health as part of their *Framework for the Response to Alcohol and Drug Problems in Ontario* (1988). Their report, which is abstracted below, established the tools for local communities to plan and develop a comprehensive range of services for alcohol and drug problems.

The likelihood of an individual experiencing alcohol problems is directly related to the amount of alcohol consumed (levels) and the conditions under which it is consumed (contexts). Certain drinking levels and contexts have a low association with problems, and are known as "low risk" behaviours. Each of these behaviours has a "risk" counterpart, which has a higher association with problems.

As drinkers cross "low risk" thresholds, the likelihood of them experiencing problems increases. In this concept, risk is an expression of probability. The level of risk increases with both the extent to which the drinker exceeds the "low risk" thresholds and the frequency of these departures. Accordingly, risk can be expressed along a continuum, as depicted in Figure 1.

FIGURE 1

THE RISK CONTINUUM FOR ALCOHOL PROBLEMS

	ALCOHOL PROBLEMS HAVE NOT DEVELOPED	ALCOHOL PROBLEMS HAVE DEVELOPED	
NO RISK	LOW RISK	MODERATE RISK	HIGH RISK

The risk continuum is a conceptual tool designed for planning purposes. In actual populations, drinkers frequently change their drinking patterns and, in doing so, can migrate from one category to another. Also, the development of alcohol problems is not as simple as crossing over a line: alcohol-related problems tend to progress slowly over time, but can sometimes progress rapidly.

While no specific details are available for offenders under the jurisdiction of the CSC, it would be safe to assume that the offenders are not evenly distributed across the four risk categories. Rather, unlike the general population, it is likely that most individuals are clustered into the moderate-risk and high risk categories, with increasingly smaller proportions found in the no risk and low-risk categories respectively. This can be illustrated by examining the distribution of the offender population according to its "average level of consumption."

Essentially, the average level of consumption is a measure of the number of standard drinks (a standardized unit which takes into account the type of beverage and its alcohol content) which a person usually consumes in the course of a week. It is a valid indicator of risk, and can be aligned with the risk categories as follows:

FIGURE 2

RISK CATEGORY AVERAGE CONSUMPTION (STANDARD DRINKS FOR MEN)

NO RISK	No Alcohol Consumption
LOW RISK	1 - 14 drinks per week
MODERATE RISK	15 - 34 drinks per week
HIGH RISK	35 drinks or more per week.

It should be noted that the above consumption figures are based on a standard drink (341 ml/12 oz. of beer), (142 ml/5 oz. of table wine), (99 ml/3.5 oz. of fortified wine) or (43 ml/1.5 oz. of spirits).

These numbers are for a 70 kg (154 lb.) male who will reach a Blood Alcohol Level of 0.05% if he consumes two ordinary sized drinks within approximately one hour. In a 55 kg (120 lb.) woman, one and one half drinks will result in similar levels.

From a biomedical standpoint, the limit of non-hazardous consumption is not known. There is some evidence that a level as low as three or four drinks of alcohol daily appears to carry significant risks. Daily consumption of five or six drinks for men is more widely accepted as a level at which significant risk occurs. It should be noted that periodic episodes of acute intoxication with periods of abstinence are also deleterious. There are a number of variables such as history, style of drinking, type of beverage, and the role of other toxic agents that must be considered in assessing risk level as well as age and gender.

A number of signs and symptoms are associated with chronic intake of alcohol. Alcohol-related problems are seldom isolated; it should be recognized that alcohol-induced physiological changes generally have associated behaviourial changes and that behaviourial changes often result in health-related problems. It is easy to forget that the problem is multi-dimensional (ARF, 1989).

3. OFFENDER POPULATION

A. Relationship of Substance Abuse to Crime

The CSC Mission Statement indicates that the focus must be on reducing the probability of an offender committing new offences when released to the community. Particular emphasis is placed on reducing the potential for harm that individual offenders may present to other people. Violence against others is considered the most serious type of harm.

Although abundant evidence indicates that alcohol and criminal behaviour are linked, the exact nature of the relationship remains ambiguous (Collins, 1981). It is not clear whether the often demonstrated relationship is causal or only statistical - whether alcohol use is a cause of crime or merely a correlate. Blount (1982) indicates that some authors seem to be saying that addiction causes delinquency. Other researchers consider that the delinquency precedes the addiction while mentioning a certain correlation. Still, others (McBride and McCoy, 1982) consider this correlation is artificial. For these authors, addictions and crime may both be products of other interrelated variables. Innes (1988) noted that similar circumstances may lead persons to commit crimes and develop habits of drug and alcohol abuse. Thus, for him the relationship between addiction and crime is not causal. Brochu and Brodeur (1988) conclude that to identify a causal relationship between addiction and delinquency is to abuse language.

Regardless of the exact nature of the relationship, it has long been recognized that a link exists between alcohol and drug use and criminal behaviour. Alcohol has been found to be associated with the full range of criminal acts. It is implicated not only in breaches of liquor laws or traffic offences, but also in crimes of violence including assault, rape and homicide (Ross and Lightfoot, 1985).

According to the ARF of Ontario, 80% of acts of violence are committed by persons while they are intoxicated. As reported in Ross and Lightfoot (1985), there is a growing body of evidence that alcohol use by the offender or the victim, or both, precedes a high proportion of violent criminal acts (Pernanen, 1976; Roizenand Schneberk, 1977). Alcohol is implicated in as many as 53% to 64% of

cases of homicide (Voss and Hepburn, 1968; Wolfgang, 1958), and in 34% to 72% of cases of rape (Amir, 1971; Johnson, Gibson and Linden, 1978; Rada, 1975). As many of 58% of offenders convicted of assault were drinking at the time of the offence (Mayfield, 1976). Some 64% of offenders convicted of assaulting police were drinking or drunk at the time of the offence (Meyer, Magendanz, Kieselhorst and Chapman, 1978).

More importantly, according to Ross and Lightfoot (1985), "A large number have drinking problems which seriously interfere with their ability to function in a **non-criminal** manner. Alcohol use is also associated with parole failure and recidivism." In a 1985 report, CSC recognized that there is a relationship between consumption of alcohol and (1) recidivism, (2) maladjustment to transition houses, and (3) violation of parole conditions. Ross and Gendreau (1982) point to several studies indicating alcohol as an important factor in recidivism. As well, they established that favourable decisions on parole for an inmate often depend on whether or not he follows treatment.

Effective substance abuse programs both in the institutions and in the community must be developed and implemented to address the problems of offenders that relate to criminal behaviour.

The Mental Health Survey (DIS, 1988), which was a joint initiative of Health Care Services/ Research Branch, represented the first major attempt by the CSC to estimate the prevalence, nature and severity of mental health problems among the offender population, by applying objective diagnostic criteria commonly used by mental health professionals. The survey relied on the administration of the Diagnostic Interview Schedule (DIS) which was designed for research on a large number of the general population, both male and female, and has also been used to diagnose the incidence of mental and behaviourial disorders among incarcerated populations. The results showed, among other things, that 66% of the total male offender population were found to have met the criteria for antisocial personality while at the same time having alcohol and/or drug abuse/ dependence.

Significantly, nearly one out of five offenders met the criteria for a dual diagnosis of antisocial personality and alcohol abuse/dependence. Data from this same study indicate that approximately 50% of the offender population suffers from some type of substance abuse problem.

A 1985 study by Lightfoot et al. investigated the treatment needs of inmates. The investigation revealed that 20.8% of inmates described themselves as "alcoholics," while 33.9% reported that they "drank a lot." Objective measurements showed that before their incarceration, 86.5% of inmates consumed doses of alcohol high enough to be a risk to their health. The inmates questioned reported that they drank an average of 14 glasses a day. Some 78.5% of inmates reported that alcohol was at the origin of at least one problem, 65.3% felt that drugs had ruined their lives, and 80% reported that they needed treatment in order to solve their drug and alcohol problems. Only 56% of inmates who described themselves as "alcoholics" and 42% of those who stated that they "drank a lot" indicated that they had received help during the last six months.

B. Drug Abuse Disorder

The Diagnostic Interview Schedule (DIS) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) are tools that diagnose both drug abuse and dependence for the following:

- cannabis, barbiturates/hypnotics, opioids and amphetamines; and
- for cocaine and hallucinogens only, the diagnosis of abuse is made.

A diagnosis of drug abuse includes the following:

- interference with social or occupational functioning as a result of using any of these drugs;
- pathological use of at least one of the drugs;
- social or occupational impairment including fights, loss of friends, absence from work, loss of a job; and
- legal difficulties greater than a single drug-related arrest.

A diagnosis of dependence requires the following:

- evidence for tolerance to or withdrawal symptoms from any of the drugs listed above; and
- social or occupational impairment for cannabis only.

It should be noted that while the DSM III-R does **not** provide a summary diagnosis of "drug abuse or dependence," the DIS can sum up the individual drug categories to provide such a category.

According to the DIS, the national lifetime prevalence rates for those having had no substance abuse or dependence was 46.3%; substance abuse, severe was 11.8%; substance dependence, severe was 3.9%; substance abuse, not severe was 3.5%; substance dependence, not severe was 4.7%; substance abuse/dependence, severe was 26.0%; and substance abuse/dependence, not severe was 3.9%

The DIS table shown below presents nationally and by region the lifetime prevalence rates of the various criteria met for a diagnosis of substance abuse disorder.

Lifetime Prevalence Rates of Substance Abuse Disorders by Region

	REGION				
Criteria Met	Atlantic	Quebec	Ontario	Prairies	Pacific
No Abuse or Dependence	46.3	41.7	50.6	45.9	48.3
Abuse, severe	10.7	17.2	10.3	9.1	7.3
Dependence, severe	2.8	4.9	3.3	4.3	2.9
Abuse, not severe	3.1	4.0	3.1	3.8	3.4
Dependence, not severe	4.3	2.9	5.7	6.2	4.7
Abuse/dependence, severe	27.9	27.1	23.4	26.1	27.2
Abuse/dependence, not severe	4.9	2.3	3.6	4.5	6.2

Lifetime prevalence is defined as the percentage of the population that showed evidence of a particular disorder at least once in their lifetime.

C. Alcohol Abuse Disorder

The DIS/DSM III-R diagnose both alcohol "abuse" and "dependence":

- A diagnosis of "dependence" requires tolerance or withdrawal along with a pattern of pathological use **or** impairment on social and occupational functioning.

- A diagnosis of "abuse" requires the presence of tolerance or withdrawal **and** impairment in social and occupational functioning.

According to the DIS, the national lifetime prevalence rates for those having no alcohol abuse or dependence was 29.9%; alcohol abuse without dependence was 19.0%; alcohol dependence without abuse was 3.7%; and alcohol abuse/dependence present was 47.4%.

The table shown below presents, regionally, the lifetime prevalence rates of the various criteria met for a diagnosis of alcohol abuse disorder.

Lifetime Prevalence Rates of Alcohol Abuse Disorder by Region

	REGION				
Criteria Met	Atlantic	Quebec	Ontario	Prairies	Pacific
No abuse or dependence	23.8	33.3	30.6	24.0	33.1
Abuse without dependence	22.9	15.2	19.3	23.0	18.8
Dependence without abuse	1.8	5.6	4.0	1.2	3.5
Abuse/dependence present	51.6	45.9	46.2	51.8	44.6

The problem of drugs in prisons, including their contribution to prison violence, is also significant. Consequently, CSC Custody and Control Branch has indicated that a significant percentage of institutional security measures are devoted to drug detection and reducing illegal sales of drugs. Prison violence often occurs to obtain drugs or to settle debts related to the sale of drugs. From 1981 to 1986, 49 persons were killed in Canadian penitentiaries; many of these crimes were a direct result of alcohol or drug use and trafficking in drugs. During 1985-1986 alone, 181 major violent incidents occurred, of which 106 (58%) were believed to be related to drug abuse.

Recognizing the serious contribution to institutional violence made by the presence and use of alcohol and other drugs in penitentiaries, the significant effect of continuing drug and alcohol abuse on criminal activity after release, as well as the general debilitating effect of substance abuse on individual and family life, the CSC has undertaken formal prevention, education and treatment measures in recent years. Stress has been placed on interdiction and apprehension, education and the treatment of addicted offenders - an approach continued to the present.

These results indicate that substance abuse is a serious problem within federal prisons and that there is a compelling need for a conceptual framework that sets the strategic framework for the development and delivery of a comprehensive array of substance abuse services and programs for offenders over the next five to ten years.

4. FEDERAL GOVERNMENT INITIATIVES

A. Speech from the Throne (1986)

The Speech from the Throne in October 1986 gave official federal government recognition to the fact that Canada faced a drug problem and that something had to be done.

B. National Drug Strategy

On May 25, 1987, the federal government formally launched the National Drug Strategy. The National Drug Strategy was a multi-faceted response to a complex and still evolving problem. Within the framework of the Strategy, individual initiatives were developed to provide a balanced comprehensive approach to the problem of substance abuse. The Strategy called for and concerted action on six fronts:

1. Education and Prevention;
2. Enforcement and Control;
3. Treatment and Rehabilitation;
4. Information and Research;
5. International Co-operation; and
6. National Focus.

In reporting on the first year of the National Drug Strategy, the Prime Minister wrote in the introduction of *Action on Drug Use*, "Through our schools and communities, in the workplace and at home, Canadians have been working together to tackle substance abuse. Enormous effort and accomplishment have marked the last twelve months. Our commitment remains: to ensure that our children, families and friends live and work in a safe and healthy environment. We are continuing our commitment to interdiction and enforcement recognizing, however, that these activities must be coupled with concerted efforts to reduce demand. Knowledge, attitude and social perception are keys to changing behaviour. All Canadians have a role to play in creating an overall climate where substance abuse is no longer acceptable: our actions can make a difference."

The report went on to state: "It is not possible to measure accurately the full extent of alcohol and drug abuse in Canada. Although we live in a world of statistics, none are completely accurate and all are subject to differing interpretations. What the available drug and alcohol statistics can do, however, is give us a sense of the scope of the problem and highlight emerging trends.

"What the statistics fail to show is the personal and social costs of drug abuse. The loss of human potential, the destruction of physical and mental health, the breakdown of marriages and families, and the disruption of communities and social order, directly or indirectly, affect us all. Drug abuse, including the abuse of alcohol, is a societal problem of many dimensions with unacceptable human and economic costs."

The overall objective of the Strategy is to reduce the harm to individuals, families and communities from the abuse of alcohol and other drugs through a balanced approach that is acceptable to Canadians.

The Strategy was developed following extensive consultations with provincial governments, non-government sector organizations and individuals knowledgeable in the addiction field.

5. CSC INITIATIVES

A. Corporate Objectives

Inauguration of the government's National Drug Strategy in May 1987 gave rise to a number of proposals and the following initiatives became part of the CSC/Substance Abuse Strategy:

1. Development of a drug education module for use in the reception and orientation program to provide inmates with information about drugs and the means of reducing abuse of drugs;

2. Development and implementation on a pilot basis of a standardized assessment tool to identify the nature and severity of abuse;

3. Development of a pre-release alcohol and other drug information program to help offenders avoid drug-related problems on release;

4. Development and implementation of an extensive staff training program to educate staff about drugs and their effects, and about drug-abuse intervention and treatment programs;

5. Evaluation of one existing substance abuse treatment program within each of the regions;

6. Detection of drug and alcohol use by offenders through urinalysis and other techniques to control violence stemming from abuse and trafficking;

7. Development of a co-ordinated approach to substance abuse with Health Care Services Branch as the focal point; and

8. Initiation of a Task Force on Substance Abuse to integrate the most up-to-date information regarding education and treatment modalities into a co-ordinated approach to substance abuse, including a national policy and a set of operational standards for treatment.

B. Mission Statement

Given the prevalence rates of substance abuse among the offender population and the objectives of the Service, the CSC needed a well-defined substance abuse strategic framework, consistent with its Mission Statement, regional and demographic variations, and prevailing community and professional standards. It is imperative to respect the essence of the Mission and its core values in generating and implementing new policies and programs. The conceptual framework presented in this document adopts the Mission Statement as its primary source of guidance, the heart of which is found in the following core values.

CORE VALUE 1
We respect the dignity of individuals, the rights of all members of society and the potential for human growth and development.

CORE VALUE 2
We recognize that the offender has the potential to live as a law-abiding citizen.

CORE VALUE 3
We believe that our strength and our major resource in achieving our objectives is our staff and that human relationships are the cornerstone of our endeavour.

CORE VALUE 4
We believe that the sharing of ideas, knowledge, values and experience, nationally and internationally, is essential to the achievement of the Mission.

CORE VALUE 5
We believe in managing the service with openness and integrity and we are accountable to the Solicitor General.

The Guiding Principles to **Core Value 2** state: "Accepting that offenders can best demonstrate their ability to function as law-abiding citizens in the community, we will provide programs, assistance and supervision to support the gradual release of offenders at the earliest time that such release can be safely effected." For CSC staff members to recommend release, they must be assured that programs exist to address the needs of the offenders. The same level of confidence in the adequacy of our programs must, of course, exist in the minds of the decision makers, whether they be the institutional wardens or members of the National Parole Board.

6. MANDATE OF THE TASK FORCE

The mandate of the Task Force was "to develop a policy framework within which the CSC could plan and implement programs, services and policies to reduce the incidence, prevalence, and severity of problems associated with the use of alcohol and other drugs among offenders from the commencement of sentence at the institutional level to warrant expiry date in the community." Alcohol is, of course, a drug but it is identified separately in this document in recognition of its dominant role as a drug of dependence. The Task Force developed a strategic action plan designed to guide and direct substance abuse programming for the next five years.

The Task Force has:

1. Conducted an extensive literature review;

2. Assessed research needs and directed research;

3. Conducted a program survey to gather information on all CSC substance abuse programs across the country;

4. Reviewed existing substance abuse policy;

5. Examined existing innovative and well-developed programs both nationally and internationally. A seminar of European experts in alcohol/drug addiction and treatment was arranged in St. John's, Newfoundland;

6. Consulted with provincial addiction agencies across the country, as well as with non-governmental agencies.

7. Analyzed and integrated findings; and

8. Prepared a final report.

7. METHODOLOGY

The CSC Substance Abuse Strategy comprises two dimensions. The first is that of providing a process, a continuum of care including intake screening, case management follow-up and assessment; pre/post treatment assessment; treatment planning and delivery; relapse prevention planning and assessment; community supervision treatment services; and follow-up.

The second dimension is that of content. This defines the needs of a target offender population for programs and services based on the prevalence of substance abuse, cultural and demographic variations, and the needs of special offender groups such as aboriginals and women. The results of a number of studies and task forces (e.g., The Community and Institutional Programs Task Force, the Task Force on Federally Sentenced Women, Task Force on Aboriginal People in Federal Corrections, The Contraband Control Study) were also considered in the Report.

The management of the Task Force was structured as follows:

Steering Committee: composed of senior officials from the CSC, the CSC employees' unions, Health and Welfare Canada, the National Parole Board, the Ministry Secretariat, and the Alcohol Research Foundation (ARF) of Ontario.

Working Group: composed of staff representing all regions and sectors with particular expertise in the subject of substance abuse. Representatives from Health and Welfare Canada, the Department of National Defence, the Nechi Institute and the ARF of Ontario were also part of the actual Working Group.

The Steering Committee provided the overall direction, perspective and context for the Task Force. This work included defining the terms of reference, establishing priorities and approving the time frame and action plan. The Steering Committee acted as an advisory body to the Working Group and met at regular intervals throughout the duration of the project.

The Working Group conducted the activities of the Task Force, including the definition of specific objectives, development of work plans, direction of research, consultation with relevant groups, scheduling of discussions and drafting of a series of discussion papers encompassing the various issues identified. The names of the Steering Committee and Working Group members are found in the appendix.

The Task Force adopted a matrix approach in addressing the issues. The services of representatives from the various agencies with subject-matter expertise were retained, while members of the Working Group were responsible for co-ordinating one or more sub-tasks.

Task Force Report

The report comprises three volumes. **Volume One** is the Task Force Final Report itself, a compilation and consolidation of the original discussion papers. This volume consists of the background material, a Substance Abuse Strategy consistent with the CSC's Mission and strategic objectives governing the planning and delivery of substance abuse services and programs aimed at offenders. This strategy is the core of the Final Report.

The Task Force Final Report is accompanied by two companion volumes: **Volume Two** details the background papers, which expand upon the individual subject matter. **Volume Three** details the literature research conducted by Dr. Serge Brochu as well as the results of the evaluations conducted by Dr. Paul Gendreau on all independent substance abuse programs operated or contracted by the CSC.

8. ISSUES

There are a number of unresolved, long standing issues pertaining to the development, management, delivery and evaluation of CSC substance abuse programs, many of which have been well substantiated in various policy papers, reports and task forces over the last 20 years.

Central to the various concerns have been questions of adequacy, effectiveness and efficacy of substance abuse programs. The lack of a clearly defined organizational responsibility for alcohol and drug abuse programs is an important issue. It has fluctuated over time but, at present, responsibility for program delivery at the institutions lies with Leisure Activities, Education and Training, Correctional Programs, Case Management and Psychology.

Other issues that must be considered in the development of a strategy to reduce drug abuse include:

1. The geographic isolation of a number of CSC institutions from major resource centres where rehabilitation programs are based;

2. Co-ordination, both regionally and nationally, which has resulted in a wide variety of programs that have not been evaluated as to effectiveness or efficiency;

3. Programs that have operated more for historical reasons than for reasons of proven effectiveness;

4. Assessment instrument(s) that upon admission of the offender, identifies the severity and nature of the abuse, and then matches the offender to program requirements and/or program availability;

5. A lack of educational/preventative programs for inmates relating to substance abuse for inmates;

6. No existing bridge which links institutional programming to pre-release and community programming;

7. An historical absence of educational and preventative training on substance abuse for staff. There has been training in recent years but a more targeted and advanced approach is needed;

8. Program delivery by staff is a demanding task, which requires a high level of personal energy, integrity and people skills. While using CSC staff as part of the delivery team has raised the level of awareness, there exists a need for proper training, recognition of achievement, and workload reallocation and realignment. Program delivery by staff has been further complicated by institutional reorganization, work force cutbacks and reductions in overtime budgets;

9. No comprehensive list exists of institutional and community programs; and

10. Evaluation mechanisms have not been built into most existing programs, which would assist in further decisions regarding effectiveness and efficacy.

Despite many serious structural and organizational problems, there have been significant advances in both program delivery and in regional responses to the issues. On the one hand, a great deal needs to be done based on what already exists; on the other hand, due to recent regional initiatives, a great deal can be done based on what already exists. There is no need to "reinvent the wheel." Instead, there is a need to expand the existing well-developed initiatives within the proposed framework.

9. CORRECTIONAL PROGRAM PRINCIPLES

In his introduction to the report of the CSC Task Force on Community and Institutional Programs, the Commissioner states: "The strong community focus of this report reflects our commitment to reducing the probability of offences being committed when an inmate is released to the community. This focus is also evident in the strengthening and redirection of institutional programming towards the eventual safe release of the offender. The goal is to ensure that programs commenced in the institution are continued on release to provide the offender with the support and assistance necessary for successful reintegration."

The CSC Task Force on Community and Institutional Programs went on to outline the following set of correctional program principles that form the framework within which programs are established:

1. Offenders are accountable for their behaviour;

2. All activities of the CSC will support the objective of reducing the risk posed when an offender is released to the community. The Service will use an active interventionist approach to corrections;

3. The entire correctional environment, including institutions and community operations will be oriented towards changing the offender's criminal behaviour. All staff of the CSC will reinforce this environment;

4. The Service will respond to each offender as an individual. Having assessed the risk that the offender presents, the Service will address the problems that lead to the offender's criminal behaviour; and

5. The community has a responsibility to assist in the reintegration of offenders; the CSC will actively seek the support and participation of the community during the sentence and encourage the provision of ongoing support to the offenders after the sentence expires.

It was against this background that a variety of proposals were made. In particular, with respect to substance abuse, it was proposed to develop and pilot programs along a range of viable and tested treatment options for various offender groups.

10. STATEMENT OF PRINCIPLES

Based on the discussion papers, a number of principles and recommendations were developed. The Task Force on the Reduction of Substance Abuse proposes that the following **Statement of Principles** be adopted by the CSC:

1. The CSC should ensure that the substance abuse treatment of offenders is in keeping with the Mission, the Canadian Charter of Rights and Freedoms, and community and professional standards of service delivery;

2. The CSC should ensure that policies, programs and standards of service delivery respond to the needs of federal offenders, and target behaviour that will reduce the likelihood of recidivism;

3. The delivery of substance abuse services should be an integral part of the overall programming philosophy of the Service, and the case management, decision-making and long-term planning processes used by the Service;

4. The CSC should continue to develop and maintain linkages with provincial, federal and community-based addiction agencies, as well as the universities, in the delivery of substance abuse services; and

5. The CSC should develop expertise and a level of excellence in substance abuse services.

Chapter 2

Health Promotion Strategy

Chapter 2

HEALTH PROMOTION STRATEGY

1. INTRODUCTION

Health promotion and prevention of substance abuse for offenders in the correctional community are broad concepts that embrace many of the Core Values, Guiding Principles and Strategic Objectives of the Mission Statement of the CSC, and the premises and recommendations of the Aboriginal and Women Offenders Task Forces. To be effective, Health promotion must include and address the offender, his/her family, and both the institutional community and the community to which the offender will return. This will require extensive support and policy development if we are to make significant advances in reducing the problems of substance abuse among the inmate population.

The Task Force on the Reduction of Substance Abuse has adopted a Health Promotion Model as a basis for the strategic action plan aimed at preventing and reducing drug and alcohol problems among offenders from initial sentencing to warrant expiry in the community. Accordingly, the CSC must also consider policies and programming that address the offender's needs in the broader social and environmental contexts in which these programs are placed.

The recently released CSC Contraband Control Study (October, 1989) states "it is commonly accepted that many offenders have significant problems with alcohol or drug abuse that relate to their criminal behaviour," and that "Drugs and alcohol can be identified as the most important contraband problem... The vast majority of security incidents are attributed to trafficking and drug use, and the toll of violence is high."

"The incidence of substance abuse among offenders means that:

1) A significant number of offenders may continue to use substances during their incarceration which creates a heavy demand for drugs and alcohol within institutions; and

2) Many, or most of these offenders will be at high risk for re-offending if their substance use/ abuse problems are not dealt with effectively."

Substance abuse problems appear to permeate all areas of the institution and community. These problems, if not dealt with effectively, can jeopardize the ability of the CSC to fulfil its mission to **"actively encourage and assist offenders to become law-abiding citizens."**

Support and commitment for substance abuse programming will require action at all levels, as well as policy and procedures that support them in responding to changing priorities.

2. A HEALTH PROMOTION APPROACH TO DRUG ABUSE PROBLEMS

To respond to current perspectives, Health and Welfare Canada, Health Promotion Branch has assumed a broader scope in order to accommodate the social, economic and environmental realities that offenders face.

DEFINITION:

> **"Health promotion is the process of enabling individuals and communities to increase control over the determinants of health, and thereby, improve their health." - Freire (1988).**

This definition implies:

> **"a commitment to dealing with the challenges of reducing inequities, extending the scope of prevention, and helping people to cope with their circumstances. It means fostering public participation, strengthening community health services, and coordinating healthy public policy. Moreover, it means creating environments conducive to health in which people are better able to take care of themselves, and to offer each other support in solving and managing collective health problems." - Health and Welfare Canada (1989.3)**

The endorsement of the above definition, which is consistent with CSC's Mission, should empower the Service as a whole, as well as the respective institutions to create a supportive physical and social environment. Working with local, regional and national organizations to develop policies, and creating regulations will assist the Service to implement and maintain the support system critical for a safe and healthy environment.

Health promotion recognizes the importance of the psycho-social development process, the role of self-esteem, self-reliance and personal responsibility in reacting positively to the daily challenges of life and the environment.

In the context of institutional regulations and policies regarding the use of intoxicants, the health promotion and prevention strategies should be co-ordinated in such a fashion that the **supply** and **demand** reduction policies reinforce one another. To achieve the level of support required health promotion strategies must be aimed at the entire organization.

3. CHALLENGES TO BE ADDRESSED

In addressing the issue of health promotion, three challenges need to be examined: 1) the creation of opportunities, 2) strengthening substance abuse prevention and intervention strategies, and 3) enhancing the individual offender's ability to cope with life situations.

A. Creation of Opportunities

The CSC should ensure that the offender has access to a range of high-quality prevention and intervention substance abuse programming in institutions and in the community. These should be provided in a supportive physical and psychosocial environment. Although there are many high-quality programs within the Service, a great deal of variability exists within and between regions.

Both male and female offenders who are currently serving their sentence in a provincial institution lack access in many cases to levels of programming that meet their needs. Many provincial institutions do provide awareness or pre-treatment sessions. However, these sessions are targeted appropriately at the majority of their offender population serving six months or less. For federal offenders serving two years or more with identified substance abuse problems this level of intervention is inadequate.

Although offenders must be treated equally, access to substance-abuse-specific programming will still be subject to the Service's assessment of the offender's risk to society and individual needs.

B. Strengthening Substance Abuse Prevention/Intervention Strategies

Substance abuse prevention and intervention strategies should "involve actions aimed at a defined target population, and at the relevant physical and social environments." The three types of action are:

Primary: Action taken prior to the onset of a substance abuse problem;

Secondary: Action taken when the problem has become recognizable; and

Tertiary: Rehabilitation efforts to minimize the effects of a problem once it has occurred to prevent further deterioration and to begin to restore health.

These terms assist in clarifying the intent and target population of a particular intervention. While the prevention and intervention programs and activities identified under any of these three headings will be quite different in nature and level of intensity, they will have complementary objectives.

Prevention strategies target the **person** (offender), the **drug** (substance(s) used) and the **environment** (institution and community). The following are definitions of the types of behaviour change strategies that can influence the offender directly, or support and influence individual and collective behaviour indirectly by changing the physical or social environment. These strategies are global in context and affect all levels of intervention throughout the Service extending from primary prevention, through to secondary and tertiary interventions.

Influence and Persuasion activities range from providing information to offenders in reception to more structured education components as part of secondary and tertiary intervention programs. Influence and persuasion strategies attempt to influence the attitudes, beliefs and intent of the offender by examining the effects of substance abuse in his/her life, and to provide the information needed for change.

Competence Development is intended to improve the offender's skills and ability to cope with everyday situations. Competence development is extremely important in changing behaviour. Skills and competencies such as literacy and vocational as well as social and interpersonal skills, reduce the offender's vulnerability to using and abusing substances and assist the offender who is dependent on alcohol and drugs in the process of recovery. As offenders increase their ability to cope, they are in an improved position to take control and responsibility of their life.

Control Approaches within CSC are measures used to limit access to, and the use of, drugs and alcohol by the offender within the institution and the community. The largest single contraband problem the Service faces relates to alcohol and drugs. The Service's Report on Contraband Control concluded that an over-reliance on traditional tools, largely involving personal searches of inmates and others, is unsuccessful and expensive. Many personal search techniques are not guaranteed to discover the contraband sought, and the use of regular searching requires a significant level of resources.

The notion of deterrence also requires close attention. Deterrence will only work if:

1. Transgressors are always detected;

2. Disciplinary measures are consistently applied when the transgression is detected; and

3. Everybody is aware that they can be caught and disciplined.

Thus, the challenge is to establish control techniques and policies that meet these requirements as well as addressing the need for the Service to have a balanced combination of enforcement and programs which encourage demand reduction.

Once the offender is released to the community he/she will be also be subject to federal and provincial legislation and regulations regarding the control of alcohol and drugs. The community employs such measures as pricing, purity and content, availability, advertising, and laws governing where and when individuals can consume alcohol and drugs.

Some examples are setting a minimum drinking age, penalties for drinking and driving, granting permits to serve alcohol, and advertising regulations regarding lifestyle advertising. The actions are aimed at reducing the use and abuse of alcohol and drugs.

Environmental Design Approach is concerned with improving satisfaction with or reducing the stresses within the offender's relevant environments. This strategy is not directed at the individual offender, but is aimed at improving the physical and psycho-social environment in which the offender is attempting to change his/her behaviour.

C. Enhancing the Ability to Cope

The challenge to the Service is to develop programs that enhance the offender's ability to cope with everyday situations through developing such skills as anger and stress management.

Enhancing coping comprises three dimensions:

a) Equipping offenders, families and communities to cope with foreseeable transitions. For example, gradually and adequately preparing the offender and the community for reintegration by developing a comprehensive pre-release plan. Referral to community programming should build on the skills the offender has gained and should ensure the availability of support systems;

b) Strengthening the offender's individual and collective capacity to deal with the number of physical and psychological problems that can accompany substance abuse problems; and

c) Enhancing and reinforcing the efforts of families and caregivers in providing a wide range of support systems including continuing care counselling and programming.

4. THREE BASIC MECHANISMS OF HEALTH PROMOTION

The Task Force endorses the major challenges involved in promoting and implementing an overall health promotion strategy. The following mechanisms are key components to their implementation.

A. Self-Care and Personal Responsibility

Self-care is a process in which the offender is one of the primary resources in the prevention and treatment of substance abuse problems. Self-care implies individual confidence and the ability to manage one's overall physical and mental health. It is a process whereby the offender can function effectively on his/her own behalf in developing positive health behaviours, as well as taking responsibility for involvement in his/her recovery.

In order to assume this responsibility, offenders should be provided with accurate and timely information about, and access to, substance abuse intervention programming. Programs should provide meaningful options that allow the offender to make responsible choices.

B. Mutual-Aid/Self-Help Groups

Individuals in the offender's social network who have had similar experiences often possess a special understanding and knowledge about particular health problems and life stressors, enabling them to cope with an ongoing problem. To seek or accept advice and support from significant others may be a very beneficial coping strategy.

People have always understood, almost intuitively, that individuals in one's social network who have "been there," "walked the walk," and can "talk the talk," have a special understanding and wisdom about particular life stressors and problems, and that to seek or accept advice and support from these "veterans" may be a very beneficial coping strategy.

By their very nature, mutual-aid and self-help groups have two core preventative features: they provide a range of social support, and they increase coping skills and repertoires through information and sharing experiences. Self-help groups such as Alcoholics and Narcotics Anonymous, Adult Children of Alcoholics, and Alanon have provided support for the offender both within the institution and the community. Indeed, in many communities, these groups provide the only source of continuing support for offenders and their families. Culturally specific groups and communication in one's own language also strengthen feelings of belonging and the ability to share.

Mutual-aid and self-help groups represent an important mechanism to assist offenders in coping with substance abuse and related problems. Methods must be found for incorporating informal helping approaches and mutual-aid strategies into the planning mechanisms for substance abuse programming without co-opting these resources as adjunct services under professional control, and without viewing these resources as a cheaper substitute for ongoing comprehensive substance abuse services.

C. Creation of a Healthy Environment

Social and physical environments play an essential role in motivating and supporting health behaviour. Prevention and health promotion programming that do not take into account the stresses in the environment and concentrate on interventions aimed directly at the individual are largely unsuccessful, especially in creating a sustained behaviour change.

Healthy environments can be created by developing healthy practices within the correctional environment: by providing offenders with improved living conditions; by offering a full range of recreational services; by fostering mutual aid; by encouraging self-care in offenders; and by offering social, educational and vocational programs.

The CSC has an opportunity to provide a healthy environment to the offender. The Service is in a position to create an environment that is supportive and conducive of change, capable of providing opportunities for self-development, enhancing self-esteem and personal growth.

5. IMPLEMENTATION STRATEGIES

To ensure the explicit support for the concept of health promotion these concepts should be supported by policies and practices within the Service. The following strategies form the basis of action in the field.

A. Fostering Staff, Offender and Community Participation

Fostering participation in the context of the Service means that the offender, the correctional staff, the community and the Service itself are working towards becoming more involved in improving the environment, thereby reaching those concerned and affected by the issue of substance abuse.

By giving a greater voice to offender, staff and community in shaping policy, the CSC can promote health and increase involvement by the respective communities in decisions that directly affect them.

As offenders are actively supported and encouraged to participate in decisions that directly affect them, they gain valuable skills which will assist them in contributing to the institution community,

as well as the community at large when they are released. Offenders need to gain experience in being involved and taking responsibility. This experience is critical if they are to use these skills in other spheres of their life.

B. Strengthening Community and Institutional Substance Abuse Services and Policy Development

The CSC and community-based drug and alcohol agencies already play an indispensable role in the prevention and intervention of substance abuse problems. This is evidenced by the activities and programs of the various institutions, self-help groups, continuing care and community-based services. As a major participant in the substance abuse field, it is essential for the CSC to become involved in policy development and decision-making at the national, provincial, municipal and the individual agency or institutional levels. Future challenges will require shifting priorities, and a further expansion of both community and institutional services to better meet the recovery needs of the offender.

The CSC must continue to encourage and support community and institutional involvement in the planning, delivery and evaluation of substance abuse services.

The Service must examine the existing areas of involvement and explore such questions as:

1) How effective is the existing level of communication and participation?

2 How can communication and participation be improved?

In strengthening both institutional and community substance abuse services, it is critical the CSC create a balanced continuum of services for the offender bridging the gap between the institution and the community.

The development of supportive policies and co-ordination of services at all levels is necessary to provide services to the offender in a timely, cost-effective manner, and to facilitate communication and co-operation prerequisites to the process of change.

6. GUIDING PRINCIPLES

The mutually reinforcing strategies and the associated mechanisms comprise the basic elements of the health promotion strategy. One strategy, or mechanism standing alone, will be of little significance. Only by putting all these pieces together and developing a strategic action plan, assigning resources, and setting regional, institutional and district priorities can the Service be assured of responding effectively to reduce the problems of substance abuse among offenders.

One of the most attractive features of the health promotion/ prevention/intervention approach is that rather than depending only upon massive new programs, both within the institution and the community, it depends more upon the redirection and strengthening of existing programs, and building on the strengths and resources of staff and offenders. The following principles guide the Service in this process:

1. A healthier environment is conducive to and supportive of change and essential to facilitate and maintain healthy behaviours;

2. The concepts of health promotion form the basis of a continuum of interventions and services for the offender from the point of sentencing to warrant expiry in the community;

3. Mutual-aid, self-help groups, peer support and peer counselling in the prevention and intervention of substance abuse problems within the Service need to be fostered and supported. Training for these groups should be provided where necessary;

4. CSC staff must become involved in policy development for substance abuse from the national to the local levels if a balanced co-ordinated continuum of services accessible to the offender in the larger community is to be realized;

5. The CSC must develop a balanced demand and supply reduction policy as recommended by the Contraband Control Study; and

6. Staff, the offender and the community should be involved in the planning, delivery and evaluation of substance abuse prevention and intervention programs.

7. RECOMMENDATIONS

The Task Force recommends that:

1. **The CSC adopt the Health Promotion Model as the core of the Substance Abuse Strategy for federal offenders.**

2. **The CSC develop and implement a range of substance abuse services and programs available to offenders from their reception until warrant expiry date.**

3. **The CSC develop a national substance abuse policy that is consistent with the principles and recommendations outlined in the Contraband Control Study, the report of the Task Force on Federally Sentenced Women, and the report of the Task Force on Aboriginal People in Federal Corrections.**

4. **National Headquarters of the CSC develop processes and policies that give guidance and direction in the overall planning, delivery and evaluation of substance abuse related services and programs.**

5. **Each region develop, implement and evaluate a regional substance abuse plan for their respective offender population, based on the prevalence of substance abuse problems, the prevailing cultural and demographic factors, and resource levels.**

6. **The CSC continue to develop and maintain linkages with federal, provincial and community-based addiction agencies to ensure a co-ordinated continuum of care for the offender.**

Chapter 3

Model for Substance Abuse

Chapter 3

MODEL FOR SUBSTANCE ABUSE PROGRAMMING WITHIN CSC

1. INTRODUCTION

It is consistent with the Mission to ensure that the CSC has a well-defined and articulated strategic action plan that will guide and direct substance abuse programming from initial sentencing at the institutional level to warrant expiry in the community. The action plan should be guided by an overall strategic framework, consistent with regional and demographic variations, and "state of the art" prevention and intervention programming from the substance abuse field, as well as identified offender needs.

The CSC is adopting a health promotion/prevention approach to reduce the incidence, prevalence and severity of problems associated with alcohol and other drugs use among offenders from the commencement of sentence in an institution to warrant expiry in the community. The Service is committed to a comprehensive strategy which considers the institutional and community environments, the offender, the substances offenders are using, as well as the protection of society when developing this strategic planning model.

The substance abuse planning model Annex I is a **"Broad Spectrum"** approach built within a **"comprehensive framework"** that considers all aspects of the institution and community. This approach facilitates the development of a mix of appropriate, complementary preventative actions and helping interventions, and attempts to ensure the appropriate match with the selected offender population.

This model recognizes that:

1. Substance abuse is multi-causational;

2. There must be a range of interventions available;

3. Early identification and intervention of alcohol-and drug-related problems is crucial to the recovery process;

4. Screening and assessment of offenders for substance abuse problems is essential early in the sentence;

5. Offenders experience different levels of severity of alcohol and drug problems;

6. Offenders within each level of severity require different types and intensities of interventions;

7. A range of services and programs should be available to the offender throughout the sentence;

8. Health promotion approaches can prevent the offender from becoming cross-addicted or dependent, and enhance the recovery process;

9. Environmental factors must be considered when developing intervention strategies;

10. Effective rehabilitation is enhanced in a supportive environment; and

11. Prevention and intervention approaches to substance abuse problems should be multi-disciplinary.

The critical question in deciding on an appropriate intervention is whether the course of action chosen has the potential to impact positively on the offender's capacity to make health-promoting rather than health-detracting behaviour choices. In addition, does the intervention contribute to reduce drug and alcohol abuse among offenders who are under the mandate of the CSC, and ultimately enhance their potential to live as law-abiding citizens?

The model assumes that unless a comprehensive range of health promotion and intervention services and programs are available and accessible in varying degrees of intensity:

1. Offenders at a particular level of severity are at risk of further deterioration in terms of their substance abuse problem;

2. Those offenders who have not experienced a substance abuse problem are at high risk for developing a problem in an environment in which drug and alcohol use may be advocated and supported; and

3. Those offenders who are attempting to change their behaviour are at high risk for relapse if they are returned to an unsupportive environment.

Identifying offenders who have a substance abuse problem should be accomplished during the initial screening at reception as should an assessment of offenders' needs in all areas of their life. This assessment is crucial to the development of a comprehensive recovery and relapse prevention plan.

This recovery plan would be the basis for the range of interventions required to maintain behaviour change within the institution, and on release to the community.

The initial screening process will be able to provide a data base of the prevalence, degree and nature of drug abuse problems, as well as a profile of the intervention needs of the offender population. Until this information has been gathered, however, the general breakdown of the percentages of offenders requiring different levels of intervention as illustrated in Figure 3 can be utilized when determining program and resource needs.

Primary prevention programs and activities would be directed towards the entire offender population who may, or may not have a substance abuse problem. These activities would be considered preventative for approximately 30% of the offender population, who are not experiencing drug or alcohol problems.

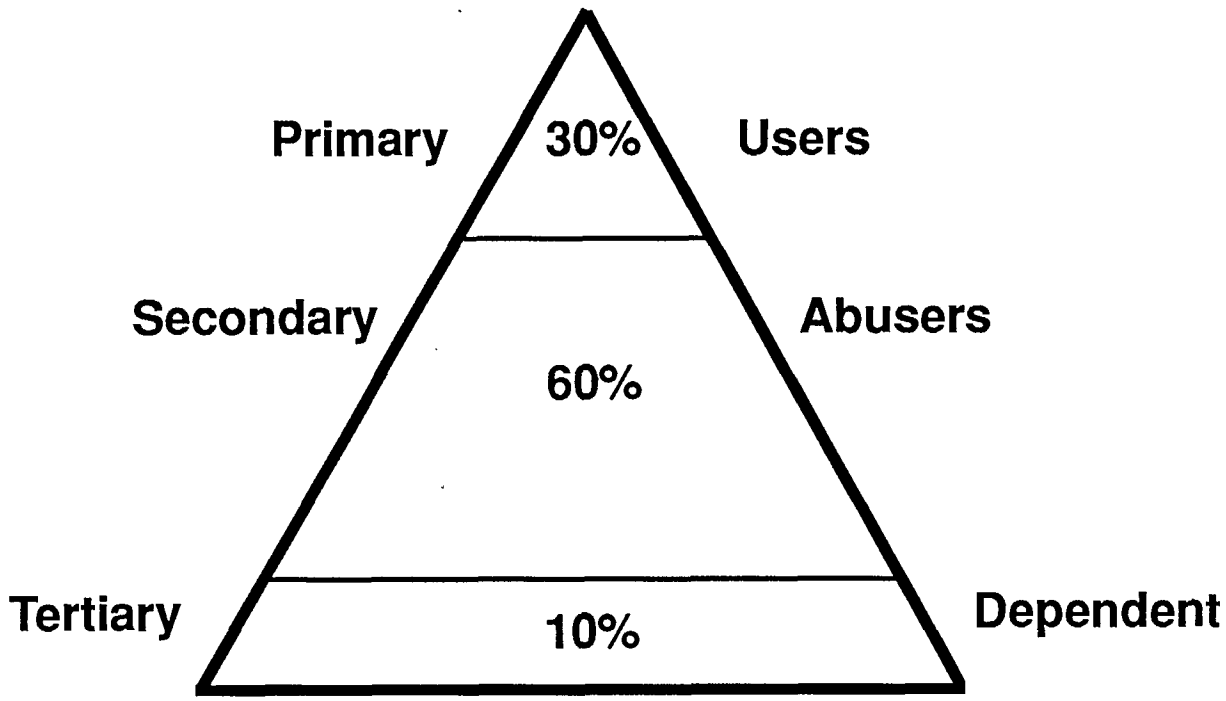


Figure 3

Secondary intervention programs and activities are directed at approximately 60% of the offender population who have been identified as abusing alcohol and/or drugs, are experiencing some degree of dependency, and who risk developing severe problems without further intervention.

Tertiary intervention programs and activities would be directed at approximately 10% of the offender population who have been identified as having a chronic substance abuse problem. The aim of tertiary intervention is to prevent the problem from deteriorating and to begin the process of rehabilitation.

The intensity of low, medium and high levels of interventions (frequency and duration) are generally related to the extent to which the offender is, and has been, chemically dependent. The level of intensity does not refer to the intensity of the program experience to the offender. Other factors to be considered are availability of family and social supports.

A. Guiding Principles of Intervention

The CSC is committed to the development of an effective strategic action plan that contains a comprehensive range of services and complementary health promotion and prevention strategies. Offenders should be:

1. Matched to the most appropriate, timely and cost- effective forms of interventions;

2. Provided with services in an environment that is supportive and amenable to behaviour change;

3. Experiencing incentives and disincentives that are important or critical to their needs;

4. Supported in their behaviour change by the CSC staff, their family, social networks, including peers, and volunteers;

5. Provided with the necessary information and skills to sustain and strengthen their behaviour change; and

6. Given appropriate referrals to other helping agents in cases of special need.

Interventions should be provided by:

Trained CSC staff, volunteers or contract persons who possess the personal attitudes, attributes, knowledge and skills necessary to assist the offender address their drug and alcohol problems. Staff must also be sensitive to the issues of gender, ethnicity and language.

B. RECOMMENDATIONS

The Task Force recommends that:

1. **The CSC adopt a multi-disciplinary approach when developing and implementing substance abuse programs and services.**

2. **The CSC adopt the principles of primary, secondary and tertiary intervention as part of the strategic action plan for substance abuse programs and services.**

3. **Each region develop a strategic action plan for the implementation of the recommendations for substance abuse programs and services based on the CSC Substance Abuse Strategy.**

CONTINUUM OF INTERVENTION STRATEGIES WITHIN CSC

	PRIMARY INTERVENTION		SECONDARY INTERVENTION		TERTIARY INTERVENTION	
	100% HEALTH ENHANCEMENT	30% PRIMARY PREVENTION	LOW INTENSITY 60%	MEDIUM INTENSITY	HIGH INTENSITY 10%	THERAPEUTIC COMMUNITY-
DEFINITION	Health enhancement and wellness programming are practices that enhance health and reduce the risk of illness.	Action taken prior to the onset of a substance abuse problem.	Minimal interventions of short duration.	Interventions that are of medium duration, and are based on education and skill development.	These programs are often based on the principles of AA and the disease concept of alcoholism.	A structured supportive environment that provides positive that provide positive change by confirming behaviours and attitudes that are destructive for individual.
GOALS	1) To create a healthy environment, in which offenders can make informed decisions about their lifestyle, 2) reduce the likely of the offender abuse alcohol and drugs.	To strengthen the offenders' physical, psychological and social resistance to avoid the abuse of alcohol or drugs.	To create an awareness to assist the offender in evaluating the problematic involvement with alcohol and drugs.	To motivate the offender to either abstain from substance use, or to moderate his/her substance use ot acceptable non-problematic levels.	To assist offender to achieve complete abstinence from alcohol and drugs.	To achieve abstinence from substance by achievement of a level of personal development coping that would permit functioning in the community as law abiding citizens
TARGET GROUP	Total offender population.	Total offender population. Maximum benefit, however, would be the 30% of the offender population who could be at risk of developing an alcohol or drug problem.	Offenders who have been identified as 1) having abused alcohol and drugs; 2) experienced minimal consequences and a low level of dependency on alcohol and/or drugs; 3) adequate cognitive and literacy skills; 4) high conceptual level; 5) internal locus of control.	Offenders who have been identified as abusing drugs and alcohol and experiencing 1) a low to medium level of dependency on alcohol and/or drugs; 2) possess adequate literacy and cognitive skills, and 3) a high conceptual level.	Offenders who have 1) been assessed as having a severe dependency, 2) experienced compulsive drinking and loss of control, 3) low social stability, 4) highly affiliative needs, 5) a spiritual orientation, and 6) experienced treatment failure with other less intensive interventions.	Offenders who have identified as having: 1) a severe dependency, 2) numerous criminal activities directly related to drugs and alcohol abuse, 3) no severe learning disabilities, 4) no multiple diagnosis 5) accept a highly structured direct approach 6) poor social/interpersonal skills, low low social stability, & 7) motivated to participate.
DELIVERY METHODS	The content and length of program issue or topic specific.	*Influence Approach* involving a range of awareness sessions, maximum two hours each. *Competence development* approaches such as vocational and literacy skills would be regular ongoing programs. The length of personal social skills training would be issue or topic specific.	The degree of guidance, feedback, and counselling required by the offender would be decided on an individual basis by the case managers. Education programs should be a minimum of 20 hours.	Programs at this level would be of medium duration and delivered over a number of weeks. Programming should be at least 80 hours, with ongoing support of recovery and relapse prevention programming.	A 21 to 35 day residential intensive program delivered in a residential setting followed by continuing care sessions.	Limited interaction with the general inmate population. The program should be 18 months in length.
PROGRAM COMPONENTS	General health awareness, education, individual/peer counselling, programs on fitness, sports, leisure, smoking cessation, weight loss, nutrition therapy, stress reduction, relaxation techniques. Personal and social skills training, assertiveness training, and cognitive restructuring	General awareness sessions, reading books on addiction, participating in institutional drug and alcohol committees, interactive theatre and video presentations. Skill development activities such as literacy and vocation skills training, and personal development programs such as individual, group, family, marital and spiritual counselling.	Bibliotherapy, self-help manuals, audiovisuals, education sessions, self-help groups, peer, individual, spiritual and family counselling, life and social skills training.	Education and skill development sessions, conducted as part of an overall treatment program, individual and group counselling, spiritual, family, marital counselling, parenting skills, and access to self-help groups.	Education on the disease concept of alcoholism, signs and symptoms of the disease, 12 steps of AA, recovery and relapse prevention issues, and the need for abstinence, family dynamics, individual/ group/family and spiritual counselling, attendance at AA or NA.	Behavioural limits and sanctions, positive peer pressure, mutual-aid, supportive feedback, promoting personal social responsibility and sufficiency, decision-making, individual/ group counselling, education and formal skill training, organized recreation, family and spiritual counselling.

STRATEGIES MODEL FOR SUBSTANCE ABUSE PROGRAMMING WITHIN CSC

HEALTH PROMOTION INTERVENTIONS

Reception	Health Enhancement	Institutions	Community	Recovery Mainten. Phase	Warrant Ex. Date

Initial Screening
Induction
Assessment
Referral

WELLNESS PROGRAMMING

- Smoking cessation
- Nutrition/weight
- Exercise/rest
- Stress/attitude
- Safety
- Leisure
- Relaxation

PRIMARY PREVENTION

Influence
General awareness sessions
Drug & Alcohol committies
Interactive theatre presentations
Interactive video presentations

Competence Development
Literacy skills
Vocational skills
Parenting skills
Personal development programs
Decision making skills

Control
Random urine sampling
Parole conditions
Frisking and searching
Disciplinary sanctions

Environmental Design
Creating a supportive, physical and psycho-social environment
Creating Alternatives

Secondary Prevention

Low Intensity

Education
Bibliotherapy
Self-help manuals
Peer/group/family/spiritual counselling
Self-help groups

Low Intensity

Education
Bibliotherapy
Self-help manuals
Peer/group/family/spiritual counselling
Self-help groups

Medium Intensity

Education
Individual/group counselling
Family counselling
Spiritual counselling
Self-help groups

Medium Intensity

Education
Individual/group counselling
Family counselling
Spiritual counselling
Self-help groups

Self-help groups
Recovery training sessions
Fellowship meetings
Ex-offender counselling
Drug Free Activities

Recovery and Relapse Prevention Planning → W.E.D.

Tertiary Prevention

High Intensity

Education
Psychotherapy
Individual/group/family/spiritual counselling
Cognitive behavioural therapy
Pharmacotherapy
Self-help groups

High Intensity

Education
Psychotherapy
Individual/group/family/spiritual counselling
Cognitive behavioural therapy
Pharmacotherapy
Self-help groups

Self-help groups
Recovery training sessions
Fellowship meetings
Ex-offender counselling
Drug Free Activities

Therapeutic Community

Behavioural limits and sanctions
Positive peer pressure,
Mutual-aid
Supportive feedback
Open system communication
Individual/group/family/spiritual counselling
Education and formal skill training

Therapeutic Community

Behavioural limits and sanctions
Positive peer pressure,
Mutual-aid
Supportive feedback
Open system communication
Individual/group/family/spiritual counselling
Education and formal skill training

NO TREATMENT

2. RECEPTION

Commissioner's Directive 500, *Reception and Orientation of Offenders*, requires that offenders be provided with "counselling regarding adaptation to the specific institution and information about the physical setting, program opportunities, and regulations specific to that institution." This requirement is viewed by the Task Force to be particularly relevant with respect to drugs and alcohol within institutions.

Although some offenders do not present a risk to abuse drugs and alcohol, the majority of offenders are at risk of continuing to abuse, or at risk of developing a pattern of abuse. It is important that all offenders participate in a reception process that immediately provides essential information to them about the social and personal consequences of substance abuse, and assesses their level of risk and needs for substance abuse interventions.

It is at this point in the offender's sentence that the Task Force strongly endorses the assessment of all offenders to guide the case management process and the presentation of key factual information to provide guidance and motivation so that they are more able to make informed decisions in the development of their plans.

A. Screening of Offenders

To provide adequate treatment to offenders based on their needs gives rise to the requirement for a broad-based screening procedure. This would allow the CSC to properly identify and assess the extent or nature of an individual offender's substance abuse problem, the seriousness of the problem, and it will aid in the identification and planning of an appropriate and effective treatment plan. What is also required is a means of determining the types of substance abuse interventions and programs the CSC should develop.

B. Summaries of Assessment and Screening Instruments

The following represent a sampling of the assessment instruments commonly available in Canada that have found application in a limited number of programs for offenders:

The Alcohol Dependence Scale (ADS) is a 25-item self-report scale, which assesses the severity of alcohol dependence on four dimensions: 1) loss of behaviourial control, 2) psycho-perceptual withdrawal symptoms 3) psycho-physical withdrawal symptoms and 4) obsessive-compulsive drinking style.

The Drug Abuse Screening Test (DAST) is a brief instrument for clinical screening and treatment evaluation. It is a 20-item scale which yields a quantitative index of the degree of consequences related to drug use, for adults and adolescents.

The Modified Michigan Alcoholism Screening Test (Modified MAST) is a behaviourial scale assessing the responsible use of alcohol beverages of adults. It includes 24 questions describing circumstances often associated with the use of alcohol and a new set of questions which substitute the words "drugs" for "alcohol" and "drug user" for "drinker."

A Structured Addictions Assessment Interview for Selecting Treatment for Inmates (ASIST-I) uses a structured interview format modified for use with incarcerated offenders from an instrument developed by the Addiction Research Foundation of Ontario. It is a comprehensive psycho-social assessment interview, designed to ensure that a standard set of questions is posed to each assessed offender. It provides a comprehensive picture of his/her alcohol and drug use history, and the types and severity of problems experienced, particularly problems associated with alcohol and drug use. It also acts as a tool for treatment planning.

C. Assessment of Substance Abuse in the CSC

Traditionally, the assessment of substance abuse problems has been based on the self-report. Offenders are identified as substance abusers on the basis of whether they admit to having a problem with drugs or alcohol. With the development of offender classification systems such as Case Management Strategies, additional information is gathered with respect to the offender's use of drugs and alcohol. This information, with its limitations, is used to identify whether an offender has a substance abuse problem and whether or not intervention is required.

The information gathered may or may not provide any information about:

1. The extent and nature of an offender's substance use;
2. The extent it is associated with his/her crimes;
3. Whether the offender was intoxicated when he/she committed the crime;
4. His/her perceptions of whether and how substance abuse affected his/her criminal behaviour; or
5. Whether the offender commits crimes when he/she is <u>not</u> impaired.

While a number of assessment instruments are available, the majority assess either alcohol dependency or drug dependency, but they do not always assess both. Neither do they provide information on how the offender's abuse of drugs and/or alcohol relates to his/her criminal behaviour.

D. Matching of Offenders and Interventions

There are many different kinds of alcohol and drug problems among users. Current thought is that multiple types of alcohol and drug problems require matched interventions. A number of studies have demonstrated that when individuals are "matched" on the basis of a variety of factors, improved outcomes are observed. Annis and Chan (1983) have shown in their study that indiscriminate interventions are ineffective and can have negative effects on the future outcome for participants.

The Task Force believes that CSC requires a comprehensive screening procedure to provide information on the prevalence of substance abuse problems among incarcerated offenders, the relationship between an individual's drug and alcohol abuse and his/her criminal behaviour, and a means to identify factors predictive of an offenders' response to interventions.

Proper assessment of substance abuse among offenders must also include information about the social context of drug and alcohol use, which is important in understanding and treating offenders' drug and alcohol use problems such as:

1. Where, when, and with whom offenders used drugs and/or alcohol, both typically and at the time of their crime;

2. Whether or not the crime was related to the purchase or distribution of drugs;

3. Whether or not the person with whom the offender was drinking or using drugs prior to the offence had ever been involved in substance abuse or crime and whether or not these persons influenced or were involved in the offence; and

4. Characteristics of the victim of the crime, e.g., their relationship to the offender and whether or not they were using drugs or alcohol, and the offender's perceptions of the victim's influence on the crime.

In order to provide effective, matched treatment for drug and alcohol abusing offenders, the initial assessment of offenders must be comprehensive since it is widely accepted that addiction problems seldom occur in isolation. The components of such an offender addiction assessment procedure, described in Ross and Lightfoot (1985), are as follows:

1. Relevant social and demographic information, the nature and extent of alcohol and drug use, the history of use, current pattern of drug use, and the degree of dependence;

2. Life-health functioning in the following areas: physical health, emotional health, marital and other social relationships, vocational satisfaction and financial status, leisure-time interests and activities, legal involvement;

3. Client personal resources and potential social support systems; and

4. Client treatment preferences.

Each of these components are incorporated in the Computerized Lifestyle Screening Instrument developed by the Ministry of the Solicitor General of Canada and the CSC in 1988.

E. Computerized Lifestyle Screening Instrument

This instrument was developed to obtain information about the extent and nature of offenders' drug and alcohol problems in order to assess the need for intervention programs, and to guide future program development.

The objectives of applying the Lifestyle Screening Instrument are:

1. To provide estimates of the prevalence of crime-related drug and alcohol dependency problems among offenders entering the federal correctional system;

2. To provide a comprehensive data base on crime-related drug and alcohol dependency problems among offenders entering federal institutions;

3. To assist in the development of a comprehensive assessment and referral procedure for drug and alcohol problems in the federal correctional system; and

4. To provide information on treatment-relevant characteristics of newly admitted federal offenders which can be used to develop offender "typologies" which, in turn, will aid in the development of meaningful treatment interventions and programs.

The instrument serves two primary functions. First, it provides an individualized front-end assessment. This assessment provides both the offender and the Case Management Officer with feedback which identifies the specific needs of the offender, who can then be placed in already existing interventions and programs. Second, it collects a database of descriptive data, which can then be analyzed and used to develop offender typologies. New treatment interventions and programs can be developed or existing ones enhanced to meet the needs of the various groups identified. With limited resources available for new programming, such information is essential for CSC managers to make decisions regarding whether or not additional or new interventions and programs are needed, and how large a population a program needs to serve.

The Lifestyle Screening Instrument provides the kind of comprehensive screening information required to develop a cost-effective intervention model for the CSC.

F. Overview of Substance Abuse Assessment

Clearly, research literature on substance abuse suggests that the most productive thrust for the development of substance abuse treatment within the CSC is to assess offenders in order to develop offender substance abuse typologies, which can be used to match offenders to types to treatment.

The Task Force recognizes that, while the Lifestyle Screening Instrument represents the most appropriate currently available tool for broad-based screening of offenders in the correctional environment, the current body of knowledge in this area is nevertheless rapidly expanding as the result of vigorous efforts by the professional community to improve assessment methodology.

G. Assessment of Aboriginal Offenders

The aboriginal offender population within the CSC is a heterogeneous and significantly large population with a broad range of cultures, traditions and social backgrounds. It is important that any assessment take these factors into consideration. If there is doubt about a particular method of assessment in relation to these considerations, it should not be used.

The Computerized Lifestyle Screening Instrument is currently being piloted for validation on a male aboriginal offender population in the Prairie Region. This is a significant step towards providing appropriately normed instruments for this population, recommended by the Report of the Task Force on Aboriginal People in Federal Corrections. Both the individual outputs and the aggregated data base will greatly assist in the development of culturally appropriate interventions, programs and activities for this significant sub-group of offenders.

H. Assessment of the Female Offender

Assessment tools used with women need to be sensitive to the differences between men and women. Many existing instruments have been validated for both male and female populations. It should be noted, however, that the Lifestyle Screening Instruments is presently only intended for male offender populations.

The female substance abuser may not initially identify a substance abuse problem, but may present with symptoms of low self-esteem, anxiety and depression. Also, the amounts of alcohol or other drugs that women are using may be lower than for men. Long-term health consequences for women can occur at much lower levels of consumption. Other issues that need to be taken into account in assessment include:

1. Presence or absence of a primary affective disorder;
2. Presence or absence of life crisis or transition preceding onset of problem use;
3. Sexual or reproductive history and current psycho-social circumstances; and
4. Any history of sexual or physical abuse victimization.
5. The Task Force considered the possibility of extending the Lifestyle Screening Instrument for use with female offenders, but rejected this alternative. Given the relatively small number of female offenders, it is much more expeditious to assess on an individual basis using existing instruments normed to the female population and structured interviews to obtain this information.

I. Recommendations

The Task Force recommends that:

1. **The CSC use the Lifestyle Screening Instrument to assess offenders upon reception in each region.**
2. **The CSC continue to monitor developments in the field of substance abuse assessment instruments and techniques. The purpose will be to improve CSC's capabilities in this area in response to the experience of other jurisdictions as well as the results of ongoing monitoring of the Computerized Lifestyle Screening Instrument.**
3. **The Computerized Lifestyle Screening Instrument be validated for use with aboriginal offenders.**
4. **Appropriate training programs on the use and interpretation of the instruments chosen by the CSC to determine substance abuse characteristics and treatment referral of offenders be developed and provided to Case Management staff.**

5. **Female offenders be individually assessed for substance abuse problems through the use of established assessment instruments and structured interviews which are normed and validated for female populations rather than by the use of broad-based screening instruments.**

3. ROLE OF CASE MANAGEMENT IN ASSESSMENT AND INTERVENTION PLANNING

The case management process is a comprehensive approach to the assessment and management of offenders. It addresses a series of offender needs and legal requirements within the context of the Mission of the Service. Some of the key elements of this process are information gathering; assessment of risk and needs; correctional planning with an emphasis on active intervention with the offender to address criminogenic factors; and the supervision of the offender. The objective is to prepare offenders for a safe return to the community as law-abiding persons.

The issue of substance abuse is one that addressed at specific junctures in the process and in various assessment tools. Because of its prominence as a criminogenic factor, substance abuse is an issue specifically dealt with in determining risk and needs and in developing correctional plans for offenders.

The case management process provides a framework for the identification and management of offenders with substance abuse problems. The objectives of the case management process with respect to substance abuse are as follows:

1. Identify the problem;
2. Assist the offender to accept the problem;
3. Assess the risk of reoffending;
4. Recommend/refer for treatment;
5. Assess the likely efficacy of treatment;
6. Assess the outcome of treatment;
7. Identify other intervention strategies to deal with other criminogenic needs, which may or may not be connected to the substance abuse problem;
8. Understand and recognize the potential for and indicators of a return to criminal behaviour; and
9. Apply appropriate interventions upon a return to criminal activity or when increased potential for a return is possible.

The way in which the case management process addresses substance abuse problems can be illustrated by reviewing the way in which substance abuse is dealt with during the five phases of case management, which are:

1. Assessment and Placement;
2. Planning and Institutional Supervision;
3. Preparing Cases for Decision;
4. National Parole Board Decision and Release; and
5. Community Supervision.

A. Assessment and Placement

CSC contact with offenders begins immediately upon commencement of a sentence of two years or more. The assessment and placement phase, whether it occurs while the offender remains in a remand facility or after his arrival at a reception centre, focuses upon the immediate identification of risk and needs, the gathering of information about the offender and penitentiary placement.

Particularly for offenders serving sentences of four years or less, the early identification of a substance abuse problem is critical. Consideration should be given to appropriate institutional interventions and programming and to appropriate community-based interventions and programming where the offender does not present an undue risk for release. If risk is manageable within the community, then there will be considerable focus on the development of release plans, and in the case of the substance abuser, the identification of appropriate community-based intervention and treatment.

It is especially important in this phase to not only identify whether a substance abuse problem exists but to identify also the relationship between substance abuse, the offence and the pattern of offending.

A number of tools exist to identify whether substance abuse ought to be a concern and whether it is a criminogenic factor for any particular offender. These tools include:

1. **Penitentiary Placement Interview:** In discussing involvement in the offence, the offender's developmental and social history, and in identifying personal needs, the offender will usually disclose whether there is a substance abuse problem.

2. **Post-Sentence Community Assessment:** Family, friends and significant others are important sources of information in isolating criminogenic factors. It will be important to confirm through the views of others the nature of the substance abuse problem, the offender's acceptance of the problem, the consequences of substance abuse for the offender and previous involvement in treatment programs.

3. **Case Management Strategies (CMS) Interview**: The CMS interview facilitates a wide-ranging enquiry into the offender's developmental and social history, lifestyle and criminal behaviour. The relationship of alcohol/drug use to these issues is explored. The CMS interview also yields a classification for the offender, which is used to guide the approach to correctional planning and supervision of the offender.

4. **Force Field Analysis of Needs**: The various factors that contribute to criminal behaviour are itemized and ranked as to their relative influence.

5. **Criminal Profile Report**: The Criminal Profile Report provides a description of the current crime and an analysis of recent and past criminal behaviour. Where it is a factor, the link between the use of alcohol and drugs and offending must be clearly identified.

6. **Psychiatric/Psychological Assessments:** Professional assessments are required in the case of all Category 1 (in general terms, violent) offenders. In these cases the assessment protocol, such as the Diagnostic Instrument Schedule (DIS), used by CSC and contract professionals should include an examination of substance abuse as a criminogenic factor.

B. Planning and Institutional Supervision

The **Correctional Plan** is the key document in outlining the nature and extent of the substance abuse problem and can include an approach to intervention.

The **Casework Record** is used to outline short-term objectives along with offender and supervisor action plans. Treatment interventions are specifically outlined. The offender's response to various interventions is to be carefully recorded.

Assessment and referral is a primary activity within the case management process. By using case management tools to identify a substance abuse problem, correctional staff can assist the offender in recognizing the problem and developing the motivation to act involved in an appropriate treatment intervention or program. Case management tasks also include making the offender aware of available interventions and programs. In this way the Case Management Officer is actively involved in the intervention process.

The overall approach to developing and supervising a Correctional Plan is guided by which of the four Case Management Strategy groupings the offender is classified. These groupings will give some indication as to the usefulness of treatment in a particular case and the use of treatment relative to other forms of intervention such as stricter monitoring, but will not likely indicate the most appropriate kind of treatment. It should be noted that the Case Management Strategies give a general indication of a substance abuse problem. The Case Management Officer should then have a few tools to choose from such as the Computerized Lifestyle Screening Instrument to further identify and substantiate that a problem exists. The key is to have independent assessment instruments available for the effective use of a Case Management Officer.

The current case management assessment instruments do not determine specifically the kind of treatment most appropriate for offenders but they do provide a good picture of the offender's needs and abilities. It becomes the responsibility of case management and correctional staff to familiarize themselves with intervention programs available to the offender, so that appropriate intervention referral can be made.

Implementation and monitoring of the Correctional Plan requires a comprehensive and integrated effort on the part of all correctional and program staff. Treatment intervention and the management of the offender within the institution can be enhanced if information is shared amongst staff. A variety of staff should be aware whether the offender is involved in a treatment program and whether he attends regularly. All staff must be alert to indications that an offender may be using illicit substances. This kind of awareness can support treatment efforts as well as contribute to a safer institution.

Case conferences are a key feature of an effective case management process and are used to share information amongst staff and to provide feedback to the offender regarding his/her performance. The initial sharing of information with treatment personnel and an ongoing dialogue between treatment personnel and case management staff is critical to providing quality treatment and assessment.

C. Preparing Cases for Decision

In preparing cases for the National Parole Board, case management staff must ensure that all relevant information for decision-making is obtained, that the case is prepared comprehensively and that a quality recommendation is tendered.

A written report, the Progress Summary, is prepared by a Parole Officer after consultation with the institutional Case Management Officer and Correctional Officer II. Written reports are obtained from treatment or program personnel, who must also be consulted on the offender's program participation and progress.

A review of the release plan is made by way of community assessment. In most cases, this involves contact with those family and friends who are lending support to the release plan. Consultation also occurs with the destination police force and, where appropriate, the victim is consulted. If the release plan involves release on day parole to a Community Residential Facility (C.F.R.), then a screening is conducted by a C.R.F. committee. Where treatment programs are included in the release plan, the case is discussed with the treatment agency.

Prior to the National Parole Board (NPB) hearing, CSC will have provided to the Board relevant background material such as police reports, victim statements, judges' remarks at sentencing, the Criminal Profile, Pre-Sentence Report and available pre-trial psychiatric or psychological assessments. In the case of Category 1 offenders, a professional psychiatric or psychological report is obtained.

D. National Parole Board Decision and Release

The assessment of risk is of primary concern to the NPB. In making a preliminary risk assessment in all cases, the NPB considers the offender's score from the General Statistical Information on Recidivism (an actuarial predictor of risk based primarily upon the offender's past criminal history) and a number of case-specific factors of which alcohol and drug use is one.

In making their final risk assessment, the NPB will consider whether the offender has participated in and benefited from institutional programs, and whether the offender has sufficient understanding of the offence and the role alcohol and drugs played. The NPB will also consider whether there is a release plan with appropriate support and control.

The NPB can impose special conditions requiring absolute abstinence from alcohol and/or drugs or requiring participation in a particular treatment program. The use of special conditions to manage the potential for substance abuse can pose a dilemma in terms of the service objective to safely reintegrate offenders into the community. Special conditions can assist in the management of risk in particular cases and therefore increase the number of releases. On the other hand, violations of special conditions can be commonplace and even predictable in certain cases. Consequently, the use of special conditions can contribute to both the number of releases and the number of failures. Special conditions are imposed by NPB where they are reasonable and deemed necessary to reduce or manage the risk the offenders release would otherwise represent or to facilitate the offender's reintegration as a law-abiding person.

E. Community Supervision

The final phase is especially critical as it focuses on the management of the offender in the community. Although a separate phase of the case management process, it incorporates many of the elements of previous phases: assessment of risk and need is ongoing; the Correctional Plan may need updating upon the offender's release; short-term objectives are revised and updated; and cases are prepared for review by NPB and for other administrative decisions depending upon changing circumstances and risk presented.

In determining how intensively an offender ought to be supervised in the community, the parole officer will rate the offender on a community risk/needs management scale. Risk is determined based upon the NPB preliminary risk assessment, which considers alcohol and drug use as a case-specific factor. Alcohol use and drug abuse are specific items in reviewing the needs of the offender. In this way substance abuse is considered from both a risk and a needs perspective in the community.

Where substance abuse has been identified as a criminogenic factor it usually follows that something must be done about it. In many cases, the offender is a reluctant participant. A lot of effort, arranging and encouraging are required on the part of the parole supervisor to facilitate an appropriate intervention. Interventions commonly used include:

1. Out-patient counselling;
2. Self-help groups such as AA and NA;
3. Residential programs; and
4. Adjunctive programming (e.g., life skills, personal counselling).

The determination of an appropriate treatment program can be a difficult choice. Although there are treatment options in the community, accessability is sometimes a problem for correctional clients. Certainly programs are not always available when an immediate need arises. To make appropriate referrals, parole staff must establish working relationships with treatment facilities in their communities and become familiar with the admission criteria for each.

Managing the substance abuse problems of the offender in the community includes these major elements:

1. Monitoring the offender's behaviour with particular attention to risk factors (relapse prevention);

2. Making the offender aware of treatment options available in the community;

3. Encouraging the offender to participate in treatment programs;

4. Monitoring the offender for adherence to special conditions such as abstinence or participation in a treatment program;

5. Utilizing special instructions to respond to changing circumstances and risk; and

6. Other interventions of a disciplinary/supervision nature may also be appropriate in response to violations and situations of increased risk. These interventions include disciplinary interviews, special instructions/ conditions, enforcement of special conditions and suspension.

4. INDUCTION INFORMATION MODULE FOR SUBSTANCE ABUSE

At present, delivery of an induction module is not consistent throughout institutions. A delivery guide, entitled *Getting It Straight*, was developed in 1987 and distributed to institutions at that time. The guide received mixed reviews, and was used by some institutions, but not others. Some institutions modified the package, but others do not have a consistent introductory session for substance abuse.

A review of the *Getting It Straight* module determined that, while it was comprehensive and well-developed, the module was not ideally suited for a mixed offender audience of non-users, users and substance abusers. As a result the Task Force endorses the concept of developing a set of goals and objectives for an induction module that would better satisfy the broad spectrum of needs that exist among newly admitted offenders.

The goal of the proposed module is to provide education and information on CSC policies and procedures in order to influence offender attitudes and intentions against abusing drugs and alcohol, and encourage participation in programs which address individual needs.

The Task Force suggests that, upon completion of the module, offenders should be able to:

1. Describe aspects in a person's life that are negatively affected by the abuse of drugs and alcohol;

2. Identify CSC policies and procedures that address the use of alcohol and drugs;

3. Discuss the links between substance abuse and criminality, violence in the institution, and re-integration into society;

4. Identify personal/social consequences of using/not using drugs and alcohol in prison; and

5. Describe program opportunities available to them, and how they will get involved.

A. Teaching or Learning Approach for the Induction Module

The Task Force suggests that the following guidelines be used in the presentation of the substance abuse induction module for offenders.

1. To maximize the value of the session, and wherever possible, the module should be delivered after the inmate has completed Computerized Lifestyle Screening;

2. Teaching should be done in an interactive style, which is suitable to adult learners;

3. The time frame for this session should be about two hours;

4. The person delivering the program must be credible and knowledgeable;

5. A credible inmate may be a valuable resource as a helper in the delivery of this module;

6. The delivery of the module, and written materials, must be written in language offenders easily understand; and

7. Handouts to summarize salient points should be provided;

8. At the end of the session, offenders should be encouraged to review the results of their computerized lifestyle screening report.

B. Recommendations

The Task Force recommends that:

1. **The CSC develop a new Substance Abuse Induction Module targeted to all newly admitted inmates based on the framework outlined by the Task Force.**

2. **All institutions be required to deliver this module to every newly admitted inmate.**

3. **The module be adapted to the learning needs of aboriginal and women offenders.**

5. SUBSTANCE ABUSE EDUCATION

Education about substance abuse is **an interactive process, which provides the offender with the knowledge and awareness to critically evaluate the impact of substance abuse on his/her life.**

This definition makes some important statements:

1. The interactive process is based on the concepts and principles of adult learning. Adults are not empty vessels waiting to be filled; they bring a wide range of experiences and motivating influences, that will significantly affect the learning experience;

2. Education provides knowledge, which can influence a person's attitudes, beliefs and intentions, and affect behaviour. Skills acquisition, which is an integral part of long-term behaviour change, is addressed in other components in the overall strategy that deal with intervention, individual and group counselling, recovery and relapse prevention. These components are closely linked with and built on the educational component; and for the purposes of this discussion, education will provide the knowledge base upon which the other concepts are built;

3. Education provides the knowledge and awareness necessary for the offender to critically evaluate the impact of substance abuse on his/her life. For treatment to be effective, the offender should be motivated to participate in his/her own recovery. The manner in which the information is presented is an important factor in how effectively we influenced an offender's awareness and attitudes towards substance abuse, and his/her willingness to take action; and

4. For offenders experiencing moderate to severe substance abuse problems, education alone is usually insufficient to effect behaviour change. Research has demonstrated that, while providing information may have positive short-term effects, it is insufficient to sustain the long-term behaviour change necessary for recovery. It is an important first step in influencing attitudes, beliefs and intentions, and can prepare the offender for other interventions as required.

A. Target Group for Education

The target audience for a comprehensive education component are offenders assessed as having substance abuse problems, and who require further intervention. For this group the Task Force has identified key elements of an education component.

B. Key Elements of an Education Component

From the material available, the Task Force first identified a number of key subject areas. These were then developed into a selection of key elements, which should form the core of all educational components of programs for offenders assessed as being at high risk of abusing, already abusing or chemically dependent. They are:

VALUES AND ATTITUDES

This subject area should introduce an education program as it provides a framework, and is a subject that can generate discussion and participation.

DRUGS AND ALCOHOL

In order for offenders to make informed decisions about their situation of use and abuse of drugs and alcohol, it is important that they have factual information about the characteristics of drugs and alcohol and the physical and behaviourial effects.

PROFILE OF AN ABUSER

Substance abuse may be progressive, with various signs along the way, which indicate the stages of a developing dependency. It is important that offenders recognize these signs, so they may assess their own history of abuse and dependency.

SOCIAL ISSUES

An earlier subject area dealt with the physical effects of substance abuse; however, of equal significance is the impact of abuse on the social milieu.

FAMILY

This area deserves special consideration. The family plays a significant role in the life of a substance abuser, as he/she plays a significant role in the lives of family members.

RECOVERY AND RELAPSE

Previous subjects have outlined the various impact of substance abuse. It is important now to tell offenders that there is a light at the end of the tunnel.

TREATMENT RESOURCES

It is important that offenders are aware of the treatment resources and referral procedures within the institution, and the community at large.

Throughout the process of delivering these key elements, special attention should be paid to the relationship between the topic area and the implications for the offender's recovery.

Offenders for whom the cognitive living skills program is indicated, should receive this program prior to the education session on substance abuse whenever possible. The living skills program can enhance an offender's ability to think and reason, and therefore will help them get the most out of the education sessions on substance abuse.

The information contained in these key elements can be delivered in a variety of ways, depending on the needs of the offender. For instance, these elements can be delivered as a "stand-alone" module strictly for education, as part of a low-intensity intervention and delivered in greater or lesser detail as required, or they may form an integral part of a more comprehensive secondary or tertiary intervention treatment program.

C. Video Materials

The field of substance abuse education and treatment is rapidly evolving with new information, and new teaching aids such as audio-visual materials. It is a daunting task for staff in institutions to keep abreast of the "state of the art."

The importance of how to deliver the message cannot be overemphasized. It has already been stated that an adult learning approach must be adopted. In this context effective visual aids can be a significant asset to the presenter.

The Task Force was impressed with the education program on impaired driving, targeting the 15 to 17-year-old age group, which was developed by the National Steering Committee on Impaired Driving under the auspices of Health and Welfare Canada, Health Promotion Branch. The package consists of a series of short videos professionally developed after extensive consultation with several focus groups including the target group. The videos, accompanied by a facilitator's guide, serve to trigger discussion on selected topics. While this particular package is inappropriate for the offender population, the effective and appropriate use of an interactive video developed for an offender population has considerable potential.

D. Recommendations

The Task Force recommends that:

1. **The key educational elements identified by this Task Force be adopted as a standard governing the delivery of education programs within the CSC.**
2. **A reference manual be developed for use by CSC staff, using the key education elements as a base. The reference manual would provide:**
   - **Complete, concise information on key subject areas which would allow CSC staff to develop lesson plans based on the material; and**
   - **A standard for use by operational managers when developing requests for proposals for contracted services.**
3. **The CSC develop a series of short professionally developed videos specifically for the offender population, for use as a teaching aid.**
4. **Educational materials developed be culturally sensitive and be adapted to the needs of aboriginal and female offenders.**

6. HEALTH PROMOTION AND PREVENTION PROGRAMMING

A. Introduction

A comprehensive approach to health means creating, developing and supporting a combination of health promotion strategies. Targeting all operational units, the CSC should develop co-ordinated policies which will facilitate positive change.

Health promotion and prevention programming are global strategies, which affect both the institutional environment and the general health of the offender population as well as specific programming initiatives aimed at reducing offender abuse of alcohol or drugs. This special health programming encourages the offender to adopt improved personal health habits, eliminates self-imposed risk, and enhances his/her ability to cope with life stresses.

Research in the last decade has indicated that overall lifestyle habits can affect a person's ability to cope with a number of situations. Accordingly, many treatment centres address the nutritional, rest and recreational needs of the person as part of the prevention and treatment of addiction problems. Nutritional therapy, for instance, has become an integral part of programming.

The offender's ability to cope is affected by his/her body chemistry. For offenders who have experienced a long-term substance abuse problem, this over-consumption of alcohol and drugs can result in vitamin and mineral deficiencies such as: "low blood sugar" or hypoglycaemia. Symptoms of hypoglycaemia can range from depression, insomnia, anxiety, irritability, crying spells and difficulty concentrating to headaches, muscle pains, backaches and exhaustion. For this reason, offenders who have been identified as substance abusers should receive, at the very least, nutritional counselling and, if necessary, nutrition therapy. For example, offenders who have experienced substance abuse problems (including nicotine withdrawal), often have a craving for sugar. The intake of foods containing high levels of sugar or carbohydrates can contribute to depressive or anxiety reactions and behaviours that resemble a "dry drunk," which can put the offender at high risk for relapse.

Achieving better health may serve as a motivating factor for behaviour change. By increasing the acceptability and desirability of not using drugs or alcohol, non-use may be introduced and integrated into a range of other healthy lifestyle practices such as fitness, nutrition and non-smoking.

Offenders, staff and community members who deliver the service, should play an active role in designing, implementing and evaluating prevention and intervention programs. Programming is then more likely to be supported by all concerned, particularly at the grassroots level.

Health promotion that includes a range of programming interventions and activities should be implemented within the context of an overall health promotion strategy, which has the support of management and program staff at all levels of the institution and community.

Global strategies for health promotion such as participation in national and provincial drug and alcohol organizations and special activities should be developed in co-operation with the regions. It is essential each institution establish and maintain mechanisms for fostering and maintaining staff, offender and community participation.

Sharing methods, standards and services, and drawing on the strengths and knowledge of staff and offenders will provide an opportunity for them to share in shaping current addiction programs and services, both within the institution and the community. Encouraging and supporting research and evaluation will also contribute to the continued development of the CSC knowledge and information base in the addictions field.

B. Key Elements

The following elements should be present in a successful health promotion and prevention program:

1. The components of the Health Promotion Model should be adopted to create a healthy environment, which will strengthen and complement health promotion programming such as health enhancement and wellness;

2. A range of health enhancement and wellness programming should be made available;

3. Offenders should be informed of all available programming so they can make informed decisions about, and take responsibility for, their health;

4. All operational units should have co-ordinated strategies which involve key members of the institution and community;

5. Volunteers, offenders, staff and community members should be encouraged to assist in developing and delivering new programming initiatives, as well as strengthening or enhancing regular ongoing programs; and

6. The development of peer support and mutual-aid groups should be encouraged.

C. Health Enhancement and Wellness Programming

Health enhancement and wellness programming are directed at the offender and help create a healthy environment.

DEFINITION

Health enhancement and wellness programming are practices that enhance health and reduce the risk of illness.

GOALS

1) To create a healthy environment in which offenders can make informed decisions about their lifestyle;

2) Reduce the likelihood of the offender abusing alcohol and drugs; and

3) Ultimately reduce the demand for drugs and alcohol within the institution and community.

TARGET GROUP

Total offender population.

DELIVERY METHODS

The content and length of a program are issue- or topic-specific. Volunteers, and offenders would be encouraged to participate in the design and delivery of many of these programs/activities.

PROGRAM COMPONENTS

General health awareness education; individual or peer counselling; and programs on fitness, sports, leisure, smoking cessation, weight loss, nutritional counselling, stress reduction and relaxation techniques. Programs that enhance the offender's personal competence and ability to cope such as personal and social skills training, assertiveness training and cognitive restructuring contribute to the overall health of the offender and thereby reduce the likelihood of his/her becoming involved in substance abuse.

D. Recommendations

The Task Force recommends that:

1. **Each institution establish mechanisms for the development and/or training of peer support, mutual-aid groups and volunteers.**

2. **Each institution involve offenders, staff, volunteers and community members in the development and delivery of new substance abuse programming initiatives as well as in strengthening or enhancing regular ongoing programs.**

3. **Each institution develop and implement a range of health enhancement and wellness programs.**

4. **Each institution, in recognition of the role of nutrition therapy in the withdrawal and recovery from substance abuse, establish appropriate dietary schedules for offenders in recovery programs.**

7. PRIMARY PREVENTION PROGRAMMING

A. Introduction

DEFINITION

"Action taken prior to the onset of a substance abuse problem."

Primary prevention programs and activities are aimed at the entire offender population. For the approximately 30% of offenders who are defined as users, and have not experienced problems related to their use, the goal is to **reduce the likelihood of a problem developing.** Those offenders showing signs of an abuse problem - the other 70% will require more specific substance abuse interventions. It will help them avoid another addiction and/or a more severe level of dependence.

The underlying premise of primary prevention is that a number of health and lifestyle issues, as well as specific skills development, promote a lifestyle free of drug and alcohol abuse. These include lifestyle issues such as proper diet, rest, exercise and productive use of leisure time. Literacy, vocational training, social and personal development, and occupational development are examples of competencies and skills that enable offenders to deal with the stresses impacting on their lives.

Primary prevention programs and activities are also aimed at the relevant physical and social environments of the offender, as well as providing appropriate incentives and disincentives designed to encourage the offender to avoid abusing alcohol and drugs. Prevention approaches target the **offender**, the **drugs** used, and the institutional and community **environment** where they are ingested. See Annex 3.

Major components of primary prevention that can influence the offender to change a lifestyle conducive to drug and alcohol use are the:

Offenders

Current knowledge, attitudes, intentions and skills possessed concerning the use of alcohol and drugs.

Drug

Availability of the drug, and whether the drug is legal (e.g., prescription or over-the-counter medication), or illegal (e.g., cocaine, hashish).

Environment

The availability and physical context in which drugs are obtained or used, the level of incentives and disincentives in the institution or community regarding drug and alcohol use, and institutional and community norms regarding the quantity and quality of drug use considered acceptable.

Key preventive actions can then be taken aimed at these three major components. These actions however, should be implemented within the context of an overall health promotion strategy that strengthens and supports primary prevention.

The Influence Approach involves awareness information programs directed at the offender's attitudes, beliefs and intent to use alcohol and drugs, which enables the offender to critically examine and evaluate the effects of substance use/abuse on his/her life. These programs may include key influencers in the offender's life who model responsible health behaviours and can be instrumental in persuading the offender to adopt positive health behaviours.

The Competence Development Approach is directed at improving the offender's skills to enhance his/her ability to cope. Skill development programs can raise the offender's self-esteem and thereby reduce his/her vulnerability to abusing alcohol and drugs. For instance, the inability of many offenders to find adequate employment can be extremely stressful and is one of the main factors that can put the offender at high risk of becoming involved with alcohol and drugs and for reoffending. This is particularly true for the aboriginal and women offenders, as outlined in the respective task force reports.

The educational and vocational training offenders receive, as part of regular programming, assist the offender in obtaining marketable skills and employment adequate to his/her financial needs. These courses are preventive in nature. When combined with influence strategies, they become a crucial part of the learning and change process.

The Control Approach in the Institution is designed to limit the offender's access to, and his/her use of, alcohol and drugs through such measures as random urine sampling, parole conditions, frisking and searching. The Service concluded through its study on contraband that the following control approach would be most effective:

1. Use, **abuse** and **trafficking** of substances other than those prescribed for medical or health purposes by offenders is **completely unacceptable** in the correctional system. These activities are the largest single cause of violence among offenders, and also create a major barrier to the effectiveness of the Correction Service and the successful reintegration of offenders.

2. **Urinalysis** should be the major detection tool for alcohol and drugs. Random sampling urinalysis, where the chances of being detected are strong and when all inmates are subject to testing at some point, has been shown to reduce demand for substances. As offenders realize that the program is consistently and equally applied, there would be less demand, which supports the various illicit networks attempting to import or circulate contraband within the institutions.

3. **Traditional personal search methods** would be used as and when necessary, with specific purposes or at times when institutional management requires them, particularly to detect types of contraband other than alcohol or drugs.

4. **Policy and legislative clarification of definitions, authorities, and types of searches are being developed** to establish a basic framework within which to work and also to meet the requirements of the **Charter of Rights and Freedoms.** Searches and any use of search powers by the government must be consistent with the Charter.

5. **Balance** and **co-operation** between enforcement and programming functions should exist, so that those offenders who require active intervention to deal with their substance abuse problems are identified and dealt with. "Programming" should be understood as a broad concept, since successful intervention can be achieved in many ways.

Control mechanisms must also address prescribing patterns and minimize the inappropriate prescription of mood-altering drugs. For example, the Health Care Advisory Committee to CSC recommends that "No request by a patient for hypnotic or sedative medication be prescribed by the institutional physician without a search for evidence that the patient's sleep is disturbed, as reported by nurses or health care officers."

When the offender is released into the community, he/she would be subject to the federal and provincial laws and regulations of the respective community. In addition, he/she would be subject to the normal conditions of parole supervision and sometimes special conditions of the Parole Board, such as submitting to urinalysis testing or perhaps abstaining entirely.

The Environmental Design Approach would involve addressing specific stressors in the environment by altering the physical environment, such as access to recreational facilities, CSC staff play a key role in creating a positive correctional environment, which impacts on the psycho-social health of offenders. In addition, staff can be positive role models, which demonstrate behaviours offenders can emulate.

The four prevention approaches outlined above are directed at the offender, the drug and the environment. They encompass both the issues of supply and demand reduction, creating a balanced, co-ordinated approach. Prevention programs and activities are also employed at each level of secondary and tertiary intervention. However, the goal and the components, and the intensity of the programs and activities employed, will vary, depending on the needs of the offender, the institution and the community.

B. Key Elements of Primary Prevention Programming

The following elements should be present in a successful primary prevention approach:

1. The programs and activities of the four approaches should balance and support one another;

2. A range of programming and activities should be available supporting each of these approaches;

3. The control measures should be supported by the development of national policies and procedures;

4. Wherever possible, offenders, staff and the community should be involved in the development and delivery of influence and competency development programming and activities; and

5. The offender, staff and community should become involved in national initiatives that address substance abuse such as National Drug Awareness Week, and local drug and alcohol committees.

C. Primary Prevention Programs

DEFINITION

Action taken prior to the onset of a substance abuse problem.

GOAL

To strengthen the offender's physical, psychological and social resistance to avoid the abuse of alcohol or drugs.

TARGET GROUP

The offender population motivated to participate in the activities.
Maximum benefit, however, would be to the 30% of the offender population at risk of developing an alcohol or drug problem due to a number of variables including a family history of alcoholism and drug abuse.

DELIVERY METHODS

The **influence approach** would involve a range of short awareness sessions of two hours maximum, delivered to a large audience. **Competence development** techniques such as education programs, vocational and literacy skills are already ongoing programs of the institution. The length of personal and social skills training would depend on the issue and topic involved. Offenders and volunteers would be encouraged to assist in the development and delivery of these programs.

PROGRAM COMPONENTS

General awareness sessions; cultural and spiritual programs; reading newspaper articles or books on addiction; participating in institutional drug and alcohol committees, which could involve writing and publishing articles on addiction; interactive theatre; and video presentations. Skill development activities such as literacy and vocational skills training; and personal development programs such as individual, group, family, marital and spiritual counselling.

D. Recommendations

The Task Force recommends that:

1. **The CSC develop and implement within each of the four prevention approaches a range of prevention programs that are balanced and supportive of each other.**

2. **Each institution involve offenders, staff, volunteers, and the community in national, provincial and local community initiatives, such as National Drug Awareness Week, and local drug and alcohol committees to reduce substance abuse problems.**

8. SECONDARY INTERVENTION PROGRAMMING

A. Introduction

DEFINITION:

"Action taken when the problem has become recognizable. Intervention at this level has the potential for preventing the offender from developing a more severe dependency."

The early identification of and intervention in an offender's alcohol or drug problem is crucial in order to minimize biological, psychological, or social consequences following the first signs of substance abuse. According to Miller and Hester (1985), "the first interventions offered should be the least intensive and intrusive, with other more heroic and expensive interventions employed only after others have failed."

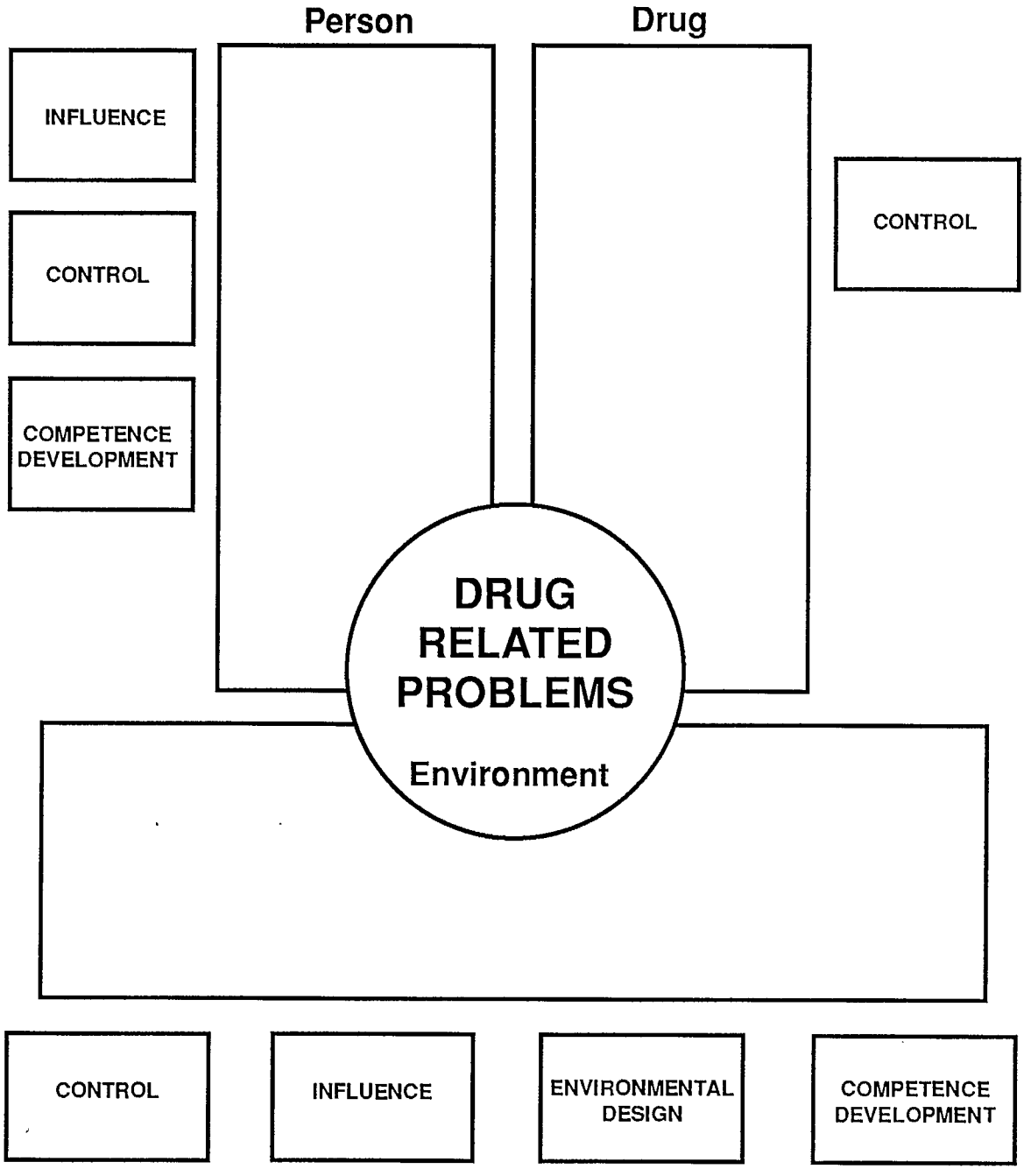
Secondary intervention programs incorporate a broad-spectrum approach that consists of a range of interventions from bibliotherapy, self-control strategies and substance abuse education to more structured programs, such as individual and group counselling. However, according to Aasland (1990), the excessive use of alcohol and drugs "apart from damaging brain, kidneys, and other organ systems also has the effect of (freezing) the normal process of maturation and socialization." In these cases of high need, if major life areas are not addressed in conjunction with the substance abuse problem, the offender is at high risk of reoffending.

Intervention programs based on the social learning model, which enhance the offenders competencies in a number of life areas, should be available. Programs such as life and social skills training, decision-making, anger management, family, marital therapy, and parenting skills, are critical as they can assist the offender in reintegrating into the community and maintaining long-term sobriety.

There are many secondary intervention programs within the CSC, both in the institution and community, which are based on the philosophy and principles of Alcoholics Anonymous (AA). The Service also utilizes a cognitive-behaviourial approach, notably the cognitive skills programs developed by Elizabeth Fabiano and the Pre-Release Substance Abuse program developed by Dr. Lynn Lightfoot.

There is a need within the Service to expand, enhance and co-ordinate secondary intervention programming to meet offender needs in a holistic manner. This should include a range of program options, specifically in the area of low-intensity programming such as bibliotherapy and self-help manuals. These should also include training and skill development in a number of lifestyle areas. Medium-intensity programs should contain expanded knowledge and skill components on addiction and related lifestyle issues as well as individual and group counselling based on social learning and cognitive-behaviourial models.

PREVENTION STRATEGIES IN A CORRECTIONAL SETTING



Current programming in many communities may be inappropriate to offender needs. Many components of low-intensity programming, for instance, are non-existent in some areas. If these programs are not presently available, CSC should ensure that they are provided to the offender through programming initiatives within the institution or the community.

B. Key Elements of Secondary Intervention Programming

The following key elements outline the basis for the implementation of the components of secondary intervention programs:

1. Education, individual and group counselling sessions must be designed to facilitate a change in attitudes, beliefs and intent of the offender and provide the skills necessary for change, both inside the institution and after release;

2. Whenever possible, where cognitive and social skills training are indicated as learning needs, these programs should precede substance abuse programming;

3. The design and delivery of secondary intervention programs must be based on the concepts and principles of adult learning;

4. Individual and group counselling sessions should emphasize the stimulation of critical thinking on issues offenders face in their social and cultural contexts;

5. The knowledge and skill components outlined in the Substance Abuse Education section of this report, should be addressed within the substance abuse program; and

6. A client-based evaluation of each program should be conducted to assist the offender to evaluate the relevance of each program to his/her learning needs and recovery goals.

C. Secondary Intervention Programs

Secondary intervention programs are directed at the approximately 60% of the offender population who have been identified as abusing alcohol or drugs. Offenders would be referred to a low- or medium-level program depending on their identified needs, and the matching criteria as outlined in the target group section of each level. The goal of secondary intervention is to prevent the offender from developing a more severe dependency.

LEVEL - LOW INTENSITY

DEFINITION

Minimal interventions of short duration which rely on the self-direction, initiative and motivation of the offender to take responsibility for his/her substance abuse problem.

GOAL

To create an awareness that assists the offender in evaluating his/her problematic involvement with alcohol and drugs.

TARGET GROUP

Offenders who have been identified as having: 1) abused alcohol and drugs; 2) experienced minimal consequences and a low level of dependency on alcohol and/or drugs; 3) adequate cognitive and literacy skills; 4) high conceptual level; 5) internal locus of control; and 6) experienced a higher degree of dependency but are self-directed, and motivated.

DELIVERY METHODS

The degree of guidance, feedback and counselling required by the offender, would be decided on an individual basis by the case managers. Education programs should be a minimum of 20 hours in length. Life and social skills programs may be delivered concurrently.

PROGRAM COMPONENTS

Bibliotherapy; self-help manuals; audio-visuals; education sessions; self-help groups; peer, individual, spiritual and family counselling; life and social skills training.

MEDIUM INTENSITY

DEFINITION

Interventions of medium duration and based on education and skill development.

GOAL

To motivate the offender to either abstain from substance use, or to moderate his/her substance use to acceptable non-problematic levels, in order to prevent him/her from developing a more severe dependency.

TARGET GROUP

Offenders identified as having: 1) A low-medium level of dependency; 2) A severe dependency, but cannot for a variety of reasons access a higher intensity program; 3) adequate literacy and cognitive skills; and 4) a high conceptual level.

DELIVERY

Programs at this level would be of medium duration and delivered over a number of weeks. Programming should be least 80 hours in length, with ongoing support for recovery and relapse prevention programming. Life and social skills may be delivered as part of the program or concurrently.

COMPONENTS

Education and skill development sessions, conducted as part of an overall treatment program; individual and group counselling; spiritual, family and marital counselling; parenting skills; and access to self-help groups. Highly confrontational approaches are not recommended.

D. Recommendations

The Task Force recommends that:

1. **The CSC develop and pilot a bibliotherapy program to meet the specific needs of offenders.**
2. **Secondary intervention programs should include skills and competency development based on the identified learning needs of the offender.**
3. **Secondary intervention education components should include the key elements recommended by the Task Force in the Substance Abuse Education section of this report.**
4. **All offenders, having completed secondary intervention programming, should be matched to available compatible programs and organized follow-up and recovery support both in the institution and in the community.**

9. TERTIARY INTERVENTION PROGRAMMING

A. Introduction

DEFINITION

> **"Rehabilitation efforts to minimize the effects of a problem once it has occurred to prevent further deterioration and to begin to restore health."**

Tertiary intervention programs are primarily intensive treatment programs designed to address the needs of the offender population who have been identified as having severe substance abuse problems. Tertiary intervention programs differ from secondary interventions in the duration, intensity and structure of the program.

Within the Correctional Service and in the community, the most commonly practiced tertiary intervention programs include such techniques as therapeutic communities, therapeutic groups, cognitive-behaviour therapy, pharmacotherapy, 12-step programs, and self-help groups as well as broad spectrum programs using a psycho-social model.

Most of the strategies in tertiary intervention should be used in conjunction with other components and be supportive of one another. Therapeutic communities have components within their structure that are usually comprehensive and inclusive of offender needs. Due to the length and severity of the substance abuse, tertiary interventions should also include skills training in a number of life areas as well as inter-personal and social skills, which will enhance the offender's ability to cope.

From an institutional perspective, completion of a tertiary intervention program could involve a transfer to a lower security level institution or release into the community. Community release should be effected in conjunction with an appropriate support system.

B. Key Elements of Tertiary Intervention Programming

To ensure a comprehensive substance abuse strategic plan a full range of services should be available to the offender. The following principles assist in achieving this reality:

1. High-intensity programming should be available in each region;
2. A therapeutic community should be available to offenders in regions where sufficient numbers warrant their development;
3. For offenders who have participated in a therapeutic community, a phase of social re-integration and relapse prevention planning is necessary to prevent relapse or recidivism; and
4. For offenders who have completed either a high-intensity program or participated in a therapeutic community and are not released, continued participation in self-help and recovery groups is essential to maintain abstinence.

C. Tertiary Intervention Programs

Approximately 10% of offenders would be referred to the following tertiary intervention programs, and/or a therapeutic community, depending on their individual needs and the level of dependency. The goal of tertiary intervention is to prevent further deterioration and begin to restore health.

HIGH INTENSITY

DEFINITION

"High-intensity programs are usually intensive residential treatment programs designed to meet the needs of the offender population who have severe substance abuse problems."

12-STEP PROGRAMS

The majority of high-intensity programs in the institutions and the community are usually based on the 12-step AA programs.

DEFINITION

These programs are often based on the principles of Alcoholics Anonymous, and adherence to the disease concept of alcoholism.

GOALS

To achieve complete abstinence from substance abuse by: 1) recognizing and accepting offenders have an addiction to alcohol and/or drugs; 2) accepting personal responsibility for their recovery; 3) understanding personal factors involved in their addiction; 4) understanding the philosophy and principles of 12-step programs; and 5) exploring and developing new patterns of living based on the 12 steps.

TARGET GROUP

Offenders who have: 1) a severe level of dependence; 2) experienced compulsive drinking and loss of control; 3) low social stability; 4) highly affiliative needs; 5) a spiritual orientation; and 6) experienced treatment failure with other less intensive interventions.

DELIVERY METHODS

A 21-35 day intensive program delivered in a residential setting followed by continuing care sessions or alumni groups. Program staff are usually paraprofessionals who themselves are "recovering" alcoholics or drug addicts, as well as a qualified clinician to ensure staff supervision and co-ordinate therapeutic interventions.

PROGRAM COMPONENTS

Education on the disease concept of alcoholism; signs and symptoms of the disease; twelve steps of Alcoholics Anonymous; recovery and relapse prevention issues and the need for abstinence; family dynamics; individual, group, family and spiritual counselling; attendance at AA and NA as support for maintaining sobriety.

THERAPEUTIC COMMUNITIES

One of the primary strategies used in tertiary intervention is the therapeutic community model. This model has been implemented in the Quebec region at the Donnacona and Leclerc Institutions, and in various communities in Quebec, Ontario and the Prairies.

DEFINITION

A structured supportive environment that provides for positive change by confronting behaviours and attitudes that are destructive for the individual.

GOALS

Achievement of abstinence from substances by attaining of a level of personal development and coping skills that would permit offenders to function in the community as law-abiding citizens.

TARGET GROUP

Offenders who have: 1) a severe dependence on alcohol or drugs; 2) been involved in numerous criminal activities directly related to their drug and alcohol abuse; 3) no severe learning disabilities; 4) no multiple diagnoses; 5) a personality that accepts a highly structured directive approach that stresses adherence to rules, and minimal self-direction; 6) poor social and interpersonal skills, and low social stability; and 7) the motivation to participate.

DELIVERY METHODS

Limited or no interaction with the general inmate population. The program should be 12 to 18 months in length. Staff for the unit should be trained in the therapeutic community treatment process. As well, a qualified clinician is required to supervise staff and co-ordinate therapeutic interventions.

PROGRAM COMPONENTS

Behaviourial limits and sanctions, positive peer pressure, mutual-aid, confrontation, supportive feedback, promoting personal and social responsibility and self-sufficiency, sharing of information and decision-making, individual and group counselling, education and formal skills training, supervised external contacts, organized recreation, ritual participation, family and spiritual counselling.

BROAD SPECTRUM PROGRAMS

DEFINITION

These programs generally employ an eclectic therapeutic approach though some have a specifically socio-behaviourial orientation and use individual, group and family therapy modalities.

GOALS

To achieve abstinence from the problem substance(s) and make appropriate lifestyle changes to maintain abstinence and restore health.

TARGET GROUPS

Offenders who have: 1) multiple or severe alcohol/drug-related disabilities; 2) experienced treatment failure with other less intensive methods; and 3) absence of or receiving treatment for serious psychiatric problems.

DELIVERY METHODS

A 21 to 35-day program delivery usually in a residential setting (either hospital or community-based) but may be offered on day basis, with continued aftercare. Program staff are usually multidisciplinary and include some recovered individuals.

PROGRAM COMPONENTS

Education about alcohol and drugs, and their effects; group and individual therapy; involvement of family members; lifeskills (social skills, leisure counselling, problem-solving skills, vocational/occupational counselling, stress management) and other topic groups relevant to the client population; introduction to AA/NA/CA/Women for Sobriety. Some programs may use protective drugs such as Antabuse. Some hospital-based programs may provide a detoxification phase.

OTHER ADJUNCT THERAPY

The following interventions are usually clinical programs, which should be supported by other clinical interventions, both within the institution and the community.

1. COGNITIVE-BEHAVIOUR THERAPY

One method used successfully with offenders who have substance abuse problems is cognitive-behaviour therapy. This technique teaches offenders to increase their capacity to reason in a socially appropriate manner and to cope with stresses related to daily life.

The approach trains offenders to control their emotions and behaviour through a structured thinking process. The techniques of this therapy when applied to tertiary intervention are also used to train the offender in relapse prevention skills.

2. PSYCHOTHERAPY GROUPS

Therapeutic groups are usually conducted by a health-care professional. These groups address a variety of behaviourial, emotional and cognitive problems which contribute to criminal activity, drug and alcohol use. Various psychotherapy techniques may be employed.

3. PHARMACOTHERAPY

A number of different chemical treatments have been used to aid substance abusers to deal with their problems. The two main categories of drugs employed are 1) chemical aversion (Antabuse), and 2) chemical substitution (Methadone). Although these techniques have not been used extensively with federal offenders, limited experience has shown that chemical substitution is an alternative for offenders with a history of chronic substance abuse problems and treatment failure with other methods.

4. SELF-HELP GROUPS

Groups such as AA, CA, NA and Women for Sobriety offer positive support to individuals experiencing drug and alcohol problems, and may also provide support to the families and significant others. It should be noted that in the correctional setting, these groups provide an important support to offenders in maintaining sobriety if used as a supportive component to other intervention strategies. The profile of self-help groups are changing to accommodate younger individuals, as well as gender-specific groups to meet the needs of women and native persons.

D. Recommendations

The Task Force recommends that:

1. **CSC implement therapeutic communities in each region where the number of offenders warrant.**

2. **All offenders having completed tertiary intervention programming be matched to acompatible program and organized follow-up recovery support in the institution and in the community.**

10. SECONDARY AND TERTIARY INTERVENTION AND THE TRANSITION TO THE COMMUNITY

In the context of corrections any substance abuse program is a "pre-release" program. Several programming elements address the transition from the institution to the community. These include:

1. Employment and job-finding skills;

2. Leisure time and lifestyle planning;

3. Release planning to identify the availability of supports and resources for the offender; and

4. Relapse prevention skills training and relapse prevention planning.

A. Community Integration Skills for Substance Abusers

The first three elements listed above are found universally in traditional life skills or community integration skills programs in CSC institutions. Throughout the offender's sentence, the Case Management process also targets these issues as areas in the development of release plans.

Although they are present in programming, the Task Force feels that these elements must be revisited as they have a strong bearing on the substance-abusing offender's success or failure in the community. The Task Force strongly supports their integration into all secondary and tertiary programs for inmates who are likely to be released in the near future. If it is not possible or not appropriate, these elements should be provided concurrently in other programs.

B. Secondary and Tertiary Intervention and Relapse Prevention Training

DEFINITION:

"Relapse is defined as a failure to maintain previously achieved behaviour change."

This is an issue in both secondary and tertiary intervention programs as the likelihood of relapse is very high with all individuals who are attempting to change their substance-abusing behaviour. As with any intervention with offenders, relapse prevention strategies are more effective with less dependant early stage substance abusers. Relapse prevention planning is part of the overall recovery plan that should be developed upon identification of the problem during the assessment process.

Relapse prevention training is the acquisition of a set of skills by which the offender learns:

1. The meaning of a lapse and a relapse;

2. To identify situations and stimuli at which he/she is at risk ("trigger" situations); and

3. To evaluate and select alternative behaviours and actions that prevent relapse.

Relapse prevention planning is the development by the offender of a plan to follow to:

1. Reduce the risk of relapse;

2. Pre-develop contingency plans for situations the offender is likely to encounter;

3. Pre-develop plans in the event that the offender "lapses" or resumes substance use and is moving towards relapse; and

4. Monitor his/her own plan.

There are several models in the literature (e.g., Annis, Gorski, Marlatt, Daley, etc.) which apply this concept to substance abusers in general; examples of this concept being applied in the corrections setting are seen in Lightfoot's *Pre-Release Substance Abuse Program for Federal Offenders (1989)*; and the *Atlantic Substance Abuse Program (ASAP)*.

The community integration skills previously described differ significantly from relapse prevention. Substance abuse is a context for the learning of community integration skills. However, relapse prevention is targeted to the substance abuser as a basic element of the recovery plan.

The research literature strongly supports the view that relapse prevention must be addressed in all secondary and tertiary intervention programs for appropriately matched offenders. For instance, offenders who have been matched to a high-intensity 12-step program, Gorski's model, which is strongly oriented to the disease concept of addiction and the "loss of control concept" would be a more appropriate choice. Marlatt and Annis' models, which are cognitive-behaviourly based are more suited to the secondary intervention broad spectrum program that uses a psycho-social model and therapeutic community programs.

While many existing programs allege to cover relapse prevention, with the definitions used here it is clear that they are providing only community integration skills such as release resource planning rather than teaching the offender a contingency planning approach. Both practitioners and program managers must be made aware of the nature of true relapse prevention.

C. Timing and Continuity

Approaching the issue from a conventional pre-release perspective, one would expect this process to follow on the heels of programs just prior to the inmate's release. However, this time frame was too restrictive.

Recognizing that, first, many inmates require substance abuse intervention early in long sentences to promote better institutional behaviour, and, second, that not every inmate who completes a program is immediately released to implement his/her pre-developed plan, a longer view of the relapse prevention approach must be taken.

Whether the inmate is immediately released or not, there is a danger of relapse. For this reason, relapse planning and strategies must be implemented upon completion of all secondary and tertiary interventions. This further implies that as the offender's circumstances change, the relapse prevention plans must be reviewed, refocused and re-implemented. In an extreme example, an inmate who is treated in a maximum security facility could revise his/her plan after each transfer to lower security, transfer to a Correctional Community Centre or Community Residential Facility, on full release to the community, and yet again on transfer to a new parole officer after a move to a new jurisdiction. At each stage different risks, trigger situations and resources would be considered leading to a new plan.

For relapse prevention to be effective, it must be managed throughout the sentence. From the originating program when the training takes place, there must be continuity to support and replan. This role can be taken by substance abuse counsellors, case managers, chaplains, psychologists, or parole officers who are trained in relapse prevention strategies. In the case of highly committed offenders who are able to continue to apply their understanding, the staff member's role is that of monitoring. For the less-motivated or adept offender, the staff's role is to review, reteach and monitor.

Self-help groups focusing on recovery and relapse issues in the institutions and the community should be used to assist offenders in maintaining long-term recovery. Where these groups do not currently exist, the CSC and the community should establish mechanisms to assist in their development.

D. Limitations in the Correctional Context

The NPB can impose Special Conditions on released offenders such as "to abstain from alcohol," "to abstain from drugs," or "to abstain from intoxicants." These conditions can pose a dilemma in regard to relapse prevention. Special Conditions carry an unbending obligation for CSC staff; if there is any violation of the condition the case must be suspended, and the offender's case must be referred back to the NPB for review.
The immediacy and the certainty of the enforcement of Special Conditions by the CSC is premised on the idea that the Service is first managing the risk associated with the offender. However, from the point of view of relapse prevention strategies, NPB policies and practices do not allow for "slips" or "lapses," which are inevitable for the substance abuser in recovery.

It should also be noted that an offender who is successfully self-monitoring may "slip," yet successfully get back on track with his/her recovery before being detected by the CSC. Under current policy, if the offender were to admit to this "slip" at any later time, he/she would be suspended just as the offender who was immediately detected.

It is essential that CSC enter into a dialogue with the NPB to review this policy area. Perhaps a new balance can be reached, weighing the need to manage immediate risk against the reality that "lapses" and "slips" are inevitable events in the successful recovery from substance abuse. The Task Force by no means suggests that Special Conditions be abandoned, as there are many cases in which the risk presented by the offender is too great, and the swift and certain consequences of the present policy are essential. What should be sought is an understanding that relapse prevention is a legitimate strategy which, if applied realistically, might eliminate the need for or change the nature of some Special Conditions, or recognize that it may be a factor in the post-violation and post-suspension review of abstinence violators. The dilemma of Special Conditions and relapse must be resolved so that CSC's staff can respond both to the recovery of the offender and the NPB's policies in a holistic way that advances both objectives.

E. Key Elements

1. All secondary and tertiary intervention programs for inmates nearing release have community integration skills development components either integrally in the program or concurrent to the program;

2. All secondary and tertiary intervention programs should include a relapse prevention training and planning component. Where it is not feasible to integrate this within the program, it should be made concurrent to the program;

3. Relapse prevention strategies must be pursued from completion of treatment, either early or late in the sentence, until warrant expiry; and

4. Staff who manage or support the offender's progress through the system receive training to enable them to knowledgeably review, revise and monitor relapse prevention plans with the offender.

F. Recommendations For Relapse Prevention

The Task Force recommends that:

1. The CSC develop a relapse prevention program for offenders to support secondary and tertiary interventions that take place during the sentence and consider the realities of the correctional context. This development must involve consultation with the NPB in relation to the imposition of Special Conditions ordering offenders to abstain from intoxicants.

G. Recommendations for Community Programs

The Task Force recommends that:

1. All offenders who have completed tertiary intervention have compatible, organized follow-up recovery support in the community.

2. Contracts with community substance abuse agencies be reviewed for consistency with the principles and recommendations of the Task Force. Priority in new contracts should be given to organizations whose program conforms with the CSC for intervention and are congruent with findings on efficacy.

3. A comprehensive national resource network for substance abuse programs be established to assure that the needed programs are available to offenders released to community supervision.

4. Whenever possible, offenders should receive the major portion of interventions after release from the institution. Initial assessment should identify the potential for intervention effectiveness, but weighing other relevant factors such as eligibility for release and risk to community.

5. If offenders cannot be treated in a timely way within the institution prior to eligibility for release, their release plans be developed to include appropriately matched interventions to be delivered in the community, provided that the factor of risk of reoffending is not overriding.

Chapter 4

Special Needs of Federally Sentenced Women

Chapter 4

SPECIAL NEEDS OF FEDERALLY SENTENCED WOMEN

1. INTRODUCTION

Only in the last two decades has the treatment system recognized women as a significant population with different needs from those of men. Though women now have much greater visibility, they continue to remain a minority in community substance abuse treatment programs. The majority of these programs were designed to assist men with substance abuse problems and thus have not until recently considered the issues of whether their services are appropriate for women.

Over the last while, an increasing number of recovering women and women professionals have written about and developed programs for women. Though federally sentenced women may have needs specific to their incarceration and life circumstances, like women anywhere, they are a heterogeneous group. The issues identified in the literature on substance-abusing women, and in the experience programs for women, can provide part of the framework within which to make recommendations for services to federally sentenced women. Any recommendations should be made keeping in mind the recommendations from the Task Force on Federally Sentenced Women.

The following sections will discuss the extent of alcohol and other drug use by women in general, characteristics of women seeking treatment, and issues related to accessibility and appropriate treatment for women.

2. USE OF SUBSTANCES BY WOMEN IN THE GENERAL POPULATION

A. Alcohol

Other than caffeine, alcohol is the most popular drug used by women. About 76% of women in Canada are current drinkers, with the likelihood of being a non-drinker increasing with age. Only 50% of women aged 65 years or over are current drinkers versus 88% of women 20 to 24 years of age. However, drink for drink women are more vulnerable to the effects of alcohol because of smaller frames, more fat (and hence less body water to dilute the alcohol) and also because of recently discovered metabolic differences.

B. Tobacco

Smoking rates of women now almost equal those of men, with about one-third of women in Canada being smokers. Women in the 20 to 44 year age group have the highest rates of smoking. Among Aboriginal women, smoking rates are much higher. A recent study in the Northwest Territories found that 66% of 15 to 19 year olds smoked.

C. Prescribed Mood-altering Drugs

In contrast to alcohol, women are much more likely than men to be using prescribed mood-altering substances, particularly those categorized as central nervous system depressants such as sleeping pills and tranquillizers. A recent study in Ontario, which examined drug use among victims of physical and sexual abuse, found high rates of prescription drug use. Women who were victims of sexual abuse as adults had sedative use rates three to four times higher than non-victims.

D. Illicit Drugs

Generally women are less likely than men to report use of illicit substances such as cannabis and cocaine. However, Canada's recent Health Promotion Survey reports that in the youngest age group 15 to 24 years of age, a similar proportion of women to men report use of cannabis, approximately 12%.

The most recent 1989 survey of Ontario adults, by the ARF reported that the use of a number of substances by young women in the 18 to 29 year age group had increased significantly; these substances included sleeping pills, tranquillizers, cannabis, stimulants and the weekly consumption of five or more alcoholic drinks at a single sitting.

Street youth of both sexes are much more likely to be using substances as well as engaging in other high-risk behaviours such as sharing needles and prostitution.

Non-urban aboriginal women may be more likely to be using alcohol and solvents rather than other types of drugs.

3. WOMEN IN TREATMENT

A. Substance Use

Both survey and anecdotal reports would indicate that a majority of women now entering treatment programs are under 30 and are multiple-substance users - alcohol, illicit and prescribed drugs. A recent survey of clients at the Clinical Institute ARF in Toronto indicated that one-third of clients with a primary cocaine problem were women. This finding is reflected in anecdotal reports from other Canadian treatment agencies.

B. Physiological Functioning

As noted earlier, women are more vulnerable drink for drink to the effects of alcohol than men. This is reflected in usually a shorter drinking career until problem use is identified, as well as greater likelihood of developing alcohol-related physical health problems such as cirrhosis of the liver, mental deterioration and anaemia. Women substance abusers also report more obstetrical/gynecological problems than women in the general population and women are more likely than men to be admitted to hospital with a toxic reaction to prescribed drugs (probably because of their greater rates of use).

C. Psychological Functioning

The literature generally reports that women substance abusers have lower self-esteem and self-concept than male substance abusers. Some of this difference may be due to the greater stigma attached to substance abuse by women. However, many women with a history of violence, incest or sexual assault have very low self-esteem and little sense of control over their lives. Women alcoholics are also more likely than male alcoholics to experience an affective disorder prior to the development of a drinking problem and to be at high risk for suicide.

D. Family Functioning

Women substance abusers frequently have a history of physical or sexual abuse. Figures on the percentage of women who report they are incest survivors or sexual assault victims range from 30% to 70%. Women substance abusers are also more likely than male substance abusers to have come from disruptive family backgrounds -backgrounds ranging from having and alcoholic parent or parents to losing a parent through death or divorce. Women substance abusers are also more likely to have a substance-abusing spouse or partner than are male substance abusers.

4. ACCESS TO PROGRAMS

Women tend to need a great deal of support to enter a program and the traditional "confrontational" model is not appropriate for most women since it further reinforces their low self-esteem. In many cases close family members, particularly spouses, are not supportive. In fact, they have a tendency to deny the problem.

Women experience more barriers to treatment than men. One major barrier is care of dependent children. Many women will not entrust their children to family and children's services for fear of being assessed as being unfit mothers, with the subsequent loss of custody of their children. Unfortunately, very few agencies in Canada provide any kind of childcare. Another barrier may be financial; even if the program is free, it may be difficult for women to take time away from work because women tend to be in lower paying, lower level jobs with fewer benefits. They may also be unable to leave their home to go into a longer stay residential program. For women on social support, keeping a home intact for themselves and their children often becomes an insurmountable problem; and yet without a home, it may be difficult to obtain custody of their children. Also, male spouses or partners are far less likely to participate in any kind of family or marital counselling than females.

5. PROFILE OF FEDERALLY SENTENCED WOMEN

The following is a profile of women currently serving a federal sentence. Their special program needs were assessed by this Task Force with reference to the findings of the report of the Task Force on Federally Sentenced Women, and on consultations with provincial drug and alcohol agencies, counsellors, federal and provincial institutions, and women offenders.

Approximately 69% of the women interviewed by members of the Task Force on Federally Sentenced Women stated that "substance abuse played a major part in their offense or their offending history." Among the aboriginal women interviewed, substance abuse was even higher than the

general population. Aboriginal women tended to be heavily dependent over a period of 10 to 25 years. A survey of drug use patterns at the Prison for Women by Lynn Lightfoot (1985), revealed that approximately 40% to 85% of the women had difficulties with alcohol and/or drugs.

Women also tend to be multiple-substance users - alcohol, illicit and prescribed drugs. The availability of drugs in prisons and the high drug use mentioned by the women interviewed makes the need for substance abuse programming that is sensitive to the needs of women.

Physical and sexual abuse among the federally sentenced women is substantially higher than for women in the community. Approximately 80% of the women interviewed had been either physically or sexually abused, compared to 30% to 70% of women in the community. Among aboriginal women the abuse rate is even more prevalent with 90% of the women stating they had been physically abused regularly over long periods of time.

Educational levels were very low with two-thirds of the women not completing high school, or not having any training or qualifications. Aboriginal women had an even greater disadvantage with some who said they had never attended school and some who had dropped out of grade school.

As in the general population, the majority of imprisoned women had had jobs lower paying, lower level jobs with fewer benefits. Many women were also single parents with few resources to access treatment in the community due to the lack of support of their family and partners. Federally sentenced women were in, and would be returning to, abusive relationships. Many women would be returning to situations where their family, friends, spouses or partners abuse alcohol and drugs.

6. IMPLICATIONS OF THE HEALTH PROMOTION APPROACH TO DRUG ABUSE PROBLEMS.

The report of the Task Force on Federally Sentenced Women outlined many of the needs of women in the federal system. Meeting these needs in a holistic manner is the crucial message. The following is an outline of the proposed strategic planning model for the CSC, and the areas of special programming needs for women.

A. Assessment

Assessment tools used with women must be sensitive to the differences between men and women. Many women will not identify alcohol or other drug problems, but may present with symptoms of low self-esteem, anxiety and depression. Also the amounts of alcohol or other drugs that women are using may be lower than for men. Long-term health consequences can accrue at the level of two to three drinks a day or at therapeutic dosages of prescribed drugs.

Other issues that need to be taken into account in assessment include: presence or absence of a primary affective disorder; presence or absence of life crisis or transition preceding onset of problem use; sexual and reproductive history and current psycho-social circumstances. Psycho-social circumstances include family history of substance use by partner and primary family; support for sobriety and responsibilities. Planning for recovery should begin at the point of identification and be monitored and supported throughout the sentence and community release.

B. Health Promotion Programming

For many imprisoned women involved in substance abuse, the likelihood of severe long-term damage to their overall physical and mental health is high. The creation of a healthier environment, which will strengthen and compliment health and wellness programming, is essential to begin to restore health. Programs that enhance self-esteem and the ability to cope such as assertiveness training, stress management, problem solving, communication or social skills, financial management, leisure and recreational counselling, are crucial. Until a woman feels empowered to take responsibility for managing her life, she is very vulnerable to returning to alcohol and drugs. Many addiction programs place a high importance on dealing with the underlying issues.

Nutrition has been found to be extremely important also in restoring health. Substance abuse treatment centres for women pay special attention to nutritional counselling and therapy, and ensure that during the recovery period, appropriate diets are followed. The literature and clinical observation by counsellors attests to the effect of poor nutrition in exacerbating the symptoms of Premenstrual Syndrome. It is documented that women are most vulnerable to relapse during this time.

Federally sentenced women, staff and community members should all be involved in the design, development and delivery of substance abuse programs in prison. This would ensure the relevance of all programs to women's needs. Self-help groups, peer counselling and mutual-aid groups should be encouraged, particularly in the area of coping skills.

C. Primary Prevention

The Influence Approach would include general awareness with special importance placed on the need for aboriginal women to have access to material, resources and involvement in groups that are culturally and gender relevant.

Competence Development in literacy and marketable job skills is essential if women are to become self-reliant and responsible. This fact was reinforced by everyone interviewed by members of the Task Force on Substance Abuse. The lack of control women feel in having to be reliant on social assistance or minimal subsistence is devastating. Women with few skills to support themselves are at risk of returning to abusive or non-supportive relationships. This is particularly so with aboriginal women who are taught to be dependent by their families and the myriad of systems they find themselves in without a voice. Many women spoke of the need for parenting and childcare skills, as well as social and interpersonal skills.

Control Approaches outlined elsewhere in this report were developed with the general male population in mind, and thus may not be appropriate for facilities for federally sentenced women. Therefore, any substance abuse programming intended for such facilities should include a control component developed according to the special needs of women and to the manner in which such facilities operate.

Environmental Design and the need for a supportive environment has been outlined and changes to this effect are the main thrust of the report of the Task Force on Federally Sentenced Women. Women who were interviewed by members of the Task Force on Substance Abuse felt that the drug use in the institutions was necessary to deal with the stresses of the physical and psychological environment. They were very candid and felt that unless the environment changed, using drugs to cope was a sane way to survive the experience.

D. Secondary Intervention

Programming at this level is cognitively behaviourally oriented. The education and skills sessions, however, will have to be developed to meet the needs of women. With the high rate of physical and sexual abuse experienced by federally sentenced women, this issue should be dealt with in the context of the intervention program. As most of the women are serving fairly long sentences, the opportunity exists to deal with these issues and provide the required support. However, if the environment is not conducive, women will be reluctant to share their feelings and experiences so necessary in the healing and recovery process. Many of the women are also daughters of alcoholics and need to deal with these issues in recovery as well.

There is evidence in the literature that women may do well with minimal, less intrusive interventions such as bibliotherapy. Confrontational approaches should not be used. For aboriginal women, the ability to receive peer counselling and peer support in their own language, as well as cultural and spiritual counselling, from elders and volunteers is important to the sharing and healing process.

E. Tertiary Intervention

It is felt that due to the long-term abuse of alcohol and drugs by aboriginal women, in particular, that long-term residential programming would be more beneficial. Programs that are spiritually based such as many of the 12-step programs could be modified to ensure the programs are women-centred. The Task Force on Federally Sentenced Women recommended that a "healing lodge" be built in the Prairies for aboriginal women. This facility would be planned and developed with the principles and concepts of a healthy (therapeutic) community. For non-aboriginal women, other program models would have to be reviewed for their applicability to women's needs. Traditional therapeutic community models that are highly confrontational are not recommended for women at any level of dependency.

F. Community Transition

As outlined in the Task Force on Federally Sentenced Women, there is a need to ensure a continuum of care for women that matches their needs. Currently in many of the provinces there are few women-only centres. The Service may be required to develop programs in the community that meet the needs of women, particularly on issues of child care, vocational skills, and ongoing support during their recovery. Community release centres usually have a ratio of 15 men to 1 woman in residence. Aside from one-to-one counselling and community support groups, it would be difficult for women to open up and share their concerns in this environment. It would even be less likely if they had been physically and/or sexually abused. In fact, in this situation, they would be under a tremendous amount of stress, which would not be conducive to their recovery.

Many relapse prevention strategies and programs, like many addiction programs, were initially developed for men. Some studies indicate that factors leading to relapse may be different for women. For instance, many counsellors and recovered women talk about the lack of support they receive from families, children and spouses as one of the main causes of relapse, as well as unresolved issues such as physical, sexual abuse and incest. In many communities, programs that deal with these issues for women are non-existent and relapse is almost a certainty.

Very few community programs treat the family and children, as well as provide vocational, education and literacy skills. Where these programs do exist, for instance the St. Norbert Foundation in Manitoba, women do not wish to attend a program that is anywhere from six to eighteen months in length upon release from an institution - and rightly so. They would much rather attend a three-week program, even though the program may not meet their need for reintegration into the community, parenting skills, or vocational retraining.

However, for those women who are severely substance-dependent, with a history of offences, minimal skills, and a history of physical and/or sexual abuse, a long-term recovery program is required. There has been suggestions in this context that day parole be granted for women to attend these agencies where they exist. Where they do not exist, the Correctional Service may have to establish them which would be similar in principle to the "healing lodge."

G. Guiding Principles

Substance abuse, particularly among aboriginal women, is inter-related to other aspects of female reality, such as lack of power/control and self-esteem, sexual abuse, anger and dependency. These problems must be dealt with prior to, or in conjunction with, a substance abuse program that is health, not substance, focused. There is a need to have a range of viable choices, and to empower women to take control of their lives and responsibility for their recovery. Penal institutions are the very opposite to the principles of holistic treatment and health, particularly the current environment of the Prison for Women.

The Task Force for the Reduction of Substance Abuse supports the recommendations of the Task Force on Federally Sentenced Women for the provision of a "healing lodge" - a cottage set aside to provide an environment conducive to healing - and the need for follow-up in the community by agencies with a compatible philosophy.

The following principles are crucial in developing interventions for women:

1. Having women counsellors and women in decision-making roles within the agency/institution in order to provide role models and access to women therapists.

2. An approach that uses concepts and principles which empower women to take responsibility and control of their lives.

3. Involvement of women in the development, delivery and evaluation of programs and services.

4. An approach that emphasizes women as equal partners in treatment planning and goal setting, and de-emphasizes a confrontational approach, which may further erode a woman's self-esteem.

5. Information be made available about substances and their physical and psycho-social effects.

6. Activities to build skills required to maintain a drug-free lifestyle such as relapse prevention, the development of support networks, access to self-help groups such as AA, NA and Women for Sobriety.

7. Providing opportunities for women-only groups, which allow women to expose sensitive issues, to learn to value themselves and other women (rather than seeing them as rivals) and help them develop a network of support.8.Activities that help women develop self-esteem and coping skills. These include activities such as assertiveness training, stress management, communication or social skills, financial management, leisure and recreational counselling, problem-solving skills, etc.

9. Family services including parenting training, childcare and an assessment and intervention program for children run by appropriate local agencies; as well as the opportunity for involvement of partners and significant others to solicit their support and encouragement. For some women, their partners and significant others may be other women. Women who are mothers may also need an opportunity to discuss issues such as being a sober parent, guilt about leaving their children, and how their substance abuse has affected their children.

10. Access to vocational rehabilitation services while in treatment or aftercare. These may include assessment, job readiness or vocational training and job-seeking support.

11. Ability of program staff to respond to and make appropriate referrals to assist clients in dealing with issues of violence, incest and sexual assault. Other problems that may require appropriate referral include eating disorders and depression.

12. Health promotion including nutrition, physical exercise, relaxation, sexuality and health choices.

13. Sensitivity to women of different sexual orientation.

14. Staff who are knowledgeable about the range of services that women may need and can make referrals to women-sensitive services. These may include legal, medical, psychiatric, financial and vocational services.

H. Evaluation

Because women have been a minority in treatment programs, little attention has been paid to gender differences in the treatment outcome literature, and very little with women offenders. Several extensive reviews of this literature by such authors as Annis and Vannecelli indicate that where a study did examine outcome by gender, women generally did as well as men. Because most women's programs are relatively new, the outcome literature does not tell us whether women do better, or whether women do better in single-sex versus co-educational programs.The work of researchers such as Miller, who has examined "what works and what doesn't work" in the alcohol treatment field, did not report on gender differences. One area where the outcome for women is better than men is in the early intervention work of Martha Sanchez-Craig using a "brief treatment" approach with or without a therapist condition. It appears from her treatment method, and also a similar project in British Columbia, that the outcome for women is better than for men in reducing their consumption of or abstaining from alcohol.

Management information systems need to take into account male/female differences. These may include history of violence or sexual assault, family/childcare responsibilities and presence or absence of a support network.

7. RECOMMENDATIONS

The Task Force recommends that:

1. **The Service develop a substance-abuse strategy tailored to the needs of federally sentenced women according to the principles outlined in the report of the Task Force on Federally Sentenced Women, and that this strategy, including related programming, be planned and implemented so as to be consistent with any final government decisions on the accommodation of federally sentenced women.**

2. **The development and implementation of substance abuse programming be undertaken in consultation with the committee advising on the implementation of the Task Force on Federally Sentenced Women as well as with staff, offenders and women-centred agencies.**

Chapter 5

Special Needs of Aboriginal Offenders

Chapter 5

SPECIAL NEEDS OF ABORIGINAL OFFENDERS

1. INTRODUCTION

Aboriginal offenders are an especially disadvantaged group facing serious problems both while in the correctional system and upon release into the community. CSC and the Solicitor General Secretariat are concerned about aboriginal offender issues and have made concerted policy and program efforts over the past 20 years aimed at increasing the aboriginal offenders' chances of successfully reintegrating with society. Yet much more remains to be done.

2. BACKGROUND INFORMATION ABOUT THE ABORIGINAL OFFENDER

Despite the overt evidence of serious problems related to substance abuse among the aboriginal offender population, little specific data have been gathered on this topic. In the Ministry's 1989 evaluation of the automatic day parole review provisions of Bill C-67, the aboriginal files sampled indicated that 83% of those aboriginal inmates reported alcohol use, 54% reported soft drug use and 3% did not indicate any alcohol or drug use. This compares to the non-aboriginal male sample, which revealed that 64% admitted to alcohol use, 48% admitted soft drug use and 14% indicated no alcohol or drug use. It should be noted that these statistics are for self-admitted use and may be lower than the actual number of users/abusers. In a 1988 study of aboriginal women at the Portage La Prairie Correctional Centre in Manitoba, 70% mentioned alcohol and drugs as a reason for their being in prison.

Aboriginal offenders are over-represented in correctional system. (In 1987, 9.6% of the federal penitentiary population was aboriginal versus 2% of the general population. About half of these inmates are status Indians and, of this group, about half come from reserves).

Aboriginal Canadians are a diverse group with many different languages and cultural roots. They generally have a lower average level of education, fewer marketable skills and employment opportunities, and higher unemployment, mortality, suicide and violent death rates than the Canadian average. Their backgrounds are, to an even greater extent than non-aboriginal offenders, characterized by family instability, substance and sexual abuse, and other socially disadvantaging conditions.

Many aboriginal inmates perceive themselves, and are perceived by others, as significantly different from their non-aboriginal counterparts in terms of their attitudes, values, interests, identities and backgrounds - all of which have important implications for prevention and treatment. Aboriginal inmate participation in rehabilitation and other types of programs has historically been low, except where those programs have a specific cultural focus and are provided by aboriginal organizations and/or staff.

Current specific correctional programming for aboriginals owes much to the input of aboriginal community interest groups (the Native Liaison Support System being an excellent early example) and certain CSC policies such as the 1985 policy on aboriginal spirituality and the 1987 policy on Native Offenders Programs. Aboriginal-specific substance abuse treatment is presently offered in a number of CSC institutions. This programming includes Sacred Circle groups, Native Alcoholics Anonymous and a"boriginal life skills groups with a substance abuse focus.

A new innovative project funded jointly by CSC, the Solicitor General Secretariat, and the National Native Alcohol and Drug Abuse Program is being piloted in two British Columbia institutions. This culturally specific "Substance Abuse Pre-Treatment Program" involves the family and significant others in all phases of the recovery process and is intended to build trust in the treatment process, and develop personal insights and motivational changes that will allow the aboriginal offender to derive maximum benefit from subsequent participation in a treatment program funded by the National Native Alcohol Drug Abuse Program. If this pilot project brings positive results, wider pilot testing - including in the Prison for Women, and a facility that has a protective custody component - would be desirable.

All correctional activities share the fundamental aim of improving the offender's opportunities to become a law-abiding citizen, both while within the custody or control of the CSC or a contracted party or parties, and upon full release into the community.

The Correctional Law Review article, "Correctional Philosophy," speaks to the need to involve the larger aboriginal community in the correctional system and recognizes that "Lay participation in corrections and the determination of community interests with regard to correctional matters is integral to the maintenance and restoration of membership in the community of incarcerated persons and should at all times be fostered and facilitated by the correctional service." How these words translate into actual programming activities is a matter requiring constant review and a willingness to try innovative approaches based on sound culturally sensitive principles of action.

Several of the 61 recommendations of the Task Force on Aboriginal Peoples in Federal Corrections approved by the Executive Committee (all except four of which are being implemented) are providing an important blueprint for action covering both prevention and treatment approaches with CSC (Recommendations 39.1, 40.1 and 41.1). The implementation of all the recommendations is being monitored by the Service and the Solicitor General Secretariat.

With respect to the prevention and treatment of substance abuse, it is important to stress again the importance of culturally specific programming, a strong focus on spirituality and program delivery by aboriginal organizations/staff.

There is increasing support for the proposition that elders and other traditional teachers have a positive impact on the behaviour of aboriginal inmates and that their involvement should become an integral part of any strategy to deal with substance abuse among aboriginal offenders. As well, aboriginal substance programs and services will only be really effective if they are designed and delivered by aboriginal people and communities. If that is not possible,any program should at least be seen by the aboriginal inmates as having significant aboriginal input at all stages of its development and delivery.

Developing health promotion and intervention programs that are culturally specific and relevant to aboriginal offenders' needs and learning styles may mean designing programs that do not look like programs designed for the general offender population.

3. RECOMMENDATIONS

The Task Force recommends that:

1. **Programming be culturally sensitive and meaningful to the participating offenders.**

2. **Traditional concepts and practices of spirituality include the involvement of elders and be addressed as an appropriate response to substance abuse problems experienced by aboriginal offenders.**

3. **The CSC encourage that more programs or facilities be operated and/or staffed by aboriginal people.**

Chapter 6

Staff Training in Substance Abuse

Chapter 6

STAFF TRAINING IN SUBSTANCE ABUSE

1. THE ROLE OF STAFF IN SUBSTANCE ABUSE PROGRAMMING

Substance abuse intervention presumes a variety of interventions that have continuity with each other and a logical relationship to the objective of reducing substance abuse. Accordingly, interventions can be carried out by a variety of persons. Qualified leaders in the substance abuse field come from a variety of professions and occupations. They can be different categories of CSC staff (e.g., CO-1, CO-2, Case Management personnel, psychology, social work), contract personnel (chaplains, teachers, health care, food services, etc.), agency personnel from the community (addiction foundations, John Howard Society, etc.), or volunteers (AA, chaplaincy volunteers, etc.)

Regardless of the formal accountability and responsibilities a large organization like the CSC must assign, it is essential that an understanding team approach be maintained where the active roles taken by the staff are not defined by their department or position, but by their ability to effect change. This may be limited by the need for professional qualifications or specialization in substance abuse but the majority of activities and programs are not restricted this way. However, there is a need to define the tasks and responsibilities of staff in order to provide them with specific knowledge and skills, and the necessity of all staff to receive information on substance abuse in a general induction program.

2. GENERAL STAFF AWARENESS TRAINING

The Substance Abuse Health Promotion model proposed in this report for dealing with substance abuse would rely heavily for its success on the awareness and commitment of all CSC staff. It is not sufficient for only specialists, treatment staff or contractors to have an understanding of this model. The environment in which they operate also must reflect and reinforce the model's principles. Consequently, general staff awareness, understanding and support are essential components of the strategic model, as staff play a major role in shaping the correctional environment.

At present, staff awareness training in the substance abuse area varies from region to region and within regions themselves. The Task Force recommends that a national training module be designed to provide all staff, volunteers and contractors involved in the correctional process with an overview and a basic awareness of the CSC Substance Abuse Strategy. The basic awareness training could form a part of the induction and orientation of all new Service employees. It could also be used to train existing staff, volunteer and private agency staff on an ongoing basis. The awareness training should not only provide information, but focus on the important role staff, including contractors, volunteers and community participants involved in the correctional process can play in supporting the principles and objectives of the substance prevention and programming effort.

3. ADVANCED TRAINING IN SUBSTANCE ABUSE

Advanced training is also required for staff involved in planning, designing, delivering, monitoring and evaluating both the current and new initiatives in substance abuse programming. The need for timely and relevant training has been a constant theme as members of the Task Force interviewed staff in various regions.

The need for education and training in substance abuse was also reflected in a recent general survey of training needs of Welfare Program (WP) staff. The involvement of relevant staff in the design and delivery of substance abuse programming is imperative if the training provided is to be pertinent.

Many staff members involved in past training initiatives in substance abuse were unable to use and develop these skills as either their job did not involve this responsibility, or their job responsibilities changed shortly after. Consequently, these skills were lost. These staff members feel that in order to become involved in substance abuse programming, they require, at the very least, a series of refresher courses.

The following generic skills and knowledge have been identified through the development of the substance abuse programming model (Annex 1).

a) Knowledge Base in Substance Abuse

A sound knowledge base of the current theories and models of substance abuse, social issues, pharmacology, identification and referral, prevention and intervention approaches, role of self-help, mutual-aid groups, effects on family, and the recovery process is essential. This knowledge allows staff to identify and intervene in the process of addiction, as well as develop prevention approaches that will assist offenders in developing healthier behaviours.

b) Specific Knowledge of Pharmacology

Specific knowledge of the withdrawal process and the behaviours of offenders while under the influence of psychoactive drugs and combinations thereof is essential for the appropriate management of these offenders. General knowledge of psychoactive drugs and their effects should be included in the induction program.

c) Knowledge of Self-Help and Mutual-Aid Groups

Self-help and mutual-aid groups are the main continuing care resources for offenders and their families both within the institution and the community. Knowledge of the programs and principles as well as the ability of staff to assist in their formation and training of volunteers is essential.

d) Proficiency in Counselling Skills

Service staff should be knowledgeable about, and proficient in communication and counselling skills based on the client-centred approach as well as cognitive-behaviourial models. These models form the basis of the interactive process and take into consideration the social-emotional environment of the counselling process.

e) Ability to Work Effectively in Groups

As group counselling is one of the major components of substance abuse intervention programs, staff must possess an understanding of the developmental process, and the dynamics of groups. Group counselling sessions should emphasize the stimulation of critical thinking on issues offenders face in their social and cultural contexts. Experience and competencies in the decision-making, problem-solving mechanisms of groups is critical in assisting offenders in the recovery process.

f) Proficiency in Recovery and Relapse Prevention Planning

Recovery planning, relapse prevention training and monitoring form the core of the involvement of staff in the identification, intervention and recovery process for the offender beginning at reception. Staff must possess skills in needs assessment, recovery planning including assisting the offender to develop recovery and relapse prevention goals and objectives, relapse prevention training, and monitoring the recovery process.

g) Proficiency in Family and Marital Counselling

Family support is extremely important to the ongoing recovery of the offender. Staff are able to assist with this aspect of reintegration into the community as well as the adjustment of the offender in the institution.

The family is integral to the offender's recovery and relapse prevention planning and should be included where appropriate as soon as possible in the process as they are in a position to intervene given the information and skills.

h) Proficiency in Training Offenders in a Range of Competency Development Skills

Competency development enhances the offenders ability to cope with a range of life situations is critical to the prevention of substance abuse problems. Consequently, staff should be proficient in delivering a range of programs such as assertiveness interpersonal, life and social skills training, problem-solving, relaxation techniques, anger management, parenting and child care.

i) Ability to Design and Deliver a Range of Education and Intervention Programs

The Substance Abuse Health Promotion Model recommends a range of programming whose design and delivery is based on the concepts and principles of adult learning. Staff must be able to design and deliver programming based on this participatory interactive approach to learning and intervention in substance abuse.

j) Assessment and Referral

Staff should possess skills and knowledge of various assessment instruments, be able to interpret the results and know the limitations of the instruments. Staff should possess a sound knowledge of and theoretical base in addictions, as well as the range of services and programming available in the institution and community in order to match the offender with the most appropriate programs to meet his/her needs.

The CSC should develop a comprehensive training model for substance abuse that incorporate the following principles:

1. The development of this model requires a needs assessment of staff's current knowledge and skill levels on the subject of substance abuse.

2. The training model must apply to the full range of prevention and intervention settings that exist in the Service, and focus on generic knowledge and skills in the field of addictions.

3. The training program and assessment techniques must be competency-based. This means that the job description must outline the specific responsibilities of staff for substance abuse prevention and intervention programming including performance standards.

4. The training model must take into consideration the need for accessibility of staff across Canada, which couldinclude developing a "trainer of trainers" approach to the implementation of the model.

5. The training model must take into consideration the previous training of staff received from the Service, addiction agencies, and colleges and universities.

6. The training model must establish mechanisms for ongoing development and support of skills obtained by staff.

7. The training model be developed in conjunction with an accredited educational institution to ensure the training received by staff is recognized.

4. RECOMMENDATIONS

The Task Force recommends that:

1. **A substance abuse training module that reflects the basic principles and objectives of the CSC Substance Abuse Health Promotion Model be developed and provided as part of the induction and orientation of all staff, volunteers and contract personnel working within the CSC.**

2. **A comprehensive training plan be developed that reflect the advanced training needs of staff responsible for the design and delivery of a range of prevention and intervention programs in substance abuse.**

3. **Both human and financial resources be provided to each district office and institution hire appropriate professional expertise in substance abuse to provide programming in each operational unit.**

4. **CSC develop standards and guidelines for the selection and hiring of substance abuse counsellors.**

5. **CSC pursue, along with other federal, provincial and community addiction agencies, standards for substance abuse counsellor certification.**

TRAINING DEVELOPMENT CHART

ANNEX 1.1

RESPONSIBILITIES/TASKS	CORE KNOWLEDGE OF	CORE SKILLS IN
ASSESSES AND REFERS OFFENDERS TO A APPROPRIATE LEVEL OF SUBSTANCE ABUSE PROGRAMMING	Lifestyle Screening Instrument. Assessment Techniques and Tools i.e., MAST, DAST Case Management Techniques Substance Abuse Programming Within the Institution and Community Cultural and Gender Differences Interviewing Techniques Personal Attitudes and Values to Substance Abuse Pharmacology of Psychoactive Drugs Mechanisms of Drug Action Concepts of Dependence, Tolerance, Cross-dependencies and Withdrawal Signs and Symptoms of Abuse and Dependency Intervention Techniques Issues of Co-dependency Self-help Groups Women's Issues in Chemical Dependency Issues in Interviewing Natives Chemical Dependency and the Family	Assessing level of dependency and making an appropriate referral. Developing an initial recovery plan with offenders. Analyzing the reports and making initial assessment.
CONDUCTS INDIVIDUAL COUNSELLING SESSIONS WITH OFFENDERS	Techniques Used in Behavioural Contracting Counsellor Roles and Responsibilities Methods of Trust Building Theories of Human Needs and Motivation Transference and Counter Transference Communication Techniques Counselling Theories with an Emphasis on Client centred, and Cognitive-behaviouralApproaches	Encouraging offenders in self-exploration of the consequences of their behaviour. Assisting offenders in recognizing their strengths and limitations. Identifying and responding to issues that arise in counselling. Facilitating problem-solving and development of alternatives. Demonstrating reflective and directive skills: 1) Attending) 2) Paraphrasing) - Reflective 3) Reflection of feelings) 4) Summarizing 5) Probing) 6) Interpreting) - Directive 7) Confrontation) 8) Self-disclosure) Demonstrating empathy, genuiness, respect, concretcness and immediacy when interacting with offenders.

RESPONSIBILITIES/TASKS	CORE KNOWLEDGE OF	CORE SKILLS IN
MONITORS OFFENDERS RECOVERY AND RELAPSE PREVENTION PLAN AND TAKES APPROPRIATE ACTION WHERE REQUIRED. **TRAINS OFFENDERS IN RELAPSE PREVENTION TECHNIQUES.**	Knowledge of Resources Relapse Dynamics Warning Signs of Relapse Developmental Stages of Recovery Goal-getting Techniques Action-planning Techniques Grieving Process Problem-solving Methods and Process Theories and Behavioural Components of Change A Range of Relapse Prevention Theories and Programs i.e., Gorski, Marlatt, Awnis, Daley Communication Skills Conflict-resolution Techniques The Change Process Warning Signs of Relapse Physical and Psychological Symptoms of the Post-acute Withdrawal Syndrome Pharmacology of Alcohol and Drugs Interactions Commonly Prescribed Medications, Purposes, Intended Effects, Side-effects and Storage Procedures Genetic Theory and Implications for Recovery High-Risk Situations for Recovering Persons	Providing support and encouragement in establishing and maintaining changes in behaviour. Recognizing the warning signs of impending relapse and taking appropriate action. Identifying and responding to the critical periods in the recovery process. Assisting persons in developing linkages to various self-help groups. Identifying specific and special needs and making referrals based on referrals based on emerging needs. Assisting offenders to evaluate their own progress. Assisting in the rewriting of recovering of recovery goals, and ongoing action plans for relapse prevention specially in high-risk situation. Matching counselling techniques with client needs. Matching relapse prevention approach to the offender's level of dependency and learning goals. Monitoring offender's progress towards their goals. Identifying signs and symptoms of impending relapse. Identifying and responding to offender's attitudes, fears, beliefs, needs that affect them and their relationship with others. Assisting offenders to improve their communication skills. Where appropriate, assisting/coaching offenders in an assertive versus aggressive manner. Assisting offenders in using problem-solving conflict resolution skills in responding to on-the-job situations. Assisting offenders to address issues in recovery through a variety of problem-solving techniques.

TRAINING DEVELOPMENT CHART

ANNEX 1.2

RESPONSIBILITIES/TASKS	CORE KNOWLEDGE OF	CORE SKILLS IN
	ACOA and Implications for Recovery	Assisting offenders to explore alternatives utilizing experiential learning techniques.
	Anger Management	Assisting offenders to develop alternative behaviours, utilizing experimental techniques.
		Assisting offenders with developing a high-risk prevention plan.
		Assisting offenders to identify stressors in their lives, and explore through conflict management, problem-solving and anger management techniques, alternative ways of responding.
DEVELOPS AND FACILITATES HEALTH ENHANCEMENT, PREVENTION PROGRAMS	Historical perspectives	Community mobilization
	Modes of Prevention	Stress-management training
	Community mobilization	Relaxation training
	Prevention Strategies	Developing prevention projects
	Causes, Concepts Trends	Stop smoking programs
	Communications and health promotion	Nutrition counselling
	Stress Management Techniques	Decision-making
	Relation Training Techniques	Conflict management
	Nutrition, Eating Disorders	Anger management
	Consulting and Networking Techniques	Peer counselling training
		Assertiveness training
		Consulting and networking skills

TRAINING DEVELOPMENT CHART

ANNEX 1.3

RESPONSIBILITIES/TASKS	CORE KNOWLEDGE OF	CORE SKILLS IN
FACILITIES RECOVERY GROUPS	Purposes and Functions of Group Group Counsellor Intervention Models Therapeutic Factors of Group Counselling Patterns of Behaviour in Groups Behaviours that may affect Group Patient Outcome Group Development Theories Behaviours Common to Groups at Various Stages of Development Group Techniques and Exercises, their Purposes and Possible Consequences Group Orientation Process Problem -solving Techniques Conflict Resolution and Management Peer Counselling Models Adult Learning in Groups Effects of Alcohol and Drug Use on the Offender's Relationship with Self, Others and Society Impact of Alcoholism/Drug Dependencies and Recovery on Family Members/Significant Others ACOA Issues and Their Implications for Recovery Family Systems Theory Dysfunctional/Survival Roles Families Adopt Issues of Intimacy in Recovery	Designing criteria and procedures for selecting group members. Designing and selecting orientation procedures for group members. Designing and selecting group experiences and exercises that coincide with group purposes, stages of development and specific needs of the session. Establishing and maintaining a therapeutic atmosphere in a group. Facilitating group interaction and decision-making. Balancing individual and group needs. Processing the impact of group counselling techniques on individual group members as well as the groups as a whole. Assessing the mood and atmosphere of the group. Facilitate group exploration of feelings regarding critical incidents and underlying issues. Preparing group members for termination and/or change in group membership. Utilizing methods and techniques of adult development and learning to enhance group process. Establishing group goals. Assisting offenders in reviewing their recreation and leisure time. Assisting offender to explore issues of intimacy utilizing exercises and a case-study approach. Assisting offenders in developing linkages to a variety of self-help groups. Assisting offenders in developing linkages to volunteer agencies/resources in their community.

RESPONSIBILITIES/TASKS	CORE KNOWLEDGE OF	CORE SKILLS IN
PLANS ORGANIZES AND DELIVERS A RANGE OF SUBSTANCE ABUSE EDUCATION AND SKILL RELATED TRAINING SESSIONS	Adult Learning Theory and Principles and Their Implications for the Design and Delivery of Presentations to Recovery Group Awareness of Learning and Teaching Styles Values, Clarification Theories and Techniques Presentation Techniques Experiential Learning Techniques Needs Assessment Techniques	Application of Adult Learning Theory and Principles in the Delivery of Education Sessions. Adjusting Individuals preferred style to the needs of the group. Facilitating values clarification exercises. Demonstrating a variety of Presentation Skills. Utilizing a variety of Experiential Techniques. Conducting an evaluation of all sessions from offender's perspective Evaluation of Education program; as evidenced by learning outcomes of offenders.
ASSISTS FAMILY MEMBERS AND/OR OFFENDERS TO RESOLVE CO-DEPENDENCY CHALLENGES	Family Systems Theory. Family Dynamics. ACOA and COA issues in recovery. Effects of Alcoholism/Drug Abuse on the Family. Self-help Groups. Structured Intervention Theory and Dynamics. Crisis Counselling Techniques. Parenting Skills. Family Violence Issues. Sexual Abuse Issues.	Providing current and accurate information/education to family members and significant others on Chemical Dependency Issues and the Recovery Process. Informing significant others about and encourage participation in appropriate self-help groups. Assisting significant others to understand roles. Assisting significant others in identifying and understanding their attitudes and behaviour in relation to chemical dependency. Organizing a structured intervention involving family members and/or significant others with the goals of : 1) to get the offender to accept treatment and/or 2) to intervene in a potential relapse situation. Identifying and involving family and significant others in the recovery process. Observing and responding to the interaction between offenders, family members and significant others. Identifying and responding to a potential or actual crisis situation, ie. family violence.

Chapter 7

Research and Evaluation

Chapter 7

RESEARCH AND EVALUATION

1. INTRODUCTION

The design of successful correctional programs are founded upon sound empirical knowledge regarding the interventions that promote positive change in offender populations. A strong commitment to research and evaluation will be necessary if the CSC is to develop effective new approaches to treating the substance abuse problems of offenders. As well, knowledge gained from research and evaluation activities will be essential to the ongoing process of building upon and enhancing the quality of our existing treatment efforts in this area.

Research is needed in a number of areas; for example, regarding the most efficient ways of classifying substance abuse problems and giving offenders to the most appropriate treatments. CSC program development has not always proceeded from a strong research base. The majority of the Service's substance abuse programs have not been systematically evaluated. Clearly, programming efforts will be more successful as some of these gaps in knowledge are closed.

The role of research and evaluation should encompass four broad areas:

a) **Existing Research** - the use of existing research about substance abuse program effectiveness in corrections to guide the design of new interventions;

b) **Special Research Initiatives** - the use of special research initiatives to generate new knowledge about substance abuse among offenders and to develop new and innovative programming alternatives;

c) **Outcome Evaluation** - the ongoing use of outcome evaluation procedures to test the effectiveness of new and existing programs; and

d) **Global Criteria** - the identification and use of global criteria to progress in the development of CSC's substance abuse strategy over time.

2. EXISTING KNOWLEDGE

A minimum condition for successful substance abuse programming is that program components be based on techniques that have been shown to be effective. Yet many programs are implemented when little or no evidence of their potential effectiveness can be identified. This situation is unacceptable given the enormous amount of literature on programming for substance abusers and on the principles of correctional treatment. Although researchers do not have all the answers, program designers must attempt to identifythe program characteristics that research suggests are "state-of-the-art." Proposals for new programs should be based on thorough reviews of existing literature on substance abuse and correctional treatment of offenders.

3. SPECIAL RESEARCH INITIATIVES

Given the existing gaps in knowledge, the possibilities for special research initiatives on substance abuse in the CSC are endless. However, there are specific issues on which research efforts should be especially focussed. Two broad areas possess considerable promise:

a) Research on the development of treatment-relevant typologies for substance-abusing offenders; and

b) Research on innovative ways to deliver substance abuse programs to offenders.

An enduring problem concerns CSC's ability to classify offenders for special substance abuse programming. As a comprehensive survey of substance use patterns, criminal behaviour, and other areas of functioning, the Lifestyle Screening Instrument will furnish a strong data base for investigating this problem. Special research initiatives will also contribute to the development of effective new methods for treating substance-abusing offenders. The Task Force assumes that this type of research will increase as the understanding of substance abuse problems among offenders, and therefore, the CSC's ability to provide effective programming will be improved.

4. OUTCOME EVALUATION

"Outcome" implies specific criteria against which programming efforts can be judged. In the CSC, all programming efforts relate to the Mission objective of "... actively encouraging and assisting offenders to become law-abiding citizens, while exercising reasonable, safe, secure and humane control." Therefore, the Task Force recommends that the ultimate effectiveness of substance abuse programs be judged by their ability to reduce criminal recidivism.

A number of mechanisms should be in place to evaluate program effectiveness. Since evaluation procedures implemented after the delivery of a program may threaten the validity of the conclusions, new substance abuse programs should incorporate an evaluation component at the initial stage of program design. To enhance theirintegrity and evaluability, all major new substance abuse programs should include the following:

a) Definition of what type of offenders the program is targeting and how participants are selected;

b) Clear statements of intended outcomes;

c) Specification of the program's practices and procedures (e.g., assessment techniques, relapse prevention, etc.);

d) Pre-post-measurement of the behaviours the program is intended to influence; and

e) Measurement of relevant offender characteristics which may predict who gains most from participation in the program.

It is imperative that evaluations of major programming initiatives be well-coordinated. The need for careful planning, as emphasized above, means that the evaluation procedures are developed in advance of program implementation and that arrangements are made for all facets of the collection, analysis, and interpretation of evaluation data. This will be particularly crucial for large-scale initiatives involving more than one region.

5. GLOBAL CRITERIA

While the evaluation of particular programs is essential, global evaluation of the Service's progress should not be overlooked - especially at a time when the CSC has recognized substance abuse as a major problem that demands its focused attention. To assess the pace of movement toward objectives, performance on the measures taken could be monitored every three to five years at the national and regional level.

A variety of global measures could be developed to assess the CSC's success in institutional and community settings. Examples include levels of offender participation in programming; trends in results of random urinalysis testing; rates of recidivism and post-release substance abuse patterns of offenders who participate in substance abuse programming; and the level of staff awareness and participation in substance abuse training.

6. RECOMMENDATIONS

The Task Force recommends that:

1. **All new programs be firmly grounded in the findings of existing research.**

2. **Through the guidance and participation of the Regional Research Committees and the Research Branch at National Headquarters, CSC develop a focused program of research on substance abuse over the next few years.**

3. **All new programs incorporate evaluation components at the program design stage, and that all major new initiatives be subjected to outcome evaluation.**

4. **Global criteria for assessing the progress of our substance abuse strategy be developed and employed.**

Chapter 8

Summary of Recommendations

Chapter 8

SUMMARY OF RECOMMENDATIONS

The Task Force recommends that:

Health Promotion Strategy

1. The CSC adopt the Health Promotion Model as the core of the substance abuse strategy for federal offenders.

2. The CSC develop and implement a range of substance abuse services and programs available to offenders from their reception until warrant expiry date.

3. The CSC develop a national substance abuse policy that is consistent with the principles and recommendations outlined in the Contraband Control Study, the report of the Task Force on Federally Sentenced Women, and the report of the Task Force on Aboriginal People in Federal Corrections.

4. National Headquarters of the CSC develop processes and policies that give guidance and direction in the overall planning, delivery and evaluation of substance abuse related services and programs.

5. Each Region develop, implement and evaluate a regional substance abuse plan for their respective offender population, based on the prevalence of substance abuse problems, the prevailing cultural and demographic factors, and resource levels.

6. The CSC continue to develop and maintain linkages with federal, provincial and community based-addiction agencies to ensure a co-ordinated continuum of care for the offender.

Model for Substance Abuse Programming within CSC

7. The CSC adopt a multi-disciplinary approach when developing and implementing substance abuse programs and services.

8. The CSC adopt the principles of primary, secondary and tertiary intervention as part of the strategic action plan for substance abuse programs and services.

9. Each region develop a strategic action plan for the implementation of the recommendations for substance abuse programs and services based on the CSC National Substance Abuse Strategy.

Assessment of Offenders

10. The CSC use the Lifestyle Screening Instrument to assess offenders upon reception in each region.

11. The CSC continue to monitor developments in the field of substance abuse assessment instruments and techniques. The purpose will be to improve CSC's capabilities in this area in response to the experience of other jurisdictions as well as the results of ongoing monitoring of the Computerized Lifestyle Screening Instrument.

12. The Computerized Lifestyle Screening Instrument be validated for use with aboriginal offenders.

13. Appropriate training programs on the use and interpretation of the instruments chosen by the CSC to determine substance abuse characteristics and treatment referral of offenders be developed and provided to Case Management staff.

14. Female offenders be individually assessed for substance abuse problems through the use of established assessment instruments and structured interviews which are normed and validated for female populations rather than by the use of broad-based screening instruments.

Induction Programming

15. CSC develop a new Substance Abuse Induction Module targeted to all newly admitted inmates based on the framework outlined by the Task Force.

16. All institutions be required to deliver this module to every newly admitted inmate.

17. The module be adapted to the learning needs of aboriginal and women offenders.

Education

18. The key educational objectives identified by this Task Force be adopted as a standard governing the delivery of education programs within the CSC.

19. A reference manual be developed for use by CSC staff, using the key education elements as a base. The reference manual would provide:

- Complete, concise information on key subject areas which would allow CSC staff to develop lesson plans based on the material; and

- A standard for use by operational managers when developing requests for proposals for contracted services.

20. CSC develop a series of short professionally developed videos specifically for the offender population, for use a teaching aid.

21. Educational materials developed be culturally sensitive and be adapted to the needs of aboriginal and female offenders.

Health Promotion and Prevention Programming

22. Each institution establish mechanisms for the development and/or training of peer support, mutual-aid groups and volunteers.

23. Each institution involve offenders, staff, volunteers and community members in the development and delivery of new substance abuse programming initiatives as well as in strengthening or enhancing regular ongoing programs.

24. Each institution develop and implement a range of health enhancement and wellness programs.

25. Each institution, in recognition of the role of nutrition therapy in the withdrawal and recovery from substance abuse, establish appropriate dietary schedules for offenders in recovery programs.

Primary Prevention Programming

26. The CSC develop and implement within each of the four prevention approaches a range of prevention programs that are balanced and supportive of each other.

27. Each institution involve offenders, staff, volunteers, and the community in national, provincial, and local community initiatives to reduce substance abuse problems such as National Drug Awareness Week, and local drug and alcohol committees.

Secondary Intervention Programming

28. The CSC develop and pilot a bibliotherapy program to meet the specific needs of offenders.

29. Secondary intervention programs should include skills and competency development based on the identified learning needs of the offender.

30. Secondary intervention education components should include the key elements recommended by the Task Force in the Substance Abuse Education section of this report.

31. All offenders, having completed secondary intervention programming, should be matched to available compatible programs and organized follow-up and recovery support both in the institution and in the community.

Tertiary Intervention Programming

32. CSC implement therapeutic communities in each region where the number of offenders warrant.

33. All offenders, having completed tertiary intervention programming, be matched to a compatible program and organized follow-up recovery support in the institution and in the community.

Relapse Prevention

34. That the CSC develop a relapse prevention program for offenders to support secondary and tertiary interventions that take place during the sentence and consider the realities of the correctional context. This development must involve consultation with the NPB in relation to the imposition of Special Conditions ordering offenders to abstain from intoxicants.

Community Programs

35. All offenders who have completed tertiary intervention have compatible, organized follow-up recovery support in the community.

36. Contracts with community substance abuse agencies be reviewed for consistency with the principles and recommendations of the Task Force. Priority in new contracts should be given to organizations whose program conforms with the CSC for intervention and are congruent with findings on efficacy.

37. A comprehensive resource network for substance abuse programs be established to assure that the needed programs are available to offenders released to community supervision.

38. Whenever possible, offenders should receive the major portion of interventions after release from the institution. Initial assessment should identify the potential for intervention effectiveness, but weighing other relevant factors such as eligibility for release and risk to community.

39. If offenders cannot be treated in a timely way within the institution prior to eligibility for release, their release plans be developed to include appropriately matched interventions to be delivered in the community, provided that the factor of risk of reoffending is not overriding.

Women Offenders

40. The Service develop a substance-abuse strategy tailored to the needs of federally sentenced women according to the principles outlined in the report of the Task Force on Federally Sentenced Women, and that this strategy, including related programming, be planned and implemented so as to be consistent with any final government decisions on the accommodation of federally sentenced women.

41. The development and implementation of substance abuse programming be undertaken in consultation with the committee advising on the implementation of the Task Force on Federally Sentenced Women as well as with staff, offenders and women-centred agencies.

Aboriginal Offenders

42. Programming be culturally sensitive and meaningful to the participating offenders.

43. Traditional concepts and practices of spirituality include the involvement of elders and be addressed as anappropriate response to substance abuse problems experienced by aboriginal offenders.

44. The CSC encourage that more programs or facilities be operated and/or staffed by aboriginal people.

Staff Training

45. A substance abuse training module that reflects the principles and objectives of the CSC Substance Abuse Health Promotion Model be developed and provided as part of the induction and orientation of all staff, volunteers and contract personnel working within the CSC.

46. A comprehensive training plan be developed that reflects the advanced training needs of staff responsible for the design and delivery of a range of prevention and intervention programs in substance abuse.

47. Both human and financial resources be provided to each district office and institution to hire appropriate professional expertise in substance abuse programming in each operational unit.

48. CSC develop standards and guidelines for the selection and hiring of substance abuse counsellors.

49. CSC pursue, along with other federal, provincial and community addiction agencies, standards for substance abuse counsellor certification.

Research and Evaluation

50. All new programs be firmly grounded in the findings of existing research.

51. Through the guidance and participation of the Regional Research Committees and the Research Branch at National Headquarters, CSC develop a focused program of research on substance abuse over the next few years.

52. All new programs incorporate evaluation components at the program design stage, and that all major new initiatives be subjected to outcome evaluation.

53. Global criteria for assessing the progress of our substance abuse strategy be developed and employed.

Chapter 9

Glossary

Glossary

ABUSE (ALCOHOL/DRUG) - when alcohol/drug consumption is harmful but not so extreme as to achieve the criteria for dependence.

ABUSE POTENTIAL - the likelihood that a person will abuse a drug, based on drug effects, toxicity level of the drug, the dose and frequency of drug use and the social context within which the drug is taken.

ADDICTION POTENTIAL - the likelihood that a drug will produce addiction in chronic users.

BIBLIOTHERAPY - a cognitive behaviour program that attempts to pinpoint the current consumption problem, reduce consumption and empower the individual, and effectively confront situations that lead to excessive consumption.

BRIDGING - phase of the substance abuse delivery process covering that portion of the sentence immediately following release and ensuring a program linkage between the institution and the community.

CAREGIVERS - persons who offer service and assistance to offenders.

CATEGORIES OF CARE-levels of intensity, i.e., high, medium, low.

CATEGORIES OF RISK - based on the risks of physical damage associated with various levels of alcohol consumption.

COMPETENCE DEVELOPMENT - improvement of the offenders skills in order to enhance their ability to cope.

COMPUTERIZED LIFESTYLE - a substance abuse diagnostic device.

SCREENING INSTRUMENT - utilizing a computer that provides feedback on the person's level of dependency.

CONTINUUM OF CARE-a multi-modality treatment system that incorporates a wide range of service functions and a multi-disciplinary approach to treatment.

CRACK COCAINE - an adulterated form of cocaine.

CROSS DEPENDENCE - the ability of a drug to suppress withdrawal in an individual physically dependent on another drug with similar pharmacological effects.

CROSS TOLERANCE - condition of reduced sensitivity to the effects of a drug due to the acquired tolerance to another drug that produced similar pharmacological effects.

DIAGNOSTIC INTERVIEW - SCHEDULE (DIS)(DSM III-R) - a substance abuse diagnostic tool.

DRUG - any substance, including alcohol, used to produce desired physiological or psychological effects.

DRUG DEPENDENCE - a state of dependence upon a drug that is harmful to physical and/or mental health, social well-being and/or economic functioning.

DEPENDENCE (PHYSICAL) - a state characterized by the appearance of physical signs and symptoms when the chronic administration of a drug is abruptly discontinued.

DEPENDENCE (PSYCHOLOGICAL) - a state characterized by an intensewish to use a specific drug, a pattern of compulsive administration, and a feeling of severe anxiety if it is unavailable.

DEPENDENCE (LIABILITY) - the likelihood that a person will become physically or psychologically dependent on a drug.

DETOXIFICATION - a process to assist the client to overcome both the medical and non-medical symptoms of withdrawal.

FORCE FIELD ANALYSIS - the factors which contribute to criminal behaviour ranked according to their relative strengths.

HAZARDOUS DRINKING - the regular consumption of three or more units of alcohol per day by the average healthy adult. A unit is defined as a half-pint of beer, 4 oz. of wine or 1 oz. of liquor.

HEALTH PROMOTION - the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health.

ICE - street name of Speed (Methadrine).

INTERVENTIONS (SECONDARY) - action taken when the problem has become recognizable to prevent a further dependency.

(TERTIARY) - actions to minimize the effects of a "condition" once it has occurred and to begin the process of rehabilitation.

LOW-INTENSITY PROGRAMS - minimal interventions only are required. Offenders take responsibility for addressing their problems through self-direction and personal initiative.

MATCHING - matching the characteristics of the offender and their level of dependency with an appropriate level of intervention.

MEDIUM-INTENSITY PROGRAM - interventions of short duration and based upon education and skills developments.

PHARMACOTHERAPY - chemical intervention which can be supportive (Lithium) or aversive (Antabuse).

PRIMARY PREVENTION - action taken prior to the onset of a substance abuse problem to prevent its occurrence.

PSYCHOACTIVE DRUG - drugs that affect perception, emotions and/or behaviour.

RECOVERY PLANNING - efforts to help the person recover involving all aspects of their personal life, i.e., social, emotional, spiritual.

RELAPSE PREVENTION - efforts taken to maintain behaviour and prevent a reoccurrence of the former behaviour.

THERAPEUTIC COMMUNITY - a structured supportive environment that provides for positive change by focusing on behaviours and confronting attitudes that are destructive for the individual. Therapeutic communities can be open or closed.

TOLERANCE - reduced sensitivity to a drug resulting from the adaptation of the body to that drug.

TYPOLOGIES - groupings of phenomena having common characteristics, i.e., behaviour traits.

WELLNESS - the promotion of health.

Chapter 10

Bibliography

BIBLIOGRAPHY

Aassland, Olaf Gjerlow. *Dope or Death? Survival Strategies for Young Offenders.* Paper presented at the Addictions in the 90's Conference, St. John's Newfoundland, May 3, 1990.

Achieving Health for All: A Framework for Health Promotion. Health and Welfare Canada, 1986.

Addiction Counselling Training. Health and Welfare Canada, Minister of Supply and Services Canada. Published by the Addiction Research Foundation, 1987.

Adlaf, Edward M. and Reginald S. Smart. *The Ontario Adult and Other Drug Use Survey 1977-1989.* Addiction Research Foundation of Ontario, 1989.

A Framework for the Response to Alcohol and Drug Problems in Ontario. Ministry of Health, 1988.

Alcohol and Health for Special Report to the US Congress. Department of Health and Human Services, 1987.

Allen, B. and H. Skinner. Lifestyle Assessment Using Microcomputers. In Butcher, J.N. *The Practitioner's Guide to Computer-Based Psychological Testing.* New York: Basic Books.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorder.* Third Edition Revised. Washington, D.C.: American Psychiatric Association, 1987.

Andrews, Florence and Irving Rootman. "Alcohol Use Among Women," in V. Carver and C. Ponee (eds.) *Women, Work and Wellness.* Addiction Research Foundation, Toronto, 1989.

Annis, Helen M. and Christine S. Davis. "Relapse Prevention," in R.K. Hester and W.R. Miller (eds.) *Handbook of Alcoholism Treatment Approaches.* New York: Pergamon Press, 1989.

Annis, Helen M. and Carolyn B. Liban. "Alcoholism in Women: Treatment Modalities and Outcomes," in O.J. Kalant (ed.) *Alcohol and Drug Problems in Women.* New York: Plenum Press, 1980, pp. 385-422.

Beckman L. "Treatment Needs and Women Alcoholics." *Alcoholism Treatment Quarterly,* 1(2), (1984), 101-113.

Brochu, Serge. *Regional Plan for Addiction Services for Judicialized Persons*. Document submitted to the Administrative Commission on Alcoholism and Other Addictions, Quebec, April 19, 1989.

Brochu, Serge and Charles Forget. *Survey of Literature on Substance Intervention for Inmates*. Report submitted to the Task Force on Alcohol and Drug Abuse, Correctional Service of Canada, March 1990.

Brookfield, Stephen D. *Understanding and Facilitating Adult Learning*. San Francisco: Jossey-Bass Inc., 1986.

Callahan, M. *Background and Rationale for a National Survey of Drug and Alcohol Abuse Problems Among Female Offenders*. Ottawa: Ministry Secretariat, Solicitor General Canada, April 1987.

Callahan, M. *National Survey of Drug and Alcohol Abuse Problems Among Federal Offenders: Developmental Phase - Final Report*. Ottawa: Ministry Secretariat, Solicitor General Canada, December 1987.

Callahan, M. and F.J. Porporino. *Rationale and Objectives for a National Survey of Drug and Alcohol Dependency Problems Among Federal Offenders*. Ottawa: Correctional Service of Canada, February 1987.

Carkhuff, Robert R. *Helping and Human Relationships*. Vol. 1 - 11. New York: Holt, Reinhart and Winston, Inc., 1969.

Carkhuff, Robert R. and B.G. Berenson. *Beyond Counselling and Therapy*. New York: Holt, Reinhart and Winston, Inc., 1967.

Chaudron, C.D. and D.A. Wilkinson. *Theories on Alcoholism*. Alcoholism and Drug Addiction Research Foundation, Toronto, 1988.

Cheek, F.E. *Stress Management for Correctional Officers and Their Families*. American Correctional Association, Maryland, 1984.

Chemical Dependency Intervention. Alcoholism Foundation of Manitoba, 1989.

Chick, Jonathan. *Minimum Intervention for Early Alcoholism*. Abstract, Edinburgh University, Department of Psychiatry, Royal Edinburgh Hospital, Scotland.

Collins, J.J. Jr. "Alcohol Use and Criminal Behavior: An Empirical, Theoretical, and Methodological Overview," in: Collins, J.J. Jr. (ed.) *Drinking and Crime. Perspectives on the Relationships Between Alcohol Consumption and Criminal Behavior*. New York: Guilford Press, 1981, 288-316.

Contraband Control Final Report. Vol. 1, October 1989.

Coordinating Healthy Public Policy: An Analytic Literature Review and Bibliography. Health Services and Promotion Branch, Working Paper, Health and Welfare Canada, January 1988.

Consumers' Association of Canada, *Policy Statement Consumers and Health Care*, 1989.

Covington, Stephanie. Chemically Dependant Women and Sexuality. Plenary Session. Women and Substance Abuse: Strategies for the 90s. Winnipeg, Manitoba.

Criminology Research Centre, School of Criminology, Simon Fraser University. *An Examination of the Alcohol/Drug Treatment Program at Mission Institution, Mission, B.C.*, 1988.

CSC Information Package on Unit Management.

Cullen, F. and P. Gendreau. "The Effectiveness of Correctional Rehabilitation," in L. Goodstein and D.L. Mackenzie (eds.) *The American Prison: Issues in Research Policy.* New York: Plenum, 1988.

Daley, Dennis C. *Relapse Prevention Treatment Alternatives and Counseling Aids.* Bradenton, Fl.: Human Services Institute, Inc., 1988.

Davis, M. et al. *The Relaxation and Stress Reduction Workbook.* 2nd ed., Oakland, Ca.: New Harbinger Publications, 1982.

DeVitallaer, Michael. *Substance Abuse Monitor 1989.* Hamilton Centre, Addiction Research Foundation.

Edwards, G. and M.M. Gross. "Alcohol Dependence: Provisional Description of a Clinical Syndrome." *British Medical Journal*, 1 (1976), 1058-1061.

Edwards, G. et al. *Alcohol Related Disabilities.* Geneva: World Health Organization, 1977.

Enhancing Coping. Department of Psychology, University of Concordia, Working Paper, Health and Welfare Canada, November 1987.

Ewing, John A. "Matching Therapy and Patients - The Cafeteria Plan." *British Journal of Addiction*, 72 (1977), 13-18.

Farrell, G. *Summary of the Individual Substance Abuse Evaluations, Atlantic, Ontario, Prairie, Pacific.* Correctional Service of Canada, Ottawa, 1988.

Fielding, Jonathan E. "The Proof of the Health Promotion Pudding Is..." *Journal of Occupational Medecine*, 30(2), February 1988, 113-115.

Fillmore, Kaye Middleton. *Alcohol Use Across the Life Course.* Addiction Research Foundation, Toronto, 1988.

Fostering Public Participation. Canadian Council on Social Development, Working Paper, Health and Welfare Canada, January 1988.

Freire, P. *The Politics of Education.* South Hadley, Mass.: Bergin and Garvey, 1985.

Gavin, D.R. et al. "Diagnostic Validity of the Drug Abuse Screening Test in the Assessment of DSN-111 Drug Disorders." *British Journal of Addictions.* In Press.

Gendreau, P. and R.R. Ross. "Revivification of Rehabilitation: Evidence From the 1980's." *Justice Quarterly*, 4 (1987), 349-407.

Glaser, D. and E. Erez. *Evaluation Research and Decision Guidance.* New Brunswick: Transaction Books, 1988.

Goldberg, P. *Executive Health.* New York: McGraw-Hill, 1978.

Groeneveld, J. and M. Shain. *Drug Use Among Victims and Physical and Sexual Abuse: A Preliminary Report.* Addiction Research Foundation, 1989.

Hanson, Philip G. *Learning Through Groups: A Trainer's Basic Guide.* San Diego, Ca.: University Associates, Inc., 1981.

Harvitz, M. *Peer Self-Help Psycho-therapy Groups and Their Implication for Psycho-therapy.* Psycho-therapy Theory Research Practice, 7:1, 1970, pp. 41-49.

Health Promotion: Concept and Principles. Health Services and Promotion Branch, Working Paper, Health and Welfare Canada, 1986.

Healthy Environments for Canadians. Small and Associates, Wendy Presnitz and Associates, Working Paper, Health and Welfare Canada.

Hubbard, Robert L. et al. *Drug Abuse Treatment: A National Study of Effectiveness.* The University of North Carolina Press, 1989.

Increasing Prevention: Some Economic and Political Constraints. Faculty of Administration, University of Ottawa, Working Paper, Health and Welfare Canada.

Kaplan, Harold S. et al. *Textbook of Psychiatry IV,* 4th ed. Baltimore, Md.: Williams and Wilkins, 1985.

Knowledge Development for Health Promotion: A Call for Action. Health Services and Promotion Branch, Working Paper, Health and Welfare Canada, March 1989.

Knowles, M.S. *Andragogy in Action: Applying Modern Principles of Adult Learning.* San Francisco, Ca.: Jossey-Bass, 1984.

Lamarche, Pierre. Tobacco use in *Canada's Health Promotion Survey, Technical Report,* Health and Welfare Canada, 1988.

Lamarche, Pierre and I. Rootman. Drug Use in *Canada's Health Promotion Survey, Technical Report*, Health and Welfare Canada, 1988.

Lewin, Kand-Grabbe P. "Conduct, Knowledge and Acceptance of New Values." *The Journal of Social Issues*, 1 (3), August 1945.

Lightfoot, L.O. and D. Hodgins. *Characteristics of Offender Substance Abusers: Implications for Treatment Programming*. Paper presented at American Society of Criminology 39th Annual Meeting, November 1987.

Lightfoot, L.O. and D. Hodgins. "A Survey of Alcohol and Drug Problems in Incarcerated Offenders." *The International Journal of Addictions*, 23(7), (1988), 687-706.

Lightfoot, L.O. and D. Hodgins. "Types of Male Alcohol and Drug-Abusing Incarcerated Offenders." *British Journal of Addiction*, (1988), 1201-1213.

Lord, John. "The Potential of Consumer Participation: Sources of Understanding." *Canada's Mental Health*, Health and Welfare Canada, 37 (2), (1989), 15-17.

Lundy, Colleen. Programs for Chemically Dependant Women, in V. Carver and C. Ponee (eds.) *Women, Work and Wellness*. Addiction Research Foundation, Toronto, 1989.

Marlatt, Alan G. *Relapse Prevention*. Workshop materials, Department of Psychology, Addictive Behaviors Research Center, University of Washington, Seattle, Wa.

Marlatt, A. and J. Gordon. "Determinants of Relapse: Implications for the Maintenance of Behaviorial Change, Behaviorial Medecine." *Changing Health Lifestyles*. New York: Brunner/Mazel, 1979.

McDermott, R.R. et al. New York State Department of Corrections Comprehension Drug Treatment Strategy, Thomas A. Coughlin III, Commissioner, New York, State Department of Correctional Services.

McKim, William A. *Drugs and Behavior*. New Jersey: Prentice Hall, 19—.

Mental Health for Canadians: Striking a Balance. Health and Welfare Canada, 1988.

Miller, William R. *The Addictive Behaviors*. Oxford: Pergamon Press, 1980.

Miller, William R. "Treating Problem Drinkers: What Works?" *Behaviour Therapist*, 5 (1), 1984, 15-18.

Miller, William R. "Motivation for Treatment for Treatment: A Review with Special Emphasis on Alcoholism." *Psychological Bulletin*, 98 (1), 1984, 84-107.

Miller, William R. and R.K. Hester. "The Effectiveness of Alcoholism Treatment: What Research Reveals." in W.R. Miller and N. Heather (eds.) *Treating Addictive Behaviors: Process of Change*. New York: Plenum Press, 1986.

Miller, William R. and R.K. Hester. *Matching Problem Drinkers with Optimal Treatments.* Paper presented at the Third International Conference on Treatment of Addictive Behaviors, North Berwick, Scotland, August 1984.

Miller, William R. and J. Peterson. *Tobacco Use by Youth in the Canadian Arctic*, Ottawa Minister of Supply and Services, 1989.

Mission of the Correctional Service of Canada. Correctional Services of Canada, April 1989.

Monograph 1 Essential Concepts and Strategies. Addiction Research Foundation in co-operation with Health and Welfare Canada and
Supply and Services Canada, Toronto, 1986.

Monograph 2 Change Agent Skills. Addiction Research Foundation in co-operation with Health and Welfare Canada and Supply and Services Canada, Toronto, 1986.

Mutual Aid as a Mechanism for Health Promotion and Disease Prevention. Clark Institute of Psychiatry, Working Paper, Health and Welfare Canada.

National Alcohol and Other Drugs Survey: Action on Drug Abuse. Health and Welfare Canada, June 1990.

New York State Department of Correctional Services, *Network Program, Procedural Manual,* 1979.

O'Donnell, Michael. "View Point - Cost Benefit Analysis is Not Cost Effective." *American Journal of Health Promotion,* 3(1), (1988), 74-75.

Pattison, E. Mansell. *Selection of Treatment For Alcoholics.* New Brunswick, New Jersey: Journal of Studies on Alcohol Incorporated, 1982.

Peavy, Vance R. *Counselling Adults for Decision-making: A Pragmatic Orientation.* Occupational and Career Analysis and Development Branch, Canada Employment and Immigration Commission, Ottawa-Hull, 1981.

Pelletier, K. *Healthy People in Unhealthy Places: Stress and Fitness at Work.* New York: Dell Publishing, 1984.

Poirier, M. et al. *E.C.H.O. Program of Personal Development for Inmates*, 1990.

Rachman, A.W. and M.E. Heller. "Peer Group Psycho-therapy with Adolescent Drug Abusers." *Int. J. Group Psycho-therapy*, 1974.

Radford, J.L. et al. *Street Youth and AIDS.* Queen's University, Kingston, 1989.

Reducing Inequalities in Health: A Review of the Literature. National Health Research Scholar, Applied Research/Psychiatry, University Hospital, University of Saskatchewan, Working Paper, Health and Welfare Canada.

Reed, Beth Glover. "Drug Misuse and Dependency in Women: The Meaning and

Implications of Being Considered a Special Population and Minority Group." *The International Journal of the Addictions*, 10 (1), 1985, 13-62.

Reed, Beth Glover. "Developing Women-Sensitive Drug Dependence Treatment Services: Why so Difficult?" *Journal of Psychiatric Drugs*, 19 (2), 151-164.

Riley, Diane M. et al. "Behavioral Treatment of Alcohol Problems: A Review and a Comparison of Behavioral and Non behavioral Studies." *Treatment and Prevention of Alcohol Problems: A Resource Manual.* Toronto: Academic Press, Inc., 1987.

Roizen, J. and D. Schneberk. "Alcohol and Crime," in Aarens, M., Cameron, T., Roizen, J., Roizen R., Room, R., Schneberk, D., and Wingard, D. (eds.) *Alcohol, Casualties and Crime*. Alcohol, Casualties and Crime Project Final Report. Report no. C-18. Berkeley: Social Research Group, University of California, 1977, 289-465.

Rosenbaum, Marsha. *Just Say What? An Alternative View on Solving America's Drug Problem.* San Francisco: National Council on Crime and Delinquency, 1989.

Ross, R.R. and E.A. Fabiano. *A Time to Think: A Cognitive Model of Delinquency Prevention and Offender Rehabilitation.* Johnson City, Tenn.: Institute of Social Sciences and Arts Inc., 1985.

Ross, R.R. and P. Gendreau. *Effective Correctional Treatment.* Toronto: Butterworths, 1980.

Ross, R.R. and L.O. Lightfoot. *Treatment of the Alcohol Abusing Offender.* Springfield, Illinois: C.C. Thomas, 1985.

Rush, B. and C. Timmey. *Treatment Services for Alcohol and Drug Abuse in Ontario: Results of a Provincial Survey*, 1983, Addiction Research Foundation, Toronto, 1983.

Rutman, L. *Evaluation Research Methods: A Basic Guide.* 2nd ed. Beverly Hills, Ca.: Sage, 1984.

Sanchez-Craig, M. et al. "Superior Outcome of Females over Males after Brief Treatment for the Reduction of Heavy Drinking." *British Journal of Addiction*, 1987. In Press.

Sanchez-Craig, Martha. *Toward Client Choice in Treatment for Alcohol-Related Problems*, Alcoholism and Drug Addiction Research Foundation, Toronto, 1989.

Saunders, J.B. and O.G. Aasland. *W.H.O. Collaborative Project on Identification and Treatment of Persons with Harmful Alcohol Consumption: Report on Phase 1 Development of a Screening Instrument.* World Health Organization: Geneva, 1987.

Self-Care: A Review of the Literature, Information Technology Centre, Clinical Research Institute of Montreal, Working Paper, Health and Welfare Canada, December 1987.

Service correctionnel du Canada, *Programme de toxicomanie, Établissement Donna-*

cona, Cadre d'évaluation et revue des opérations, mars 1989.

Skinner, H.A. *The Drug Abuse Screening Test (DAST): Guidelines for Administration and Scoring.* Addiction Research Foundation, Toronto, 1982.

Skirow, Jan. *Primary Prevention: A New Approach to Adolescents & Alcohol.* Alberta Drug and Alcohol Abuse Commission, 1985.

Skirow, Jan and Edward Sawka. *Prevention Strategies: An Overview.* Alberta Drug and Alcohol Drug Abuse Commission, March 1987.

Simpson, O.C. et al. *Getting Well Again.* New York: St. Martin's Press, 1978.

Smart, R.G. and E.M. Adlaf. *The Ontario Student Drug Survey: Trends Between 1977-1989.* ARF, 1989.

Sobell, Mark B. et al. "Alcohol Treatment Outcome Evaluation Methodology: State of the Art 1980-1984." *Addictive Behaviors*, 12, (1987), 113-128.

Sobell, Mark B. et al. "Alcohol and Drug Problems." In A.S. Bellack, M. Hersen and A.E. Kazdin (eds.) *International Handbook of Behavior Modification.* New York: Plenum (in press), 1989.

Steele, R. and J. Oliver. *Prevention in the Drug Field: Instructional Motivational Strategies into Instructional Plans.* St. Francis Xavier University, 1989.

Strengthening Community Health Services: Framework, Issues and Strategies, A.H. Neufeldlt and Associates, Ontario, Working Paper, Health and Welfare Canada.

Sugarman, Barry. *Prevention's Big Opportunity: But Where is the Strategy?* Working Paper.

Therapeutic Communities for Addictions. George DeLeon and James T. Ziegenfuss (eds.) Springfield, Ill.: Charles C. Thomas Publishers, 1986.

The Self-Help Guide. Kriplau Center for Holistic Health, Lennox, Mass., 3rd Printing, 1984.

Travis, J. and R. Ryan. *Wellness Workbook.* 2nd ed. Berkley, Ca.: Ten Speed Press, 1984.

Truax, C.B. and R. Carkhuff. *Toward Effective Counselling and Psychotherapy.* Chicago: Adline, 1967.

Turcotte, L. *Projet de toxicomanie de Donnacona en collaboration avec le centre Portage*, Service correctionnel du Canada, 1988.

U.S. Department of Health and Human Services, Public Health Service, Centers for

Disease Control. Premature mortality due to alcohol-related motor vehicle traffic fatalities. United States, 1987. MMWR 37 (49): 753-766, 1988.

Vannicelli, Marsha. *Treatment Outcome of Alcoholic Women: The State of the Art in Relation to Sex Bias and Expectancy Effects, in Alcoholic Women.* Sharon Wilsnack and Linda Beckman (eds.) New York: Guilford Press, 1984.

Wallerstein, Dr. P.H. and Dr. E. Berstein. "Empowerment Education: Friere's Ideals Adapted to Health Education," *Health Education Quarterly*, 15 (4), Winter 1988, 379-394.

Wellness: Optimal Health and Longevity. Richmond, Va.: Time-Life Books, 1984.

Wilsnack, Sharon. "New Knowledge about Women and Alcohol: Implications for Treatment and Prevention." Plenary Session, Women and Substance Abuse: Strategies for the 90s. Winnipeg, Manitoba.

Yablonsky, L. *The Tunnel Back Synanon.* New York: Pelican Press, 1964.

Zimbardo, P. and E. Ebbesen. *Influencing Attitudes and Changing Behavior.* Reading, Mass.: Addison-Wesley Publishing Company, 1970.

Appendix

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