

CURRENT SUBSTANCE ABUSE INTERVENTIONS, RESEARCH AND EMERGING DEVELOPMENTS

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I. INTRODUCTION

Recently, a number of new approaches to the treatment of addiction and substance abuse have been developed. Many of these approaches work well within the correctional context and the following section provides an overview of these approaches. The purpose is not to provide a detailed explanation of any one of these approaches, but to provide a description and sense of how they are applicable to working with offenders who have substance problems.

The paper also presents the results of new research and development activities that are underway within the Correctional Service Canada. These examples are presented in part to highlight the concepts discussed in this, and the other papers in this series, and partly to demonstrate how a research programme can be involved in the development of programming. These examples should bring together many of the concepts that have been discussed and provide concrete examples of their use. It is hoped that through these examples, the importance of research for both developing and maintaining substance abuse interventions within a correctional system will be evident.

II. GENERAL STRATEGIES IN TREATMENT

Four treatment approaches will be presented in this section, harm reduction, stages of change, relapse prevention, and motivational interviewing.

A. Harm Reduction

Harm reduction is a concept that grew from awareness of the deadly consequences of injection drug use following the appearance of HIV/AIDS. Through the very common practice of sharing syringes and other drug paraphernalia it became possible for an individual to suddenly have an incurable, fatal disease. People working with drug abusers recognized the need to take some action that would lessen the probability of the spread of disease without passing judgment on the drug using behaviour. Since those origins, harm reduction has become a strategy for dealing with the behaviour and consequences of all types of substance abuse. The approach is often misunderstood and rejected outright by some decision makers and programme delivery experts. Usually, the rejection of the approach results from seeing it as simply a call for needle exchange programmes and safe injection sites.

Harm reduction is more than a number of specific interventions. It is an approach to intervention that seeks to reduce the negative consequences of substance abuse to the individual and to the society. Rather than looking at drug or alcohol misuse as an inherently bad thing, harm reduction takes no position on the acceptability of the behaviour. However, it recognizes that substance abuse has negative effects and therefore actions can be taken to reduce those harms. Simply reducing the harms may help to stabilize the behaviour of individuals, assist in keeping them alive and reduce the negative consequence for the community in which the substance abusing individual lives.

Harm reduction is not a treatment programme, but an intervention. However, one of the values of harm reduction is that it can provide opportunities for further intervention with addicted individuals that may lead to their participation in more traditional programming, thereby leading to a reduction in their use of drugs and alcohol, and in many cases to their total abstinence from drug and alcohol use if that is warranted.

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Marlatt (1998a) provides a more detailed picture of harm reduction approaches in different countries as it relates to different substances, populations and challenges. Marlatt (1998b) provides a set of five principles for harm reduction (pp. 49 - 58):

(i) *Harm reduction is a public health alternative to the moral/criminal and disease models of drug use and addiction*

Harm reduction does not presume that substance abuse is morally wrong and must therefore be punished using criminal sanctions, nor does it take the view that substance abuse is a disease that requires treatment. However, given the negative consequences of substance abuse, encouraging people to stop using is a goal as indicated in the next principle.

(ii) *Harm reduction recognizes abstinence as an ideal outcome, but accepts alternatives that reduce harm*

Harm reduction can be viewed as having a continuum of responses. At one end of the continuum is the cessation of all substance abusing behaviours, thereby eliminating all of the harms associated with substance abuse. At the other end of the continuum is any small reduction in the harms caused by substance abuse. Frequently, harm reduction becomes associated with only the most controversial options such as safe injection sites. While safe injection sites are at the leading edge of harm reduction, they are not the place to start developing a harm reduction policy. A Correctional system can take a harm reduction approach by ensuring that its policies and procedures go as far as they can to reduce the harms associated with substance abuse.

(iii) *Harm reduction has emerged primarily as a "bottom up" approach based on addict advocacy, rather than a "top-down" policy promoted by drug policy makers*

As a result of how the harm reduction approach was developed, it is well accepted and meets the needs of people who require intervention.

(iv) *Harm reduction promotes low-threshold access to services as an alternative to traditional, high threshold approaches*

Traditionally, many programmes required a commitment to total abstinence before a person could be accepted into treatment. If there was drug or alcohol use during the programme the person was removed from treatment. These types of strict rules set high-thresholds for participation. Programmes that have low-threshold access have very few rules for initiating and participating in the intervention. Effective needle exchange programmes do not require anything of the substance abuser other than collecting clean syringes. It is easy to image a needle exchange programme that required participation in treatment, completion of forms, etc. to obtain clean needles. Experience has shown that any of these requirements reduces the effectiveness of needle exchange. Another example of a low threshold programme is a methadone treatment programme offered in Halifax, Canada, in which there are a minimum number of requirements for participation, unlike most methadone programmes. Individuals in this programme must obtain their methadone each day, and must undergo urinalysis to check for the presence of other drugs. The presence of other drugs results in counselling, and cessation of methadone only occurs if the level of use of other drugs is seen as a threat to health.

(v) *Harm reduction is based on the tenets of compassionate pragmatism versus moralistic idealism*

Making condoms available in correctional settings is one example of compassionate pragmatism. We recognize that sexual activities will occur in prison, we want to prevent the spread of diseases, and providing condoms does not provide any security risk, therefore they are made available.

Harm reduction approaches are not only applicable to treatment after an addiction or problem behaviour has occurred. Harm reduction approaches can be applied to prevention programmes as well. Recognizing that there are safe and unsafe behaviours associated with an activity and promoting the safer methods is one way to reduce harm. Programmes to reduce drinking and driving are an example of harm reduction programmes at the prevention level. These programmes recognize that the consumption of alcohol will occur away from home and provide alternative behaviours to driving to reduce the likelihood of accidents. Alternatives include, taking a taxi, arranging for a designated driver, or staying overnight at the location of the event.

B. Stages of Change

Prochaska and DiClemente (1992) propose a model of readiness to change that allows treatment providers to match treatment to an individual's willingness to change. In their model, they propose five stages of change and provide examples of what should be addressed at each stage and what is required for the person to move to the next stage (Connors, Donovan & DiClemente, 2001). These stages are meant to be representative of what happens and individuals will not pass through the stages as if they were discrete events.

1. Pre-contemplation

In the pre-contemplation phase an individual has no intent to change behaviour and current substance abuse may be viewed as being both positive and negative for the individual. During this phase it is not useful to focus on changing behaviour, but rather to use motivational techniques that will move the person to the next phase. The person may need to acknowledge that there is a problem, develop a better understanding of the negative consequences of the substance abuse behaviour and develop an understanding of the factors that trigger drug or alcohol use. An individual at this stage may believe they are in control and can stop anytime and believe that the benefits of using outweigh the benefits of not using.

2. Contemplation

In the contemplation stage the individual is thinking about their problem and is looking for information that will help them to understand it. They are looking at the positive and negative characteristics of their substance abuse problem, but they are not yet prepared to stop using drugs or alcohol. Intervention at this stage involves providing increased understanding of the effects of substance abuse, evaluation of life goals and consideration of the context in which the person may be living. In the case of offenders, if they are incarcerated it is a good opportunity to point out the negative impacts that being in prison have on their life and what the alternatives might be.

At this stage, the person must make a decision to act if they are to move to the next stage. They might begin to take some preliminary action such as meeting with a counselor, changing behaviour to reduce consumption, or to reduce the risk associated with drugs and alcohol use.

3. Preparation

The third stage is preparation to change. Persons in this stage are prepared to change both their attitudes and their behaviour. They may have taken some early steps to monitor their use of alcohol or drugs with the goal of reducing consumption. They are ready to be encouraged to participate in treatment so intervention should work to increase their commitment to stopping their use of drugs or alcohol. This can be done by further development of information on the consequences of substance abuse and the positive benefits they may experience by reducing their use of substances or stopping completely.

At this stage individuals will need to establish goals and priorities that can be set to help them stop abusing substances. They will need to develop a change plan that can guide them to stopping their use.

4. Action

In the action stage individuals have begun to change their behaviour. They are learning new skills that help them to remain free from drug and alcohol use. Their desire to change at this stage makes them ideal candidates for programmes that apply behaviour change practices in treatment. Treatment needs to provide skills development that will assist in the cessation of the drug and alcohol use and while providing alternatives to their former life-style. Participants also need to learn about what may trigger their desire to use drugs and alcohol so they can avoid these situations.

Prochaska and DiClemente (1992) suggest that interventions in this stage should last for an average of six months, and work is needed with the individual to increase their belief that they can maintain the desired changes in behaviour.

5. Maintenance

The final stage in this model is maintenance, the process by which the individual maintains their desired behaviour. This is a critical phase as it is the one that must last for the remainder of a person's life if they are to avoid returning to an addictive state. They must have in place practices that will allow them to avoid

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substance abuse and continue to practice the skills learned in treatment. Very often, treatment programmes do not provide for maintenance support. Rather, the programme is delivered, the person successfully completes it and then is expected to maintain the change without any additional support. Effective programmes have maintenance components that provide support and skills reinforcement during the maintenance stage.

An individual does not move through these stages in a straight line. They may move from precontemplation to preparation, only to slip back to the contemplation stage. Or, they move all the way to maintenance, but as a result of life circumstances, may find themselves starting the process again (Connors, Donovan & DiClemente, 2001). This is both expected and normal and is one of the reasons that effective programmes stress the need for understanding of lapses in drug and alcohol use during and after treatment.

C. Relapse Prevention

Relapse prevention should be an important component of treatment programmes. As noted earlier, relapse is a common occurrence and the individual who abuses substances needs to be prepared for it when it occurs. The goals of relapse prevention are to provide information useful in recognizing high risk situations that may lead to relapse and providing the skills needed to deal with the relapse when it does occur. At the time of a relapse, it is important that the client does not give up.

Seven models of relapse are identified by Connors, Donovan and DiClemente (2001), but there is a consistency across the approaches they present. The model presented by Marlatt and Gordon (1985) is based on cognitive behavioural principles and is a good example to use here. In this model, relapse is seen as the interaction between the high risk situations associated with drug or alcohol use and the individual's perceptions of his/her ability to control the situation and therefore, avoid using drugs and alcohol. The individuals' expectations about the usefulness of drugs and alcohol in the particular situation will also play a role in whether or not they choose to relapse (Connors, Donovan & DiClemente, 2001).

When the high risk situation arises, the individual who has learned coping skills to deal with the event or environment will be more likely to resist the relapse. The coping skills that have been learned will provide alternative courses of action, that hopefully will avoid the relapse. Individuals who have not learned appropriate coping skills will be less able to choose alternative behaviours and therefore will be more likely to return to substance use.

For the Marlatt model, there are two key components that must be addressed during treatment, identifying the high risk situations and developing coping skills to deal with the situations in a positive way. Treatment programmes that use relapse prevention spend time helping the offender to identify their unique high risk situations through review of past events and their outcomes. Events that consistently lead to drug and alcohol use become the targets for developing coping strategies.

Developing coping strategies follow the identification of the high risk situations. For each high risk situation the offender must identify a number of alternative ways of dealing with the risk created. For example, if meeting with friends in a large group is a high risk situation, then coping strategies might include avoiding being with friends in large groups, leaving the group when it gets large, or finding alternative activities that are normally done only in small groups of two or three people. Other coping strategies that have been identified in the research literature include, reminders of the consequence of drug or alcohol use, thinking about the positive effects of not using drugs or alcohol, recalling periods of non-use that were positive, and remembering that avoiding use is an important personal goal.

The coping strategies are identified on an individual basis following discussion in groups. After identification of coping strategies, they must be practiced in role play activities. Through the identification of the high risk situations, development of coping strategies and practicing the strategies the offender is better prepared to deal with the situations when they occur.

Relapses are to be expected and may be viewed as learning experiences. Analysis of the relapse events, the antecedent behaviours and the results will assist in the development of more effective coping strategies that can be used during the next high risk situation. Following the relapse, or lapse, the client needs to be reassured that they can continue without using drugs and alcohol. The treatment programme should include

discussion of what to do after a relapse and how to restart the process of remaining drug and alcohol free. This is one of the main reasons that treatment maintenance programmes are important. It is during the maintenance sessions that lapses and relapses can be addressed in a supportive environment.

D. Motivation Interviewing

Miller and Rollnick (1991) state:

Motivational interviewing is a particular way to help people recognize and do something about their present or potential problem. It is particularly useful with people who are reluctant to change and ambivalent about changing. (p. 52).

Many offenders are not willing to commit to changing their drug or alcohol using behaviours. There are too many positive features associated with their lifestyle. They are in the precontemplative stage of change. However, treatment providers must work to encourage these individuals to move forward along the continuum towards change. Motivational interviewing is one of the methods that have been shown to be effective for starting the change process.

Miller and Rollnick (1991) present five general principles of motivational interviewing.

1. Express Empathy

For motivational interviewing to be effective the counselor must express empathy with the client. The client is accepted for what he or she is at the time of counseling, there is no judgment about how they arrived at that point, or the consequences of their behaviour. Accepting the individuals as they are reduces their resistance to the counseling setting. Ambivalence about change is acceptable for the client.

2. Develop Discrepancy

Developing discrepancy has to do with gently demonstrating the conflicting values in a person's life and guiding them towards the more appropriate goals. This is different from confrontation that may result in resistance to change. While discussing the current situation with the client the counselor looks for positive personal goals that the individual has and contrasts these with the current behaviours that prevent the achievement of these goals. The object is to encourage the client to see the importance of alternative goals they have and to give these greater priority than the desire to use drugs and alcohol.

3. Avoid Argumentation

The counselor needs to avoid argumentation to maintain a positive therapeutic relationship with the client. However, this does not mean that the therapeutic interview follows the client's thoughts. Rather, inconsistencies are detected and used to correct judgments and beliefs. Miller and Rollnick (1991) refer to this as "soft confrontation". They also note that in many treatment settings argumentation can occur around the need to admit to having a problem. This is unnecessary at this early stage of change, and may only be recognized as a goal much later. Recall that the purpose of motivational interviewing is to prepare the client for change, to move them along the continuum so they are ready to start the change process or in some cases after a relapse, to re-start the process.

4. Roll with Resistance

It is to be expected that the offender will be resistant to change, and it is the job of the counselor in motivational interviewing to work with this resistance to find ways to reframe and redirect the resistance. Redirecting the resistance can motivate offenders to find their own solution which is the ultimate goal.

5. Support Self-Efficacy

The offender will often feel that they are unable to succeed in treatment so why bother trying. Motivational interviewing helps the offender to believe that they can change; it works with their desire to change and develops confidence that change is possible. The counselor may encourage small steps towards change to assist the offender to build on success.

Motivational interviewing is often used as an adjunct to other therapies. An offender who is in the precontemplative, or even the contemplative stage of change is not ready for a directive behavioural programme. Motivational interviewing can move them along so they better understand the need for change,

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see the value it may provide for them, and provide the belief that they have the ability to stop using drugs and alcohol if they want to. Miller and Rollnick (1991) also point out that results from an assessment process can be an effective tool during motivational interviewing. A parole office reviewing the results of objective testing can provide the offender with concrete evidence of how his or her addiction compares to that of other offenders.

The report produced by the Correctional Service Canada's Computerized Assessment of Substance Abuse (CASA) is designed to be shared with the offender for this reason. It is our intention, in the near future, to include normative data in the report, so offenders can see how their problem compares to that of other people. This approach should help to address problems of denial that are common among drug and alcohol abusers.

III. CORRECTIONAL SERVICE CANADA RESEARCH AND DEVELOPMENT

A. Women Offenders Substance Abuse Programme

The Women Offenders Substance Abuse Programme (WOSAP) has been developed over two and half years and will be implemented in the women's correctional facilities in Canada in June of 2003. The programme has a number of unique characteristics that represent attempts to design a programme consistent with evidence based programme development (Hume & Grant, 2001).

First, the programme was designed through consultation with women offenders, experts in women offender treatment and operational staff at correctional facilities. Early consultations with international experts indicated the programming we had available did not adequately meet the needs of women offenders. Following a decision to develop a new programme, additional consultations were held to determine the programming model that was to be used and the structure of the programme (Hume & Grant, 2001). In its design and development, the programme was to be women-centred, not a derivation of a programme for men, and was to address the unique characteristics of women with substance abuse problems.

The second feature of the programme is that it takes account of the entire sentence. Rather than a programme that lasts for a set period of time, the programme is designed to deliver elements throughout the entire sentence, and do this in a consistent manner. While we refer to it as a single programme it is actually four programmes.

The third feature of the programme is it tries to combine two approaches to treatment that have in the past been seen as incompatible. To meet current standards of effective correctional programming the programme needed to have a cognitive behavioural component that would encourage skill development for addressing substance abuse problems. However, experts in women's programming advised that the problems of substance abuse for women are often entangled with relationship issues and if these are not addressed then it is likely the programme would not be successful. The challenge has been to combine these two approaches within one programme.

As noted above, the programme has four major components:

1. Education

The education component of the programme has 8 sessions designed to teach women about the negative effects of substance abuse on their lives, both long and short term effects, provide basic information on how to deal with triggers that cause cravings, and to motivate them to continue the process of change. It is anticipated that all women offenders will be assigned to participate in this component of the programme as almost all women offenders have a connection to the problems of substance abuse either through their own experience, or through a spouse or family member.

2. Intensive Treatment

The intensive treatment component consists of two parallel programmes one designed from a cognitive behavioural perspective and one based on relational theory. These programmes proceed in parallel so issues discussed in one part are also discussed in the other ensuring consistency of message and learning. Each programme is 20 sessions in length would

3. Maintenance

The maintenance component is a 20 week follow-up programme with sessions offered once per week. To ensure continuity with the community the same maintenance programme is available after offenders are released. This approach ensures there is a consistent experience in both the institution and the community. One of the major challenges we face with the programme is how to deliver the maintenance session in the community when the women participants are widely dispersed across the country.

4. Community Building

The community building component of the programme is designed to create an environment within the institution that promotes a drug and alcohol free lifestyle and provides support to those offenders who are trying to change their behaviour. This component has two characteristics, peer led discussion groups and institution wide activities. The peer led discussions groups have programming material available, but the participants choose the topic to be discussed each week. The community building exercises include health activities that involve correctional staff, social activities, and community activities in which individuals from outside the prison come to present information of relevance to the women.

Unfortunately, this programme has not yet been evaluated as it is too new. However, an evaluation plan has been established and we should have preliminary results within one to two years. The evaluation will address perceptions of the programme, intermediate and long term outcomes, and measures of recidivism.

B. Intensive Support Units

In an effort to provide environments for offenders that will support their efforts to reduce drug and alcohol dependency, Intensive Support Units (ISU) have been established in all prisons (Grant, Varis & Lefebvre, 2004). These units are part of the regular prison environment, but they provided increased assurance that drugs are not available on the unit. Offenders wishing to live on the units must sign an agreement in which they accept increased testing for the presence of drugs and increased searching for drugs and alcohol. The staff on these units receive additional training on the problems of substance abuse and the challenges faced by offenders with an addiction. With the training, staff can provide additional support to the offenders when they experience problems.

To evaluate the effectiveness of the units, participants completed a number of surveys when they first joined the units and again when they moved to other prisons or were released. Data are not yet available on the recidivism outcomes from participants, but intermediate measures of impact of the units indicate that both staff and inmates believe the units will make a difference in their ability to stay away from drugs and alcohol, that the units will have a positive effect on their lives after release from custody and that the units have fewer drugs available. Analyses of misconduct and search data for the units indicates that there are increased searches, but few drugs found and misconduct by offenders on the units are lower than for offenders on other units (Varis, 2001).

C. Methadone Maintenance Treatment

Methadone maintenance treatment has been available to offenders in the Correctional Service for a number of years. However, until recently only those offenders who had been prescribed methadone in the community could receive it in the institution. Recently, a study was conducted to compare the release outcomes of offenders who had participated in the methadone maintenance programme and a comparison group consisting of those offenders who had not participated in the methadone programme.

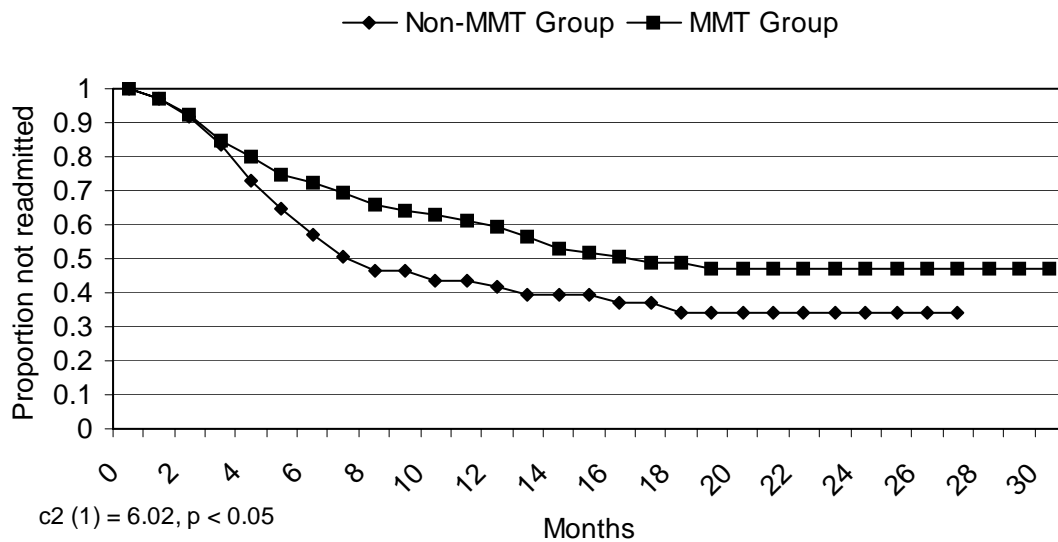
Previous research has indicated that methadone maintenance treatment can produce reductions in illicit opiate use (Marsch, 1998); reductions in other drug use (Fischer, et.al., 1999); HIV risk behaviours (Darke, Kaye & Finlay-Jones, 1998); criminal behaviour (Coid, et.al., 2000; Maddux & Desmond, 1997); and access to health care (Marsch, 1998). The purpose of this study was to determine if we could identify a reduction in criminal behaviour after release from prison for those offenders who participated in the MMT programme.

One of the challenges in research of this type is to determine who should be in the comparison group. The offenders who receive MMT are the most seriously addicted offenders and generally the most problematic. They have a high rate of recidivism so comparing them to the general population of offenders would certainly indicate the MMT had no effect. We were able, within our data systems, to identify a group

of offenders who had tested positive for opiates in random drug testing and who were identified at admission as having a substance abuse problem. This group served as a comparison for the MMT group.

The results of the study are summarized in Figure 1 in the form of a survival analysis. The survival analysis indicates that both groups had a high probability of failure in the community

Figure 1. Survival Analysis for MMT Study: Readmission Rate



While more than 50% of the MMT group were readmitted to prison within 24 months of their release, almost 65% of the comparison group were readmitted. The observed differences are statistically reliable. Similar results were identified when a new offence was used as the outcome measure, but the results were not statistically reliable.

D. Offender Substance Abuse Pre-release Programme (OSAPP)

The Offender Substance Abuse Pre-release Programme has been in use within the Correctional Service for more than ten years. Five years ago a study was conducted to determine how effective the programme was at reducing recidivism (T³ Associates, 1999).

The programme follows a behavioural model employing cognitive behavioural techniques. Modules in the programme include alcohol and drug education, self-management, problem-solving skills, social skills, leisure and lifestyle planning and pre-release planning. In addition to the 26 structured group treatment sessions of approximately 3 hours each, the programme includes three individual sessions with facilitators. A summary of session topics are presented in Table 2.

The evaluation of the programme was based on approximately 1,600 offenders, from across the country, who completed the programme. The completion rate for the programme was 89%. Evaluation of intermediate measures indicated that participants increased their knowledge of the consequences of substance abuse, improved their understanding of how their use of substances were affected by other people, increased their ability to communicate effectively with peers about their substance abuse problem and increased their problem solving skills.

A 12 month follow-up was conducted to determine the programmes effect on recidivism. Almost 800 cases were included in the follow-up and these cases were matched to other offenders to provide a comparison group. Of those offenders who completed the programme, 42% were readmitted after one year,

compared to 49% of the comparison group. New offences were committed by 15% of the programme group and 22% of the comparison group (T³ Associates, 1999).

Figure 2. Offender Substance Abuse Pre-release Programme: Units and Sessions

Unit I: Introduction

Session 1: Programme Introduction
Session 2: Orientation and Pretesting

Unit II: Alcohol and Drug Education

Session 3: Alcohol & Drug Education I
Session 4: Alcohol & Drug Education II
Session 5: Alcohol & Drug Education III
Session 6: Alcohol & Drug Education IV
Session 7: Alcohol & Drug Education V

Unit III: Self-Management Training

Session 8: Self-Management Training
Individual Counselling Session I
Session 9: Understanding Your Behaviour
Session 10: Substance Use Self-Management Skills Training
Session 11: Problem Solving
Session 12: Coping by Acting
Session 13: Coping by Thinking
Session 14: A Review of Problem Solving
Individual Counselling Session II

Unit IV: Social Skills Training

Session 15: Basic Communication Skills
Session 16: Assertion Training
Session 17: Using Social Skills in Personal Relationships

Unit V: Job Skills Refresher

Session 18: Employment Readiness
Session 19: Job Finding Skills

Unit VI: Leisure and Lifestyle

Session 20: Leisure and Lifestyle

Unit VII: Pre-Release Planning

Session 21: Pre-Release Planning Exercise
Session 22: Pre-Release Planning (Cont'd)

Unit VIII: Relapse Prevention and Management

Session 23: Relapse Prevention
Session 24: Relapse Management

Unit IX: Post Testing and Graduation

Session 25: Programme Review and Post-Testing
Session 26: Graduation
Individual Counselling Session III
Maintenance

Additional results indicate that the combination of the programme with other interventions such as the Correctional Service's Choices programme offered in the community and participation in self-help programmes decreased the recidivism rate further.

E. Computerized Assessment of Substance Abuse (CASA)

The Computerized Assessment of Substance Abuse is a computerized assessment system provides an assessment of substance abuse severity for both drugs and alcohol, along with measures of the link between substance abusing behaviour and criminal activities. The system provides a written report to the parole officer and this can be shared with the offender. Results of the assessment are used to determine the level of programming required by the offender.

The system incorporates a number of unique features that improve its functionality within the correctional environment. Literacy is often a challenge with assessment systems but in addition to presenting the questions in text form, offenders have the option of having the questions read to them along with the possible responses.

The system also incorporates the Paulhus Deception Scale (Paulhus, 1999) that provides information on the likelihood that an offender is answering in a manner designed to enhance his image, that is, is responding untruthfully. The Paulhus Deception scale provides measures of Impression Management and Self-deception Enhancement.

The system is also designed to be time efficient, so questions that do not apply to an offender are not asked. If at the beginning of the assessment an offender indicates he or she has never consumed alcohol the alcohol questions will not be asked. However, later in the assessment another question will be asked about alcohol use, but in a slightly different way. If they respond positively the second time they are asked all of the alcohol questions.

One additional feature that was added to the system during the testing phase is a brief tracking game that provides the offender with the opportunity to practice mouse skills. Some offenders may be unfamiliar with using a computer mouse so the game was designed to give them practice tracking a bouncing ball on the computer screen. After the practice session they are ready to proceed to the test.

Results from the testing are available immediately to the parole officers, but they are also stored in a data file that is sent electronically to the Addictions Research Centre each month. These data are available for analysis to develop profiles of offenders and other research activities. Data from the early version of the system have been shared with external researchers who have used the information to determine the costs of crime associated with drug use (Pernanen, Cousineau, Brochu & Sun, 2002).

F. International Experts Forum

The International Experts Forum was held in May 2002 and brought together 150 researchers, academics and clinicians from across Canada and 10 other countries. The goal of the Forum was to develop priorities for research and development in substance abuse for corrections. While the initial hope had been to develop specific projects that could be worked on together in a collaborative manner, this proved to be an impossible task. There was too much information to share about current research activities and research needs were too varied to identify specific projects. The participants identified two broad issues, the need for collaboration and the need for additional research and development. For each of these, three themes emerged as presented in Table 1. For each of the themes specific project ideas were also identified.

Table 1. Priorities for Research and Development in Substance Abuse and Corrections

Need for Collaboration
(i) Provide opportunities for dialogue, networking and collaboration
(ii) Communicate relevant and timely research results to a range of audiences
(iii) Create a climate to foster dialogue that acknowledges and challenges existing ideologies and practices
Research and Development
(iv) Research on the effectiveness of existing and emerging correctional models and interventions
(v) Respond to the differing needs of offender populations including gender, culture/ethnicity, and age, as well as issues related to mental & physical health
(vi) Research on the impact of correctional cultures and environments on treatment models and regimes

The proceedings of the Forum and the summary of the priority setting exercises that were undertaken at the Forum are due for publication within the next two months (Grant, Hume & Kunic, 2004).

IV. SUMMARY AND CONCLUSIONS

A number of approaches to treating offenders with substance abuse problems have been reviewed and discussed. Overall, the most important approach is that of harm reduction that seeks to reduce the harms that substance abuse causes to individuals and to communities. Using a harm reduction approach, criminal justice agencies can work to reduce the impact of substance abuse on our communities. Samples of research studies were presented to highlight various methodological issues and to demonstrate the integration of research and programme development within a correctional system.

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