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Profile
Substance Abuse Treatment and Rehabilitation in Canada

Prepared by
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in collaboration with Gillian Leigh and Lorraine Adam

for the
Office of Alcohol, Drugs and Dependency Issues
Health Canada

canada's drug strategy

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Introduction and Methodology

Substance abuse remains a major health, legal and social issue in Canada. The economic cost associated with alcohol in Canada in 1992 was estimated conservatively at about $7.52 billion, with 6,701 deaths attributed to its abuse. Illicit drug abuse accounted for 732 deaths and $1.37 billion in costs in that same year. Within these costs were an estimated $290 million spent on specialized substance abuse treatment *(Single et al., 1996).* In the context of the very significant human and financial costs associated with the abuse of alcohol and other drugs, it is timely to investigate treatment and rehabilitation activity to clarify what is being done and to determine how we might be more effective.

This report is one of two initiated by Health Canada in collaboration with the provinces and territories to provide current baseline information concerning substance abuse treatment and rehabilitation. The purpose of this report is to provide current information on the scope and nature of substance abuse services at the federal, provincial and territorial levels. To complement this profile of "where we are now", the other report, *Best Practices – Substance Abuse Treatment and Rehabilitation,* provides advice on "where we need to go" in substance abuse treatment and rehabilitation in Canada. These reports together will help guide Health Canada and the provinces and territories in the area of alcohol and other drug treatment and rehabilitation in this country.

Rush and Ogborne (1992) and *Ogborne, Smart and Rush (1998)* have respectively described the historical development of Canada's treatment of people with alcohol and other drug problems and this report benefits from these two articles. As well, this profile draws on a national survey of substance abuse treatment programs conducted for this project. Information on 870 programs was collected (estimated to comprise over 70% of the programs in Canada) which is now available as the Treatment Database in the Canadian Centre on Substance Abuse Internet site (http://www.ccsa.ca). Also contributing to this report is a series of key informant interviews, involving at least one person from each province, the Northwest Territories and Yukon. Those interviewed were identified by the person in charge of substance abuse treatment in each jurisdiction as very knowledgeable about treatment and rehabilitation.

Both the key informant and program surveys present data on the nature and scope of treatment in Canada, including who provides treatment in the provinces and territories, and the role of the federal government. We present information on a wide range of issues which have an impact on treatment effectiveness, such as government standards, program evaluations, professional development, treatment philosophies, practices, and special services across the country. The report concludes with a discussion on gaps, challenges and emerging issues largely drawn from the key informant survey.

This profile and the program and key informant surveys investigate both systems and program issues. A substance abuse treatment system is broadly defined as the set of programs and services in a region that are in some way coordinated and available to clients experiencing substance abuse problems. This typically includes those services that deal specifically with alcohol and other drug problems (often referred to as the "specialized sector"), as well as general health and social services that also routinely encounter individuals with these problems (the non-specialized sector). This project focuses on the specialized sector.

We regard tobacco use cessation within and outside substance abuse treatment as extremely important; however, we did not review cessation services in depth because a separate review of tobacco cessation programs in Canada was developed concurrent to this profile (and can be found at the Health Canada Web site—http://www.hc-sc.gc.ca/health-promotion-sante as the *Guide to Tobacco Use Cessation Programs in Canada*).

It should also be noted that drinking-driver remediation treatment services are largely excluded from consideration in this report. However, a description of the current status of these services can be found in *Stoduto et al. (1997).*

Through the course of this project, a number of non-peer-reviewed Canadian articles relating to treatment effectiveness came to our attention through a search of the National Clearinghouse on Substance Abuse Information, a general solicitation undertaken during the survey of treatment programs, and discussions with a number of government officials. At the end of this report is an annotated list of these reports that should be viewed as an illustrative rather than exhaustive inventory of Canadian articles, studies and reports produced across the country in the past several years.

1. The development of alcohol and other drug treatment in Canada

Treatment for alcohol and other drug problems in Canada defies simple characterization. For the most part, substance abuse treatment is the responsibility of the provinces and territories, and arrangements for treatment vary between and within these jurisdictions. Local social, economic and political conditions contribute to uneven patterns of substance use and differing treatment responses across the country. Any profile of treatment in Canada must acknowledge the evolving role of the federal government in overseeing the country's health system and in delivering treatment to particular populations.

Rush and Ogborne (1992) identified four phases in the development of treatment for alcohol problems in Canada and to a large extent these four phases are also reflected in the development of treatment for drug problems. The first phase, ending in the late 1940s, was dominated by moralistic attitudes and a general lack of attention to treatment. Some treatment for alcoholics and drug addicts was available in private asylums and some counselling services for narcotic addicts were established in prisons. However, most people with alcohol or other drug problems had little access to treatment services and the dominant view was that these problems resulted from a lack of "will power" or from personality defects.

The second phase, ending in the mid-1960s, was characterized by a change in attitudes to alcoholism and, to a lesser extent, changes in attitudes to problems involving other drugs. A major influence during this period was the growth of Alcoholics Anonymous (AA). AA promoted the view that alcoholism, although incurable, could be arrested if treatment was provided for withdrawal and the alcoholic followed a 12-step recovery program. With the support of some community leaders, AA members lobbied successfully for government-sponsored treatment and education programs. Efforts to secure government support for alcoholism services were also spurred by the view of alcoholism as a preventable and treatable "disease" rather than a symptom of moral weakness. Dr. Gordon Bell's pioneering work in alcoholism treatment throughout this period led to greater medical attention to alcoholism and to a model of treatment drawn upon by programs across the country.

By the end of the 1950s, most provinces had established departments, commissions or foundations to provide or coordinate addiction treatment services, with many new services established. Initially, these agencies were principally concerned with alcohol-related problems but later, as problems with other drugs began to increase, their mandates were

expanded to encompass problems involving other drugs. However, it is important to note that treatment for people who used illegal drugs took place in the context of a strong punitive approach to dealing with drug abuse *(Ogborne, Smart and Rush, 1998).*

The third phase identified by *Rush and Ogborne (1992)* began in the mid-1960s and was characterized by a rapid expansion of services for addictions. The most rapid growth occurred between 1970 and 1976. Of approximately 340 specialized agencies operating in 1976, two-thirds were established after 1970, and expenditures on treatment services increased from $14 million to $70 million during the same period. A range of services was established during this period and included detoxification centres, outpatient programs, short- and long-term residential facilities and aftercare services. Some services for people with problems involving drugs other than alcohol were provided by programs established to serve those with alcohol problems, but some specialized "drug" treatment services were also established during this period, including a number of therapeutic communities *(Smart, 1983).* Throughout this period, individuals in treatment were increasingly found to be abusing other drugs in addition to alcohol.

This period also witnessed the first broad program of compulsory substance abuse treatment implemented in Canadian history. In 1978, the Government of British Columbia passed Bill 18, the "Heroin Treatment Act", arguing that compulsory treatment for heroin abusers was justified on economic grounds. As *Boyd, Millard and Webster (1985)* indicate, this legislation immediately ran into a number of problems, not the least of which were: public perceptions that the act contributed to "the continued irresponsibility of drug users" and, a court challenge to the constitutionality of the bill by a methadone-dependent individual who argued that her civil rights would be in jeopardy because the police would have the power to remove her from her children and husband. In October 1979, the Supreme Court of British Columbia ruled the Act unconstitutional, ending that experiment in compulsory substance abuse treatment for heroin dependence.

The fourth phase identified by *Rush and Ogborne (1992)* began during the 1980s, and featured the relative autonomy of the provincial foundations and commissions within their respective health and social service systems. In many cases, addiction research, education and treatment occurred in systems that paralleled and did not fully integrate with the general community health and social services systems. Despite this, there was a growing appreciation for the role of non-specialized health and social services in identifying and supporting specialized substance abuse treatment services.

This phase can also be characterized by the diversification and specialization of alcohol and drug treatment services, with growth in special services for women, youth and Aboriginal people occurring particularly. This trend was driven by research indicating that people respond differently to various types of treatment and by a growing belief that treatment should be adjusted for different populations and types of drug problems. While various

modifications of the medical model of treatment were prevalent across the country, a number of other treatments based on cognitive, behavioral and social theories and research emerged during this period. Canada's Drug Strategy, conceived as a multisectoral partnership, was launched in 1987, and served to stimulate a range of activity, including the support of innovative treatment and rehabilitation services across the country.

2. Current treatment systems

It might be said that Canadian substance abuse treatment systems entered a fifth phase in the early 1990s, fueled by dramatic changes in the structure of health services across the country. Within a general environment of reduced expenditures for health services, most government substance abuse services have been integrated into community health and social services delivery systems. Only three provinces now have specialized alcohol and drug abuse foundations or commissions. In Ontario, the Addiction Research Foundation amalgamated with two mental health agencies and one other addictions agency to become the Centre for Addiction and Mental Health.

This integration of services for various health problems has been supported by adoption of a Population Health model by the provinces, territories and the federal government. This approach repositions the role played by health care services in determining the health of a population, giving greater priority to broad socio-economic factors. Accompanying this model has been an increased awareness of the need to better integrate alcohol and drug services, not only into the general health system, but into larger social welfare policy and social support systems as well.

Concurrent with this trend toward service integration has been a general devolving of responsibility and decision making to regional or district health boards that deliver a range of health services, including substance abuse services. The province of Quebec led this process, initiating a decentralized approach in the early 1970s. Quebec has recently passed still more responsibility to regional services, emphasizing integration of the various service areas, including substance abuse.

The majority of funds for alcohol and drug treatment and rehabilitation in Canada are provided by the provinces and territories through local taxes, provincial health insurance funds and federal transfer funds under the *Canada Health Act* and other federal programs. The estimate of the total costs of specialized substance abuse treatment was more than $290 million in 1992 *(Single et al., 1996).* The capacity of the systems across the country can be reflected in the number of substance abuse treatment programs, estimated to be 1200, and counselling staff, estimated to be 7200 in 1997. The 72% of programs responding to the program survey conducted for this report represents 1544 detoxification beds, 1775 short-term residential beds and 3010 long-term residential beds (see Table 1).

Table 1: Detoxification and residential treatment services beds across Canada*

Province/Territories	Detoxification Beds		Short-term Residential Beds		Long-term Residential Beds	
	Male	**Female**	**Male**	**Female**	**Male**	**Female**
Newfoundland	17	4	24	6	43	8
Nova Scotia	30	14	27	16	49	12
Prince Edward Island	22	10	16	0	18	9
New Brunswick	47	17	17	5	43	8
Quebec	433	246	369	145	678	187
Ontario	309	108	144	125	748	176
Manitoba	25	15	100	42	238	78
Saskatchewan	29	22	98	20	87	2
Alberta	57	18	87	41	192	60
British Columbia	82	19	374	100	275	69
Northwest Territories	6	4	0	0	30	0
Yukon	7	3	10	9	0	0
TOTAL	**1064**	**480**	**1266**	**509**	**2401**	**609**

* Please refer to the Glossary in Section 10 for definitions of terms used in this table.

Persons experiencing alcohol problems generally predominate in treatment services' case loads. To illustrate, the Canadian Community Epidemiology Network on Drug Use (CCENDU), which examined data from six major cities, reports the following: "About 69% of persons entering treatment in Vancouver in 1993/94 identified alcohol as their drug of choice. In Calgary, 64% of people entering community-based and 58% of those entering hospital-based treatment identified alcohol as their most frequently used and major problem substance respectively. Alcohol was a presenting problem for 87% of clients entering treatment in Winnipeg in 1995. In 1995, 28% of women and 36% of men in treatment in Montreal reported using alcohol. In Halifax, 82% of all those in treatment during 1995 reported using alcohol" *(Poulin, 1997).* Toronto did not report data on this issue.

What is less known is the extent to which existing services in Canada fulfil treatment needs. Although research suggests that only a small proportion of alcohol or drug dependent persons seek and receive treatment, the actual proportion of those needing treatment who receive treatment in Canada is not known.

Table 2: Substance abuse treatment services offered across Canada*

	Outpatient	Day/even. treatment	Short-term Residential	Long-term Residential	Outreach	Walk-in/ crisis	TOTAL
Newfoundland	13	2	5	0	2	7	**29**
Nova Scotia	9	7	7	6	9	4	**42**
Prince Edward Island	2	1	1	1	1	2	**8**
New Brunswick	5	3	3	2	3	5	**21**
Quebec	72	52	59	43	48	44	**318**
Ontario	110	55	43	51	61	64	**384**
Manitoba	12	5	8	10	8	10	**53**
Saskatchewan	24	9	10	5	14	14	**76**
Alberta	41	22	22	13	14	27	**139**
British Columbia	128	43	39	28	70	77	**385**
Northwest Territories	7	5	3	2	7	7	**31**
Yukon	2	1	2	0	0	2	**7**
TOTAL	**425**	**205**	**202**	**161**	**237**	**263**	**1493**

*Please refer to the Glossary in Section 10 for definitions of terms used in this table.

3. The federal role in substance abuse treatment

The *Canada Health Act*, passed in 1984, stipulates the criteria for the funding and administration of provincial and territorial health care services. Under this Act, the provinces and territories receive transfer payments to provide insured health services under each jurisdiction's health care insurance plan, including some extended health care services. In order for each jurisdiction to receive a full financial contribution for each fiscal year, its health care insurance plan must satisfy the five tenets of the *Canada Health Act*: health insurance must be publicly administered, comprehensive, universal, portable, and accessible to all provincial and territorial residents *(Statutes of Canada, 1993).*

The federal government provides direct funding for treatment and rehabilitation services for such groups as on-reserve First Nations Peoples and Inuit, members of the Royal Canadian Mounted Police (RCMP), members of the Canadian Armed Forces, persons serving a term in a federal penitentiary, and persons who have not lived in a province or territory long enough to receive insured health services. Unlike residents of provinces and territories who are considered "insured persons" under the *Canada Health Act*, these groups cannot access services under their respective provincial or territorial health insurance plans. The health status of these groups is insured by the federal government directly *(Statutes of Canada, 1993).*

The federal government provides funding for treatment and rehabilitation services for on-reserve First Nations and Inuit people through the National Native Alcohol and Drug Abuse Program (NNADAP), supported by the Medical Services Branch of Health Canada. Treatment is one of four major program components of the NNADAP program, which is broken down according to prevention, treatment, research and development, and training.

Treatment and rehabilitation services for federal offenders is provided by Correctional Service Canada (CSC). The core of CSC programming involves four levels of treatment intensity to which inmates are matched according to a comprehensive assessment. The CSC also provides programs for long-term offenders, a program for offenders just released from prison to prevent relapse, a gender-specific program for women and the Native Offender Pre-Treatment Substance Abuse Program. All program facilitators receive intensive training, with a certification process applied to training in the men's system.

In 1980, the Department of National Defence (DND) established its own treatment and rehabilitation program, entitled the Addictions Rehabilitation Program (ARP). Until recently, the ARP was available to military personnel and their families through designated military clinics across Canada. However, within a larger restructuring of DND substance

abuse services, the one remaining addiction rehabilitation clinic is now located at Canadian Forces Base Halifax. Military personnel not located in that geograhical region must obtain inpatient treatment at civilian treatment centres. According to the new arrangement, client assessment and follow-up will still be provided by each military base.

Treatment and rehabilitation services for members of the RCMP are administered through the Health Services Program. This program provides RCMP members with access to assistance for substance abuse and other personal problems. RCMP and civilian treatment services are utilized, with a Health Services Officer servicing each province and territory, serving a case management role (i.e., assessment, referral and follow-up).

For a number of years, the federal government has sponsored two programs that provide funding support for substance abuse treatment, based on agreements with provincial/territorial authorities:

Alcohol and Drug Treatment and Rehabilitation

The Alcohol and Drug Treatment and Rehabilitation (ADTR) Program is available to the provinces and territories and aims to ensure access to a range of effective and innovative substance abuse treatment and rehabilitation services, particularly those directed to women and youth. These services and programs include detoxification, assessment and referral, counselling/ case management, therapeutic intervention (residential, outpatient and outreach), continuing care/clinical follow-up, research and evaluation, early identification and intervention, awareness and development, special access services and knowledge dissemination.

Employability Assistance Program for People with Disabilities

The Employability Assistance Program for People with Disabilities (EAPD) replaces the Vocational Rehabilitation of Disabled Persons (VRDP) program. The focus of the EAPD program, an employability-based initiative, is to help people with disabilities overcome barriers to mainstream employment. The program has been designed to support programs and services that help people prepare for, find and maintain employment. Examples of interventions include counselling and assessment, skills development, vocational crisis interventions and self-employment.

4. Who provides treatment and rehabilitation in the provinces and territories?

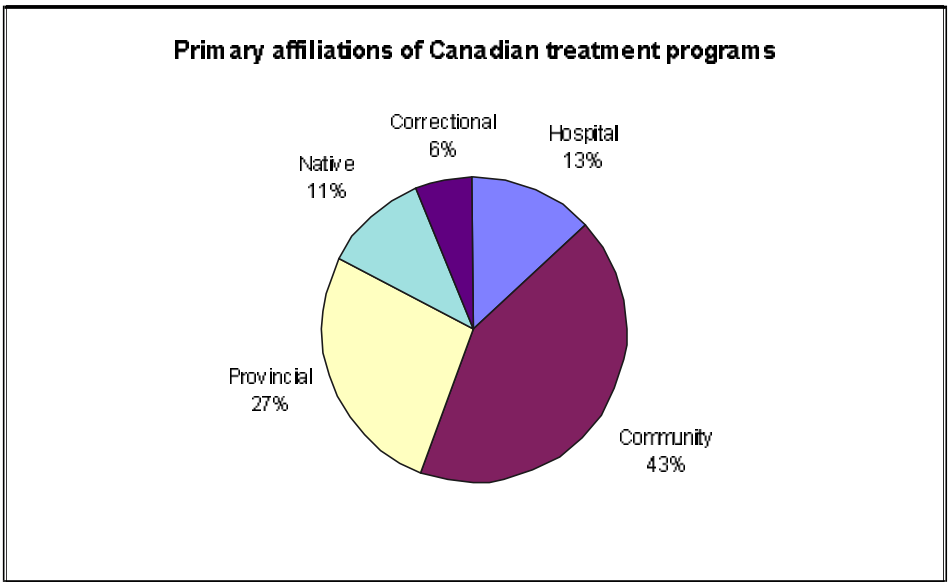
Typically, addiction services fall within the responsibility of the provincial/territorial ministry of health. In Alberta, the Ministry of Community Development is responsible for funding treatment services through the Alberta Alcohol and Drug Abuse Commission (AADAC), and in British Columbia, the Ministry for Children and Families has responsibility. In Ontario, other ministries besides the Ministry of Health (i.e., Community and Social Services and provincial Corrections) also fund addiction treatment services.

The proportion of services provided by various agencies varies considerably across the country. In the Yukon, 95% of services are reportedly provided directly by the government, but in no other jurisdiction except British Columbia is the government directly involved in service provision. In British Columbia, 30% of services are reportedly run directly by the government.

In the Atlantic Provinces, regional health boards are the dominant players in the direct delivery of services, providing 85% to 100% of all services in these provinces. Regional health boards also provide 60% of services in Saskatchewan and similar boards are expected to be prominent in Ontario, once an ongoing rationalization project is completed. In Manitoba and currently in Ontario, a high proportion of services is provided by provincially funded private, non-profit agencies. In Alberta, British Columbia and Northwest Territories, provincially funded private, non-profit agencies provide from 60% to more than 80% of services.

The primary affiliation of a treatment program provides some indication of the nature and orientation of its services (Figure 1). For the country as a whole, 43% of treatment programs can be described as community-based services, while 13% are affiliated with hospitals and 27% are associated with a provincial/territorial government. Eleven percent of the country's treatment programs are affiliated with Native services, while correctional treatment services account for the remainder of programs across the country (6%).

Figure 1



The workplace remains an important setting for substance abuse intervention. Employee assistance programs (EAPs) continue to be seen by substance abuse services as having an important role in identifying and assisting employees with these problems. For example, particular effort is being made in British Columbia to increase the number of EAP coordinators that can function as effective substance abuse treatment case managers. Also, respondents in some regions note that the 225 private EAP providers in the country *(CCSA, 1996)* are increasingly providing brief substance abuse counselling (in addition to assessment and referral).

Government-funded programs in Alberta and British Columbia charge fees to cover room and board in residential programs. Fee schedules in these provinces are reportedly geared to income and are often paid by employee assistance programs or other third parties. Continued restructuring of systems may result in further consolidations and more fee-for-service arrangements. Just over half of the treatment programs in the country accept out-of-province referrals, with most (84%) not requiring an extra fee.

5. Standards, monitoring and evaluation

As the direct delivery of treatment services devolves to regional bodies, provincial ministries are becoming more involved in setting and monitoring service delivery standards, in both the prevention and treatment areas. Notably, the British Columbia government has contracted with CARF, the Rehabilitation Accreditation Commission, a U.S.-based organization, to manage a credentialling system in which treatment programs receiving government funds will, over time, be required to participate. Begun in 1991 as a pilot, 21 agencies have been surveyed and accredited. In Manitoba, there are standards for all services run by the Addictions Foundation of Manitoba and standards are part of new funding agreements for services funded by Manitoba Health. In spring 1997, the Nova Scotia government introduced treatment and prevention standards for substance abuse services delivered by regional health boards. No government currently oversees treatment delivery standards for private agencies where they exist. Plans for a province-wide policy in Quebec in the early 1990s did not materialize; however, several regions in that province are moving ahead to apply standards for private agencies.

Client information systems are in place in almost all jurisdictions. These systems typically capture basic intake (i.e., client characteristics) and service information. When fully developed, the systems in Ontario and Nova Scotia will also monitor service costs.

More intensive evaluations of service have been conducted in some provinces, particularly Manitoba, Alberta and Ontario. Efforts to increase program evaluation are underway in most other regions, as resources permit. Just under half of the programs responding to the program survey indicated they have conducted client satisfaction surveys, while 26% report having conducted quality assurance evaluations. Twenty-eight percent of agencies indicate that their own staff have conducted outcome evaluations, and 14% have had independent outcome evaluations conducted. CSC continues a long tradition of substance abuse treatment evaluation within the Canadian justice system *(Ogborne, Smart & Rush, 1998).*

6. Professional development

Counsellor standards of practice and codes of ethics are reported to be generally prevalent and well communicated across the country, although it was noted that this extends only to those counsellors with a professional designation or those certified as counsellors by the national certifying body, the Addiction Intervention Association, with under 1000 counsellors currently certified.

Minimum qualification for substance abuse counsellors in government-funded agencies varies from none to a graduate university degree. The most stringent minimum requirements for counsellors in government-funded services are Nova Scotia's (Master's-level counselling degree), Newfoundland's (counselling degree with a professional designation) and New Brunswick's (Bachelor of Social Work). Minimum requirements for counsellors in other agencies were reported to be highly variable. The situation in Quebec is likely typical, where it is reported that better budgets assured for government-funded agencies allow them to recruit, train and retain more qualified staff than most private agencies can.

The formal certification of addictions counsellors was reported as an ongoing issue for staff of addiction treatment services except in Newfoundland, New Brunswick, Nova Scotia and British Columbia. A survey in Ontario found that 50% of the counsellors in specialized addiction treatment services were considering certification, although only 12% were certified at the time of the survey. However, most managers of addiction services did not require staff to be certified *(Ogborne, Braun & Schmidt, 1996*). Certification is an issue for governments or their agencies in Manitoba, Saskatchewan and the Northwest Territories. In Quebec, counsellors in the private sector view certification as an issue, as do a number of the government regional services organizations.

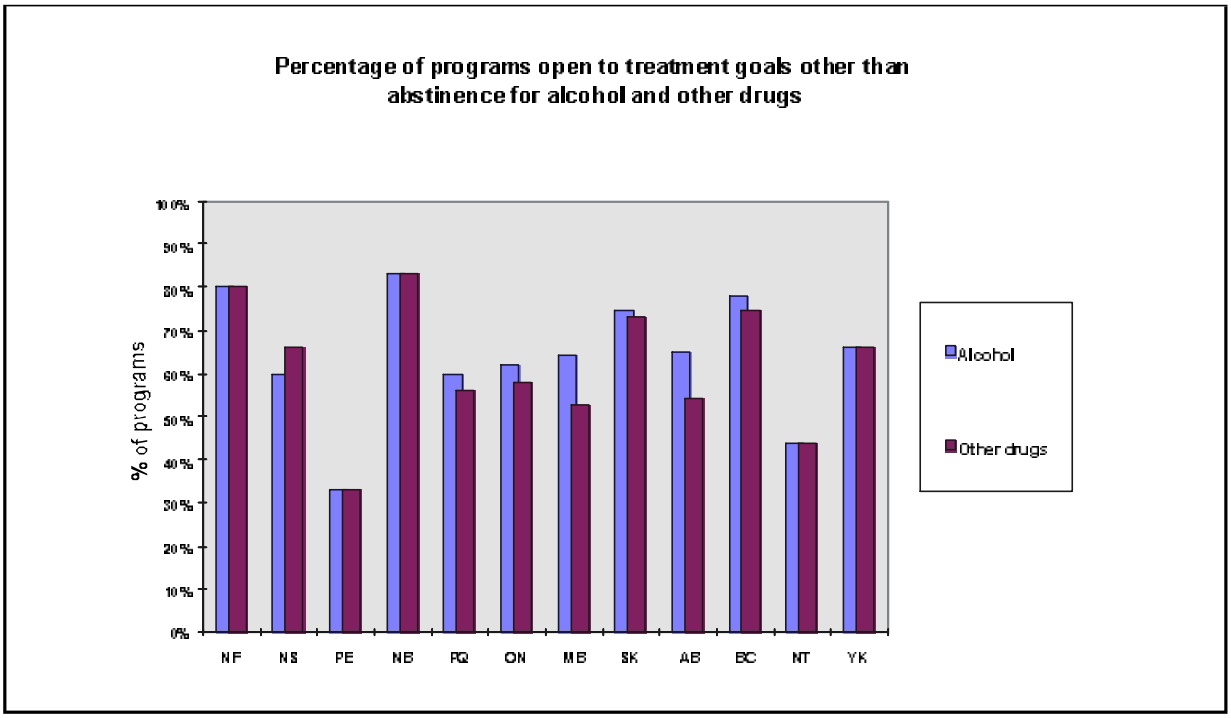
Entry-level training opportunities and resources were considered to be available in most regions except Newfoundland, New Brunswick, Nova Scotia, Saskatchewan and Yukon. As addiction services in most jurisdictions were folded into their associated ministries through the 1990s, centralized training that previously existed through these agencies dissipated. A portion of the need for basic and more advanced substance abuse counsellor training is being met by the 67 community colleges and universities across the country which sponsor course work in this area *(CCSA, 1996).* However, uneven access to training is noted in a number of recent investigations *(Ogborne, Braun & Schmidt, 1996; Corbett, 1994; CCSA, 1997).* McMaster University, in separate projects with the Canadian Centre on Substance Abuse and the ARF, has used Internet delivery for several of its courses as a way to increase professional development in this area. Currently McMaster is working with the ARF to compare different modes of course delivery including through the Internet.

In recent years, efforts have been made to advance the professional development of physicians on addictions issues. A 1989 meeting of Canadian medical educators contributed to increased attention to alcohol and drug problems in undergraduate medical school training - from approximately three hours of education to about eight hours - in subsequent years. The Canadian Society of Addiction Medicine, which represents 200 physicians identifying Addiction Medicine as their specialty, is promoting standards development in this area of practice. More recently, Health Canada has sponsored and coordinated a project to develop an interfaculty training plan for physicians, nurses and pharmacists. In Ontario, Project CREATE involves the development and evaluation of a common curriculum for medical students in the five Ontario medical schools.

7. Treatment philosophies and practices

Most respondents indicate that service providers in their regions increasingly view addiction as a complex bio-psycho-social phenomenon, often recognizing a "spiritual" component. However, support for the various modifications of the disease model continues in some service sectors. Harm reduction is viewed as a valid philosophy in five jurisdictions. The program survey would seem to support this, with just over half (51%) of treatment providers in Canada indicating an openness to treatment goals other than abstinence for alcohol problems, while somewhat fewer (47%) report the same openness for clients being treated for problems with other drugs.

Figure 2

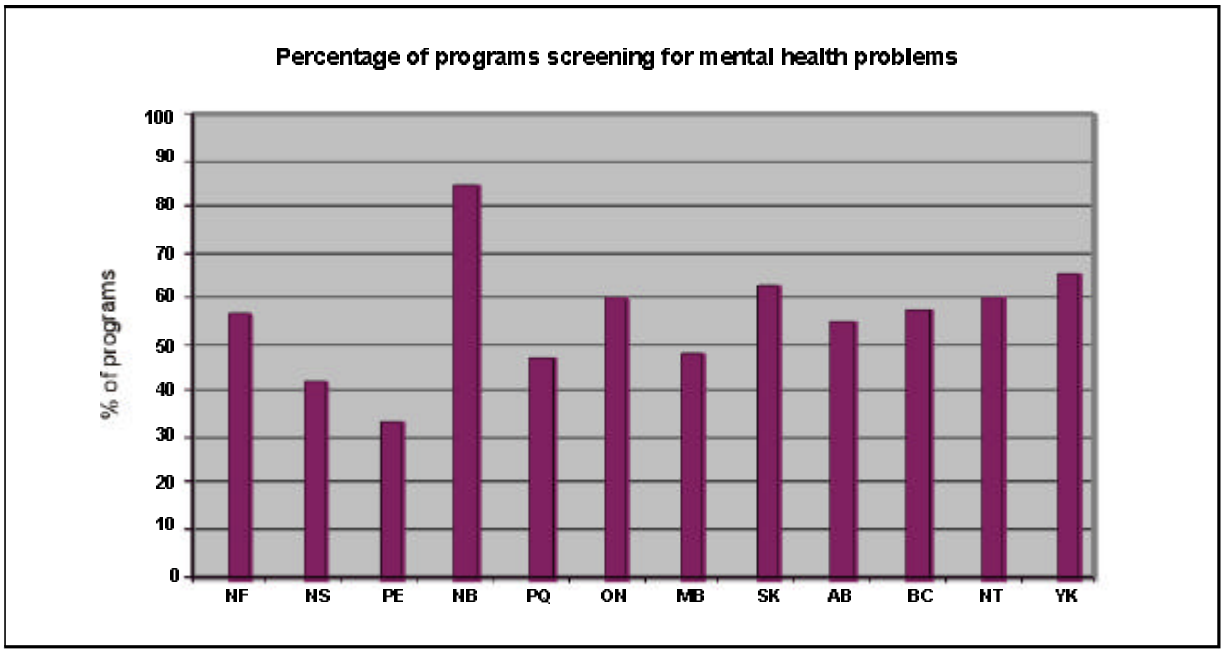


The practice of client assessment is well accepted in Canada; however, there is little uniformity in this practice across the country. Thirty-three percent of programs use a structured test for assessment (set of questions on substance abuse that has been psychometrically tested, such as MAST, AUI), while 55% use a structured interview (interview format for asking set questions, possibly including other life areas). Specific tools mentioned were: Addiction Severity Index (ASI), A Semi-Structured Interview for Selecting Treatment (ASSIST), Substance Abuse Subtle Screening Inventory (SASSI), Alcohol Dependence Scale (ADS), Michigan Alcoholism Screening Test (MAST), Substance Use

Disorder Diagnostic Schedule (SUDDS), Substance Abuse/Life Circumstance Evaluation (SALCE) and Medical Triggers Screening Tool. In Quebec, most rehabilitation centres are using the ASI or *Indice de gravité de la toxicomanie* (IGT) which is promoted by the government. Thirty-one percent of programs report use of unstructured assessments. A computerized lifestyle assessment is used by the CSC. In summary, clear consistencies did not emerge in assessment practices across the country.

Reflecting an understanding of the co-occurrence between mental health problems and substance abuse, 47% of substance abuse treatment programs screen clients for mental health problems. With the recent proliferation of gambling opportunities available to Canadians, an emerging concern in most jurisdictions is problem gambling. At least 30% of programs in Canada screen their clients for gambling problems.

Figure 3



Understanding the difficulty in "separating out" treatment activities which are often multi-modal, key informants were asked to rate the prevalence of specific types of interventions in their province. Across the country, confrontation is used least in government agencies. The program survey suggests that these interventions may be more prevalent in agencies not funded by government, with 31% of programs indicating use of confrontation, while 10% use anti-alcohol drug therapy and 6% use some other form of drug therapy. A total of 38 programs in the survey provide methadone maintenance treatment. Half of these programs use a higher dose regimen (60-100 mg/d), which has been evaluated more favourably in the research literature. In British Columbia, particularly,

pharmacological treatment is reportedly quite prevalent, no doubt because of the use of methadone in the treatment of heroin addiction. British Columbia has the highest proportion of heroin addicts using methadone in the country.

Close to 40% of programs surveyed report the use of psychotherapy. The use of this approach varies across the country and appears to be most common in Newfoundland, Nova Scotia and British Columbia, while it is hardly ever used in Alberta or the Northwest Territories. The most prevalent treatment activities, with approximately 7 in 10 programs reporting use, are alcohol-drug education, problem-solving counselling, and skills training, with stress management, assertiveness and behavioural self-control training emerging as the most common forms of skills training used. Over half (54%) of the treatment programs report using activities based on a 12-step, modified disease model approach within their program.

In general, governments do not promote any specific types of treatment. However, Saskatchewan promotes a form of motivational interviewing and a developmental model of recovery. The B.C. government has a policy promoting holistic, gender-relevant treatment. The CSC views substance abuse as learned behaviour and uses treatment strategies based largely on cognitive-behavioural and social learning theory, as well as on the trans-theoretical model of change.

8. Gaps in services

The key informant survey did not reveal any common patterns of gaps or conditions that affect the delivery of effective services across the country. Multi-problem clients, injection drug users, problem gamblers and clients in rural communities were variously mentioned. Four jurisdictions identified services for youth as an area of need. The need for more culturally sensitive services for Native people and more gender-sensitive services for women was also noted. A broad survey conducted by the Quebec government in 1996 revealed that a strong continuum of service and effective “first contact” interventions from the general health and social services were regarded as the most important gaps.

The need to improve services for severely addicted clients within the justice system, an Aboriginal-specific intervention for men, and the need for community-based interventions for justice system clients were noted by CSC.

When asked to comment on services for specific populations, a variety of particular measures were reported. For adolescents, most respondents noted that special services existed or were being developed. These included residential and outpatient services as well as school-based services for those considered at risk. This contention appears to be supported by the program survey which indicates that 207 treatment programs (24%) in the country offer special services for youth. Forty-nine programs offer special services for inhalant abusers, most of whom are young people. Of note is the establishment of a provincial youth treatment strategy by the New Brunswick government based on a stages-of-change approach, and involving the recruitment of specialized youth counsellors in all regions and the provision of training for all guidance counsellors in the province.

Gender-specific or gender-sensitive programs were noted as being promoted, developed or available in all regions, except Prince Edward Island, where this was identified as a continuing need. Two hundred and twenty programs (25%) report offering special services for women. Saskatchewan is experiencing a high demand for services for Aboriginal women in abusive “co-dependent” relationships, whereas in Yukon a priority is the development of a comprehensive training program to prevent fetal alcohol syndrome (FAS) and fetal alcohol effects (FAE). Seventy-eight programs across the country make special provisions for pregnant clients.

Table 3: Prevalence of special substance abuse treatment programming in Canada

	Females	Adolescents	Pregnant clients	HIV+ clients	Dual disorders	Heroin users	Inhalant users
Newfoundland	2	3	1	0	0	0	0
Nova Scotia	9	11	0	1	1	2	0
Prince Edward Island	2	2	0	0	0	0	0
New Brunswick	6	5	1	0	0	0	0
Quebec	48	48	21	24	34	22	21
Ontario	59	52	17	15	37	11	5
Manitoba	9	5	3	1	0	1	2
Saskatchewan	5	11	4	3	3	1	7
Alberta	10	15	7	5	6	5	6
British Columbia	65	48	22	22	18	14	5
Northwest Territories.	4	6	2	1	1	1	3
Yukon	1	1	0	0	0	0	0
TOTAL	**220**	**207**	**78**	**72**	**100**	**57**	**49**

In most regions, there are ongoing discussions concerning the treatment of substance abusers with mental health problems. In the meantime, special provisions for dually diagnosed cases do exist, with 58% of programs accepting clients with mental health problems and 100 programs offering special services.

Fifty-seven programs across the country offer special services for heroin addicts. Respondents from Newfoundland, Prince Edward Island and New Brunswick indicate a limited need for treatment for opiate addicts; the Northwest Territories and Yukon report that opiate addiction is on the increase and that new programs are needed. Elsewhere, there is a move to expand methadone maintenance treatment services and to license and train physicians for work with opiate addicts who have been stabilized on methadone.

The special need for business and industry to have easy access to assessment and treatment services is a growing issue, as corporate interest in substance abuse increases. In response, AADAC has established a treatment clinic specifically designed for business and industry. In British Columbia, a formal procedure smoothing access of EAP referrals to treatment has been established between government treatment services and employee assistance program associations in the province.

9. Ongoing challenges and emerging issues

Key informants report that addiction treatment services typically serve a diverse population of clients and that many clients have multiple problems. Clients with cognitive impairments, those involved with the criminal justice system, who have HIV or AIDS, mental health or gambling problems, and those prone to violence are especially challenging from both a systems and clinical perspective.

In various jurisdictions, the coordination of services to best meet the needs of clients with co-occurring mental health and substance abuse problems looms as a significant emerging issue. For example, a task force report sponsored by the Ontario Division of the Canadian Mental Health Association noted that efforts at coordination need to occur both within and between the mental health and substance abuse systems. Collaboration between the sectors in the form of joint training, information sharing, cross-appointments of staff and protocols to integrate treatment with community support were highlighted *(CMHA, 1997).*

Similarly pressing is the need for services and policies to be adapted to address effectively HIV/AIDS and substance abuse among injection drug users. Although an issue in different parts of the country, both rural and urban, the problem is particularly acute in Vancouver where the rate of new HIV infections among injection drug users is the highest in North America *(Strathdee et al., 1997).* A recent National Task Force report on this issue recommended a better coordinated system staffed by providers knowledgeable about both AIDS and drug use and operating with a harm reduction approach *(CCSA/CPHA, 1997).*

At the clinical level, there is concern that some service staff lack the skills to address effectively clients with multiple problems and that some, in fact, have difficulty adapting to new approaches and ways of relating to clients. An example mentioned was the need for special efforts to be made to change the attitudes of addiction service providers to the use of medication by clients with psychiatric problems. This is contrary to the “abstinence only” philosophy that has historically dominated the addiction treatment field. The need to educate service providers about the use of medication was also evident from a recent survey of providers in Ontario *(Ogborne, et al., 1996).* Clearly, advanced training and development are essential for the provision of effective services to address this range of clients and problems.

The challenge of providing services to people in rural areas is a concern in several regions. This problem has been met in several ways, including the establishment of satellite offices from urban services and the use of urban residential services as supportive housing for out-of-town clients. *Rush and Ogborne (1992)* reported that some provinces were

experimenting with “community mobile treatment,” involving a visiting team of addiction, mental health and community development specialists providing intensive service over an extended period. While demonstrating promise *(W eibe, 1994),* many of these efforts have dissipated, apparently due to cost cutting and system reforms.

New Brunswick addiction services are moving into telecounselling for clients with gambling problems, with the intention of expanding this to clients with substance abuse problems. Similarly, some agencies in Ontario can offer telephone assessment and limited counselling. Similarly, some agencies in Ontario are experimenting with telephone assessment and counselling. One region in Nova Scotia is using a team service delivery approach wherein representatives from various services (i.e. detox, inpatient, outpatient, adolescent and prevention services) meet regularly and work closely with the community to coordinate services.

Limited, and in many cases, diminishing resources for addiction services are compounding other challenges to providing effective treatment. Many agencies have received significant cutbacks in recent years. Possibly exacerbating the situation, substance abuse organizations are increasingly being asked to address problem gambling. While additional funding often accompanies this new mandate, there is some concern that attention given to problem gambling may draw scarce resources from substance abuse treatment.

Similarly, Bill C-41, which permits court-ordered substance abuse treatment at a judge’s discretion, has an impact on substance abuse assessment and treatment resources. Bill C-41 includes extensive legal provisions for court-ordered treatment. The legislation endorses a general principle that for many offenders, community service and/or treatment is preferable to incarceration, when warranted by circumstances specific to the case. For offenders with substance abuse problems, Bill C-41 provides a legal mechanism for diverting offenders away from costly trial and incarceration procedures and toward treatment programs for alcohol and other drug abuse.

The issue of mandatory treatment has also arisen in Manitoba where the Supreme Court of Canada ruled against an appeal from Winnipeg Child and Family Services to be permitted to require an Aboriginal woman to take treatment for solvent abuse. The case raised fundamental issues around human rights and the efficacy of mandated treatment. Among the intervenors who appeared before this court was the Yukon government which has had the option to mandate treatment for pregnant women since the 1980s through its *Child Protection Act.*

Another area in which substance abuse services may be challenged to become more involved is with smoking cessation. Since over 80% of drug-dependent persons also smoke, it makes sense to consider the inclusion of cessation programming in substance abuse treatment programs - particularly in light of the fact that an alcohol-dependent person is more likely to die from smoking than from alcohol use *(Abrams, 1993).* Currently, 22% of substance abuse treatment programs in the country offer tobacco cessation support within their service.

Canadian treatment services may also be affected by increased referrals from business and industry. Corporate interest in substance abuse is occurring for a variety of reasons, but it is particularly due to US legislation which, as of July 1, 1997, requires all Canadian road transport carriers to drug test their drivers who cross the border and to send drivers who test positive to a "Substance Abuse Professional" for assessment, possible treatment and follow-up. The actual activity for substance abuse programs stemming from this legislation remains to be seen.

Turbulence in the administrative environments surrounding addiction services is posing a challenge in some regions. In Ontario, for example, addiction services are being restructured in the context of other significant changes to the health and social service system. As addiction services become more fully integrated with other health and social services across the country, there is concern that alcohol and drug services will suffer a loss of focus. The concern is perhaps most acute in those jurisdictions where government addiction agencies have closed (Newfoundland, Nova Scotia, New Brunswick, and Saskatchewan).

This loss of focus is being felt at the local levels as well, where regionalization of services is seen by some as creating a potentially competitive environment among treatment services and between substance abuse and other community health services providers. Above all, the regionalization of services is creating a requirement for new linkages among local providers. For example, AADAC is being called on to forge links with children's services authorities and regional health boards throughout the province. While these new linkages have the potential to offer more seamless service to individuals in their regions, it is suspected that the very process of fostering and maintaining these partnerships will place further pressure on scarce local resources. Finally, regionalization also requires a new relationship between provincial and local addictions treatment interests. As authority for decisions concerning the level and nature of substance abuse treatment moves to the regions, provincial funders are seeking new mechanisms to support and account for local treatment activity.

At the clinical level, the issue of coordination plays out as a concern for a continuum of care that will match a variety of clients to the most appropriate service. However, the lack of standardized assessment and the absence of research-based evidence to support matching was seen as limiting developments in these areas. More research is clearly needed on matching to maximize the cost-effectiveness of treatment systems.

Where there are challenges, there are also opportunities. As substance abuse practitioners forge new partnerships with other health and human service professionals, there should be strong opportunity for transfer of information and skills. This is important because the majority of people who experience problems with alcohol and other drugs do not seek treatment from specialized services; only when their problems become serious and resistant to change are they likely to come into contact with specialized services. While people need to be encouraged to seek help - and at an earlier stage - from substance abuse treatment services, it is also important to note that many people who experience alcohol and other drug problems resolve these problems on their own, through self-help/mutual aid groups or with brief interventions that can be provided by general health and social service agencies. In the past, these services have often failed to recognize alcohol and drug-related problems among their clients.

It is hoped that these new alliances will lead to greater opportunities for exchange of knowledge and skill among substance abuse and other human services providers. The growing contribution of these other providers as a complement to the work of treatment specialists and self-help groups has the potential to greatly improve the effectiveness of society’s response to substance abuse problems.

10. Glossary of treatment definitions

Assessment: Systematic procedures for the identification of a client's major strengths and problem areas, culminating in a treatment plan and referral for assistance.

Client Satisfaction: Formal survey of clients on level of satisfaction with various aspects of service.

Continuing Care (aftercare): Resources or services that provide continuing encouragement and additional services as needed following a client's completion of a treatment plan.

Day/ Evening Treatment: Intensive, structured non-residential treatment, typically provided five days a week (e.g. 3-4 hours per day). Such programs may also be provided in institutional settings (e.g. Corrections).

Family/Marital Therapy: Involvement of spouse, family members and/or significant others in the therapeutic process in order to improve communication, problem-solving and other skills in the family, thereby modifying alcohol and other drug use by the client and providing support to the family. In some programs, family members are clients in their own right.

HIV Prevention: Activities targeted at clients to educate them about the risk factors associated with the transmission of HIV infection and/or to provide supportive counselling to those identified as HIV positive.

Home Detoxification: Individuals are assisted through withdrawal at home by trained community personnel.

Medical Detoxification: The use of drugs such as diazepam or chlormethiazole to assist in the withdrawal from alcohol and other drugs.

Methadone Maintenance Treatment: The use of methadone in a prescribed and systematic fashion as a substitute for opiates in order to stabilize the user while lifestyle and interpersonal changes are attempted.

Methadone Maintenance Treatment – high dose: Average dosage of 60-100 mg/d.

Methadone Maintenance Treatment – low dose: Average dosage of 30-50 mg/d.

Needle Exchange Program: The free exchange of used or clean needles and other material required for the safer injection of drugs (i.e. bleach kits).

Outcome Evaluation: Investigates the impact of the delivered services on the client (e.g. percentage of clients that reduce alcohol use by 80% for 12 months following treatment).

Outpatient Treatment: Treatment provided on a non-residential basis, usually in regularly scheduled sessions (e.g. 1-2 hours per week).

Outreach: A service that reaches out beyond the usual boundaries of agency activity to identify and engage individuals known to have, or to be at risk of having, alcohol or drug problems.

Problem Drinking: Drinking that results in health or social problems that are usually considered to be less severe than those associated with alcohol dependence.

Quality Assurance: Systematic process designed to maintain satisfactory levels of service delivery and to improve quality of care.

Residential Treatment (long-term): Treatment and/or rehabilitation services provided for a period of time typically longer than 40 days. These programs include recovery homes, halfway houses, three-quarter-way houses and therapeutic communities.

Residential Treatment (short-term): Treatment provided for an intensive, structured period of time while the client resides in-house. The length of stay is typically less than 40 days.

Social Detoxification: Assistance with the withdrawal from alcohol or drugs without the aid of drug therapy.

Social-Medical Detoxification: An approach combining elements of both approaches.

Twelve Step Self-help: Treatment activities based on the disease perspective of alcoholism and other chemical dependencies, and the 12-step approach of AA or similar self-help groups.

Walk-in and Crisis Service: A service which emphasizes ease and immediacy of access and which provides assistance, support, advice or attention to urgent medical, psycho-social and basic needs.

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12. Annotated bibliography

Through the course of this project, a number of non-peer-reviewed Canadian articles relating to treatment effectiveness came to our attention through a search of the National Clearinghouse on Substance Abuse, a general solicitation undertaken during the survey of treatment and rehabilitation programs, and discussions with a number of government officials. This is intended to be an illustrative rather than exhaustive inventory of Canadian articles, studies and reports that have been produced across the country in the past several years.

ABORIGINAL PEOPLES COLLECTION (1992): *The Native Inmate Substance Pre-Treatment Program: A demonstration project*. Solicitor General of Canada, User Report 1991-11, Supply and Services Canada, Cat. No. JS5-1/3-19160-9.

> This demonstration project was set up to address the need within the justice system for education and training in cross-cultural awareness, addictions and the treatment process. The purpose of this demonstration project was: to develop a Native pre-treatment program model and manual for implementation in correctional institutions; to develop treatment centre guidelines for treating the Native offender; to field test and evaluate the Native pre-treatment program model and manual; and to develop a public relations brochure on the treatment program model and manual. The demonstration project was divided into four phases: research and development; pilot testing of program model; program final development; and community research. The treatment model involved eight weeks of intensive treatment and educational activities, a four-year continuum of care plan, one-to-one counselling opportunities, and a disease model orientation which emphasized sobriety and education. The program model was pilot tested at two federal correctional institutions in British Columbia with positive outcome.

ADDICTION RESEARCH FOUNDATION (1997): *Co-occurring Mental Disorders and Addictions: Scientific Evidence on Epidemiology and Treatment Outcomes.* Toronto: Addiction Research Foundation.

> This report provides a summary of available literature on co-occurring addiction and mental health problems in order to examine implications for services in Ontario. It followed a needs assessment conducted in this area by the Addiction Research Foundation. The stated concern was to ensure that services for clients with concurrent disorders are as effective, efficient and cost-effective as possible. The searched literature revealed that findings are too weak to demonstrate the superiority of any particular model of treatment or service organization. At present, an empirically based model for integrated treatment is not available, and there appears to be no clear scientific evidence to support the choice of an integrated

treatment system over other alternatives. Recommendations to improve current services included better referral and coordination between agencies, examination of agency exclusion criteria, and the provision of staff training in assessing, referring and treating co-occurring disorders. The report stresses the need for empirical evidence for effective treatment models, and more research in epidemiology, service demand, patterns of co-occurring disorders, and service organization and utilization. It identifies an urgent need for sound clinical trials across the full range of co-occurring disorders and co-morbid population groups.

ADDICTIONS FOUNDATION OF MANITOBA (1995): *Rural and Northern Youth Intervention Strategy (RNYIS) Project: Final Report*. Proactive Information Services Inc.

This project was developed in 1993 to address information and counselling needs of high school students in 18 schools across the province. The report provides a detailed evaluation of both project implementation and outcome. Indications were that most schools accepted an early intervention approach to chemical dependency at Grade 9, and recommended it for Grades 7 and 8 or lower. The number of self-referrals increased, as did informal discussion with counsellors. A significant reduction in alcohol use was found among students when comparing pre- and post-treatment questionnaires. The most important benefit indicated was that students were provided with counselling. Students also became more aware of alcohol and drug policies in their school.

ANISHINAABEG MEDICAL PROFESSIONALS (1993): *Okunongegayin: Challenging Chronic Solvent Abuse*. Demonstration Project Final Report, and Summary of the Demonstration Project Final Report, Ontario Ministry of Health.

This demonstration project was financed by the Health Innovation Fund in collaboration with the Lake of the Woods District Hospital, Kenora and Wabaseemoong Independent First Nations, Whitedog. Okunongegayin, meaning "breath of life," describes a dynamic model for healing illnesses associated with substance abuse, especially solvents, in small Northern communities. It was seen to be both a therapeutic program, and also a model for collaboration and partnership among the agencies, institutions and communities involved with chronic solvent abusers. Over the two-year program, about 80% of the 136 clients were between 15 and 29 years of age, and most were poly-drug abusers, with 86% using solvents as their drug of choice. Treatment was offered in a bush camp, to help clients make changes in a context connected with daily life. With improved health, change was rapidly effected. The project promoted family and community involvement, flexibility and innovative ideas to facilitate change within the context of community life.

ARCHIBALD, C., OFNER, M., PATRICK, D., STRATHDEE, S. ET AL. (1996): *The Point Project: A Study of Risk Factors for HIV Infection among Vancouver's Injection Drug Using Community: Summary of Final Results*. British Columbia Ministry of Health.

> The Point Project was launched in 1995 to identify the underlying reasons for the rapid increase in HIV infection in injection drug users. The purpose of the study was to identify risk factors in this community. The project was conducted in two phases: in-depth interviews were conducted with 16 participants, and qualitative information from these interviews was used to create a questionnaire for a case-control study, in which 89 injection drug users who had just been diagnosed with HIV were compared to 192 persons who had tested HIV negative on two occasions. Findings included: a perception of increased severity of addiction problems in Vancouver in the past few years; a social and demographic profile of a transient population, with early onset of injection drug use, injection of both cocaine and heroin, and frequent use of services; and needle sharing and increased risk of infection. The project recommended the need for safe and stable housing, harm reduction education, including education for needle exchange and outreach, safer sex education, mandatory training for police personnel, methadone programs, mental health outreach and the need for research into the management of cocaine addiction.

BEAUDOIN, C. (Unpublished): Differences Among AFM Clients with Respect to History of Parental Alcoholism. (Draft) Faculty of Medicine, University of Manitoba.

> Fifty-six percent of AFM clients sampled in the 1992-93 Winnipeg health and drinking survey indicated having an alcoholic parent. The effects of having at least one alcoholic parent on demographics, severity of alcohol problems and on a variety of personality measures were assessed for this sample of 451 men and women. The analysis revealed that there were no differences in demographics, but that differences in the extent of alcohol-related problems and personality features were quite pronounced. Specifically, those with at least one alcoholic parent reported a greater number of family and social problems related to their drinking than those with no parental history of alcoholism. Those with an alcoholic parent experienced more anxiety and nervousness, had a weaker self-concept and a greater tendency toward aggressive and impulsive behaviours. Male clients tended to be significantly more negatively affected by the presence of an alcoholic parent than the female clients. Based on a six-month follow-up which captured 70% of the original sample, it was found that those clients with an alcoholic parent were significantly less likely than other clients to be abstaining or drinking responsibly, leading to a recommendation that the Foundation consider tailoring its programs to address the particular issues of clients with at least one alcoholic parent.

BEAUDOIN C., (1997): *A Comparison of In-treatment Female Alcoholics and Female Alcoholics from the General Population.* (Draft) Faculty of Medicine, University of Manitoba.

> The Addiction Foundation of Manitoba was interested in determining if there were any differences between the females entering AFM treatment programs and female alcoholics not in treatment identified in a general population survey. Demographically, there were no differences observed in the two groups. However, differences were observed in other respects, with those having been in treatment showing more severe drinking and drinking-related problems and a greater likelihood of maladaptive personality characteristics. The author speculates that the differences observed between the two groups may be the reason why individuals enter treatment in the first place.

BLOOD, L. (1995): *Choices Program: A Treatment Outcome Study: Preliminary Results.* Nova Scotia Department of Health, Drug Dependency Services.

> This report gives the preliminary results of the CHOICES program, by reviewing data collected on 130 adolescents who completed the program. The program, which has been operating since 1990 in Nova Scotia, comprises a range of services for adolescents who are harmfully involved with alcohol and other drugs. It offers outpatient services, and inpatient and day treatment intervention programs. Data were collected pre-treatment, post-treatment and 12 months after discharge, using the Adolescent Alcohol Involvement Scale, the DAST-10, measures of self-esteem, family relations and peer relations. The average age was 16 years, with 65% male, 35% female. The degree of substance abuse was found to be well within the clinical range. Overall, pre-post treatment comparisons found increased self-esteem, reductions in behavioural problems, improved family and peer relations, and reduction in alcohol, cannabis, and solvent use and abuse.

BRITISH COLUMBIA MINISTRY OF HEALTH AND MINISTRY RESPONSIBLE FOR SENIORS (1996): *Outcome Measures for Alcohol and Drug Services: A Resource for Program Evaluation.*

> The report outlines components of program evaluation and outcome evaluation and gives a summary of steps usually taken in program evaluation and a sample of a program evaluation report outline. The guide also provides sample outcome measures for agencies in the Alcohol and Drug Services (ADS) System of Care, as a foundation for conducting outcome monitoring or outcome evaluation.

CENTRE INTERNATIONAL DE CRIMINOLOGIE COMPARÉE POUR LE COMITÉ TOXICO-JUSTICE, *Persistance en traitement et impact de réadaptation des personnes toxicomanes judiciarisées admises à Domrémy-Montréal / R apport 5,* mars 1995, 46 p.

This study compares the impact of the rehabilitation program on clients subject to judicial control and those who are not. It shows that, for both groups, the impact is the same for people staying in their programs for the same length of time. The study does reveal, however, that persons subject to judicial control in treatment in Domrémy-Montreal abandon their programs earlier than those who are not subject to judicial control. The overall findings of the study confirm those of previous studies, i.e., that the best indicator of the impact of treatment is the time spent in treatment. This is a very major study, considering that treatment services are being requested increasingly by the courts for persons with alcohol or drug problems.

COMITÉ AVISEUR SUR LA RECHERCHE ET L'ÉVALUATION EN TOXICOMANIE : *Avis no 1, Les priorités de recherche dans le domaine de la toxicomanie,* Québec, MSSS, mars 1992, 8 p. et 2 annexes.

The Advisory Committee is made up of representatives from the following organizations: *the Conférence des Régies régionales, la Fédération des centres de réadaptation en toxicomanie du Québec, the Association des hôpitaux du Québec,* the *Fédération des CLSC ,* the private sector, universities and the Department of Health and Social Services. This committee has assumed an important role in the development and promotion of research into alcoholism and drug addiction in Quebec. It was created in the early 1990s and has a mandate to:

- give opinions to the Department of Health and Social Services on the areas of development of research in drug addiction;
- promote partnerships between the fields of research and development. To this end, it cooperates closely with the *Conseil québécois de la recherche sociale* (CQRS) to develop links between these areas and to consolidate them in the two alcohol and drug addiction research teams;
- promote the transfer of knowledge from the research area to the intervention area and vice-versa.

The result of a broad-based consultation with interested parties throughout Quebec, this paper presents the result of research priorities which the advisory committee believes are the most important. The priorities include knowledge of those clients and populations at risk, development of evaluative research of programs, analysis of professional practices in alcoholism and drug addiction, and the contribution of natural and community environments. Appendix 2 of the paper contains the findings of the consultation on the priority research and development orientations.

COMITÉ AVISEUR SUR LA RECHERCHE ET L'ÉVALUATION EN TOXICOMANIE *: Avis no 2, Les questions relatives à la toxicomanie au sein de l'enquête sociale et de santé de 1992* (Enquête Santé Québec), Québec, MSSS, mars 1992, 7 p. et 2 annexes.

> This is a notice of intent to officials heading up the *Santé Québec* survey to improve the data pertaining to alcoholism and drug addictions to increase the knowledge of alcohol and drug consumption habits of Quebec residents. It is a proposal to improve the alcoholism-drug addiction facet of the social and health survey of 1992. It recommends that those in charge of the *Santé Québec* survey add two objectives to the social survey (i.e. to preserve comparability with the other surveys both inside and outside Quebec, and to gather information on the social determinants of consumption to support the development of preventive action).

COMITÉ AVISEUR SUR LA RECHERCHE ET L'ÉVALUATION EN TOXICOMANIE *: Avis no 3, Le point sur les besoins d'enquêtes épidémiologiques en matière de toxicomanie au Québec*, Québec, MSSS, mai 1993, 14 p. et 2 annexes.

> This notice deals with the need for epidemiological data and the survey procedures to be emphasized. The findings are based on extensive consultations with Quebec, Canadian, American and European researchers and Quebec data users. This paper contains clarifications of user needs, the status of surveys, parameters for the structure of epidemiological databases for alcoholism and drug addictions, and advisory committee recommendations pertaining to improvement of data banks and transmission of data.

DESJARDINS, N., KISHCHUK N., OUELLET F., PERREAULT N . *L'évaluation de programmes en alcoolisme-toxicomanie : Un cadre de référence*, Montréal, août 1996, 106 p. (Document de travail).

> This report is the result of a subsidy given to the Montreal-Centre Public Health Branch by the Department of Health and Social Services. The purpose is to provide officials organizing programs, decision makers and other parties in the alcoholism and drug addiction field with various tools to evaluate the programs. Specific objectives are to make those in related fields aware of the contributions, conditions and terms of program evaluation, and to equip the intervention and evaluation fields with a proposed accessible frame of reference, which can generate valid, original and useful evaluations. Basic definitions and definitions of types of evaluations are found in the first part of the report, along with the three major approaches in program evaluation. The second part deals with the context of evaluation and process. The authors describe a few points of reference when conducting an alcoholism-drug addiction-related program evaluation.

GOUVERNEMENT DU QUÉBEC, MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX : *Normes de reconnaissance pour les organismes offrant des services d'aide et de soutien aux personnes alcooliques et toxicomanes*, avril 1994, 89p.

This report describes a series of standards intended to ensure the quality of services for vulnerable people (i.e. those grappling with drug addiction problems). These standards cover administrative components, aid and support services and physical facilities. In total, more than 120 quality indicators have been identified to evaluate and guarantee the quality of services offered.

GOVERNMENT OF NEW BRUNSWICK. Standards for Addiction Services, in: *Standards for Hospitals in New Brunswick*. (Draft) Fredericton, June.

This document was developed to guide the delivery of addictions services by the seven regional hospital corporations in the province. The standards approach addiction as a bio-psycho-social problem and adopt the principle of least-to-most intrusive intervention depending on need. The standards cover a "continuum of services" that includes training and prevention. Problem gambling is also understood to be covered by addiction services. Issues addressed in the standards include criteria for admission, safety and security, family involvement, use of protective drugs, and pregnancy and addictions. The document includes a bibliography with 69 citations.

GRIFFITHS, C.T., GLACKMAN, W., ESPERSON, T., DAVIES, G. (undated): *Programs and Services for Urban Native Indian Alcohol and Substance Abusers: Initiatives, outcomes and issues.* Burnaby, B.C., Simon Fraser University, School of Criminology.

This report reviews the availability and effectiveness of alcohol and substance abuse programs and services for urban Native Indians. The majority of programs in Canada are community- or reserve-based, operating in rural areas, and have little relevance for individuals living in urban areas. In reviewing the current literature, the authors found no data on urban Aboriginal people which could be used as a basis for developing treatment programs and services, and they were unable to judge treatment effectiveness from the current programs. They identified a lack of understanding of the etiology of Native drinking, with no studies which documented the variations in drinking styles among Native Indians in rural or urban areas. Problems include lack of systematic data collection, small sample sizes, poor methodology and lack of information on the cultural, psychological and socio-economic factors related to alcohol and substance abuse among this population. The authors suggest that the treatment of urban Native Indian alcohol and substance abusers cannot be undertaken in isolation from the larger socio-economic and environmental context within which Native Indians live. They recommend holistic programs, in which regenerated spiritual values foster abstinence after treatment has ended, and the development of positive social support networks combined with educational and economic opportunities.

GUYON, L., GEOFFRION, Y. : *La toxicomanie au Québec :* Bilan des études épidémiologiques faites depuis 1990, MSSS, mai 1997.

> This report discusses the work performed in the past 10 years to delimit the phenomenon of alcoholism and drug addiction in Quebec and to take action. It provides data on the prevalence rate, socio-economic characteristics and related factors and highlights. The report has been divided into three parts: the general situation of alcohol, drug and prescription drug consumption; alcohol, drug and prescription drug consumption in specific groups; and problems associated with alcohol, drug and prescription drug consumption.

HADEN, M. (1997): *Program Evaluation Report: The Central Clinic.* Alcohol and Drug Services, Ministry for Children and Families, Province of British Columbia.

> This report provides a descriptive evaluation of five program areas (orientation group, intake assessment, education group, support group, one-to-one treatment). A range of domains was evaluated, showing the programs to be very effective in helping clients to achieve abstinence, reduce substance use, improve emotional, psychological and spiritual health, gain understanding of substance misuse, feel welcome and receive an orientation. Clients report that the programs are somewhat effective in improving physical health, social and family relationships, and employment/school situation.

HARVEY-JANSEN, Z'A. (1995): *Adolescent Treatment: Excellence Through Evaluation.* Alberta Alcohol and Drug Abuse Commission.

> This report provides a summary of an evaluation of AADAC's Adolescent Treatment System, which was initiated in 1992. This system provides treatment for approximately 1500 adolescents aged 12 to 17 years through 26 outpatient treatment facilities across Alberta, addressing alcohol and drug use problems. The evaluation comprised five studies, including program model and description of all programs; a survey conducted with referral agents; a treatment staff survey; a review of the recent (1980-93) literature of adolescent and drug treatment effectiveness; and an evaluation of treatment effectiveness. The review offered recommendations to improve treatment provision in the following ways: to match level of care with the client's level of alcohol and drug problems, psychiatric severity, conceptual level and social stability; to assess readiness for change; to ensure provision for residential support in intensive day treatment for adolescents in need of this service; to enhance communication in and about the treatment system; to encourage family involvement; to increase government and other agency collaboration; and to actively explore and incorporate the findings of the evaluation.

KERR, D. (1994): *Matching Clients with Substance Abuse Problems to Treatments: A Review of the Literature.* Prepared for Alberta Alcohol and Drug Abuse Commission.

> In reviewing the literature related to client-treatment matching, the author identifies three types of studies with increasing complexity: general outcome studies; studies of specific treatment approaches; and matching studies. The review discusses methodological difficulties in treatment evaluation, and describes several outstanding treatment studies. Treatment methods which have empirical support are reviewed, based on the reviews of Miller and Hester. Matching variables are reviewed, related to the client (conceptual level, cognitive abilities, locus of control, self-esteem, psychiatric severity, social stability and severity of alcohol problems), and to the therapist (empathy, degree of "fit"). The author notes that reviewers caution that some matches may cause harm. They identify four levels at which matching can occur: before treatment (program-patient); at initiation of treatment (patient setting); during the treatment process (patient treatment); and following primary care (post-treatment environment). The author concludes that matching requires a holistic perspective of the client's relevant issues. Matching is seen as an ongoing process, in which all the interacting variables cannot at present be controlled. Assessment is an important component, as well as well-defined quality treatment which is accurately monitored and reported.

KIMBERLEY, DENNIS (1994): *Humberwood Residential Treatment Program Implementation Evaluation and Program Consultation*. Drug Dependency Services, Newfoundland & Labrador.

> This review consists of an executive summary and process analysis of the province's sole residential treatment program which began operation in 1990. The analyses and recommendations cover assessment, referral, intake and selection, programming, treatment, psycho-social education and activities, policy, staffing, evaluation and cost-efficiency.

McAMMOND, D., SKIRROW, J. (1997): *Care, Treatment & Support for Injection Drug Users: Living with HIV/AIDS.* A consultation report prepared for the AIDS Care Treatment and Support Program, Health Canada.

> The purpose of this report was to obtain a better understanding of the issues in serving injection drug users living with HIV/AIDS. The report is divided into three sections: Section 1 used a consultation process of interviews with key informants in Vancouver, Toronto and Montreal. Section 2 comprised an epidemiological study of HIV infection among injection drug users. In Section 3, the current services were examined to determine which clients were being served, what was being done and how it was working. HIV infection appears to be continuing to increase at a high rate in Canada, particularly in women. Present support services noted include needle exchange, outreach primary care, outreach education and support, access to substance abuse and rehabilitation services and access to supportive housing.

Program/service issues included ethical/legal dilemmas, inappropriate services, rigid program entry criteria, limited substance abuse services, lack of adequate housing, inadequate staff training, and correctional and legal issues. Based on the findings, the report proposes a framework for action, based upon a holistic approach, with more responsive clinical services; new or enhanced support services; improved service coordination; improved provider information and training; more responsive housing and residential care; and attention to legal issues surrounding drug use.

NOVA SCOTIA DEPARTMENT OF HEALTH (1996): *Outcome Monitoring System: Short-term Residential and Day Programs Procedures Manual*.

This manual was prepared by the Western Region of Drug Dependency Services in affiliation with Operations and Regional Support Branch, Drug Dependency, Nova Scotia Department of Health. It describes the procedures for developing an Outcome Monitoring System in short-term residential and day treatment programs. The system was adapted from the Alberta Alcohol and Drug Abuse Commission system. The purpose of the system is twofold: to provide accurate information for government data collection; and to assist in program planning. Central components are client feedback and follow-up surveys. Six steps are provided with detailed information on distributing forms, obtaining consent, administering the client feedback survey, selecting the sample and administering the follow-up survey, and summarizing the results.

RUSH, B., CHEVENDRA,V., VINCENT, S. (1993): *An Overview of the Drug and Alcohol Registry of Treatment (DART)*. London, Ont., Addiction Research Foundation.

The extensive use of US treatment programs by Ontario residents highlighted the shortage of some types of treatment services in Ontario and the need for better information for service planning. The Drug and Alcohol Registry of Treatment was developed by the Addiction Research Foundation with province-wide consultation as a three-year demonstration project. It serves two functions: to collect and update information on the availability and accessibility of treatment services, and to report this information to service providers and stakeholders.

SASKATCHEWAN ALCOHOL AND DRUG ABUSE COMMISSION (1992): *Meeting the Challenges: The Saskatchewan Model of Recovery Services*.

This document outlines the strategic direction of the Saskatchewan Alcohol and Drug Abuse Commission, using what is termed a “developmental model of recovery services,” which involves 16 principles and 24 strategic goals. The service proposes to adopt the WHO definition of alcohol and drug use disorders, and defines dependency recovery as an individualized, personal, life-long process that is abstinence-based, with a developmental growth process. The tasks to be completed for recovery are seen to be stage-specific through transition, stabilization, early recovery, middle recovery, late recovery and maintenance. A continuum of recovery

services is presented, based on levels of need, from 12-step, self-help programs, through different levels of intensity. Each level is seen to involve more structure and professional services.

SASKATCHEWAN ALCOHOL AND DRUG ABUSE COMMISSION (1993): *Drug Treatment and the Needs of Special Populations: Promoting Opportunities for Better Health.*

This working paper was prepared by the Evaluation and Research Unit. Special Populations are defined as those who are at higher risk of abusing mood-altering substances. A risk factor is a condition that increases an individual's chance of becoming involved in especially harmful use of substances, including family dysfunction, physical and sexual abuse, mental disability, unemployment, low educational levels, illiteracy, racial discrimination, and poverty. The authors conclude that a traditional addiction treatment approach has not met the special needs of many groups, and that programs are needed which integrate services to address personal problems with those that address broader structural issues, such as unemployment, social welfare and gender inequality. The needs of special populations are reviewed, including women, seniors, street youth, Aboriginal Canadians, dually diagnosed, and individuals with physical impairments. The authors recommend integrating substance use programs into already existing agencies where possible.

SASKATCHEWAN HEALTH (1994): *Review of Provincial Residential Addiction Treatment Services.*

This report presents the findings of a review of six residential addiction treatment programs funded and/or delivered by the province of Saskatchewan. Its purpose was to plan future residential addiction services, based on information gathered from addiction professionals and referral sources on the availability and accessibility of existing resources, occupancy rates, home residence of clients and other related data. Each facility is profiled, and referrals reviewed. The reviewers recommended developing a clearer understanding of referral and assessment practices, an increase in community-based and day-patient services before reducing residential services, development of equitable referral practices with other provinces, a review of impaired driver treatment options, consistency across residential programs, and the integration of adult and adolescent treatment programs into one facility.

THOMPSON, J. (1994): *Efficacy, Outcome and Alcohol Effect Expectancies as Predictors of Alcohol Treatment Outcome: An 18-Month Follow-up Study.* Alberta Alcohol and Drug Abuse Commission.

> This study examined the relationship between expectancies and drinking outcome following treatment for alcoholism. The clients (N = 306) were contacted every three months over an 18-month period following discharge. Measures were the Situational Confidence Questionnaire, Outcome Expectancy Scale, Alcohol Effects Questionnaire, and three measures of drinking behaviour (weekly frequency, weekly quantity and average daily consumption). Results showed that discharge self-efficacy expectancies or confidence in being able to resist drinking heavily are predictive of the average weekly frequency of drinking and average weekly quantity over three and eighteen months. The author concluded that positive self-efficacy contributes to successful outcome.

VERMETTE, G. *Inventaire analytique de programmes de réadaptation en alcoolisme et autres toxicomanies* (tome 1), MSSS, novembre 1996, 234 p. annexe en sus.

VERMETTE, G. *Répertoire de programmes de réadaptation en alcoolisme et autres toxicomanies* (tome 2), MSSS, novembre 1996, 318 p.

VERMETTE, G. *Inventaire analytique et Répertoire de programmes de désintoxication* (tome 3), MSSS, novembre 1996, 58 p. annexe en sus.

VERMETTE, G. *Inventaire analytique de programmes d'aide et de soutien en alcoolisme et autres toxicomanies* (tome 4), MSSS, novembre 1996, 158 p. annexe en sus.

VERMETTE, G. *Répertoire de programmes d'aide et de soutien en alcoolisme et autres toxicomanies* (tome 5), MSSS, novembre 1996, 202 p.

> The author of this study provides an inventory of detoxification, rehabilitation, aid and support programs in Quebec; develops a detailed description of the programs in each category to illustrate the various types of programs in a structured way; analyzes the characteristics of the programs in each of the categories; and reports on the development of programs to respond in a relevant and effective way to the clients served. Descriptive variables and contextual variables relating to the analytical inventory have been provided for volumes 1, 3 (first part) and 4. Moreover, highlights are cited in each of the analytical inventories, and opinions are offered about those items which, in the author's view, require improvement. Finally, the analytical inventories describe the characteristics of clients served and data on how the program is used and works for each of the organizations or establishments. Volumes 2, 3 (second part) and 5 provide data on organizations and establishments providing aid, support, detoxification and rehabilitation services.

WHYNOT, E. (1996): *Health Impact of Injection Drug Use and HIV in Vancouver.* British Columbia Medical Health Office.

> The purpose of this report was to summarize available information concerning the impact of injection drug use on the Vancouver health system, to describe current efforts to lessen it, and to provide recommendations for future management. The report contains: recommendations from the medical health officer's report of May 1996; current information on injection drug use and HIV in Vancouver; recent and current planning and research initiatives; a summary of community consultations; current interventions and gaps; and recommendations for action. Recommendations include recognizing the prevention and reduction of illness resulting from injection drug use as a priority for the Vancouver Health Board and coordination of funding initiatives. Two objectives were proposed, each with detailed steps to assure implementation: to reduce health risks associated with injection drug use in Vancouver; and to coordinate and improve health, outreach and residential services for injection drug users with HIV and other diseases.

WILBUR, B.D. (1997): *Health Standards: Edition 1; Public Health Services and Drug Dependency Services*. Nova Scotia Department of Health.

> This document was prepared as a tool to assist Nova Scotia Regional Health Boards in service planning and delivery. Health standards are defined as "the minimum acceptable level of service and/or result." Future services will be based on standards and outcome, with identification of core services to ensure that Nova Scotians have reasonable access to services within each health region. The document provides a framework for standards development, and identifies program areas of mental health, acute care, public health, drug dependency, home care and long-term care. The present edition covers only drug dependency and public health services. Service standards are provided in each of the core services for drug dependency and public health. Core services in drug dependency include: prevention and community education (health promotion, training of allied professionals, community development); community-based drug dependency treatment services (assessment, intervention, detoxification day program, therapy/counselling, structured modular programs); regional drug dependency treatment services (assessment, intervention, inpatient detoxification, therapy/counselling, structured orientation, residential rehabilitation, long-term and halfway sheltered treatment); and targeted drug dependency services (adolescent, women, driving while impaired).

ZARCHIKOFF, W. (1992): *A Review of Solvent Abuse Literature and Existing Solvent Abuse Programs in North America, and Recommendations to Develop a Training and Solvent Abuse Program for Adolescents in the Northwest Territories, Canada.*

This report was prepared for Northern Addiction Services, Northwest Territories. It summarizes and interprets the available literature on solvent abuse from 1985 to the present. It concentrates where possible on Native adolescents. An annotated bibliography of 81 studies is provided. The report recognizes that inhalant treatment has not been compatible within the standard drug treatment system. Treatment strategies must be designed to the particular needs of these clients' symptoms, patterns of use and psycho-social and emotional needs. The report sees a need for simple goals of treatment, targeted to basic health needs, and including staff nurturing, support and patience. It recommends discouragement of confrontation, and enhancement of self-esteem and building of coping skills. It describes a model program to treat adolescents who are solvent abusers in the Northwest Territories. The program's primary objective is to provide the adolescent (age 13-17 years) solvent abuser with a comprehensive treatment program to assist the individual to change his/her present lifestyle to a solvent and drug-free lifestyle. It would offer residential care, behavioural management, a wilderness program and an outpatient and recovery program.

13. Index of annotated reports

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COMITÉ AVISEUR SUR LA RECHERCHE ET L'ÉVALUATION EN TOXICOMANIE *: Avis No 3, Le point sur les besoins d'enquêtes épidémiologiques en matière de toxicomanie au Québec,* Québec, MSSS, mai 1993, 14 p. et 2 annexes.

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