REPORT OF THE TASK FORCE ON THE REDUCTION OF SUBSTANCE ABUSE

VOLUME 2
BACKGROUND PAPERS

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HEALTH PROMOTION STRATEGY

BACKGROUND PAPER
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HEALTH PROMOTION STRATEGY

1. BACKGROUND

Health Promotion and Prevention Strategies are the core on which the Substance Abuse Strategic Action Plan is built. Health Promotion and Prevention are broad concepts which embrace and actualize many of the Core Values and Strategic Objectives of the Mission Statement of the Correctional Service of Canada.

Health Promotion, in the past decade, has been equated mainly with health education, health care, health administration or public health. Health Promotion programming targeted the individual and his/her lifestyle, and sought to curb rising sick-care costs by targeting unhealthy individual behaviours for change. Smoking, obesity, sexual promiscuity, and drug abuse were the major lifestyle behaviours targeted for change.

While the lifestyles approach to health promotion has undeniably scored some successes and found a place in our popular culture, the limitations of the individual lifestyle approach also became increasingly evident. Poverty, unemployment, social inequalities, lack of adequate social networks and community supports, acted as an overpowering barricade in making lifestyle changes impossible to achieve for a significant portion of the Canadian population.

There is recognition that neither lifestyles, nor the modern epidemic of chronic disease, as our population ages, can be viewed in isolation from the social, economic, industrial and political structures. The triad of the individual, family and community must be addressed holistically, and requires extensive support and policy development if we wish to make significant advances in reducing the problems of drug and alcohol abuse in our society.

Accordingly, to respond to current perspectives, Health Promotion has assumed a broader scope in order to accommodate these social, economic and environmental realities that we as Canadians face. Health promotion has been redefined to include all of the following elements:

> **"Health promotion 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 Task Force on the Reduction of Substance Abuse has adopted a Health Promotion and Prevention Model as a basis for the strategic action plan and program design to reduce drug and alcohol problems among offenders, from sentencing to warrant expiry in the community. Accordingly, the CSC must also consider policies and programming which shift from the individual offender and programs targeting only substance abuse to considering the broader social and environmental contexts in which these programs are placed.

Substance Abuse problems rank as the third leading health problem facing Canadians today, with alcohol by far, the first drug of choice among all age groups. Substance abuse problems and trafficking among offenders constitutes the greatest single problem the CSC faces within the institution.

The recently released CSC Contraband Control Study states that "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 reoffending if their substance use/abuse problems are not dealt with effectively".

The substance abuse problem appears to permeate all areas of the institution and community. This problem, 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".

In order to succeed in ameliorating this problem, the CSC must recognize that the substance abuse problem did not suddenly appear overnight despite is "discovery" by the media in recent years, but rather it has been a long term problem for generations, evolving over time from one drug to another.

Thus, to be successful the strategies employed must be implemented intensively over a period of time, have a sound theoretical base, match interventions which are effective with offenders, have appropriately trained staff, and ensure that the social and environmental support are available for the offender within the institution as well as the community. It is critical

that pre-release programming prepare the offender for reintegration into the community and prepare the community for the offender.

Policies and strategies aimed at reducing substance abuse require the support and commitment of all levels of the Service, over the long-term, and one should not expect a "quick and dirty" simple solution to a complex and pervasive problem.

If the support and commitment are not manifested by policy statements and action at all levels, then, the work of the Task Force may fall prey to the ever changing priorities and the burden on administrators to develop more programs to meet ever changing needs with shrinking resources.

2. A HEALTH PROMOTION APPROACH TO DRUG ABUSE PROBLEMS

The Health Promotion approach empowers communities to create a supportive physical and social environment by working with local, regional and national organizations to develop policies, create regulations and provide the necessary ingredients to implement and maintain the support system for a safe and healthy environment. Health promotion recognizes the importance of the psycho-social development process, and the role of self-esteem, and self-reliance in reacting positively to the daily challenges of life and the environment. Annex I outlines the conceptual model.

In addressing substance abuse problems from a community context, health promotion strategies focus on <u>demand reduction</u>, rather than expending the majority of energy and resources in <u>controlling the supply.</u>

In the context of institutional regulations and policies regarding the use of alcohol and drugs, the health promotion and prevention strategies should be coordinated in such a fashion that the <u>supply</u> and <u>demand</u> reduction policies support and reinforce one another.

The health promotion approach involves enabling communities to address the challenges of 1) reducing inequities within the system, 2) increasing substance abuse prevention efforts, and 3) enhancing the offender's ability to cope with inter and intra personal and environmental stressors which contribute to substance abuse problems.

To address these challenges and thereby increase the offender's ability to cope with his/her environment three basic mechanisms can be used: self-care, mutual aid, and the creation of healthy environments. Three strategies are proposed to implement these mechanisms: fostering of staff and offender participation, strengthening community and institutional health services, coordinating healthy community and institutional policy, and fostering consumer participation.

A) Challenges

1. Reducing Inequities

The challenge to reduce inequities is associated with factors such as education, gender and ethnicity which are articulated in the recently completed document on offender rights and privileges. This document indicates that offenders are entitled to equality; not only in the correctional process itself but also in the administration of the process.

The CSC is responsible for providing the best possible correctional services. Programs and opportunities must provide for the personal growth of offenders. The Service must develop as wide a range of sound programming as possible, in order to meet the needs of individual offenders.

Although offenders must be treated equally, access to substance abuse specific programming will be subject to the Service's assessment of the offender's risk to society and individual needs. Substance Abuse programming specific to the special needs of Aboriginals and women is being developed.

The document on offender rights and privileges is consistent with the Mission of the Service, and more specifically with Core Value 1 and 4.

> **"We respect the dignity of individuals, the rights of all members of society, and the potential for human growth and development."**
>
> **We believe that the sharing of ideas, knowledge, values and experience, nationally and internationally, is essential to the achievement of our Missions".**

2. Substance Abuse Prevention Strategies

The Task Force on the Reduction of Substance Abuse has adopted the "Conceptual Framework" on prevention strategies. In utilizing this model as a basis for a strategic action plan and program interventions, the creation of the necessary interlinking elements needed to foster and maintain positive health behaviours through the health promotion strategies will be facilitated.

The Prevention Strategies Paper in this document outlines in greater detail the components, targets, and activities of the influence, control, competence development and environmental design strategies.

3. Enhancing the Ability to Cope

The challenge to the Service is to develop and/or coordinate current programs which enhance the offender's ability to cope with everyday situations, through the development of a range of competencies such as literacy and vocational skills and interpersonal skills such as anger and stress management.

There are two types of coping resources: intrapersonal and interpersonal. Intrapersonal resources refer to the offender's personality, his/her self confidence, and self-esteem. Interpersonal resources refer to external resources, such as families, friends, and other inmates, volunteers and correctional staff at all levels.

Enhancing coping comprises three dimensions:

1. Equipping offenders, families and communities to cope with foreseeable transitions (physical, social, psychological or economical). For example, gradually and adequately preparing the offender and the community for reintegration by developing a comprehensive pre-release plan focusing on recovery and relapse prevention goals and referral to community programming which build on the skills gained, and ensure the availability of support systems;

2. Strengthening the offender's individual and collective capacity to deal with the number of physical and psychological problems which can accompany substance abuse problems; and

3. Enhancing and reinforcing the efforts of families and caregivers to provide a wide range of supports, including continuing care counselling and programming.

B. Basic Mechanisms

1. Self-Care

Self-Care is a process in which the offender is one of the primary resources in the prevention and treatment of substance abuse problems. 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 his/her own recovery.

All Service personnel, health care professionals, and correctional staff should encourage the offender to assume responsibility for developing positive health behaviours. Offenders should learn to exercise the following steps necessary to self-care:

1. Recognize lifestyle habits and their potential for the prevention and intervention of substance abuse problems;

2. Modifying lifestyle habits, which put the offender at risk of developing long term health problems;

3. Recognizing the signs and symptoms of a variety of health problems, and evaluating their positive or negative potential to their overall health;

4. Deciding on both the short and long term action to alleviate the problems when identified;

5. Access and actively participate in the program of their choice; and

6. Evaluating the impact of their program choice to their prevention or recovery needs;

Self-care implies individual confidence and the ability to manage one's overall health and life. It also implies that the offender should assume responsibility for his/her life, and be encouraged to actively participate in all levels of interventions necessary to regain or maintain health.

2. Mutual Aid/Self-Help Groups

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

Health and Welfare Canada (1987) defines mutual aid as follows:

> **"Mutual help (aid) occurs only when the helper and the person being helped share a history of the same problem. The essence of the process is mutuality and reciprocity. The helper may not be a peer in any other sense, or the person being helped, but he or she is a "survivor" who, having coped successfully with the problem has acquired a useful experience based on practical experience rather than special education (...) Moreover, the sharing experience benefits both the person being helped and the helper".**

Although there are a variety of formal program models for supplying mutual aid, self-help and mutual aid groups have received the broadest public attention. Mutual aid groups are defined as:

> **"Voluntary, small group structures usually formed by persons with a common purpose. The groups come together to provide emotional support and mutual assistance in "overcoming" a common handicap to a life-disrupting problem and bringing about desired social and/or personal change", Katz and Bender, (1976, pg.9).**

The following characteristics are common to most self-help mutual-aid groups:

* Common experience of members;
* Mutual exchange of help and support;
* The helper benefits by helping;
* Collective will-power and belief;
* Provision of information, education, anticipatory guidance; and
* Constructive action towards shared goals.

The formats and techniques used by self-help groups are wide-ranging and depend highly on the personal experiences and beliefs of the founders and members for what is needed and what works. Self-help groups, however, retain a certain structure and engage in similar basic processes. They have:

* An organizational structure;
* Election of officers;
* Devised special procedures for organizational continuity;
* Autonomy and are self-supporting; and
* Confidentiality of membership.

The basic activities common to most self-help groups include:

* Emotional support;
* Information and practical advice (in some cases sharing individually how they coped or dealt with a particular problem or situation);
* Direct services;
* Social activities; and
* Pressure group activities.

The basic processes shared by self-help groups include:

* The concept of universality;
* Acceptance of the problem;
* Hope that the problem can be dealt with;
* Sharing of experiences;
* Cognitive restructuring;
* Helper therapy;
* Role modelling;
* Vicarious learning;
* Desensitizing;
* Social comparison;
* Collective ideology;
* Empowerment; and
* Self-care and personal control.

Self-help groups must be distinguished from "self-care" which usually encompasses personal health care activities that are often carried out on an ad hoc basis in natural private settings, and it does not necessarily imply an organized purposeful approach involving mutual aid.

Other types of mutual aid include **mutual aid networks** which are not organized to the same extent as self-help groups; **didactic support interventions**, (therapeutic partnerships which deliberately create "buddy systems, peer helpers and peer leaders or tutors, one-to-one support provided by an indigenous lay companion, etc.); and **"support groups"** (a generic term encompassing a wide range of specific therapeutic modalities, such as disease management and psycho-educational groups, all of which feature the active involvement of professional and/or para-professionals and sharing and benefitting from like experiences by participants).

There is increasingly strong evidence from the research linking social support and social networks in a causal manner to the protection of health and the prevention or moderation of illness through both a "main effect" and a "buffering" influence.

Three major strategies for interrupting the causal link between stress and illness have been identified: 1) decreasing stressors, 2) reducing vulnerabilities, and 3) increasing social support. Although the concept of mutual aid comprises only one form of social support, its potential influence on health are believed to be unique and broad in scope.

By their very nature, self-help groups have two core preventative features: they provide a range of social support systems and they increase coping skills and repertoires through information and sharing experiences. Indeed, the processes and activities of these groups commonly encompass all identified types of social support, i.e. information, emotional, instrumental and appraisal.

Self-help groups such as Alcoholics and Narcotics Anonymous, Adult Children of Alcoholics, and Alanon, etc. have provided a necessary community link for the substance abuse and corrections field. Indeed, in many communities, these groups provide the only source of continuing support for those individuals and their families with substance abuse problems.

Self-help groups represent an important mechanism to assist offenders in coping with substance abuse and related problems, while, at the same time, promoting healthy behaviours. Methods must be found for incorporating informal helping approaches and mutual aid strategies into the planning mechanisms for substance abuse programming, **without coopting these resources as adjunct services under professional control, and without viewing these resources as a cheaper substitute for ongoing comprehensive substance abuse services**.

3. Creation of a Healthy Environment

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

The creation of healthy environments can be accomplished through the development of healthy practices within the correctional environment by providing offenders with improved living

conditions; by offering recreational services; by fostering mutual aid; by encouraging self-care in offenders; and by increasing the number and accessibility of social/educational vocational programs.

Due to the nature of the correctional environment, the Service is in a position create an environment that is supportive and conducive of change, providing opportunities for self-development, enhancing self-esteem, and personal growth.

C. Implementation Strategies

1. Fostering Staff and Offender Participation

The working definition of participation is "The individual and a collective action of people becoming involved in, and improving their community", Mary Powell, (1988). Involvement in a process of improving their community has two points, 1) a community needs a socially-engaged or socially-involved public, and 2) participation has its own intrinsic value and should be encouraged on this basis, as well as for any benefits it may bring in terms of community betterment.

Fostering participation in the context of the Service means the offender, the staff, and the community are working towards becoming more involved in, and improving their environment. It implies increased emphasis on involving all parties concerned with, or affected by the issue of substance abuse within the Service and the community. Active participation by the offender assists him/her to assert control over the factors which affect his/her overall health, and contribute to the stresses which increase the demand for drugs and alcohol.

By fostering offender, staff and community participation with those who had, in the past, little influence in shaping policy, the CSC can promote health and encourage community involvement. Giving a greater voice in shaping policy means actively involving offenders, staff and the community in decisions which affect them and their respective communities.

To facilitate the endorsement of any new program and the delivery of any service, CSC staff and community agency personnel and/or volunteers who deliver the programs and the offenders who are the consumers of the programs should be actively involved in their design and implementation.

Two main political and social implications need to be considered when fostering offender population. First, as fostering and encouraging participation at all levels involves giving more power to individuals, groups and communities, it therefore has the potential to create antagonism amongst those whose power is diminished.

This is particularly true of attempts to actively encourage demand reduction for substances. There are vested interests in maintaining or increasing the demand for drugs and alcohol within the institution and the community according to the CSC Contraband Control Study, "Importing drugs into institutions is perhaps, even more profitable than on the street", (...) there is an awareness of the high profit that could result from drug operations in the community whose sole purpose is to feed the federal institutional market". There will be enormous pressure applied by those who smuggle and sell drugs to actively subvert health promotion efforts as this will affect the total environment and any reduction in demand will affect the inmate economy. This may mitigate against many inmates becoming involved initially. Any action taken by the respective institutions will of necessity take into consideration the social cultural milieu of the institution and the rate of change the institution will support.

As staff, offenders and the community are actively supported and encouraged to participate in decisions that directly affect them, valuable skills are gained which will assist them in contributing to the institutional community, as well as the community at large.

2. Strengthening Community and Institutional Substance Abuse Services

CSC and community agencies already play an indispensable role in the prevention and treatment 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 the CSC becomes a major player in the substance abuse field, 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. Essentially, both the institution and the community serve the same constituency --the offender intervening in the substance abuse problem at different points in time.

The CSC must encourage and support increased 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:

- How effective is the existing level of communication and participation?, and

- How to improve communication and participation?

In strengthening both institutional and community substance abuse services, it is critical the CSC create a balanced coordinated continuum of services accessible to the offender, bridging the gap between the institution and the community. Such coordination is necessary to provide services to the offender in a timely cost effective manner. This objective, stipulated within the Mission of the Service, must continue to be actively pursued and mechanisms must be developed to enhance the communication and participation of the community and the institution.

3. Coordinating Community and Institutional Substance Abuse Policies

Policy development is a consensus on the ideas that form the basis of action in the field of substance abuse and underlies decision-making at the international, national (macro), provincial and municipal (meso) and the individual agency or institution (micro) levels.

A coordinated approach to the development of substance abuse policies at all levels require changes in orientation and focus, in ways of operating, and in the locus of power and control. Recent initiatives in the drug field, for instance, provide research opportunities to learn more about coordination when such programs cross both jurisdictional and sectoral lines.

> **"The process of developing healthy (community and institutional) policy is marked by complex conceptual and practical demands: that it be multisectoral and multidisciplinary; that its problems are multifaceted, that it view human activity in environmental and ecological contexts, and that it be participatory." (HWC, 1988:v).**

Coordination of community and institutions on substance abuse policies thus requires new arrangements between and within organizations. These will facilitate the needed communication and cooperation which are a prerequisite to the change process.

2

PREVENTION STRATEGIES

BACKGROUND PAPER
BY COLLEEN ALLAN

I HISTORY OF THE EVOLUTION OF PREVENTION IN THE SUBSTANCE ABUSE FIELD

The following paper is drawn extensively from the work of Jan Skirrow and Edward Sawka "Prevention Strategies An Overview," (1987, and Monograph I "Essential Concepts and Strategies," Health and Welfare Canada, (1986).

A. MANDATE FOR PREVENTION

As the narrow clinical concept of dependence has expanded to include a broader range of problems arising through the abuse of misuse of alcohol and other psychoactive drugs, the numbers of people affected becomes very large. In the not atypical case of Canada, about 10% of the adult population reported that they had experienced at least one of a range of problems related to their alcohol consumption over the previous year (Working Group on Alcohol Statistics, 1984). Research illustrates that substance abuse is enormously damaging to the health and well-being of users and their families. It also imposes a major financial burden on the community through lost productivity and expenditures for health care and social support.

Faced with an enormous drain on provincial and federal resources involved in treating substance abusers and their families federal government and provincial jurisdictions are investing resources in major prevention initiatives. Practitioners in the field recognize that the consequences of drug abuse develop over long periods of time and are supported, facilitated or condoned by existing values and institutions. If reduction in problem levels are to be achieved, comprehensive strategies and programs must be applied consistently over long periods of time.

B. MODELS OF PREVENTION

Prevention in the substance abuse field in Canada, although far from being a mature discipline, rests upon an increasingly substantial theoretical foundation. Great strides have been made in the prevention field towards a comprehensive strategic model that has as its cornerstone the concept of health promotion.

Until the early 1980's prevention practitioners employed a number of various strategies which involved a tremendous amount of various program initiatives, but without an underlying guiding conceptual framework.

Unfortunately, these initiatives were employed in a compartmentalized fashion. With the result that, within a given community, actions and strategies to reduce substance abuse problems resembled a "scattergun" or "smorgasborg" approach. Problem definition and the selection of interventions largely depended on individual prevention practitioners' assumptions concerning causative factors of substance abuse.

The United States' current position on prevention initiatives, the lack of a comprehensive theoretical framework,and the resulting frustration is illustrated in a quote from a recent paper of Dr. Barry Sugarman (1989) who states, **"Prevention of substance abuse has never received more overt recognition and support including financial than it now receives in 1989. Yet, unfortunately, we have no guiding prevention strategy that is based on research and widely shared."**

The evolution of prevention theory in Canada has resulted in a theoretical framework that has combined models on both theoretical and practical levels . It has become increasingly clear that the more complex our society becomes, the more necessary it is to build a comprehensive framework that facilitates the development of a mix of timely, appropriate and complementary preventative actions.

The following are direct excerpts from a paper developed by Jan Skirrow and Edward Sawka (1987) which outline the major prevention models, the current conceptual prevention framework that has evolved, their key principles, empirical foundations and the strategies each recommends with their individual strengths and weaknesses.

1. THE PUBLIC HEALTH MODEL

The modern era of addictions prevention began around 1950. It was based heavily on an approach begun well over a century earlier in the revolution that led to the creation of the field of preventive medicine and public health. It firmly established the public health model, at least until recently, as a basis for all prevention.

a) Structure of the Public Health Model

The classic public health model identifies a disease agent, a host for the disease, and an environment (or vector) through which the agent gets to the host. Together, these elements interact in a dynamic, ecological field. Health is seen in this context as neither fixed nor absolute. Rather, it represents an "adaptive balance" in which the host undergoes frequent change in response to other system elements. Thus, health status is seen as being relative, variable, and extremely complex in nature. It is always capable of shifting in the direction of either ideal health or death for any individual or population.

Diseases are assumed to follow a predictable, natural history consisting first of a period of pre-pathogenesis, followed by a period of pathogenesis, or manifest disorder in the host. The model advances the well-known three level continuum of prevention used in public health:

Primary Prevention - Usually involving a simplified health promotion concept (e.g., health education, inducements to proper nutrition, and support for a healthy family life) and specific measures implemented during the period of pre-pathogenesis (e.g., immunization, water purification, and protection from specific environmental hazards such as carcinogens);

Secondary Prevention - Essentially entailing case-finding for prompt diagnosis, treatment and disability limitation early in the period of pathogenesis; and

Tertiary Prevention - Largely comprising treatment and rehabilitation measures to control existing disease and to restore the patient's functioning during the later stages of pathogenesis.

b) Strategies and Impact of the Public Health Model

For primary prevention, three core strategies are identified as follows:

1. Removing the noxious agent, e.g. a virus;

2. Preventing contact between the agent and the host; and

3. Strengthening the host to increase resistance to the noxious agent, i.e. by immunization.

Most addictions prevention programs undertaken today continue to embody these core strategies in one form or another although different terminology, supporting rationales, and technology have evolved. Public health workers in industrialized countries have applied this knowledge and developed strategies and technology to realize a revolution in public health that has yielded progressive gains in overall health and longevity for the general population.

c) Limitations of the Public Health Model for Addictions Prevention

Addictions prevention workers have not been able to duplicate the dramatic successes achieved in public health. This has been due mostly to a limited understanding of the etiology of addiction, coupled with the assumption that addiction is essentially similar

to those conditions successfully attacked in public health. Other significant limitations are their failure to consider elements integral to addiction, but which were missing, or unimportant in the pioneering of public health efforts, or that may simply have been overlooked by historians attempting to reconstruct early experiences in the field.

These elements include: the underpinnings of drug use and abuse in characteristics of the individual, the social and economic structures which stimulate or discourage substance use, and the need for political action to effect the legal and institutional changes necessary for successful prevention.

d) Positive Impact of the Public Health Model

Working on the basis of the public health model, researchers have developed promising method of detecting incipient alcoholism based on widely available laboratory tests and such physical signs as trauma. Screening programs with heavy drinkers and medical patients have also been employed with some success (Skinner et al., 1984). Some prevention programs appear to be capable of producing "immunization" effects with young people by helping them to manage peer pressure more effectively and make more informed choices about whether or not to use tobacco and other psychoactive drugs.

2. SOCIAL SCIENCE (OR SOCIO-CULTURAL) MODEL

This eclectic model incorporates constructs and findings from psychiatry, epidemiology, and the social sciences. At the macro level, it rests mainly on the theory and research that attempt to explain the differential rates of alcoholism and alcohol problems exhibited by national and religious groups in various countries.

a) Structure of the Social Science Model

The model identifies socio-cultural factors that are considered to be key determinants of consumption patterns, and of problem rates. Of special interest are the norms and expectations that designated groups have regarding alcohol and drug use. For example, the model forecasts low rates of alcohol abuse problems in societies where group attitudes towards alcohol, drinking customs, and norms are unambiguous and understood by all. Particularly, lower rates are thought to be associated with clear prescriptions for moderate drinking and clear proscriptions against excessive drinking.

b) Strategies of the Social Science Model

1. **Integration of drinking practices** in order to make alcohol use an incidental part of routine social and family activities. This would include taking wine with meals and other so-called continental drinking customs.

2. **Removal of the mystique and ambivalence** that surrounds beverage alcohol which North American culture has historically associated with the initiation of young people into the use of alcohol and its effects. Thus, the model suggests that children should be introduced to alcohol in the home environment, the drinking age lowered, and alcoholic beverages made as readily available as any other commodity.

3. **Establishment an ethic of responsible drinking** in order to assist people in making informed choices about alcohol, and to achieve moderation by bringing their drinking under normative controls. Traditional drug education programs, as well as many of the newer lifestyle campaigns concerned with alcohol use typically concentrate upon this theme. This is especially true for programs actively supported by the beverage alcohol industry.

4. **Establishment of national drinking norms** through efforts to develop consensus at the community and national levels as to what constitutes acceptable and unacceptable drinking behaviours. For example, considerable effort has been devoted to mass media-based persuasion campaigns and community publicity programs intended to rally public opinion against impaired driving and drug use.

Much has been learned about the socio-cultural and environmental factors that mediate drug use and abuse. In North America, the social science model has recently dominated prevention efforts. Most attempts based on this approach are very broad in scope and endeavor to effect macro-level changes in society. For example, the liberalization of alcohol control policies in North America over the last 20 years draw their main supporting rationale from this approach. Currently campaigns against impaired driving "Saying No to Drugs," "Dialogue on Drinking," "Participaction," and "Drug Awareness Week" are also generally structured in accordance with this model.

c) Limitations of the Social Science Model

Although there have been some promising outcomes, the overall record of results of prevention efforts drawing inspiration and guidance from the social science model are decidedly mixed. The

model is open to a number of criticisms, especially with respect to the North American situation, including:

- It maintains the thrust for moderation, while ignoring the importance and pleasure, which is too often excessive, that North Americans attach to drinking.

- It promotes attitude change assuming that a behaviour will then change, but fails to explain fully the relationship between attitude and behaviourial change,or outline any resulting operational implications.

- Especially for alcohol the model seriously misrepresents the distinction between the visible **social** problems (e.g., public drunkenness, violence, and impaired driving) that result more from how alcohol is socialized than from anything intrinsic to the drug, with the largely **physical** problems (e.g., alcoholism, cancers, liver cirrhosis, gastro-intestinal problems and nutritional deficiencies)that are an inevitable result of the chemical effects of alcohol on the consumer.

On this last point, the beverage industry tends to view social problems, as noted above, as arising only from the inappropriate alcohol use. They are not prepared to acknowledge, it seems, the inevitability of the physical health problems mentioned.

d) Positive Impact of the Socio-Cultural Model

Although the health problems associated with heavy drinking may remain high, programs based on the social science model may be expected to achieve reductions of related social problems. Education and persuasion campaigns are highly favoured proponents of the model. There is a simplistic face validity to the assumption that provision of information and education are essential because they provide the basis for making informed choices. Information, when carefully structured and presented, serves the recipient in a number of ways. It may provide reassurance of the wisdom of current behaviour, enable self-monitoring against realistic standards, and inoculate against over-reaction in stressful situations.

3. DISTRIBUTION OF CONSUMPTION MODEL

The distribution of consumption or "single distribution" model considers alcoholism and its prevention from an empirical perspective. At its core, lie a set of statistical findings characterizing the drinking practices of large populations. The model developed from the pioneering work of the French

mathematicians, Sully & Ledermann, during the 1950's. More recently, attempts have been made to extend the model to other drugs.

a) Structure of the Distribution of Consumption Model

The model rests on a considerable body of empirical research regarding alcohol consumption in Western societies. Despite wide variation in per-capita intake of alcohol, and regardless of specific social drinking practices, alcohol consumption patterns show a striking similarity. All conform consistently to a single mathematical distribution : unimodal, highly skewed, and log-normal. It demonstrates progressively smaller proportions of heavier drinkers in the upper tail.

Ledermann hypothesized that two critical mathematical parameters of the distribution - the mean and the variance are very closely related. Thus, knowing a population's overall consumption level of alcohol (usually expressed as average, per-capita consumption) allows calculation of the variance. If the model is valid, the variance is a direct measure of the number of drinkers at each level of consumption and, in particular, the number of heavy, alcohol-dependent drinkers in the upper tail.

The main implication of the model for prevention is that, due to the invariant nature of the log-normal curve, heavy, at-risk drinkers cannot be considered separately from all other alcohol consumers in a society. The model suggests that any reduction in the drinking levels of the former group can only be accomplished within the context of an average reduction for the general population, thus the focus on mean consumption.

b) Strategies of the Distribution of Consumption Model

Rush and Gliksman (1986) state that: **"Restrictions on the availability of alcohol will lower the population's level of consumption, and in turn, reduce the level of damage."**

This proposition is a direct implication of the model and leads to specific recommendations for preventative action. These involve three related strategy groups:

1. Production and trade controls;

2. Distribution controls; and

3. Measures aimed at consumer behaviour which include controls on the price of alcohol, conditions of purchase, and on the methods of advertising and promotion.

Distribution controls typically involve regulating the manner in which the opportunity to obtain alcohol is offered to the public. These might include, for example, raising the legal drinking age, and establishing appropriate licensing and zoning regulations.

Although a number of specific actions are suggested the model concentrates on attempting to reduce per-capita consumption by manipulating tax levels to raise the price of alcohol substantially relative to disposable income. In addition to adopting a policy to increase the relative price of alcohol, supporters of the model also recommend that there be no further liberalization of existing alcohol control policies.
Prevention planners recognize the need for alcohol control policies as a necessary public health measure, but not as a moral imperative. Suitable control strategies must have a central role in a comprehensive addictions prevention approach. Provincial and federal governments are considering with renewed interest the prospect of raising additional revenues through higher alcohol taxes, and find the possibility of justifying this action with a health rationale quite attractive.

c) Limitations of the Distribution of Consumption Model

The distribution of consumption model has been quite controversial. Much of the debate has centred on whether the relationship between the mathematical mean and variance are as close as supporters have indicated. Tested against consumption data from numerous countries, the model has performed well enough to support a consensus that it has a reasonable degree of validity. However, there is sufficient variation in the actual distributions to prevent the model from predicting the proportion of heavy, at-risk drinkers with acceptable accuracy.

The model's biggest weakness stems from the fact that it is purely descriptive. It explains nothing about **why** people drink, how one person's drinking might be linked to another's or what causal mechanism makes it necessary to focus on a reduction of per-capita (average) consumption in order to reduce the incidence of heavy drinking.

From a primary prevention point of view, the model's traditional narrow conceptualization greatly limits its usefulness. Over-emphasis on the single distribution model may create a major impediment to other preventative approaches. Implementing control policies that restrict access and availability may trigger negative effects such as home production and "bootlegging" of the product.

d) Positive Impact of the Distribution Consumption Model

Supporting the distribution of consumption model is a considerable body of research showing a decline in the rates of alcoholism and liver cirrhosis following reductions in alcohol supply. This is observed even within groups so addicted as to be thought very resistant to these influences. Such changes have occurred in association with decreased overall consumption throughout the population following restrictions in supply during Prohibition or wartime, or even with quite modest increases in the relative price of alcohol. Similar effects have been observed in drug abusers when supplies of illicit drugs have become erratic or very expensive.

4. THE PROSCRIPTIVE MODEL

The proscriptive model takes a moral approach to alcohol and drug issues. It focuses on the physical, psychological, and spiritual hazards associated with the use of alcohol and other drugs.

a) Structure of the Proscriptive Model

Proscriptive approaches, especially those with a religious basis, tend to be "ascientific" in nature. Little or no supporting evidence of the correlates and determinants of drug use and abuse is either presented or seen to be needed. Abusive patterns are thought to arise because of a weakness in the individuals moral fibre.

b) Key Strategies of the Proscriptive Model

Supporters of this model generally favour the twin goals of abstention from use and prohibition of availability. The United States experiment with Prohibition from 1919 to 1932 was an attempt to implement a broad alcohol policy based largely on this model. During the 1950's and 1960's, prevention programs concerned with marijuana and heroin relied heavily on strategies of explanation, exhortation, and fear arousal in an attempt to discourage use of these drugs. Preventative messages indicating that "good" and "responsible" people don't drink and drive, or use illicit drugs, contain elements of the moralism that lies at the heart of the proscriptive model. This kind of approach is currently receiving much emphasis in the United States.

c) Limitations of the Proscriptive Model

The moralist has a rigid stand on abstinence. There is frequently a tendency to attribute all abuse problems to seductive qualities inherent in the drug and to trivialize or

ignore the contribution of both the user and the environment. The term "demon drum" emanated from the espousing of this model. These views are not consistent with the bulk of available evidence. Initiatives based on the proscriptive model have in practice often alarmed and alienated user groups. This has resulted in a loss of program credibility and in a fostering of hostile relations between users and authorities.

d) Positive Impact of the Proscriptive Model

The proscriptive model has an obvious, if not very useful, central validity. If a drug is simply not available, possibly as a result of harsh legal sanctions, it will obviously not constitute a problem.

However, attempts to implement programs based on the proscriptive model have demonstrated a propensity for producing unanticipated negative effects.

5. EVOLUTION OF PREVENTION THEORIES

It is recommended that treatment and prevention workers move from their "downstream" position of attending to drug problem casualties to a much more "upstream" position in the developmental chain of events that exist in leading to the emergence of substance abuse problems. This entails a shift in perspective away from seeing alcohol and drug problems exclusively within an individual-based framework, towards viewing them as enmeshed within the operation of larger social system components.

Consequently, treatment and prevention planners must look beyond individual-oriented solutions for substance abuse to consider important contributing factors in the environment, as well as access, availability and control. Interactions between the person, the community, and the substance must be considered and addressed.

Key program strategies that concentrate on the development of generic skills will enable the individual to respond flexibly to a variety of environmental hazards in a preventative sense. It also emphasizes the importance of relapse prevention skills.

One of the most attractive features of this approach is that rather than depending upon massive new programs, it depends more upon redirecting existing programs. It also reserves the key roles for parents, schools, and other mainstream social institutions.

There is a growing realization that the chances are indeed remote of finding single, simple solutions to alcohol and drug problems. The path of further development is increasingly clear: **We must adopt a "broad spectrum" approach to treatment and prevention and build a broad contextual framework that facilitates the development of a mix of appropriate, complementary preventative actions and treatment interventions and ensures the appropriate match with the selected target population.**

In order to develop a comprehensive strategic model, a number of issues in the substance abuse field require a shift in traditional thinking.

The following is a summary of the major concepts prevention practitioners will have to consider as the field evolves:

* From a mono-causal etiology to a multiple-causality view of addiction problems and mental disorders.

* From frameworks that ignore the person (in favour of a focus on the drug), or at best consider the individual in isolation to ones that view the individual in a state of interdependence (in a dynamic environment which includes many relevant facts besides drugs)

* From prevention programs based narrowly on the medical model and the narrow debate on social versus biological causation, to ones directed by broader behaviour and development models that focus on the acquisition of social skills, self-esteem, competence development and other generic behaviours in the prevention and treatment of addiction.

* From targeting individual (micro) and society-wide (macro) programs to targeting mid-range interventions involving individuals, small groups or organizations, and the community.

* From the assumption that prevention and treatment programs have single monolithic and positive impacts to the recognition that they produce multiple, subtle, and gradually evolving outcomes along with a range of unanticipated and frequently negative side effects.

II CONCEPTUAL FRAMEWORK FOR PREVENTATIVE ACTION

The following are excerpts taken directly from Monograph I "Essential Prevention Strategies (HWC, 1986)

A. VALUE OF A PREVENTION FRAMEWORK

The model that is developed should be broad based recognizing the deficiencies of current narrowly defined prevention theories. It should modify the weaknesses and build on the strengths; constructing a broad contextual framework that facilitates the development of an appropriate mix of complementary preventative treatment actions.

Such a framework assists in identifying the range of possible factors that may play a role in generating substance abuse problems. This provides addiction and prevention workers with the ability to undertake several prevention strategies either concurrently or sequentially, targeting specific components to be influenced.

The strategies undertaken may be for different but complementary purposes. The focus is clearly not on a particular drug or strategic approach, rather, it is on the individual's health behaviour and identifies the many factors that combine to determine that behaviour. The framework describes the interrelationships between the components and strategies and highlights the importance of each to the behaviour change process. It suggests that a prevention plan for a given community/institution which draws on as many of the strategies as possible in a carefully planned and coordinated fashion and takes into account the various individual and environmental factors, has the best chance of bringing about sustained behaviour change in a significant fraction of the target population.

B. DEFINITION OF PREVENTION AND HEALTH PROMOTION

Prevention as a Continuum of Intervention

Jan Skirrow (1987) states "Addictions prevention involves actions aimed at a defined target population and at the relevant physical and social environments. Despite weaknesses in the public health model, it remains that the largest existing societal system capable of undertaking broadly defined prevention activities is the mainstream health structure. In addition, there is an emerging belief that the fundamental causal factors for a wide variety of social or lifestyle-related problems are essentially

the same. If this turns out to be correct, then it is important that any comprehensive addictions model have points of contact with the existing public health model."

The definition of prevention utilizing the traditional health model is "Prevention can be described as anticipatory action taken for one or both of two purposes: 1) to reduce the possibility of an event or condition from occurring or developing, 2) to minimize the damage that may result from an event or condition. In the first instance, the event has already occurred or the condition has developed. The purpose of the action is to reduce its impact." (1985, HWC) Anticipatory action can take place at different points in time. It can occur before there is any indication of a problem. The three types of action referred to in the literature are primary, secondary and tertiary prevention. These concepts are also derived from the public health field.

Primary Prevention: Action taken prior to the onset of a problem event or activity. The target population in a given community is on a macro level where it is not certain who will develop a problem. It could also be in the shape of programming to prevent relapse and enhance recovery which would be at a mid-level in a community or institution.

Secondary Prevention: Action/prevention taken when the problem has become recognizable. The target group is more narrowly defined with experience suggesting that some of the members of the community/institution are likely to experience an increase in problems related to substance abuse if no intervention occurs.

Tertiary Prevention: Rehabilitation efforts to minimize the effects of a condition once it has occurred and to begin to restore health. This target group is very narrowly defined as already demonstrating pathology and requiring an immediate intervention.

Primary, secondary and tertiary should be conceived not as discrete, easily defined intervention points related to the development of a condition or concern, but rather simply as denoting somewhat fuzzy intervals along a broad continuum of interventions. It is useful to state these terms when developing addictions programming to assist in clarifying the intent of a particular intervention . It is assumed interventions identified under any of the three headings will be quite different in nature and level of intensity, but will have complementary objectives.

Prevention in the addiction field has moved within the last five years to encompass Health Promotion. The Employee Assistance Programs have gradually embraced the concept of a broad brush

approach to substance abuse in the workplace and a focus of assisting management to consider prevention strategies as part of a global health strategy. Many "Employee Assistance Programs" have been retitled "Health Promotion in the Workplace." They assist employees to deal with and relieve the stresses in their environment through alternative lifestyle management.

In the World Health Organization's Global Strategy for "Health for All by the Year 2000," the document proposed the "health field concept," a way of viewing health as a product of interactions between the environment, lifestyle, human biology and health care organization.

Health promotion involves encouraging improved personal health habits eliminating self-imposed risks, and enhancing the ability to cope particularly with the ineffective, distressing or destructive patterns of thought or behaviour - such as chronic anxiety, heavy alcohol or drug use, and family violence.

Far from being a synonym for "quiet endurance," coping is a positive active process. It means coming to grips with a situation, proving oneself a match for a task or challenge, and enhancing one's ability to cope both personally and collectively.

To enhance coping means creating a climate that supports interdisciplinary action and advocacy for needed environmental change, and it implies the development of coordinated policies that are supportive and conducive to change.

In the document "Achieving Health for All," mutual aid is presented as a key health promotion mechanism. The concept of mutual aid builds upon people's ability to define and address the problems that they share, to pool resources, and to take advantage of common opportunities. Individual insight and energy at once enrich and are enriched by the group process. The health field abounds with examples of mutual aid groups with the addiction field leading the way in terms of Alcoholic's Anonymous, Narcotics Anonymous, Al-Anon, Adult Children of Alcoholics , etc.

Voluntary groups can perform crucial functions in the addictions field in the communities and institutions. These include anticipating and responding to community and institutional needs, raising awareness of issues to be addressed, advocating for change, promoting tolerant attitudes and healthy lifestyles, and offering emotional and practical support that the more formal services cannot provide.

Applying the principle of mutual aid and voluntary service means examining and confronting those procedures that make it difficult for the formal organizations, agencies, institutions and professions to work with mutual aid groups and voluntary services towards common goals. The principle of mutual aid and voluntary services provides the cornerstone for which programming in prevention can be developed and implemented with all concerned and affected in a given institution or community, particularly at the grassroots level.

C. PREVENTION TARGETS

The traditional public health model poses that three types of action could be taken when carrying out any preventative effort.

1. The resistance of the host or person can be improved;

2. Action can be taken to decrease the virulence of the agent; and

3. A barrier can be created in the environment in order to prevent the agent from reaching the host. These three key factors of person, drug and environment can be considered as targets for preventative action in the drug field.

D. PREVENTION TARGET COMPONENTS

The major components of the person that research indicates influences abandonment of their use of drugs, and adoption of health are:

1. PERSON

KNOWLEDGE: Knowledge is the information that individuals possess about various substances and their effects. The individual is exposed to information related to the behaviour. If the information is comprehended and learned, knowledge about the behaviour will follow.

ATTITUDES: Attitudes refer to the way individuals feel about the if, how, when, and where particular substances should be used. The formation of attitudes is complex and influenced by many factors; the major ones being:

a) Knowledge, beliefs and opinions about the behaviour's consequences and payoffs;

b) Values regarding the importance of these consequences and payoffs;

c) Beliefs and expectations about their own susceptibility and vulnerability to the consequences of engaging in a negative form of the behaviour, as well as about the personal costs and likely benefits of adopting the positive form of the behaviour; and

d) Existing attitudes about drug related matters.

INTENTIONS: Intentions refer to individuals' plans to carry out particular actions. An intention to adopt a positive behaviour or abandon a negative one will be influenced by the attitudes towards the behaviour, social values and pressures, and legal sanctions.

SKILLS: Skills are the individual's actual or potential abilities to perform certain activities and whether the necessary resources, incentives and supports are available in the physical and social environment to assist in the performance.

2. THE DRUG

The key components of the drug are:

COMPOSITION: Composition refers to the pharmacological nature of the drug. This would include for example the purity of a particular substance or the percentage of ethanol content in alcohol.

LABELLING: The information that is contained on the label of the package such as warnings about hazardous use of that substance. Packaging is the container in which the substance or drug itself is made available. With respect to alcohol, in particular, the size of the bottle is especially important.

PRICING: Pricing refers to the cost of a particular substance. Pricing is determined by a variety of factors including demand, income, inflation, and in the case of alcohol, the revenue requirements of the province.

3. THE ENVIRONMENT

The social and physical environment plays 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. The key components of the environment that must be considered in the development of any behaviour change program are:

ADVERTISING/AND PROMOTION: Refers to a set of marketing techniques employed to encourage the sale of particular commodities e.g. the sale of alcohol, and the prescribing of drugs by physicians.

AVAILABILITY: Availability is the degree of difficulty involved in obtaining a particular drug.

PHYSICAL CONTEXT: Physical context is the actual environment within which a substance is obtained or ingested. In supporting behaviour change the range and type of physical facilities are important for encouraging and supporting healthy behaviour.

LEGAL SANCTIONS: Legal sanctions refer to the existing set of laws and regulations which limit the use of certain drugs and which proscribe the carrying out of particular activities in relation to specified drugs such as driving under the influence of alcohol.

* Legislation or powerful social norms concerning the acceptability or legality of a behaviour can also influence its occurrence. The nature, severity, speed and certainty of punishment for non-compliance, as well as counter-forces which encourage the behaviour will affect the success of such controls.

* Prevention planners and substance abuse workers should assess the effects of existing social and legal controls on the target behaviour and to consider ways in which the establishing of further controls might be used to motivate and sustain healthy behaviour.

SOCIOCULTURAL CONTEXT: The social environment within which substances are obtained or ingested. This includes the prevalent attitudes and norms regarding drug use including quality and quantity of drug use considered acceptable and the circumstances for such use.

* Economic and residential security is a realistic barrier to establishing healthy lifestyles if the person does not possess a basic level of economic well-being. Poverty and poor living conditions are among the greatest barriers to the adoption of healthy behaviours necessary to maintaining a proper diet, taking a responsible approach to alcohol and drugs, or managing high levels of stress.

* Social and family supports are particularly important. Health behaviour is to a large extent determined and maintained by the family and social networks which surround the individual.

* Prevention strategies intended to change behaviour which does not take this into account will not likely have much sustained success.

E. PREVENTION STRATEGIES

Once the prevention targets have been identified, key preventative actions or strategies become the final step in the process of developing a conceptual framework. The key strategies were identified by reviewing the relevant literature and organizing the relevant information into a conceptual framework. The following are the definitions of the types of behaviour change strategies which can influence the individual directly, or support and influence individual behaviour indirectly by changing the physical or social environment.

1. Influence Strategies

Influence refers to a variety of activities ranging from the provision of information and persuasion strategies to more structured efforts which attempt to modify individuals' attitudes in a certain direction. The strategies are targeted towards the individual: attempt to encourage positive health behaviours, and prevent negative ones through the presentation of relatively unbiased information. Awareness and knowledge is expected to provide the incentive to adopt a healthier lifestyle.

Persuasive strategies are also targeted directly at the individual and attempt to change attitudes and behaviour by presenting a message which is biased or emotionally loaded by the manner in which it is structured and presented. The message may convey information, but is designed to affect beliefs, opinions, expectations and attitudes.

2. Control Strategies

The control strategy includes those actions which encourage the enactment, revision or enforcement of legislation or regulations in order to modify a drug, its availability, or its demand. Behaviour can be modified by means of manipulating "rewards and punishments" which the organization/institution controls and which are critical to the target individual. The individual can choose not to comply however, but must bear the consequences of non-compliance.

The success of these measures depends on the importance the rewards and punishments have for the individual in question, how much control the manipulator has over them, and whether the individual in fact possesses the skills and ability necessary for compliance. If rapid change for a short period of time is necessary and resistance is likely, control strategies can be effective.

However, they are unlikely to increase commitment to the behaviour or lifestyle change in the long term. Thus, if other strategies are not in place to support the behaviour change the behaviour may drop off if surveillance is reduced, or if the consistency of the application of either the rewards or punishments declines.

3. Competence Development

Programs and activities within this strategy are intended to improve individuals' skills in order to enhance their self-esteem or their ability to cope with everyday situations. These competencies usually include such programs as decision-making, assertiveness, social, life skills, self-motivation techniques, as well as skills for coping with frustration and conflict, and for monitoring and interpreting the outcomes of personal behaviour
and the quality of the experience.

Competence development strategies are extremely important in changing behaviour. A persuasive strategy may successfully create an intention to assume a new health behaviour, but unless the individual possesses the skills to adopt and maintain it, the intention by itself is useless. When competence development strategies are combined with education and persuasion strategies, they become a crucial part of the change process.

4. Environmental Design Strategy

This strategy is concerned with improving satisfaction with, or reducing the stresses within an individual's relevant environments, in particular the workplace, school and community. The strategies do not focus on the individual, but are aimed at improving the environment in which the behaviours of interest occur. In order for sustained attitude and behaviour change to occur the environment must be supportive and conducive of the change. By providing facilities, services, incentives, security, and social supports in such a way as to create or allow a more supportive climate for adoption of healthy behaviour by the individual.

III MISSION STATEMENT, CORE VALUES AND GUIDING PRINCIPLES.

In April of 1989, the CSC introduced a document outlining its Mission, Core values, Guiding Principles, and Strategic Objectives. The purpose of this document is to provide guidance to all staff within the Service in carrying out their responsibilities. It is also intended to provide a focus when developing and implementing new strategies, policies and programs. The Mission document outlines the goals we are striving to achieve the fundamental ideals of the Service, and charts a course of action.

> **"The CSC as part of the criminal justice system contributes to the protection of society by actively encouraging and assisting offenders to become law-abiding citizens, while exercising reasonable, safe, secure and humane control."**

There is a requirement to ensure the CSC has a well-defined and articulated strategic action plan that will guide and direct substance abuse programming from sentence at the institutional level to warrant expiry in the community. The action plan should be guided by an overall strategic framework, consistent with its Mission statement, regional and demographic variations, and "state of the art" prevention and treatment programming in the substance abuse field. It is imperative to respect the essence of the Mission and its core values in generating and implementing new policies and programs.

The conceptual prevention framework that is presented in this document adopts the Mission statement and core values as its primary source of guidance, the nucleus of which is expressed by 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 grown 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 are the cornerstone of our endeavour.

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

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

IV IMPLICATIONS OF THE CONCEPTUAL FRAMEWORK FOR PREVENTION TO CSC STRATEGIC ACTION PLAN

Although CSC has a plethora of substance abuse programs throughout the various regions, there is a lack of consistency, coordination and an overall strategic framework to guide the development and implementation of prevention and treatment strategies.

If the goal of the Task Force is to develop a policy framework to **"To reduce drug and alcohol abuse among offenders within the CSC from the commencement of sentence at the institutional level to warrant expiry in the community,"** then the guiding framework adopted by the Service should have the potential to effectively guide the development of large scale prevention programs intended to influence health behaviours, both in the substance abuse and general health areas.

In utilizing the intervention model based on the Health Promotion Strategy as a basis for a strategic action plan and program design, the creation of the necessary interlinking elements needed to foster and maintain positive health behaviours will be facilitated. Considering the major shift in traditional thinking, and if the model is understood and applied appropriately, it will be difficult to accept the unimodal, unidimensional,isolated, mono-causal etiology prevention and treatment strategies that has plagued the development of substance abuse programming in the past.

Treatment programs that attempt to treat the substance abuser, irrespective of a global health perspective, have been doomed to failure. Relapse statistics attest to the dismal success rate of this narrow unidimensional unimodal approach.

The model also clearly demonstrates that the solutions to substance abuse problems are not the exclusive province of any one department or one profession, but rather to all segments of the Service and reflected in each respective institution. This allows all of the concerned groups and individuals, including representatives from the offender population, to identify the

unique role each might play in reducing the substance abuse problem among offenders at the institutional and community levels.

The acceptance of this responsibility by the CSC is embodied in the mission statement and the guiding principles of Core Value 1: **"As we respect the rule of law, we will respect the rights of all individuals - offenders, staff and those involved in the correctional process. We believe that respecting the right of all concerned individuals to be informed participants in the correctional process contributes to the quality of the process and of the decisions made."**

In designing preventative strategies to reduce substance abuse problems, each of the four strategies discussed previously might be successful in its own in bringing about specific behaviour change within the institution. However, research and experience has shown that these gains are short term and are not conducive to sustained long term behaviour change.

If the long term goal of the service is to successfully reintegrate the offender into the community, and ultimately reduce the risk of relapse, and if the return to substance abuse is highly correlated with the risk of re-offending, it makes imminent sense to design a strategy with draws on the strengths of each model in a carefully planned and coordinated fashion that is most likely to bring about sustained behaviour change in a significant proportion of the target population.

Since the different strategies complement and reinforce one another, they are thus best used in combination. If resource or time constraints limit program options, the model can help to clarify the effects of neglecting particular kinds of strategies. For example, if an offender lacks the competencies and skills to make the initial and/or maintain the behaviour change, information-education and persuasive strategies would likely have minimal effect on short term behaviour and a negligible effect on long term behaviour.

Another example would be the offender who possesses the information and skills necessary to maintain a given health behaviour, however, the environment is not supportive of the behaviour change. If the supportive environment is absent, then long term behaviour change would be very difficult to maintain. In this situation, resources might be more profitably directed towards improving environmental supports for the behaviour.

The respective institutions can be viewed as individual communities with their own values, social and cultural norms regarding the use, distribution of alcohol and drugs, an economic climate that is based on the proceeds of these drugs, and strong vested interests that wish to maintain the status quo. To return or attempt to treat an offender in an environment that is not conducive to positive behaviour changes, and indeed actively mitigates against them, is likened to returning a young offender with a substance abuse problem to a family with a rampant abuse problem, and reintegrating him/her into the school community where the drug dealers thrive. Strategies that are aimed at improving the environment make it possible, or at least easier for the offender to implement and sustain positive behaviours.

Assisting the offender to change to health behaviour requires a variety of various programs and strategies as described above.

Another example of complementary programs would be persuasion and education programs to assist the offender in understanding the nature of his/her problem and incentives to change his/her behaviour such as assertiveness skills to resist peer and social pressures to use self-monitoring skills to assess the motivations and rewards for his/her not using stress-management skills to cope positively with the pressures and stresses that arise from changing his/her behaviour, family counselling to ensure a supportive environment and social network and specific recovery relapse prevention plans that are developed and monitored.

A. OUTCOME GOAL OF HEALTH PROMOTION AND PREVENTION

The outcome goal of preventative action in the substance abuse field is the **"improvement of health (physical, psychological, social, and spiritual) through a reduction of substance abuse related problems."** The outcome goal of preventative action is directly in concert with the mandate of the Task Force **"to reduce drug and alcohol abuse among offenders within the CSC from the commencement of sentence at the institutional level to warrant expiry in the community."** If there is a reduction in drug related problems, the greater is the possibility of a lifestyle change that would preclude a return to criminal activity, and success for return to the community.

B. MODEL FOR SUBSTANCE ABUSE INTERVENTION AND PROGRAM PLANNING

In order to reduce drug and alcohol abuse among offenders at the institutional as well as to warrant expiry in the community, the programs and services provided must complement and be guided by a **"broad spectrum"** approach to treatment and prevention. The

framework should be consistent with a multiple-causality view of substance abuse problems, and within the conceptual framework, develop a mix of appropriate, complementary preventative actions and treatment interventions. See Annex I

The model is based on the conceptual model of prevention and the underlying principles of early intervention. The underlying conceptual model theorizes that individuals within a given community/institution experience various levels of severity with alcohol and drug problems and those individuals within each level will require different types and intensities of interventions.

The model assumes that unless comprehensive prevention strategies and treatment services/programs are available and accessible in varying degrees of intensity that:

1. Offenders at a particular level of severity are at risk of:

   a) progressing to a higher level unless there is action taken to avoid specific conditions and problems before they arise;

   b) further deteriorating in terms of their addiction.

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 use is advocated and supported.

3. Those offenders who are attempting to change their behaviour are at high-risk for relapse, due to the unsupportive environment.

With the development of a comprehensive range of services and complementary prevention strategies then:

1. The offender can be matched to the most appropriate, time and cost effective forms of interventions.

2. The services are provided in an environment that is supportive of and amenable to the behaviour change.

3. The rewards or punishments that are important or critical to the offender act as incentives for behaviour change.

4. The behaviour change is supported and maintained by the offenders family and social networks,

5. The offender is provided with the necessary information and skills to sustain and strengthen his/her behaviour change.

The Mission document states that the Service **"must provide programs and opportunities to meet the unique needs of the various types of offenders with whom we deal, to assist them in changing their criminal behaviour and to enhance their potential for successful reintegration with the community."**

Core Value 2 and Strategic Objective 2.1 state **"to ensure the needs of individual offenders are identified at admission and that special attention is given to addressing mental disorders."** Objective 2.3 states **" to ensure that the special needs of female and native offenders are addressed properly."**

In fulfilling the mandate of the Mission and accomplishing the Strategic Objectives 2.1 and 2.2, the accurate assessment of individual needs of the offender becomes paramount.

The initial screening/assessment at reception and the continuous assessment/reassessment of individual needs is critical to the initial prevention and recovery planning process, and ultimately to the reintegration of the offender within the community.

The initial screening and assessment process should be comprehensive and responsive to the offenders' individual and "special needs" as well as identifying other dependency problems and compulsive disorders. The screening and assessment would provide a data base of the prevalence, degree and nature of substance abuse problems as well as identify the health behaviours, social and environmental supports that would sustain the behaviour and assist in the change process.

Health Promotion and primary prevention strategies focus broadly on the institution they encourage and foster the adoption of health-enhancing behaviours. These strategies capitalize on identifying activities and programs that could be employed to strengthen the resilience, skills and abilities of offenders, and enabling them to cope effectively with life situations. The ability to manage effectively in a range of life situations is crucial to the behaviour change process in recovery. Character development, intellectual and physical competence, social and technical skills, ability to access and understand, and use information would be areas of interest to prevention programmers.

Health promotion and primary prevention activities and strategies can also act as a barrier in reducing the possibility of the offender becoming dependent,or further involved in substance abuse. Offenders who have been assessed as having a substance

abuse problem may not choose to attend a program that deals directly with their problem, but instead choose to access, or be referred to a general health program that ultimately may influence them to adopt positive behaviour change.

The attractiveness of health promotion and primary prevention programming is that it depends more upon the redirection, enhancement, and coordination of existing programming than on the development of massive new programming.

Primary, secondary and tertiary prevention programs should not be perceived as discrete, easily defined intervention points related to the development of a condition or concern, but rather simply as denoting somewhat fuzzy intervals along a broad continuum of interventions ranging from low to high intensity.

It is assumed the interventions identified under any of the three headings would be quite different in nature and level of intensity, but will have complementary objectives.

Referral to any of these levels would be based on the assessment of individual offender needs, and identification of a substance abuse problem requiring a specific level and intensity of intervention. Case management planning could then take into consideration the various priorities and timing of treatment interventions in a range of problem areas to ensure continuity of programming to the community level. Programs within each level would be developed or enhancements of current programs undertaken based on the research as to what constitutes effective treatment for which offender population.

Pre-release programming focusing on relapse prevention, knowledge and skills is essential to the short-term maintenance of a required behaviour change. Referral to a community program or agency, that matches the recovery needs of the offender and continues to monitor the recovery and relapse prevention plan,and assists the offender in achieving the short-term maintenance goals and objectives, is also essential to the recovery process.

The necessity of developing a range of long-term programs designed to assist the offender in maintaining the long-term behaviour changes is just beginning to be realized. Programs whose main focus is to assist recovering persons to develop and monitor ongoing recovery and relapse prevention goals and objectives are relatively few at present. However," while our obligation ends at warrant expiry, we must also prepare offenders to take advantage of community programs which may provide support beyond the Service's mandate," where they exist, and where possible, encourage their development if they do not exist.

3

S U B S T A N C E A B U S E

E D U C A T I O N

BACKGROUND PAPER
BY GERRY COWIE

SUBSTANCE ABUSE EDUCATION

This section of the report addresses the education component of the overall strategy for dealing with substance abuse. It is important at the outset to define what we mean by the term education for the purposes of this report, and to clarify the role of an education process in reducing drug and alcohol abuse among offenders.

Education is defined as: **"an interactive process which provides the offender with the knowledge and awareness to critically evaluate the impact of substance abuse on his/her lifestyle."**

This definition makes some important statements:

1. The interactive process is based on the concepts and principles of adult learning. Adult learners bring a wide range of experiences and motivating influences to a learning situation. Adults are not empty vessels waiting to be filled, but can, in fact, contribute significantly to the learning experience.

2. Education provides knowledge which can influence a person's attitudes, beliefs and intentions, and can affect behaviour. Skill 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 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 be able to critically evaluate the impact of substance abuse on his/her lifestyle. 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 influence an offender's awareness and attitudes towards substance abuse, and his/her willingness to take the appropriate action.

4. For offenders experiencing more 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. Education is, however, the important first step in influencing attitudes, beliefs and intentions, and can prepare the offender for other interventions as required.

TARGET AUDIENCE

There are essentially two target audiences for the education component:

1. All offenders upon admission to an institution. For these offenders, an outline for a reception/induction module has been developed; and

2. Offenders assessed as having substance abuse problems, and who require further intervention. For this group, key elements of an education component have been identified.

#I RECEPTION/INDUCTION MODULE FOR SUBSTANCE ABUSE

At the present time, delivery of a reception/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 audience of non-users, users, abusers and chemically dependent offenders. As a result of this review, the goal for a reception/induction module was established:

GOAL:

"To provide education and information on CSC policies and procedures and the effects of drugs in order to:

1. Influence offenders attitudes and intentions against abusing drugs and alcohol; and

2. Encourage participation in programs which address individual needs."

The "Getting It Straight" package only partially meets this goal; an outline which identifies specific objectives was developed and is attached as Annex "A".

#II KEY ELEMENTS OF AN EDUCATION COMPONENT

Within CSC today, there are many education programs in place. These may be stand-alone programs, designed strictly for educational purposes, or they may be part of a more comprehensive treatment program. They may also be delivered through contract, or by CSC staff. Some of these programs were assessed as being generally complete, and well put together. It was also noted that, during the review of both CSC and non CSC material, there was a high degree of consistency in the topic areas presented.

From the material available, a number of key topic areas were identified. These were developed into a selection of core topic areas, which should be made available to offenders assessed as being at high risk of abusing, already abusing or chemically dependent. Details of these topic areas are attached as Annex "B".

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

Finally, the importance of how to deliver the message cannot be overemphasized. It has already been stated that an adult learning approach must be adopted, and this is reinforced to the extent that the use of effective visual aids can be a significant asset to the presenter. The Education Sub-Committee was impressed with the education program on impaired driving, targeting the 15-17 year old age group, which was developed by the Task Force on Impaired Driving operating under the auspices of the National Health and Welfare, Health Promotion Branch.

The package consists of a series of short videos which were professionally developed after extensive consultation with several focus groups including the 15 - 17 year old age group. The videos, accompanied by a facilitator's guide, serve as triggers to focus discussion on selected topics.

While this particular package is inappropriate for the offender population, the effective and appropriate use of an interactive video developed with an offender population does have potential.

A N N E X "A"

SUBSTANCE ABUSE RECEPTION/INDUCTION MODULE

GOAL(S):

To provide education and information on CSC policies and procedures in order to: 1) Influence offender attitudes and intentions against abusing drugs and alcohol; and 2) Encourage participation in programs which address individual needs.

OBJECTIVES:

Upon completion of the modules offenders will be able to:

1. Describe areas 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.

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

The desired outcome of this module is that the offender will be motivated to examine his/her own personal situation regarding substance abuse and to be receptive to program opportunities.

Objective #1

"Areas in a person's life that are negatively affected by the abuse of drugs and alcohol."

Life-style components which should be emphasized include:

- mental health
- employment
- family
- physical health, including nutrition and infectious diseases such as AIDS
- spiritual/cultural
- social

Objective #2

"CSC policies and procedures that address the use of alcohol and drugs."

Offenders should be given a clear understanding of the CSC's and of the Institution's policies with respect to drug/alcohol use, and the disciplinary and/or legal consequences.

Objective #3

"Links between substance abuse and criminality, violence in the institution, and re-integration into society."

Offenders should understand that CSC policies on substance abuse are based on the linkage between substance abuse and criminality. CSC's Mission of encouraging and assisting offenders to become law-abiding citizens means that, if substance abuse is related to criminality, it must be addressed.

Objective #4

"Personal and social consequences of using/not using drugs/alcohol in prison."

Using or not using drugs or alcohol in an institution will have a number of possible consequences to the offender and his/her family.

- the possible impact on family visits, temporary absences, socials and open visits, and its resulting effect on the family
- how well, or how badly, he or she does time
- possible impact on release plans
- possible muscling, debts, pressure on family
- labelling by staff and other inmates

Objective #5

"Treatment program opportunities available to offenders, and how to get involved."

Offenders should be aware of the following:

- programs available and their prerequisites
- procedures to access the program
- names of contact persons
- their responsibility to take the initiative
- CSC has a responsibility to provide opportunities and encourage participation in programming

TEACHING OR LEARNING APPROACH

1. To maximize the value of the session, and wherever possible deliver the module after the inmate has completed the Computerized Lifestyle Assessment.

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. A handout(s) in language understood by offenders to summarize salient points should be provided.

7. The delivery of the module and written materials/exercises must be in a language easily understood by offenders.

8. At the end of the session, offenders should be encouraged to review the results of their Computerized Lifestyle Assessment, and ask themselves honestly, if they might have a problem. They should then be asked "if they do have a problem, what are they going to do about it?"

A N N E X "B"

KEY ELEMENTS OF AN EDUCATION COMPONENT

1. Values and Attitudes
2. Drugs and Alcohol - Their effects on the individual
3. Profile of an Abuser
4. Social Issues
5. Family
6. Recovery and Relapse
7. Treatment Resources

#1 VALUES AND ATTITUDES

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

OBJECTIVE: To provide the offender with an understanding of society's responses to the use and abuse of substances.

Discussion should include such topics as attitudes towards drinking and society's formal and legal responses, for example, prohibition and impaired driving legislation.

At the end of the session participants should be able to respond to such questions as:

What values did parents, teachers, and significant others try to impart while they were young?

To what extent are they still influenced by these early values?

What impact does advertising have on drug and alcohol abuse?

What are the main reasons for drinking or using drugs?

#2 DRUGS AND ALCOHOL

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

OBJECTIVE: To provide offenders with knowledge and understanding of the following:

- drugs and their classifications
- the physical effects of drugs and alcohol
- the psychological effects of drugs and alcohol

At the end of this session participants should be able to respond to such questions as:

What are the major drug groupings?

Does the use of opiates cause dependence or addiction?

What are the long and short term effects of amphetamines?

What is the impact of mixing drugs, for example sedative-hypnotics with alcohol?

#3 PROFILE OF AN ABUSER

The road to alcoholism and drug dependency is a progressive one with various signs along the way, which indicate the stages of a developing dependency. It is important that offenders recognize these signs, in order that they be in a better position to assess their own history of use/abuse and possible dependency.

OBJECTIVE: To familiarize offenders with the progressive nature of substance abuse problems.

The following topic areas should be reflected:

- signs and symptoms
- tactics and defence mechanisms
- denial
- concepts and theories

- attitudes toward authority
- stages and events in the development of a substance abuse problem
- risk-taking behaviours
- personal history of abuse (Computerized Lifestyle Assessment can serve as a useful tool for this purpose)

At the end of the session participants should be able to answer such questions as:

What are some of the signs of a dependency?

What are the indicators which tell someone, he/she is on the road to developing a chemical dependency.

Where do I see myself in the progression toward chemical dependency.

#4 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.

OBJECTIVE: To provide offenders with the knowledge of the interactive effects of substance abuse on an individual's social and interpersonal relationships.

Issues to be covered include:

- impact on lifestyle and environment
- importance of appropriate use of leisure time and relaxation skills
- concept of balanced living
- impact of peer pressure on an individual, and how to deal with it
- alternatives to drug use
- AIDS as a social issue

At the end of the session participants should be able to answer such questions as:

What are the indicators that tell you substance abuse is affecting your job?

How does peer pressure influence me to use drugs? What can I do to avoid this?

How has substance abuse affected my relationships with my friends?

#5 FAMILY

This area deserves special consideration. The family plays a significant role in the life of an alcoholic, as the alcoholic plays a significant role in the lives of family members.

OBJECTIVE: To illustrate the effects of the dynamics of substance abuse on the family system.

Specific topics to be covered are:

- significant others (spouse, parents, siblings), and their relationship with someone who is chemically dependent
- adult children of alcoholics
- co-dependency
- family violence/sexual abuse
- grieving process

At the end of the session participants should be able to answer such questions as:

What are some of the enabling behaviours of the spouse or parent which may unwittingly support problem drinking or drug use?

What can I do to help my family help me to stop abuse drugs and/or alcohol?

Am I a product of a chemically dependent family and how has this influenced my life?

Why is chemical dependency considered a family disease?

#6 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 - they can recover!

OBJECTIVE: To introduce participants to the concepts of recovery and relapse prevention.

The following topic areas should be included:

- the process of recovery in progressive stages (e.g., admission, surrender, acceptance, conviction)
- the development of personal recovery plans
- the concept of relapse
- the progressive stages of relapse (warning signs)
- goal setting and planning to prevent relapse
- the importance of health and wellness in preventing relapse (nutrition, infectious diseases, physical fitness, mental health)
- coping skills to aid in prevention relapse, including:
    - stress management
    - self-esteem
    - assertiveness
    - problem solving techniques
    - self-awareness
    - communication skills
    - building and maintaining relationships
    - coping with anger, resentment, frustration

At the end of the session, participants should be able to answer such questions as:

What are the stages of recovery?

Why is it important to have recovery goals and a specific plan?

What are my personal recovery goals, and what are the steps, I can take to achieve these goals?

What is an example of a nutritious meal?

What are the coping skills I need to develop, and what programs are available to assist me in developing these skills?

#7 TREATMENT RESOURCES

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

OBJECTIVE: To introduce offenders to the scope and means of referral for substance abuse programs/resources available within institutions, CSC community, and the community at large.

The following are examples of resources which should be identified:

- CSC based treatment programs
- treatment programs offered in the community
- self-help groups (AA, NA, etc.)
- pastoral counselling
- bridging programs

Once the resources have been described, time should be devoted to providing guidelines and information on the referral process, and how the offender is able to take advantage of the programs offered.

At the end of the session participants should be able to answer such questions as:

How do I access these programs?

What program is best suited to my needs?

IMPORTANT CONSIDERATIONS

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

2. 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 program can enhance an offender's ability to think and reason, and therefore is viewed as an ideal program for those offenders to take prior to education sessions on substance abuse.

3. 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 a lone" module, of strictly 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.

4

REPORT OF THE ASSESSMENT SUB-TASK GROUP

BACKGROUND PAPER
BY LIZ FABIANO

REPORT OF THE ASSESSMENT SUB-TASK GROUP

The assessment sub-task group was originally provided with the mandate of examining the role and nature of assessment in the framework to reduce drug and alcohol abuse among offenders within the Correctional Service of Canada. An initial review of the mandate resulted in the development of a number of sub-objectives:

1. To examine the types and purposes of substance abuse related assessments;

2. To examine when, where, how and which type of assessment should be conducted in the process of incarceration from reception to release;

3. To examine how assessment of substance abuse fits into the overall assessment of an offender's risk and needs level and the preparation of an offender's treatment and aftercare plan; and

4. To examine and/or develop linkages between assessment, outcome research and process evaluation.

The establishment of these objectives initially prompted the group to move in the direction of identifying and evaluating the large number of independent self-report assessment measures available within the addictions field. However, in our review of the original sub-objective, that of examining the purpose of the substance abuse assessments, it became very evident that the key issue was to examine, **what is required within the CSC with respect to assessment, what is available, and what is it that we hope to achieve with respect to assessment.**

The need to provide adequate treatment to offenders, based on their needs, gives rise to the need for an assessment procedure which 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 to prescribe an appropriate and effective treatment plan. What is also required is a means of determining, based on offender needs, the types of substance abuse programs that should be developed or that are required within the CSC.

Currently, there is a lack of strong physical evidence supporting any particular form of treatment for both offender and non-offender populations. There is a realization, with respect to substance abuse, that there are many different kinds of alcohol and drug problems among users. The current thought about treatment and goals is that multiple types of alcohol and drug problems require matched treatment (Lightfoot and Hodgins, 1988).

A number of studies have demonstrated that when individuals are "matched" to treatment on the basis of a variety of factors, improved outcomes are observed (Lightfoot and Hodgins, 1988; Annis and Chan, 1983). In fact Annis and Chan (1983), have shown in their study, that indiscriminantly applied treatment may not only be ineffective; it can actually have negative effects on the future well-being of participants.

In essence, it was determined that what is required within the CSC is a comprehensive assessment procedure which would provide the Service with information on the prevalence of drug and alcohol dependency problems among incarcerated offenders; the relationship between an individual's drug and alcohol abuse and their criminal behaviour; and a means to identify factors predictive of an offender's treatment prognosis (Callahan, 1987).

Traditionally, within corrections the assessment of substance abuse problems was based on self-report. In other words, offenders were identified as alcohol and/or drug abusers on the basis of whether they admitted to having a problem with drugs/or alcohol. With the development of offender classification systems, and most recently, with the introduction of Case Management Strategies, additional information is gathered with respect to the offender's use of drugs and alcohol. This information, while somewhat limited, is used to identify whether an offender has a substance abuse problem and whether or not intervention is required with respect to drug and/or alcohol. The information gathered does not, however, provide us with any information about the extent and nature of an offender's drug and alcohol use or, to what extent it is associated or contributes to his/her crimes. While we may ascertain some information with respect to whether offenders were intoxicated on drugs and/or alcohol when they committed these crimes, we do not know whether they were more impaired than usual at the time; their perceptions of whether and how substance abuse affected their criminal behaviour, or whether offenders commit crimes when they are <u>not</u> impaired (Callahan, 1988).

While there are a number of assessment instruments and assessment batteries available, some of which are described in Appendix I, the majority of these instruments are specific in nature, i.e., they assess alcohol dependency, or drug dependency, they do not assess both.

More importantly, they do not provide information on how their abuse of drugs and/or alcohol relates to their criminal behaviour. Current offender surveys and assessment batteries do not provide information with respect to the relationship between

the crimes offenders commit and the types and patterns of substance abuse, or on how an offender's prior criminal background may relate to patterns of substance abuse (Callahan, 1987).

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 offender's drug and alcohol use problems. According to Callahan (1987), key issues include:

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

b) Whether or not the crime was related to the purchase or distribution of drugs;

c) 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

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

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

a) Pertinent social and demographic information; nature and extent of alcohol/drug use; history of use; current pattern of drug use; and degree of dependence.

b) 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.

c) Client personal resources and potential social support systems.

d) Client treatment preferences.

Each of these components are incorporated in the eleven sections of the Computerized Lifestyle Assessment Procedure developed by the Ministry of the Solicitor General of Canada and the CSC in 1988. The Lifestyle Assessment Procedure is the first comprehensive assessment procedure of its kind designed specifically for use with an offender population.

The key purpose behind the development of this instrument was to obtain information about the extent and nature of offenders' drug and alcohol problems in order to assess the need for drug/alcohol treatment programs, and to guide future program development. Specifically, in identifying and determining the seriousness of an offender's alcohol/drug problem and, through the provision of feedback reports for the offender and case management, the instrument allows case management to implement an appropriate treatment plan.

The information that will be gathered with this instrument can also be used to identify offender typologies that will assist in the development of new substance abuse programs. Programs can then be designed to target specific treatment needs in a more comprehensive and systematic manner.

A large body of research has confirmed that there is a strong association between drug and alcohol abuse and criminal behaviour. Surveys of offender populations have revealed that drug and/or alcohol use precedes the criminal acts of a high proportion of offenders. Moreover, many drug or alcohol abusing offenders have related problems which interfere with their ability to behave in a socially appropriate, <u>non</u>-criminal way. Data have also indicated that generally, a very low proportion of incarcerated offenders with these type of problems, receive adequate treatment (e.g., Ontario Offender Population Survey, 1989).

Accurate information on the magnitude and nature of drug and alcohol problems among Canadian federal offenders is unavailable. Generally, information on the incidence of drug and alcohol problems among offenders is based on U.S. data. The only^R

information available on the incidence of abuse among offenders is from a sample of offenders in the Ontario Region (Lightfoot and Hodgins, 1988).

Based on the above, the objectives of applying the Lifestyle Assessment Instrument within the CSC are as follows:

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

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

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

d) To provide information on treatment relevant characteristics of newly admitted federal offenders which can be used to develop offender "typologies" which in turn will aide in the development of meaningful treatment programs. (Lifestyle Assessment Manual, 1989)

Figure I graphically depicts the objectives listed above. As we can see in Figure I, the instrument is intended to serve two primary functions. The first is to provide an individualized front-end assessment capacity. This assessment will provide both the offender and the Case Management Officer with feedback which identifies the specific needs of the offender who in turn can be placed in already existing programs. The second primary function of the instrument will be to collect a database of information (descriptive data) which can then be analyzed and used to develop a number of offender typologies (based in part on degree of abuse, nature of abuse and other needs). Once these typologies are identified, new treatment programs can be developed or existing programs enhanced to meet the needs of the various groups identified. With limited resources available for new programming, such information is essential for program managers to make decisions regarding whether or not additional or new programs are needed, how large a population a program needs to serve, and what types of programs are needed.

In essence, the Lifestyle Assessment Instrument will provide the Service with the kind of comprehensive diagnostic information required to develop a cost-effective treatment service delivery model for the CSC. An example of the type of service delivery model that can be developed with the use of the Lifestyle Assessment Procedure, and an explanation of how it can practically be used within the CSC, is outlined in the Lifestyle Assessment Procedure Manual (1989).

CONCLUSION

Clearly, the research literature in the area of substance abuse suggests that the most productive thrust for the development of substance abuse treatment within the CSC is to provide for the assessment of offenders so as to develop Offender Substance Abuse Treatment typologies which can be used to match offender types to treatment.

It is recognized that, while the Lifestyle Assessment procedure represents the most appropriate tool for the correctional environment which is readily available to the Service at this time, the current body of knowledge in this area is rapidly expanding as the result of vigorous efforts by the professional community to improve assessment methodology through the application of research and evaluation techniques.

Note:

Contained within Appendix I is a cursory review and outline of some of the most popular substance abuse assessment instruments, specifically the ADS, DAST, Assist-I, Modified Mast. Two of these instruments the Alcohol Dependence Scale (ADS), and the Drug Abuse Screening Test (DAST), are contained in their entirety within the Lifestyle Assessment Procedure.

A drawback to administering a number of independent assessment instruments is the fact that the interpretation of assessment is the fact that the interpretation of assessment findings and psychological tests can often require a high level of knowledge and experience, often characteristic of only professional staff, e.g. registered Psychologists or Psychometrists.

APPENDIX 1

SUMMARIES OF ASSESSMENT INSTRUMENTS

The Alcohol Dependence Scale (ADS)

Is a 25 item self-report scale which assesses the severity of alcohol dependence on these dimensions: 1) loss of behavioural control, 2) psycho-perceptual withdrawal symptoms and 3) psycho-physical withdrawal symptoms and obsessive-compulsive drinking style.

The Drug Abuse Screening Test (DAST)

The DAST is a brief instrument for clinical screening and treatment evaluation. This is a 20 item scale which yields a quantitative index of the degree of consequences related to drug use.

The Modified Michigan Alcoholism Screening Test (Modified Mast)

Is a behavioural scale assessing the responsible use of alcohol beverages of adults and adolescents. 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 (ASSIST-I)

Is a structured interview format modified for use with incarcerated offenders from an instrument developed by the Addictions Research Foundation. It is a comprehensive psycho-social assessment interview. It was designed to ensure that a standard set of questions would be posed to each assessed offender, in order to provide a comprehensive picture of their alcohol and drug use history, and the types and severity of problems experienced, particularly those problems that appear to be associated with alcohol and drug use.

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5

UNIT MANAGEMENT

Unit Management

Unit Management is the correctional model chosen by the Correctional Service of Canada to manage it's offender population.

> Unit Management "is a decentralized approach to inmate management. It uses smaller, more manageable units and emphasizes extensive interaction with inmates. (...) In Operational terms, the Unit Management system divides an institution into small units centred on an inmate-housing unit, related static security posts and specified program functions." (Info. package, 1988:2)

Unit Management ensures that all aspects of correctional operations (security and case management) are the responsibility of one manager, that the lines of authority are well-defined, that decision-making processes are delegated to the unit level (when possible), and that extensive interaction between the staff and inmates exists. Team work between all staff is an integral element of Unit Management. Case management, security and programs should be integrated at the font line and administrative levels.

In terms of substance abuse identification and treatment-intervention strategies for offenders the key will be that all correctional team members, which include correctional officers, health care staff, psychologists, volunteers, chaplains, contract staff and all staff who have personal interaction with inmates, be knowledgeable about the case management process, the intervention strategies identified and their role in relation to working with offenders with substance abuse problems.

Unit Management can and must create an environment in our institutions where all our staff relate meaningfully with offenders, especially those with specialized needs such as substance abuse problems. This environment must encourage and support an offender in addressing his needs, and promote a safe and humane but also human and positive atmosphere conducive to treatment and effective interventions with offenders.

It should be stressed that identifying substance abuse problems and consequently effective intervention strategies will require meaningful face to face interactions between staff and offenders. Although the degree and frequency of contact may vary, the requirement of all correctional staff to be knowledgeable about the intervention strategies is critical. It must be stressed that a multidisciplinary approach, which includes involvement by all staff regarding substance abuse intervention, is seen as essential. The success of this process and the contribution it makes to achieving the Mission for the Service is directly linked to the quality and regularity of applying the intervention strategies developed for use by staff with offenders who have an identified substance abuse problem.

6

SECONDARY INTERVENTION PROGRAMS

BACKGROUND PAPER
BY COLLEEN ALLAN

SECONDARY INTERVENTION PROGRAMS

EVOLUTION OF SECONDARY INTERVENTION PROGRAMS IN THE ADDICTION FIELD

I BACKGROUND

As outlined in the Treatment and Education sections of this report, jurisdictional mandated agencies began developing in the late 1940's. The ideology of these treatment centres were derived from the principles of Alcoholics Anonymous, and involved short-term residential approach to treatment; heavy reliance on paraprofessional staff who themselves were "recovered" alcoholics; education in the disease concept of alcoholism; abstinence as the only acceptable criterion for a successful outcome; group and individual counselling to confront "denial" of the seriousness of the problem, and to assist the person to become comfortable with an abstinent lifestyle. The length of the program was approximately a month long residential treatment followed by frequent aftercare meetings and attendance at meetings of Alcoholic Anonymous.

In the late 1960's and early 1970's, the Continuum of Care Concept evolved from the recognition by many treatment centres that the addictions field had focused upon 15% of the alcoholic population, namely, the hard core, chronic, or late stage alcoholic who were typically male, and identified with the skid row stereotype. This target population required a highly structured type of intervention with particular emphasis upon the rehabilitative aspects of treatment.

While continuing to meet the needs of the chronic late stage alcoholic, the field expanded its treatment alternatives to include substance abusers, as well as the hi-risk population. New target populations such as women, youth, native and elderly required a multi-modality treatment system that incorporated a range of service functions and a multidisciplinary approach to treatment.

Consequently, although necessarily limited by cost-effectiveness considerations, substance abuse treatment has become increasingly multimodal and multidisciplinary. A comprehensive system of services is essential if the varying treatment needs of substance abusers are to be met. This comprehensive system of services includes at least the following: Detoxification, inpatient rehabilitation, out-patient services, including clinic, day hospital, and partial hospital services, family treatment, aftercare and short and long term residential or supervised living services.

The following is an outline of the services that should be available, within a given region for persons who have been identified as being hi-risk or experiencing a low to medium degree of dependency on drugs and/or alcohol.

A. TREATMENT MODALITIES

1. Detoxification

Research over the past decade has continued to show that detoxification can be accomplished in a variety of ways. Depending on the severity of withdrawal, the course of detoxification may be managed either medically or nonmedically.

a) **Medical Detox** - It is generally accepted that clients experience severe withdrawal symptoms and patient suffering from coexisting illnesses such as serious cardiac disease, hypertension, seizure disorders and over-psychotic reactions will require medical management of the detoxification process.

b) **Non-medical or Social Setting Detox** - For clients experiencing mild to moderate withdrawal symptoms, without coexisting medical problems, however, numerous studies suggest that detoxification may be accomplished safely, in a nonmedical setting, and without medication.

2. Short-Term Rehabilitation

Short-term rehabilitation programs provide the opportunity for intensive education, counselling, and self-evaluation with regard to the process of addiction. Traditionally, they have been residential in nature, approximately 28 days in length, and were thought to be the only way to treat addiction problems. However, with emerging populations of a younger and more stable (socially, financially, occupationally, and familially) clientele as a result of early case finding, and intervention efforts, the need for full residential functions are being reduced with an increasing requirement for **non-residential and day and evening programming.**

Residential, non-residential, day and evening programming usually consists of educational sessions in the form of lectures, films, and discussion groups on a number of topic areas such as the medical aspects of addictions, relapse prevention, and communications. Programs usually provide patients with individual and group counselling as well as orientation to AA and NA philosophies and practices.

3. Out-Patient Programs

Out-patient programs can serve to complement the initial learning and lifestyle changes that have taken place during the short-term program Secondly, these programs can serve the hi-risk, early,

and middle stage addicted population, who are still employed and functional in the community, and in many cases still living in, intact family situations.

4. Continuing Care Services

It is widely accepted among treatment professionals that continuing care is a critical component of a comprehensive alcoholism treatment service. It is considered essential because of the relatively long period of recovery that many persons appear to need, and the high probability of relapse noted among alcoholics who leave treatment early.

Continuing care, however, is often poorly developed. Many practitioners in the addiction field often do not differentiate between the primary treatment issues and the issues which emerge as a result of the developmental process of recovery.

Consequently, counsellors may see issues in terms of resistance and denial, rather than assisting the client to adjust and disengage from their destructive lifestyle patterns.

B. TREATMENT METHODS

Most treatment centres in Canada offer education, individual and group counselling, psychiatric and psychological services.

1. Education

The education component of many addiction treatment centres consist of a series of lectures on the disease concept of alcoholism, issues in sobriety, relapse prevention, films, discussion groups, tapes and assigned readings.

The education components of addiction treatment interventions according to Miller, (1985) have proven ineffective in changing drinking and related behaviours. In the past five years, however, the Health Promotion approach to addiction treatment has been adopted by many addiction agencies. The implications of adult learning techniques to addiction treatment have been examined and many treatment centres have developed their education modules to reflect this orientation. For a further explanation of this approach please refer to the section on Education in this report.

2. Counselling and Psychotherapy

Although individual and group counselling and some form of "psychotherapy" are widespread in the modern treatment of alcoholics, little is known with certainty about such procedures. Traditional dynamic psychotherapy has not been regarded as a treatment of choice for alcoholics, but it maybe a useful adjunct for the treatment of a coexisting psychopathology in some alcoholics. Treatment relies heavily on group methods (e.g. Blume, 1985; Mcrady and Sher, 1983). Thet have provided a recent comprehensive review of research on client and treatment variables.

In contrast to classical, dynamic, insight-oriented psychotherapy, alcoholism counselling is directive, supportive, client centred, focused on the present, and oriented toward real world behaviour changes. Counsellors vary in the importance they place on feelings expressed by the clients during therapy sessions.

Counsellors also differ in the degree of confrontation they use or will use with resistant clients. Some counsellors will use aggressive, or even hostile confrontations with clients, while others regard such behaviours as counter-productive. Indeed, for some clients it may be psychologically damaging. Evidence is beginning to emerge that clients with a history of physical and sexual abuse should not be subjected to aggressive or hostile confrontations.

Although, the benefits derived from aggressive hostile confrontation are counter-productive, evidence has shown that sharing information about the clients condition in a realistic straightforward and non-threatening manner may be beneficial.

Cartwright (1981), has discussed the fact that only a small fraction of studies of alcoholism treatment have dealt with the counsellors perspective. Earlier papers have indicated that there are large differences in the counsellor's ability to keep clients in treatment. Differences were attributable to therapist behaviours because the characteristics of clients of the successful counsellors did not differ from the characteristics of the clients of the unsuccessful counsellors. Valle (1981), for example, has shown that counsellors with higher levels of functioning have clients who show fewer relapses, fewer relapse days and less use of alcohol during the two years of treatment.

Given the crucial role that counsellors and therapists of various therapeutic perspectives play in the treatment of addiction, it

is evident that considerably more empirical study of counsellor behaviours, styles, attitudes, beliefs and personality characteristics is needed in the field of addiction treatment.

The Addiction Research Foundation (1981), the National Centre for Alcohol Education, the National Institute on Alcohol Abuse and Alcoholism,(1977) and the National Planning Committee of the Department of National Health and Welfare (1985) list the following counselling skills as being effective when counselling clients with substance abuse problems.

Counsellor responses have been classified as either **Reflective** or **Directive. Reflective responses** are counsellor responses which do not add new material to what the client has said and thus reflect information that has been received by the client back to the client. **Directive skills** are those counsellor responses that either add new material to what the client has told the counsellor, or, explicitly direct the client to explore a specific topic or a new perspective at greater length.

<u>Reflective Skills</u>

Attending	Demonstration of the counsellor's concern for, and interest in the client by eye contact, body posture, and accurate verbal following.
Paraphrasing	A counsellor statement that mirrors the client's statement in exact or similar wording.
Reflection of Feeling	The essence of the client's feelings, either stated or implied, as expressed by the counsellor.
Summarizing	A brief review of the main points discussed in the session to ensure continuity in a focused direction.

<u>Directive Skills</u>

Probing	A counsellor's response phrased as an open-ended question which directs the client to explore a specific subject at greater length.
Interpretation	A counsellor response directed at helping the client explore an alternative perspective on a problematic issue.

Confrontation A counsellor response which constructively illustrates the discrepancies that a client is presenting.

3. Marital and Family Therapy

Substance abuse problems affect and are affected by the patient's family situation. Marital and family therapy includes a variety of therapeutic techniques used by clinicians who share a conviction that a disturbed family life plays a significant role in individual pathology and that treating the family will produce positive change.

In some approaches, treatment targets not only the drinking and drinking-related behaviours of the client, but also the patterns of family communication and interaction. Therapeutic approaches that involve the family have given encouraging results, Moos and Moos (1984). Controlled studies of marital or family therapy for alcoholics have found moderately better short-term outcomes than individual approaches, McCrady et al.,(in press).

In the past decade, clinicians have come to recognize family members as primary targets, deserving of treatment in their own right, and not simply as adjuncts to treatment of the alcoholic. Modern treatment of spouses and children recognizes the stress of living in an alcoholic family situation can, in some instances, have devastating effects upon the emotional and psychological health of family members. These problems must be addressed therapeutically whether or not alcoholic family members recover. Treatment of spouses, dependent children and adult children of alcoholics have become central therapeutic issues, and demand is increasing for therapeutic services for these groups independent of traditional alcoholism treatment.

Unfortunately, although, research has shown the necessity of treating the family, services to the family of the alcoholic are still very fragmented. In some Canadian centres, treatment for the family of alcoholics who have been admitted for treatment has just begun to be provided. In many cases, where it is provided, treatment consists of education sessions on the family dynamics rather than marital or family counselling.

Counselling services for adult children of alcoholics is almost non-existent in Canada. In spite, of the increased awareness of the record of the physically and psychologically damaging effects of alcoholism on children, there are few resources available for these children unless the alcoholic or spouse actively seeks treatment.

Hopefully, workers in the various agencies such as child care workers, guidance counsellors, probation officers and teachers will become more sensitive and aware of these children and how to meet their needs. At present, except for the occasional individual doctor, teacher, minister or probation officer who looks below the surface behaviour, these children can expect little attention or comfort from society.

4. Behavioural Approaches

The development of clinical behavioural approaches to drug problems has been simultaneously influenced by two different sources: a) developments in behaviour therapy, and b) developments in knowledge about substance abuse, Sobell (1987). These influences are most identifiable where alcohol is the substance of concern, but similar patterns can be traced for other drugs.

a) Relaxation Training

The theoretical rationale underlying applications of relaxation training techniques usually involves two assumptions: (1) the problem is caused or exacerbated by tension or anxiety, and (2) relaxation training can effectively deal with the problem either by reducing anxiety or by increasing the individual's perceived control in stressful situations according to Klajner, Hartman, and Sobell, (1984).

At the present time, the most popular relaxation training techniques are progressive muscle relaxation, Jacobson, (1938); Wolpe, (1958); and meditation, Benson, (1975); Marlatt and Marques (1977). Others include autogenic training, biofeedback, and hypnotically-induced relaxation, Benson, (1975); Taylor (1978).

Despite the popularity of relaxation training with alcohol abusers, very little conclusive evidence is available as the results of the majority of studies are unreliable due to methodological problems. As these techniques are often used with other behavioural therapies, evidence regarding the efficacy of relaxation as a treatment for addiction problems, in and of itself, is equivocal. Another issue according to Miller (1984), is the danger of prematurely dismissing a treatment as ineffective because of a possible lack of impact within an undifferentiated population. Failure to differentiate on critical predictor dimensions may mask the value of a treatment technique for a particular subgroup.

b) Skills Training

The main assumption underlying skills-training techniques is that substance abusers have deficiencies in these skills. At present, however, there is a general lack of evidence to support this assumption accordingly to Sobell, (1987). Therefore, clinicians would be well advised to assess the client's individual needs and abilities before referring him/her to a skills development program. Currently, many addiction treatment centres, do not have well-developed skills development programs. In the majority of cases the approach is educative rather than actual skills development.

c) Behavioural Self-Control Training

Training in drinking skills is based on the view that excessive drinking is a learned response that has short-term effectiveness for the drinker in specific situations, particularly when the individual lacks effective non-drinking responses. Drinking skills training is used to teach alcohol abusers to drink in a non-abusive manner as an alternative to abstinence, and usually forms part of a more broad-based treatment program, Sobell (1984)

Although research findings have been mixed, (Elal-Lawrence, (1984), the most consistent predictors of favourable prognosis for controlled drinking have been lower duration and severity of drinking symptoms and problems. Orford (1985), by contrast, found no relationship between severity of alcohol dependence and abstinence versus controlled drinking outcomes. Instead, Orford found that outcome was predictable from client beliefs about alcohol and alcoholism. Clients endorsing traditional "disease" conceptions of their alcohol problems tended to become abstinent, whereas, clients rejecting tenets of a disease conception were more likely to attain moderation.

d) Interpersonal Skills

Individuals with substance abuse problems are often deficient in social skills. Several controlled studies have examined the value of adding social skills training to an alcoholism treatment problem and the results to date have been quite consistent. Freedberg and Johnston (1978b) found that the addition of assertiveness training to a three-week inpatient program substantially improved treatment outcome at one year follow-up. Human relations, assertiveness and cognitive restructuring were addressed in the training program.

Controlled research to date clearly supports social skills training as a helpful addition to alcoholism treatment. Comparative findings currently available, Miller (1984) suggest that optimal elements include assertiveness training, group training with practice, branching programmed instruction (if written materials are used) and attention to cognitive inhibitions.

Studies in relapse prevention suggest that alcohol abusers may drink as a coping response to stressful interpersonal situations. Alcohol abusers often report retrospectively that their relapses were initiated by stressful situations, Cummings, Gordon & Marlatt, (1980). Therefore, it is possible that interpersonal skills training may increase the individual's real control over the stressor or increase the individual's perception of control over the stressor. In either case, this could prevent the individual from slipping or relapsing in that situation or circumstances.

e) Cognitive Skills

Cognitive-behavioural therapy has become a popular technique for dealing with a wide range of problems (e.g. drinking, depression, anxiety, Beck, (1976); Mahoney,(1974); Sanchez-Craig, Wilkinson & Walker (1984). Cognitive skills training for alcohol abusers is based on several assumptions: that drinking problems are often the result of maladaptive cognitions, that alcohol misuse is an attempt to solve such problems and that training aimed at developing alternative cognitions will decrease alcohol use.

In two different studies, Sanchez-Craig and her colleagues trained halfway-house residents in the use of cognitive coping skills. Although these studies showed no differences among the treatments on any of the outcome variables at 6, 12, and 18 month follow-ups, the authors, Sanchez-Craig & Walker (1982), suggested that the failure to obtain differences may relate to memory deficits observed among 30% - 60% of the sample. Most subjects could recite problem-solving strategies during the program, but were unable to recall the strategies at the follow-up interviews. These results, together with those of Jones, et al (1982), suggest that cognitive techniques may not be appropriate for cognitively impaired populations.

f) Bibliotherapy

Bibliotherapy is therapy through the reading of literary works on alcoholism and addiction. The reading makes the individual aware of the problem; an awareness created by the

process of the dynamic interaction which develops between the reader and the literature, Cormier et al, (1987). The positive effects are the results of an accommodation to literary reality. The best predictor of success utilizing this technique is the intervention at the early stage of an individual's addiction problem. The drinkers least affected have the best chances of success, Cormier et al., (1987). The necessity of making a differential assessment before developing and recommending an intervention is imperative.

g) Relapse Prevention Strategies

An important recent development in the alcohol field has been a reconceptualization of the relapse process, Curry and Marlatt, (1987). While the traditional model of alcoholism suggests that alcohol problems and recovery from these problems are an all-or none phenomena, the treatment outcome literature strongly indicates that alcohol problems tend to be recurrent, even when individuals show great improvement over time. Marlatt, (1984), has suggested that recovery is best conceptualized as a gradual, rather than abrupt process. This theory has spurred much research on the antecedents to relapse, methods to prevent relapse and ways to minimize the adverse consequences of a relapse, if it does occur.

According to Sobell, Sobell, Leo, Riley and Klaner (1987), relapse prevention bridges the gap between scientific knowledge and clinical practice and is particularly timely given the research which indicates alcohol problems tend to be highly recurrent. To acknowledge that alcohol problems frequently reoccur would bring beliefs about the nature of alcohol problems closer to what the empirical evidence demonstrates, Madden, (1984).

h) Community Reinforcement Approach

The Community Reinforcement Approach (CRA) is designed to restructure family, social and vocational reinforcers in a manner that reinforces sobriety, while discouraging further drinking. The program consists of problem-solving training, behavioural family therapy, social counselling, vocational skills, optional disulfiram, a "buddy) system and daily self-monitoring of moods as an early warning system for impending relapse.

A series of well-controlled studies have provided strong evidence that this intervention has a powerful impact on alcohol and drug use and general adjustment. However, the community reinforcement approach remains little known and is seldom used, Miller, (1984).

5. Alcoholics Anonymous

Programs such as AA, Al-Anon, Alateen, NA and ACOA groups continue to provide critically needed community-based support services for substance abusers and their families. Precisely how many people recover through AA alone, or AA in conjunction with professional treatment services, is not known with certainty. The research, therefore, has focused on predictors of affiliation or attendance which are at best indirect indicators of outcome. AA attendance has been reported to be related to authoritarianism and lower educational levels, less psychopathology, affiliative and dependency needs, field dependence, greater severity of alcohol-related problems and higher overall use of external sources of aid to stop drinking. There is evidence that attendance at AA meetings is positively correlated with the maintenance of abstinence, Cordis et al., (1981).

6. Pharmacotherapies

Although there has been a staggering number of studies of drug therapies for alcoholics, there have been surprisingly few controlled investigations that have included an adequate outcome measure of drinking behaviour. Dropout rates as high as 50% in some studies, as well as noncompliance with dosage regimens, have also posed major problems for interpretation of findings, Miller and Hester, (1984).

a) Disulfiram (Antabuse)

In general, Antabuse is no longer recommended for use in the treatment of alcoholism, but it may be used as an adjunct to a more comprehensive treatment regimen. Studies have shown that the effectiveness of Antabuse may be related to client characteristics, including age, motivation, compulsivity and ability to form dependent relationships.

The usefulness of Antabuse may be simply as a short-term influence over the decision to remain abstinent, while the client seeks to establish an initial program of recovery. It is also possible that the willingness to take Antabuse is only a corollary of a strong motivation to quit drinking and that individuals, who are willing to take the drug daily, would likely have a successful treatment outcome, even if they did not take it.

Miller and Hester, (1984), question the wisdom of the use of Antabuse as a routine therapeutic agent, particularly, the ethics and effectiveness of mandating Antabuse as a consequence of alcohol-related offences.

7. Length and Setting of Treatment

Controlled research on the length and intensity of treatment provides a very clear and consistent message: more treatment is not necessarily better treatment. If anything, the differences that have emerged in controlled research to date would favour shorter and less intensive approaches. This finding has remained consistent across a variety of theoretical orientations and populations.

Further research should determine whether length or intensity are determinants of outcomes within treatment having documented effectiveness. Certain subpopulations may benefit from longer more intensive levels of certain kinds of treatment. The necessity for differential assessment and the availability of a range of treatment alternatives becomes critical if we to match clients with the optimal cost-effective interventions.

II IMPLICATIONS OF THE ADULT LEARNING MODEL FOR THE DESIGN AND DELIVERY OF SECONDARY INTERVENTION PROGRAMS

ADULT LEARNING CONCEPTS AND PRINCIPLES

1. Concept of the Learner

The client is involved in the treatment process through interviews and setting learning and competency goals for each component of the treatment program. Clients are encouraged to evaluate their learning in a collaborative atmosphere with counsellors and to explore alternatives for change and the opportunity for feedback.

2. Role of the Learner's Experience

Adults define themselves in terms of their experiences. If this experience is not used, or its worth minimized, adults perceive it as rejection. It is important that new knowledge, concepts, skills or interpretative frameworks be integrated with the client's experience. Experiential/participatory learning methods are used wherever possible during the treatment program. Greater emphasis is placed on techniques that involve the learner and tap his/her experiences. Techniques such as group-discussion, case methods, simulation exercises, role-playing and skill practice

sessions allow the client to make the connections between information and experience. These techniques give the client the opportunity to critically examine the experience, recognize and prepare for change.

3. Readiness to Learn

An adult's readiness to learn becomes increasingly oriented to the development of social values and results in his/her readiness to learn and "teachable" moments. For clients a critical incident or accumulation of incidents, situations and circumstances has brought them to treatment. Thus, clients are encouraged to set and evaluate learning goals and objectives as an important preamble to develop the readiness to learn. The treatment process is open and identifies the skills clients need to attain and cope with individual circumstances. As most clients have either been subtly or directly coerced into treatment, feelings of resentment and resistance must be handled before learning can occur.

4. Orientation to Learning

As adults mature their perspective on learning focuses on problems and resolution. The problems and concerns clients have upon entry to a treatment program are logical and appropriate starting points for a learning experience. This is significant for all aspects of treatment. Most intake counsellors priorize client concerns to be addressed in individual counselling sessions. If all aspects of adult counselling are viewed as part of a learning or re-learning process, individual and group counselling sessions can focus on assisting clients to develop problem-solving techniques as a learning requirement.

5. Motivation to Learn

Clients are encouraged to experience as much self-directed pressure as circumstances will allow. Although external pressures may exist, it remains that the decision to learn is voluntary. A physical and psychological climate is established in which improved self-esteem, confidence and actualization can occur.

III IMPLICATIONS OF ADULT LEARNING CONCEPTS AND PRINCIPLES FOR INDIVIDUAL AND GROUP COUNSELLING

There has been recognition in the counselling field that the principles of adult learning have implications for the individual and group counselling components of treatment as well as the educational components. The following are three sets of concepts based on principles of adult learning and development which have implications for both effective education and counselling strategies in addiction treatment programming:

1. **Lewin (1945)** has identified three types of adult learning:

   a) Learning resulting in a change in cognitive structure (analyzing one's behaviour - thinking patterns - decision-making skills);

   b) Learning resulting in a change in motivation (change in belief or attitude; and

   c) Learning resulting in a change in behaviour (developing a skill).

2. **Peavey** (1981) has developed a working definition of counselling which states that counselling is a learning activity in which a counsellor assists a client:

   a) To develop an understanding of his/herself and life situation;

   b) To develop a critical evaluation of his/herself and life situation; and

   c) To undertake conscious and goal-directed use of possibilities within his/her life situation.

3. **Freire (1985)** has defined an approach to education which emphasizes the stimulation of critical thinking on the issues in the context of social and cultural realities. Friere's approach, called "empowering education", has been used in alcohol and substance abuse prevention programs in New Mexico, as well as being incorporated into individual and group counselling.

A survey of substance abuse programs within the CSC, in both the institutional and community levels, revealed that the majority of substance abuse programs are grounded in the ideology of AA and based on the Twelve Steps.

Many of the addiction treatment centres in Canada, which have a Disease Model orientation, are adapting their treatment programs, and applying the concepts and principles of adult learning. The application of these principles can maximize the possibilities for change in their client population and reduce the resistance to the change process. These centres have also adopted cognitive behavioural relapse prevention program models based on social learning theory.

Cognitive-behavioural oriented treatments, based on the social learning model in the substance abuse field, are not usually subject to the deficiencies in the design and delivery of treatment programs based on the disease model. These programs are designed to facilitate specific learning which is behaviourally and competency based. Program goals and objectives are specific and measurable, with a critical evaluation of the learning by the counsellor/instructor, usually an integral part of the program.

Cognitive-behavioural programs can assist the client to develop coping skills and competencies in a range of lifestyle areas such as life, social, problem solving, assertiveness, inter-personal, communication and cognitive skills, anger and stress management and conflict resolution. As the inability to cope and interpersonal conflicts contribute to the relapse process, the availability of these programs as part of addiction programming is critical.

Many programs, however, particularly the twelve step programs offered within the institutions and the traditional three to four week residential treatment centres in the community may not address these issues, other than discussing them as possible topics in education or group counselling sessions of approximately 60 to 90 minutes in length within the overall program.

The above issues have implications for the design and delivery of effective substance abuse programming for offenders that should be examined irrespective of the program content.

The CSC may find that some current programming and referral sources appropriate to offender needs may be non-existent in many communities in the area of secondary intervention, particularly in the areas of cognitive-behavioural skills, self-directed learning and alternatives to abstinence.

Secondary intervention institutional and community programs will have to be reviewed to ascertain whether the substance abuse programs are competency bases, and if not, to ensure these

components are provided for the offender through adjunct programming at some point from sentencing to warrant expiry in the community.

The following are possible issues to consider when reviewing secondary intervention programs:

1. Offenders receive pre-learning and treatment such as cognitive skills training and/or education sessions on addiction issues.

2. The design and delivery of education and treatment programs based on effective learning techniques and the concepts and principles of adult learning.

3. Education sessions designed to facilitate a change in the attitudes, beliefs and intent of the offender, and provide the skills necessary to action the change.

4. Program goals and objectives written in behavioural terms, related to the learning need, describing what the learning will accomplish and what the learner will achieve.

5. The instructional design and techniques that reflect the learning goals and objectives.

6. Individual and group counselling sessions that emphasize the stimulation of critical thinking on the issues in the context of the social and cultural realities offenders face.

7. Utilizing suitable teaching and audio-visual aids which enhance the learning process and are related to the session goals and objectives. Ideally, films and videos, should be of less than 20 minutes duration and trigger discussion on relevant issues.

8. Evaluation of the program be conducted on a regular basis from the offenders perspective. This will assist the offender to evaluate the relevance of each session or education component to his/her learning needs and recovery goals.

7

THERAPEUTIC COMMUNITIES

BACKGROUND PAPER
BY LISE TURCOTTE
AND JANICE RUSSELL

BACKGROUND

The therapeutic community concept has been around since the late 1940's in its democratic version and since the late 1960's in its hierarchical version. This hierarchical version was patterned after the original Synanon model developed by Charles Dederich in 1958.

In effect, Dederich developed a new treatment model for heroine addicts in New York (Yablonsky, 1964). The program, which was called "Synanon", revolutionized the treatment of substance abusers and became a model in North America.

The treatment model promoted by Dederich was a therapeutic community (TC). One of the most innovative characteristics of this model was the fact that the counsellors themselves were ex-drug addicts.

Dederich, an ex-alcoholic, rejected any input by the medical profession and relied solely on ex-addicts as staff. He argued that traditional medical methods were useless when treating addicts because of their extreme manipulativeness.

As with AA programs, this treatment model is based on self-help between the participants (Hurvitz, 1972). The emphasis placed on the theme "here and now". This is done according to socially acceptable values and norms, but not necessarily religious ones.

Again, as with AA groups, the therapeutic community offers an alternative lifestyle based on self-help and the participants acting as role models and offering support with regard to abstinence from drugs and alcohol. Contrary to AA, one can note the influence of psycho-analysis in the TC model because of the complete character restructuring. Despite the extent of the problem, the efficiency of the model has been demonstrated and in the following years, many other centres have been developed in the U.S.A. and Europe. These centres were developed by dissident ex-addicts from the Synanon Community or militant non-addicts who had spent time at Synanon as observers.

Kaplan indicated that "The underlying philosophy of Synanon and of the more than 300 therapeutic communities that have evolved from Synanon is that the drug addict is emotionally immature and requires a total immersion in a specialised social structure in order to modify lifelong, destructive behavioral patterns. The goal is to effect a complete change of lifestyle including abstinence from drugs, the development of personal honesty and useful social skills, and the elimination of anti-social attitudes and criminal behaviour." (1)

In this fashion, the Daytop Village and Phoenix House in New York also began. Later, people from Daytop also developed Liberty Village and Gateway House in New Jersey. Ex-members in Phoenix opened Sera and Vérités in New York. In Quebec, the Centre

Portage Inc. was opened in the 1970's. The intensive treatment program (12 to 18 months) is applied at the residence at Lac Echo whereas the social re-integration phase occurs in open centres located in Montreal.

THERAPEUTIC COMMUNITY IN A CORRECTIONAL SETTING

On a correctional level, the Network Program (2) which started in 1979 used the TC approach model for implementation in four American penitentiaries in New York State. Network was designed to establish living/learning units within the correctional facilities supervised and operated by specifically trained Correctional officers and supervisors.

The program had two specific objectives which were to:

- Provide inmates with a means to learn life coping skills; and
- Enrich the role of the correctional officer in this change process.

Network operates in selected facilities in New York State at all levels of security: maximum, medium and minimum security. It has also been integrated into the correctional system in the State of Vermont under the name Vanguard.

In 1987, a closed therapeutic community was implemented in Donnaconna, a multi-level institution in the Quebec region. This model was modified to reflect the Network program when the institution was converted to a medium security facility. In January 1989, a similar program was opened in the Leclerc institution.

In both penitentiaries, the program was implemented in two open units, i.e. inmates involved have daily contacts with the other inmates in the institution. The therapeutic activities are held in the evening and comprise essentially of compulsory and/or optional group activities. Mutual confrontation is also used as a method of change. The unit staff have been specifically trained in the TC Approach to play a support and control role to help the residant in the change process. According to McDermott, 1988 (7) it was demonstrated that the type of employees, their level of involvement are the determining factors in the efficiency TC.

Each TC has its own admission criteria and rules of conduct that are to be observed by all participants. If they are not observed, participants may be excluded from the program. The offender's motivation is the key element in his completing successfully the program.

As indicated by Sugarman, 1984 (6), the treatment of substance abusers in therapeutic communities is divided into five important phases. These phases are superficial adaptation; self-awareness assimilation of new values; improved social attitudes; the progressive integration of these values; and finally, the application of these new values and attitudes within community contacts when he/she is released. Sugarman, 1984 (6) and A McDermott, 1988 (7) stress the importance of the existence of a follow-up and appropriate support structure to facilitate the individual's return to the community.

An operational review completed on the closed TC at Donnaconna in March 1989 indicated that the degree of satisfaction with the program, both by staff and inmate participants, was of a high level. (3) To date, no formal evaluation has been completed on the Network Programs.

TARGET GROUP

The TC model was developed to address the needs of individuals having a severe physical or psychological dependence on drugs and/or those unable to complete other substance abuse problems.

The experience at Donnacona has shown that the offender who has experienced severe substance abuse problems has been involved in numerous criminal activities related to his drug abuse and is totally unmotivated in terms of doing time, appears to be the type of individual who benefits the most from the TC. An essential element in the success rate of this program is the client's willingness to participate in it since a poorly motivated individual will disrupt the TC.

Miller's matching hypotheses states that "clients who are appropriately matched to treatment will show superior outcome relative to those who are unmatched or mismatched."(4) It is therefore important to ensure that the clients referred to treatment have the capacity to participate actively in the change process. It is recommended that individuals having severe learning disabilities or psychiatric problems not participate in TC programs developed for the "general population"; rather, they should be integrated into special programs tailored to their specific needs.

It is also important to differentiate between offenders who in the context of a criminal lifestyle abuse drugs and/or alcohol from those whom have exhibited a dependence on these substances and have therefore become involved in criminal activities in order to support their addiction. The latter can benefit from the TC whereas the former rarely do. Secondary prevention programming could be more useful for the first group of offenders.

Donnacona's experience since 1987 demonstrates that the two types of clients most likely to benefit from the TC program are the multi-recidivists who are saturated from doing time (carreer criminals) and drug abusers, those that are conscious that using/abusing alcohol and/or drugs will result in criminal recidivism if they are not treated before release.

The operational review (ref) completed in March 1989, traced a profile of 50 candidates admitted on a voluntary basis: the average age was 26.5 years; 53% were serving sentences of 5 to 10 years; their criminality increasing in terms of seriousness; 60% of them had completed more than two penitentiary terms; 54.8% began taking drugs between the ages of 12 and 14 years and 28.6% between the ages of 15 and 18 years; 94.9% were intoxicated during the commission of their offences.

The motivation to change remains the principal factor affecting the success in this program; therefore, it is important that participation be voluntary.

The clientele least receptive to the proposed help and most difficult to involve in a treatment program were the young offenders (18 - 20 years of age) incarcerated for the first time in a federal penitentiary, who adhere strongly to criminal values and who, at this point in time, have not done any self-analysis.

PHILOSOPHY

A TC requires a positive environment in a caring community where individuals can help themselves and each other. Staff and participants work together to establish and maintain positive growth-filled environments within the institution. Community members focus on behavioural change and confront attitudes which are destructive to individuals and the life of the program.

WORKING HYPOTHESES

- The TC is an environment that generates positive attitudes and which promotes attitude change from egocentrism to social consciousness.

- Individuals that accept integration into a TC have a significant chance of experiencing profound change.

- The individual who has attained a level of personal development that would allow social reintegration will no longer need to abuse drugs and/or alcohol, resulting in a reduced risk of recidivism.

OBJECTIVES

The principal objectives of the TC program in correctional facilities are to:

a) Support the participant's attainment of a level of personal development and life-coping skills that would allow him/her to function in the community as a law-abiding citizen.

b) Reduce the risk of recidivism that are directly related to substance abuse.

c) Enhance the role of the correctional officer.

PROGRAM

Inmates in the program learn and practice socialization and employment skills, communication, decision-making and critical thinking skills as members of a community geared to positive growth and change. The program is designed to be a total learning environment, an approach which encourages involvement, self-direction and individual responsibility.

Positive behaviours which support individual and community growth are expected while negative behaviours are confronted and targeted to be changed.

General Selection Criteria

The selection criteria used for correctional TC's are the following:

- Inmates who have a problem of substance abuse;
- Inmates without severe psychiatric or learning problems;
- Inmates motivated to participate in the TC program; and
- Inmates without a history of violence in the institution in the last six months.

TC Rules - Cardinal Rules

- No violence or threats of violence; and
- No alcohol or drugs.

General Rules

General rules that are used to aid the individual to increase self-discipline to encourage him/her to function adequately in the institution and in the community, are developed for each TC.

PROGRAM COMPONENTS

Group process is used in the Network Program to support the development of an effective social system. Groups are useful because one elementary way in which people learn is by interacting with other people. Individuals participating in groups learn through involvement and feedback.

Several studies of group work indicate that the intervention tools or methods employed benefits those participating in groups. These can be summarized as follows:

- Problem Solving: Participants can work together on tasks, decision-making and problems experienced both in custody and the community

- Values Clarification: Through interaction with staff and peers, participants can clarify their own values and understand basic social values. Participants can explore the meaning of concepts like freedom and responsibility, honesty, influenceability, etc.

- Support and Feedback: Positive behaviours which enable growth can be recognized and supported by peers. Negative behaviours can be confronted. Groups provide a setting to demonstrate how a person stimulates, bores, aggravates others, etc. Participants can give feed-back to each other

about the effects behaviors have on them. Feedback from several people about the same behaviour can offset possible denial by the recipient. Confrontation or feedback is a distinctive form of peer helping crucial to the TC and should be conducted in a constructive manner.

- Social Action: The offender can learn to become responsible for his/her life, to take action in the community in ways which can lead to effective change.

- Planning: Individuals learn to prevent or avoid problem situations and create positive situations by exploring possible events which might occur and choices open to them.

- Communication and community: Individuals learn how to speak to others in order to be understood. They also learn how to interact positively with other people in groups. Sometimes people feel alone or alienated from others because they feel that they are the only ones to experience certain emotions or situations. Groups permit people to see their commonality, to see themselves both like others while maintaining their individuality.

- Feedback: All group and individual sessions should be followed by a staff feedback session. Staff should evaluate the group process in terms of participation, influence, decision-making, goals, group atmosphere, feelings and norms. Staff should evaluate their own performance in these categories as well. When offenders are used as co-leaders in groups, they should also participate in the staff feedback sessions as a part of their ongoing training.

- Group Process: Support groups should be regularly scheduled in addition to the special groups listed here. Supportive groups can focus on topics or on particular areas of interest to individuals. In general, support groups allow members the opportunity to share feelings and ideas with each other and to demonstrate their willingness to be actively involved with community members.

- Counselling: Informal counselling is included above in all activities; more formal counselling also plays a significant role in the TC and may be done by psychologists or chaplains according to the individuals needs.

IMPLICATION OF COMMUNITY AND FAMILY

The involvement of the family and volunteers from the community is encouraged in the final phases of the program.

ORGANIZATIONAL STRUCTURE

A specific unit should be identified as a TC within the institution in order to facilitate the group dynamics. Staff for the unit should be trained in both the security and the TC treatment process, and the co-ordinator of clinical activities should be added to the usual staff complement to ensure supervision of staff and coordinate therapeutic intervention.

Use of correctional staff is preferable to use of contract staff because of their expertise in dealing with offenders.

EVALUATION

In his "revue de la littérature concernant l'intervention auprès des détenus toxicomanes" Brochu (1990) mentions that although the Alcohol Program in Leclerc Institution has been in place for only a year, it appears that inmates employees have observed the benefits of this program in the improved atmosphere and the general allure. A complete operational review completed in March 1989 of the TC at Donnacona Institution, indicated that after 18 months of operation the degree of satisfaction with this program, both by staff and participants, was at a high level (4). One notes that the inmate's personal perceptions of each other are more open, confident and positive and the atmosphere in the unit appears to be that which the CSC is to promoting by the implementation of the unit management. The program allows correctional staff to acquire improved intervention techniques, which in turn make them better prepared to participate in competitions for possible promotions. Interestingly, absenteeism for Unit personnel fell to half of what it was in the rest of the institution. The Virage Programs, implemented in December 1989 in an open unit in a medium sector of Donnacona institution is also based on the TC model. No formal evaluation has been completed to date. However, comments received up to now are similar to those obtained from the Echo program in Leclerc. It should be noted that in March 1989, during the operational review at the closed unit, a complete evaluation framework was developed with regard to the TC Program for substance abusers in Donnacona (5). This evaluation framework is sufficiently flexible to be used as a framework for all treatment programs based on a TC model whether they take place in a closed or open unit.

ISSUES/CONSIDERATIONS

1. The initial experience with the closed therapeutic unit indicated that the number of cells allocated for such a program should be closely evaluated.

2. No supplementary costs incurred for operation of closed or open unit some additional capital costing may be required for a closed unit depending on the physical structure of the institution.

3. Staff and inmates participating in these programs are highly satisfied.

4. The TC model fosters positive, confident and open interaction between inmates and staff. This is similar to results desired by unit management.

5. Staff acquire intervention techniques permitting them to work more comfortably with the offender.

6. Absenteeism among staff is significantly reduced where the personnel is stable on the unit 2.5 times lower than the rest of the institution (sick leave, for family leave 36% less).

7. No disciplinary offence reported to the disciplinary court which enhances the dynamic security of the institution (close unit).

8. No incidents related to drugs in the closed unit.

9. It is necessary to have a clinical co-ordinator for the program to ensure staff training, program continuity and supervision of therapeutic activities.

10. Clinical co-ordinator requires specialized training (psychology degree).

11. Support for the program by administration at all levels is necessary to ensure program credibility.

12. The program image can affect administration positively or negatively.

13. Usage of institutional personnel is preferable to the usage of contract workers because of their expertise in dealing with offenders.

14. Staff employed in the unit perform better if their presence was voluntary.

15. A phase of social re-integration is imperative to avoid release or recidivism.

16. The TC model is not applicable to all substance abusers and requires a motivated participant.

17. Continual evaluation of the participant is necessary in order to adjust program to their needs.

CONSIDERATION FOR IMPLEMENTATION

Closed Therapeutic Community

We suggest that each region have one closed therapeutic unit which be located in a maximum, multi-level or medium security institution, in order to permit all offenders wishing to effect a significant personal change to be eligible for the program. This unit will be closed off from the general population with a maximum capacity of 20 - 30 inmates in order to ensure maximum use. Regions with a smaller offender population may wish to reduce the size.

Personnel in this unit should be trained in diverse therapeutic techniques and should not be rotated within the institution. A clinical co-ordinator is also required.

The criteria for admission would be the same as those described in this document including a requirement for motivated and voluntary participation. It is to be noted that successful completion of this program should optimally result in a gradual release program to a specialized CCC. Therefore, eligibility for parole should be at a minimum within 12 months. Emphasis should be placed on these individuals since they may be released shortly to the community. Although it is recognized that offenders serving long sentences may need this specialized type of treatment, it is not recommended that they participate until the end of their sentence since the program renders them too vulnerable to cope with the "law of the milieu."

Open unit

Depending on regional needs, it is suggested that one or more open units be made available in medium security institutions. Since the inmate in this type of unit is required to mix with the general population, it is considered to be more realistic to integrate this unit in a medium security since the "law of the milieu" is less oppressive than in the maximums security institutions. The offender will also be able to benefit from a longer time period, in medium, facilitating his personal change, whereas in a minimum security setting, his release may be pre-eminent.

This therapeutic community should have a capacity of 40 cells with a supplementary unit of 40 cells for a preparatory period. Because the treatment level in this TC is less intensive than in the closed unit, more offenders would be able to benefit from this program.

Personnel should be trained in TC techniques and where possible work shifts should be stabilized.

Again a clinical co-ordinator attached to the unit is necessary.

MINIMUM SECURITY INSTITUTION

Offenders who have completed a tertiary program and are not eligible for a day parole as well as offenders who have completed primary and/or secondary intervention programs could participate in self-help groups, and pre-release programming.

SPECIALIZED CCC OR CRC

In order to ensure continuity in treatment and support of the offender, a CCC in each region should be identified to offer specific programming for substance abuse. It is necessary that this program be a continuum of the tertiary program offered within the institution and offer a needed support system to the offender in the community.

Staff in the CCC or CRC should benefit from the same training as institutional staff as well as supplementary sections concerning community realities. The same intervention model and techniques should be applied at this stage of the treatment.

The CCC/CRC should also act as a resource for ex-residents should therapeutic help be required.

Particularly at this stage, ex-residents could participate as peer helpers in the therapeutic process.

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8

PRE-RELEASE AND BRIDGING PROGRAMMING

BACKGROUND PAPER
BY BRIAN COUGHEY

PRE-RELEASE AND BRIDGING PROGRAMMING

TRANSITIONAL PROGRAM ELEMENTS

In the context of corrections, most substance abuse programs can be considered "pre-release" programs, as the majority of our population is serving determinate sentences of less than five years and most inmates are released within this period of time.

Currently, there are several program elements which address the transition of the offender from the institution to the community. These include:

- Employment and job finding skills.
- Leisure time and lifestyle planning.
- Release planning to identify the availability of community and social supports and resources for the offender.
- Relapse prevention skills training and relapse prevention planning.

COMMUNITY INTEGRATION SKILLS

The first three elements relating to employment, leisure, and release resource planning are integrated into most Life Skills or Community Integration Skills programs in many Correctional Service of Canada institutions. Throughout the offender's sentence, the Case Management process also targets these issues as areas to be addressed in the development of release plans.

Although these elements are present in many of the programs, it is felt they should be reviewed to ensure these specific elements are included as these skills can contribute to the offender's success or failure in the community in dealing with his/her substance abuse problem. It is strongly supported that these elements be integrated into all secondary and tertiary programs for inmates who are likely to be released in the near future. If this is not possible or appropriate, they should be provided concurrently in other programs.

THE RECOVERY PROCESS

Recovery from substance abuse in much more than just not drinking or using drugs. Recovery is a long term process, not an event. Chemical dependency is a way of life, and developing a balanced healthy lifestyle requires time. Recovery is both learning to abstain from alcohol or other mood altering drugs, and changing oneself and one's lifestyle to support abstinence. The areas of requiring change during recovery are unique to individual needs. Areas that may require change during recovery may relate to physical, psychological, social, family or spiritual functions.

Practitioners in the field believe, and research states, that some individuals may take as long as two years to recover from an addiction problem. As the recovery from an addiction problem often requires help and support from other - professionals, other recovering people, family or friends, it is important to involve significant others where possible in the recovery planning process. An essential element in developing a plan for continuing recovery is the offender's willingness to assume personal responsibility for his/her plan.

RELAPSE PREVENTION

For the majority of offenders with substance abuse problems, some post-treatment drinking or drug use is predictable. In fact, according to Marlatt, (1987) a lapse or relapse is considered the most predictable outcome of treatment.

Definition of Relapse

The following are definitions of relapse by the leading clinicians and researchers in the field of substance abuse.

> **"A process that occurs with a patient. It manifests itself in a progressive pattern of behaviour that reactivates the symptoms of a disease or creates debilitating conditions in a patient who has previously experienced remission." Gorski and Miller, .(1982)**
>
> **"The event of resumption of substance use after a period of abstinence, or the process of returning to substance use (i.e. manifesting behaviours or attitudes which indicate a person is likely to resume substance abuse, unless interventive measures are taken.)" Daley, (1987)"**
>
> **"A breakdown or setback in a person's attempt to change or modify any target behaviour."**

Relapse Statistics

The following are current relapse statistics by Marlatt, (1987)

- Approximately 2/3 of all relapses occur within the first 90 days (alcohol/drugs, smoking, diets, gambling).
- Determinants of relapse are very similar regardless of the drug.

- 76% of relapses occur when coping with:
  * negative emotional states - boredom, loneliness, anger;
  * interpersonal conflicts - assertiveness, anger, problem solving; and
  * social pressure - direct or indirect.
- Relapse locations
  * 63% bar/tavern
  * 12% home
  * 9% others' homes.
- Relapse times
  * 46% evening
  * 42% afternoon
- Average length of a relapse is 30 days.
- A single slip followed by a full blown relapse - 90%
  * 10% stopped after the first drink
  * 31% regained abstinence.

Coping with stresses (negative feelings, interpersonal conflict and social pressures) is a strong determinant of relapse. It makes imminent sense, therefore, to ensure that all substance abuse programs both between the institution and the community have components on relapse prevention that are skill based.

Types of Relapses in Addiction

According to Daley, (1987) relapses among alcoholics and drug addicts will vary. The different types of relapses include:

- Fatal
- Severe negative consequences
- Moderate negative consequences
- Mild or no negative consequences
- Therapeutic - aids recovery

Relapse Prevention Models

The substance abuse field has seen the emergence of several relapse prevention models within the last decade. Clinicians and researchers such as Annis, Marlatt, Gorski, and Daley have developed relapse prevention programs which are being integrated into substance abuse treatment programs across the country. Essentially, these programs fall into two major theoretical camps, namely, the "disease model," and the "cognitive-behavioural model." The major difference in the theoretical constructs are the ultimate treatment goals. The Disease Model orientation models apply an "abstinence" goal, while the Cognitive-Behaviourists allow the client to choose between a moderation and abstinence goal. Although there are a number of models, relapse prevention training programs have similar goals.

General Goals of Relapse Prevention

The goals of relapse prevention include:

1. Providing clients with information on the dynamic of relapse.

2. Assisting clients to identify "triggers" in high-risk situations.

3. Assisting clients to select alternative behaviours and actions to cope with high-risk situations.

4. Rehearsing and implementing the strategies.

5. Learning cognitive restructuring procedures in order to challenge negative cognitions and to cope with the "Abstinence Violation Effect."

6. Assisting client to develop a relapse prevention plan.

Relapse Prevention Planning

The offender can be prepared in advance to cope with the possibility of lapse, and therefore be able to apply some "brakes" so the slip does not escalate into a full-blown relapse. The offender must be prepared to cope with the Abstinence Violation Effect using cognitive restructuring procedures. By providing the offender with an alternative cognitive interpretation to the Abstinence Violation Effect, the counsellor may be able to forestall or minimize the sense of personal failure that is often associated with a slip.

The Community Integration Skills differ significantly from Relapse Prevention Planning Skills. It is critical, therefore, to ensure that relapse prevention planning be addressed in all secondary and tertiary intervention programs, irrespective of whether the substance program is delivered within the institution or the community.

Currently in Corrections, relapse prevention programs are being conducted in three regions, Ontario, Prairies and the Atlantic, utilizing the relapse prevention package, developed by Lynn Lightfoot, entitled Pre-Release Substance Abuse Programs for Federal Offenders, (1988). This package has been developed specifically for the offender and is based on a cognitive-behaviour model.

While many existing programs allege to cover the issue of relapse prevention within their structure, it is clear, upon review, that many provide only Life Skills, such as resource planning rather than teaching a contingency planning approach. Staff training in future for practitioners and program managers should include relapse planning, intervention, and management, in order to be in a position to assist the offender to develop these skills.

Timing Considerations of Relapse Prevention Training

Traditionally in the Service, offenders have been referred to relapse prevention programs just prior to their release date. The Working Group, however, felt that this time frame was too restrictive. Recovery planning for these offenders, identified as having a substance abuse problem, should be addressed as early in their sentence as possible, regardless of the length of the sentence.

Relapse prevention planning can assist the offender to cope with the stresses within the institution which can contribute to the relapse process. This also assists the offender to practice relapse prevention skills and identify the high-risk situations which trigger relapse. As the inmate/parolee's circumstances change, the overall recovery plan as well as the specific behaviours of the relapse prevention plan can be reviewed, monitored and rewritten as the circumstances warrant.

The recovery and relapse prevention plans should become part of the tracking process so all involved, at all levels, can assist the offender in evaluating the plan. In an extreme example, an inmate who is serving a long sentence and attends a substance abuse program, develops a relapse prevention plan in a maximum security facility could revise the plan in the transition to progressively lower levels of security within the institution, release to a Community Correctional Centre, or Community Release

Facility, and to release and supervision in the community. At each stage of this process, different risks, triggers and different coping strategies would be required. Consequently, the original recovery and relapse prevention plan, developed in maximum security a number of years ago, should be drastically different to the revised plan in the community.

Responsibility for Managing Relapse Prevention

In order for Relapse Prevention Planning to be effective, it must be managed throughout the sentence. From the originating substance abuse program where the relapse prevention training takes place, there must be continuity and support for the offender to continually review and evaluate the plan. This role can be taken by Substance Abuse Counsellors, Case Managers, Chaplains, Psychologists, etc. who are trained in Relapse Prevention Strategies. In the case of committed offenders who are able with minimal assistance to continue to apply the strategies, the staff member's role is reviewing the plan on a regular basis with the offender and assisting to evaluate and re-establish new recovery goals and plans as circumstances necessitate. Some offenders, however, may require retraining in the skills or if a major relapse has occurred, reentry into a substance abuse program can be considered.

The Consequences of Special Conditions Imposed by NPB

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 obligation for CSC staff which is unbending. That is, 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 we are first managing the risk associated with the offender. However, from the point of view of Relapse Prevention strategies, our 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" and be undetected by the CSC, and successfully get back on track with his/her recovery. 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 a dialogue be entered into 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 addictions. It is by no means suggested that Special Conditions not be used, 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 some Special Conditions, change the nature of some Special Conditions or recognize that it may a factor in post-violation and post-suspension review of abstinence violators. The dilemma of Special Conditions and relapse must be elucidated so that CSC's staff can respond both to the recovery of the offender and the NPB's policies in a holistic way which advances both objectives.

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SPECIAL NEEDS OF FEDERALLY SENTENCED WOMEN

BACKGROUND PAPER
BY VIRGINIA CARVER

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 have always been and continue to remain a minority in community treatment programs. The majority of these programs were designed initially to assist men with substance abuse problems and thus have not until recently considered the issues of appropriateness of their services 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 incarcerated 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 provide part of the framework within which to make recommendations for services to incarcerated women. These 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 increasing age. Only 50% of women aged 65 years or over are current drinkers versus 88% of women 20 to 24 years of age. Women are overall less likely to drink than men; they drink less frequently and when they do drink, they have fewer drinks. 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. Data from the recent Canada Healthy Promotion Survey identifies 1.5% of women in the heavy drinking category of 21 or more drinks a week. These heavy drinking women are more likely to be working and in labour related occupations.

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 old age group have the highest rates of smoking. The increasing convergence among male/female smoking rates is due to the more rapid decline in the proportion of men who are smokers.

Among Native and Inuit women, smoking rates are much higher. A recent study in the North West Territories found that 66% of 15 to 19 year old women smoked, with the highest rates being among Inuit women (77% in this age group), followed by Native women (66%) and non-Native women (47%).

In Canada, lung cancer among women is overtaking breast cancer as the biggest cancer killer of women.

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. Canada's Health Promotion Survey reports that 10% of women are using sleeping pills and 8% are using tranquillizers. These rates are approximately doubled in women aged 65 years and over. Use is also higher among widowed and separated or divorced women, and women who are not working. Generally, women are twice as likely to be using such substances as men. 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 to report use of illicit substances such as cannabis and cocaine. However, Canada's 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, approximately 12%.

The biannual survey of adult alcohol and other drug use in Ontario, carried out by the Addiction Research Foundation, reports consistently lower levels of use by women of illicit substances. However, in the most recent 1989 survey, 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 drinks at a single sitting.

This is especially interesting when we note that the survey indicates for males in this age group that there is no consistent pattern of increase across all these substances.

Street youths 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 thirty and are multiple substance users - alcohol, illicit and prescribed drugs. This differs from the picture a decade ago when a majority of women in treatment were in their thirties and forties with a primary alcohol problem. A recent survey of clients at the ARF programs in Toronto indicated that a third of clients with a primary cocaine problem were women. This finding is reflected in anecdotal reports from other treatment agencies.

b) Physiological Functioning

As noted earlier, women are more vulnerable than men drink for drink to the effects of alcohol. This is reflected in usually a shorter or telescoped 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/gynaecological 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 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 abuser to have come from disruptive family backgrounds - these may range from alcoholic parent(s) to loss of parent through death or divorce. Women substance abusers are also more likely to have a spouse or partner who is abusing substances than is true of 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. A recent study of clients of addiction agencies in one Canadian city found that less than half of women clients (47.1%) had access to a supportive person who would attend interviews to help her change her substance use. This contrasted with 60.5% of men. In many cases, close family members, particularly spouses, are not supportive of their partners entering a program and in fact have a tendency to deny the problem.

Women experience more barriers to treatment than men. A major barrier for women is care of dependent children. Many woman fear entrusting their children to family and children's services in case they are assessed as being unfit mothers and lose the 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, overall, they are in lower paying, lower level jobs with fewer benefits, or they may not be able to leave their home in order to go into a longer stay residential program. For those women on social support, keeping a home intact for themselves and their children to return to often becomes an insurmountable problem, and yet without a home, it may be difficult to obtain custody of their children. Also, spouses or partners are far less likely to participate in any kind of family or marital counselling than is true for males.

5. ASSESSMENT

Any assessment tools used with women need to be sensitive to the differences between men and women. Many women will not initially identify an alcohol or other drug problem, but may present symptoms of low self-esteem, anxiety, depression, etc. 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 the level of 2 to 3 drinks a day. Other issues which 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 or reproductive history and current psycho-social circumstances. Psycho-social circumstances include such issues as substance use by partner, support for sobriety and, of course, family care responsibilities. The latter is an issue not just during the phase of intensive treatment, but also during aftercare. If a woman has young children, what kind of arrangements is she able to make in order to attend aftercare. Some women, because of their very low self-esteem, may find it difficult to muster the resources to consider doing something about their alcohol or drug problem and they may continue to confirm by their behaviour the negative self-image they have of themselves. Also, women often have so many things going on in their lives - work outside the home, family responsibilities, care of older relatives, running a household, etc., that they find it difficult to find the time and energy to care for themselves.

6. DETOXIFICATION

In Ontario, at least, the majority of detox centres were initially established for men. It is only recently that beds have been added for women, or free-standing detoxes for women established. Those detox centres, which served both men and women in Ontario, were generally underutilized by women who apparently did not feel safe or comfortable in this environment. Detox centres which serve only women, or have made provision for separate living space for women, have attracted larger numbers of female clients. Women, because they are more likely to be using prescribed mood altering substances, may also require longer detox periods than men.

7. TREATMENT

During the last two decades, there has been increasing awareness of the need to develop specific programs to assist women with substance abuse problems. Though the majority of programs are still co-educational, there is now a significant body of experience with programs for women run by women. These include such programs as River House in Manitoba, started in the mid-sixties; Amethyst Women's Addiction Centre in Ottawa, initially funded by a Health and Welfare grant in the late seventies; Aurora House in B.C., etc.

In addition, a number of the provincial addiction foundations/commissions have developed specific program and training modules for women such as those developed by the Nova Scotia Commission. These initiatives were developed to respond to the minority status of women in most co-educational programs; to reflect the different social reality of women; the concern about the effectiveness of programs for women; concern about the reality of women participating in a group where they were a distinct minority; and the lack of attention to issues of concern to women.

Whether in the context of a co-educational or women only program, issues which need to be taken into account in developing interventions for women include the following:

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

- An approach which uses principles and approaches that empower women.

- Involvement of consumers of service in the development and evaluation of services.

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

- Education about substances and their physical and psycho-social effects.

- 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.

- All women's groups which allow women to expose sensitive issues, to learn to value themselves and other women (rather than seeing them as rivals) and help develop a network of support.

- Activities which help women develop self-esteem and coping skills. These include skill building activities such as assertiveness training, stress management, communication or social skills, financial management, leisure and recreational counselling, problem solving skills, etc.

- Family and children services including parenting training, childcare and an assessment and intervention program for children; 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 the opportunity to discuss issues such as being a sober parent, guilt about leaving their children, and how their substance abuse has affected their children.

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

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

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

- Sensitivity to women of different sexual orientation.

- Staff who are knowledgeable about a 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.

8. EVALUATION

Because women have been a minority in treatment programs, little attention has been paid to gender differences in the treatment outcome literature. 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 which 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 examine 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 B.C., that the outcome for women is better than for men in terms of reducing or abstaining from alcohol.

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

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10

A B O R I G I N A L O F F E N D E R S

BACKGROUND PAPER
BY PIETER DE GROOT

ABORIGINAL OFFENDERS

1. INTRODUCTION

Aboriginal offenders are a specially disadvantaged group in Canada who face serious problems (1)in the correctional system and (2)upon reintegration into the community. These facts are not new revelations and have been recognized within CSC, by special interest groups, and by native leadership throughout the country and others.

The special challenges relating to the aboriginal offender have been written about in numerous sources and there is little entirely new which can currently be added, except perhaps some innovative approaches which hitherto have not progressed from the thinking to the action stage. Three particularly helpful sources of information about the aboriginal offender are the papers: "CORRECTIONAL ISSUES AFFECTING NATIVE PEOPLES", Correctional Law Review Paper No. 7; February, 1988; The "FINAL REPORT: TASK FORCE ON ABORIGINAL PEOPLES IN FEDERAL CORRECTIONS"; and the User Report: "ABORIGINAL SUBSTANCE ABUSE TREATMENT CENTRES AND ABORIGINAL FEDERAL OFFENDERS", both issued by the Solicitor General Canada. The following content borrows heavily from the first two documents.

2. BACKGROUND INFORMATION ABOUT THE ABORIGINAL OFFENDER AND THE SUBSTANCE ABUSING ABORIGINAL OFFENDER.

Aboriginal offenders are over-represented in the correctional system, and their proportion seems to be increasing (with one regional decrease exception in the Atlantic Region, and relative stability in Quebec). Aboriginal people make up only about 2% of the population in Canada, whereas in 1987 about 9.6% of the federal penitentiary population was Aboriginal (regional proportional representation in 1987 varied from 1% in Quebec to 32.2% in the Prairies Region).

Aboriginal Canadians are not a homogenous group with a single language and culture (There are at least 16 aboriginal languages in widespread use in Canada, out of a total of 53 distinct aboriginal languages).

Generally, Aboriginal Canadians have a lower average level of education, fewer marketable skills and higher rates of unemployment, higher mortality rates and lower life expectancy.

Data derived from vital statistics regarding mortality patterns among Aboriginal Peoples show that Aboriginal people are more likely to die from violent causes, namely from accidents, injuries, suicide or homicide, than non-Aboriginal Canadians. For example, between 1980 and 1984, only 8% of the total Canadian population died from either injury or poisoning, while 33.5% of all Indian deaths and 28.7% of all Inuit deaths were from those

causes. Conversely, while 44.5% of the total population died from circulatory problems, only 23.3% of Indian and 15.5% of Inuit deaths were from that cause. Alcohol and other substance abuse is recognized as a leading contributing factor in the high accidental death rate among Aboriginal Peoples.

Suicide among Aboriginal Peoples is extra-ordinarily high. In 1984, the suicide rate per 100,000 population was 67.5 for Aboriginal males (compared to 21.4 for non-Aboriginal males); 18.9 for Aboriginal females (as compared to 6.1) and 43.5 for all Aboriginal Peoples (as compared to 13.5).

Another type of mortality statistic is homicide. Based on data collected by the Canadian Centre for Justice Statistics in October 1988, while Aboriginal people comprise only approximately 2% of the population, 14.8% of homicide victims and 19.9% of suspects are Aboriginal people. In addition, the proportion of federal admissions for violent crimes comprised over 54% of all Aboriginal admissions as compared to only 16% for non-Aboriginal admissions.

Aboriginal offenders, perhaps to an even greater extent than non-Aboriginal offenders, come from backgrounds characterized by a high degree of family instability, substance and sexual abuse and considerable contact with various types of institutions operated by social service and criminal justice agencies. Aboriginal offenders show a high incidence of single-parent homes, family problems and foster home placements.

The majority of Aboriginal offenders have long criminal records both as juveniles and as adults. Aboriginal offenders are more likely to be admitted to correctional facilities for a violent offence than are non-Aboriginals, and alcohol abuse tends to be a serious problem for the majority of Aboriginal offenders.

About half of the Aboriginal federal inmate population are status Indians, and of this group, about a third come from reserves.

3. ABORIGINAL OFFENDERS WITHIN THE PENITENTIARY SYSTEM

The Task Force Report states that: "A substantial portion of Native inmates perceive themselves, and are perceived by others, as significantly different from their non-Native counterparts in terms of their attitudes, values, interests, identities and backgrounds." This statement has important implications for program activities aimed at Aboriginal offenders.

Aboriginal inmates tend not to participate to any meaningful extent in general rehabilitation programs within penitentiaries. Often, they appear to be unfamiliar with the workings of the

correctional system; although it does appear that Aboriginal offenders are most likely to participate in programs if they are run by Native organizations which are not identified as being a part of the system.

Aboriginal offender participation rate tends to be high for Aboriginal-specific programs involving private sector parties, such as Native Brotherhoods or Sisterhoods and educational and cultural programs such as the Sacred Circle. There is evidence of an increase in native culture and spiritual awareness among Aboriginal inmates.

Many Aboriginal offenders have special social, cultural and spiritual needs and for Aboriginal offenders who have not had much prior contact with traditional culture and spirituality, the opportunity for instruction and participation in these areas can become an important positive aspect of their incarceration experience and provide an important link to their Aboriginal community and cultural roots.

Many Aboriginal offenders are serving their sentence in correctional facilities which are a long distance from their home community - a problem even more pronounced for female Aboriginal offenders as there is only one federal penitentiary for females. Through the use of Exchange of Service Agreements, CSC has attempted to alleviate distance problems for offenders of both sexes. However, distances remain a problem, particularly for offenders from northern and other isolated communities for whom it is more difficult to maintain family and community ties.

Aboriginal offenders tend to waive their rights for a parole hearing more often than do non-Aboriginals, choosing not to be considered for parole, which has implications not just for the offender's length of incarceration but also for institutional space needs and costs.

Aboriginal inmates are more unfamiliar with parole regulations than their non-Aboriginal counterparts. Aboriginal inmates coming from a reserve may face restricted parole opportunity because the offender is unwelcome on the reserve or because the reserve lacks required supervision or rehabilitation resources.

Significantly fewer full paroles are granted to Aboriginals than non-Aboriginal offenders. There has been questioning about the fairness or appropriateness of certain parole criteria and assessment factors considered in preparation for parole hearings. The "Working-Group On The Re-Integration of Aboriginal Offenders as Law-Abiding Citizens" has made recommendations for improving the opportunities for Aboriginal offenders to re-integrate into society.

4. ABORIGINAL SPECIFIC CORRECTIONAL PROGRAMMING

Special programs and policies aimed at assisting the Aboriginal offender have been developed over the past twenty years. Notable among them are the Native Liaison Support System developed in the early seventies, which resulted in an extensive network of services, such as the Native Counselling Services of Alberta and the Para-Judicial Native Counselling Services of Quebec.

CSC's 1985 policy on Aboriginal Spirituality and its 1987 policy on Native Offenders Programs have both facilitated the development of programs valuable to the rehabilitation of the Native offender.

Aboriginal-specific substance abuse treatment is presently offered in a number of CSC institutions, including Sacred Circle groups, Native Alcoholics Anonymous and Aboriginal life skills groups with a substance abuse focus. One newer innovative pilot project, being implemented in response to the Task Force Report, is a culturally specific "Substance Abuse Pre-Treatment Program" which is being piloted in two British Columbia institutions. This program is jointly funded by the CSC, the Solicitor General Secretariat and the National Native Alcohol and Drug Abuse Program of Health and Welfare Canada. Family and other significant persons from the community are involved in the entire process from the pre-treatment phase onward. If the evaluation of this pilot project indicates positive results, wider pilot testing would be desirable, including in the Prison for Women and one or more facilities with a protective custody component.

5. STAFFING AND REHABILITATION FACTORS

Attempts to recruit and retain significant numbers of Aboriginal staff into the correctional service have had modest results. Aboriginal staff who do work in the correctional setting often find themselves under pressure from both Aboriginal offenders and other staff, suggesting the need for increased and "sensitized" supervisory support. (Aboriginal prisoners often expect Aboriginal staff to make special allowances for them while the non-Native staff sometimes feel that the Aboriginal staff are making too many allowances - and even if they are reasonable, other prisoners sometimes perceive them as unfair advantages/favours; or Aboriginal offenders expect staff to give them support and show solidarity with them - essentially give them special consideration, while the non-Aboriginal staff are concerned that the Aboriginal staff not play "favourites".)

It is often difficult for Non-Aboriginal correctional workers to understand the social, cultural, spiritual and religious backgrounds of Aboriginal offenders and thus understand the

specific factors in the specific Aboriginal inmate's life situation. No general typology of inmates can provide such specific, yet very pertinent information. What is needed is staff training which recognizes regional differences in Aboriginal cultures. Decentralized staff training would provide the opportunity to access local cultural resources.

The linkage between Aboriginal criminality and socio-economic conditions requires that any attempted ameliorative measures "... address these socio-economic conditions, which include unemployment, poverty, alcoholism and family breakdown ... factors of violence, lengthy criminal record, alcohol abuse and lack of community ties are strongly associated with risk, and cannot be ignored when individual case management and release decisions are made".

6. LEGAL CONTEXT ISSUES

Aboriginal people in Canada have a unique legal status which, in turn, has implications for correctional measures. Correctional legislation which "discriminates" in favour of Aboriginal people is permitted under the "equality rights" section of the Charter (section 15) for several reasons including the rights of aboriginal peoples to self-government. The James Bay and Northern Quebec Agreement between the federal government, the province of Quebec, and the Cree and Inuit of Northern Quebec, signed in 1975, provided for specialized correctional institutions, programs and services appropriately modified to meet the needs of Cree and Inuit offenders. Equality of results, and not just the equality of opportunity, is the fundamental concern of affirmative action programs and means that such programs must include both "equal opportunity" and "remedial" measures.

7. IMPROVING THE CHANCES OF Aboriginal OFFENDERS TO BECOME LAW-ABIDING CITIZENS.

All of the foregoing content is relevant to the subject of this section, which is "how to improve the likelihood that the Aboriginal offender will become a law-abiding citizen?" (as a minimum aim) and a responsible contributing member of his/her community as a further aim.

Also relevant is much of the content of the working paper "Correctional Philosophy", particularly strategies c), d) and e) which emphasize the rehabilitation of the offender "...through the provisions of a wide range of program opportunities responsive to their individual needs" and principle 7 which speaks to the need to involve the larger Aboriginal community in

the correctional system. "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 services".

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ROLE OF RESEARCH AND EVALUATION IN THE SUBSTANCE ABUSE STRATEGY

BACKGROUND PAPER
BY DAVE ROBINSON

RESEARCH AND EVALUATION

INTRODUCTION

In this background paper, we outline the role of research and evaluation activities in the overall framework for the design and delivery of substance abuse programming.

The design of successful correctional programs is dependent upon the existence of sound empirical knowledge regarding the interventions that promote positive change in offender populations. It is well-recognized that a strong commitment to the objectives of research and evaluation will be necessary if the Correctional Service of Canada is to develop effective new approaches to treating offenders with substance abuse problems. In addition, 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.

While we have made achievements in understanding and treating substance abusers, our need for research-based knowledge about the extent of substance abuse problems and the strategies for addressing them in our offender population remain significant.

For example, we are continually confronted with the variety and complexity of substance abuse problems in our correctional setting. However, our knowledge remains limited regarding the most appropriate ways of classifying offenders according to types of substance abuse problems and assigning them to appropriate programs. In addition, we are aware of an immense diversity in the types of substance abuse programming extended to offenders across the five regions of our Service. However, some of these programs were not built on a strong research base, and the majority have not been subject to systematic evaluation. It is clear that we will achieve greater progress as we begin to close some of these gaps in our knowledge.

THE ROLE OF RESEARCH AND EVALUATION

The role of research and evaluation should encompass four broad areas of strategic action which will significantly contribute to our ability to address the problem of substance abuse among offenders:

> Existing Research - the reliance on existing research and evaluation knowledge about substance abuse program effectiveness in corrections to guide the design of new interventions.

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.

Outcome Evaluation - the ongoing use of outcome evaluation procedures to test the effectiveness of new and existing programs.

Global Criteria - the identification and use of global criteria for the measurement of progress in the development of our substance abuse strategy over time.

EXISTING KNOWLEDGE

Discussions of research and evaluation often focus on the potential contribution of new research, while failing to acknowledge existing bases of knowledge.

A minimum requirement for the development of successful substance abuse programming is that program components be based on techniques which have been shown to be effective through research. For this reason, proposals for new programs should be based on thorough reviews of existing literature in the area of substance abuse and treatment programming for offenders.

Many programs become introduced even when little or no evidence of their potential effectiveness can be identified. Clearly this situation is intolerable when it is considered that an enormous literature exists on programming for substance abusers and on the principles of correctional treatment. Although researchers have not answered all of the questions that must be addressed in this important area, program designers must make every attempt to identify what research and outcome evaluation findings suggest is the "state-of-the-art" in effective programming.

SPECIAL RESEARCH INITIATIVES

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

- Research on the development of typologies of substance abuse offenders; and

- Research aimed at developing innovative methods for delivering substance abuse programs.

An enduring problem concerns our ability to link offenders with differing needs for substance abuse services to the appropriate types of treatment approaches. Although the differentiation of offenders according to severity of substance abuse is one approach which will continue to guide our programming, there is also a need to explore alternative methods of categorizing substance abuse problems. For example, the relationship between criminal activities and substance abuse patterns represents one possible focus of classification for treatment.

The Lifestyle Screening Survey provides a research avenue for the exploration of substance abuser typologies of offenders. As a comprehensive survey of substance abuse patterns, criminal behaviour, and other areas of functioning, the Lifestyle instrument will furnish a strong data base for investigating this problem. The Lifestyle data base can be used to identify multiple types of substance abusing offenders (e.g. substance abusers with narcotic related offences, violent offenders with dependence on alcohol). As the Lifestyle data base grows over time, one research strategy would be to examine the natural flow of different types of offenders through the various substance abuse programs in our system.

Special research initiatives will also contribute to our ability to develop innovative approaches to the treatment of substance abusing offenders. A basic assumption underlying support for this type of research in the CSC is that as our understanding of substance abuse among offenders increases, our ability to provide effective programming will be greatly enhanced.

A number of focused research projects aimed at program development could be pursued. Research on offenders who have been successful in maintaining alcohol or drug free lifestyles following release would provide helpful information that could be used to design more effective programs. The objective of this type of research would be to identify the various circumstances and successful treatment experiences that were associated with the prevention of relapse.

We also need more research knowledge about the relationship between violent offending and substance abuse. The link between substance abuse and the commission of sex offences also requires further clarification. Another important area of research involves investigation of appropriate methods for delivering substance abuse programs to Aboriginal offenders. Greater

understanding of these phenomena will place us in a better position to develop effective substance abuse programming alternatives.

There are also a number of research problems related to the question of who benefits most from substance abuse interventions. The assignment of offenders to various treatment programs must be informed by knowledge about which offenders have the most to gain from programming. The relationship between offender characteristics and treatment success is an important area which should be routinely investigated in all projects involving research on new substance abuse programs. These questions can be best addressed within the context of outcome evaluations.

OUTCOME EVALUATION

Evaluations were recently conducted on four substance Abuse Programs which were believed to be representative of successful programs offered in the Atlantic, Ontario, Prairies, and Pacific Regions (Farrell, 1988). The evaluation focused on providing program descriptive information, and solicited opinions about the programs from inmate participants, program staff, and correctional staff in the institutions and community. The project also collected limited follow-up information on offenders who had participated in the substance abuse treatment programs. We have drawn from the findings and recommendations of this evaluation project.

The earlier report acknowledged the need to conduct research aimed at identifying the effectiveness of substance abuse programs. In the discussion that follows, we focus on this aspect of evaluation, which we refer to as "outcome evaluation".

Outcome evaluation involves the use of objective procedures for assessing the extent to which programs achieve their stated objectives (Rutman, 1984). In other words, the conduct of outcome evaluation relates to the issue of demonstrating program effectiveness. The advantages of conducting valid outcome evaluations include program accountability, objective information on which resource allocation can be based, and direction regarding possible modifications or improvements to programs.

The use of the term "outcome" in relation to substance abuse programs implies that there are specific criteria against which our programming efforts must be judged. In the CSC, the principle outcome criteria of all programming efforts pertains to our Mission objective of "... actively encouraging and assisting offenders to become law-abiding citizens, while exercising reasonable, safe, secure and humane control."

It follows that the outcome criterion of substance abuse interventions in the CSC must reflect this objective. Therefore, we recommend that the ultimate effectiveness of substance abuse programs be judged by their ability to reduce criminal recidivism. The emphasis on substance abuse interventions as an integral component of our correctional programming is also consistent with the Corporate Objectives for 1990-1993. Corporate Objective 3 states:

> To further develop, implement and evaluate drug and alcohol (substance abuse) programs, focusing on prevention, education and treatment in order to reduce recidivism.

By the very nature of substance abuse programming, it is assumed that our interventions will be effective in reducing the levels of substance abuse exhibited by offenders who participate in substance abuse programming. In addition to the outcome criterion of reducing criminal recidivism, we also recognize that the reduction of substance abuse must be included as an indicator of the success of our substance abuse programming.

A number of mechanisms must be in place in order to evaluate the effectiveness of substance abuse programs. The application of evaluation procedures following the delivery of a program threatens the evaluator's ability to reach valid conclusions about the outcomes of a program. For this reason, it is essential that new substance abuse programs incorporate an evaluation component at the initial stage of program design. Below we propose a number of program design strategies that facilitate the conduct of outcome evaluations. These components should be included in the design of all major new substance abuse programming initiatives in the CSC.

- Definition of what type of offenders the program is targeting and how they are selected for participation.
- Clear statements of the intended outcomes of the program.
- Specification of the practices and procedures that constitute the program (e.g., pre-service assessment procedures, relapse prevention techniques, etc.)
- Pre/Post measurement of the offender behaviours which the program is intended to change.

- Measurement of all relevant offender characteristics which may be predictive of who gains most from exposure to the program.

The introduction of the above evaluation components would enhance the integrity and evaluability of new programs as well as programs which already exist in the CSC.

Ideally, the use of the full outcome evaluation model would serve as a standard for all substance abuse programs offered in our institutional and community settings. However, in practice, we recognize that there are a number of restrictions on our ability to implement rigorous evaluation designs for all programs. A major limitation involves the lack of research expertise necessary for designing and conducting evaluations at the program level. However, as a minimum standard, we reiterate that the basic evaluation model should be applied to all new major programming initiatives. In these cases, the model should be extended to include post-program follow-up measurement of the use of substances and criminal behaviour of program participants.

In order for the CSC to derive maximum benefits from the results of outcome evaluations, it is imperative that evaluations of major programming initiatives be well-coordinated. The need for careful planning of outcome evaluations, as emphasized above, dictates that the evaluation procedures are planned in advance and that provisions are made for all facets of the collection, analysis, and interpretation of evaluation data. This is particularly crucial for large scale initiatives involving the participation of more than one region.

GLOBAL CRITERIA

While evaluation of specific program initiatives is an important goal, more global assessments of our progress in developing a successful substance abuse strategy should not be overlooked. This is especially true at a time when the CSC has recognized substance abuse as a major problem requiring focused attention. For this reason, it is proposed that global measures of our performance in implementing the recommendations of the Substance Abuse Task Force be devised.

A number of possible global measures are proposed below:

- The levels of offender participation in substance abuse programming.

- The number of new substance abuse programs introduced in the community and institutions.

The number of substance abuse programs which have been subjected to outcome evaluations.

- Trends in the results of random urinalysis testing.
- The prevalence of alcohol and drug contraband in the institutions.
- The rates of criminal recidivism of offenders who participated in substance abuse programming.
- The post-release substance abuse patterns of offenders who participated in substance abuse programming.
- The levels of participation in staff substance abuse training.
- The attitudes and commitment of staff toward substance abuse programming.
- The number of Task Force recommendations which have been implemented and the level of implementation.

The global measures might be examined after periods of 3 to 5 years to provide an objective assessment of movement toward our objectives in the area of substance abuse. Performance on the measures could be monitored over time at the national and regional levels. The measures could also be applied to individual institutions and community settings.

The role of research and evaluation as described above emphasizes the importance of knowledge acquisition strategies in the development of substance abuse programming. There is a need to become more reliant on existing research on substance abuse in offender populations. We also need to identify and pursue research questions that will allow us to develop new and innovative approaches to the unique substance abuse problems that we are confronted within the CSC. It is also essential that the effectiveness of new initiatives be subjected to outcome research. Finally, a comprehensive research and evaluation scheme would also incorporate the development of global criteria for monitoring the overall progress of the substance abuse strategy to be adopted by the Service.

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CASE MANAGEMENT ROLES

BACKGROUND PAPER
BY JIM MARSHALL

CASE MANAGEMENT ROLES FOR CORRECTIONAL TEAM MEMBERS IN THE UNIT MANAGEMENT CONCEPT

INTRODUCTION

All correctional team members, which includes all staff who have personal interaction with inmates, must be knowledgeable about the case management process, and have a clear understanding of their specific case management tasks. The purpose of the following Case Management Role Paper is to define correctional team member involvement in the case management process, within the Unit Management concept. **It should be stressed that case management is a process. The success of the process and the contribution it makes to achieving the Mission of the Service, is directly linked to the information provided, as a result of face to face interactions between inmates and staff.** Therefore, it is essential that all correctional team members observe and have face to face interaction with inmates, in all areas where inmate activities occur. These observations and interactions must be recorded and utilized in assessing inmates for the earliest possible release. This will also contribute to a more secure, safe and controlled correctional environment. In this way all correctional team members who have personal interaction with inmates, whether they be correctional officers, shop instructors, kitchen stewards, educational/program personnel, or farm workers, have an important role to play in contributing to, and being actively involved in the case management process with inmates.

A. CORRECTIONAL OFFICER I (CO-I)

The CO-I will participate actively in the case management process for inmates, under the overall direction of a Unit Manager and the direct supervision of the Correctional Supervisor. The CO-I is not assigned an inmate caseload, however, he/she is an integral part of the case management process. He/she will be required to act as an initial point of contact for inmates. The CO-I will be required to observe, interact and record behavioural information regarding inmates. In this way, they will be contributing valuable information to the case management process. The most common form used for this purpose will be the Activity Record.

The CO-I will also be able to develop an awareness of individual and group behaviour patterns through interaction and observation. In this way they are better prepared to document and forward all unusual activities for appropriate review. This information contributes towards a more safe and secure correctional environment. The CO-I should as much as is operationally feasible, visit all areas of inmate activity regularly to solicit and share information about

inmates with other staff members. In addition, the CO-I will be working in the cell block areas on a rotational basis. This will provide an opportunity to interact with offenders and learn about case management processes. This will provide for more enhanced dynamic interaction between staff and offenders at the line level, which will make for more effective case management and security within the institution. The CO-I should be encouraged to solicit advice and direction from the Correctional Supervisor, Case Management Officer and front line caseworkers on case management procedures.

CASE MANAGEMENT TASKS FOR THE CO-I (CO-I)

1. ACTIVITY RECORDS: As a member of the unit team, the CO-I must ensure that his/her front line, day-to-day observations and interactions with inmates be recorded and forwarded for review. For this reason, the CO-I shall complete Activity Records which indicate behavioural observations that are related to the area in which the officer will be observing and interacting with inmates. For example, if the officer is posted to cell block, most of his/her Activity Records will relate observations concerning the interactions between inmates in that area, while a CO-I posted in the yard will make observations concerning the groupings of specific inmates and their interactions.

2. PERFORMANCE NOTICES: The Performance Notice is intended to function as a tool to promote positive behaviour change. The CO-I will use the Performance Notice in a manner which is consistent with the Service's desire to deal with inmate behaviour at the lowest level of intervention.

   Frequency/Timeframes: The Performance Notice shall be employed as necessary, and under the guidance of Correctional Supervisors and Unit Managers.

B. CORRECTIONAL OFFICER-II (CO-II)

The CO-II will participate actively in the case management process with inmates, under the overall direction of a Unit Manager, the direct supervision of a Correctional Supervisor and the functional supervision of a Case Management Officer. The CO-II will act as the first point of contact for inmates on his/her assigned caseload. The CO-II will be expected to complete case management tasks that are critical in encouraging and motivating inmates to participate in programs and to take the steps necessary, to address their criminality. This means the CO-II will be very much involved in using the Case Management Strategies approach, in the day-to-day management of inmates. More specifically, the CO-II will be an active participant in using the Case Management Strategies interview, and in determining the intervention group. They will also be active participants in the development of the correctional plan for inmates on his/her caseload. Teamwork between the Case Management Officer and the CO-II will be necessary to ensure that consistent and effective case management planning, documentation and appropriate intervention strategies are established.

It must be stressed that the case management process is made up of a documentation component, in combination with face to face interaction between staff and inmates. It is critical that the CO-II have a thorough understanding of the inmate's correctional plan to most effectively enhance the security and case management of the institution. This will be essential in order for the CO-II to be actively and effectively involved in the information sharing process with inmates. It will prove especially important in providing appropriate feedback to the inmate regarding his/her behaviour in relation to the correctional plan developed.

This in essence means that although a CO-II may be assigned to a unit, he/she will be required to be deployed in areas where inmate activities are occurring. The CO-II must be actively involved in monitoring the inmate's progress through visits to shop instructors, recreation/visits and correspondence areas, meal lines, medication parades and educational/program locations. The knowledge gained by the CO-II through active involvement in the case management process, in combination with the mobility to interact with inmates in all areas where activities occur, will be the key to success in this approach to managing inmates.

PHASED APPROACH FOR CO-II INVOLVEMENT IN THE CASE MANAGEMENT PROCESS

The involvement of CO-II in the case management process will vary according to the strategies that are developed in the institutions to fully implement the Unit Management concept. In order to accommodate the evolutionary stages that will be required to have CO-II meaningfully and effectively involved in the case management process, a phased approach to their involvement will be taken. The Case Management Officer remains the architect of the case and remains ultimately responsible for the process.

PHASE I

Phase I is the initial level of involvement that will be expected for all CO-II on a National basis. It is recognized that staff must be assisted through appropriate training to take on their new roles. To effectively allow for this transition process to occur this phase will be implemented fully by December 1, 1991. The tasks of this phase are described as follows:

PHASE I TASKS

1. Completes Activity Records.

2. Participates in the completion of Casework Records with the Case Management Officer.

3. Organizes and participates in bi-monthly case conferences.

4. Provides information sharing with offenders.

5. Attends NPB hearings as operationally feasible.

6. Participates in the orientation for new inmates regarding the case management process.

7. Participates in the Case Management Assessment interview with the Case Management Officer.

8. Participates in the Force-Field Analysis of Needs development with the Case Management Officer.

9. Participates in the development of the Correctional Plan with the Case Management Officer.

10. Participates in the ongoing monitoring of the Correctional Plan.

11. Participates in the recommendation process to releasing authorities (i.e., Warden and NPB).

12. Participates in providing comments for Temporary Absences, Earned Remission, Private Family Visits, Employment and Programming Boards, Segregation Review Boards, Inmate Transfers, and Disciplinary Boards.

PHASE II

The second phase outlines those case management tasks that will require more enhanced training to accomplish satisfactorily, and will establish the full level of involvement for CO-II on a National basis.

The goals will be to have all CO-II on a National basis carry out the Phase II tasks as described. To effectively allow for this transition process to occur, this phase will be implemented fully by December 1, 1993. These tasks are described as follows:

1. Completes the case management orientation session.

2. In consultation with the Case Management Officer, completes the Case Management Assessment interview.

3. In consultation with the Case Management Officer, completes the Force-Field Analysis of Needs.

4. In consultation with the Case Management Officer, develops and completes the Correctional Plans.

5. In consultation with the Case Management Officer, provides recommendations for Earned Remission, Private Family Visits, Employment, Programming, Segregation Review and Disciplinary Boards, and Inmate Transfers.

6. In consultation with the Case Management Officer writes Progress Summaries for Private Family Visits and Temporary Absences.

PHASE III

It is recognized that some tasks are to be completed only by the Case Management Officer. However, to promote the development of CO-II staff, these tasks could be delegated to a CO-II.

The Unit Manager may delegate case management responsibilities after consultation with the Coordinator Case Management, Case Management Officer and Correctional Supervisor. The delegation of additional case management responsibilities will be documented in the Performance Appraisal.

PHASE III TASKS

1. Criminal Profile Report.

2. Progress Summaries.

3. Completes all tasks as identified in Phases I and II.

MAJOR CASE MANAGEMENT TASKS FOR CO-II
(CO-II)

1. ORIENTATION ON CASE MANAGEMENT: The CO-II will be assigned a small caseload of inmates (usually between four and eight). The CO-II responsible for the case shall be involved in the process of providing each inmate on his/her caseload with information concerning the case management process, i.e., timeframes for release.

   Frequency/Timeframes: The CO-II is responsible for participating in or providing to each inmate on his/her caseload, an individual orientation on the case management process within two weeks of the inmate's assignment to the unit.

   Phase I: participates in the case management orientation;

   Phase II: responsible for the delivery of the case management orientation.

2. CASE MANAGEMENT ASSESSMENT INTERVIEW: The initial in-depth, semi-structured interview will be conducted with new federal inmates by the CO-II or the Case Management Officer to whose caseload they have been assigned. This allows the front line officer to become familiar with all of the significant factors concerning the background and personal history of each of the new inmates on his/her caseload. It will also provide the information which is necessary to complete the Force Field Analysis of Needs and the Correctional Plan.

   Frequency/Timeframes: The CO-II or the Case Management Officer will complete the Case Management Assessment interview, score the interview items, and determine the intervention group for each of the inmates assigned to his/her caseload within thirty (30) days following the date of sentencing (the timeframe may be extended by 15 days in those regions using a centralized penitentiary placement process).

   Phase I: participates in the Case Management Assessment interview with the Case Management Officer;

   Phase II: In consultation with the Case Management Officer, is responsible for completing the Case Management Assessment interview.

3. FORCE-FIELD ANALYSIS OF NEEDS: The Force-Field Analysis of Needs involves the in-depth examination of the major positive and negative factors which contribute to each individual offender's ability to function successfully in the community. The Force-Field Analysis of Needs is completed jointly by the CO-II and the Case Management Officer in a case conference setting. The responsibility for completing the document rests with the Case Management Officer.

Frequency/Timeframes: The Force-Field Analysis of Needs Report is to be completed by the CO-II or the Case Management Officer, within thirty (30) days following the date of sentencing. (The timeframe may be extended by 15 days in those regions using a centralized placement process).

Phase I: participates in the development of the Force-Field Analysis of Needs with the Case Management Officer;

Phase II: in consultation with the Case Management Officer, develops and completes the Force-Field Analysis of Needs.

4. CORRECTIONAL PLAN: The Correctional Plan is the document in which the most prevalent of the inmates' needs are stated and the strategies for their treatment are presented. It is a plan which is negotiated with the inmate, and against which progress can be assessed. The Correctional Plan is developed jointly by the CO-II and the Case Management Officer. The Case Management Officer is responsible for the writing of the Correctional Plan.

Frequency/Timeframes: The Correctional Plan(s) is to be completed by the CO-II or the Case Management Officer within ninety days of admission to federal custody.

Phase I: participates in the development of the Correctional Plan with the Case Management Officer;

Phase II: in consultation with the Case Management Officer, develops and completes the Correctional Plan.

5. THE CASEWORK RECORD: The CO-II or the Case Management Officer is responsible for completing a summary of the offender's progress towards the Correctional Plan on the Casework Record at regular intervals, usually to correspond with the bi-monthly case conference for each of the inmates on his/her caseload. The primary purpose of the Casework Record is to provide a summary of the progress each inmate has made towards the goal(s) outlined in the Correctional Treatment Plan, including the role of intervention and where necessary, to update and revise the plan. The record is intended to link the Correctional Plan with the day-to-day activities of the inmate. This is facilitated by the use of the Activity Records which indicate significant observations and behaviours relating to the inmate from staff and areas throughout the institution. As the focus of both the inmate and the correctional staff should always be on following the Correctional Plan and attaining the objectives set out in the Correctional Plan, this record ensures that CO-II's are regularly monitoring and counselling inmates on their caseload towards meeting the objectives.

Frequency/Timeframes: The Casework Record shall be utilized on an ongoing basis, noting significant behaviour, interaction and Case Management Activities regarding the Correctional Plan.

6. ACTIVITY RECORDS: The Activity Record is a communication tool used by all staff to record observations and inform the responsible CO-II and CMO of the inmate's behaviour. CO-IIs will not ordinarily use the Activity Record for those inmates on their caseload as the Casework Record will be the primary recording document (except where the information may be inconsistent with the use of the Casework Record). CO-IIs will use the Activity Record to record observations about inmates, not their caseload. These Activity Record entries may include comments/ observations about a particular inmate's progress with respect to his/her Correctional Plan as well as recording the inmate's behaviour in the unit and in program areas.

Frequency/Timeframes: The CO-II shall complete Activity Records for all inmates when significant behaviour is observed or when notable information arises from a discussion with the inmate or about the inmate.

7. PROGRESS SUMMARY REPORT: The Progress Summary Report is completed in all cases where a major decision is to be made concerning an inmate's level of security (e.g., institutional transfer) or freedom in the community (e.g., conditional release, temporary absence). This report provides a summary of case information and a recommendation for the decision-maker. The completion of the Progress Summary Report is the responsibility of the Case Management Officer. A case conference which includes the CO-II and the Case Management Officer must occur prior to the writing of the report. The purpose of the case conference is to ensure that all information, particularly the progress achieved towards meeting the goals expressed in the Correctional Plan, is considered prior to a recommendation being made.

Frequency/Timeframes: The Progress Summary Report is completed as required according to the procedures set out in the Case Management Manual.

Phase I: Participates with the Case Management Officer in completing Progress Summaries by providing comments concerning Correctional Plan progress and the development of recommendations for decision-makers;

Phase II: In consultation with the Case Management Officer, prepares Progress Summary Reports for Private Family Visits and Temporary Absences;

Phase III: In consultation with the Case Management Officer, prepares Progress Summary Reports for release considerations.

8. BI-MONTHLY CASE CONFERENCE: The case conference is intended to function as a forum whereby the two principle persons responsible for providing case management services to the inmate are able to discuss the offender's progress against the Correctional Plan, and to develop future strategies to assist the offender to meet his objectives and prepare for conditional release. The CO-II is responsible for ensuring that case conferences with the Case Management Officer occur, regarding each of the inmates on his/her caseload. The discussion which takes place at the case conference provides direct input for the completion of the Casework Record, and later for the Progress Summary Report.

Frequency/Timeframes: The CO-II shall arrange and participate in a case conference bi-monthly for each of the inmates on his/her caseload.

9. INFORMATION SHARING WITH INMATES: As the front line or primary caseworker for a small caseload of inmates, the CO-II shall be responsible for sharing all case management reports with the inmate. These include all reports authored by the CO-II as well as the Case Management Officer. They are to be shared in accordance with the Access to Information legislation and the procedures set out in the Case Management Manual.

10. ATTENDANCE AT NATIONAL PAROLE BOARD AND SEGREGATION REVIEW HEARINGS: The CO-II shall, wherever operationally feasible, attend National Parole Board and Segregation Review Hearings for the inmates on his/her caseload.

C. THE CASE MANAGEMENT OFFICER

The CMO is directly responsible to the Unit Manager for all aspects of case management in the unit. This means that the CMO is responsible to coordinate, promote and control the case management process for the inmates within the unit and the institution. This involves the functional supervision of case management tasks being completed by line staff, as well as direct responsibility for all case management activities and counselling for inmates. One of the primary roles of the CMO will be to take a leadership role in developing and coaching line staff in case management related activities. This can be most effectively accomplished when the CMO is located in the unit. Quality control of the case management process will be a high priority for CMOs. This will be essential, as a broad network of staff will be contributing information to, and be actively involved in the case management of inmates. Feedback by the CMO to correctional team members completing case management documentation will be essential to not only ensure professional quality and timely reports, but to ensure the Correctional Plan for the inmate is current and accurate.

The CMO will provide feedback to the Correctional Supervisor and Unit Manager on Correctional Officers' case management performance. This feedback will be especially important as the CMO will participate with the Unit Manager and Correctional Supervisor, in delegating case management duties as appropriate to individual Correctional Officers.

The CMO is the architect of the case management approach being utilized for inmates within the institution. They will be required to compile information from diverse sources, and synthesize it in such a manner that it links directly with the Correctional Plan of the offender. In this way, correctional team members will work together to help inmates address their criminality. It should be noted that as aspects are delegated to other team members, the CMO maintains ultimate responsibility for the process. As CO-IIs take on more responsibility for completing case management tasks, the CMO should have more time for direct counselling of offenders.

CASE MANAGEMENT TASKS FOR THE CMO (CMO)

1. CRIMINAL PROFILE REPORT: The Criminal Profile Report is a comprehensive case management document completed upon admission to a federal institution. It shall be the responsibility of the CMO to complete (this may be delegated to the CO-II - refer to Phase III). The sources of the information which will be analyzed and contained in the report are varied and include police, court, community, provincial and private agency information. This document will serve as a reference to assist in future case planning and decision-making.

   Frequency/Timeframes: The Criminal Profile Report shall be completed in time for the One-Sixth Review for all offenders serving four years and less. In all other cases, the Criminal Profile Report will be completed within one hundred and twenty (120) days from the date of admission to the institution of initial placement. Amendments may be required according to the procedures provided in the Case Management Manual.

2. CASEWORK RECORDS: The CMO shall record all significant interactions which occur with each inmate on his or her caseload on the Casework Record. These must be considered when assessing progress towards the goals set out in the Correctional Plan, and included in the Correctional Plan Progress Report.

3. FORCE-FIELD ANALYSIS OF NEEDS: The Force-Field Analysis of Needs involves the in-depth examination of the major positive and negative factors which contribute to each individual offender's ability to function successfully in the community. The CMO is responsible for completing the Force-Field Analysis of Needs exercise in conjunction with the CO-II.

Frequency/Timeframes: The Force-Field Analysis of Needs shall be completed by the CMO or the delegated CO-II within thirty (30) days.

4. CORRECTIONAL PLAN: The Correctional Plan is the document in which the most prevalent of the inmates' needs are stated and the strategies for their treatment are presented. It is a Plan which is negotiated with the inmate, and against which progress can be assessed. The completion of the Correctional Plan document is the responsibility of the CMO (or the CO-II-see Phase II). The actual development of the Plan shall be done in a cooperative exercise with the CMO and the CO-II.

Frequency/Timeframes: The Correctional Plan document shall be completed by the CMO or CO-II within ninety (90) days of the inmate's admission to federal custody.

5. BI-MONTHLY CASE CONFERENCE: The CMO is required to participate in a case conference for each of the inmates on his/her caseload. The case conference will be arranged by the respective CO-II for each inmate on his/her caseload. The assessments and decisions made during this case conference will be documented in the Casework Record.

Frequency/Timeframes: The CO-II will arrange a conference for each of the inmates on his/her caseload, which will be attended by the CMO bi-monthly.

6. PROGRESS SUMMARY REPORT: The Progress Summary Report is completed in all cases where a major decision is to be made concerning an inmate's level of security (e.g., institutional transfer) or freedom in the community (e.g., conditional release, temporary absence). This report provides a summary of case information and a recommendation for the decision-maker. The CMO (or CO-II - see Phases I and II) is responsible for completing all Progress Summaries (i.e., Segregation Review, Private Family Visits, Institutional Transfers, Conditional Release, Temporary Absences). As a document which provides a recommendation to a decision-

maker concerning some nature of release or significant change in institutional conditions, the information and analysis contained in the report must be comprehensive with a strong emphasis on the progress made by the inmate on his/her Correctional Plan. It is therefore required that the CMO and CO-II discuss the relevant factors and the recommendation which will be made to the decision-maker, in a case conference setting prior to the writing of the report.

Frequency/Timeframes: The Progress Summary Report is completed as required according the Case Management Manual.

7. COMMUNITY ASSESSMENT REPORT REQUESTS: The CMO is responsible for requesting all Community Assessment Reports from the applicable Parole Office. As the officer responsible for the completion of the Progress Summary Report, the CMO must ensure that the information required for the completion of this report is obtained from the community.

   Frequency/Timeframes: Community Assessment Report requests will be made by the CMO at such times as are indicated by the procedures contained in the Case Management Manual.

8. ATTENDANCE AT NATIONAL PAROLE BOARD AND SEGREGATION REVIEW HEARINGS: The CMO must attend all hearings for the inmates on his/her caseload when their cases are being considered by either the National Parole Board or The Segregation Review Board. As a CSC representative who is familiar with the inmate's progress and individual needs, the CMO functions as the resource person for the members of these two decision-making boards.

D. THE COORDINATOR OF CASE MANAGEMENT

The Coordinator Case Management reports directly to the Deputy Warden Correctional Operations and is responsible to provide expert advice to the institutional management team regarding the planning and delivery of case management services, Case Management Strategies and related programs. The Coordinators' role is client centered in that he/she has several primary clients such as the Warden, Unit Manager, CMO, Correctional Supervisor and both levels of Correctional Officers. In essence then, though the Coordinator works directly for the Deputy Warden, the role must be primarily

one of support and assistance to the clients named above, in all case management related matters, rather than supervision and direct authority.

The Coordinator Case Management has an important role to play in enhancing and solidifying teamwork and open communications among Unit Managers, Correctional Supervisors and CMOs. This can be accomplished most effectively when the Coordinator regularly liaises with staff and inmates in the cell block areas, and attends staff briefings as much as possible. Regular meetings between the Unit Managers, CMOs and Correctional Supervisors will be essential in fostering case management planning.

Developing and conducting operational assistance reviews, with regard to case management, will be an important task for the Coordinator Case Management. This can be accomplished by designing and implementing effective quality control mechanisms and performing regular audits to ensure that high case management standards are consistently met. These quality control processes must not only ensure quality and timeliness of reports, but ensure that the Correctional Plan for the inmate is current and accurate. The Coordinator will also be responsible to assist the Unit Manager in developing, implementing, and operating individual unit monitoring systems relative to case management activities, such as Case Management Strategies and completed Correctional Plans. This will be essential to ensure that the case management procedures are being completed as per established expectations. The Coordinator will assist Unit Managers, Correctional Supervisors and CMOs in planning the unit's case management training. This will mean identifying and recommending staff training needs, delivering training as required to all institutional staff, including unit staff, in the case management process, Case Management Strategies and related responsibilities. In addition, the Coordinator will act as a resource person for other staff required to deliver case management training. The Coordinator will assist Unit Managers in completing Performance Appraisals on CMOs, by providing information regarding observed case management performance. The Coordinator may also be required to initiate or attend Case Management, Parole, Temporary Absence, Citizens Advisory Committee, Inmate Committee or other meetings as needed.

The Coordinator Case Management will liaise with the National Parole Board to discuss operational, case management and policy issues.

CASE MANAGEMENT TASKS FOR THE COORDINATOR OF CASE MANAGEMENT (CCM)

1. REPORT MONITORING SYSTEM: The CCM is required to develop and control a "bring forward (BF)" system to ensure the timeliness of case management reports, including the Criminal Profile, Force-Field Analysis of Needs, and Correctional Plan. It is essential that in order to ensure the effective analysis of inmate needs, planning of strategies and monitoring of progress, that the steps of the casework process are carried out in an efficient and timely manner. The information provided by the BF system is to be conveyed on a regular basis to the individual Unit Managers and Deputy Warden in order that they may take corrective action wherever necessary.

   Frequency/Timeframes: The CCM shall provide each Unit Manager, on a monthly basis, with a listing of all Criminal Profile, Case Management Strategies, Force-Field Analysis of Needs and Correctional Plan reports, by unit, which are overdue, and which are due in the following thirty (30) days.

2. OPERATIONAL REVIEWS: The CCM is responsible for reviewing a sample of the case management reports completed by the CMOs/CO-IIs in each unit. Ten (10) percent of inmate files from each unit shall be reviewed with specific focus on the content, quality and timeliness of Assessment Interview, Criminal Profile, Force-Field Analysis of Needs, Correctional Plans, Correctional Plan Progress and Progress Summary Reports. A summary of the operational review shall be forwarded to the individual Unit Managers for their information and action where necessary. An ongoing review of case management documentation quality is necessary to ensure that cases are properly analyzed. This will ensure that a dynamic casework approach is being carried out, and that decision-makers are provided with the information on which they are able to make informed quality decisions.

   Frequency/Timeframes: The CCM shall provide each Unit Manager with a quarterly report summarizing the findings of the operational review, by unit, for that period.

3. IDENTIFICATION OF TRAINING NEEDS FOR UNIT MANAGEMENT STAFF RE THE CASE MANAGEMENT PROCESS: All unit staff will be in direct contact and have daily interaction with inmates. As such, it is essential that they are cognizant in the workings of the case management process. The CCM shall monitor and record training which has taken place for all unit staff with respect to case management functions. This information will be provided to the Unit Manager and the Staff Training Coordinator, and will serve to identify training needs for staff within the units.

   Frequency/Timeframes: The CCM and Unit Manager will provide a written report to the Deputy Warden Correctional Operations and Staff Training Coordinator every six (6) months which outlines what training/information sessions that each unit staff member has received re the case management process.

4. TRAINING DELIVERY FOR CASE MANAGEMENT FUNCTIONS: The CCM shall provide or coordinate the training/ information sessions for all unit staff involved in the case management process. This includes training by the CCM in such skills as the Case Management Assessment semi-structured interview, and the development of the Force-Field Analysis of Needs and Case Plan. The CCM will consult with the Unit Manager to determine unit and individual training needs.

   Frequency/Timeframes: Training/information sessions will be delivered as unit needs are identified.

5. ANNUAL REVIEW OF UNIT PLAN: The CCM is required to assist the Unit Manager in completing the Annual Review of the Unit Plan from a case management perspective. As the person most aware of the overall state of the case management process in both the individual unit and the institution as a whole, including training needs, quality control of case management reports and current case management issues, he/she is in the best position to advise the Unit Manager with regards to revising the Unit Plan.

   Frequency/Timeframes: The CCM will provide input to each Unit Manager annually on case management issues for inclusion in the Unit Plan.

6. CASE MANAGEMENT REPORT DELEGATION: The CCM will provide his/her input, in conjunction with input from the CMO and the Correctional Supervisor, to the Unit Manager when he/she is considering the decision to delegate the completion a case management report from a CMO to a CO-II. As a result of his/her functions of quality control and training delivery, the CCM is in a position to provide qualified advice as to whether a CO-II is capable of preparing certain case management reports.

7. PERFORMANCE APPRAISALS FOR CMOS: The CCM is responsible for providing the Unit Manager with evaluative input concerning each CMO who is assigned to his/her particular unit. The CCM is aware of the quality of the reports, and the case management services provided by each CMO as a result of quarterly operational reviews, and training which has been delivered.

   Frequency/Timeframes: As required by the Performance Appraisal cycle, the CCM will provide the Unit Manager with oral or written evaluations of each CMOs abilities, performance and needs with respect to their case management functions.

8. INFORMATION DISSEMINATION: The CCM is responsible for ensuring that Unit Managers are aware of the intent and operational impact of national and regional directives and current initiatives which involve the case management process. As the expert on issues and directives concerning the case management process, the CCM must ensure that Unit Managers remain current in this regard. The CCM will also be responsible to ensure correctional staff are trained in "the sharing Information Policies" that have been established for the Correctional Service of Canada.

E. THE CORRECTIONAL SUPERVISOR

The Correctional Supervisor is directly responsible to the Unit Manager for the administration and supervision of a team of officers assigned to a specific unit. The Correctional Supervisor will participate in the case management process by supervising, monitoring and assessing the performance of Correctional Officers completing case

management assignments. It is therefore essential that the Correctional Supervisor maintain a thorough working knowledge of the case management process, and be assigned to the unit as much as possible. The Correctional Supervisor will also be required to maintain a knowledge of each Correctional Officer's strengths, weaknesses and training needs regarding all correctional practices, including case management. This information will be obtained through an ongoing assessment of staff effort and effectiveness regarding the case management process. This can best be accommodated through regular meetings between the Correctional Supervisor and CMOs to discuss and assess individual correctional officer's contributions to the case management process, as well as completion of individual case management tasks. This will prove to be very important as the Correctional Supervisor will be required to complete a Performance Appraisal for those staff they directly supervise as assigned, in their unit. The knowledge obtained regarding staff performance in the case management process will be of benefit as well, because the Correctional Supervisor will be expected to participate with the Unit Manager, CCM and CMO in delegating case management duties as appropriate to individual correctional officers. Teamwork between the Correctional Supervisors, CMOs, CCM and Unit Managers is an effective means of achieving consistent casework planning.

The Correctional Supervisor will be responsible for assigning inmate caseloads to CO-II in consultation with the CMO. The Correctional Supervisor must take an active leadership role in monitoring the timely and consistent completion of case management tasks and reports completed by Correctional Officers.

This means the Correctional Supervisor must participate in case conferences as required to assess staff performance in an interview setting and provide input into the case management of individual inmates. In addition, the Correctional Supervisor will meet regularly with the CMO to discuss and resolve casework procedures and policy within the unit, and provide assistance to staff on case management related matters.

It will be especially important that the Correctional Supervisor meet regularly with both CO-I and II to discuss specific case management duties and performance in order to ensure a consistent contribution to the case management process and to ensure case management standards are being met.

CASE MANAGEMENT TASKS FOR THE CORRECTIONAL SUPERVISOR

1. MONITORING OF CASE MANAGEMENT FUNCTIONS: The Correctional Supervisor is required to be involved in the Report Monitoring System (BF) as it affects the CO-Is and CO-IIs under his/her supervision. This includes the completion of all structured interviews and Correctional Plan Progress Reports, as well as all other report responsibilities which have been delegated to the CO-II. As the direct supervisor of a number of Correctional Officers, the Correctional Supervisor must be aware of both the timeliness and quality of reports and case management services provided by them. The Correctional Supervisor is responsible for ensuring that the information from the BF system is utilized as a constructive supervisory aid, and that problems with report completion and quality are documented for future Performance Appraisals and training plans.

   Frequency/Timeframes: The case management report BF system, provided by the CCM to the Unit Manager, should be reviewed by the Correctional Supervisor on a monthly basis.

2. CASELOAD ASSIGNMENTS: The Correctional Supervisor is responsible for assigning inmate caseloads for his/her unit. In making caseload assignments, the Correctional Supervisor should be cognizant of the relative abilities and skills of the CO-IIs. This will ensure that workload distribution and case management skills and abilities are effectively managed.

   Frequency/Timeframes: The Correctional Supervisor is required to assign new inmates to a CO-II within seven days of admission to the unit.

3. CASE MANAGEMENT REPORT DELEGATION: The Correctional Supervisor provides input, along with the CMO and CCM, to the Unit Manager when consideration is being made to delegate the responsibility for report writing to the CO-II. In his/her position as the direct supervisor of the CO-II, the Correctional Supervisor is able to provide information to the Unit Manager making the decision, concerning the abilities of the individual.

4. BI-MONTHLY MEETINGS WITH CMOS: The Correctional Supervisor is responsible for arranging and attending scheduled meetings with the CMOs who provide case management functions for the unit. The CMO, in his/her capacity of working with the CO-II on a common caseload, is in a position to provide the Correctional Supervisor with information which may assist in effective ongoing supervision and assessment.

   Frequency/Timeframes: The Correctional Supervisor is responsible for arranging and attending a meeting every two (2) months with each CMO who provides case management services in conjunction with the CO-II's who come under the supervision of the Correctional Supervisor.

5. CASE CONFERENCE ATTENDANCE: The Correctional Supervisor will attend on a bi-annual basis, case conferences which occur between the CO-IIs (under the supervision of the Correctional Supervisor) and CMOs. In attending case conferences, the Correctional Supervisor will obtain a first hand understanding of the CO-IIs abilities to perform case management functions. This in turn will ensure that training and developmental needs are identified. The observations made by the Correctional Supervisor concerning the CO-IIs role during the case conference shall be recorded in the Supervisor's Log and considered for inclusion in the CO-IIs Performance Appraisal.

   Frequency/Timeframes: The Correctional Supervisor is required to attend, on a bi-annual basis, a case conference which is being conducted between the CO-II and the CMO. This shall take place for each of the CO-IIs under the supervision of the Correctional Supervisor.

6. CONFERENCES WITH CO-Is AND CO-IIs (TWO PER YEAR): The Correctional Supervisor is required to meet regularly, on an individual basis, with each of the CO-Is and CO-IIs who come under his/her supervision. The purpose

of this interaction is to provide verbal feedback concerning case management functions carried out by the COs. The information obtained during meetings between the Correctional Supervisor and the CMO who works with the CO, and the information obtained from the Report Monitoring System (BF), will form the basis for this meeting. It is also an opportunity to discuss with the COs their specific developmental and training needs, as well as potential future delegation of case management functions to the CO-IIs. The observations and decisions reached during the case conference will be recorded in the Supervisor's log and be included in individual Performance Appraisals.

Frequency/Timeframes: A conference with each CO-I and CO-II under the supervision of the Correctional Supervisor will take place twice per year.

7. PERFORMANCE APPRAISALS FOR CO-Is AND CO-IIs: The Correctional Supervisor, in carrying out his/her function of completing Performance Appraisals for the CO-Is and CO-IIs under his/her supervision will specifically evaluate the officers' roles and involvement in the case management process. Case conferences with CMOs, regular meetings with other Correctional Supervisors, bi-annual conferences with the COs, and information obtained from the Report Monitoring System will be taken into consideration in developing the Performance Appraisal. In addition, the training undertaken, as indicated by the CCM, as well as the training and developmental needs assessed by the Correctional Supervisor will be indicated in the appraisal. Finally, the Correctional Supervisor is required to indicate in the Performance Appraisal whether or not, in the opinion of the Correctional Supervisor, the CO has obtained the necessary training and has the ability to be delegated further case management functions.

Frequency/Timeframes: The Correctional Supervisor will complete the Performance Appraisals for all CO-Is and CO-IIs under his/her supervision according to the timeframes set out in the Performance Review cycle. The Performance Appraisals will specifically evaluate case management functions carried out by the individual Correctional Officer.

F. UNIT MANAGER

The Unit Manager is directly responsible to the Deputy Warden Correctional Operations for the administration and management of a specific unit. The Unit Manager will supervise a team of officers consisting of: Correctional Supervisor(s); CMO(s); and two levels of Correctional Officers. The Unit Manager will manage the provision of case management services in the unit, and effectively integrate Unit Management principles with unit objectives and operations.

The Unit Manager will be responsible to ensure that all correctional team members are fully aware of the case management process and their role within that process. The Unit Manager will establish daily workloads and will assign caseloads to CMOs. The Unit Manager will meet with the Coordinator Case Management and CMO to develop goals, case management programs and plans which meet established institutional objectives.

The Unit Manager will monitor the progress of inmate case management. This can best be accomplished through the development and maintenance of a unit quality control process which must include a report monitoring system, operational assistance reviews, and institutional and unit self audits. It will be essential to establish the quality control process in consultation with the Coordinator Case Management. In addition, the Unit Manager must monitor the performance of CMOs and Correctional Supervisors in relation to established case management standards, as well as defined priorities and objectives. The Unit Manager will be responsible for completing Performance Appraisals on CMOs and Correctional Supervisors. It will be necessary to meet with the Coordinator Case Management to discuss staff performance and receive feedback regarding case management performance from their perspective. The Unit Manager must also ensure that Correctional Supervisors regularly review Correctional Officers I and II performance in relation to established role expectations and case management standards. An important aspect of the unit quality control process will be the effective monitoring and auditing of inmate progress in relation to established correctional plans.

The Unit Manager must establish unit procedures which encourage participation of all staff in the decision-making and case management process. This will be especially important as the Unit Manager will be delegating decision-making and additional case management responsibilities to staff after assessment and consultation concerning

individual officers is completed. Delegation of further responsibilities in these areas will occur only when validated through the Performance Appraisal process and after consultation with the Coordinator Case Management, CMO and Correctional Supervisor has taken place. The Unit Manager will meet regularly with all unit staff to share information and encourage team problem solving for case management and correctional practices issues. Through the evaluation process of all unit staff, the Unit Manager will be responsible for identifying training and developmental needs. It will be important to discuss the assessment of training needs with the Coordinator Case Management, and take the necessary action to ensure continued competence in case management and all correctional operations practices.

The Unit Manager will be required to participate in or to chair various institutional boards/unit committees, such as private family visits, transfers, segregation review temporary absences, security clearances and earned remission. The Unit Manager will be responsible to ensure that the Unit Plan is updated annually in relation to established standards for case management activities.

CASE MANAGEMENT TASKS FOR THE UNIT MANAGER

1. MANAGEMENT OF CASE MANAGEMENT ACTIVITIES: By reviewing the results of the Report Monitoring System and Operational Reviews conducted by the CCM, the Unit Manager is able to monitor the quality and timeliness of the case management services in the unit. The Unit Manager must ensure that this information is analyzed effectively in order that any identified weaknesses are brought to the attention of the respective CO-II or CMO, through the appropriate supervisor. In addition, this information will assist the Unit Manager to effectively plan training in case management processes for the unit.

   Frequency/Timeframes: The Unit Manager is responsible for reviewing the Report Monitoring System data on a monthly basis and the analysis emanating from the Operational Reviews quarterly, and taking action where necessary.

2. PERFORMANCE APPRAISALS FOR CMOs: The Unit Manager is required to meet with the CCM regarding the quality of case management services and reports for the CMOs assigned to his/her unit. This information, in addition to the written documentation received from the

Operational Reviews and Report Monitoring System is to be incorporated into a Performance Appraisal completed on the CMOs under the supervision of the Unit Manager.

Frequency/Timeframes: Performance Appraisals are to be completed by the Unit Manager for all CMOs assigned to his/her unit according to the timeframes set out in the Performance Appraisal cycle.

3. ASSESSMENT OF TRAINING NEEDS: By reviewing the training reports completed by the CCM, and reviewing the Performance Appraisal completed by the Correctional Supervisors for CO-Is and CO-IIs, the Unit Manager is required to determine the training needs for case management for the unit. He/she shall discuss the identified needs with the CCM and ensure that objectives are set for training/development of case management skills on a regular basis. He will actively pursue the development of in-house, on-the-job training.

   Frequency/Timeframes: The Unit Manager, in consultation with the CCM is required to assess training/developmental needs in case management, and set out unit objectives in this regard on an annual basis.

4. CASE MANAGEMENT REPORT DELEGATION: The Unit Manager, in consultation with the CCM, CMO and Correctional Supervisor, may delegate the writing of one or more of the following case management reports to the CO-II: the Force-Field Analysis of Needs; the Correctional Plan; and, Progress Summaries. This delegation will be based upon demonstrated skills and abilities as evidenced through the Performance Appraisal system. In cases where delegation occurs, the CMO must review and sign off the report, thus ensuring quality control.

   Frequency/Timeframes: The Unit Manager will review the potential for delegation of case management reports to the CO-II on an annual basis according to identified skills and training received which are documented in the Performance Appraisal.

5. ANNUAL REVIEW OF UNIT PLAN: The Unit Manager is responsible for ensuring that the Unit Plan provides an update of objectives and goals with respect to case management activities and training. The CCM is to be consulted for his/her input into the Unit Plan update.

Frequency/Timeframes: As directed by the Commissioner's Directive, the Unit Manager shall update the Unit Plans on an annual basis. In consultation with the CCM, the plans shall consider the state of case management on the unit.

6. CO-SIGNING OF CASE MANAGEMENT REPORTS: The Unit Manager is responsible to review and co-sign case management reports as defined in the Case Management Manual.

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CHAPLAINCY AND SUBSTANCE ABUSE

BACKGROUND PAPER
BY REV. CHRIS CARR

CHAPLAINCY AND SUBSTANCE ABUSE

INTRODUCTION

The importance of spiritual issues in the treatment of substance abuse problems is widely recognized. Spirituality has had an historic role in the development of substance abuse programming. As the field evolves, spirituality in its various forms is still seen as having an important role to play. Spirituality itself is challenged to be more comprehensive in its outlook. A good spiritual outlook provides both a healing process for substance dependency and motivation to go through various forms of treatment which are often difficult undertakings. In the penitentiary, chaplaincy is responsible for the delivery of spiritual programs. Native elders have responsibility for promoting native spirituality.

MANDATE OF CHAPLAINCY WITHIN A CORRECTIONAL SETTING

Chaplaincy provides a spiritual service for inmates and staff of each penitentiary. The mandate of chaplaincy is a "pastoral" or "spiritual" one and this mandate is given by the respective communities of faith.

To fulfill this mandate, chaplaincy offers a variety of activities in the closed world of the penitentiary as a way of bringing to reality the "beyond", the hope and reality of a higher normalcy, health, forgiveness and love. These include visiting throughout the institution; providing opportunities for worship and or sacraments; meeting with people where they live and work; being a sign of dignity and hope, counselling; promoting reconciliation; acting as facilitators of communication with families, staff, the community and others and advocating appropriate policies and actions.

Programming issues spring out of this pastoral mandate. While it is important to recognize that many activities in chaplaincy do not lend themselves to description by program goals and objectives, chaplains are still expected to deliver, or to provide for the delivery of, programs to fulfill their mandate. These programs can stand alone or be offered as part of an integrated approach to offender education. The scope of chaplaincy programs can be wide. They are designed according to the needs of the institution, the chaplain's job description and the particular skills of the incumbent chaplain. Even the "essential" programs such as worship and religious education are susceptible of wide degrees of emphasis in their implementation.

These program initiatives should include efforts to combat substance abuse.

TRAINING

While many chaplains have a natural and sympathetic interest in substance abuse, not all are competent in the field (although there are notable exceptions). Improved individual competency in substance abuse knowledge could assist chaplains in their helping role.

This training can easily be integrated into the structure of training presently in place for chaplains.

New chaplains are given a professional orientation to their work in corrections which takes place in four phases over a 12 to 15 month period.

> In Phase I, the new chaplain is involved in an accompaniment process with an experienced chaplain. They meet regularly over a period of about six months to discuss issues in ministry and in an effort to improve the efficacy of the interventions of the new chaplain. An awareness by the accompanier of the importance of the substance abuse issue in the life of most inmates could help insure that the new chaplain is in tune with this also.
>
> In Phase II, the new chaplains meet for a week of content oriented learning, which could easily include an introduction to the substance abuse issue and model in use for treatment.
>
> Phase III permits the new chaplain to choose an area of learning related to their ministry and to study it more in depth. In some institutions and for some chaplains, this training could be in areas related to substance abuse. One chaplain has chosen an education program in substance abuse and family healing.
>
> Phase IV is a brief meeting in which the chaplain is encouraged to identify future learning issues and to keep the learning approach active.

Other training opportunities for chaplains include ongoing professional development and regional in-service training. In both cases there are opportunities for further learning in substance abuse.

Chaplains should receive training in areas that most closely relate to their natural field of involvement such as:

- The model for substance abuse interventions in the CSC;

- A thorough understanding of 12-step programs, the role of chaplains in these programs (including but not limited to steps 4 and 5) and their relationship with other modes of intervention; and

- A familiarity with recovery issues, including relapse prevention and the role of the family in recovery.

COMMUNITY CHAPLAINCY

Community Chaplaincy is a new initiative of the chaplaincy division. It has been recognized for a long time that it is extremely difficult for ex-offenders to integrate into local faith communities after their release, even if they have had significant contact with the chaplaincy community inside the penitentiary. This is an intermediate bridge group that will help ex-offenders continue to grow spiritually and to make contact with the faith community of their choice. It is another way in which the community of good can influence the community of crime.

Community chaplaincies are taking various forms. With very few exceptions, CSC requires a plan that the level of government funding drop to a level of $10-15K at the end of three years. This implies that a plan for substantial community ownership of the Community Chaplaincy must be in place. This community support is fundamental to the concept. Community support also takes other forms through an ecumenical board of directors, volunteer involvement, etc.

These chaplaincies have the potential to bridge institutional and community living. In the field of substance abuse they would seem well placed to work at relapse prevention and family issues. They also have the advantage of being able to maintain contact with the ex-offender beyond warrant expiry date.

Because of the evolving role of community chaplaincies, the opportunities for intervention will have to be developed with sensitivity to pressures and priorities in the local situation.

INTERVENTION STRATEGIES FOR CHAPLAINCY

PRIMARY

Chaplains should recognize that all they do to create wholesome healthy attitudes and lifestyles is a contribution towards prevention of substance abuse and the overall health of the environment. Spiritual teaching, participation of volunteers,

involvement with the family will contribute to healthy living - a primary step in the prevention of substance abuse.

SECONDARY

There are several programs which address the issues of substance abuse directly and in which chaplains have assumed leadership roles. Some examples are:

- A Christian Education program for alcoholics has been offered for nearly 10 successive years at Springhill. Over 75 offenders participate annually;
- An Adult Children of Alcoholics program has been introduced and led or actively supported by chaplains in several institutions (notably Drumheller and LaMacaza);
- Chaplaincy played an influential role in the implementation of the Brentwood program in the Ontario region and in the modifications now being introduced;
- Chaplains have often acted as facilitators for the AA program;
- Chaplains have often been invited to be facilitators for steps 4 & 5 of the 12-step programs;
- Several chaplains have received extensive training in pastoral counselling and deal with substance abuse issues frequently in this context; and
- At least one chaplain has run "stop-smoking" educational programs.

Chaplains can lead these or similar programs; or they can act as motivators by encouraging offenders to participate in different programs of secondary intervention.

TERTIARY

Within the therapeutic community (TC), chaplains can play various roles. Traditional spiritual teaching usually places a very high value on community living, and many chaplains would find the TC a very satisfying place to work (as has been the experience with other staff). Their specific role in this community would be in developing the opportunities for spiritual growth that are in harmony with the philosophy of the specific program.

Some chaplains have the ability to lead such TCs.

TARGETS FOR INTERVENTION

Substance abuse prevention strategies target the environment, the abuser, or the substance itself. Chaplaincy initiatives should take into account these three targets.

Chaplaincy can affect the environment by discouraging substance abuse in its programs (smoking and excessive use of coffee).

Chaplaincy can focus effectively on the abuser through its invitation to participate in a new lifestyle, and the various programs it puts in place to support such a choice.

Chaplaincy may not be able to influence the availability of the substance of abuse, but chaplains should be aware of the different kinds of drugs available and of their impact on the body. They can also by their teaching reduction demand.

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ROLE OF NURSING AND SUBSTANCE ABUSE

BACKGROUND PAPER
BY GABRIELLE LANDRY

ROLE OF NURSING AND SUBSTANCE ABUSE

Throughout the years of modern nursing, educational preparation has steadily expanded. A vast body of knowledge has permitted nurses to move from bedside to a definite professional role.

Nursing management facilitates effective working relationship with other professionals and assists in fulfilling the Mission Statement of The Correctional Service of Canada. This is accomplished through a wide range of functions, a variety of backgrounds, clinical interests and attitudes toward all offenders. In addition, these versatile functions represent a unique opportunity for offenders with a substance abuse problem.

Nurses bring many assets to the Correctional Service of Canada. They understand developmental process and strengthen institutional programs. They are concerned with the quality of care and will provide it through multiple nursing functions available to offenders from reception to warrant expiry date. They carry out these functions directly or indirectly utilizing the nursing process through a care plan. Further, it is their responsibility to maintain accurate, precise, descriptive records of each offender's condition and treatment and his/her response to the care he/she has received.

The experience of nurses as program coordinators, researchers and consultants in the field of substance abuse and prevention program is well established. In 1988, the American Nurses' Association and the National Nurses Society on addictions were the first to publish Standards of Addictions Nursing Practice with Selected Diagnoses and Criteria, a guideline for contemporary addictions nursing practice which include care of clients with a broad range of abuse and addiction patterns.

In view of the present Task Force on Substance Abuse, it is recommended that appropriate professional expertise be retained to provide substance abuse programming in each operational unit as well as to optimise the available resources in place. The use of a single point accountability should permit a sophistication and efficacy of program consistent with community practice.

The health promotion model and the strategic program model, to be adopted by the CSC as the core of the substance abuse programming, will enable nursing to play a major role. The nurse can facilitate the offender's own vested interests in a manner congruent with his needs. The nature and scope of nursing practices include responses to health-conducive behaviour.

Nurses are capable of analyzing factors that impact on health at the individual, family and community levels. They also bring group skills, teaching expertise, inter-agency awareness, consultation skills, and a keen conceptualization of alcohol and drug abuse. They educate and help prevent and/or correct actual or potential health problems related to patterns of abuse and addiction. Nurses will assist offenders in learning new ways to address stress, maintain self-control and integrate health-coping behaviour into their lifestyle.

They serve as role models and provide the offender with the opportunity to learn principles of wellness and health promotion. Within this concept, nurses are well involved in the:

- prevention and promotion of AIDS;
- hepatitis B vaccinations;
- infection control;
- health awareness program;
- nutrition and diet;
- eating disorders;
- exercises and fitness;
- anger and stress management;
- behaviour modification;
- life skills;
- coping skills mechanisms, and
- suicide prevention.

They collaborate with the multidisciplinary team and consult with other health care providers in assessing, planning, implementing, and evaluating health services that attend to the primary, secondary, and tertiary prevention and intervention of substance abuse.

Nurses have long been adept at combining time, space, and people to serve offenders. They are used to negotiating the resources and have assumed the role of advocate making the health care team aware of the offender's needs and ensuring that appropriate actions are taken. Nursing representatives on drug and alcohol committees demonstrate support and commitment for substance abuse programming and allow a flow of continuing communication.

The counselling role is an inherent component of nursing practice. It includes giving information about the existence of self-help groups which provide support within the institution and the community, complement the offender's effort to recovery and ultimately assist the offender in taking charge of his/her life (Adult Children of Alcoholic, Alcoholic and Narcotic Anonymous, Alanon). Nurses encourage and motivate offenders to attend these associations. Nurses can also train offenders to help, support and counsel their peers.

They document interventions, offender participation in the program and responses to the counselling process. An ongoing and systematic monitoring is used to evaluate the responses of offenders with substance abuse problems. They apply knowledge of pharmacological principles and make pertinent observations and judgments concerning the effects of the medication used.

Nurses have a pivotal role to play in educating offenders about healthy lifestyles and encouraging them to enhance their health by using physiological, psychological, social, cultural and developmental experiences. The exciting process toward the promotion of quality care demands the expertise of the nurses in the area of substance abuse. Because of their ever changing role and a deep concern for humankind, nurses have taken the responsibility to develop that expertise.

They have accepted the mandate to increase their awareness, skills and knowledge so that the disabling and crippling problem of substance abuse is appropriately managed. There is no doubt as to why, how, where, and what nurses have done to increase their understanding so they can utilize nursing education and practice to intervene efficiently with substance abuse and offenders.

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ROLE OF PSYCHOLOGISTS

SUBSTANCE ABUSE

BACKGROUND PAPER
BY GABRIELLE LANDRY

ROLE OF PSYCHOLOGISTS
SUBSTANCE ABUSE

There are three principle functions envisioned for the psychologist:

ASSESSMENT

The principal role will be the assessment and subsequent referral of offenders for substance abuse treatment and counselling. This will occur both at intake and throughout the course of the sentence as these problems surface. The key to this aspect will be the integration of a standard assessment instrument as part of the assessment battery at reception.

TREATMENT

Because resources are limited and the vast majority of intervention will best be delivered by adjunctive therapists (counsellors, nurses, case managers), it is important to distinguish treatment from intervention. Treatment should be reserved for tat relatively small proportion of offenders who require intensive, tertiary programs. Cases such as those suffering from a dual diagnosis of mental disorder and substance abuse will likely fall into this category. Because this is bona-fide treatment, it must be delivered, supervised and evaluated by clinicians. These programs will be among those falling under the responsibility of psychologists. The majority of programs are not treatment, however, and careful distinction must be make between them.

EVALUATION

Psychologists could play a useful role in the evaluation of interventions delivered by other staff or under contract. Analyses of outcome and comparative studies to determine the relative efficacy of programs are among the elements that could be evaluated by psychologists.

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APPENDIX

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