

PERSPECTIVES ON CANADIAN DRUG POLICY

Volume 2

The John Howard Society of Canada

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PERSPECTIVES ON CANADIAN DRUG POLICY, VOLUME TWO: INTRODUCTION

Over the last several years, there has been significant activity in the area of illicit drug policy in Canada. Highlights include the tabling of official reports from the Auditor General of Canada (December 2001), the Senate Special Committee on Illegal Drugs (September 2002) and the House Special Committee on the Non-Medical Use of Drugs (December 2002), the temporary suspension of cannabis prohibition laws in Ontario and elsewhere (May – October 2003), the introduction of the Cannabis Reform Bill (C-38) in Parliament (May 2003), the renewal of Canada's National Drug Strategy (May 2003), and the opening of North America's first supervised injection facility in Vancouver, B.C. (September 2003). While not all of these reports and initiatives have led to actual changes to Canada's drug policies, taken together they demonstrate that significant movement is indeed occurring in this important and highly politicized issue area.

In the midst of these significant policy developments, the John Howard Society of Canada implemented the Policy Analysis Enhancement Project (PAEP). Funding for the project originated from the Voluntary Sector Initiative of the Privy Council with the intent of assisting individuals working in organizations within the voluntary sector to develop expertise in public policy analysis. The PAEP is a two-year project that takes select members of voluntary sector organizations and guides them through the creation of policy-relevant research related to Canadian drug policy. This volume presents the research undertaken by the second-year participants of project.

The first article, by Jeff Packer from the John Howard Society of Durham Region, presents a moral analysis of Canadian drug policy. The purpose of his article is to examine the underlying moral attitudes that are central to the debates around drug policy in Canada in order to better understand both the obstacles and avenues to change. Mr. Packer begins with a brief discussion on morality and the stages of moral development and then moves to examine the social, political, and economic factors that influence our moral perspectives on illicit drugs. The third section provides a moral analysis of three major perspectives on drug policy: prohibition, harm reduction and drug liberalization. Finally, the author discusses factors that appear to be limiting movement in drug policy and suggests options for refocusing our moral compass to direct us to a much more effective Canadian drug policy.

In an article entitled "Opening the Gates on the National Drug Strategy for the Correctional Services of Canada," Lisa Finateri of the John Howard Society of Kingston, critically analyses CSC's drug policy and discusses the implications for CSC if cannabis is legalized or decriminalized in Canadian society. Two points of analysis are considered: (1) the theoretical realm, and (2) the human, penal and social costs. The theoretical section of the article contrasts the punitive and harm reductionist ideologies in relation to drugs and drug use. The social, penal and human costs are discussed in terms of both the use of cannabis and the illegality of the substance. In conclusion, the perspectives considered in Ms. Finateri's article are used as a point of departure to advocate for a more comprehensive harm reduction approach to cannabis and other illicit substances, both in our federal penitentiaries and in Canadian society.

The third article, by Susan O'Neill of the John Howard Society of New Brunswick, Saint John Branch, seeks to assess the attitudes and perceptions of social policy elites in Saint John, New Brunswick toward various harm reduction initiatives. Specifically, her research works to document the existence of attitudes and perceptions held by relevant social policy elites that may work against the further development and implementation of harm reduction programs in the Saint John community. The first part of the article presents background on the three main philosophical perspectives on illicit drugs: prohibition, harm reduction and legalization. The harm reduction approach is then discussed at some length providing the

reader with an understanding of both the concept more generally, and of various programs and initiatives that fall under its rubric. The next section reports on the results of a survey of the attitudes and perceptions of local social policy elites in Saint John, New Brunswick related to harm reduction. In conclusion, Ms. O'Neill suggests that social policy elites in Saint John hold subtle but pervasive attitudes about illicit drugs that may work against the development, implementation, and sustainability of innovative harm reduction initiatives at the local level. She suggests that efforts to address these biases may be necessary to ensure effective reform of drug policy in the Saint John area.

In an article entitled: "Drug Treatment Courts in Canada: Who Benefits?" Cynthia Kirby from the John Howard Society of New Brunswick presents a critical analysis of the drug treatment court (DTC) approach to dealing with drug users in Canada. The overall purpose of her article is to explore the question: who benefits from drug treatment courts? It begins with a brief overview of DTC's and the structure they have taken in Canada to date. The article then critically examines the claim that DTC's are beneficial to both DTC clients and society finding that the benefits to both may be overstated by supporters of DTC's. The paper then examines whether there is alternative explanation for the increasing popularity of DTC's in Canada. Finally, the paper discusses whether there is a better, less intrusive option for achieving the stated goals of drug treatment courts.

The fifth article, by Cathy Ann Kelly from the St. Leonard's Society of Canada, is entitled: "Challenges in the Management of Mentally Disturbed Offenders on Psychotropic Medication." Ms. Kelly's research presents some background on the issue of mentally disordered offenders and then reviews the experiences of three individuals with mental illnesses who have come into contact with the Canadian federal correctional system. She then uses her cases to illuminate some of the significant challenges facing our correctional and mental health systems as they manage mentally disordered offenders on psychotropic medication.

The next article by Rick Lines and Ralf Jürgens of the Canadian HIV/AIDS Legal Network is entitled: "Prison Syringe Exchange Programs: Can They Be Implemented in Canada?" The authors review the international evidence on HIV, hepatitis C and injection drug use in prisons, existing Canadian and international health guidelines and human rights covenants related to the treatment of prisoners, legislation relating to prison health services and HIV prevention and reviews the experiences of prison syringe exchange programs that have been implemented in several countries around the world. Based upon this context and evidence, the authors provides evidence-based responses to a number of key questions relating to prison needle exchange programs, and encourages the federal and provincial governments to act immediately to implement needle exchange programs within Canadian prisons.

The last article, by Gerald Thomas from the John Howard Society of Canada, is entitled: "Taking the Principles of Effective Corrections Seriously in CSC's Approach to the Rehabilitation of Drug Abusing Prisoners." Dr. Thomas' article assesses the relative progress made by the Correctional Service of Canada (CSC) in implementing the principles of effective corrections in its rehabilitative programming for prisoners. The paper begins by presenting basic information on the five principles of effective corrections. Next, it analyzes the relative attention that CSC has placed on the principles in its research since 1989. The article then analyzes the relative progress made by CSC in implementing the "what works" principles, with particular emphasis on their application to programs directed at prisoners who misuse drugs and alcohol. Finally, the author offers numerous recommendations designed to further improve CSC's approach to the rehabilitation of federal prisoners in Canada.

Taken as a whole, these seven articles present a broad analysis of current and emerging issues related to illicit drug policy in Canada from the perspective of the voluntary sector. The John Howard Society of Canada is pleased to publish these important and timely analyses and make them available to

professionals working in this field to further improve Canada's response to problems associated with the use of drugs in our society.

Gerald Thomas
Kingston, Ontario
November 2003

A MORAL ANALYSIS OF CANADIAN DRUG POLICY

Jeff Packer
The John Howard Society of Durham Region

INTRODUCTION

Spending the last ten months exploring the waters of Canadian drug policy was both an exciting and disheartening voyage. Initially, I had to examine my core beliefs and opinions about right and wrong or good and bad behaviour. Long-standing perceptions about various drugs, drug use/misuse and about drug users all came into question. My thoughts and emotions rode the waves of information like a tiny boat at sea, rising to enthusiastic heights of optimism at the crests and then, suddenly, falling into doubt and pessimism as waves of confusion, frustration and disagreement enveloped me. The tidal waves of contradictory information threatened the very journey of discovery I was on. As I was pushed from side to side in these stormy seas, it became clear that I had joined all those seafaring policy analysts who were lost in the quest to “save” Canadian drug policy from sinking further into the depths of ineffectiveness. It was this journey that led to the conclusion that what we individually and collectively think is the best approach, our moral position, ultimately influences the direction we take in addressing the drug issue.

The purpose of this paper is to examine the underlying moral attitudes that are central to the debates around drug policy in Canada in order to better understand both the obstacles and avenues to change. The author begins with a brief discussion on morality and the stages of moral development. The next section examines the social, political, and economic factors that influence our moral perspectives on illicit drugs. The third section provides a moral analysis of three major perspectives informing drug policy development: prohibition, harm reduction and drug liberalization. Finally, the author discusses factors that appear to be limiting movement in drug policy and suggests options for refocusing our moral compass to direct us to a much more effective Canadian drug policy.

MORALITY AND MORAL DEVELOPMENT

Morality and ethical decision-making pertain to the principles of right and wrong behaviour or conduct (Funk and Wagnalls, 1976:218 and 423). Morals are rules that one develops about proper conduct in order to “judge their own and others’ behaviour” (Wortman and Loftus, 1985:235). Our personal experiences help us to develop and adopt opinions about which behaviours are helpful and which behaviours are not. Following from cognitive-behavioural theory, one’s attitude toward drug use contributes to how one feels about it and, in turn, how one behaves with respect to drugs (e.g., the decision to use drugs or not). Similarly, our attitudes also influence the feelings we have and actions we take when we interact with those who choose to use drugs. Attitudes about whether drug use is good or not, in any given situation, are ultimately personal moral perspectives that are arrived at as individuals consider a variety of complex factors. How do people progress in moral development in general and what factors help people determine what is the best or preferred approach to drugs and drug policy? If we agree that thoughts fuel our feelings and, subsequently, our behaviours, then understanding the factors that shape moral opinions is essential to better understand current and future drug policy development.

Senator Claude Nolin, in the Report of the Senate Special Committee on Illegal Drugs, clearly articulates the importance of moral or ethical concerns in drug policy:

Ethical considerations take us through what is, that is the realm of facts, to the realm of what should be, what would be desirable, moving from recognized facts to standards, then more

importantly to values and finally to the means of passing on and above all implementing these values. This is why ethics was our first subject [in the Senate Committee's Report on Cannabis] (Senate, 2002:11).

Moral development, as articulated in Lawrence Kolberg's famous cognitive-developmental approach, seems to follow a sequence of three stages that progress from early childhood well into adulthood. Kolberg asserts that a child at the first, or "pre-conventional" level of moral development follows rules and norms out of fear of the consequences and, thus, "acts 'good' to avoid punishment" (Wortman and Loftus, 1985:238). In Kolberg's second stage, referred to as "conventional," the child is guided by the desire to win the approval of others by "meeting their standards and expectations" (p.238). At Kolberg's third and final stage of moral development, a person "recognizes that universal ethical principles can transcend the laws of society" (p. 239).¹ Among other things, Kolberg's theory on moral development suggests that, at the highest level of development, we should be cautious when creating and implementing societal laws as these policies or laws do not always correspond with what specific individuals consider to be 'right' or with what may ultimately be 'best' in a particular situation.² Because people have widely differing views about proper conduct, and are at varying levels of moral reasoning, working through ethical dilemmas and differences of moral opinion requires wisdom, patience, maturity and the ability to hear new information and identify with the opinions of others.

Heated discussions involving morality are more likely to arise around issues that involve safety, security and harm to one's self or others. Drugs and drug use certainly involve these concerns. Moral positions contain a certain amount of judgement based upon one's cognitive appraisal of both the situation and of the factors impinging upon it. Parents, citizens, business and community leaders, and policy makers at all levels of government make decisions based at least partially on moral judgments about what is 'best' in a particular situation or for a certain group of people (in this case drug users). In terms of Kolberg's stages of moral development, individuals and society can develop responses to the drug issue based on: (1) a fear of punishment, (2) a need to win the approval and acceptance of others, or (3) an informed personal sense of what is "right." Hence, one can postulate that the stage or level of moral reasoning dominant in our culture partially determines how drug policy will be designed and implemented. The relevant question becomes: Is current drug policy based on fear of punishment, the desire for acceptance, or a well-informed sense of 'best' practices?³

Drug policy issues are complex and multifaceted. Typical questions that provoke one to consider moral positions in the area of drug policy include: Should people have the right to determine all drug use (i.e., medicinal and recreational) for themselves? If so, at what age should they be allowed to make these choices? Are people capable of managing their conduct with minimal external intervention? At what point is external intervention necessary or effective? Facing complex and somewhat irreconcilable questions and positions, it often seems easier to just grasp for narrow and simplistic solutions. For example, simplistic approaches to the drug issue have been characterized by statements like: "just lock up drug users" or "no recreational drug use is tolerable." Searching for the easy answers to complex problems, however, is almost always a frustrating and fruitless endeavor. Identifying, understanding and

¹ Kolberg asserts that only a small percentage of adults ever reach this third and final stage of moral development.

² The Dali Llama appears to be referencing Kolberg's third stage of moral reasoning when he admonishes us to "learn the rules so you know when it's appropriate to break them."

³ To provide an example of this from current drug policy, the political machinations regarding the reform of Canadian marijuana legislation demonstrates how the courts and politicians have wrestled with a drug policy issue as they attempt to move from fear-based decisions and concerns for acceptance (especially from the United States and United Nations) to a decision more in line with what is best for Canadian society overall. If Canadian cannabis laws were to become more punitive and criminalized at this point, one could argue that politicians are acting at the lowest level of moral development. That is, they are "acting good" to avoid repercussions from our neighbours to the south.

implementing workable solutions to such problems requires considerable time and effort and also takes a willingness to critically examine the diverse opinions and the factors that influence them.

The development of one's personal moral position on drugs and drug use does not take place in a vacuum, however. The next section discusses some of the social, political and economic influences that help shape personal perceptions regarding drugs and drug use in Canada.

SOCIAL, POLITICAL, AND ECONOMIC INFLUENCES ON INDIVIDUAL PERCEPTIONS OF DRUGS

Politics, The Media, and Drug Policy

How we are socialized or raised to think about an issue or problem greatly influences our individual and collective approaches to dealing with that issue. Unfortunately, our perspectives on drugs and drug users can be (and are) influenced by propaganda and misinformation. For example, policy related research and reports by governments and others involved in making drug policy are often skewed depending on who is funding the research and the opinions they hold on drugs. Consider your views on the following questions:

- Do drugs have more power (i.e., addiction) than one's personal will?
- Why and how do some users quit without treatment?
- Do people need protection from drugs, and should this protection come through education or enforcement?

As stated previously, our experiences help us to develop belief systems that then influence our policy choices. The relationship between experience and beliefs is not unidirectional, however: our experiences not only influence our beliefs and opinions, but our beliefs and opinions also influence our experiences. For instance, if you believe a certain drug to be "bad" or "dangerous," and you see someone hospitalized for taking too much of it, your interpretation of that event may lead you to see the drug as the culprit. From this perspective, you may wish to direct your efforts at prohibiting access to the drug. Another person, however, could see the drug as neither good nor bad but instead place the focus on assisting the drug user rather than on prohibiting access to the drug itself. This perspective may lead one toward a policy response that focuses on educating and/or rehabilitating the person who misused the drug rather on restricting all access it.

Speaking over 30 years ago about the legalization of cannabis, Goode (1969:138) highlights the influence of opinions on policy:

Obviously, one's posture toward legalization is largely, although not solely, shaped by one's perception of the effects of marijuana. Those who believe that it stimulates violence and leads to heroin addiction will oppose legalization, while those who believe it to be a harmless substance will favour legalization. But there are also those who feel that marijuana, although basically harmless, might, in some people, have a deleterious effect. For this group, legalization becomes a question of civil liberties: a question of whether its negative effect on the few would over-balance its neutral effect on the many.

Shaping public opinion is, therefore, a critical part of public policy development. The media plays a central role in shaping public opinion yet there are surprisingly few constraints with respect to presenting accurate information. The media receives information from the public, interest groups and government and then re-packages it and conveys it back to all of the above. In a study by Goldberg and Meyers into

the influence of the media on public attitudes about drug policy, the authors found that the knowledge reporters have about drug issues often “reflects ignorance, fear and false preconceptions” (1980:144). They argue that since the media strives to portray the “sensational or dramatic aspects of the drug abuse story...myths are reported as fact” (p. 144). In their analysis, reporters tended to “disassociate themselves from addicts” and failed to “cross-check official information with sources on the street” (p. 144). For one reason or another, Goldberg and Meyers conclude, “newspapers are unwilling or unable to go beyond government-provided propaganda” on drugs and drug policy (p. 144). In the course of conducting their study, one reporter openly admitted that “...[we’ve] failed to explore the culture of the drug user fairly, and we’ve failed to dispassionately explore the entire phenomenon of drug use” (p. 144).

It is easier to understand how the media continues to convey misinformation when the federal government struggles to compile accurate and up to date data about the drug situation in Canada. This is made clear in the 2001 report of the Auditor General of Canada:

Key information on the drug environment, such as frequency and prevalence of drug use, and its impact on society, is either not available or not up to date. Of particular concern is the almost complete absence of basic management information on spending of resources, on expectations, and on results of an activity that accounts for more than \$500 million each year (Auditor General, 2001:15).

Misinformation about the impact of drug use can be considered a major contributor to the development of hard line views on drugs and drug users. Exaggerations about the negative impact of drugs have perpetuated a misguided and overly punitive approach to drug policy that has ballooned into a massive industry over the past half-century (Green, 2002; Levine and Reinerman, 1993). For instance, empirical evidence about the relatively benign impact of cannabis on one’s social, intellectual, physiological, and psychological functioning (Green, 2002; Goldstein, 2001; Goldberg, 1999; Goode, 1969; Allentuck and Bowman, 1942) continues to be overshadowed, in the US and elsewhere, by outlandish claims that began with the “Reefer Madness” era in the 1930’s (Levine and Reinerman, 1993:183).⁴ Medical researchers have repeatedly documented the relatively benign impact of cannabis use, similar to the following assessment that two medical doctors so clearly stated over fifty years ago:

There is no evidence to suggest that the continued use of marijuana is a stepping-stone to the use of opiates. Prolonged use of the drug does not lead to physical, mental, or moral degeneration, nor have we observed any permanent deleterious effects from its continued use. Quite the contrary, marijuana and its derivatives and allied synthetics have potentially valuable therapeutic applications which merit future investigation (Allentuck and Bowman, 1942:2).

Are criminal sanctions against cannabis users resulting in greater harm than use of the drug itself? In light of the consistent and well-documented evidence about cannabis’s relatively benign effects on users, how is it that public opinion and public policy has been so noticeably misinformed? This may point to the media’s choice of what information to share, which in turn shapes whether one views drugs in a positive or negative light. Consider recent advertisements about Zoloft or Viagra. What impact have these commercials had on your opinion about these products? What accurate information do you actually have about these fairly new products and about their short and long-term physiological impact? Now,

⁴ This observation applies to other drugs as well. At a recent conference in BC, two medical doctors involved in the upcoming heroin maintenance trials in Canada were asked: “What are the negative physical effects of long term heroin use.” To the surprise of all attending the session, the answers were: (1) there is some preliminary evidence of minor effects on hormonal balances in the body (especially in women), (2) the development of physical dependence on the drug (e.g., addiction), and (3) constipation. One incredulous person in the audience compared these “harms” to those associated with long-term alcohol and tobacco use and then commented: “All this for constipation?”

consider the recent U.S. advertisements that exaggerate the harmfulness of cannabis by depicting how it can contribute to killing people. These television commercials seemed to emerge on the heels of the Canadian parliamentary reports indicating that evidence supports the decriminalization and potential legalization of cannabis (Senate, 2002; House, 2002:127-131). On the other hand, where are the U.S. or Canadian advertisements about the proven medicinal uses of cannabis? In fact, the therapeutic use of cannabis has been greatly under-utilized, partially because it has been deemed illegal along with the act of using it. When it comes to the many medicinal applications for cannabis, Green (2002), in his thorough review of the 6000 year history of cannabis use, documents medicinal uses “from A to Z” for people suffering from:

AIDS, arthritis, asthma, cough, Crohn’s disease, depression, eating disorders, emphysema, epilepsy, glaucoma, head injuries and stroke, herpes skin infections, high blood pressure, insomnia, migraine, movement disorders (e.g. Tourette’s syndrome), multiple sclerosis, nausea and vomiting, pain, Schizophrenia, tumours and ulcerative colitis (Green, 2002:202-219).

Strict prohibition and enforcement practices, and uneven coverage of drug issues in the media, have contributed to negative public opinions about cannabis and to a lack of research to could provide useful and accurate information about the drug (Kleiman, 1992). In addition, evidence has been mounting for over fifty years that disproves “the thesis that the use of cannabis either inevitably or generally causes, leads to or precipitates criminal, violent, aggressive or delinquent [behaviour] of a sexual or non-sexual nature” (Kersey, 1994:175; citing the Canadian Le Dain Commission Report of 1972). This discussion is not intended to imply that everyone should go out and use cannabis. It is, however, attempting to highlight the need to question our moral positions on drugs and on drug policies, many of which have been shaped by misinformation. With “drug-war” expenditures in the billions and no significant reduction in either the flow of illicit drugs into the country or in the percentage of people using them, it should be fairly clear that, as Bayer (1993:98) notes, “only a radical change in drug policy will reduce outlandish expenditures, violations of civil liberties and the clog in the justice system.”

The Economics of Drug Policy

There is a general consensus that drug-related harms costs society greatly. Disagreement lies in whether one believes the harm comes mainly from the drugs themselves, from the enforcement efforts used to reduce or eradicate them or, one may postulate, from the opinions and judgments about drugs that we have internalized through years of socialization. Is it possible to accurately detail the costs and benefits of the current drug strategy and the impact of drug misuse? Can those who advocate for more liberal drug policy accurately estimate the costs and benefits of that policy choice? The complexity of analyses required to sort out the “true” costs of the drug problem also makes it quite easy for misinformation to exist. Despite the bantering that occurs on this issue, MacCoun and Reuter (2001) suggest a detailed and systematic analysis is possible. They assert: “No drug is without adverse consequence. Making choices involves comparing those adverse consequences best translated into costs so that systematic comparisons can be made” (p. 102). This is a detailed process that involves looking at three facets that are causally associated with drug-related harms or costs: “use of the drug, illegality of the drug per se and enforcement of drug laws” (p. 109).

The illicit drug problem costs Canadian taxpayers hundreds of millions each year. The Auditor General of Canada (2001) found that the federal government spends approximately \$500M a year to address the issue of illicit drugs. Their study determined that more than 93% of this amount goes toward efforts to reduce the supply of illicit drugs (enforcement), leaving a meagre 7% for drug treatment, education and harm reduction (Auditor General, 2001). Well-formulated arguments are repeatedly been made to shift funds from enforcement into prevention and treatment. However, drug policy is still defined largely as a criminal justice rather than a health issue in Canada.

While drug arrests in Canada are 28% lower than they were in the mid-1970s, Canada continues to arrest over 177 people per 100,000 for drug offences (Statistics Canada, 2001; Hung and Quann, 2000:2). Although Canada's incarceration rate is high by international standards, the United States' rate is three times that of Canada's and their "drug war is estimated to cost U.S. taxpayers over \$18B annually," twenty times that of Canada's (Armentano, 2003:1). Speaking with great concern about American incarceration rates, Dan Gardner (2003:B4) writes: "There are now two million men and women in American prisons, a population six times bigger than in 1972, and double what it was in 1990." He adds: "56 percent were sentenced for non-violent crimes." In Canada, research has determined that two thirds of drug related arrests are for possession (Hung and Quann, 2000) and "cannabis offences accounted for almost two-thirds (64%) of all drug offences in 1998, followed by cocaine (26%), and heroin (3%)" (p. 2-3).

Much greater than the costs associated with illicit drugs are the health and social costs related to alcohol and tobacco use. This is remarkable given that there is no "war" on alcohol and tobacco. People are instead, at a reasonable age, permitted to make decisions about the use of these substances. Mind you, they also have to live with the consequences of those decisions, as do the rest of us. The cost to taxpayers for tobacco and alcohol is enormous. According to Health Canada, substance abuse cost the Canadian economy more than \$18.4 billion in 1992. That's approximately \$650 per person. Alcohol costs were approximately \$7.5 billion while tobacco accounted for over half of all drug related costs at \$9.5 billion. The costs for all illegal drugs combined were \$1.4 billion (Single et al., 1996).

In the introduction to their book entitled *Drug War Heresies*, MacCoun and Reuter (2001:1) state what studies have repeatedly concluded: "The most conspicuous harms of drugs currently are those caused by America's highly punitive version of prohibition," one that is "intrusive, divisive, and expensive." These authors point out that there is little research on drug control, or in the area of crime control generally, suggesting that conservatives and liberals alike hold on to a naive faith that enforcement works (p. 406). In Libby Davis' supplementary report to the House of Commons Special Committee on the Non-Medical Use of Drugs, the MP for Vancouver East pointed to the failure of drug enforcement, stating:

Law enforcement efforts have almost completely failed to stop the flow of illicit drugs into Canada. A Canadian Customs and Revenue Agency witness...suggested that Canada stops only about 10% of the drugs destined for our country. This focus on interdiction ("supply reduction") has drawn resources away from other measures that could be far more effective in reducing substance misuse and its related harms (House, 2002:180).

Numerous authors agree that attempts to resolve drug problems through supply-side reduction are ineffective at best and outright harmful at worst (Wood et al., 2003; Nadelmann, 2003 and 1992; Senate, 2002:37; Oscapella, 2001; Levine and Reinerman, 1993:187; Bayer 1993:71-72). This is particularly the case with cannabis. Ethan Nadelmann (1992:78), Executive Director of the Drug Policy Alliance, asserts: "Every independent commission to examine cannabis policy, from Australia to the United States, has concluded that punitive prohibitions do more harm than good." The punitive harms that numerous authors directly attribute to the war on cannabis include the perpetuation of myths about its physiological impact, exaggerated reports about it leading to harder drugs (a.k.a., the gateway theory), and, most notably, that thousands of casual users that become entangled in the criminal justice system every year. Kenneth Warner (1993:341) writes about the economics of legalization, stating that: "At the heart of Nadelmann's analysis favouring legalization is the argument that the major costs associated with illegal drugs are created by the fact of their illegality."

Despite recent statements by Canadian politicians, Nadelmann disagrees with the notion that decriminalizing cannabis will lead to an increase in use. He reports that the "best U.S. study of cannabis decriminalization (by a Canadian scholar, Eric Single) found no difference in cannabis consumption

between the 11 states that decriminalized cannabis during the 1970's and others that did not" (Nadelmann, 2003). With respect to cocaine and heroin, a portion of the associated health and social costs can also be linked to prohibition-based strategies (for example, the unnecessary spread of infectious diseases such as HIV/AIDS and hepatitis C). In spite of these facts, disagreement among supporters of prohibition, liberalization and harm reduction continue to confuse and restrain effective drug policy development. The next section provides a moral analysis of these three leading drug policy perspectives.

A MORAL ANALYSIS OF PROHIBITION, HARM REDUCTION AND DRUG LIBERALIZATION

Prohibition

The noun prohibition derives from the verb prohibit which the Merriam-Websters Dictionary defines as: (1) to forbid by authority and (2) to prevent from doing something. The beliefs that may sit behind society's moral position to prohibit the use of certain substances include: (1) drugs are bad, (2) drugs are very dangerous and addictive, (3) one should not use drugs for pleasure, and (4) the need for social control and order takes precedent over our desire for individual freedom and choice.

Is it better to consume legal drugs versus illegal ones? Who decides and based upon what information? Perhaps being socialized about the perils of illicit drugs may, in fact, add curiosity and inadvertently fuel one's desire to consume drugs. Further, what is the impact on youth and on their faith in authority when they find information provided by "official" sources about the impact of drug use turns out to be false or exaggerated? Do their opinions about what was thought to be best get thrown out completely, possibly contributing to higher levels of drug use? On the issue of drug addiction, we are not scientifically aware of the influence of being repeatedly told that "drugs are addictive" and "very hard to quit." What is the cognitive-behavioural outcome of this type of indoctrination on one's ability to stop using drugs?

Proponents of the prohibition approach have most likely witnessed the impact of chronic drug misuse. The perils can indeed be horrendous for individuals and for society. Does this mean we create an intrusive and harmful policy to deal with the behaviour of a minority of citizens who are struggling with drug abuse? Supporters of prohibition make the argument that the legality of drugs like alcohol and tobacco are to blame for their high rate of use and, also, for the massive social costs associated with these substances. This argument does not hold true with respect to Eric Single's research mentioned above where no increased use of cannabis was found in the eleven U.S. states that have decriminalized possession. Perhaps the massive harms associated with alcohol and tobacco relate more to their relatively harmful nature, and to the lax approach that society took in managing the use of these substances in the past, than to the fact that they are legal to possess and use.

An analysis of the moral reasoning underlying our current prohibitionist drug strategy seems to suggest this approach to substance use/misuse is based more upon fear of perceived consequences and on gaining social acceptance than on accurate, well-informed decision-making. We now turn to a moral analysis of harm reduction.

Harm Reduction

Harm reduction, as an approach to drug misuse, means to reduce, weaken or diminish the real and potential negative effects of drug and alcohol misuse. Diane Riley (1991:1) defines harm reduction as an approach that "attempts to reduce the harm caused to the individual and society by the use and misuse of alcohol and drugs. It does not view the elimination of alcohol and drug use as a primary goal." Given the above definition, the values underlying harm reduction may be: (1) reducing drug-related harm is a

priority, (2) people should be free to choose whether they take drugs as long as it does not harm others and; (3) society should help those who intentionally harm themselves through drug use. Those who oppose the harm reduction approach tend to view its supporters as condoning drug use for pleasure and, interestingly enough, as not being sufficiently concerned about the potential harms derived from the misuse of drugs.

Researchers agree that one of the major influencing developments in the harm reduction/abstinence debate was the emergence of HIV/AIDS in the 1970's and knowledge about its transmission via intravenous drug use. The Auditor General of Canada has estimated that 34 percent of all new HIV infections in Canada result from unsafe injection drug use (Auditor General, 2001:9). Fear about the spread of diseases like HIV/AIDS and hepatitis C has contributed greatly toward the acceptance and expansion of harm reduction measures, both in Canada and around the world. This is also true in the area of sexuality, where harm reduction efforts quickly developed and, for a time, overshadowed the more orthodox approach of abstinence.

The logic of harm reduction is stated clearly in this quote from Donald MacPherson, the drug policy coordinator for the City of Vancouver:

The notion of harm reduction is that if people are going to use drugs, we may not like it and we may not approve of it, but let's try to keep them alive and as healthy as possible, and not see them get HIV and hepatitis C, so they can move into rehab programs and treatment programs and other sorts of programs (quoted in House, 2002:80).

Harm reduction includes a broad cross section of approaches including primary prevention components designed to address the individual and societal factors that contribute to drug misuse: intellectual, physical and psychological challenges, domestic violence, abuse, neglect, poverty and homelessness, unemployment and underemployment and systemic marginalization. Harm reduction, because it espouses an evidence-based approach to drug policy and practice, seems to be founded upon higher-level moral reasoning than prohibition. The harm reduction approach moves beyond simple fear-based control and emphasizes the need for evidence-based practice. That is, harm reduction suggests that we should use experience to gain knowledge and then translating that knowledge into wise practice.

Drug Liberalization

In direct contrast to the prohibitionist approach to substance use is that of drug liberalization. Liberalizers move a step beyond harm reduction arguing that policies like decriminalization are only half measures that do little to control problems like drug cartels and organized crime. For example, Senator Claude Nolin from the Senate Special Committee on Illegal Drugs claims decriminalization and harm reduction will not, by themselves, adequately or sufficiently improve Canadian drug policy. Reflecting on the Committee's recommendations, he states:

Harm reduction was not enough. Not enough, in many ways. Not enough because it left in place one of the worst inventions of the human mind-- those provisions of the criminal law in every known national code of laws that make criminals of people who possess substances for ingestion into their own bodies. Not enough because by providing humane aspects to a destructive system, it tends to help preserve and perpetuate that system. For these and many other reasons I am now working for full legalization of drugs (quoted in Smith, 2003).

Based upon lessons of alcohol prohibition, and upon the obvious failure of prohibition to stem the use of illicit drugs, Levine and others (Kersey, 1994; Luper-Foy and Brown 1994) call for outright legalization

of drugs with a drugstore type regulatory system.⁵ Will adults make better decisions about illicit drugs should they become legalized and regulated than they have with alcohol, a drug that, in the United States, “still leads to 100,000 deaths annually” (MacCoun and Reuter, 2001:7)? The choice by some individuals to misuse drugs is a given, whether they are illegal or not. The black market drug trade and organized crime businesses can, however, be significantly decreased if society were to move away from prohibition.

Eugene O’Scapella, in his response to the Senate Special Committee on Illicit Drugs, explains how the system of drug prohibition has, in fact, “become a major, if not the major, source of funding for many terrorist groups” (2001:1). He further argues that: “focussing on traditional measures to suppress the drug trade, including law enforcement, crop substitution and measures to reduce the movement and laundering of drug money, will fail to significantly reduce the flow of drug money to terrorists” (p. 1). O’Scapella concludes the following:

We cannot maintain prohibition and yet still hope to deprive terrorist and criminal organizations of the profits associated with the drug trade. It is as simple as that. Without prohibition, the drug trade would not be a factor in terrorism. Because of prohibition, the drug trade is the major source of financing of terrorism. We must decide which version of drug policy we want – one that fosters terrorism and enriches terrorists, or one that does not (2001:1).

One can argue that some of those wanting to liberalize drug laws may be more in line with Kolberg’s higher stage morality. The advanced level of moral development calls for universal ethical principals, such as acceptance, tolerance and equality, and recognizes that these principles may, at times, even transcend accepted laws. According to drug liberalizers, status quo drug policy, the prohibition-based approach, should be transcended toward a drug strategy that promotes individuality, freedom of choice along with responsibility, community safety and the overall health of society. This approach requires leadership that is not driven by fear and misinformation or by the desire for approval and acceptance.

DISCUSSION

Prohibitionists, harm reduction advocates and drug liberalizers generally want the same thing: a safe society that promotes the health and development of its citizens. They appear to agree on the value of all human life, however they disagree on just how to go about protecting citizens and about what health promotion should look like. Each supports the need for people to exercise restraint when it comes to drug use, however, there appears to be significant disagreement about how the goal of restraint is to be conveyed/transferred to the public.

In the moral section of their report on cannabis, the Senate Special Committee on Illegal drugs reminds us that: “the goal of governance is freedom and not control” (Senate, 2002:11). The Committee goes on to state that: “...all of the means that the state has at its disposal [including criminal law] must work toward facilitating human action, particularly the processes allowing for the...governance of the self” (p. 11). This statement appears to be referencing Kolberg’s higher state of moral reasoning and, in particular, the need to create conditions in society that will enable the highest percentage of citizens to reach the third stage of moral development. The heart of the matter here is, of course, the need to balance the competing goals of social order and personal autonomy.⁶

⁵ In the context of the failure of alcohol prohibition, Rockefeller stated his rationale for replacing alcohol prohibition with legalized state-run liquor stores: “Only in the profit motive is there any hope of controlling the liquor traffic in the interests of a decent society. To approach the problem from any other angle is only to tinker with it and ensure failure” (quoted in Levine and Reinerman, 1993:181).

⁶ This is the logic that sits behind our traditional approach to law that suggests that we should proscribe behaviour only when it involves significant harm to others, not just harm to self. Of all the major areas of modern criminal

From this perspective, it is possible to assess the contributions that prohibition, harm reduction, and drug liberalization may make to creating the conditions necessary for the advanced moral development of society. On the one extreme, we have the policy of strict prohibition which appears to indiscriminately promote social control and order over personal freedom by proscribing all uses of illicit drugs regardless of whether or not that use is harmful to others. On the other extreme, we have the policy of complete drug liberalization which appears to indiscriminately promote personal freedom over social order by allowing all those who wish to use drugs to do so without reproach. In the middle, we have the pragmatic policy of harm reduction which appears to strike a balance between the competing goals of social order and personal freedom by allowing individuals to use drugs while at the same time working to minimize the social and individual harms associated with that use.

The area of public safety and health is where the most intense moral disagreements arise (Luper-Foy and Brown, 1994). Should the safety and health of society be placed in jeopardy in order to uphold individual freedom and choice? Responding to this question, Bonnie Steinbock's study exposes the heartbreaking aspects of maternal drug misuse for babies born in New York's inner city hospitals (cited in Luper-Foy and Brown, 1994:217-219). This example is used to support Steinbock's approach to drug policy that balances health and safety with liberty and autonomy. Steinbock clearly identifies the complexity involved as one ponders whether or not to extend or limit personal choice when it comes to drug access and use. It seems reasonable to limit one's choice in the case of the pregnant mother, yet, to which drugs and at what point? With evidence mounting on the negative impact of prenatal use of alcohol, cannabis and tobacco on child development (Richardson et al., 2002; Cornelius et al., 2001), should there be constraints placed upon mothers who use these drugs? When risks such as these threaten the health and safety of both innocent children and adults, moral decisions about what is best quickly become emotionally charged debates. Finding the right balance or blend of opinions, emotions and empirical evidence is necessary for creating an effective drug policy, yet this appears much easier to state than to create.

The above discussion highlights the complexities involved in drug policy development. It also points out the need to be more inclusive rather than exclusive. Much of the drug policy debate gets caught up in "either/or" factions. Goldberg (1999:179), pointing to the polarized drug policy debate in Sweden, indicates, "either you support current drug policies or you are a drug liberal." Finger pointing such as this is often aimed at silencing those who challenge the orthodox approach to drug policy. Prohibition camps hold tirelessly to the ethos that, as Goldberg (1999:179) states, "narcotics constitute a grave peril to society and therefore must not be permitted." In the extreme, Goldberg continues, "prohibitionists believe that it is possible to create, or at least approximate, a 'narcotics-free society'" (p.179). Harm reduction advocates, on the other hand, see their approach as more of a practical necessity than a moral imperative. They, however, espouse the belief that people have a right to choose to use drugs provided they are not harming others, and further maintain that if these same people do not make "good" choices, they are entitled to public assistance and support. However, on what moral basis does a society both permit an individual's right to self-harming behaviour *and* provide the assistance to address those harms? Canada has socialized health care which means that all drug use that leads to a need for health care ultimately becomes a social issue. How do we reconcile these difficult moral issues?

CONCLUSION

The issue of illicit drug policy has been on the official agenda of the Canadian government now for several years. Whether the current round of policy deliberations on this issue lead to significant change or

law, however, drug policy is the one area where this limit has undoubtedly been compromised in the name of social control and order.

not, it is clear that status quo drug policy (i.e., prohibition) is no longer viewed as acceptable by a large proportion of society. We are indeed in the midst of a “window” of policy change. But change, as described by Senator Nolin below, is never easy, even in the face of clear evidence:

We also knew at the outset that research expertise would be available to us, but it is still difficult to overcome attitudes and opinions that we have long taken for granted. Whether one is in favour of enhanced enforcement or, on the contrary, greater liberalization, opinions often resist the facts and in a field such as this the production of facts, even through scientific research, is not necessarily a neutral undertaking. We, like you, have our prejudices and preconceptions. Together we must make the effort to go beyond such predispositions” (Senate, 2002:7).

Drug policy is intended to provide the guidelines that foster a safe and healthy community. Policies that are not sufficiently supported by evidence, however, contribute to confusion and misinterpretation and can also cause significant additional harm. Developing evidence-based drug policy is, therefore, essential in order to provide clear, consistent and meaningful guidelines and also to reduce the opportunity for those in powerful positions to attain moral, political or economic gain. Drug policy legislation that invests 93% of the taxpayers’ resources in prohibition, despite the evidence of its failure, attempts to control drug use by inciting the fear of punishment in both the drug user and non-user alike. This approach is premised on the misguided notion that illicit drug users will readily choose not to take drugs either to avoid punishment or perhaps to become accepted by society. Of course, certain prohibitions are necessary, however, who decides which drugs are ok for dispensing in pharmacies and by doctors and which ones should remain illegal? Who benefits from these decisions? Perhaps those who benefit the most from the status quo drug policy are heavily influencing leadership, research agendas and the media’s presentation of information on this issue? What would happen to organized crime if drugs were suddenly legalized and appropriately regulated to protect people from misuse? How far would they go to make sure legalization does not happen?

Both reports, the Senate Special Committee on Illegal Drugs and the Report of the House Special Committee on the Non-Medical Use of Drugs, spark little in the way of hope for a more humane approach to Canadian drug policy. Both reports seem to waffle when it comes to identifying the forces that have chronically undermined the development of effective drug policy. Each report outlines the complexities of the topic and suggests some minor tinkering that might help, however, it is quite disappointing that such a large investment of time and energy resulted in so little clear direction. There seems to be a fear, or at least major apprehension, to identify the true beneficiaries of existing drug policies and the moral positions that support them. Is this topic avoided because it can elicit political and economic sanctions and perhaps even threatening consequences for those who raise the issue? Are our political leaders acting out of fear or out of the desire to win approval or acceptance of our powerful neighbors to the south? If so, this would suggest that current Canadian drug policy is founded upon what Kolberg calls pre-conventional or conventional levels of morality. Exorbitant expenditures, ineffectiveness, chaos and the harms perpetuated by our current approach to drug policy and practice indicates a fault in the very foundation of our social policy.

Policy development is a political process and, like anything else, is one that has the capacity to assume an inclusive or exclusive stance. To date, drug policy has been quite exclusive, excluding opposing opinions and approaches just as the policies exclude, through legal and stigmatizing processes, those who choose to misuse drugs. Rick Lines (1997:1) suggests this blatant “marginalization is a political process. It’s an identifiable process. It’s the end result of political and economic forces which make certain groups of people expendable.” This highly marketable, punitive, criminal-justice approach is one that politicians use to get additional votes despite it’s apparent ineffectiveness. Politicians gain acceptance and avoid the consequence of losing their parliamentary position. One can only imagine the pressures placed upon policy makers to maintain the status quo. Additionally, it is entirely possible that leaders are also the

victims of misinformation and propaganda about drugs and drug misuse. Having journeyed through Canadian drug policy these past eleven months, current drug policies seem much more clearly supportive of the attainment of individual and societal wealth over individual and social health. Until the moral beliefs and perspectives that underlying current drug policy are critically examined and reconciled, I do not believe there will not be any meaningful improvement in our approach to drugs and social policy.

Surely there is a way to combine evidence-based research with informed moral judgements as we work to improve Canadian drug policy? This requires all relevant stakeholders, both inside and outside of government, to incorporate the best available knowledge (research) with values that are mature or “post-conventional” according to Kolberg’s theory. Although, as Kolberg claims, most people do not reach the highest level of moral development and reasoning, this should not keep us from striving for this in ourselves and our political leaders. Finding a way to better combine available knowledge and values is essential to “passing on and above-all implementing” effective drug policy (Senate, 2002:11). Leaders in policy development need to transcend current thinking and existing structures and put forward a new policy that incorporates elements of prohibition, harm reduction, legalization and regulation. Such an approach may just liberate both the enforcer and the “drug addict,” offering each new choices. This type of policy would seek ways to include those in society who are struggling. To end, I offer this quote:

“No problem can be solved from the same level of consciousness that created it.”
--Albert Einstein

Based on the analysis presented in this paper, perhaps this famous quote can be restated as: “No problem can be solved from the same level of moral development that created it.”

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OPENING THE GATES ON THE NATIONAL DRUG STRATEGY FOR THE CORRECTIONAL SERVICE OF CANADA: IMPLICATIONS OF THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS REPORT ON CANNABIS

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As a social policy directed at reducing the harms of drugs, prohibition is a failure. As an ideology, it must be regarded as one of the greatest success stories of the twentieth century.

--Erickson and Butters 1998, pg. 177.

INTRODUCTION

The Correctional Service of Canada's (CSC's) drug policy is reflective of Canada's National Drug Strategy (NDS). However, differences arise within a correctional setting where policies are designed, first and foremost, to maintain the good order of the institution. As CSC's Drug Strategy states, "the nature of [the drug] issue...demands different approaches to achieve the same goals" (CSC, 1996:1). CSC applies a zero tolerance approach to cannabis and other illicit substances under the assumption that "a safe, drug free institutional environment is a fundamental condition for the success of the reintegration of inmates into society as law-abiding citizens" (CSC, 1996:1). The purpose of this paper is to critically analyse CSC's drug policy and to discuss the implications for CSC if cannabis is legalized or decriminalized in Canadian society. Two points of analysis are considered: (1) the theoretical realm, and (2) the human, penal and social costs. The theoretical section contrasts the punitive and harm reductionist ideologies in relation to drugs and drug use. The social, penal and human costs are discussed in terms of both the use of cannabis and the illegality of the substance. In conclusion, the perspectives considered in this paper are used as a point of departure to advocate for a more comprehensive harm reduction approach to cannabis and other illicit substances, both in our federal penitentiaries and in Canadian society.

BACKGROUND

With the recent publication of the report of the Senate Special Committee on Illegal Drugs entitled, *Cannabis: Our Position for a Canadian Public Policy*, the gates have opened once again to review Canadian drug policy. This paper will consider the possible impact of the Senate Report on drug policy at CSC, specifically in relation to cannabis, should the following recommendation be implemented into public law and/or policy:

The legalization of cannabis in Canada through the creation of a legal exemption scheme dictating licensing for the cultivation and selling of cannabis, in addition to criminal sanctions for the illegal trafficking and importation of cannabis (Senate, 2002:46).

CSC's Drug Strategy employs terminology reflective of both the punitive and rehabilitative theoretical models, with hints of a harm reduction approach. Zilkowsky (2001), writing for the Strategic Planning Division of CSC, states that: "[CSC's Drug] Strategy promotes a balance between restricting the supply of drugs and reducing demand for drugs. It does not alter the government's lack of tolerance for trafficking; however, it positions substance abuse as being primarily a health issue rather than an enforcement issue" (pg. 3). According to the 2001 Report of the Auditor General, however, CSC currently allocates \$169M toward the National Drug Strategy (NDS) with 93% devoted to enforcement

and 7% toward prevention and treatment (Auditor General, 2001). Thus, it appears as though CSC's Drug Strategy applies the term "balance" while actual outlays do not reflect a balanced approach.

In reviewing Canada's National Drug Strategy, the Senate Special Committee writes that "since Canada has a balanced strategy, it is important that there be clear goals for the balance it is seeking and clear indicators of what it is achieving" (Senate, 2002:39). Similarly, CSC's Drug Strategy states that: "each institution shall develop and implement drug strategies to balance detection, deterrence and treatment that are reflective of the nature of the institution" (CSC, 1996:1). A clearer understanding of balance, not just theoretically implied but in actual practical emphasis, is obviously required.

THE THEORETICAL REALM: BALANCE OR CONTRADICTION?

Just Deserts: The Classical/Punitive Model

Restricting the supply of drugs involves applying security measures to deter drug use and trafficking in prison. Enforcement budgets at CSC are applied to support this goal through use of ion scanners, x-ray machines, drug dogs, urinalysis, and investigative work (i.e. informants, telephone surveillance, etc.). It is also important to note that CSC's Drug Strategy allows for both disciplinary sanctions and/or administrative consequences as punishment and repercussions for cannabis possession and use. This is based on the theory of deterrence which views human's as rational beings who constantly apply a cost-benefit analysis to their actions and behaviour. However, the deterrent effect of a punitive approach in relation to drug use, especially the use of cannabis, is not supported by research (Fisher and Smart, 1996; Erickson and Fischer 1995).

Indeed, research on the principle of deterrence shows that the severity of punishment is not as important as the certainty and swiftness of sanction (Pholf, 1994). The punishment for a positive urinalysis test (or possession) is not swift, as such charges are dealt with in institutional (or criminal) court. In addition, the majority of urinalysis testing inside prison is random, not certain. It also seems logical to note that within prison, it is possible that the deterrent effect is even lower since the individual is already imprisoned and the threat of the loss of liberty is diminished. There are those of course, that choose not to use cannabis and other substances while in prison for fear of detection and subsequent sanction. Logically, this would seem true for individuals serving a life sentence or an indeterminate sentence because their eventual release into the community is not certain and must be earned. This may also be the case of individuals serving long terms of imprisonment or any sentence for that matter who wish to seek early release. Most importantly, while deterrence theory may have an impact on recreational users within the prison population CSC's deterrence-based policy ignores the fact that addiction (whether psychological or physical) is not rational.

Positivism: The Rehabilitative Model

In Canada, when drug legislation first came into effect in the form of the *Opium Act* of 1908, the government applied a punitive approach to opiate users and traffickers. "Early drug legislation was largely based on a moral panic, racist sentiment¹ and a notorious absence of debate" (Senate, 2002). Over time, other drugs were added to the list of prohibited substances including cannabis in 1923. In the

¹ Research by Giffen et al. (1991) does not support the claim that initial drug laws were enacted based on racist sentiment, but rather, a concern for the use of opiates by the Caucasian middle class, especially women and youths. However, it may be argued that such reasoning displays prejudicial categorizations based on race and class. In addition, the practical implementation of these laws over the years have clearly targeted racial groups.

1960's, the use of illicit substances increased in the general Canadian population. At that time, the positivistic/rehabilitative approach emerged whereby individuals using drugs were viewed as pathological (sick) requiring treatment instead of bad (criminal) requiring punishment. Over time, the severity of sanctions related to cannabis possession were reduced at the functional level: there was liberal police discretion in laying official charges in addition to judicial discretion allowing for less severe sanctions being handed down when possession charges were laid, even though the legislation did not readily reflect the change in practical implementation by the police or courts (Fisher and Smart, 1996). However, the *Narcotics Control Act*, implemented in the early 1960s, continued to reflect the prohibitionist agenda.

In 1972, the Le Dain Commission advocated for dramatic changes to the *Narcotics Control Act* and called for the decriminalization of cannabis in Canada. It was not until 1987, in the middle of a renewal of the US "war on drugs," that Canada's National Drug Strategy (NDS) emerged as official policy. In written form the NDS represented a shift toward a more liberal approach to drugs and drug use with 70% of funds allocated for prevention and treatment (Fischer and Smart, 1996). In practice however, not much changed as the government continued to support a prohibitionist agenda even though illicit drug use had been declining since the late-1970s (Fischer, 1994).

Harm Reduction: A Pragmatic Public Health Model

Today, Canada's National Drug Strategy, which was re-authorized in 1998 and revised in 2003, includes a harm reduction component. The harm reduction approach acknowledges that the use and/or abuse of drugs can cause harm to both individuals and society, however, it applies a judgement-free analysis whereby the main goal is not to reduce drug use by individuals per se, but rather, to manage the harms related to drug use, including the harms deriving from prohibitionist drug laws. At its core, harm reduction is a pragmatic, human health-based approach to drug control that seeks to reduce the harms associated with drugs, such as violence, crime, poverty, HIV and hepatitis C transmission, without requiring abstinence from drug users. Harm reduction practices presently in place at CSC include the provisioning of bleach kits (for prisoners to sterilize injection equipment), and the methadone maintenance program. Combining aspects of the harm reduction model with the rehabilitative and punitive approaches in public policy creates problems, as there are inherent conflicts involved.

The Rhetoric of Moral Reform(ers)

Moral theory involves analysing basic assumptions about the nature of human beings. As presented in Giffen et al. (1991), modern drug legislation in Canada arose out of moral panic: those who implemented prohibitionist drug policies viewed the substances themselves as morally corrupting. Both classical deterrence and rehabilitative ideology apply an assumption of drug use as a negative behaviour that suggests that non-drug are somehow superior to drug users. The harm reduction approach, however, eliminates moral judgement from the issue and focuses our attention on diminishing the harms suffered by individuals and the community due to the use of substances and by their illegality. Any public policy that criminalizes and penalizes individuals while at the same time trying to treat their "illness" is contradictory in nature and therefore, will yield sub-optimal outcomes. This is especially true in an environment that incapacitates and isolates at the same time that it attempts to rehabilitate, such as prison.²

² The Mission Statement of the Correctional Service of Canada states: "The Correctional Service of Canada, as part of the criminal justice system and respecting the rule of law, contributes to the protection of society by actively encouraging and assisting offenders to become law-abiding citizens, while exercising reasonable, safe, secure and humane control."

INDIVIDUAL, SOCIAL AND PENAL COSTS: Harm, Harm and More Harm

If “the long-term goal of Canada’s Drug Strategy is to reduce the harm associated with alcohol and other drugs to individuals, families, and communities” (Health Canada, 1998) then any policy or practice relating to the use, sale, cultivation/manufacturing or importation of cannabis should facilitate that goal. Where research shows that public policy and/or practice hinders that goal, it should be either modified or removed to create best practices that aid in reducing overall harms. CSC’s Drug Strategy states that:

...the Correctional Service of Canada, in achieving its mission, will not tolerate drug or alcohol use or the trafficking of drugs in federal institutions. A safe, drug free institutional environment is a fundamental condition for the success of the reintegration of inmates into society as law-abiding citizens. ...For every inmate, regardless of the existence or level of drug or alcohol problems, a clause shall be included in the Correctional Plan specifying that the inmate is expected to remain “drug and alcohol free” for the duration of his or her incarceration, in doing so, progress can be measured on this aspect, and administrative measures can be applied in this context. (CSC, 1996:1-2)

Reducing the harm associated with drug use is not even mentioned as an objective or a responsibility of the Correctional Service of Canada.

Costs to the Individual

In federal prison, like in the community, there are various individual harms associated with the prohibition of cannabis that often outweigh the costs to the individual for using the substance itself (Senate, 2002; Casavant and Collin, 2001; Jensen and Gerber; 1998, Jürgens, 1998). This is not to suggest that the use of cannabis carries no dangers. Physically, while less harmful to the body than other illicit substances, “the smoke produced [by cannabis inhalation] is approximately 50 percent more carcinogenic than that of tobacco. Lung capacity is reduced in chronic smokers and their airways have shown obstructions” (Fishbin and Pearse, 1996:314). Increased respiratory problems and rates of throat cancer are also noted in chronic cannabis users (Senate, 2002). The psychoactive effects of cannabis can last from 2-7 hours depending on the THC content, consumption of other substances and amount consumed. Most significantly, cannabis has not been shown to enable violence, delinquency or crime, and does not lead to the use of “hard drugs,” such as heroin and cocaine (Senate, 2002).

In prison, the harms resulting from the prohibition of cannabis are realized through charges laid (major or minor), disciplinary court (and possibly criminal court), disciplinary sanctions and administrative consequences, all of which can lead to the degradation of perceived reintegration potential. CSC employs random urine analysis testing in order to detect cannabis use in prison. CSC policy states that prisoners have a right to refuse to provide a urine sample for random testing, however, the sanctions associated with refusal are identical to those for a positive test. According to Commissioner’s Directive (CD) 566-10, urinalysis testing occurs by:

- random selection;³
- demand based on reasonable grounds;
- required for acceptance into a program or activity requiring abstinence; and

³ CSC National Headquarters randomly selects five percent of federal prisoners to provide urine samples every month. Individual institutions have thirty days to process the tests. They are to occur randomly throughout the month at the discretion of each institution. However, research shows that higher rates of testing occur in the middle of the month and only ten percent occur on the weekends when one would expect 27% to occur if the test were truly random (MacPherson, 2001:54).

- a volunteer program approved by the prisoner.

Cannabis possession in prison can be processed by way of a criminal or institutional charge. Possession of cannabis, a positive urinalysis test, or refusal to submit to a urinalysis test can result in a minor or major charge. Disciplinary action, in conjunction with administrative consequences, are to be taken if a prisoner is found guilty of transgressing the CCRA 40(k)(1): “tak(ing) an intoxicant into the inmates’ body” and “fail[ure] or refu[sal] to provide a urine sample” by the Independent Chairperson in Institutional Court. Both are considered serious offences.⁴

Disciplinary sanctions are officially considered punishment. According to CD 585, “a disciplinary sanction which includes the loss of privileges shall be limited to a loss of access to activities that are recreational in nature and non-essential. The loss of privileges shall not be imposed where it would be contrary to the inmate’s Correctional Plan” (CSC, 1996:4). According to CD580 - Discipline of Inmates, possible sanctions for drug possession may include one or more of the following:

- a warning or reprimand;
- a loss of privileges;
- an order to make restitution;
- a fine;
- performance of extra duties;
- in the case of a serious disciplinary offence, segregation from other inmates for a maximum of thirty (30) days.

Administrative consequences involve a loss of privileges but are not to be used as punishment nor are they allowed to interfere with a prisoner’s correctional plan. According to CSC’s Drug Strategy, “administrative consequences shall be based on consideration of a person’s safety, institutional security and/or operational requirements. They are intended to manage the risk presented by the inmate and may be applied when there is a clear link to the use and/or trafficking of drugs” (CSC, 1996:2-3).

Administrative consequences, as laid out in CD 585, may include, but are not limited to:

- a review of the Correctional Plan and the modification of the plan where necessary;
- a review of participation in a program of conditional release, including temporary absences, work releases and parole;
- a suspension or recommendation to the National parole Board to suspend a program of conditional release;
- the restriction of open visits and/or other community contact, including general social events, visits from family or volunteers;
- the restriction of private family visits;
- the review of security classification and placement which may lead to placement in special facilities;
- the referral to relevant programming;
- the suspension from a job that requires a degree of trust or affords freedom of movement throughout the institution, and consequential pay impacts;
- the restricted access to work programs in the community;
- a review of the inmate(s) accounts, including canteen expenditures.

Many of the harms associated with cannabis use in prison do not result from the use of the substance itself, but from the underground market created by its prohibition: violence in relation to prisoner debts, disciplinary sanctions and administrative consequences. A positive urinalysis test, like refusing a request

⁴ According to CD: 580 - Discipline of Inmates, a serious offence is one “where an inmate commits a serious breach of security, exhibits violent behaviour, commits or attempts to commit an act that could generate such behaviour on the part of others, or could cause harmful consequences to staff members of inmates” (CSC, 1996:3).

to provide a urine sample (a prisoner's legal right), involves an automatic major charge and a \$20 fine (prisoners earn \$1.50-\$6.90 a day). In this case, the harm to the individual in prison is somewhat different than the harm associated with criminal prosecution in the community because prisoners already have a criminal record and are already imprisoned. However, prisoners can face longer terms of imprisonment if they provide a positive urinalysis sample for THC or are found in possession of cannabis. This, in turn, may lead to a loss of perceived reintegration potential. Although administrative consequences are not meant as punishment, they can and do delay conditional release. The cancellation of a program of conditional release delays an individual's potential of being granted day or full parole, and any additional programming that may be assigned can significantly delay a prisoner's release plan. In addition, prisoners can face monetary loss through fines, additional prison time if sent to criminal court, a loss of employment opportunities and/or a decrease in pay. Finally, administrative consequences not only affect the prisoner; loss of visits and private family visits are possible administrative consequences that inflict harm on prisoners' families.

A positive urinalysis test for THC may or may not lead to an increase in security classification, although repeated positive tests surely will. Since drug use is considered a risk factor for recidivism, even though the research relating to cannabis does not support these findings (Roy, 2001), cannabis is still considered an illicit drug and, therefore, can effect parole considerations through the loss of case management support or through the National Parole Board (NPB) denying or revoking parole because of a positive urinalysis test in the community. Once again, the monetary costs of longer terms of imprisonment should be weighed against the real risk that individuals who use cannabis pose to the community. The gateway theory, whereby "soft drug" use leads to "hard drug" use, is often stated as a reason for these practices; however, the theory is not supported by research (Senate, 2002).

Penal Costs

Another area that requires further research in relation to drug use is that the highest rates of positive urinalysis tests are found in maximum-security institutions (MacPherson, 2001). Not only do maximum-security prisons have the highest rate of positive urinalysis, but they also have the highest rates of positive tests for harder drugs (heroin, cocaine), and higher rates of refusing an order to provide a urine sample (Plourde, 2001). One may argue that the deterrence factor for positive testing is not as severe for prisoners in maximum-security institutions, however, one need also consider the impact that the environment itself has on drug use. A study by Alexander et al. (1981) found that laboratory mice housed in *isolated and unnatural environments* self medicated with narcotics at a significantly higher rate than mice placed in more natural settings. In addition, hard drugs such as cocaine and heroin are easier to smuggle into prison than cannabis, making them preferable in maximum-security settings. Of course, it must also be remembered that prisoners that are the most disruptive, least likely to acclimate to the prison regime and who have the highest rates of interpersonal, emotional and addiction issues are found in maximum-security facilities. Therefore, perhaps CSC's current drug policy has not only failed to significantly deter drug use behind the walls, but it has also created conditions that promote the use of hard drugs by prisoners looking for a temporary escape.

With regard to cannabis, the probability of being caught using in prison is substantially higher than for other illicit substances because Tetrahydrocannabinol (THC), the psychoactive ingredient in cannabis, can remain detectable in the body by urinalysis for up to five weeks after chronic use. In comparison, opiates are detectable in the body for only 1-2 days after use (MacPherson, 2001). Currently, there is anecdotal support for the claim that prisoners have been switching from cannabis to "hard drugs" (i.e., heroin and cocaine) in order to "beat" detection by the urinalysis testing program (Jürgens, 1998). Indeed, intravenous drug use within the federal prison population appears to be on the rise (Jürgens, 1999). This

puts an ironic twist on the gateway theory whereby, in prison, “soft drug” use leads to “hard drug” use because of the methods used by CSC for surveillance, detection and sanction.

One of the main issues concerning the prison population and drug use, not just for individual prisoners but the penal environment as a whole, relates to the self-reports of a higher rate of intravenous drug use in the federal population (Ford, 1999; Jürgens, 1996). While the higher rates of injection drug use are of concern in and of themselves, the rising rates of HIV and hepatitis C infection in Canadian prisons make this an extremely pressing issue. Since the introduction of urinalysis testing across all CSC regions for THC in 1995, the prison population has seen a significant rise in intravenous drug use and consequently, rising rates of HIV and hepatitis C infection (Ford, 1999, Jürgens, 1996).⁵ “The number of federal inmates known to be living with HIV or AIDS reached 200 for the first time in April 1999 - an increase of nearly 100 percent since 1994. The rate of hepatitis C is estimated at between 25% to 40% of the offender population” (Roy, 2001:5). The legalization of cannabis and the limiting of urinalysis testing to illicit substances other than THC may very well aid in addressing this concern.

On the other hand, MacPherson (2001) uses results from CSC’s random urinalysis testing to argue that prison drug use has remained relatively stable since the introduction of urinalysis testing. However, this argument ignores the very basis of the issue--that the switch to hard drugs in prison occurs as an attempt to “cheat” detection because hard drugs are expelled from the body quicker than THC. Thus, positive urinalysis tests for hard drugs would not show an increase over time via “not quite random” urinalysis testing (see footnote 3). It is of interest to know how many prisoners have shifted their drug use from cannabis to harder drugs to avoid detection. Jürgens (1996) states that Canadian prisoners confirm anecdotally that the switch is indeed occurring. The future cost to health care could be astronomical. This is of concern to society in general, as the majority of prisoners are eventually released back into the community. Clearly, further research is required to address these concerns.

In addition, some prisoners with substance abuse issues do not receive treatment in prison because they hide their drug problem from officials for fear of “doing more time.” Thus, some individuals with very real substance abuse issues may be able to control their addiction within the prison environment and therefore, not receive treatment even though they are not able to function drug free once they are returned to the community.

Social Costs

This leads to a discussion of the social costs of CSC drug policy in relation to cannabis. Social costs refer to harm experienced by both the prison community and Canadian society. Much like the harm created at the individual level, social harms result not so much from individuals using cannabis, but rather from its illegality. The violence associated with the cultivation, importation and trafficking of cannabis, both in prison and in the community, is a result of the substance being deemed illicit rather than the qualities and characteristics of the substance itself. THC, the active ingredient in cannabis, does not promote violence (Senate, 2002; Brochu et al., 2001). The violence that occurs in the underground drug market (due to debts, turf wars, etc.) is often used by those in favour of prohibition to justify current drug policies, including those prohibiting cannabis. This argument fails to acknowledge that the use of cannabis does not induce violence, but, rather, that cannabis-related violence is derived from its strict prohibition.

⁵ Urinalysis testing was introduced into the federal correctional system in 1985. However, various court challenges quickly halted sample collecting (except in treatment programs). In 1992 urinalysis testing within federal institutions was codified into law under the Corrections and Conditional Release Act. In 1993 a pilot, random urinalysis program was implemented in three penitentiaries. The program was implemented across the country in August 1995 except in the Pacific Region pending further court challenges. In August of 1996 the program went nation wide (MacPherson, 2001).

Another drug policy issue that carries social significance is the monetary cost of enforcing prohibition. The percentage of CSC's budget allocated to its Drug Strategy is difficult to accurately assess. Available information indicates that approximately \$2.1M is spent per year on the urinalysis program, \$2.7M was spent purchasing drug detection equipment (ion scanners), \$350,000 a year is spent on maintaining and operating ion scanners, and \$1.4M was spent over a three-year period on the drug dog program. If, according to the Auditor General (2001), \$12M a year is spent on demand reduction programs, such as drug rehabilitation and the methadone maintenance program, then are we to assume that the remaining \$120M of CSC's drug related budget is spent on enforcement (investigations, search, seizures, incarcerating those convicted under drug laws, etc.)? Clearly, a more detailed accounting of CSC's drug control expenditures is required to get an accurate sense of the costs related to cannabis.

Prevention within CSC is based on the deterrent effect of random urinalysis testing which has been discussed previously. The random urinalysis testing of inmates means that the 37% of the prison population that do not use drugs are also subjected to testing (Roy, 2001). The Offender Pre-Release Substance Abuse Program (OSAPP) and Choices (its community-based variant), which often have long waiting lists, seem to be the only form of treatment available, in addition to the Methadone Treatment Program. CSC is required to provide these programs before a day/full parole application date, which is generally at 1/3 of an individual's sentence. That means that treatment is provided just before an individual is placed back into the community, rather than at the beginning of their sentence. This is significant because completion of one's correctional plan, including required substance abuse programming, is a prerequisite to obtaining conditional release by the National Parole Board. Therefore, if this trend continues, some prisoners can expect to do more time through no fault of their own causing a higher cost to taxpayers. Specialized treatment facilities, such as The Northern Treatment Centre in the Ontario Region, are no longer available within the prison as funding has been cut. Now, specialized treatment is only available in the community and therefore, not accessible to maximum and most medium security prisoners. Ironically, Roy (2001), states that while CSC research shows that completion of OSAPP has a positive impact on recidivism, "other CSC data indicate that while most offenders choose abstinence, offenders who completed OSAPP with the goal of moderating their use of alcohol and other drugs were reconvicted at a significantly *lower* rate than those who were attempting to abstain completely from all intoxicants"(p. 6).⁶ Perhaps then, by CSCs own research, zero tolerance is not the answer to the drug problem.

CONCLUSION

Canadians have a war on drugs that translates into a war on Canadian citizens who choose to use substances deemed illicit, including cannabis. Nowhere is this more evident than in our penal system. The practical reality of Canada's National Drug Strategy (NDS) ensures the continuation of this war that is almost 100 years old. Yet, in the same breath, Canadian drug policy advocates the treatment and rehabilitation of our prisoners of war. So, are drug users bad requiring punishment or sick requiring treatment? According to this analysis, CSC treats them as both; a contradiction that leads to serious social and individual costs. Many experts acknowledge that we are losing this war against ourselves and our loved ones, however, instead of admitting defeat and applying new approaches, we continue to call for stricter rules and more money for drug enforcement (House, 2002). In relation to cannabis, we need to redefine the issue based on reliable knowledge and good research as opposed to succumbing to American pressure, discriminatory practices and moral judgements.

⁶ It is important to note that the sample this study employs does not reflect those individuals assessed as having severe substance abuse issues. See: CSC (1994).

Should Canadians choose to abandon the war on drugs, the decriminalisation of cannabis is a logical first step. “Harm reduction provides a middle ground for the de-escalation of the war on drugs, without resorting to all-out legalization or continuing the punitive and harm-promoting practices of the war on drugs” (Erickson and Butters, 1998:196). Minimizing the harms associated with both the use and abuse of drugs for the individual and society allows for the reallocation of funds toward prevention and treatment. Decriminalizing cannabis would indicate a first step in that direction. Both in society and in prison, cannabis accounts for the majority of drug control expenditures for the state. Eliminating urinalysis testing for THC in the federal penal system would allow for the reallocation of limited funds to deal with individuals requiring treatment for problematic drug use, a concern for both individual and societal health, in addition to allowing CSC to concentrate on the importation and trafficking of illegal substances in its institutions.

The argument for the decriminalization of cannabis in federal penitentiaries resembles the arguments for decriminalization in society. While the reasoning will be similar whether cannabis is legalized or decriminalized, the case for ending urinalysis testing is stronger if THC is removed from *Controlled Substances Act* altogether. A major ideological shift will have to occur as “the focus of the legal debate on cannabis, has always been on what penalties should be, rather than on whether there should be any” (Erickson and Fischer, 1995). Should public debate finally acknowledge that perhaps there should not be any, then it must be decided if Canadian law should reflect this new understanding through legalization.

Even with legalization, the CCRA still allows for prohibition. The prohibition of alcohol within the penal environment is an example. Alcohol is prohibited because its consumption jeopardizes the security of the institution. Therefore, should cannabis be legalized or decriminalized in Canada, it may not necessarily be allowed within the federal penal system. Cannabis use and possession may still carry disciplinary sanction and/or administrative consequences, as does alcohol. Medical marijuana is now part of public policy in Canadian society and individuals prescribed cannabis by a registered physician can possess and consume cannabis without legal repercussion. Within the federal penal system, individuals prescribed medical marijuana are supplied with THC pills but still face disciplinary sanction or administrative consequences for possession of cannabis or a positive urinalysis test. THC pills contain lower doses of synthetic THC than does inhaling cannabis smoke. The legality of this practice is currently being challenged in Nova Scotia by Michael Patriquen, a federal prisoner. The argument being made against CSC cannabis prohibition is based on the characteristics of THC, namely, that it does not enable violence, as does alcohol. The second argument relates to the underground economy and the violence perpetuated by it. Importing and trafficking by unauthorized dealers would remain a criminal offence. If cannabis is legalized, then the prison canteen would sell cannabis as it does tobacco. The price could be lowered and, therefore, debts would be reduced or eliminated in relation to cannabis.

The problem is slightly more difficult if cannabis is simply decriminalized. However, either way, the CCRA still allows for CSC to prohibit any substance it finds to be a threat to the security of the institution. Other questions would require consideration as well. If the State regulates the sale of cannabis, would CSC fit the description of a legal trafficker? If not, it could not readily be sold on canteen. If it is made available on canteen, it is reasonable to believe that there would be limits on quantities purchased, like tobacco, to control it being applied as currency on the underground market. Either way, CSC could continue their current practice until it is legally challenged. Hopefully, if society reviews and amends its cannabis policy, so will CSC. “Imprisonment may take away a prisoner’s freedom, but it does not nullify a prisoner’s right to equal treatment under the law, and it must never be allowed to sever the ties that link a prisoner to the brotherhood and sisterhood the *Universal Declaration of Human Rights* accords us all” (Jackson, 2002).

If legalization or decriminalization of cannabis occurs in Canadian society then CSC should respond accordingly. Theoretically, either legalization or decriminalization of cannabis are possible within the

penal system. Obviously, there are distinct differences between the community and the prison environment and therefore, policies for each will have their differences. Namely, legalization of cannabis within Canada would most likely result in decriminalization of cannabis within the penal system. Decriminalization would justify the ceasing of THC testing within Canadian federal prisons. The selling of cannabis on canteen in any case would be surprising. However, an argument can be made to eliminate urinalysis testing for THC within the federal prison population as the policy stands today. Indeed, recent newspaper articles indicate that CSC has been considering the possibility of removing THC from its community urinalysis testing program (Malarek, 2002). Currently CSC chooses which substances to test for and can choose to eliminate THC for all the reasons discussed above, namely that the harms created by the prohibition of cannabis, at the individual, penal and societal levels, far outweigh the individual and social costs presented by the substance itself. This does not mean that CSC supports or even tolerates the use of cannabis or any other drug, but that it does not waste limited funds on vigorous prosecution of cannabis use. In considering these arguments, it is difficult to dispute the Senate's conclusion that "in effect, the main social costs of cannabis are a result of public policy choices, primarily its continued criminalization, while the consequences of its use represent a small fraction of the social costs attributable to the use of illegal drugs"(Senate, 2002:29).

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ATTITUDES AND PERCEPTIONS OF HARM REDUCTION INITIATIVES AMONG SOCIAL POLICY ELITES IN SAINT JOHN, NEW BRUNSWICK

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INTRODUCTION

In December 2001, the Auditor General of Canada released a report that found that 93% of the \$500 million spent annually by the Federal Government on illicit drugs is allocated for enforcement. The report also stated that Canada's Drug Strategy should embody a more balanced approach by significantly involving education, prevention/treatment and harm reduction (Auditor General, 2001). A report issued by the House Special Committee on Non-Medical Use of Drugs a year later stated that: "The cornerstone of a renewed drug strategy must remain the long-term goal of reducing the harm associated with alcohol, tobacco and other substances to individuals, families and communities" (House, 2002:41).

In May 2003, the government renewed Canada's National Drug Strategy (NDS) and reserved a significant role for harm reduction policies and programs. However, a move toward harm reduction will require more than another rhetorical endorsement of the concept. In the end, it will require a significant modification in how we perceive and respond to the issues of substance use and abuse. Among other things, the effective implementation of harm reduction in Canada's drug policy demands a philosophical shift from treatment approaches emphasizing abstinence to ones that allows for less judgmental and more pragmatic approaches to dealing with problems created by drugs and drug users.

Indeed, meaningful shifts in drug strategies rely not only on changing legislation, but also on changing our perceptions of the illicit drug problem and, especially, changing the perceptions of those tasked with delivering drug treatment services. At this point, policy makers are left with the task of developing and implementing integrated service delivery solutions and innovative harm reduction programs for the renewed drug strategy. Recent developments suggest that Canada is beginning the process of exploring alternative legal frameworks and piloting innovative approaches in its response to the complex phenomena of drug use and abuse. However, long-standing socio-political attitudes that enable prohibition are a powerful influence on our responses to illicit drugs and those who use them. The viability of innovative initiatives for dealing with the drug issue, therefore, cannot be properly interpreted without a consideration of the attitudes of social policy elites who will be involved in implementing harm reduction at the local level. A major shift toward innovative treatment programs, such as those included under the umbrella of the harm reduction approach, depend both on favorable public opinion and the support of top-level decision makers in local organizations, agencies and institutions involved in developing and implementing such programs.

This paper seeks to assess the attitudes and perceptions of social policy elites in Saint John, NB toward various harm reduction initiatives. Specifically, this paper seeks to document the existence of attitudes and perceptions held by relevant social policy elites that may work against the development, implementation and sustainability of harm reduction programs in the Saint John community. The first part of the paper presents some background on the three main philosophical perspectives on illicit drugs: prohibition, legalization, and harm reduction. The harm reduction approach is then discussed at some length providing the reader with an understanding of both the concept more generally, and of various programs and initiatives that fall under its rubric. The next section reports on the results of a survey of the attitudes and perceptions of local social policy elites related to harm reduction in Saint John, New Brunswick.

BACKGROUND

Canada's Drug Problem: A Social Construct?

Since the early 1900s, criminal statutes have been enacted in Canada to prohibit particular drugs and control those who use them. This started with the *Opium and Drug Act* (1908) and continued through the *Narcotic Control Act* (1960), the *Food and Drugs Act* (1985), and the recently implemented *Controlled Drugs and Substances Act* (1996) (Canadian HIV/AIDS Legal Network, 2002). The criminalizing of certain drugs and their use legitimized a particular perspective on illicit drug use and gave rise to the perception of Canada's "drug problem." Accompanying this was the broad institutionalization of abstinence-based approaches to drug abuse treatment (i.e., "high-threshold" programming). Thus it may be argued that the general attitudes and perceptions of Canada's "drug problem" are a social construct created with the onset and implementation of the prohibitionist approach to drug control.

The prohibitionist approach attempts to control illicit drug use by applying criminal sanctions to those who manufacture, use, supply or possess controlled substances. Law enforcement announcements on illicit drug seizures and drug-related crimes, and sensationalist media reports of the dire straights of the drug addicted, have fueled public perceptions of the illicit drug use as a morally corrupt behavior that needs to be strictly controlled (Cheung, 2000). Major criticisms of the prohibitionist approach cite the inability of enforcement-based strategies to decrease the availability and consumption of illicit drugs in Canadian society. In fact, many critics point out that prohibition helps fuel the drug crisis by creating the conditions that enable a lucrative and violent black market in illicit drugs. In addition, prohibition creates a tremendous financial strain on the criminal justice system by placing large numbers of drug users in the category of criminals (Haden, 2002). Most important for this discussion, however, is the high relapse rate for those addicted to drugs within high-threshold abstinence-based treatment initiatives spawned from the prohibitionist approach to drug control.

Contrasted with the prohibitionist approach to drug control is the libertarian or "legalization" approach. For example, Canada's oldest and most active civil liberties organization, the B.C. Civil Liberties Association (BCCLA), opposes the criminal prohibition of drugs. The BCCLA is opposed to the government imposing moral judgments on conduct that is not, in and of itself, a serious risk to others or to society (Lyster, 2001). The basis of their opposition rests on the principle of "respect for personal autonomy" which admonishes non-interference by government with the personal choices made by its citizens. The extreme libertarian view, such as that advocated by the BCCLA, presses for the legalization of illicit drugs, which, according to its supporters, will lead to the end of the black market, a lessening of the financial strain on the criminal justice system, and freeing up funding for a wider range of addiction treatment and harm reduction programs. Supporters of the libertarian approach reserve a role for criminal sanctions, but want them restricted to consequences of drug use that involve interpersonal harm (such as drugged driving, etc.). Critics of the legalization approach, however, fear that an increase in the number of new illicit drug users, including youth, will emerge in society once they are free from criminal sanctions directed to the use and possession of drugs.

Harm reduction falls in between the extreme libertarian and prohibitionist approaches to drug control. The harm reduction approach avoids passing judgment on the issue of illicit drug use and abuse and is based on the desire to reduce drug-related harms for both drug users and the wider community. Harm reduction circumvents the problematic ethical and social mores inherent in the prohibitionist approach through gradual reforms focused on increasing the overall well being of the whole community. Thus, the harm reduction approach accepts that illicit drug users are at varying levels of readiness to be treated and legitimizes a wide range of treatment options from abstinence to drug assisted therapy.

The emergence of the harm reduction model by no means signifies the demise of the prohibition and legalization approaches, but instead makes way for a more pragmatic, health-based approach to dealing with illicit use and drug users. It is problematic drug users (i.e., addicts) that make the harm reduction approach a tough sell to both drug enforcers and substance abuse service providers as many people working in these fields still carry strong judgments against those who choose to use illicit drugs. These attitudes are even more pronounced when considering the issue of youth and drugs. The pervasive belief that initiatives intended to prevent associated harms of drug use condone such behaviors remains a common misperception. Thus it is often a moral and ethical dilemma for many individuals to promote the more innovative aspects of the medium and low-threshold harm reduction programs within their community when they believe that the message they might be sending to their youth is that it is all right to engage in illicit drug use.

While the present Canadian Drug Strategy continues the shift toward health-based harm reduction approaches, pervasive attitudes favoring prohibition and the associated abstinence-based treatment philosophies may hinder the successful implementation of local harm reduction initiatives. With much of the general population agreeing with the basic philosophy behind harm reduction, negative perceptions toward our nation's marginalized illicit drug users and the intense fear surrounding the topic of youth and drugs can overwhelm the more tolerant perspective of harm reduction and fuel the perception of Canada's "criminal drug problem" instead of our "public health problem."

The Harm Reduction Perspective: A Neutral View?

The harm reduction approach has demonstrated its effectiveness at reducing drug related problems, such as crime, public drug use, the transmission of HIV and hepatitis C, and overdose deaths in several countries including Australia, Britain and the Netherlands (Fisher, et al., 2000). Harm reduction initiatives are not only directed at reducing harms to individual drug users, but also those externalized to the broader community. Harm reduction explicitly recognizes that abstinence may be neither a realistic nor a desirable goal when delivering services to drug users. The approach is pragmatic in that it accepts that some use of illicit drugs is inevitable, and this results in an approach that sees individual drug use as a secondary issue to the harms resulting from that use. Major pragmatic goals associated with harm reduction initiatives are to reduce the incidence of blood born diseases, drug overdoses, and public nuisance associated with injection drug use, improving the general health of injection drug users (IDU's), and increasing the drug users' use of appropriate primary health care and social services.

Harm reduction incorporates a spectrum of strategies from abstinence-based treatments for drug use (i.e., "high threshold" programs) to therapeutic programs including social and health care which manage the users' drug of choice (i.e., "medium threshold" programs) to initiatives which focus on safe ways to engage in drug use for those users not presently willing to end their addiction ("low threshold" programs) (MacPherson, 1999). This approach has gained popularity due to the risks associated with increases in blood borne diseases such as HIV, AIDS and hepatitis C amongst injection drug users, and to the harmful social effects associated with the prohibitionist approach in dealing with illicit drug use such as increasing incarceration rates, the expansion of gang violence, and terrorism. A broad range of accessible drug treatment programs and harm reduction services allow for drug users to enter a collective system of care addressing health and social issues at much earlier stages of their drug use than would be possible under the prohibitionist approach. It is this social integration of the drug user that helps to de-stigmatize these marginalized population groups while attending to the overall health and wellbeing of our communities.

A comprehensive drug strategy involving a balance of law enforcement, prevention/treatment and harm reduction tackles both issues of public order and public health through the implementation of a continuum of care (i.e., high, medium and low-threshold programs). The term threshold, when discerning between

treatment options, refers to the state of readiness an individual displays to participate and follow the requirements of a certain treatment and the eligibility criteria for program entrance (Kerr and Palepu, 2001). High-threshold programs hold to traditional abstinence-based approaches and target drug users who are willing to give up their drug of choice to be eligible for treatment. Programs in this category include: abstinence oriented educational programs or treatment therapies, residential treatment centres, recovery houses, detoxification centres, and 12-step programs. Unfortunately, these types of programs are often associated with high rates of relapse resulting in non-eligibility for program service (Correctional Services Canada, 2003). Ironically, those who promote abstinence-based treatment programs are well informed on the various addiction models that recognize relapse as part of the process of successfully overcoming an addiction. Despite very high relapse rates, there are individual successes that generally correlate to the addict's state of readiness to deal with their addiction. This indicates that there continues to be a need for high-threshold treatment programs in the overall continuum of care. High-threshold initiatives also include educational and promotional materials that emphasize abstinence. Substantial research, based on sophisticated methodologies on the effects of educational approaches to future drug use, indicate a general lack of success in changing drug using behavior (CCSA, 1996). However, any discussions on the negative effects of drug use and misuse will continue to be viewed as beneficial to society.

Medium-threshold programs refer to treatment initiatives with a structured regime centered on drug use and include both medical and social care. These treatments target drug users who are willing to abide by a highly structured maintenance schedule of a prescribed drug, the drug of which they are addicted or a drug replacement, in controlled dosages while abstaining from illicit drugs. Medium-threshold programs, which include methadone treatment and prescription heroin, cocaine or amphetamine treatment, constitute a significant break from the prohibitionist approach to drug control. Although, it is known that the user continues to use an illicit substance, the attitudes and perceptions surrounding the use are softened due to the highly structured, medicalized regime of the treatment and the no tolerance view toward any other illicit drug use, hence increasing public order. The goals of medium-threshold programs are enhanced physical and mental health, decrease in illicit drug use and reduction in public drug activity and criminal acts. Success of the medium-threshold programs are varied when success is measured by abstinence and are not without complications such as program treatment availability lapses (holiday clinic closures, incarceration of the participant, lack of transportation availability etc.) and user fees (House, 2001). These process inconveniences can act as barriers to maintaining sufficient levels of the drug to keep the user from using illicit drugs. In some cases, methadone programs relax their rigorous policies toward illicit drug abstinence developing the first of the low-threshold methadone programs (MacPherson, 1999). However, with supporting evidence of increased physical and mental health and decreased public disorder, there remains a place for medium-threshold programs in a comprehensive continuum of care.

Low-threshold programs are the bare bones of the harm reduction approach targeting those individuals who are not able or willing to abstain from illicit drug use. Low-threshold treatment/services focus entirely on reducing the harms that are associated with drug use and the direct and indirect effects of drug use on the community. The introduction of low-threshold programs allows for the very large proportion of drug users who are not in treatment to come into contact with health care services and social/economic supports – an estimated 80% of drug users in one Swiss study (MacPherson, 1999). Though the implementation of low-threshold programming, this marginalized and criminalized population is able to access educational materials on health and social welfare matters, treatment options and housing and employment possibilities through outreach centers and mobile support services. Low-threshold harm reduction initiatives include needle exchanges and safe injection sites where users are able to inject their drug in the presence of medical personnel and counselors. Law enforcement policies such as cautioning and referrals to health agencies, another form of low-threshold initiative, allows police discretionary power when confronted with users holding dirty needles - diverting the user from arrest and a court

appearance and leading them toward helping agencies with the expertise to address their health and addiction needs.

It is in dealing with youth drug use/abuse that prohibition and abstinence-based treatment approaches receive their greatest support. Youth-centred public health advocates have had to confront and break down many “attitude” barriers on their way to implementing low-threshold initiatives for youth such as reality-based sexual education, distribution of condoms and creating access for birth control medications and devices. The misconception that when a community implements harm reduction initiatives for what is considered an unacceptable behavior it is thereby condoning that behavior only exacerbates a general attitude that society values are too lenient with respect to our youth. Prohibition “feels good” and remains popular when the general public thinks of the multifaceted ills to youth associated with illicit drug use. Most drug treatment initiatives involving youth continue to be abstinence-based, despite an overwhelming amount of literature which indicates high relapse rates associated with abstinence based treatments and known advancements in the addiction literature indicating much quicker rates of addiction for adolescents versus adults. In fact, many medium-threshold programs, such as methadone treatment, have age requirements for program participation leaving few treatment options for human resource organizations that are required to make appropriate referrals for youth who have not been successful in high-threshold treatment programs. More often than not, the pervasive prohibitionist attitude that drives the perception of Canada’s “drug problem” legitimizes a criminal justice approach to dealing with the illicit drug use of our youth resulting in the addictive behaviors of young people being dealt with as a “criminal” matter versus a “public health” matter. Perhaps the greatest challenge of all associated with the broader implementation of harm reduction in society is bringing low and medium threshold services to youth who would benefit from them.

The “Real” Harms Associated with Drug Use - The Plight of the Injection Drug User

It is now becoming more accepted that the criminal approach to drug control may increase harms associated with the use and abuse of illicit drugs. The unknown potency of the drug purchased from an underground market, fear of criminal sanctions by the user resulting in more harmful ways of consumption, the sharing of drug paraphernalia which may be tainted with disease, and the lack of resources to provide treatment services due to high public expenditures on enforcement, all increase the potential harms for the drug user and for society. In fact, many major reports since 1997 indicate that the legal status for illicit drugs adversely affects the efforts of health officials to prevent the spread of blood born diseases among injection drug users and society’s efforts to effectively treat or reduce the harms associated with injection drug use (Canadian HIV/AIDS Legal Network, 2002).

The Federal, Provincial and Territorial Advisory Committee on Population Health found that over 100,000 Canadians are injection drug users (Canadian Medical Association, 2001). The consequences of illicit drug injection include injection-related infections, drug overdoses, blood born disease transmission, exposure to discarded needles, violence, property crime and prostitution. Every year, \$500M is spent by 11 federal departments and agencies to address illicit drug use in Canada. However, the economic costs for health care (HIV/AIDS and hepatitis C), lost productivity, property crime and enforcement are estimated to exceed \$5B annually (Auditor General of Canada, 2001). High rates of emergency department visits and hospital admissions to provide IDU’s treatment for soft tissue and bacterial infections, intoxication and withdrawal symptoms help fuel high health care costs.

A recent report from the Canadian HIV/AIDS Legal Network (2001) states that Canada is in the midst of a public health crisis with the increased onset of HIV/AIDS and hepatitis C (HCV) among the general population and more specifically among IDUs. Health Canada’s Centre for Infectious Disease Prevention and Control reported that, in 1999, approximately 30% of new HIV infections and over 60% of new HCV

infections were among people who inject drugs (Health Canada, 2000). A beginning step in addressing the issues faced by IDU's is public education aimed at removing the stigmas associated with this population group and changing discriminatory and/or uniformed public and professional attitudes. The aim of this education is to create a perspective of the IDU as an individual with the right to decide on the "best fit" intervention for them. This will lead to society creating a continuum of services that meet the variety of needs of IDU's.

Treatment for the use of dependence producing psychoactive drugs has traditionally been based on a selection of motivated patients usually moving from outpatient to inpatient status with follow-up services and geared ultimately to abstinence. The introduction of medium to low-threshold harm reduction initiatives however, imposed no preconditions, such as a period of abstinence or expectations of abstinence, for success. Under harm reduction, the pursuit of abstinence becomes a secondary issue to the threat of HIV or hepatitis C infection and its spread to the 'normal' population. The overall aim of these services is to encourage IDU's, previously out of touch with the health care system, to come into contact with a comprehensive system of care and provide easily accessible health interventions in the early stages of drug use to help stabilize their lives.

As a result of the new health-based approach to Canadian drug policy that promotes harm reduction initiatives, many more medium and low-threshold services are becoming a reality for local communities. Indeed, Health Canada is now pursuing feasibility studies on implementing safe injection facilities to curb the morbidity and mortality associated with illicit drug use (Kerr and Palpepu, 2001). The legal issues surrounding these more controversial low-threshold treatments can be addressed through efforts to gain exemption from current laws, forming administrative agreements, or passing amendments to the Controlled Drugs and Substances Act.

Historically, evidence-based public health approaches have been overlooked due to prevailing political agendas and prohibitionist ideologies. However, a key to the development and implementation of effective harm reduction initiatives is the reliance upon evidence-based decision making where a rational basis is created for setting priorities and establishing strategies which encompass the needs of the IDU's and the entire community.

HIV/AIDS and HCV – A New Brunswick Perspective

AIDS New Brunswick continues to lead efforts toward implementing a provincial HIV/AIDS strategy as New Brunswick is one of the few provinces without a working framework to clarify the roles of the Department of Health and Wellness and other community-based organizations (CBO's). In 1997, four CBO's (SIDA AIDS Moncton, AIDS Saint John, AIDS NB and Healing our Nations) formed the New Brunswick Community-Based AIDS Organizations Partnership (NBCBAOP) to provide support to persons infected or affected by HIV/AIDS and hepatitis C, and to initiate prevention programs targeted to reducing the spread of blood borne disease in the province. The Partnership indicated that a clearly defined strategy would look at a full range of initiatives, such as prevention, education and harm reduction, in the community and within prison populations (NBCBAOP, 2002).

New Brunswick Health and Wellness reported that, between 1995-2002, there were 1,376 new hepatitis C cases, 96 new HIV cases and 52 new AIDS cases in the province with Moncton, Saint John and Fredericton containing a substantial proportion of the reported cases (83% of hepatitis C, 50% HIV, 60% AID's) (New Brunswick Health and Wellness, 2002). With the incidence of HIV more than tripling in the province between 1999-2001, and a substantial increase in newly reported cases of hepatitis C (over 60% related to IDU) (NBCBAO, 2002), the Community-Based AIDS Organization Partnership began to meet frequently with the provincial Minister of Health and other officials to increase the support and

programs for IDU's in the province. In 2001, representatives from several organizations (various HIV/AIDS organizations, Health Canada, Correctional Services Canada, Addiction Services, NB Pharmacists' Association, John Howard Society, etc.) attended a meeting in Saint John to develop a strategy for dealing with health issues involving IDU's.

Collaborative work continues across the province with the aim of establishing the necessary needle exchange and methadone maintenance programs required to provide essential services for IDU's. At present, New Brunswick has four needle exchange programs located in Moncton (SIDA/AIDS), Fredericton (AIDS NB/SIDA), Saint John (AIDS SJ) and around the Atlantic Region (Healing Our Nations). The Street Outreach Options Program (SOOP), a harm reduction organization in Saint John, distributes clothes and food, materials for safer sex and legal support for IDU's when criminally charged. As these initiatives become more common, we are beginning to see New Brunswick's IDU population increasing its utilizing of social services. In 2000, AIDS Saint John needle exchange program provided an impressive 7064 needles to IDU's in the community. This was up from only 734 the year before (AIDS Saint John, 2003). Data collected by AIDS New Brunswick indicates that between July and September 2002, 41% of needle exchange clients were under the age of 21, compared to 29% between ages 21-30 and 28% between ages of 31-40 (Robichaud, 2002). These statistics are both encouraging and disturbing, as they clearly indicates a rise in the amount of IDU's seeking and obtaining health-related services, however, they also point to a large percentage of youth who require these services.

There are currently 16 physicians licensed to prescribe methadone in N.B., however, only three are presently providing the service. The city of Dieppe provides methadone maintenance services to over 80 patients across NB with 60% of these patients living with HCV (over 60% of these cases are attributable to IV drug use). Very recently in Fredericton, two doctors began providing methadone support services and there continues to be a strong collaboration between government, medical and non-profit organizations to implementing a medium-threshold methadone clinic within Saint John (AIDS Saint John, 2003). One issue of concern continues to be the strict policies and highly structured environment of the medium-threshold programs, including age restrictions that limit youth from accessing the service. Additionally, in Saint John a Methadone Support Group (Supporting Others On Methadone, SOOM) was formed providing a means by which participants are able to help each other through their experiences while participating in a maintenance program.

The Report on the Profile of Injection Drug Use in Atlantic Canada indicated that NB and Nova Scotia have the greatest number of IDU's, and that opiate (Dilaudid) and cocaine/crack are the most common drugs injected in NB (Health Canada, 2000). Respondents (IDU's) of the study attributed the popularity of Dilaudid to liberal prescription practices by some physicians and "double doctoring" where prescriptions are obtained from more than one doctor. With the older participants, addictions were most commonly associated with the consequences of a prescription for pain or injury. The most common setting for injecting was indicated to be crack houses, correctional facilities, the street and house parties. The prevalence of sharing dirty needles was found to be between 25% and 50% and the sharing of injection equipment (spoons, filters, water) as high as 50% with an estimated 75% to 100% prevalence of unsafe sex practices. Additionally it was noted that approximately 25% of the IDU's are involved in the sex trade within their communities creating an avenue for blood borne disease transmission into the general population. A trend toward younger ages for first time injections, including an increasing incidence of injection drug use by young people under the age of 25, was noted by the survey respondents who indicated this age group to be the second most common age of IDU's. Several key respondents said that they perceived youth as less apt to seek services than their older counterparts and exhibiting a "sense of invincibility" legitimizing a need for low-threshold services such as safe injection sites to more aptly include this population group within a continuum of care.

With documented evidence of young people engaging in injection drug use in New Brunswick, there needs to be a concerted effort amongst government organizations, non-profit agencies and the medical community to effectively put into place a comprehensive continuum of care that meets the needs of the local/regional IDU population. To realize this ideal, harm reduction, in all of its forms, must be perceived by the general public, and most importantly by local policy elites who have the authority to promote and implement health based initiatives at the local level, as a legitimate and morally responsible means of effectively dealing with New Brunswick's drug related issues.

Local Initiatives – A Need for Changing Perceptions

Despite movements toward a public health-based approach in drug policy, local harm reduction initiatives continue to be confronted with a variety of sociopolitical barriers to their introduction, implementation and sustainability. AIDS Saint John and the Street Options and Opportunities Program (SOOP) pointed to a variety of such barriers that confront local harm reduction interventions at the provincial and municipal level. The directors of each local initiative provided valuable information from their own experiences with regard to the personal and organizational philosophies and perspectives of government officials, community organizations, local businesses and individual community members regarding low and medium-threshold harm reduction initiatives. Of most concern was the fact that despite the official shifts in Canada's Drug Strategy, which incorporates a range of treatment options from abstinence-based treatment to harm reduction initiatives, it was perceived that there remains a lack of sincere effort on the part of the provincial government to legitimize a philosophical shift in their drug treatment agenda. Critical to the success of the few local services established is federal funding which covers the operational costs of the local needle exchange and outreach centers. At the present time, there exists no provincial funding for specialized client services or for the supplies necessary to maintain a comprehensive and cost effective public health service - even though direct health care is a responsibility of the New Brunswick Department of Health and Wellness.

People working within the local harm reduction initiatives stated that some political leaders displayed a marked ambivalence toward harm reduction in general, and specifically toward those initiatives which continue to be controversial in the minds of their constituents; many who question programs that do not focus on drug abstinence because they appear to condone the use of illicit drug use. The aforementioned sociopolitical barriers appear to emanate from a lack of knowledge by local and provincial political leaders of the empirical data pointing to the success of harm reduction programs. AIDS Saint John and SOOP personnel conveyed that the mindset held by some top-level decision makers is one which continues to view the drug users as "criminal" therefore encouraging a criminal justice-based approach rather than a health-based approach.

Another barrier mentioned by those involved in local harm reduction programs is that most program initiatives have few financial and human resources to incorporate a comprehensive quality assurance or empirical data collection system to document the impact of the services. Most often, local harm reduction initiatives begin out of a necessity for specific services with a lack of financial resources quickly creating overburdened staff when dealing with the multifaceted needs of those who require these specialized services. Obviously, there exists a need for a collaborative and supportive response between all levels of government to create a diverse interconnected system for the delivery of health care services that target drug users at any state of readiness for treatment throughout the province. A collaborative response of this sort could decrease overall expenditures by eliminating overlap but is made difficult by the multiplicity of government and non-government agencies that would be involved.

Each local harm reduction initiative contacted for this research project indicated that, during initial program implementation, there existed a surprisingly positive response from the general public and some

local businesses despite anticipated negative publicity. Public support coupled with volunteer staff comprised of members of a variety of different government organizations and community agencies was suggested as the reason for positive media coverage and post public acceptance of a controversial service. Local community acceptance suggests a general acceptance of the concept of health promotion and harm reduction including those programs that address the needs of more controversial populations such as injection drug users and offenders. Although there exists examples of local support, concerns continue to be held by those individuals who can directly influence the development and implementation of program services for a comprehensive continuum of care. In the initial stages of the implementation of a local methadone clinic, doctors who were able to prescribe methadone were concerned about the potential negative impact of providing this controversial service within their own family practices. Such perceptions indicate a need to educate key decision makers and partners with empirical evidence allowing for the demystification of the negative attitudes associated with drugs and drug users.

The respondents from the local harm reduction initiatives concluded that in order to help overcome the “criminal” stigmatization associated with IDU’s, there should be more of a focus on the notion of “addiction” when discussing harm reduction in initiatives with provincial funding sources and politicians in general. Educating the public and politician with scientifically credible research on the mechanisms of dependence and addiction, and on the pharmacological properties of psychoactive substances, will be crucial in order to dispel myths associated to drug use and misuse. Such educational efforts may be the catalyst for making the provincial government more fiscally responsible in the commitment to implementing and sustaining harm reduction programs at the local level. To achieve a comprehensive harm reduction framework, drug policies must maximize the amount of treatment and harm reduction options available and address all aspects of risk through the collaboration of front-line human resource agents (i.e., law enforcement officials, social and health care workers, etc.) while utilizing existing network of specialists and organizations involved in harm reduction measures.

METHODOLOGY

Research Objectives

The objectives of this research include: (1) to provide background information pertaining to the prohibitionist approach to drug policy in Canada and its influence on attitudes and perceptions of drug use and misuse; (2) to identify the sociopolitical barriers that may stand in the way of the successful implementation, and sustainability, of harm reduction programs in Saint John, New Brunswick; (3) to investigate the attitudes and perceptions of social policy elites in Saint John, New Brunswick toward the development and implementation of a variety of harm reduction initiatives for those individuals who are injecting psychoactive dependence producing drugs. Overall, this paper seeks to verify the existence of a pervasive, yet subtle, prohibitionist attitude and perception toward illicit drug use and treatment initiatives, specifically when concerning young people under the age of 25, despite the general acceptance of harm reduction philosophies in Saint John, New Brunswick.

Key Respondents Sampling

A list of key respondents was generated for the purpose of the project’s sampling strategy. Respondents consisted of top-level administrative personnel of human resource organizations, agencies and institutions which provide funding and support for the implementation and operation of program initiatives (municipal, provincial, federal government departments) and/or are in the position to influence the aforementioned organizations (government structured committees) within Saint John and its surrounding areas. Not included were those non-government organizations (AIDS/HCV service organizations, addiction treatment centres, John Howard/Elizabeth Fry societies) who would request funding to support

program services which may or may not be one or more of the harm reduction initiatives as indicated within the structured survey. The breakdown of the key respondents is provided in Table 1.

Table 1. Phase I Key Respondent Sampling Strategy (N=39)

1. Municipal		2
Saint John City Police Department	Patrol Services	1
	Community Police	1
2. Provincial		29
Dept. of Public Safety	Probation Services	2
	Victim Services	1
	Alternative Measures Committee	3
	Regional Correctional Centre	2
Dept. of Family & Community Services	Social Services	4
	Housing	1
	Training & Employment Development	1
Dept. of Health & Wellness	Mental Health Services	1
	Community Health Centre	1
	Public Health Advisory Committee	1
	Human Development Council	1
Dept. of Education	School District 8	2
	School District 6	3
Member of the Legislative Assembly	Progressive Conservative Party	2
	Liberal Party	1
3. Federal		8
Correctional Services Canada	Parole	6
	Corcan	1
Human Resources & Development Canada	Service Delivery	1
TOTAL		39

The research consists of surveying the attitudes of top-level administrative personnel in a variety of human resource organizations, agencies and institutions on the implementation of harm reduction/minimization initiatives for people who are injecting psychoactive dependence producing drugs. Respondents were asked to complete a six-part questionnaire in face-to-face (13) or telephone interviews (26). Participants were asked to report on their awareness, knowledge, concern and attitudes toward various harm reduction initiatives as they pertain to injection drug users, the community and youth under the age of 25. They were also asked to state their own, and their organization's willingness to support these programs if they were established.

Questionnaire Layout¹

The first part of the questionnaire was designed to determine if the respondent is in favor of a health based approach to Canadian drug policy versus a criminal justice approach, and to determine if the participant exhibits an awareness of various harm reduction initiatives.² For this part of the survey, the respondents were not given any additional information about harm reduction as a concept or about specific harm reduction programs. Question 1 asked the respondents to indicate if they are in favor of a philosophical shift in Canadian drug policy from a criminal justice approach to a health-based approach. Question 2 asks the participants if they are aware of and knowledgeable of harm reduction minimization initiatives and indicate if they are aware of and knowledgeable of specific initiatives within the three -

¹ The survey instrument is attached as an Appendix to this article.

² There exist limitations to the study within the survey design. Asking respondents to indicate if they favor one approach or another does not take into consideration those respondents who may favor both under different circumstances. Respondents did not have a clear definition of what constitutes a difference between an awareness of certain initiatives versus knowledge of the same service. The structure of the four-point scale allows for a respondent to choose between three positive responses to the question yet only one response indicates a negative choice.

threshold categories (high, medium, low). High-threshold initiatives included abstinence based education, detoxification centres and traditional drug treatment programs, medium -threshold initiatives include methadone maintenance therapy and programs which prescribe drugs under strict conditions while low -threshold initiatives included reality-based drug educational and outreach programs, needle exchange and availability programs, law enforcement policies stressing cautioning and safe injection sites.

In the second stage of the survey, those respondents who previously indicated that they were unaware of or not knowledgeable of harm reduction initiatives each received, or was read, a pamphlet defining harm reduction and describing a variety of different harm reduction initiatives so that the respondent could gain accurate knowledge on each of the main survey topics. After being briefed on the harm reduction initiatives, Question 3 asked the respondents to rate the level of importance each initiative is in the reduction of harm to those injecting psychoactive dependence producing drugs and the community in general. These questions were scored using a four-point scale (1 - not important, 2 – a little important, 3 – important, 4- very important). Question 4 asked participants to rate their level of concern, on the same four-point scale, for those individuals who are injecting psychoactive dependence producing drugs. Question 5 asks for the respondents to indicate what they believe to be the level of importance of each initiative in the reduction of harm to those young people under the age of 25 who are injecting psychoactive dependence producing drugs utilizing the same four-point scale. The last section of the survey asked the respondents whether they personally would support various harm reduction initiatives if they were established in Saint John and, additionally, whether they felt their organization would support them.

FINDINGS

The overall results of the survey are presented in Table 3 below:

Table 3: Awareness of and Knowledge of Harm Reduction Initiatives, Level of Importance to Addressing the Harms Associated with IDU, Support for Harm Reduction Initiatives

Harm Reduction Initiatives	Awareness of 67%	Knowledge of 44%	Level of Importance to Addressing Harms Associated with IDU								Personal Support	Org. Support
			IDU's and Wider Community				IDU's Under the Age of 25					
			Not Important	A Little Important	Important	Very Important	Not Important	A Little Important	Important	Very Important		
High-Threshold (HT)												
Abstinence Based Education (Just Say No)	97%	72%		8%	15%	77%	8%	8%	15%	69%	85%	89%
Detoxification Centres	92%	85%			23%	77%	3%		31%	67%	95%	95%
Abstinence-Based Drug Treatment Programs	97%	90%			15%	85%	3%		20%	77%	95%	95%
Avg. of HT programs	95%	82%		3%	17%	80%	4%	3%	22%	71%	92%	93%
Medium-Threshold (MT)												
Methadone Treatment	92%	56%	3%	8%	18%	72%	5%	10%	33%	49%	87%	95%
Prescribing of Drugs (heroin, cocaine)	67%	28%	8%	23%	18%	49%	16%	18%	32%	32%	59%	51%
Avg. of MT programs	80%	42%	6%	16%	18%	60%	11%	14%	33%	41%	73%	73%
Low-Threshold (LT)												
Educational & Outreach Centres	72%	44%	3%	3%	13%	82%		10%	10%	80%	97%	95%
Needle Exchange & Availability	97%	64%	3%	8%	26%	64%	3%	15%	23%	59%	92%	76%
Law Enforcement Policies (Cautioning)	59%	41%	3%	8%	18%	72%	3%	8%	16%	74%	95%	92%
Tolerance Areas (Injection Rooms)	59%	23%	8%	10%	23%	59%	13%	18%	18%	51%	77%	62%
Avg. of LT programs	72%	43%	4%	7%	20%	69%	5%	13%	16%	66%	90%	81%
Overall Total	82%	56%	3%	9%	18%	70%	7%	10%	24%	59%	85%	82%

Among the sample population of 39 participants, 74% of top-level administrative personnel in a variety of human resource organizations, agencies and institutions, in Saint John indicated that they were in favor of a health-based approach to Canadian drug policy. Most respondents stated in the interview that they were unsure of which approach most clearly defined their personal philosophy and indicated that they were not aware of an official shift in Canada's drug treatment strategies. Additionally, 67% of the respondents stated that they were aware of harm reduction/minimization initiatives with 44% indicating that they had a general knowledge of the same. Once asked about their awareness and knowledge of specific harm reduction programs and services, 82% of the respondents indicated an overall awareness of the different harm reduction initiatives, and 56% with a general knowledge of the services. More of the respondents indicated a familiarity with the individual program services versus the meaning of the term harm reduction.

With the harm reduction initiatives classified in the three threshold categories, the majority of respondents indicated that they had an awareness of each of the high-threshold initiatives such as abstinence-based education (97%), detoxification centres (92%) and drug treatment programs (97%). Respondents reported having general knowledge of such programs 72% for abstinence-based education, 85% for detoxification centers, and 90% for drug treatment programs. In the medium-threshold category, the majority of respondents indicated an awareness of methadone treatment programs (92%) and programs which prescribe drugs under strict guidelines (67%) with little over half indicating they had a knowledge of methadone maintenance (56%) and very few with a knowledge of prescription drug programs (28%). In terms of low-threshold programs, 72% indicated an awareness of reality-based educational and outreach centres, 59% indicated an awareness of related law enforcement policies, 59% indicating awareness of safe injection sites and 97% indicating awareness of needle exchange programs. Fewer respondents reported having general knowledge of low threshold programs: 44% for educational and outreach centres, 41% for harm reduction-related law enforcement policies, and only 23% for safe injection sites. However, 64% of participants indicated general knowledge of needle exchange and availability programs that may be attributed to the existence of that service in Saint John. Most respondents indicated during the interview that they would like to have more information on medium and low -threshold programs, including having access to research that identifies successful practices.

In the second stage of the survey, respondents were given or read a brochure that provided specific information on the various harm reduction programs within the three categories (i.e., high, medium and low-threshold), and then asked to indicate what they believe to be the level of importance each initiative has for reducing harms to both those injecting psychoactive dependence producing drugs and the community in general. Most respondents placed a high level of importance on each of the program services such as abstinence-based education (92%), detoxification centres (100%), drug treatment programs (100%), methadone treatment (89%), outreach centres (94%), needle exchanges (89%) and tolerance areas (82%) with programs providing illicit drugs on prescription drug (67%) receiving the least support (67%). Overall, more respondents indicated the importance of high (97%) and low -threshold (89%) programs with medium-threshold services identified as important to 78% of respondents. Some participants elaborated on concerns they have of complications associated to medium-threshold methadone and prescription drug programs such as program participant's use of illicit drugs while participating in the program.

When asked to rate their level of concern for injection drug users most respondents indicated their concern to be very high (79%) with 90% indicating their concern for youth under the age of 25 as very high. Most respondents elaborated on having a high level of concern for youth who are injecting drugs, many of whom worked with or continue to work with this age group.

Respondents were then asked to rate the level of importance of each initiative in the reduction of harms to young people under the age of 25 who are injecting drugs. Most indicated the importance of high-

threshold programs: abstinence based education (84% important or very important), detoxification centres (97% important or very important) and drug treatment programs (97% important or very important). In terms of medium-threshold programs and services, 85% indicated that methadone treatment was important or very important. In the low-threshold category, 90% indicated that outreach centers were important or very important, 82% indicated that needle exchanges were important or very important and 89% indicated that harm reduction related law enforcement policies were important or very important in the reduction of harm to young people. However, fewer placed a high level of importance on the prescription of illicit drugs (64%) and safe injection sites (69%). During the interview, over half of the participants stated that they were unsure of the implications of programs which allow youth to indulge in drug use and related such programs to condoning illicit drug use.

Upon comparison of the results between the perceived level of importance of initiatives in reducing the harms associated with injecting drugs to IDU's and the community in general, and the level of importance to reducing the harms for youth, there were some significant differences in the responses. Fewer respondents rated the high-threshold initiatives as being very important for youth than for IDU's and the community in general, indicating during the interview that they were unsure of the success rate of such services for youth. Specifically, some respondents referred to recent literature on abstinence-based education programs, such as DARE, which indicate a low rate of success. Additionally, approximately 20% of respondents reduced the level of importance of medium-threshold initiatives from very important to important (or not important) when rating young people under the age of 25. As for low-threshold programs, there were no overall differences when rating the level of importance of the initiatives for IDU's and the community versus youth under the age of 25.

In the last part of the survey, respondents were asked if they would personally support various harm reduction initiatives if established in Saint John. Over 85% indicated that they would support each service with the exception of the prescribing of illicit drugs (59%) and safe injections sites (77%). When asked if their organization would support each initiative, over 89% of the respondents indicated yes with the exception of needle exchanges (76%), safe injection sites (62%) and programs which prescribe illicit drugs (51%). Respondents suggested that, although they believed in the need for a full continuum of harm reduction initiatives to meet the needs of drug users at each level of treatment readiness, they were less able to support the more controversial initiatives that may be perceived as condoning illicit drug use.

CONCLUSION

With an emphasis on harm reduction in Canada's renewed Drug Strategy, a philosophical shift is beginning to occur regarding the way in which illicit drug use and treatment measures are perceived. Abstinence-based approaches to drug treatment are beginning to be supplanted by pragmatic, health-based programs and services under the rubric of harm reduction. Harm reduction measures are grounded in the health-based approach to drug control that emphasizes the need to reduce the overall harms associated with illicit drug use, both to the user and to society. However, despite an overwhelming amount of evidence supporting the successes of harm reduction programs and services from around the world, attitudes toward the most innovative aspects of harm reduction, influenced by long standing prohibitionist attitudes, continue to generate some resistance by local and provincial social policy elites. These attitudes act as a barrier to the development and implementation of harm reduction of initiatives at the local level. The ambivalence toward innovative harm reduction programs, like safe injection sites and heroin-assisted treatment, becomes even more pronounced when policies around youth are being considered.

This study first identified that there is a general lack of knowledge on harm reduction initiatives, specifically medium and low-threshold program services, by top-level decision makers within

organizations, agencies and institutions working in the human resource field in Saint John and surrounding areas. Additionally, the study identified that there exists a subtle but pervasive prohibitionist attitude and perception toward illicit drug use and certain harm reduction treatment initiatives, specifically when considering services directed at youth, despite the general acceptance of the harm reduction philosophy.

RECOMMENDATIONS

It is critical that we acknowledge the limitations of the prohibitionist approach to drug control and begin to actively reduce our reliance on programs that discriminate against people who inject drugs, coerce those seeking health care into abstinence-based treatments, and deny essential health care to those who are most in need of it. We must ensure that a comprehensive and well-coordinated provincial drug strategy is created which incorporates a fiscally balanced approach involving law enforcement, prevention services, treatment programs and harm reduction initiatives which are well planned and coordinated with one another. Integral to such a plan will be the shifting of attitudes among social policy elites in Saint John and the surrounding areas who will be tasked with developing and implementing innovative harm reduction services and programs.

A collaborative effort must be made toward a provincial HIV/AIDS strategy in NB to create and implement a working framework that clarifies the roles of the Department of Public Safety, Department of Health and Wellness and other community based organizations (CBO's). Such a clearly defined strategy would include initiatives directed at prevention, education and harm reduction in the community, and within prison populations. We must ensure core funding to enhance the sustainability of the NB CBAO Partnership thereby increasing their opportunity to provide support to persons infected or affected by HIV/AIDS and hepatitis C, to help to lessen medical problems and morbidity associated with IDU, and to initiate prevention programs targeted to reducing the spread of blood borne disease in N.B.

Additionally, we must encourage the use of evidence-based criteria to defuse drug policy debates that are currently wrought with personal opinions and value judgments. The outcomes of programs must be evaluated through performance indicators that are clearly specified and measurable. Particular attention is required to ensure that program initiatives approved for funding are monitored for unintended adverse consequences that might arise from program implementation. Most important, New Brunswick must engage in a public education campaign to eliminate the misconceptions that harm reduction programs condone illicit drug use.

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Harm Reduction Survey

Name _____ Title _____
 Organization _____

1. Please indicate if you favor a health based approach or a criminal justice approach to Canadian Drug Policy. Select only one.

Health Based Approach _____ Criminal Justice Approach _____

2. From the following list please identify those features of the survey that you are aware of by checking either yes or no. If you indicated that you are unaware of Harm Reduction/Minimization Initiatives please ask for the pamphlet which explains the initiatives.

	Awareness of		Knowledge of	
	Yes	No	Yes	No
Harm Reduction/Minimization Initiatives				
INITIATIVES				
High-Threshold (Abstinence Based)				
Abstinence Based Education (Just Say No)				
Detoxification Centres				
Drug Treatment Programs				
Medium-Threshold				
Methadone Treatment				
Prescribing of Drugs (heroin, amphetamines, cocaine etc.)				
Low-Threshold				
Educational & Outreach Centres				
Needle Exchange & Availability				
Law Enforcement Policies (Cautioning & Referrals to Health Agencies)				
Tolerance Areas (Injection Rooms)				

3. After being briefed on the following initiatives please indicate what you believe is the level of importance each initiative is in the reduction of harm to those injecting psychoactive dependence producing drugs and for the community in general

	Importance			
	Not Important	A Little Important	Important	Very Important
High-Threshold				
Abstinence Based Education				
Detoxification Centres				
Drug Treatment Programs				
Medium-Threshold				
Methadone Treatment				
Prescribing of Drugs				
Low-Threshold				
Educational & Outreach Centres				
Needle Exchange & Availability				
Law Enforcement Policies				
Tolerance Areas (Injection Rooms)				

Harm Reduction Survey (cont.)

4. Indicate your level of concern for those individuals who are injecting psychoactive dependence producing drugs.

	Concern			
	Not Important	A Little Important	Important	Very Important
Injection Drug Users				
Injection Drug Users under age 25				

5. Please indicate what you believe is the level of importance each initiative is in the reduction of harm to those young people under the age of 25 who are injecting psychoactive dependence producing drugs.

	Importance			
	Not Important	A Little Important	Important	Very Important
High-Threshold				
Abstinence Based Education				
Detoxification Centres				
Drug Treatment Programs				
Medium-Threshold				
Methadone Treatment				
Prescribing of Drugs				
Low-Threshold				
Educational & Outreach Centres				
Needle Exchange & Availability				
Law Enforcement Policies				
Tolerance Areas (Injection Rooms)				

6. Please indicate, in your opinion, if you or your organization is willing to support harm reduction / minimization initiatives if established in Saint John.

	Initiative Support	
	You would	Your Organization would
High-Threshold		
Abstinence Based Education		
Detoxification Centres		
Drug Treatment Programs		
Medium-Threshold		
Methadone Treatment		
Prescribing of Drugs		
Low-Threshold		
Educational & Outreach Centres		
Needle Exchange & Availability		
Law Enforcement Policies		
Tolerance Areas (Injection Rooms)		

Thank you !

DRUG TREATMENT COURTS IN CANADA: WHO BENEFITS?

Cynthia Kirkby
The John Howard Society of New Brunswick

INTRODUCTION

Drug Treatment Courts (DTC's) are an emerging approach to addressing the drug-crime nexus that are increasing in popularity in Canada. Based on the well-intentioned belief that incarceration does more harm than good for those accused of non-violent, drug-related offences, DTC's seek to divert these individuals away from the punitive correctional system and into mandatory, judicially-supervised drug treatment. By so doing, DTC's are purported to benefit the offender, by providing effective treatment for their drug problem, and society, by increasing public safety through reduced drug use and crime. The purpose of this paper is to critically explore the question: who benefits from drug treatment courts? It begins with a brief overview of DTC's and the structure they have taken in Canada to date. It then critically examines the claim that DTC's are beneficial to both DTC clients and society finding that the benefits to both may be overstated by supporters of DTC's. The paper then examines whether there is an alternative explanation for the increasing popularity of DTC's in Canada. Finally, the paper discusses whether there is a better, less intrusive option for achieving the stated goals of drug treatment courts.

BACKGROUND

A drug treatment court is "a mandated judicial supervision and addiction treatment alternative to incarceration for drug offenders" (Anderson, 2001:469). DTC's are based on the premise that "[j]ail merely provides another venue for drug use and drug dealing" (Bentley, 2001:4), and that drug-related crime cannot be reduced without first addressing underlying addictions. This may be achieved through comprehensive treatment, including helping the client develop life skills, return to school, and/or find "legitimate" employment, stable housing, etc. Without providing these supports, the argument goes, the same individuals will appear repeatedly before the courts for the same drug-related offences, creating a "revolving door" syndrome (Simpson, 2001:1).

In the U.S., where they are often simply referred to as "drug courts," the prevalence of DTC's (now numbering in the hundreds) can be attributed to a sense of fiscal pragmatism, since the spread of mandatory minimum sentences has led to ever-increasing numbers of offenders being incarcerated for relatively minor offences. "Between 1980 and 1996, the U.S. prison population grew from 307 to 868 inmates per 100,000 adult population, an increase of 180%" (Anderson, 2001:470). "Statistics from the U.S. Bureau of Justice show an increase in drug offenders accounted for nearly three-quarters of the growth in prison populations between 1985 and 1995" (James and Sawka, 2000:1). Drug courts relieve some of the effects of prison over-crowding and are believed to be less expensive per offender per year than imprisonment.

These same benefits are often cited in support of the implementation of DTC's in Canada. In fact, the Government of Canada appears to be so impressed with the DTC concept that it has committed to setting up drug courts in every major city in the country (Gardner, 2003a). However, the situation is not as dire in Canada with respect to overcrowded institutions, and DTC evaluations to date are acknowledged to be "limited in scientific rigour" (James and Sawka, 2000:3). There is a lack of consensus even on how to measure the success of DTC's: whether evaluators should use reduced recidivism, abstinence from drugs, or cost-effectiveness as their metric. Anecdotal evidence, supplied by program graduates or DTC judges, is often used to bolster support in the face of concerns over how DTC's negatively affect the rights of

drug users to a fair trial and potential compromises of accepted principles of due process. The next section presents an overview of the two DTC's currently operating in Canada.

Toronto's Drug Treatment Court

The Toronto DTC, established in December of 1998, "...is a court specifically designed to supervise cases of drug dependant offenders who have agreed to accept treatment for their substance abuse" (Bentley, 2001:4). It is also "...an innovative *alternative to* the criminal justice system for people with a recognizable drug addiction who are facing non-violent drug-related offences" (NCPS, no date:1; emphasis added), which seems to place the DTC outside of the criminal justice system entirely. Or, according to a presenter at the First National Drug Treatment Court Workshop, held in Toronto from September 23 through 26, 2001, the focus rests more firmly on the therapeutic aspect of therapeutic jurisprudence: "DTC's are court-directed substance abuse treatment programs" (FNDTCW, 2001:20). These varying definitions capture the dual nature of the DTC, which attempts to strike a balance between criminal justice issues and health.

According to the National Crime Prevention Strategy, the Toronto DTC has "adopted a harm-reduction approach that aims to increase public safety by reducing drug addiction and the crimes committed to support a drug habit" (NCPS, no date:1). While the NCPS does not go on to identify what these crimes could be, additional information on the "harm-reduction" principle of the Toronto DTC is provided in a paper summarizing the Federal Crown Prosecutor's perspective on DTC's:

In the Toronto Drug Treatment Court program, the principles of harm reduction are central to the court and treatment goals and operations. Although total abstinence is the ultimate goal, both treatment and court components recognize that immediate abstinence from drug use is an unrealistic goal. The use of graduated rewards and sanctions by the court reflects harm reduction principles because rewards and sanctions are imposed in response to individual client progress and treatment expectations. The requisite urine screens are used to ensure client compliance and to identify and address client needs in order to help the client realize the goal of decreasing drug related harm. This is accomplished through gradual changes in behavior that will eventually lead to total drug abstinence from cocaine and/or heroin (Luedtke et al., 2000:4-5).

These authors go on to suggest that achieving cost savings is a guiding factor in the operation of the Toronto DTC, as well as "to incorporate the Principles of Restorative Justice:"

Restorative justice principles are reflected by the Toronto Drug Treatment Court as demonstrated by (a) the court's reliance on community support and resources; and (b) the mission to assist offenders to achieve positive changes in their lives. This emphasis reflects the need to create a link between treatment providers and the court in order to address individual client needs. Restorative justice principles have also guided the decision to require regular court attendance by the clients. First, it helps to create structure in their lives and provides them with an opportunity to demonstrate responsibility; secondly, it allows the court to monitor closely client progress and group dynamics; and thirdly, it creates an environment which can foster positive personal growth and reintegration into the greater community. Many clients participating in the DTC form a cohesive social and support group. This group offers incentives to remain drug free and encourages one another to achieve personal treatment goals. The group also serves as a social support in times of relapse. Taken together, these components serve to achieve the goal of client reintegration into the community (Luedtke et al., 2000:5).

Target clientele for the Toronto DTC include "prostitutes, youth, and visible minorities" (Bentley, 2001:7), although others with drug-related offences may be eligible if they meet the additional entrance criteria of being drug-dependent, non-violent, and charged with possession or trafficking in small

quantities of crack/cocaine or heroin. “Those offenders with more serious records or who are charged with trafficking, will be required to plead guilty to the charges as a condition of entering the programme” (Bentley, 2001:7). As well, “[f]urther pre-conditions of entry include the signing of a consent to dispense with Crown disclosure, and an agreement that the imposition of a sentence will be delayed” (Bentley 2001:12).

The Crown counsel acts as “gatekeeper” (Luedtke et al., 2000:7), and there is no avenue for appeal. “While the judge has ultimate decision making power to exclude an individual that the Crown (and treatment providers) deem to be eligible, if the Crown decides to deny an application, that decision can not be reviewed by the judge” (Bentley 2001:17). In this way, it is up to the prosecutor alone, as representative of the state, first to decide whether to proceed with a charge, and then whether to divert that charge out of the criminal justice system. The judge, however, then has the authority to vet applicants, “and what he’s looking for [in a DTC participant], more than anything else, is a desire to change” (Gardner 2003b:5).

Treatment consists of two phases. The first, which takes an estimated eight to fifteen months, “...demands that participants be free of crack/cocaine and/or heroin before completion” (Bentley, 2001:22). It is at the discretion of the DTC whether occasional use of marijuana and/or alcohol will be an impediment to graduation from Phase 1. Methadone is also considered an “effective treatment option that should not [be] excluded simply because it does not fit the model of complete abstinence” (Bentley, 2001:23). This phase is required of both those participants who were required to plead guilty prior to admission, and those who were not (defined as those whose “offence is one [not] ordinarily punishable by more than three months imprisonment”) (Bentley, 2001:9).

The second phase, for those who were required to plead guilty prior to admission to the DTC programme (i.e., those “charged with an offence that would attract a custodial sentence in the range of nine months or less”) (Bentley 2001:10)), consists of an additional six to twelve month probationary period requiring continued substance abuse counselling and appearances at the DTC. An interim evaluation of the Toronto DTC concluded that the majority of “offenders admitted to the drug treatment court are Track II (post-plea) or higher risk offenders, with problems related to cocaine/crack use” (James and Sawka, 2000:6).

According to a National Crime Prevention Strategy (NCPS) evaluation, of the 284 clients referred to the Toronto DTC in its first two years of operation, 234 chose to participate in the program. Of those, 16.7% are ongoing, 13.7% are graduates, and the majority, 67.1%, have been expelled. Finally, “[a]ll DTC team members believed the DTC to be a success and were of the opinion that the DTC program worked as an effective alternative to incarceration,” although “[t]he data does not enable comparison of the performance and outcomes of Drug Treatment Court, nor enable the comparison of the participants with those of non participants who have similar and relevant characteristics (current charges, prior record, drug use)” (NCPS, no date:4).

Vancouver’s Drug Treatment Court

The Vancouver DTC is newer than its Toronto counterpart, and reflects the drug use patterns specific to the city: “Vancouver is a port city with a long time heroin problem. Cocaine and crack injection is slowly displacing heroin. Hard core users are well established in a containment area of about 16 blocks known as Downtown East Side” (FNDTCW, 2001:13).

A recent article in the *Vancouver Sun* provided some details particular to the Vancouver DTC, currently open only to addicted traffickers:

Participants appear before [Provincial Court Judge Jane] Godfrey on Tuesday or Thursday afternoons and attend various aspects of the program five days a week. In exchange for waiving their rights or entering a guilty plea, selected non-violent, small-time traffickers are subjected to a treatment and rehabilitation regimen that includes random urine tests, counselling sessions, out-patient therapy, training and education. ... The program ends when they are free of drugs, working or enrolled in a full-time educational program (Mulgrew, 2003:2).

The minimum amount of time for program completion is one-year for the treatment, plus "a two-year follow-up for most of them" (Mulgrew, 2003:2). Of the 127 participants who had entered the Vancouver program by mid-April 2003 (45 of whom are women), five had successfully completed the program and another six were set to graduate by the end of the month. A total of 43 remained in the program, with 17 "under suspension for not showing up" and the remaining 56 either having dropped out or been discharged (Mulgrew, 2003:2).

WHO BENEFITS?

We have seen that the reasons offered in support of DTC's run the gamut from "improving the quality of life for the addicted offender" (*benefits the client*) to "increases public safety" (*benefits society*). One additional, but largely unacknowledged, idea is that DTC's are may be popular because they serve to reinforce existing criminal justice structures and expand the scope of the professionals involved (*benefits the system*). This section will critically discuss the "benefits" which DTC's, as they are currently administered, are ostensibly providing to the client, society, and the system.

Benefits the Client?

Access to treatment. Even evaluations published by DTC enthusiasts recognize that there is much work to be done before DTC's are able to live up to their seemingly altruistic origins. For example, treatment and support resources are limited, particularly for such unsympathetic populations as drug addicts. Although it is likely that treatment would have more of an impact on a client submitting to it on a *volunteer* basis, it is conceivable that preferential access would be given to the "offender" in order to satisfy judicially imposed conditions. In fact, one recommendation from the First National Drug Treatment Court Workshop supports this hypothesis: "Form partnerships to create ease of access to programs for DTC participants. ... [G]et shelters to give priority access" (FNDTCW, 2001:4).

A general shortfall of treatment programs, as Anderson observes, could unintentionally lead to crime for the express purpose of bypassing the waiting list of voluntary admissions for addicts who are seeking professional assistance. "There is a definite downside if the criminal justice system were to become the preferred gateway to the treatment system. Recent efforts to expand access to the voluntary treatment system could be sabotaged through over-use of the criminal justice system as a mandated point of entry" (Anderson, 2001:473).

Shellie Adley, defence lawyer for the Toronto DTC, has witnessed this phenomenon firsthand:

"We have people in the program right now who, on their own, had tried to connect with treatment and just were not able to do so," says Addley. Too often, the only way for drug addicts to get help is to get arrested. And sometimes even that isn't enough. Addley says that in her work in the regular court system, "I deal with people all the time who tell me, I had a condition on my probation that I had to take this treatment or this counselling but my probation officer couldn't find any place for me to do it" (Gardner, 2003b:6).

The judge of the Toronto DTC is aware of the extent of the shortage of treatment for drug addicts, and that preferential access is often given to his clients. Discussing applicants to the DTC program who are turned away for lack of space, the judge provides the following scenario:

[I]f they've already spent weeks or months in jail awaiting trial, the Crown will often tell them to just stay in jail a little longer and they'll be sentenced to time served – so they would just walk away, free and clear. "And they invariably say no," Judge Bentley says. "They say: 'I've done that. I've done that when I was 18. I've done that when I was 25. I'm now 35. I've lost my kids, I've lost my home. I'm nothing but a junkie. I've got to get treatment and I can't get treatment. I'm willing to wait, judge, for another week or another two weeks until you have a space. I'm sitting in the Don Jail, three to a cell, sleeping on the floor by the toilet, but I'm willing to wait.' I kid you not. We get that every week" (Gardner, 2003b:6-7).

Access to treatment is in such short supply that individuals will remain in jail in miserable conditions for a chance to be enrolled in the DTC. As existing evaluations show, even those involved in the DTC are not guaranteed access to treatment. "Slightly more than half of the participants required a referral to a community service as part of their treatment. Significantly, nearly one-third of those referred to community services were not accepted because of lack of availability of the service or waiting lists. The long-term success of a Drug Treatment Court approach depends on the availability of community supports" (Simpson, 2001:4). No mention is made of what repercussions are involved for the participants who are unable to comply with court orders because of lack of program availability.

The flip side of potential clients engaging in criminal activity in the hopes of accessing treatment is the law criminalizing behaviour purposely to provide treatment. In the US, this is evident in the creation of mental health courts and a homeless courts (Gardner 2003b:2). In BC, a similarly heavy-handed approach was considered to force treatment on addicts:

In British Columbia, sentencing for drug possession and trafficking is lenient compared to Toronto. Very few possession charges end up in court. This means that motivating participation through the threat of prosecution is not possible. ...[O]ne strategy under consideration is to offer a meal a day, as, for most addicts, the available forms of assistance are insufficient to cover food and housing costs. ...There are few treatment resources available in Vancouver and its DTC will build on existing programs where possible; however, funding is being sought to develop a new resource to provide adequate services to DTC clients (FNDCW, 2001:13).

This passage acknowledges that treatment resources are lacking, as are other social supports such as food and housing programs. Rather than seeking to improve resources for those outside the criminal justice system who are already motivated to change, however, the focus for some who support DTC's is on providing adequate services specifically to DTC clients. In fact, one of the recommendations of the National Crime Prevention Strategy DTC evaluation is to expand the program "to include non-drug offences that are drug-related or drug-induced," in order to maximize the number of DTC clients (NCPS, no date:4).

By inducting addicts into the criminal justice system and then offering them services, DTC professionals have an external means of "motivating participation" through the threat of consequences for non-compliance. In this way, too, the criminal justice system may become the "preferred gateway" to services rather than the non-criminalized approach of offering "a meal a day," for example, and then information about (and access to) voluntary treatment when requested.

Finally, there is the question of effectiveness with regard to coerced or mandated treatment: in certain circumstances, treatment providers may become frustrated that they are compelled by court-order to continue treatment when it is clear that the participant is not and will not benefit from the program.

Further, “[a]necdotal evidence suggests individuals mandated to treatment do not become engaged and may be disruptive, uncooperative, and manipulative while participating in a treatment program” (James and Sawka, 2000:7). If treatment is more effective when voluntary, and access to voluntary treatment is already denied because of a lack of resources, then additional resources should be spent on expanding access to voluntary treatment rather than on expanding systems that follow the coerced treatment approach. This is preferential to diverting resources toward implementing and administering DTC’s in order to enforce treatment, given the concern that additional crimes may be committed to gain access, or additional behaviours criminalized to impose and provide access to services. This may also prove counterproductive considering that the additional stigma of being labelled a “criminal” (as well as an addict) can further jeopardize the stabilization of the client.

Cruel and Unusual Punishment? There are several concerns relating to sentencing as carried out under the DTC system. As demonstrated above, one of the factors that determines which phase of the Toronto DTC a participant will enter is the length of the sentence that could be expected should a finding of guilt result. Those entering Phase One are those whose “offence is one [not] ordinarily punishable by more than three months imprisonment” (Bentley 2001:9). However, the treatment takes an estimated eight to fifteen months to complete, or nearly three to five times as long as the sentence that might otherwise have resulted. Those entering Phase Two are often “charged with an offence that would attract a custodial sentence in the range of nine months or less” (Bentley 2001:10). These participants have a six to twelve month probationary period, plus the time spent in Phase One, for a total of fourteen to twenty-seven months in the DTC process.

In Vancouver, although the program is expected to end when participants “are free of drugs, working or enrolled in a full-time educational program” (Mulgrew, 2003),¹ in fact the minimum amount of time for program completion is one-year for the treatment, plus “a two-year follow-up for most of them” (Mulgrew, 2003). Again, the sentences meted out under the DTC can be considerably longer than might have occurred through the normal judicial process, and may even continue indefinitely when completion hinges on abstinence or another major lifestyle change.²

For those entering Phase Two of the Toronto DTC program, a prerequisite is a guilty plea. As well, “[i]f the offender is facing other minor non-drug charges and wishes to enter DTC, he/she will be required to plead guilty to those charges prior to entering the programme” (Bentley, 2001:10). This allows the DTC to use the fear of incarceration as an even more tangible, imminent threat to ensure participants remain in and comply with the program. If certain court-imposed requirements are not met, “[t]hose offenders who have plead guilty as a condition of entering into DTC will be expelled from the program and sentenced. Those offenders who entered DTC prior to plea will be returned to the normal court stream for adjudication” (Bentley, 2001:14).

In Vancouver, “[participants] have 30 days to change their minds, so if they drop out in the first month, the Crown strikes their guilty plea and they go back into regular court” (Mulgrew, 2003). After that thirty-day period, however, the guilty plea will be taken into consideration during the sentencing process. This is particularly problematic if access to voluntary treatment diminishes as a result of the increase in DTC related mandated treatment. If admission to treatment is contingent on pleading guilty, situations

¹ The next line reads: “It’s that, jail, or continuing to live the harrowing existence of an addict,” but it is doubtful that the last option (no intervention) is presented to potential participants instead of jail or mandated treatment.

² Interestingly, the proposed diversion initiative in Washington DC would see defendants placed in treatment for a fixed period of 12 months, which addresses the indefinite sentencing concern. (“Placed in treatment” is vague, but may address the lack of checks and balances of having the judge give and then supervise the sentence.) (www.drugpolicy.org/news/pressroom/pressrelease/pr052203.cfm)

may arise in which an accused pleads guilty solely to access treatment, but would not have been found such by the regular court process. As Anderson summarizes:

If the criminal justice system becomes an expanded point of entry for treatment, there is a danger that these casual users may get caught in a wider enforcement net and end up spending time in jail if they either decline or fail in a mandated treatment program. ... [T]he extent to which these individuals would have been incarcerated prior to implementation of the drug court program is not clear. ... *[T]here is a danger that some individuals who might previously have avoided jail time might now be incarcerated*" (Anderson, 2001:474; emphasis added).

One final concern relates to the use, more specifically the revocation, of bail. "Every offender who enters DTC is released on a bail that is specifically tailored for the programme. These conditions, which include attending all treatment sessions and providing urine samples as required by the Court, are the authority which allows the DTC to impose sanctions for non-compliance with court and treatment requirements" (Bentley, 2001:13). Bentley, goes on to discuss this particular sanction:

Certain members of the defence bar have expressed the concern about the revocation of an offender's bail for short periods (up to five days) for non-compliance with terms of their release. Such judicial action after a very brief hearing is unusual (in our courts) and may at first glance raise "fair trial" issues. We believe that the authority to vacate a previous release order arises from s. 523(2) of the Criminal Code as a consequence of a trial judge's ability, upon cause being shown, to modify the terms of an offender's release. In addition, all DTC participants are advised in writing prior to entering the programme that their bail may be revoked for failure to comply with terms of their release (Bentley, 2001:16).

A footnote to this passage indicates that, prior to consenting, participants receive details of the circumstances under which this might occur; however, given the lack of options provided and the lack of "bargaining power" of the client in this situation, the consent may be informed but hardly freely given. This is of particular concern when the attitude towards the revocation of bail seems to suggest that it is done to benefit the client, as described in the DTC Workshop Proceedings under the section heading "Rewards and Sanctions": "...particular emphasis was placed on not using bail to punish participants, *but to allow them a break from developing chaos* and a chance to re-engage in the program." (FNDTCW, 2001:2; emphasis added). While this may be portrayed as a favour to DTC clients looking for tranquillity, it may even end up being more punitive than having been sentenced to incarceration through the traditional court process: "...by racking up many brief stints in jail -- what some call 'shock incarceration' -- people in drug court can end up spending more time in jail than if they had been sentenced the usual way" (Gardner, 2003b:5).

In these three scenarios, then, the Drug Treatment Court process becomes especially onerous for the client, more so than the punishment could otherwise have been. The participant who succeeds through to graduation may be scrutinized for longer periods of time (and more intensely) than would have been required if sentenced outside the DTC. The participant who is discharged from the program may end up incarcerated on account of the requirement to plead guilty in order to access treatment, when incarceration would not have been the result of a regular court. And, in fact, a participant may end up with both situations, if "shock incarceration" is used throughout the indefinite supervision with such frequency that it exceeds the custodial sentence that may have been otherwise applied.

Effects on Due Process. We have already seen that the DTC participant is required to plead guilty in order to access treatment, and that this can compromise the client's right to a fair trial if they are expelled from the program. There are additional concerns, however, with how DTC programs are administered. Besides being required to plead guilty, the participant is also asked to sign, in the presence of counsel and after receiving legal advice, "a consent that information concerning matters necessary for treatment be

shared between the court and treatment teams" (Bentley, 2001:12). This information is disclosed at DTC team meetings, which are held prior to every sitting of the Court. The team includes the judge, prosecutor, defence lawyer/duty counsel, probation officer and court liaison members (Bentley, 2001). "At pre-court meetings, DTC practitioners discuss the progress of each participant and make recommendations to the judge. The free exchange of information at pre-court meetings allows for the discussion of some confidential information not admissible in open court" (FNDTCW, 2001:18-19).

To clarify the participation and roles of each of these individuals, however, Bentley continues: "[u]nless the judge is considering a revocation of bail or expulsion from the program, defence counsel does not attend court and duty counsel contributes simply as a member of the team" (Bentley, 2001:17). That is, not only is information being shared among team members that would have been confidential otherwise, should the participant be expelled and returned to traditional proceedings, that participant's counsel may not even be aware of the extent of information in circulation about the client.

In addition, the DTC process is supervised by the same judge who was instrumental in instituting the treatment program in the first place. This is ostensibly for the sake of continuity, since "offenders identify with the Judge and develop a personal relationship that is an important component of the dynamic of the DTC" (Bentley, 2001:13). However, this leads to a lack of checks and balances that are recognized as crucial in the traditional criminal justice system, as demonstrated by the division between the courts, sentence administrators (e.g., correctional facilities), and the National Parole Board. This issue not only reflects back on the issue of indefinite sentencing, but the judge may not have adequate training to supervise treatment. A member of the DTC team may be able to advise the judge on what constitutes a success or a failure in a treatment context (where relapse may be acceptable), but the judge may not have "sufficient detachment" to keep from taking "failures" as a personal affront. "One of the risks of a less traditional posture is that boundaries between individuals can become blurred. Social service workers are trained in this as part of their professional education, but a judge is most likely not" (FNDTCW, 2001:8).

The judge may also have difficulty communicating with the client, in "language they understand, which is neither offensive nor condescending and respects them as real human beings" (FNDTCW, 2001:8). The gap between "plain language" and legalese is large, as are the methods of the fields of health and justice and the training and education of their respective employees. For these reasons, the judge may not be the best person to oversee treatment.

One final concern relating to due process revolves around the acknowledgment that DTC's are more onerous and intrusive than other possible sentencing outcomes available to the client:

DTC's employ far greater control over the offender than the probation system. In the regular criminal justice process, an offender may receive a sentence of jail and probation for a drug offence or simply jail. In the latter case, there is no supervision once the offender is released. In those cases where probation is ordered, the amount of supervision received is often minimal and treatment may take weeks or months to arrange. Contrast this to the DTC offenders, who begins treatment often within seventy-two hours of arrest and who is required initially to return twice weekly to court (Bentley, 2001:15).

This intensity of supervision is justified by citing "the reality of life of someone who is drug dependent": "Addicts are not helpless victims of a brain disease. They have options and one of the options is to become motivated to end their addiction. However, for many addicts motivation alone is not sufficient. While ending substance abuse is a matter of personal responsibility, judicial intervention may create the necessary motivation to foster a desire to stop substance abuse" (Bentley, 2001:16). Thus, just as the consensual nature of drug offences is used to authorize expanded police powers in investigating them, the need to "motivate" drug users into abstinence-oriented treatment justifies supervising them more closely.

We will explore this briefly in the context of how "the system" benefits from such an intrusive approach to drugs and drug treatment.

Benefits Society?

We have seen that there is nothing that specifically benefits the client in the Drug Treatment Court process that could not be achieved through increased access to voluntary treatment. An additional explanation used when defending or promoting DTC's is that they benefit society by enhancing public safety and by reducing overall costs associated with dealing with drug offenders.

Reducing social cost is the more credible of the two social justifications, although there are discrepancies as to the extent that DTC's actually accomplish this goal. James and Sawka (2000:6) suggest that the "estimated cost per offender in the Toronto drug court program is \$4,500, compared to almost \$47,000 per offender, per year for incarceration." The Report of the House Special Committee on Non-Medical Use of Drugs, however, suggests that "it costs an estimated \$8000 annually to provide substance abuse treatment to a program participant, as opposed to \$45,000 to incarcerate the same offender for a year." (House, 2002:99). These estimates seem low, however, given the composition of the DTC team (judge, prosecutor, defence lawyer/duty counsel, probation officer and court liaison members) and the frequency with which it meets. As well, no thorough cost-savings analysis has yet been completed of drug treatment courts in Canada, but based on evidence collected in the US, it does appear that cost savings could be a prime motivator for calls to further expand DTC's in Canada. However, when some of the considerations discussed above are taken into account (i.e., incarceration not having been a foregone conclusion, and the possibility that the DTC participant could face additional jail time during or expelled from the program), the cost savings of DTC's may not be as significant as they appear on the surface.

The promotion of public safety is a more difficult issue because it is harder to define. In fact, the Government of Canada doesn't even try; a search of the "Safe Canada" Public Safety website has no formal definition of what the term includes or excludes, although the website provides links to such diverse issues as financial advice, weather advisories, health, and recreational boating. As a concept, "public safety" seems to be elastic enough to cover this broad a range of topics, but, with few exceptions, they are addressed through a non-criminal approach.

The House Committee Report, while generally non-committal on the issue of DTC's (recommending the deferral of policy change or additional investment until a full evaluation is conducted), believes that "participation in drug treatment courts should increase the likelihood of successful interventions with [dependent] offenders. That, in turn, could have far-reaching benefits for society as a whole, in the form of lower health care costs, as well as reduced victimization" (House, 2002:99). The other societal benefit mentioned – lowered health care costs – again places the issue in the realm of health rather than justice, and could be addressed through a variety of voluntary prevention-related programs, taxes or "interventions" similar to those used for addicts of tobacco, alcohol, and other legal drugs and foods.

The criteria for admission into the Toronto DTC offer some clues as to what is meant by Public Safety in this context. Participants can be precluded depending on the circumstances of the offence:

...entry will generally be precluded if the commission of the offence involved a young person under the age of 18 years, or the offence was committed in or near a school, on or near a playground, or at any other place ordinarily frequented by young persons under the age of 18 years. Entry will generally be precluded if the offence involved consumption of a drug in a motor vehicle, or the possession of a drug in open display within the confines of a motor vehicle (Bentley, 2001:9).

By these exceptions, it becomes apparent that an additional severity is attached to offences dealing with minors and motor vehicles – to protect youth, and because vehicles, like weapons, can cause more damage to the public than an individual on drugs on foot. In both of these instances, however, there is no solid, evidence-based reason for why drugs should be dealt with in a manner different than alcohol, at least as far as “public safety” is concerned.

Finally, the Interim Project Evaluation Findings from the National Crime Prevention Strategy explains that the Toronto DTC “aims to increase public safety by reducing drug addiction and the crimes committed to support a drug habit” (NCPS, no date:1) The question again becomes: how drug addiction itself directly threatens public safety? The crimes committed to support a drug habit are a valid concern, but they relate more to the illegality of drugs than to the addiction itself. On this issue, Gardner (2003b:3) writes:

People addicted to alcohol and cigarettes rarely land on this treadmill [of drug abuse, petty crime and punishment] because the drugs they crave are relatively cheap. Not so with illegal drugs, whose cost is vastly inflated because they are criminalized and sold on the black market. Addicts struggle with bills that sometimes total hundreds of dollars a day. Some can cope legitimately. Others are forced to cover the cost with petty property crime or prostitution. Many pay by dealing to other addicts or working for commercial traffickers.

Contrast this with the way we treat alcohol, which is a legal substance but also responsible for huge health care costs:

Alcoholics are never forced into treatment simply for having a bottle in hand. It’s only when their drinking contributes to behaviour that harms others, or risks it, that they are forced to deal with their drinking. Drunk drivers, for example, are often ordered into treatment (and to abstain from drinking). ... If it’s ethical to force a drug addict into treatment simply because he is addicted, even if his behaviour doesn’t harm others, why don’t we force alcoholics into treatment even when their behaviour doesn’t harm others? (Or, for that matter, tobacco smokers?) (Gardner 2003b: 7).

Again, the discrepancy between public policy surrounding illegal drugs and alcohol is telling. Drugs that are addictive but legal are restricted to those who have reached legal age, and are sold in measured and inspected quantities. Extra funds are spent on educational campaigns that advocate moderation, or abstinence for drugs that impair vision or motor control when the user expects to be driving. Far fewer crimes are committed for drugs that are addictive but legal and therefore easy to obtain. These drugs only result in mandatory treatment when there is a risk of harm to others, but resources are made available to diminish the harms to the individual inherent in the drug use (liver damage, lung cancer, etc).

However, one of the criteria used to evaluate the success of DTC’s is abstinence. If the true goal of DTC’s is to increase public safety, the best measure of success would be reduced recidivism as it relates to acquisitive or violent crimes (to support the habit, or as a result of increased aggression for those substances that create that physiological effect) – those crimes for which there is an identifiable victim and therefore a threat to the “public.” Abstinence may be an option that improves individual health and contributes to reduced recidivism, but in and by itself does not increase public safety.

Additionally, if public safety is the goal, then priority funding should be devoted to combating alcohol dependency over prosecuting drug users, since alcohol is statistically more prevalent than illicit drugs at the time of most crimes, particularly those of a violent nature:

Violent crimes were the most common type of offence committed by offenders who consumed alcohol on the day of the crime: there were proportionately more instances of alcohol consumption (without drugs) on the day of the crime among offenders incarcerated for committing

violent crimes, including assault (38%), murder (31%) or sexual assault (30%), than for any other crime. ...Drug use, either exclusively or combined with alcohol consumption, on the day of the crime is more strongly linked to crimes of acquisitiveness. There were proportionately more instances of drug use (either exclusively or combined with alcohol consumption) on the day of the crime among offenders incarcerated for committing theft (47%), robbery (42%) and breaking and entering (36%) than for any other crime (Brochu et al., 2001:3).

Abstinence from illicit drugs, then, is not about public safety or even about health (since needle exchanges and safe injection sites can minimize most of the associated risks), but is imposed as a requirement for graduation from DTC, as we will see later, in the name of a common morality.

Even further off course are such graduation criteria as upgrading the client's education or securing permanent employment: "before the offender will be allowed to end his or her participation in DTC, [p]articipants are also required to demonstrate a fundamental life-style change involving improved interpersonal skill development, stable and appropriate housing, and educational and vocational success. ...[T]hese requirements are necessary to improve the likelihood that the offenders will remain drug and crime free" (Bentley, 2001:24-25).

Again, the judge is undoubtedly well meaning in trying to offer the participant all the tools necessary to lead a crime-free life, but illiteracy, homelessness and unemployment are not criminal matters. Given that it takes a criminal code violation to appear before the DTC, the sole criterion for graduation should therefore be reduced recidivism; i.e., a successful graduate is one who does not reappear before the court, although a pre-determined length of time would need to be established in order to compile statistics.³ Using judicial clout and the participant's fear of revocation of bail as a mechanism to force self-improvement, as defined by the judge, on a captive participant is a heavy-handed and patriarchal approach to "public safety." On this issue, Anderson (2001:473) writes: "The irony . . . is that one of the positive outcomes of expanding access to voluntary treatment is a reduction in crime and therefore reduced involvement with the criminal justice system." (Anderson, 2001:473). Thus, even the "public safety" argument does not give ample justification for the promotion of compulsory treatment via DTC's over voluntary treatment.

We have seen that thorough cost-benefit analyses of DTC's are lacking, and the estimates of cost savings that do exist, vary widely. Also, evaluations on the effectiveness of DTC's are also lacking, although anecdotal support abounds. For the client, and for society, "there is no empirical evidence that drug courts are more or even as effective as voluntary treatment alone" (Anderson 2001:471). So why, then, are DTC's gaining in popularity in Canada?

Benefits the System?

One theory that could be used to explain support for DTC's in Canada is the popularity factor: "The fact that there are so many DTC's already established in the U.S., and many more under development, means there must be something to the idea." However, those familiar with the criminal justice system in the US must question whether or not Canada wants to emulate a system that has almost half a million people "locked up for violating a drug law (more than all of Western Europe locks up for anything)" (Nadelmann, 2003).

³ According to one evaluation, [a]s of December 31, 1999, 56 percent of those who had entered the program were still participating; nearly three-quarters of these people had not re-offended. Most of those who did re-offend committed drug offences or administration of justice offences" (Caledon, 2001:4). If addictions were left to the health department rather than the justice system, the majority of "new offences" would not have been considered offences at all.

Another theory explaining the expansion of DTC's in Canada develops from examining how it serves the criminal justice system and those that work in it. The National Crime Prevention Strategy's proposed "indicators of success" for the Toronto DTC include "reduction in substance use and criminal activity; client acceptance of personal responsibility for behaviours and situations; improved health; improved social functioning; and clients' willingness to address their substance use" (NCPS, no date:2). It is interesting to note that recidivism is only half of one of five indicators, regardless of the fact that it is the only factor traditionally under the jurisdiction of the criminal justice system. What is evident from this list is that DTC's greatly expand the range of influence of the people and systems involved in administering the drug court process beyond their traditional boundaries.

DTC's, as all involved will admit, broaden the purview of the court from the merely judicial remaking it into something called "therapeutic jurisprudence." When requirements such as those listed in the above paragraph are implemented – participants cannot graduate until appropriate housing is secured, educational and vocational success accomplished – the jurisdiction of the court expands greatly. As Toronto DTC Judge Bentley acknowledges: "The DTC model represents a radical departure from the traditional role of a judge. In DTC, the judge becomes an active player, engaging in personal and direct dialogue with each drug court participant. Working proactively with a team that includes probation officers, drug treatment specialists, and other community service providers demands skills of collaboration and cooperation in addition to the repertoire of traditional judicial competencies" (Bentley, 2001:17).

When you combine the expansion of control/power that judges experience with the lowering of personal frustration they experience in viewing the "revolving door" syndrome at close hand, DTC's begin to come across as a tool for increasing the job satisfaction of the professionals involved in their administration rather than as an effective way to deal with drug addiction. In the words of Prosecutor Kofi Barnes, describing how he became involved in the Toronto DTC, "I was particularly interested in working on such a novel project as it was the change I was looking for" (Luedtke et al., 2000:7). Luedtke et al. go on to identify their frustration at the resources being spent on "prosecuting street level addict traffickers, who were trafficking small amounts of illicit drugs primarily to support their own habits. ... I would see the same addicts back before the courts time and time again for the same offences, usually committed at the same street corners, and each time their period of time in custody was increased" (Luedtke 2000:7). To him, drug court "was an opportunity to try something new, innovative and, hopefully, more effective for drug addicted offenders" (Luedtke et al., 2000:7). Given the dearth of evidence as to their overall effectiveness, however, it cannot be overlooked that DTC's, in practice, have simultaneously served to increase the job satisfaction of the professionals involved while lessening their frustration, allowing them to learn new skills while remaining in a familiar field, and, according to them, greater discretion outside of the "fair trial" confines of the traditional adjudication process.

DTC's also represent a fairly conservative step in drug policy reform. The Special Committee on Non-Medical Use of Drugs recognizes the nature of addiction, and recommends reviewing the laws, but for the purpose of investigating alternative sentencing options, not to investigate the sensibility of the laws themselves:

[Despite the practical and ethical questions], we agree that the courts are in need of more and better options for dealing with repeat offenders whose involvement with the criminal justice system comes as a result of their dependence on illicit substances, particularly where drug treatment courts are not available. For that reason, the Committee would like to see a review of the *Controlled Drugs and Substances Act* and the *Criminal Code*, to determine whether it is possible to provide sentencing courts with more creative alternatives to fines and incarceration, in appropriate cases, that would address more effectively the underlying causes of criminality" (House 2002:100).

One has to question why the House Committee falls short of calling for a complete review of the prohibitive approach to drug control. Perhaps it is because sentencing alternatives and DTC's are less threatening to the established order than calling into question the criminal designation of illicit drugs and the enforcement dominated approach to drug control that has become so established in Canadian society.

[Supporters] see drugs courts as an effective new way of dealing with the old problem of drug addiction. For them, drug courts are a promising merger of the criminal justice system with the healing arts and social services. In law schools and courtrooms across North America, a new school of legal theory called "therapeutic jurisprudence" has sprung up over the past decade, promoting the idea that a primary goal of the law should be to promote psychological well-being (Gardner 2003b:2).

DTC proponents feel justified in using the full weight of the criminal justice system to "heal" these individuals, rather than simply releasing them to the care of health professionals. In the words of Judge Bentley: "These courts can provide necessary drug treatment to a portion of society that is the most in need of treatment and yet the least likely to receive it. The combination of judicial supervision and immediate and intensive drug treatment offers the best hope for many drug addicts to achieve a sustained reduction and an eventual elimination of their drug habit." (Bentley 2001:25-26)⁴

But why can these individuals not access treatment prior to becoming involved with the DTC? The answer is because treatment resources are scarce. As discussed above, even DTC participants sometimes have a hard time accessing treatment: "Weaknesses [identified] focused on factors that are mainly outside of the DTC's program control such as: lack of residential treatment services; services for specific populations (i.e. women, youth); shortage of community supports; lack of immediate access to treatment; and lack of housing." (NCPS, no date:2).

Given the lack of proven effectiveness of DTC's, why divert resources toward them that could be directed at voluntary treatment programs outside the criminal justice system? This would also free up the court's time for more pressing matters, such as offences that had caused harm to others. Treatment is preferable to punishment for drug offences, but DTC's keep those involved from questioning why public policy on drug use makes it an offence in the first place. In the opinion of this author, the greatest long-term danger of further expansion of drug courts in Canada is that it will allow us to put off a critical analysis of our current prohibitionist approach to drug control.

DRUG TREATMENT COURTS AND THEORIES OF PUBLIC POLICY

Many of the harms associated with illicit drugs arise from the fact that the drugs are illegal. Prohibition failed as a policy for alcohol, and now measures are in place to regulate the potency and purity, minimize the harms (from addiction and from drunk driving), prevent minors from imbibing, and even for the government to generate revenue from the sale of alcohol. Similar guidelines are in place for tobacco, which is heavily taxed and comes with graphic warnings about the damage that cigarettes do to the user. Why, then, are some drugs criminalized while alcohol and tobacco are simply regulated? In thinking about this issue, it is useful to consider the following passage:

A public policy is an articulation by the government or its institutions of a set of guiding principles for consistent action in a given area. ... Recurrent use of criminal law to maintain a policy is considered to signify a failure of its content, an absence of consensus among those affected by the

⁴ Bentley continues: "study after study has demonstrated that the longer an individual remains in treatment the greater the probability that he or she will abstain from drug use." This presumably is the justification for retaining participants in the program long after they would have been released from custody for the same offence.

policy, or a lack of sufficient government support to ensure its implementation. To view criminal law as a component of a policy and not an exceptional measure amounts to accepting the legitimacy of violence as a fundamental aspect of the government's role and a means of forcing the public to comply with its decisions (Beauchesne, 2000:2).

Beauchesne goes on to describes three different philosophical approaches to public policy.

Legal Moralism (imposing the values of specific groups through force of law):

the government has not only the responsibility to use its public policies to be a guardian of public order and protector of non-independent persons, *but also the responsibility to maintain a common morality within society*. The government may therefore have recourse to criminal law in response to behaviour that threatens the "established morality", regardless of the dangers such behaviour presents for the individual or society (Beauchesne, 2000:3).

Legal Paternalism (mandatory protection under threat of criminal sanction):

the government, in addition to being the guardian of public order, *has a paternalistic function that allows it to use certain forms of legal constraint to prevent non-independent persons from harming themselves*. ... This position, common in countries where the Catholic culture dominates, opened the door to medical control over drug use in the name of public health protection, assuming that the experts have the necessary knowledge to protect individuals who do not know better (Beauchesne, 2000:4-5).

Legal Liberalism (humanism, social responsibility and respect for citizens):

the government, as a guardian of public order, must restrict its actions to those areas that disturb the public peace in general, such as road safety, and limit its actions so as to preserve civil rights to the greatest extent possible. ... From this standpoint, the fact that many people find certain methods of drug use morally suspect does not make it legitimate for the government to regulate them by prohibition, unless such use constitutes in itself a threat to others (Beauchesne, 2000:10).

Legal moralism is difficult to justify as a basis for legitimate policy, since it can necessarily only reflect the morality of a segment of society – those empowered to develop binding legislation. In addition, moral standards evolve over time, as we have seen with alcohol prohibition, so that what is considered immoral is constantly under revision, and therefore harder to codify. In regard to drug policy, given that nearly a quarter of Canadians admitted to having used (currently) illegal drugs at least once in their lifetime (Beauchesne, 2000:6), the dissenting minority would be fairly large in opposition to the criminalization of certain drugs over others.⁵

The philosophy of legal moralism is evident in the criteria for graduation of the DTC, where the client must demonstrate to the judge satisfactory progress, as defined by the judge. This means abstinence, the procurement of stable housing, demonstrated educational and vocational success, etc. Basically, the participant is required to reflect the morality and values of the judge before being released from supervision.

Legal paternalism is also problematic, since the definition of a "non-independent person" has historically fluctuated to enable control of certain marginalized segments of the population (the working class, aboriginals, homosexuals, women). In this way it resembles legal moralism, since there is always a group

⁵ The government's own polls show that 80% of Canadians support the distribution of cannabis for medical purposes and around 70% support the decriminalization of personal possession. Why then do we still have laws criminalizing the use of cannabis even though a large majority of citizens do not feel they are justified?

that will have no say in the law - and that is the group most affected by the legislation, the group the law is constructed “to protect.” Legal paternalism does not, however, address why prohibition and criminal sanctions are viewed as a more appropriate method of “protection” than education and other resources – protections that would enable to person to become more independent over time.

The legal paternalism philosophy is evident in the DTC’s targeting of youth, prostitutes, and visible minorities – those deemed most in need of protection. Again, however, this “protection” is only offered with judicial supervision, not through policies that could circumvent the criminal justice system such as referrals to truly voluntary treatment programs.

Contrast these approaches with that of legal liberalism:

In legal liberalism, the government maintains its responsibility for management of public order by providing the safest possible environment for its citizens, as well as ensuring the social conditions most conducive to each individual’s development; however, its preferred style of management preserves individual rights and liberties to the maximum extent possible. In other words, when it comes to drugs, the government is responsible for ensuring the safest possible context for drug use and for establishing the conditions needed to minimize any harmful effects of such use (Beauchesne, 2000:10).

In practice, legal liberalism does not translate into policies designed to impose a common morality (prohibition), or policies that in effect remove any semblance of personal choice (as DTC’s do). Legal liberalism is first and foremost an acknowledgment of the autonomy of the individual and the onus is on the government to create rules that reduce the harms associated with the individual’s decision to consume drugs.⁶ As mentioned earlier, DTC’s professes to incorporate harm reduction principles in the pursuit of abstinence, but Beauchesne has a different explanation on what this would look like:

The harm reduction approach to drugs has two components: reducing high-risk use and reducing the negative consequences associated with problem use. Reducing high-risk use may involve efforts to decrease demand for the product itself if any use of that product is high-risk (as in the case of tobacco), or may involve discouraging high-risk or methods of use that are risky (such as drinking and driving). With respect to reducing the negative consequences of problem use, intervention may involve decreasing the problems associated with such use (for example, teaching abstinence or controlled drinking) or decreasing the environmental conditions that increase problem use (for example, through public policies that ensure a safe market) (Beauchesne, 2000:10-11).

Drafting drug policies based on legal liberalism would present a radical change to the existing structures. As explained by Senator Pierre Claude Nolin, Chairperson of the Canadian Senate Select Committee on Illegal Drugs, “[a]utonomy is an ethical principle of our society. It is the role of the state to promote responsible autonomy. The penal law should not be involved unless a behaviour causes significant damage to others” (DRCNet, 2003b:1).

However, to date, there have been large, systemic pressures in place to maintain prohibition, encompassing both the legal moralistic and paternalistic philosophies: “Prohibition protects conservative moral values, said Nolin, ‘and beyond the declared official rationale for these laws, other factors such as racism, prejudice and myths, the development of the pharmaceuticals industry, and the machinery of an enormous nationwide government bureaucracy to enforce

⁶ The Senate Special Committee on Illegal Drugs Report on Cannabis provides a good example of the legal liberalism approach to drug control by stating plainly: “The goal of governance is freedom, not control” (Senate, 2002:11).

restrictive criminal laws for illegal substances, are what underpin prohibition” (DRCNet, 2003a:2).

But, as we have seen, the best interests of the individual and of society may be better served through means other than prohibition and the resulting criminal justice processes, even when they are steeped in the rhetoric of “holistic justice.”

CONCLUSION

Drug Treatment Courts are based on solid principles, notably that punishment is not a solution to the “revolving door” syndrome involved with upholding drug laws. They espouse that treatment is preferable to incarceration for this population, since dealing with the addiction may lessen the client’s future involvement in crime. However, because of how DTC’s are administered, they represent a step backward in many ways.

DTC’s compromise the rights and liberties of the individual beyond that of the traditional judicial process, through additional intrusiveness, the abandonment of key aspects of due process, and what can amount to an indefinite sentence. They are not proven to be more beneficial to the client, or to society, than expanded access to voluntary treatment, which in itself can reduce criminal behaviour and therefore the necessity for induction into the criminal justice system. Treatment resources are scarce, and DTC’s encourage addicts to adopt the additional label of “criminal” in order to get priority access to the help they seek.

The main impetus behind the proliferation of DTC’s may be to retain existing systemic structures, while providing respite to the professionals involved. This allows them the opportunity to break from routine and try something new. DTC’s distract policy-makers from having to analyze the reasoning behind prohibitive drug laws by seeming to acknowledge that drug addiction is a health issue, but in reality, they broaden the scope of criminal behaviours and punishments rather than diverting addicts from the criminal justice system altogether.

Cost-effectiveness is offered as another benefit to DTC’s, but that is as compared to incarceration, which is not a foregone conclusion for the client, and may in fact be more likely a consequence for the majority of participants who end up expelled. As well, it does not address the vast resources devoted to investigating and prosecuting drug offences in the first place, which could be reallocated to education and treatment programs if legal liberalism provided the foundation for revised drug laws. This, as the models for alcohol and tobacco have shown, could even provide revenue in the form of taxes, while reducing the harms caused by the unregulated, circumspect nature of illicit drug use.

Drug Treatment Courts do not, in practice, benefit the client or society to the extent that they claim. It seems unjustifiable to further pursue this intrusive and heavy-handed option to deal with drug addiction in Canada when regulated legalization and education would provide all the benefits claimed by DTC’s and more. In addition, this would respect the autonomy of the individual to make informed decisions about what is often a victimless crime.

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CHALLENGES IN THE MANAGEMENT OF MENTALLY DISTURBED OFFENDERS ON PSYCHOTROPIC MEDICATION

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INTRODUCTION

Studies have estimated that nearly one in five Canadian adults will personally experience a mental illness during any given year (Health Canada, 2002:17). Between 1997 and 2002, the number of persons admitted to the Canadian federal correctional system with a mental condition increased significantly. Of 12,450 individuals assessed at intake to a federal institution in Canada in 2002, 20% had been previously hospitalized in a mental health facility, 11% had a current psychiatric diagnosis, and 18% had been prescribed medication to treat a mental illness (Boe, et al., 2003). Some researchers in the United States link increases in the number of mentally ill in the criminal justice system to the de-institutionalization of mental health services, which has occurred in both the US and Canada. Through the use of case studies, this paper will review the experiences of three individuals with mental illnesses who have come into contact with the Canadian federal correctional system. The purpose of this paper is to raise awareness regarding the experiences of the mentally ill in the federal correctional system in Canada.

BACKGROUND: CORRECTIONS AND MENTAL HEALTH IN CANADA

Over the last forty years, the delivery of Canada's mental health services has undergone a process of de-institutionalization (Milstone, 1995:9). De-institutionalization began with the exclusion of provincial psychiatric hospitals from the federal-provincial hospital insurance program in 1958 (Health Canada, 1994:5). This policy was initially designed to transfer treatment for people with chronic mental disorders from inpatient psychiatric institutions to community-based facilities emphasizing outpatient care (Health Canada, 2002:1). The policy of de-institutionalization was supposed to include a redistribution of funds to the community mental health sector, but this transfer did not occur as expected. Community mental health programs, now tasked with the assessment, treatment, rehabilitation, and accommodation of the mentally ill in Canada, only receive a small proportion of funding that was available to provincial mental health institutions under the previous system (Health Canada, 2002).

With a lack of adequate services available in the community, the mentally ill in Canada are left vulnerable. Forty years after de-institutionalization, people with mental illnesses are being funnelled through the over-taxed community health care system with the eventual placement of many in the correctional system. Studies of people with mental illnesses in the American criminal justice system reveal the increase in criminal justice involvement by individuals with serious mental illnesses between 1975 and 1985 mirrors the overall increase in incarceration during this period (Bazelon Centre for Mental Health Law, 2002). While community mental health agencies are overworked and under resourced, the number of offenders with mental illness who have special needs (i.e., medication maintenance) are increasing and most will eventually be released to the community. Both Canada and the United States rely on community mental health organizations to provide support for persons with mental illnesses, yet neither country provides adequate support for this sector (Bazelon Centre for Mental Health Law, 2002).

We do not have a good understanding of what the specific impact de-institutionalization has had on the criminal justice system in Canada. The lack of understanding is in large part due to a paucity of research on the relationship between mental illness and the criminal justice system. Despite the lack of empirical

data, the issue of the mentally ill being criminalized is being documented by anecdotal evidence. Health Canada reports that:

...the frequency of contact of the mentally ill with the legal and criminal justice systems in Canada has been increasing over the past decade due in part to the increasing numbers of homeless persons. According to the Canadian council on Social Development, nationwide statistics on homelessness are elusive, ranging from tens of hundreds to thousands. Nonetheless, it has been estimated that between 20-30% of the homeless in Canada are mentally ill and in need of treatment (Milstone, 1995:14).

Recently, the Federal Department of Justice has been criticized for their data collecting practices and subsequent lack of information on the conviction rates of the mentally ill.¹ In response, a Special Study on Mentally Disordered Accused and the Criminal Justice System was recently conducted by Statistics Canada (Statistics Canada, 2003). This study provides background information on possible data collection initiatives and future research initiatives on the interplay between the health and justice systems. The implementation of the recommendations of this study and attention to identified research gaps will be one important step towards a better understanding of the relationship between mental health and justice in Canada.

Empirical evidence documents that there have been an increase in the prevalence of mentally ill individuals in the criminal justice system since the implementation of the policy of de-institutionalization and the manifestation of inadequacies in community support for the mentally ill. While not all persons who are mentally ill become criminals, it is appropriate to question the response by the Canadian government to an individual with complex mental health needs. Is reliance on the criminal justice system a proper response to these situations, or should other options be explored? The following section will introduce case studies of several individuals with varying psychiatric problems and detail their experience with the criminal and mental health systems in Canada.

CASE STUDIES: THE PEOPLE WITHIN AND BETWEEN

For the purposes of this paper, mental illness is defined as alterations in thinking, mood or behaviour (or some combination thereof) bringing significant distress and impaired functioning over an extended period of time (Health Canada, 2002). There are many myths associated with mental illness and, unfortunately, there is little public understanding of the realities of living with a mental illness. The effect of a mental illness on an individual's quality of life can vary from mild to severe. As demonstrated by the case studies presented below, issues such as proper medical care, appropriate medication levels, employment, housing and supportive relationships all influence how an individual copes with a mental illness. Regardless of which mental disorder a person has, it is clear that all individuals with these afflictions need a supportive network and access to needed resources.

The following cases studies relate the experiences of three individuals involved in both the correctional and mental health systems in Canada. Through the detailed examination of personal case histories, we can develop an understanding of the complexities facing mentally ill individuals who have come into conflict with the law.

¹ In the 14th Report of the Standing Committee on Justice and Human Rights, Review of the Mental Disorder Provisions of the Criminal Code, the committee recommended that the Department of Justice and other relevant departments and agencies, in collaboration with their provincial and territorial counterparts, collect process and analyse the data necessary to facilitate a further parliamentary review of Part XX.1 of the Criminal code in 2007.

Case One: Mary

Mary² is a 31 year-old woman diagnosed with paranoid schizophrenia and is mildly developmentally delayed. Mary who is from a rural community, has 70 prior convictions. Her prior charges include: arson, multiple assaults (including a assaulting a police officer), parole violations, and fraud. She has difficulty coping with stress and completing simple tasks such as paying bills. She has no interest in programming and she cycles between mental hospitals and prisons. Over the last 14 years, she has spent an average of 48 days per year in the hospital. Mary's condition is treated with medication but she has to be reminded to take her prescriptions. Mary was charged with and served time for arson after she burned down the house of the only person who would rent to her. The individual lost everything and insurance did not cover the costs. Across the country, halfway houses and landlords find it difficult to secure housing and liability insurance for such high-risk tenants. When Mary was released from prison three years ago, there was no pre-planning completed. She was released and after two weeks of a supervised stay in a motel, a "friend of a friend" put social services in touch with the community agency that currently works with her. The program is an innovative wrap-around service offered primarily for federal offenders. The project works with women for an indefinite amount of time. Potential clients are assessed and given one on one support for however many hours per day is needed. The goal is to reduce the hours of support needed per day and work towards independent living. Mary began the program in 2000 with an assessment of 24 hours support required each day. Three years later, support workers are only needed for 13 hrs per day, from 7pm to 8am each morning. Because Mary has a history of arson, it is extremely difficult to secure housing for her. When Mary feels 'good' or if she is bothered by the side effects of her medication, she often tries to go off her meds. Because of the trusting relationship she has with the support workers, Mary admits to them when she has altered her medication regime. Support staff have discussed the implications of Mary neglecting her meds with her and for the last three years she has remained stable. Mary is well liked by the support staff and is described as a kind and funny women. Due to Mary's violent past with her family, her visits with them for the first two years were supervised by a support worker, now she has a close relationship with her family with unsupervised visitation. She finds it difficult to maintain a committed relationship with a partner. Mary visits a psychiatrist every three months. If she has a problem with her medication, she has to go to the emergency of the local hospital to receive treatment as it is difficult to get an appointment with her psychiatrist. Mary is currently classified as "stable." Mary's successful reintegration is measured in the reduction of support hours needed, the shift towards a positive relationship with her family, and her ability to talk to people when she feels a "shift" in her behaviour or attitude.

Case Two: Michael

Michael is a 28 year old male. He was charged with property related crimes and trafficking of cannabis. This was his first federal sentence. He is a construction worker by trade. He has supportive relationships with some family members. Because of his offence classification, he was not required to have a psychiatric assessment at intake to prison. Michael has 31 priors for mostly property and weapons offences, wilfully setting on fire, etc. He was assessed as having a 33% chance of re-fending. Michael was released on full parole after serving nine months of his sentence. He entered an all male halfway house with various prescriptions for anxiety disorder, depression and an inability to deal with crowds. While CSC does not recognize him as having a "mental illness" he was seeing a psychiatrist and he was on mood altering medication at the time of his release. He was paroled with only two conditions: abstain from drugs and desist

² The names of the individuals have been changed for privacy reasons.

associating with certain persons (criminal associates). There was no full psychiatric report conducted (to the house's knowledge) and his medical file was not transferred to a local community doctor. After release Michael stopped taking the medication that had been prescribed to him while he was in prison. In the community, his behaviour began to change. Because taking medication was not a condition of his parole he could not be forced to have a psychiatric assessment and he did not have proper monitoring (blood tests) of his medication levels. Michael's new family doctor prescribed him a sleep disorder medication to address his restlessness. The medication takes 3-4 days to take effect and in the interim the patient experiences increased restlessness. Michael did not like this feeling and stopped taking the sleep disorder medication before the four days were complete. Without a release form, the house could not speak to the family doctor. Michael was seeing a psychologist, but refused to agree to a treatment plan. He had no prior hospitalizations. Angry outbursts were instigated over seemingly simple things such as the house not having his favourite salad dressing. Eventually, his parole was suspended for "deteriorating behaviour." The house anticipates Michael will be re-released at his recalculated statutory release date, December 2003. This time the house will only accept Michael if a condition of parole for compliance to medication and treatment for his mental illnesses is imposed. During Michael's intake assessment he was found to have personal, behavioural and emotional issues. The house felt that during his time in the community, Michael's mental health needs were not officially recognized by Corrections Service Canada and subsequently were not properly addressed.

Case Three: George

George is in his late fifties and has spent much of his life in and out of mental institutions and prison. He is diagnosed as being bi-polar, developmentally delayed with impulse control disorder and depression. He takes lithium to control his conditions. His parole officer described him as a kind, friendly man with a very frank personality. George is a convicted sex offender. When George's lithium levels are not stable he sexually assaults children. He is severely mentally delayed and while liked by correctional staff, he can be difficult to work with and treat. Until his recent release, George has spent the last 10 years in Dorchester penitentiary. He was released on statutory release with residency and a long-term supervision order. To prepare for his release, the parole officer assigned to George began working with him two years before his statutory release date. George was released to a Community Correctional Centre (CCC) because no Community Residential Facility (CRF) would take George as a resident because of his special needs and high risk. During his time in the CCC, George met several times a week with his parole officer. The officer recognized the many challenges George faced and used creative ways to assist George in his reintegration. For example, as an incentive the officer would put stickers on a calendar in the parole office to mark each day George was in the community. George missed his 'family' at the prison and the parole officer arranged weekly calls for George with the guards at the prison. Eight weeks into his release George was involved in an incident at the CCC. While sitting in the living room one evening he urinated on himself. Other residents of the house were incensed and disgusted by his action. Irritated by their angry reaction to him, George broke a window at the CCC with his fist. Because of this violent outburst, George's parole was revoked and he was sent back to Dorchester. George has since been returned to the Community Correctional Centre.

The next section will review key challenges in the management of mentally ill individuals in the criminal justice system using the three case studies.

CORRECTIONAL AND MENTAL HEALTH SYSTEMS: IMPACT AND ISSUES

While the number of new admissions to federal prisons decreased from 1997-2001, the number of admissions with a mental disorder diagnosis at intake increased by 37% (Boe, et al., 2003).³ Explanations given by Arboleda-Flórez, et al. (1996: iX) for the high prevalence of mental illness among incarcerated offenders include the criminalization of mentally disordered behaviour, the psychiatrization of criminal behaviour, and the pathogenic nature of incarcerated environments. These issues are highlighted by the cases of Mary and George, who both have spent long periods of time in and out of both mental institutions and the correctional system.

Parole

The National Parole Board of Canada disproportionately releases mentally disordered offenders on statutory release as opposed to day or full parole (Porporino and Motiuk, 1993:17). Once released, mentally disordered offenders are more likely to receive suspension warrants or have their release revoked without committing a new offence. The majority of revocations issued were for failing to abide by supervision conditions. Comparatively, offenders without mental disorders were more likely to commit a new offence while on conditional release (Porporino and Motiuk, 1993:19). There is no clear understanding of what types of supervision conditions are violated and if there is a pattern for these violations or if they are linked to set backs in the individuals mental illness.

While on parole it is important that mentally ill offenders receive support for their conditions. Proper health care (i.e., medication maintenance) and support for mentally ill offenders reintegrating into the community are imperative as demonstrated by the case studies. In order to be successfully reintegrated into society, mentally disordered individuals need to have supportive environments that can respond to their high levels of need (Stella Burry Corporation, 2000). The Auditor General (2003) has criticized the Correctional Service of Canada (CSC) for issues related to the reintegration of female offenders, including those who are mentally disordered. The Auditor General states:

There is an increase in the proportion of offenders returned to the institutions for revocations without re-offence. Of all women offenders' parole revocations in 2001-02, 75 percent were for technical violations (compared with 64 percent among male offenders). This high percentage of technical violations exists despite the fact that women offenders are generally co-operative and receptive to assistance by parole officers. The return of offenders to institutions due to revocations has an impact on both the Service's operational activities and its use of resources (Auditor General, 2003).

CSC responded to the Auditor General's report by asserting that any suspensions for parole are based on their mandate to contribute to public safety. CSC assured the Auditor General that it monitors revocations to better understand the issues affecting women's potential for safe reintegration (Auditor General, 2003). While public safety is of paramount concern, if an offender's mental illness can be appropriately treated in the community, the principle of least necessary restriction means that the offender should remain in the community. While many parole officers do the best they can when attempting to manage mentally ill offenders in the community, they are often handicapped by limited resources and insufficient training. A parole officer interviewed by this author discussed problems obtaining access to qualified psychiatrists as a major problem for mentally disordered offenders attempting to reintegrate into the community. As discussed above, any individual who is on medication for a mental health disorder needs timely supervision by a psychiatrist in order to ensure dosage levels are adequate and medication

³ Admissions into federal custody decreased from 4,590 to 4,298 while the number of mental disorder diagnosis increased from 265 to 355 cases.

regimes are followed correctly. The Auditor General (2003) emphasized the importance of community mental health services and observed that many community services will turn away offenders who have psychiatric problems and criminal records.

Simply because an offender has a mental disorder that is being treated with medication should not affect their ability to be released in a timely manner, nor should it prevent them access to community reintegration supports or access to community mental health programs. Empirical evidence published by CSC shows that people with mental disorders commit fewer offences when released on parole in comparison to offenders without mental disorders. A critical analysis of the literature reveals that there is *no compelling scientific evidence* to suggest that mental illness *causes* violence (Health Canada, 1994: X). However, the “mentally ill” label significantly influences the manner in which such offenders are treated by the criminal justice system in Canada (Skinner, et al., 1995:3). When you add the label “ex-con” to the equation, you have a powerful combination of stereotypes that work to conceptually connect mental disorders to violence and crime. Furthermore, the negative stereotyping that occurs with people who have mental illnesses that can never be cured, only treated, perpetuates the recycling of mentally disordered individuals through the criminal justice system. The reality is that mentally disordered offenders can be challenging and extremely difficult to work with, but this is not a reason to neglect their needs or treat them more harshly than other offenders.

In a randomized sampling of halfway houses in Canada, executive directors (ED’s) were interviewed by this author for a research project assessing the overall effectiveness of community residential facilities (CRF’s).⁴ A majority of the ED’s I spoke to felt that offenders were being released with increased prevalence of substance abuse problems, learning disabilities and mental health disorders. While no data on the number of mentally ill offenders seeking admission to CRF’s exists, it stands to reason that the increase in admissions to prison of mentally ill offenders will at some point translate into an increase in the number of mentally disordered offenders needing support in the community. Although most halfway houses did not exclude offenders with a mental health illness as matter of policy, a number of ED’s felt they could not offer the support needed for high-need mentally ill offenders on psychotropic medication. This situation is very disturbing given the increased trend to treat mental disorders with medication and the tendency, especially in the prison system, to overmedicate those with mental illnesses (Langner, et al., 2002; Moloughney, 2002). Between 1997 and 2001, the percentage of inmates prescribed medication on admission to prison in Canada increased from 10% to 18%; nearly an 80% increase in just five years (Boe and Vuong, 2002:7).

Medication and the Mentally Ill Offender

The use of medication to treat the mentally ill is complex and the effects on behaviour are not well understood. Interviews conducted by Statistics Canada (2003) with various health care professionals revealed that people who come into conflict with the law have often been on medication for some time and thus have built up tolerances to their prescriptions at the time of their offence (Statistics Canada, 2003:6). The report further outlined characteristics common to mentally disordered offenders including the following:

- Severe mental illness resulting in previous hospitalisations;
- *A tendency to be treatment resistant or else non-compliant with a medical regime;* (emphasis added)
- Alcohol and drug abuse;
- Intoxication at time of offence;
- Similar diagnosis, including schizophrenia, psychoses, paranoia and others;

⁴ A research project conducted by St. Leonard’s Society of Canada the Research Branch of Correctional Service of Canada. Findings are to be released early 2004.

- Similar childhood experiences, including being from broken homes, abandoned as children or placed in several foster situations; and
- A parent or parents who have substance addictions (Statistics Canada, 2003:10-11).

Psychotropic medications are mood-altering substances that have powerful side effects on the individuals using them. While the literature states that most of these medications are not addictive, they have side effects that are often not well understood (The Clarke Institute of Psychiatry, 1999:9). Individuals become sensitive and susceptible to various environmental factors when their medication is not properly monitored through blood tests by a psychiatrist. The most common side effects for medication related to schizophrenia include muscular stiffness, tremors, muscle spasms, restlessness, dry mouth, and blurred vision. For some, long-term use of neuroleptic medication results in another disorder called tardive dyskinesia, involuntary movement of face, eyes, tongue, mouth and jaw (The Clark Institute of Psychiatry, 1999:8). Individuals who experience side effects such as these are often ridiculed and marginalized by others.

Information on the effect of psychotropic medication on the mentally ill in the correctional system is lacking. While a great deal of anecdotal information was gathered by the author through her contact with community workers, no statistical information is available on the effect of medication on an offender's eligibility for parole, success rates in the community or complications resulting from the unavailability of psychiatric care. However, in a recent study of prescribed medication use by women in Canadian prisons, the following results highlight the need for gender specific mental health services, and the challenges facing creating a continuum of care for mentally disordered female offenders (Langner, et al., 2002:10-13):

- 2/3 of women offenders in Canada have mental health problems compared with just 1/3 of men do.
- 87% of the women offenders within CSC institutions have medication orders, with an average of 4.4 medications per woman.⁵
- 42% of the medications are prescriptions for psychotropics (anti-depressants, anti-psychotics, anti-manic, sedation and mood stabilizers).
- Regionally the highest rates for medication use was in the Prairies (predominantly aboriginal offenders).
- It was found that 62% of offenders were on three or more medications. This compares with a rate of 6% in the general Canadian population matched by age.⁶

Mentally Ill Offenders on Conditional Release

When offenders with complex needs are released into the community research has shown that more than just minimum supervision is needed. As is demonstrated by the case studies presented above, the individual who received the most intensive support (Mary) was the most successful. The organization that runs this program conducted research in the needs of women who would eventually be released into the area they serviced. The Stella Burry Corporation (2000) identified the following as the needs of women being released into the community:

- safe housing,
- their own space, but not to be alone,
- intensive support,

⁵ Taken from a profile of 384 women offenders incarcerated in November 2001.

⁶ These rates can be explained, in part, by access to medication and lack of access of CSC inmates to non-traditional treatments. What is most disturbing is a report by CSC in 1996 that determined that there was no systemic bias in the treatment of federally sentenced women with psychotic disorders (CSC, 1996).

- hands-on daily support for everyday living skills,
- daily structure,
- to feel they have some choices.

An American sociologist recently released a report outlining similar needs for all offenders with mental illnesses. Hartwell (2003) evaluated data from 247 offenders with mental illness to identify characteristics that distinguish those who are returned to prison or a psychiatric hospital with those who remain in the community. Her study found that the group of offenders eventually re-incarcerated had more likely been released from misdemeanour sentences, and the group being released from felony sentences were more likely to be found in a psychiatric hospital after release from correctional custody. Her study discussed the importance of addressing the needs of these “lower profile cases that seem to cycle through social service systems, repeatedly returning to correctional custody and the criminal justice system” (Hartwell, 2003:154). In terms of these less serious misdemeanour cases, it seems clear that without significant support directed at improving the offender’s chances for successful reintegration, there is a good chance that many will eventually progress to felony status. Indeed, there is a growing body of research that suggests that supervision programs that lack treatment and rehabilitation components, such as certain forms of mandatory parole and probation, do little to improve outcomes for mentally ill persons involved in the criminal justice system.

Unfortunately we have no statistics in Canada that details revocation rates for mentally ill offenders. We also have no research on the ability of the community to cope with mentally ill offenders or the availability of community residential facilities for the mentally ill. Some community residential facility managers interviewed by this author reported that while they did not refuse admission of the mentally disordered as an official policy, many houses were reluctant to admit these types of offenders due the inability to adequately meet their high needs. The majority of halfway houses will take mentally disordered offenders only if they are not on medication.⁷ By far the biggest issue relating to exclusion was the house’s capacity to provide the support needed for high needs offenders—which directly relates to the perceived threat to public safety and indeed the safety of the individual. When managers were surveyed regarding the professional background of staff working in their halfway houses, only 8% had experience providing services to the mentally disordered and only about 1% had medical experience. In most cases, training is not available in these areas either because it is expensive; houses don’t want to invest resources in staff that they feel will leave in a year or they simply do not have time for staff to receive intensive training. As noted by the Auditor General (2003), other issues impacting the availability of mental health services in halfway houses relate to the ability of the house to connect with community service providers that are willing to work with offenders.

From the case presented above, it is clear that Mary would not last long in the community without the intensive support offered by the wraparound program she is currently enrolled in. Her needs are extremely high and she demands constant attention. The reality is she is not unlike many mentally ill offenders in what is required for successful reintegration. CSC recognized the value of intensive community support for mentally disordered offenders in their 2002 Mental Health Strategy for Women (Laishes, 2002). While this strategy presents a well-balanced approach on paper, strong organizational support and consistent financial commitment by CSC is required in order to fundamentally shift the reality of reintegration for mentally ill offenders. Issues such as adequate housing and insurance, medication use, ability to cope with stress, ability to see a psychiatrist in a timely manor, treatment while in prison and medication use while in prison and a continuum of care are just some of challenges facing Mary and many women like her.

⁷ The question on exclusion was the second part in a two-part question. Some interviews may not have continued on or stated all reasons for excluding certain offenders.

In the 2003 Auditor General report, community parole officers who had supervised women offenders whose parole was revoked or suspended between June 2001 and June 2002 revealed that the most common reason for suspension was the offender's return to substance abuse. The parole officers surveyed for the report suggested the following means that are within the Service's control to better assist woman offenders as they attempt to reintegrate back into society:

- more facilities where women offenders could be housed, supported, and treated on a timely basis during temporary suspension ("halfway back") instead of returning the offender to the institution during this period;
- more readily available appropriate housing for women;
- better access to specialized women-only programs, particularly for substance abusers;
- more continuity between programs offered in the institution and those offered in the community, especially for those with mental health problems; and
- more assistance for childcare (Auditor General, 2003).

The Auditor General's report confirmed the findings of CSC's 2001 review of community resources for women that identified various gaps in, for example, the provision of appropriate programs and services in the community related to substance abuse treatment, employment, and mental health. The review also raised concerns about *compensating organizations fairly for their delivery of services to women offenders in the community*, noting that these organizations often have *viability problems* because the number of women they serve is so small.

The Auditor General's (2003) survey also revealed that:

...timely access to substance abuse treatment programs for women is difficult to find, even in some urban areas. Although some offenders may not be motivated enough to engage in their rehabilitation, Correctional Service of Canada needs to provide suitable programs for all women offenders, especially in the most critical part of the transition period—the first three to six months after release. For some, the proper assistance and support at this critical time may be their best chance to gain some control over their lives and avoid returning to the conditions that led to their criminal behaviour. *Making enough programs and services available in the community constitutes a preventive approach* (emphasis added).

While the above recommendations made by the Auditor General were made specifically for women, male offenders with complex needs also need specialized support. As demonstrated by the cases of George and Michael, people can fall through the cracks of the mental health system in Canada. The halfway house supporting Michael identified the following as their key challenges to working with offenders who have mental disorders:

- Reluctance of mental health organizations to work with the halfway house.
- Too many mentally ill clients are being released on statutory release.
- Procedures for qualification for provincial disability and welfare services, inability for offenders to apply for Ontario Disability Support Program until warrant expiry date.
- Issue with external resources available for monitoring/support of medication use (no issue with actually having people who are on medication).
- Definition of successful reintegration by CSC – unrealistic expectations of the abilities of these high need offenders.
- Lack of employment opportunities for mentally disordered offenders.
- Confidentiality of offenders' medical histories and the houses inability to directly communicate with doctors regarding client unless client gives permission.
- Due to procedures regarding the dispensing of medication, clients do not get used to administering their own meds.

- Receiving men that come from an overmedicated culture in prison.
- Post warrant after care is a must for a continuum of care and for the sustained integration of clients into the community.

The halfway house where Michael resided recognized the positive side of working with mentally disordered offenders: the education of staff, the connections made with relevant community groups and the satisfaction of truly helping a very disadvantaged group. The house staff stressed the absolute necessity that criminogenic factors be addressed concurrently with mental health needs in this difficult population. The house felt that while Michael was a resident, they were not given the opportunity to work on his criminogenic needs; they were too busy dealing with the effects of his mental illness.

The Auditor General (2003) reviewed the services provided by CSC for male offenders and the following comments are directed the principle of continuum of care:

- Timely preparation of offenders' correctional plans is still a challenge (while the Auditor notes an improvement more work is needed).
- Some offenders remain incarcerated after they become eligible for parole (due to lack of adequate programming, if National Parole Board does not have the proper documentation, the offender can request a delay if they feel their parole will not be granted and if a court appeal/case is pending).
- Senior correctional officers are still not fulfilling their case management responsibilities (review of correctional officers were found to be inadequate).
- Quality of reports to National Parole Board for release decisions have improved but is still found to be uneven.
- Access to needed programs needs to be improved for offenders.
- There are not enough programs for offenders in the community.
- Training of parole officers needs to be improved.

The re-cycling of mentally ill individuals within and between the criminal justice and mental health systems is a serious issue in Canada. As demonstrated by the case studies presented above, we need to conduct comparative research into programs that are successful and those that have failed in order to identify best practices. Offenders being released into the community with complex needs must have access to supportive community and specialized services.

CONCLUSION

In setting out an approach to deal with the many complex problems associated with the management of mentally ill offenders on psychotropic medication it is important to recognize that the field of mental health is comprised of many competing interests that often do not agree on how policy should be implemented. This problem was highlighted by the failure of the 1987 Uniform Law Conference which brought together provinces, territories, advocates for the mentally disabled, advocates for the families of the mentally disabled, health care professionals, lawyers and legislators with the intent to create a uniform Mental Health Act to replace the (still current) system of varying mental health acts in each province and territory. In attempting to understand the failure of the Conference to rationalize and integrate mental health policy in Canada, the Conference's final report offered the following analysis:

Despite the fact that the document was based on consensus and not on majority agreement, a perception remains that the drafting process of the Act was somewhat flawed, resulting in the clinical perspective being accorded a secondary position to the legal perspective. Consumer groups were concerned about getting treatment for family members with mental disorders, rather than safeguarding the right to seriously mentally ill to refuse treatment. Others were [more] interested in the pursuit of legislative options that promoted mental health rather than those that

dealt [primarily] with committal and related matters. They were also interested in legislation that put the emphasis on mandating the provision of mental services in the community (Health Canada, 1994:28).

While mental health and criminal justice stakeholders in Canada continue to argue about what direction policy should take, the number of offenders with high-need mental health disorders in our correctional systems continues to increase. The United States has recently initiated an unprecedented national, two-year effort to prepare specific recommendations that local, state, and federal policymakers and criminal justice and mental health professionals can use to improve the criminal justice system's response to people with mental illnesses. The *Consensus Project*, as it is called, is guided by a steering committee of six organizations, and advised by over 100 of the most respected criminal justice and mental health practitioners in the United States. The Project's intent is to provide concrete, practical approaches to the management of mentally disordered offenders that can be tailored to the unique needs of specific communities (Consensus Project, ND). As this project develops it may prove to be a useful model of cooperation for Canada as it attempts to better integrate its mental health and criminal justice systems and improve its ability to manage mentally disordered offenders.

This article has worked to create linkages between existing research in the correctional and mental health fields and, through case studies, demonstrate the importance of moving toward a client-centred approach that provides a functional continuum of care for these high need individuals. Unfortunately the effects of psychotropic medication are not well understood, especially within correctional populations. While it is encouraging that some research is now being conducted by Correctional Service Canada and the Canadian Mental Health Association in this issue area, there is still much that needs to be done. Hopefully, the current interest in this topic will help us develop a clearer understanding of what programs best service the needs of mentally ill individuals and thus, improve our ability to provide them with the assistance they need before they enter the criminal justice system. For those mentally ill persons that have already found their way into the criminal justice system, we need to work to better provide them with the services they need for successful reintegration.

To end, it would seem that success stories like Mary's need to be celebrated and better understood. The integrated, wrap-around project that supported Mary's reintegration was developed with the assistance of police, correctional workers, parole offices, social workers, community workers and mental health professionals. It is clear to this author that the same level of cooperation among all relevant stakeholders will be required as Canada works to improve its ability to reintegrate mentally disordered offenders on psychotropic medication.

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PRISON SYRINGE EXCHANGE PROGRAMS: CAN THEY BE IMPLEMENTED IN CANADA?

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Authors' Note: This paper is a summary of a report, *Prison Needle Exchange: A Review of International Evidence and Experience* published in early 2004 by the Canadian HIV/AIDS Legal Network.⁸ The report was authored in collaboration with Heino Stöver, Dumitru Laticevschi, and Joachim Nelles. We are indebted to them for their assistance, and want to recognize them in this paper as no doubt some of their work and analysis has found its way into this summary document. We would also like to thank the Pompidou Group in the Council of Europe who provided financial support for the site visits under a European Fellowship for Studies and Research in Drug Abuse and Health Canada, which provided partial funding under the Canadian Strategy on HIV/AIDS.

1.1 HIV/AIDS AND HEPATITIS C IN PRISONS

In many of the countries of the world, rates of HIV-infection among prison populations are much higher than those found in the general population. This fact is often related to two factors – the proportion of prisoners who injected drugs prior to their incarceration and the rate of HIV infection among injection drug users in the wider community. In general, the jurisdictions with the highest HIV infection rates in prisons (apart from countries with large heterosexual HIV epidemics) are those where HIV infection in the general community is high amongst injection drug users. Commenting in 1991 on the situation in the United States, the U.S. National Commission on AIDS stated that “by choosing mass imprisonment as the federal and state governments’ response to the use of drugs, we have created a de facto policy of incarcerating more and more individuals with HIV infection.”⁹ Unfortunately, a criminalization approach towards drug use and drug users is not unique to the United States, and the situation described by the National Commission on AIDS is evident in many other countries, including Canada.

In Western Europe, high rates of HIV infection among incarcerated populations have been reported in many countries. In Spain, the overall rate of HIV infection among prisoners is 16.6%, with a figure as high as 38% among some prison populations.¹⁰ High HIV infection rates have also been reported in Italy, France, Switzerland, and the Netherlands.

In the countries of Central and Eastern Europe and the Former Soviet Union, high rates of HIV infection among injection drug users and prisoners are also a growing concern. In the Ukraine, where 69% of HIV infection is linked to injection drug use¹¹, it is estimated that 7% of the prison population is HIV

⁸ The report will be available on the Legal Network’s website at:
<http://www.aidslaw.ca/Maincontent/issues/prisons.htm>

⁹ US National Commission on AIDS. (1991) *Report: HIV Disease in Correctional Facilities*. Washington, DC: The Commission. p.10.

¹⁰ Spanish Focal Point (October 2001). *National Report 2001 for the European Monitoring Centre for Drugs and Drug Addiction*. Government Delegation for the National Plan on Drugs: Madrid. p.84, with reference.

¹¹ Central and Eastern Europe Harm Reduction Network (July 2002). *Injecting Drug Users, HIV/AIDS Treatment and Primary Care in Central and Eastern Europe and the Former Soviet Union*. Central and Eastern Europe Harm Reduction Network, Vilnius. p.5.

positive.¹² In Latvia, 20% of HIV infections – half of the new cases diagnosed each year – are found among prisoners. In Poland it is estimated that 20% of all people living with HIV/AIDS in the country have spent time in prison or pre-trial detention. In Lithuania in May 2002, the number of new HIV-positive test results among prisoners found in a two week period equaled all the cases of HIV identified in the entire country during all of the previous years combined.¹³ In total, 284 prisoners (15% of the total Lithuanian prison population) were diagnosed HIV-positive between May and August 2002.¹⁴

In the United States and in Canada, the geographic distribution of cases of HIV infection and AIDS is remarkably uneven. In the United States, for example, many systems have rates under 1%, while others have rates that approach or exceed 20%.¹⁵ In Canada, rates between 1% and 11.94% have been reported.¹⁶

In many countries, the health crisis created by high rates of HIV infection is compounded by high rates of hepatitis C (HCV) infection. HCV is transmitted more easily than HIV, including through the sharing of injection equipment. In fact, HCV seroprevalence rates in prisons tend to be even higher than rates of HIV infection, with many studies finding that 30 to 40% of prisoners are living with hepatitis C.¹⁷

1.2 DRUG USE IN PRISONS

Despite their illegality, the penalties for their use, and the significant amounts of money and person hours spent by prison services to stop their entry, the fact remains that drugs get into prisons, and prisoners use them. Just as in the broader society, drugs get into prisons because there is a market for them, and because there is money to be made by providing them.

Many prisoners arrive in prison with histories of past or current drug use already established. In fact, many people originally come into conflict with the law and end up in prison as a result of offences related to the criminalization of certain drugs. In many countries, significant increases in prison populations – and consequent prison overcrowding – can be traced in large part to policies of actively pursuing and imprisoning those dealing with and consuming illegal substances. Other prisoners start using drugs once in prison as a means to release tensions and to cope with living in an overcrowded and often violent environment.¹⁸

Not many prison systems have carried out studies on exactly how many prisoners use drugs while they are in penal institutions, and many systems remain reluctant to admit the extent to which drugs are being

¹² International Harm Reduction Development (2001). *Drugs, AIDS, and Harm Reduction: How to Slow the HIV Epidemic in Eastern Europe and the Former Soviet Union*. Open Society Institute, New York. p.14 with reference.

¹³ Central and Eastern Europe Harm Reduction Network. p.5 with references.

¹⁴ UNAIDS/WHO (2002). *AIDS epidemic update: December 2002*. Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization: Geneva. p.15.

¹⁵ Hammett M, Daugherty AL. 1990 Update: AIDS in Correctional Facilities. Washington, DC: The Commission, 1991, at 10.

¹⁶ Seroprevalence data is from Correctional Service Canada . HIV/AIDS in Prisons: Final Report of the Expert Committee on AIDS in Prisons. Ottawa: CSC, 1994, at 15-19; CSC. *HIV/AIDS in Prisons: Background Materials*. Ottawa: Minister of Supply and Services Canada, 1994, at 47-79; R Jürgens. *HIV/AIDS in Prisons: Final Report*. Montréal: Canadian HIV/AIDS Legal Network and Canadian AIDS Society, 1996, appendix 2, with references; R Lines. *Action on HIV/AIDS in Prisons: Too Little, Too Late – A Report Card*. Montreal: Canadian HIV/AIDS Legal Network, 2002, pp. 3-4.

¹⁷ Dolan, K. (1999). *The epidemiology of hepatitis C infection in prison populations*. National Drug and Alcohol Research Centre, UNSW, at 12, with many references.

¹⁸ For example, see Taylor, A. *et al.* (1995). Outbreak of HIV Infection in a Scottish Prison. *British Medical Journal* 310(6975): 289-292.

used in the institutions. However, most studies that have been carried out show that rates of drug use are high. In the countries of the European Union, the number of prisoners who report ever having used illegal drugs is between 29% and 86%, with most studies reporting rates of more than 50%.¹⁹ The number of prisoners actively using drugs during incarceration is between 16% and 54%. These EU studies indicate that figures for drug use are even higher among incarcerated women.²⁰ In Canada, a 1995 inmate survey by the Correctional Service of Canada found that 40% prisoners reported having used drugs since arriving at their current institution.²¹

1.3 INJECTION DRUG USE AND RISK BEHAVIOURS IN PRISONS

Given the legal prohibitions against drug use in most countries, injection drug users (IDU's) regularly find themselves coming into conflict with the law. In many cases, this results in periods of incarceration. For example, a national study in the U.S. of 25,000 injection drug users found that approximately 80% had been in prison at one time.²² A 1995 World Health Organization study of HIV risk behaviour among IDU's in twelve cities found that 60 to 90% of respondents had been in prison since commencing injection drug use. Most of them experienced incarceration on multiple occasions.²³

As discussed in Section 1.2, drug users do not necessarily cease using drugs simply because they are incarcerated. In many cases, they continue to use on a regular or occasional basis throughout the course of their imprisonment. As stated by UNAIDS in 1997, "long experience has shown that drugs, needles and syringes will find their way through the thickest and most secure of prison walls," and study after study has documented the prevalence of injection drug use in prisons throughout the world.²⁴ In fact, research in many countries has shown that a significant percentage of prisoners actually *begin* using injection drugs while incarcerated, a phenomenon sometimes exacerbated by prison urinalysis policies that screen for – and punish for – cannabis use.²⁵

A 2002 report prepared for the European Union showed that 0.3 to 34% of the prison population in the European Union and Norway injected while incarcerated. The report also found that 0.4 to 21% of people who inject drugs started injecting in prison, and that a high proportion of people who inject in prison share injection equipment. Studies in France and Germany found the prevalence of sharing injecting equipment among incarcerated women to be even higher than among incarcerated men.²⁶

¹⁹ European Monitoring Centre on Drugs and Drug Addiction (2002). *2002 Annual report on the state of the drugs problem in the European Union and Norway*. Luxembourg: Office for Official Publications of the European Communities. p.46.

²⁰ *Ibid*, p.47.

²¹ Correctional Service of Canada (1995). *1995 National Inmate Survey*. Correctional Service of Canada, Ottawa.

²² Dolan, K. (1999). at 13, with reference.

²³ Ball, A, et al. (1995) *Multi-centre Study on Drug Injecting and Risk of HIV Infection: a report prepared on behalf of the international collaborative group for the World Health Organization Programme on Substance Abuse*. World Health Organization, Geneva.

²⁴ Joint United Nations Programme on HIV/AIDS (April 1997). *Prisons and AIDS: UNAIDS Point of View*. UNAIDS Information Centre, Geneva. p.6.

²⁵ Four of the seven prisons visited for this report (Hindelbank, Obershöngrün, and Saxerriet in Switzerland and Vechta in Germany) did not screen prisoners' urine for cannabis, or did not punish for its presence if detected. Prison staff all noted that while cannabis can be detected in a urine sample for several weeks after consumption, injection drugs are undetectable after only a few days. Therefore, all these prisons had made a decision not to screen for cannabis use during urine testing in order to discourage prisoners from switching to injection drug during incarceration solely use to avoid punishment.

²⁶ European Monitoring Centre on Drugs and Drug Addiction. (2002). p. 46—47.

There is also similar evidence emerging in Eastern Europe and the Former Soviet Union. For example, a Russian study among 1,087 prisoners found that 43% had injected a drug ever in their lives, and that 20% had injected while incarcerated. Of this second group, 64% used injection equipment that had already been used by somebody else, and 13.5% started injecting in prison.²⁷ In the Oblast of Nizhni-Novgorod, which has a prisoner population of 28,000, the authorities found that all of the 220 HIV positive prisoners had contracted HIV through intravenous drug use.²⁸

High rates of injection drug use in prisons have also been found in numerous Canadian studies.

- A 2003 study of federally incarcerated women found that 19% reported engaging in injection drug use while in prison.²⁹
- A 1998 study conducted at Joyceville Penitentiary in Kingston, Ontario found that 24.3% of prisoners reported using injection drugs in prison. This was an increase from the 12% found in a similar study at the same prison in 1995.³⁰
- A 1996 survey of prisoners in a federal prison in British Columbia found that 67% reported injection drug use either in prison or outside, with 17% reporting drug use only in prison.³¹
- In 1995, the Correctional Service of Canada's National Inmate Survey found that 11% of 4,285 federal prisoners self-reported having injected since arriving in their current institution. Injection drug use was particularly high in the Pacific Region, with 23% of prisoners reporting injection drug use.³²
- A 1995 study among provincial prisoners in Montréal found that 73.3% of men and 15% of women reported drug use while incarcerated. Of these, 6.2% of men and 1.5% of women reported injecting drugs.³³
- A 1995 study of provincial prisoners in Québec City found that 12 of 499 inmates admitted injecting drugs during imprisonment, 11 of who had shared needles. Three were HIV-positive.³⁴

For injection drug users, imprisonment increases the risk of contracting HIV and HCV infection. Due to the fact that it is more difficult to smuggle syringes into prisons than it is to smuggle in drugs, needles are typically scarce. As a result, imprisoned injection drug users share and reuse syringes out of necessity. A syringe may circulate freely among (often large) numbers of people who inject drugs, or be hidden in a commonly accessible location where prisoners can use it as necessary. A syringe may be owned by one prisoner who rents it to others for a fee, or it may be used exclusively by one prisoner, but reused again and again over a period of months until it literally disintegrates.³⁵ Sometimes, injecting equipment is

²⁷ Medecins Sans Frontieres. (2000) *Health Promotion Programme in the Russian Prison System: Prisoner Survey 2000*. Cited in International Harm Reduction Development. *Drugs, AIDS, and Harm Reduction: How to Slow the HIV Epidemic in Eastern Europe and the Former Soviet Union*. Open Society Institute, New York, 2001. See also Jürgens, R., Bijl, MB (2002). *Risk Behaviours in Penal Institutions*. In Bollini P (ed). *HIV in Prison. A Manual for the Newly Independent States*. MSF, WHO, and Prison Reform International.

²⁸ Jürgens and Bijl, (2002).

²⁹ DiCenso, A et al.(2003). *Unlocking Our Futures: A National Study on Women, Prisons, HIV, and Hepatitis C*. Prisoners' HIV/AIDS Support Action Network: Toronto.

³⁰ Ford, P. (1999) HIV and Hep C Seroprevalence and Associated Risk Behaviours in a Canadian Prison. *Canadian HIV/AIDS Policy and Law Newsletter* (Volume 4, Number 2/3, Spring 1999).

³¹ Nichol, T. (March 28, 1996) Bleach Pilot Project. Second unpublished account of the introduction of bleach at Matsqui Institution. Cited in Jürgens, R. (1996) *HIV/AIDS in Prisons: Final Report*. Canadian HIV/AIDS Legal Network, Montreal.

³² Correctional Service Canada (1995).

³³ Hankins, et al. (1995) Prior Risk Factors for HIV Infection and Current Risk Behaviours Among Incarcerated Men and Women in Medium-Security Correctional Institutions – Montreal. *Canadian Journal of Infectious Diseases* 1995; 6(Suppl B): 31B. Cited in Jürgens (1996).

³⁴ Dufour, et al. (1995) HIV Prevalence Among Inmates of a Provincial Prison in Quebec City. *Canadian Journal of Infectious Diseases* 1995; 6(Suppl B): 31B. Cited in Jürgens (1996).

³⁵ Lines, R. (2002) *Pros & Cons: A Guide to Creating Successful Community-based HIV/AIDS Programmes for Prisoners*. Prisoners' HIV/AIDS Support Action Network, Toronto. p.67.

homemade, with needle substitutes fashioned out of available everyday materials, often causing vein damage, scarring, and severe infections. This situation creates a high-risk environment in many prisons where HIV and HCV infection can spread very quickly. Evidence of HIV transmission within prisons has been documented since the late 1980s.³⁶ Transmission of HCV in prison populations has also been documented in a number of studies.³⁷

1.4 HARM REDUCTION

Traditionally, concerns about disease transmission through injection drug use have been met with calls to further entrench the philosophy and practice of “zero tolerance.” Increased penalties for drug use, tightened security measures to reduce the supply of drugs, and heightened surveillance of individual drug users are often put forward as “law and order” solutions to public health problems. However, the health risks posed by HIV and HCV infection through the sharing of injection equipment have prompted many countries to recognize the limitations of a strictly zero-tolerance approach. Indeed, it has been the experience of some prisons visited for this report that urine screening of prisoners for cannabis use actually results in increasing the number who choose to inject.³⁸ This has led to the development and implementation of community health programs that enable injection drug users to reduce their risk of contracting HIV and HCV while continuing to use illegal drugs. These *harm reduction* initiatives – such as needle exchange programs – have been enacted as pragmatic responses to injection drug use, and the attendant risks that HIV and HCV infection pose to the individual and to society as a whole.

Outside prisons, extensive studies on the effectiveness of needle exchange programs have been conducted, providing scientific evidence that syringe exchange is an appropriate and important preventive health measure. For example, a 1998 U.S. study analyzed the projected cost to the government of providing access to syringe exchange, pharmacy syringe sales, and proper syringe disposal to all injection drug users in the country. The study found that “this policy would cost an estimated \$34,278 U.S. per HIV infection averted, a figure well under the estimated lifetime costs of medical care for a person with HIV infection.”³⁹ A recently published 2002 Australian report concluded that needle exchange programs in that country had prevented 25,000 cases of HIV over a 10-year period, and that the \$150 million invested on the programmes had resulted in a savings to the country of \$2.4 to 7.7 billion.⁴⁰

While many governments – including that of Canada – have recognized the value of needle exchange programs, and have supported their implementation in the general community, few have extended the availability of these programs to prisoners. Yet in many countries, drug use and drug trafficking are as much a part of prison life as they are a part of life in the general society. Some jurisdictions in Canada have implemented some harm reduction measures in prisons, such as making bleach and methadone maintenance treatment available. However, no Canadian jurisdiction has yet acted to provide sterile injecting equipment to incarcerated injection drug users.⁴¹

³⁶ Dolan, K, *et al.* (2003). Prison-based syringe exchange programmes: a review of international research and development. *Addiction*, **98**, 153-158, with references; Jürgens (1996). at 40, with references.

³⁷ Dolan (1999).

³⁸ See comments at footnote 17.

³⁹ Holtgrave, D.R., Pinkerton, S.D., Jones, T.S., Lurie, P., Vlahov, D. (1998). Cost and cost-effectiveness of increasing access to sterile syringes and needles as an HIV prevention intervention in the United States. *Journal of Acquired Immune Deficiency Syndrome and Human Retrovirology*. 1998;18 Suppl 1:S133-8

⁴⁰ Australian National Council on Drugs, Australian National Council of AIDS and Hepatitis Related Diseases (2002). “National Council backs investment on needle programs” media release dated 22 October 2002. Australian National Council on Drugs.

⁴¹ Lines, R. (2002). Action on HIV/AIDS in Prisons: Too Little, Too Late—A Report Card. Canadian HIV/AIDS Legal Network, Montreal.

According to UNAIDS, “Whether the authorities admit it or not – and however much they try to repress it – drugs are introduced and consumed by inmates in many countries. ... Denying or ignoring these facts will not help solve the problem of the continuing spread of HIV.”⁴² The experience of health services in many countries, as well as in many prison systems internationally, shows us that harm reduction provides the framework for effective action to prevent the transmission of HIV and hepatitis C.

1.5 INTERNATIONAL RECOMMENDATIONS TO ADDRESS HIV, HEPATITIS C, AND INJECTION DRUG USE IN PRISONS

“A prisoner retains all civil rights which are not taken away expressly or by necessary implication.”⁴³ For example, Principle 5 of the UN *Basic Principles for the Treatment of Prisoners* states

Except for those limitations that are demonstrably necessitated by the fact of incarceration, all prisoners shall retain the human rights and fundamental freedoms set out in the *Universal Declaration of Human Rights*, and ... the *International Covenant on Economic, Social and Cultural Rights*, and the *International Covenant on Civil and Political Rights* ... as well as such other rights as are set out in other United Nations covenants .⁴⁴

In particular, there is general consensus that prisoners have a right to health, and that the standard of health care provided must be comparable to that available in the general community. Principle 9 of the *Basic Principles for the Treatment of Prisoners* states that “Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.”⁴⁵ In the context of HIV/AIDS, “health services” would include providing prisoners the means to protect themselves from exposure to HIV and HCV.

Similar statements are found in documents emanating from the European Union and the Council of Europe. Article 35 of the *Charter of Fundamental Rights of the European Union* states “Everyone has the right to access preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices.”⁴⁶ This may be considered to apply to people in prison. Also, Recommendation 10 of Council of Europe’s *Committee of Ministers to Member States Concerning the Ethical and Organisational Aspects of Health Care in Prison* states that “Health policy in custody should be integrated into, and compatible with, national health policy. A prison health care service should be able to...implement programmes of hygiene and preventive medicine in conditions comparable to those enjoyed by the general public.”⁴⁷

This principle of equivalence of care is specifically applied to the issue of HIV/AIDS by the World Health Organization (WHO). In 1991, the WHO Regional Office for Europe recommended the provision of sterile syringes in prisons as part of a comprehensive HIV prevention strategy.⁴⁸ Two years later, the WHO published its *Guidelines on HIV Infection and AIDS in Prisons*. Principle 1 of the *Guidelines*

⁴² Joint United Nations Programme on HIV/AIDS (April 1997). p.3.

⁴³ *Raymond v. Honey*, [1982] 1 All ER 756 at 759 (HL), cited in Elliott. R. *Prisoners’ Constitutional Right to Sterile Needles and Bleach* in Jürgens (1996).

⁴⁴ Adopted by General Assembly Resolution 45/111, annex, 45 U.N. GAOR Supp. (No. 49A) at 200, U.N. Doc. A/45/49 (1990).

⁴⁵ *Ibid.*

⁴⁶ Charter of Fundamental Rights of the European Union, Article 35.

⁴⁷ Council Of Europe Committee Of Ministers. *Recommendation No. R (98) 7 of the Committee of Ministers to Member States Concerning the Ethical and Organisational Aspects of Health Care in Prison*. Adopted by the Committee of Ministers on April 8, 1998 at the 627th Meeting of the Ministers' Deputies.

⁴⁸ Stöver, H.(2002)*Drugs and HIV/AIDS Services in European Prisons*. Universitat Oldenburg, Germany. pp.127-128.

emphasizes that “All prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination...with respect to their legal status”.⁴⁹ Principle 2 further states “general principles adopted by national AIDS programmes should apply equally to prisons and to the general community.”⁵⁰ The WHO *Guidelines* are clear that “In countries where clean syringes and needles are made available to injecting drug users in the community, consideration should be given to providing clean injecting equipment during detention and on release.”⁵¹

The right of people in prison to access adequate standards of HIV/AIDS prevention and care is also supported by UNAIDS, which has stated that “With regard to effective HIV/AIDS prevention and care programmes, prisoners have a right to be provided the basic standard of medical care available in the community.”⁵² This would again support the position that where sterile syringes are provided to people who inject drugs in the community, these same programs must be implemented in prisons.

International codes of practice governing physicians and other health professionals working in prisons also support the position that comprehensive HIV and HCV prevention measures, including syringe exchange, must be made available to incarcerated populations. The *Oath of Athens for Prison Health Professionals*, adopted in 1979 by the International Council of Prison Medical Services, “recognize[s] the right of the incarcerated individuals to receive the best possible health care” and undertakes that “medical judgements be based on the needs of our patients and take priority over any non-medical matters.”⁵³

International opinion supporting the right of prisoners to health care is not limited to the documents above. Reports from the European Committee for the Prevention of Torture, the Eight United Nations Congress have expressed similar positions, as have legal scholars and medical experts within national contexts such as the United States and Australia.⁵⁴ As has been explored in detail by Jürgens (1996), recommendations on HIV/AIDS in prisons developed by the international community consistently support “equivalence of treatment of prisoners,” and stress the importance of prevention of transmission of HIV in prisons, and suggest that prevention measures – including sterile syringes – be provided to prisoners.⁵⁵

In Canada, there are also instruments that address the rights of prisoners to health care and, by extension, to sterile injecting equipment. The federal prison system is governed under the *Corrections and Conditional Release Act (CCRA)* and the accompanying *CCRA Regulations*. Under Sections 85—88 of the *CCRA*, the Correctional Service of Canada is mandated to provide every prisoner with essential health care, and reasonable access to non-essential mental health care that will contribute to his or her rehabilitation and reintegration into the community. The *CCRA* states that this medical care “shall conform to professionally accepted standards.”⁵⁶ It may be argued that since syringe exchange is the accepted standard in the community for preventing the transmission of HIV and HCV via injection drug use, then under the terms of the *CCRA* these programs must be made available to prisoners, at least in the federal system.

⁴⁹ World Health Organization. *WHO Guidelines on HIV Infection and AIDS in Prisons*. World Health Organization, Geneva. 1993. p.4.

⁵⁰ Ibid.

⁵¹ Ibid, p.6.

⁵² Joint United Nations Programme on HIV/AIDS (UNAIDS). Statement on HIV/AIDS in Prisons to the United Nations Commission on Human Rights at its Fifty-second session, April 1996.

⁵³ International Council of Prison Medical Services (1979). *Oath of Athens for Prison Health Professionals*. Adopted September 10, 1979, Athens.

⁵⁴ See Jürgens (1996) pp.81-88.

⁵⁵ Ibid.

⁵⁶ *Corrections and Conditional Release Act*, 1992. c.20. Section 86(2).

Ian Malkin⁵⁷ and Richard Elliott⁵⁸ have explored the application of Canadian tort law and *Charter* guarantees respectively within the context of HIV transmission/prevention in prisons. Both have concluded that Canadian correctional services may be vulnerable to legal challenges for denying prisoners access to basic HIV prevention measures such as sterile syringes – particularly if a prisoner can demonstrate that he or she contracted HIV while incarcerated.

Based on legal and public health arguments, numerous reports have been produced by both governmental and non-governmental bodies calling for the provision of sterile injecting equipment to prisoners. In Canada alone these included:

- 1992 – *HIV/AIDS in Prison Systems: A Comprehensive Strategy* by the Prisoners with AIDS Support Action Network⁵⁹
- 1994 – *Final Report of the Expert Committee on AIDS and Prisons* by the Expert Committee on AIDS and Prisons, Correctional Service of Canada⁶⁰
- 1996 – *HIV/AIDS and Prisons: Final Report* by the Canadian HIV/AIDS Legal Network and the Canadian AIDS Society⁶¹
- 1997 – *HIV, AIDS, and Injection Drug Use: A National Action Plan* by the Task Force on HIV/AIDS and Injection Drug Use⁶²
- 1998 – *HIV/AIDS in the Male-to Female Transsexual/Transgendered Prison Population: A Comprehensive Strategy* by the Prisoners' HIV/AIDS Support Action Network⁶³
- 1999 – *Final Report of the Study Group on Needle Exchange Programs* by the Study Group on Needle Exchange Programs, Correctional Service of Canada⁶⁴
- 2002 – *Action on HIV/AIDS and Prisons: Too Little, Too Late – A Report Card* by the Canadian HIV/AIDS Legal Network⁶⁵
- 2003 – *Unlocking Our Futures: A National Study on Women, Prisons, HIV, and Hepatitis C* by the Prisoners' HIV/AIDS Support Action Network⁶⁶
- 2003 – Report of the House of Commons Standing Committee on Health⁶⁷

⁵⁷ Malkin, I. (1996) *The Role of the Law of Negligence in Preventing Prisoners' Exposure to HIV While in Custody* in Jürgens (1996).

⁵⁸ Elliott, R. (1996) *Prisoners' Constitutional Right to Sterile Needles and Bleach* in Jürgens (1996).

⁵⁹ Prisoners with AIDS Support Action Network (June 1992) *HIV/AIDS in Prison Systems: A Comprehensive Strategy*. Prisoners with AIDS Support Action Network, Toronto.

⁶⁰ Expert Committee on AIDS and Prisons (1994) *Final Report of the Expert Committee on AIDS and Prisons*. Correctional Service of Canada, Ottawa.

⁶¹ Jürgens, R (1996) HIV/AIDS in Prisons: Final Report. Canadian HIV/AIDS Legal Network and Canadian AIDS Society, Montreal.

⁶² Task Force on HIV/AIDS and Injection Drug Use (1997) *HIV, AIDS, and Injection Drug Use: A National Action Plan*. Canadian Centre on Substance Abuse and Canadian Public Health Association, Ottawa.

⁶³ Scott, A., Lines, R. (1998). *HIV/AIDS in the Male-to Female Transsexual/Transgendered Prison Population: A Comprehensive Strategy*. Prisoners' HIV/AIDS Support Action Network: Toronto.

⁶⁴ Study Group on Needle Exchange Programs (October 1999). *Final Report of the Study Group on Needle Exchange Programs*. Correctional Service of Canada, Ottawa. Copy on file.

⁶⁵ Lines R. (2002) *Action on HIV/AIDS in Prisons: Too Little, Too Late – A Report Card*. Canadian HIV/AIDS Legal Network, Montreal.

⁶⁶ DiCenso, A., Dias, G., Gahagan, J. (2003) Unlocking Our Futures: A National Study on Women, Prisons, HIV, and Hepatitis C. Prisoners' HIV/AIDS Support Action Network, Toronto.

⁶⁷ House of Commons, Standing Committee on Health. (2003). *Strengthening the Canadian Strategy on HIV/AIDS*. The Committee, Ottawa, Ontario.

2. PRISON SYRINGE EXCHANGE PROGRAMS

As stated above, few countries have acted to expand syringe exchange programs into prisons. That said, six countries – Switzerland, Germany, Spain, Moldova, Kyrgyzstan, and Belarus – have taken this step, with significant success. This section will examine programs in these countries, and address a number of key questions related to their implementation and impact.

2.1 SUMMARY OF SITE VISITS AND SYRINGE EXCHANGE PROGRAMS IN EACH COUNTRY

As mentioned above, in addition to an extensive literature review, this report is based upon site visits to four of the countries providing sterile injection equipment in prisons. The details of these visits are below.

SWITZERLAND

- **Site visits: Hindelbank Prison (Bern), Saxerriet Prison (Salez), Obershöngrün Prison (Bern)**

Switzerland has approximately 150 prisons spread across the 26 cantons that comprise the Swiss Federation. There are approximately 6,000 prisoners in Switzerland. The largest prison has a population of 350, although the majority are small institution with fewer than 100 prisoners.

Switzerland was the first country to introduce prison needle exchange programs in 1992. The first program was initiated informally by a physician at the Oberschöngrün prison for men who, ignoring prison regulations, began distributing sterile syringes to known injection drug users under his care. In 1994, a formal needle exchange pilot project was established in the Hindelbank women's prison, where automated syringe dispensing machines were installed in five locations in the institution. When a used syringe is inserted into one of these machines, a mechanism is activated releasing a sterile one.

The Hindelbank pilot was scientifically evaluated after its first year of operation, during which time over 5,000 syringes were exchanged. The evaluators found that there were no new cases of HIV or hepatitis C in the institution, there was an overall improvement in prisoners' health, there was a significant decrease in syringe sharing, there was no increase in drug consumption, and there were no instances of syringes being used as weapons.⁶⁸

Based upon this successful pilot, prison needle exchange programmes were expanded. In 1996 and 1997, programs were established in Champ Dollon prison (Geneva) and Realta prison (Graubünden). The Champ Dollon project follows the Oberschöngrün model of syringe distribution through the medical unit, while Realta uses a single dispensing machine. In 1998, two more prison needle exchange programs were started at the Witzwil and Thorberg prisons in Bern. Both programs distribute syringes through prison medical staff. In 2000, the Saxerriet prison in Salez became the seventh Swiss prison providing sterile injecting equipment.⁶⁹

The canton of Bern recently mandated that all prisons under its administrative control must provide sterile syringes to prisoners. While this is now in place, there were concerns expressed by several persons interviewed for this report that, due to resistance from many prisons to syringe exchange, these programs have not been implemented in an effective fashion.

⁶⁸ Joint United Nations Programme on HIV/AIDS (1997). *Prisons and AIDS: UNAIDS technical update*. Joint United Nations Programme on HIV/AIDS, Geneva. pp.4, 6.

⁶⁹ Stöver, H. (2002) pp.135—136.

GERMANY

- **Site visits: Lichtenberg Prison (Berlin), Vechta Prison (Lower Saxony)**

In 1996, pilot needle exchange programs were established in two German prisons in Lower Saxony. In the women's prison in Vechta, exchanges were done using one-for-one syringe dispensing machines. In the men's prison in Lingen 1 Dept. Groß-Hesepe, exchanges were made by staff from the medical unit and the drug counseling service.

Following a successful two-year pilot phase and evaluation, needle exchange programs were expanded in Germany. In 1996, a program was started at the Vierlande prison in Hamburg, which houses over 300 men and approximately 20 women. This prison used both dispensing machines and staff to distribute sterile syringes. In 1998, needle exchange using dispensing machines was implemented in Lichtenberg prison for women and Lehrter prison for men in Berlin. In early 2000, needle exchange was made available through staff at the Hannöversand women's prison and the Am Hasenberge men's prison in Hamburg.

Over the last 12-months these programs have come under increasing political attack, and despite their success five of them have been cancelled. In 2002, the needle exchange programs operating in Hamburg were cancelled by a centre-right wing coalition government that was elected in September 2001. In May 2003, the needle exchanges in Vechta and in Lingen 1 Dept. Groß-Hesepe were also withdrawn in similar circumstances by a new centre-right government in Lower Saxony. In no case did these actions result from negative program experience or evaluation, and in some cases the programs were closed despite strong objections from prison staff (see Section 3.8, below). Rather, these decisions were based upon ideological opposition to harm reduction initiatives.

Discussions with prisoners in Vechta during the site visit revealed that since the cancellation of the program many had started to share syringes, and were reverting to the practices of borrowing or renting needles from others. It was similarly reported that in Lingen syringes were being sold on the black market for €10 or two packages of cigarettes. Before the programs were cancelled, syringes were stored safely in plastic boxes in plain sight of prison staff. They are now being hidden, therefore increasing the likelihood of accidental needle stick injuries to staff, which has created significant concerns among staff members. Overall, this is a highly regressive policy change that increases the dangers of HIV and HCV transmission among both prisoners and staff in these institutions.

These actions illustrate the continuing controversial nature of prison needle exchange, even within jurisdictions with a history of successful implementation. More broadly, it also demonstrates the vulnerability of harm reduction programs to political opportunism, and the willingness of governments to sacrifice successful public health initiatives aimed at marginalized populations when it is deemed politically expedient.

SPAIN

- **Site visit: Soto de Real Prison (Madrid)**

There are 69 prisons in Spain falling under the jurisdiction of the Spanish Ministry of the Interior. There are also a further 11 prisons that are administered by the government in the autonomous region of Cataluña.

The first prison needle exchange program was introduced in Basauri prison, Bilbao in the Basque country in July 1997. This was followed by pilot programs in Pamplona Prison (1998) and the Orense and

Tenerif Prisons (1999). All prisons distributed syringes hand-to-hand, either through medical staff or workers from external non-governmental organizations who came into the prison for this purpose.

As in Switzerland and Germany, evaluations of these programs demonstrated their significant success. In discussing the experience of nine prison needle exchanges, a 2001 report prepared by the *National Plan on Drugs* noted that, “These experiences have shown that these programmes can be reproduced in a penitentiary environment without resulting in any distortion or direct problems.”⁷⁰ The 2002 document, *Needle Exchange in Prison: Framework Program* further concluded that “Implementation of a NEP, as in the community outside of prisons, is feasible and adaptable to the conditions of execution of the prison sentence.”⁷¹

By the end of 2001, syringe exchange was provided in eleven Spanish prisons. By the end of 2002, the number of prisons providing needle exchange had grown to 27.⁷²

In June 2001, the Directorate General for Prisons ordered that needle exchange programs be implemented in all prisons. At present, the legal framework for needle exchange programs is in place for all of the 69 prisons under the jurisdiction of Spain’s Ministry of the Interior, and provision of syringe exchange is occurring in institutions where a need has been demonstrated. There is also a pilot needle exchange program in the Centro Penitenciario de Tarragona, one of the eleven prisons under the jurisdiction of the government of Cataluña.

MOLDOVA

- **Site visit: Prison Colony 18 (PC18), Branesti**

There are twenty prisons in Moldova incarcerating approximately 10,500 people. The first prison syringe exchange program in Moldova was initiated in May 1999 in Prison Colony 18 (PC18) in Branesti. Originally, sterile syringes were provided to prisoners through the prison health unit. However, after 4 to 5 months, this method of distribution was reconsidered by the prison physician based upon a low participation rate among known injection drug users in the prison. It was decided that a more confidential method of syringe distribution was required in order for the program to be successful. As a result, the prison adopted a peer-based distribution model, in which a group of eight prisoners was trained by the prison physician to act as outreach workers/educators and to provide syringe exchange. This peer-model is the one currently in operation, which makes the Moldovan project unique.

In the first nine months of 2002, 65 to 70% of known IDU’s in the prison were accessing the program through the Peer Volunteers. In 2002, the Peer Volunteers in PC18 exchanged 7,150 syringes.⁷³ Based upon the success of the pilot project in PC18, a second syringe exchange program was initiated in May 2002 in Prison Colony 4 (PC4) in Cricova. The program in PC4 is also peer-based.

⁷⁰ Spanish Focal Point (October 2001). *National Report 2001 for the European Monitoring Centre for Drugs and Drug Addiction*. Government Delegation for the National Plan on Drugs: Madrid. p.60.

⁷¹ Ministerio Del Interior/Ministerio De Sanidad y Consumo (October 2002). *Needle Exchange in Prison: Framework Program*. Ministerio Del Interior/Ministerio De Sanidad y Consumo: Madrid. p.5.

⁷² Sanz, J., Hernando, P., López Blanco, J.A. (May 2003). *Syringes Exchange Programs in Spanish Prisons*. Presentation at the conference of the European Network of Drug Services in Prison: Rome, May 22—24, 2003.

⁷³ Dr. Larisa Pintelli of Health Reform in Prisons, Moldova. Private correspondence dated May 13, 2003.

EXPERIENCES IN OTHER COUNTRIES

During the course of conducting this research, two other countries implemented prison syringe exchange programs – Kyrgyzstan and Belarus. Because these programs were not in operation at the time the work plan for this report was developed, site visits to these countries was not possible. However, basic information on each has been obtained through communication with individuals involved in the implementation and management of the projects, and from documentation provided by them.

In both Kyrgyzstan (where NEPs are currently in place in six prisons) and Belarus (where one pilot project has been implemented in a prison in Minsk), the experience has been consistent with that detailed above. Both countries utilize models of peer-based syringe distribution, and to date they have experienced no instances of syringes being used as weapons.⁷⁴

2.2 What were the identified needs of prisoners vis-à-vis injection drug use and risk behaviour that prompted the prison service to implement syringe exchange?

In all the countries examined, syringe exchange was enacted in response to evidence of high levels of HIV/HCV infection and/or injection drug use among the prison population. In some cases, this led individual prisons or NGOs to request permission to implement syringe exchange. In others, it resulted in government directives mandating prisons to implement needle exchange.

The situation regarding HIV/HCV and injection drug use in prisons in each country is summarized below. In many cases, these figures are similar to other countries – including Canada – that have not implemented syringe exchange.

SWITZERLAND: Switzerland has not undertaken extensive seroprevalence research in prisons. However, HIV infection rates have been estimated to be between 2 and 10%.

As early as 1985, blood testing among Swiss prisoners detected the presence of HLTV-III antibodies in some prisoners.⁷⁵ More recently, a 1999 report based upon interviews with 234 prisoners at Realta prison found an HIV infection rate of 5.1%, a result acknowledged as being comparable to rates in other institutions. This same study found that approximately 9% of the prisoners were current injection drug users.⁷⁶

GERMANY: Several studies have been conducted to estimate HIV seroprevalence among German prisoners, with results ranging from 1.1 to 1.9% HIV-positive. These studies found that between 2.1 to 6.3% of incarcerated injection drug users were seropositive.⁷⁷

Other research has indicated a link between incarceration, injection drug use, and the transmission of blood-borne diseases such as HIV and HCV. A 1993 study of over 612 people who inject drugs in Berlin concluded that the most significant factor for HIV infection among the group was sharing of syringes

⁷⁴ Information on Kyrgyz projects provided by Dr. Raushan Abdyl daeva, and by Elvira Muratalieva of the Open Society Institute. Information on Belarus provided by Dr. Larisa Savischeva, Project Manager.

⁷⁵ Nelles, J., Fuhrer, A., Hirsbrunner, H.P., Harding, T.W. (1998) Provision of syringes: the cutting edge of harm reduction in prison? *British Medical Journal* 1998, 317, 270–273.

⁷⁶ Nelles, J., Fuhrer, A., Vincenz, I. (1999). *Prevention of drug use and infectious diseases in the Realta Cantonal Men's Prison: Summary of the Evaluation*. University Psychiatric Services, Bern.

⁷⁷ Simon, R., Hoch, E., Hüllinghorst, R., Nöcker, G., David-Spickermann, M. Federal (November 30, 2001). *Report on the Drug Situation in Germany 2001*. German Reference Centre for the European Monitoring Centre for Drugs and Drug Addiction. p.145, with reference.

during incarceration. Imprisonment was also found to be the second most common reason cited by the participants for syringe sharing. The study concluded that a lack of access to sterile injecting equipment was counterproductive to HIV prevention measures implemented in the general community.⁷⁸

Rates of HCV infection among German prisoners are higher than those of HIV. Separate studies have found HCV seropositivity rates of 77% for IDU's, and 18% for non-IDU's. A 2001 study of prisoners who had injected drugs only in prison found a 100% rate of HCV infection.⁷⁹

SPAIN: Rates of both HIV and HCV infection among Spanish prisoners are high. While prisoners represent only 0.01% of the total Spanish population, they account for 7% of AIDS diagnoses.⁸⁰ Rates of infection are particularly high amongst those with a history of injection drug use, and people who inject drugs comprise the majority of AIDS cases among Spanish prisoners.⁸¹ Approximately 90% of prisoners living with AIDS in Spain cite injection drug use as a risk factor.⁸² Rates of HIV infection among prisoners with a history of injection drug use Spain have been cited as high as 46.1%.⁸³

The first cross sectional seroprevalence study in 1989 found an HIV infection rate among prisoners of 32%.⁸⁴ Since that time, HIV prevention and harm reduction initiatives in the community and in prisons have achieved significant results. In the early 1990s, the HIV seroprevalence rate in prisons was approximately 23%.⁸⁵ In 2000, the HIV seroprevalence rate was reported to be 16.6%.⁸⁶ A 2002 joint report by the Ministry of the Interior and the Ministry of Health and Consumer Affairs cited an infection rate of 15%.⁸⁷ In 2002, this figure had again declined to under 13%.⁸⁸ Among incarcerated women, rates of HIV infection are still very high. Statistics in 2000 cite an HIV seroprevalence rate among women prisoners of 38%.⁸⁹

Rates of hepatitis C infection are even higher, particularly among people who inject drugs. According to a 1998 Penitentiary Health Study, 46.1% of prisoners were HCV infected.⁹⁰ In 2002, the HCV infection rate was cited as being 40%.⁹¹ Among prisoners with a history of injection drug use, HCV infection rates are as high as 90%. Even among prisoners who have no history of injection drug use the rate of hepatitis C infection is high, with 20% testing positive.⁹²

MOLDOVA: As of September 2002 there were 210 known prisoners living with HIV/AIDS in prisons in Moldova, which means that the seroprevalence rate in the prison system is approximately 100 times higher than in the general community. Twelve percent of known cases of HIV infection in Moldovan

⁷⁸ Muller R, Stark K, Guggenmoos-Holzmann I, Wirth D, Bienzle U. (1995) *Imprisonment: a risk factor for HIV infection counteracting education and prevention programmes for intravenous drug users.* AIDS 1995 Feb;9(2):183-90.

⁷⁹ Simon, *et al.* p.145, with references.

⁸⁰ Ministerio Del Interior/Ministerio De Sanidad y Consumo. p.4.

⁸¹ Spanish Focal Point p.75.

⁸² Ministerio Del Interior/Ministerio De Sanidad y Consumo. p.4.

⁸³ Sanz, J., *et al.*

⁸⁴ Ministerio Del Interior/Ministerio De Sanidad y Consum. p.4.

⁸⁵ Sanz, J., *et al.*

⁸⁶ Delegación del Gobierno para el Plan Nacional sobre Drogas, Ministerio Del Interior (2001). *Plan Nacional Sobre Drogas: Memoria 2000.* Ministerio Del Interior, Madrid. p.53.

⁸⁷ Ministerio Del Interior/Ministerio De Sanidad y Consumo. p.4.

⁸⁸ Sanz, J., *et al.*

⁸⁹ Delegación del Gobierno para el Plan Nacional sobre Drogas, Ministerio Del Interior.p.55.

⁹⁰ *Ibid.* p.53.

⁹¹ Ministerio Del Interior/Ministerio De Sanidad y Consumo. p.4.

⁹² Delegación del Gobierno para el Plan Nacional sobre Drogas, Ministerio Del Interior. p.53.

prisons are among incarcerated women. However, these figures are acknowledged to be low estimates, as they only include prisoners whose HIV status is known. As not all prisoners have been tested, it is assumed that the true extent of HIV infection is higher.⁹³

HIV infection in Moldova is generally driven by unsafe injecting practices. In its 2002 report, UNAIDS and the WHO identified 66.7% of AIDS cases within Moldova (73.7% of men; 57.1% of women) as being linked to injection drug use.⁹⁴ Physicians working within the country have cited that as many as 83% of all HIV infections are now linked to injection drug use.⁹⁵

3. ANALYSIS OF FINDINGS

What implications does this collective experience of prison needle exchange programs have for Canada? There are many.

A number of objections have consistently been made against the implementation of syringe exchange programs in prisons. In many countries, including Canada, these objections form the basis for the continued rejection of these programs by politicians, correctional officials, and trade unions representing prison staff. The arguments against prison needle exchange generally fall into four categories.

Critics claim that the implementation of prison syringe exchange/distribution:

1. Would lead to increased violence and the use of syringes as weapons against prisoners and staff.
2. Would lead to an increased consumption of drugs, and/or an increased use of injection drugs among those who were previously not injecting.
3. Would undermine abstinence-based messages and programs by condoning drug use.
4. Is not relevant to other jurisdictions, as existing needle exchange programs are established in specific and unique prison environments.

Section 3 will address these objections based upon the evidence obtained for this report.

In addition to the above objections, it is also useful to address questions related to the implementation of prison syringe exchange programs. These include:

5. Do prison needle exchange programs reduce high-risk behaviour/reduce disease transmission?
6. Do needle exchange programs have other positive outcomes on prison health?
7. What methods of syringe distribution are used in prisons, and what are their features?
8. What are the common factors in successful prison needle exchange programs?
9. Is the provision of bleach alone a sufficient response to the risk of HIV/HCV transmission via syringe sharing among prisoners?
10. Is the provision of methadone alone a sufficient response to the risk of HIV/HCV transmission via syringe sharing among prisoners?

3.1 Are prison needle exchange programs safe?

Yes.

⁹³ Figures provided by Dr. Larisa Pintelli, Health Reform in Prisons, Moldova. November 2002.

⁹⁴ UNAIDS/WHO (2002). *Republic of Moldova: Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections – 2002 Update*. UNAIDS/WHO Working Group on Global HIV/AIDS, Geneva. p.6.

⁹⁵ Figure provided by Dr. Larisa Pintelli, Health Reform in Prisons, Moldova. November 2002.

One of the most important lessons to emerge from international experience is that implementing prison needle exchange programs does not necessitate a trade-off between health and security. In fact, as explained by Stöver and Nelles in a 2003 review of the evaluations conducted of prison needle exchanges,

Scientific evaluations of the pilot phase have been carried out in 11 projects (Nelles/Stöver, 2002; Rutter et al. 2001). *Generally it can be said that in no case needles had been used as weapons either against the personnel or other inmates.* This was and is of course one of the controversial issues in the whole debate. For reasons of safety in the working place, it is interesting to note, that exchange rates within needle exchange projects are nearly 1:1, so that the danger of needle stick injuries by needles not disposed properly is in fact very low.⁹⁶ [emphasis added]

The safety of these programs has been noted by officials from the Correctional Service of Canada. In January/February 1999, a delegation from the CSC's *Study Group on Needle Exchange Programs* traveled to Switzerland to observe the syringe exchange initiatives in three different prisons. Among the findings of the delegation's report was a note on the safety of these programs.

Inmates involved in the needle exchange program are required to keep their kit in a pre-determined location in their cells. This assists the staff when they enter the cell to conduct cell searches. Because syringes and needles are an approved program, there is no need for the offender to conceal them in their cells. To date, no injury has been inflicted on staff by a needle.⁹⁷

The safety of prison needle exchange has also been affirmed in Moldova and in Spain neither of which have any reports of syringes being used as weapons against either prisoners or staff.

It can also be argued that providing prisoners with access to the means necessary to protect them from contracting HIV and HCV are in fact compatible with the interests of workplace safety and of the maintenance of safety and order in the institutions.

All the international evidence indicates that there are already syringes present within the prisons of many countries, including Canada. Therefore, any suggestion that the implementation of prison needle exchange will introduce syringes into a "syringe-free" environment is demonstrably false. Therefore the question becomes "Which situation is preferable?" The status quo – where there are syringes in prisons, the number and location of which are unknown, but these syringes are most likely contaminated with disease – or the situation presented in institutions with well-managed needle exchange programs, in which the number of syringes in circulation is known, and the needles are sterile, or at least used by only one person whose identity is known. Clearly any objective measure would conclude that the second scenario is preferable to the first.

This issue is nicely summarized by the Spanish Ministry of the Interior and Ministry of Health and Consumer Affairs in their 2002 guidelines the implementation of prison needle exchange programs. On the issue of safety, it is noted that:

The start-up of a NEP should not increase the risk, but rather, as previously stated, result in greater safety. First of all, illicit syringes, which are usually hidden and unprotected, are replaced by program syringes equipped with a rigid protective case. Secondly, in the event of an accident, it is less likely that the syringe has been used because the inmate can and should exchange it for a new one at the first opportunity after use. Thirdly, in the event that the syringe has been used, it is less likely that it has been shared by various inmates, thus reducing the probability of it being infected

⁹⁶ Stöver, H., Nelles, J. (2003) *10 years of experience with needle and syringe exchange programmes in European prisons: A review of different evaluation studies*. Draft copy on file.

⁹⁷ Headrick, W. (April 9, 1999). *Report on the Needle Exchange Program in Switzerland Prisons*. Copy on file.

and enabling the user to be identified with greater certainty, which allows preventive actions to be taken if necessary. Finally, in the long term, reduction of parentally transmitted diseases will make prisons a healthier and less risky environment.⁹⁸

3.2 Do prison needle exchange programs encourage drug use or injecting among non-injectors?

No.

The belief that programs such as needle exchange promote injection drug use has historically been a barrier to the implementation of harm reduction measures in both the community and in prisons. However, within prisons this argument is complicated by the fact that many prisoners are incarcerated as a result of drugs or of drug-related offences. Consequently, providing sterile needles to prisoners is seen to be condoning or promoting behaviour that the prison should be seeking to eradicate as part of the individual's "rehabilitation." Acknowledging the reality of drug use in prisons is also difficult for prison systems as it is perceived as an admission of their failure to maintain institutional control and security.

In the case of prison syringe exchange, scientific evaluations have consistently found that the availability of sterile syringes *does not* result in an increased number of drug injectors, an increase in overall drug use, or an increase in the amount of drugs in the institutions. In a recent review of eleven evaluated prison needle exchange programs in Switzerland, Germany, and Spain, Stöver and Nelles found that in no case examined did the introduction of a needle exchange program result in increased drug use or injecting within the institution. In two prisons in Switzerland, drug use actually decreased.⁹⁹

These findings demonstrate conclusively that the provision of sterile syringes to prisoners does not result in either increased drug consumption or an increase in drug injection.

That said, there is already clear evidence in a number of countries, including Canada, that many prisoners inject drugs for the first time while in prison (see Section 1.3). The argument that a needle exchange program would lead to prisoners begin using injection drugs is therefore undermined by the fact that this behaviour is already the norm in many countries *without* prison needle exchange programs. In these jurisdictions – where sterile syringes are not provided – these individuals are forced to share or reuse needles, creating a high risk of HIV and HCV transmission.

3.3 Do prison needle exchanges condone illegal drug use and therefore undermine abstinence-based programs?

No.

On the basis of the facts, it is difficult to demonstrate that the provision of sterile syringes has resulted in the condoning of the use of illegal drugs in the institution. The provision of needle exchange in the countries examined has not resulted in prison officials permitting the possession or sale of drugs. In all cases, drugs remain prohibited within institutions where syringe exchange is in place, and security staff are instructed to locate and confiscate all such contraband. In this sense, the policy and practice is no different than in jurisdictions that do not have needle exchange. What is different, however, is the recognition that if and when drugs find their way into the prison and are used by prisoners, the priority must be to prevent the transmission of HIV and HCV via unsafe injecting practices. Therefore, while drugs themselves remain illegal, syringes that are part of the official needle exchange programs are not.

⁹⁸ Ministerio Del Interior/Ministerio De Sanidad y Consumo. p.16.

⁹⁹ Stöver, Nelles. p.15.

In many instances, particularly in the Western European examples, syringe exchange programs are only one component of a comprehensive drug service within prisons, that includes abstinence-based programs, drug treatment, drug-free units, and harm reduction measures. The availability of sterile syringes therefore does not undermine or impede the provision of other drug services, but rather offers drug users more options for improving their health status.

In the case of the German pilot programs, the evaluator found that the syringe exchange program actually *increased* the number of people accessing drug treatment services, demonstrating that needle exchange programs can serve as valuable points of contact and referral for a difficult to reach drug-using population. This was also the experience in Spain, where the Ministry of the Interior and Ministry of Health and Consumer Affairs concluded not only that “[i]t is feasible for a NEP and other drug addiction prevention or intervention programs to coexist”, but also that the “[i]mplementation of a NEP does not generally cause an increase in drug use” and that “NEP’s in prison facilitate referral of users to drug addiction treatment programs.”¹⁰⁰

This is not to say that prison officials and staff do not have to struggle with challenging philosophical and practical issues when implementing needle exchange programs. Prison staff trained within an ethos of zero tolerance have had to come to terms with confiscating drugs but not injection equipment. This is a reality to which police forces in countries with community needle exchange programs have adapted. As the Head of the Merseyside Police Drug Squad has stated:

As police officers, part of our oath is to protect life. In the drugs field that policy must include saving life as well as enforcing the law. Clearly, we must reach injectors and get them the help they require, but in the meantime we must try and keep them healthy, for we are their police as well ... People can be cured of drug addiction, but at the moment they cannot be cured of AIDS.¹⁰¹

This sentiment was echoed by Martin Lachat, the Interim Director of Hindelbank institution in Switzerland in 1994:

The transmission of HIV or any other serious disease cannot be tolerated. Given that all we can do is restrict, not suppress, the entry of drugs, we feel it is our responsibility to at least provide sterile syringes to inmates. The ambiguity of our mandate leads to a contradiction that we have to live with.¹⁰²

Ultimately, the provision of sterile syringes is not incompatible with the goal of reducing drug use in prisons. While making sterile needles available to incarcerated drug users has not led to an increase in drug use, it has led to a decrease in the number of prisoners contracting HIV, HCV, and other infections. Therefore, it can be argued that the refusal to make sterile needles available to prisoners with the knowledge that the sharing of injecting equipment is prevalent is to condone the spread of HIV and HCV among prisoners and to the community at large.

3.4 Are needle exchange programs suitable for different prison environments?

Yes.

¹⁰⁰ Ministerio Del Interior/Ministerio De Sanidad y Consumo. p.5.

¹⁰¹ Cited in D Riley. Drug Use in Prisons. In: Correctional Service of Canada. HIV/AIDS in Prisons: Background Materials. Ottawa, 1994, at 156.

¹⁰² Lachat, M. (1994) Account of a pilot project for HIV prevention in the Hindelbank Penitentiaries for Women - Press conference, 16 May 1994. Berne: Information and Public Relations Bureau of the Canton.

One of the rationales often used by prison systems to dismiss the evidence of the effectiveness of prison needle exchange programs is to characterize these programs as “boutique” projects that are in place only in unusual prison environments (i.e., small institutions, women’s prisons, low security prisons with docile prisoner populations, etc.). Therefore, this argument goes, the success of these programs cannot be replicated in other, larger, or more “difficult” prisons.

While it is true that the initial Swiss pilot projects were conducted in prisons that are “small” by most standards (Oberschöngrün has a population of 75 while Hindelbank has a population of 110), subsequent programs have been successfully implemented in a wide variety of settings in both civilian and military systems. In Germany, for example, needle exchange programs have been introduced in prisons as small as 50 people (the women’s prison in Hannöversand) and as large as 500 (Am Hasenberge men’s prison in Hamburg). In Moldova, syringe exchange programs operate in medium/maximum security men’s prisons with populations of 1,000 or more. Soto de Real prison in Madrid, which was visited in preparation of this report, has a population approaching 1,600. These Moldovan and Spanish examples are institutions with populations larger than *any* Canadian federal prison.

Indeed, Spain provides the most compelling refutation of this argument, as the framework for needle exchanges is in place in all 69 prisons (*all sizes, all security levels*). This clearly dispels the notion that prison needle exchange is limited only to unusual prison environments.

Needle exchanges have also been established in radically different prison environments. In the case of Western European programs, the prisons’ physical structures are based on ranges of individual cells, each housing one or two prisoners each. This is similar to the Canadian situation. In the case of Moldova, prisoners live in barracks-style facilities that have 70 or more men living and sleeping in a single large room. In both cases, prison needle exchange programs have been successfully and safely implemented.

The cases examined also demonstrate that needle exchange projects can be implemented in those jurisdictions that are relatively well resourced and financed (Western Europe), and those that operate with significantly less funding and infrastructural supports (Eastern Europe). Therefore, access to funding and resources alone is not an indicator of the ability of a jurisdiction to provide needle exchange to prisoners.

That said, several jurisdictions have placed some limitations on individual prisoners allowed to participate in syringe exchange programs. In some German prisons, for example, prisoners receiving methadone maintenance or involved in abstinence-based programs were not eligible to access syringe exchange programs. However, this is not a universal approach, and other countries do not enforce such restrictions. Prisoners with histories of psychosis or serious violence are also disqualified in some jurisdictions, although others assess each on a case-by-case basis, seeking to identify safe ways to provide sterile syringes, on the assumption that otherwise the individual in question will share a syringe with someone else.

Rather than institutional size, security level, or structure, prison needle exchange programs have been implemented based upon need of the prisoner population. In the cases examined for this report, syringe exchange projects have been initiated in response to high rates of HIV seroprevalence and/or high levels of injection drug use within prisons. When this need has been established, each of the jurisdictions examined has shown flexibility and creativity in adopting a model of syringe exchange that meets the needs of the prison population.

3.5 Do prison needle exchange programs reduce risk behaviour and prevent disease transmission?

Yes.

The most important lesson emerging from the international evidence on prison needle exchange is that these programs are effective in reducing injecting-related risk behaviours and therefore in preventing the transmission of HIV and HCV.

In a recent review of evaluated prison needle exchange programs in Switzerland, Germany, and Spain, Stöver and Nelles found that syringe sharing was “strongly reduced” in seven of nine prisons collecting data on this risk behaviour. In the five prisons whose evaluations included blood testing, there were no new cases of HIV/HCV infection, while two institutions experienced a strong reduction in seroprevalence rates.¹⁰³

3.6 Do needle exchange programs have other positive outcomes on prison health?

Yes.

In addition to the reductions in HIV and HCV transmission detailed in Section 3.5 (above), international evidence has shown that the provision of sterile syringes has other positive outcomes on the health of prisoners.

Perhaps the most significant is a dramatic decrease in fatal and non-fatal heroin overdoses among incarcerated injection drug users. For example, the Swiss prison of Hindelbank averaged between one and three fatal heroin overdoses annually during the years before the needle exchange program was implemented. Since the program has been in place, Hindelbank has experienced only one fatal OD in the past nine years.¹⁰⁴ This experience was also reported in the Swiss prison of Oberschöngrün (which has a heroin maintenance program in addition to a syringe exchange). Prior to the implementation of syringe exchange, staff at the prison estimated there was approximately one non-fatal overdose a week, and approximately two fatal ODs annually. Overdoses of any kind are now extremely rare, and the prison has experienced only one OD death since 1995.¹⁰⁵ Prison needle exchanges therefore save lives in ways other than the prevention of disease transmission.

The prison staff interviewed as part of this report offered two reasons why the provision of needle exchange has resulted in such significant decreases in overdoses. The first is that by providing each injection drug user with his or her own personal needle, it allows the individual to consume a smaller amount of drugs with each injection. In the past, when a syringe was shared among many prisoners, people injecting drugs would only have limited access to injecting equipment and would be more likely to inject large doses on those rare occasions when he or she was in possession of the syringe.

The second reason cited was that the provision of needle exchange, and the adoption of a harm reduction philosophy within the institution, fundamentally changed the way that prison health and social work staff were able to engage in counseling with prisoners. As injection drug use was an accepted reality inside the prisons, the counselors/health workers and prisoners were able to be much more open and frank in discussions about drug use and harm reduction. The need for prisoners to pretend to be “drug-free” was therefore removed, and honest discussions about risk behaviour and overdose were able to take place in an atmosphere where they did not fear punitive sanctions for admitting to drug use.

The other significant health benefit experienced was a decrease in abscesses and other injection-related infections. Both Hindelbank and Oberschöngrün reported a near disappearance in abscesses, which had been a major problem before the needle exchange programs were implemented. Staff at Hindelbank

¹⁰³ Stöver, Nelles. p.15.

¹⁰⁴ DeSantis, D., Hindelbank Institution (June 2, 2003). Interview with Rick Lines.

¹⁰⁵ Stutz, H., Weibel, U., Oberschöngrün Institution (June 4, 2003). Interview with Rick Lines.

noted that this has resulted in significant cost savings to the prison, as treating abscesses had previously been a significant part of the work of the prison medical staff.

3.7 What methods of syringe distribution are used in prisons, and what are their features?

Different jurisdictions have adopted different methods to distribute or exchange syringes in prisons. These include:

- distribution by a prison nurses or physicians based in a medical unit or other part(s) of the prison
- distribution by one-for-one automated syringe dispensing machines
- distribution by prisoners trained as peer outreach workers
- distribution by external NGOs or other health professionals whom come into the prison for this purpose

Each distribution method has its own unique opportunities and challenges. Some of the features of each distribution method are summarized below.¹⁰⁶

Hand-to-hand exchange by nurses and/or the prison physician:

- Provides personal contact with prisoners, and an opportunity for counseling.
- Can facilitate outreach to and contact with hard-to-reach drug users.
- Prison maintains high degree of control over access to syringes.
- One-for-one exchange, or multiple syringe distribution, possible (as necessary, and as reflects individual prison policy).
- Lower degree of anonymity and confidentiality, which may reduce the participation rate (although high acceptance by prisoners is possible if confidentiality maintained).
- Access more limited, as syringes are available only during the established hours of the health service (this is particularly true if the prison follows a strict one-for-one exchange policy).
- Creates possibility of proxy exchanges by prisoners obtaining syringes on behalf of those who do not want to participate in-person due to lack of trust with staff.

Distribution through automated dispensing machines:

- High degree of accessibility (often multiple machines are in various places in the institution, which can be accessed outside of the established hours of the medical service).
- High degree of anonymity, as there is no involvement with staff.
- High acceptance by prisoners.
- Strict one-for-one exchange.
- Machines are vulnerable to vandalism and damage by prisoners and staff who are not in favour of this program.
- Technical problems with functioning of the dispensing machines can mean syringes are unavailable for periods of time, which can decrease prisoner confidence in the program.
- Some prisons are not architecturally suited for the use of dispensing machines (i.e. lack of discreet areas freely accessible to prisoners in which machines may be placed).

Hand-to-hand exchange by peer outreach workers:

- High acceptance by prisoners.
- High degree of anonymity and trust.
- High degree of accessibility (peer outreach workers live in the prison units, and are available at all hours).
- No staff control over distribution, which can lead to increased fears among staff.

¹⁰⁶ This analysis is adapted and expanded from that found in Stöver, Nelles, J. p.14.

- One-for-one exchange more difficult to ensure.

Hand-to-hand provision by external NGO or health professionals:

- Provides personal contact with prisoners, and an opportunity for counseling.
- Facilitates outreach to and contact with hard-to-reach drug users.
- Prison maintains high degree of control over access to syringes.
- One-for-one exchange, or multiple syringe distribution, possible (as necessary, and as reflects individual prison policy).
- Provides a higher degree of anonymity and confidentiality, as there is no interaction with prison staff.
- Access more limited, as syringes are available only during set hours or set times of the week (this is particularly true if the program follows a strict one-for-one exchange policy).
- Anonymity and confidentiality may be compromised if the external agency is required to provide information on prisoner participation to the prison.
- Potential for mistrust by prison staff of the external workers providing syringes.
- External workers may experience more barriers in dealing with the prison bureaucracy than internal prison health staff.
- Turn-over in NGO staff may result in lack of program continuity, and lack of a consistent “face” for the program for prisoners and prison staff.

It is worth noting that different jurisdictions have adopted different approaches to the question on one-for-one syringe exchange (i.e. a person is only given one syringe, and only when he or she produces a used one for exchange). While some of the jurisdictions examined for this report adhere to a strict one-for-one policy, others do not. Hindelbank, for example, while using dispensing machines that operate on a one-for-one basis, will provide up to five additional “points” or needle tips to program participants who have trouble finding veins to inject into. Spain has also shown flexibility in its approach. While Spanish guidelines acknowledge that “the rule should be exchange, i.e., the previous syringe must be returned before a new kit is handed out,” they direct that “a flexible attitude should be maintained towards [the one-for-one rule’s] application keeping in mind that the primary objective of the program is to prevent shared use of syringes.”¹⁰⁷ The guidelines advise that “[t]he number of kits to be supplied depends on the frequency of exchange and the user’s consumption habits: it should be sufficient to cover the inmate’s needs so that he does not have to reuse the syringe before the next day of exchange.”¹⁰⁸

3.8 What are the common factors in successful prison needle exchange programs?

Prison needle exchange programs have adopted various methods of syringe exchange/distribution (See Section 3.7, above). Each of these methods has proved successful, and has been implemented without jeopardizing the safety or security of the institution. With the exception of the peer-based needle exchange project, all these options have been implemented in both male and female institutions. (However, this may well change shortly as Moldova, the only jurisdiction using a peer-based exchange model, plans to initiate a program in a women’s prison).

One lesson from this experience is that the actual method of distribution is less important than is ensuring that the program suits the needs of the institution, the prisoner population, and the prison staff. With this in mind, there are a number of the common factors evident in the programs explored in this report.

The issue of confidentiality has been a key factor in the creation of successful needle exchange programs. Inside any prison, absolute confidentiality is impossible. That said, the successful programs examined in

¹⁰⁷ Ministerio Del Interior/Ministerio De Sanidad y Consumo. p.11.

¹⁰⁸ Ibid, p.14.

this report have all striven to identify syringe distribution methods that would gain the trust of the prisoner population, and thereby maximize participation in the program.

In some prisons, syringe-dispensing machines have been chosen as the best mechanism for effective confidential needle exchange. In those institutions where a person-to-person method of exchange is in place, it has been shown that identifying a discreet area of the prison in which to conduct the service is a factor in its success. The importance of confidentiality was demonstrated quite vividly in the Moldovan experience, where the needle exchange pilot in Prison Colony 18 saw a significant increase in uptake when the physician decided to use peer outreach workers rather than the medical unit as a point of contact with people who inject drugs. The experience in the Spanish pilot program in Bilbao, where the evaluations found that prisoners preferred the program to be administered by an external NGO rather than prison staff, is also an indication of the importance of confidentiality to the service users.¹⁰⁹ The evaluation of the two German pilots found that a hand-to-hand distribution method through health care staff enjoyed less trust from prisoners than did the use of dispensing machines.¹¹⁰

That said, the Bilbao project also indicated that absolute anonymity is perhaps less important in some cases than is trust in the person(s) or agency running the program, and the quality of the service provided. The Bilbao evaluation found that the prisoners valued the personal interaction with the external NGO workers who conducted the exchanges, and in fact identified this as a preferable distribution method than dispensing machines.¹¹¹

In addition to maximizing confidentiality, providing adequate access to the syringe exchange program has also been a factor in determining distribution methods. In some cases, this has been accomplished by the placement of not one but multiple dispensing machines within a single institution, as was the case in the Hindelbank pilot. When person-to-person methods of distribution have been chosen, such as in the Lingen 1 Dept. Groß-Hesepe pilot in Germany or the Bilbao pilot in the Basque country, staff sought to identify areas of the prison that were both discreet *and* easily accessible. In the Moldovan experience, the decision to use a peer-based structure allowed for 24-hour access as the peer outreach workers live in the prison units where they work.

It has also been shown that the goal of reducing HIV and HCV transmission is best accomplished when prison syringe exchange is one component of a broader comprehensive harm reduction strategy that includes access to safer sex measures, methadone maintenance (and other drug treatment) programs, and educational and support programs. This has been a common feature of all the programs examined (although methadone is not yet available in Moldova). It includes the avoidance of screening for THC in urinalysis programs practiced by some prisons. Many prisons visited as part of this report have made the decision not to screen for THC, or not to penalize for the presence of THC, as they believe doing otherwise would encourage many prisoners to abandon cannabis use in favour of injection drug use solely to avoid detection.¹¹²

The support of the prison administration and staff has also been shown to be an integral part of successful programs. In the cases examined, educational workshops and consultations with prison staff have been a consistent aspect in the development of prison needle exchange. This is not to say, however, that staff in these institutions have been universally supportive from the start. In several cases, as is evidenced through

¹⁰⁹ Menoyo, C. Zulaica, D. Parras, F. (2000) Needle Exchange Programs in Prisons in Spain. *Canadian HIV/AIDS Policy & Law Review*, Vol.5, Number 4.

¹¹⁰ Stöver, H. (2000) Evaluation of Needle Exchange Pilot Projects Show Positive Results. *Canadian HIV/AIDS Policy & Law Newsletter* (vol.5, number 2/3, spring/summer 2000).

¹¹¹ Menoyo, *et al.*

¹¹² See comments in footnote 18.

the evaluations, staff were perhaps reluctant at the start, yet grew to support the program over time as its benefits were experienced first hand.

Recent events in Germany provide an interesting example of this. Staff members at prisons affected by the closure of needle exchange programs are among the most vocal critics of the governments' actions. In Vechta Prison, for example, prison staff have started a petition to lobby the government to reinstate the program. The official staff representative for the prison has written to the government to refute allegations by the Justice Minister of Lower Saxony that the withdrawal of the program came as the result of a lack of staff support. In Lichtenberg Prison in Berlin, prison staff (85% of whom opposed the initial introduction of the needle exchange program in 1998) are now the main people lobbying the government to keep the program in operation. These examples provide compelling evidence of the benefits of prison needle exchange to staff, and that strong staff support can develop for such programs.

While "bottom-up" processes that include cooperation with staff have been shown to be successful, there is mixed evidence on the success of "top-down" approaches, where the implementation of prison needle exchanges are directed by government. Switzerland has experienced problems when a strictly "top-down" approach is followed (see Section 2.1). On the other hand, the experience in Spain has shown that it is possible to legislate the implementation of programs under certain conditions.

One final common aspect is the use of a well-evaluated pilot project as a first step to broader expansion. In some countries, a single pilot has been used, while others such as Germany enacted two pilots running in parallel. The outcomes of the pilot program evaluations have then been used to guide future planning. In some instances (Switzerland, Germany, Spain) the prisons selected for the initial pilot programs were relatively small institutions and/or open or half-open institutions with lower security levels. In these cases, programs were tested and evaluated in these prison environments before they were expanded to larger, closed prisons with higher security levels. However, in Moldova the pilot needle exchange was done in a medium-maximum security prison with a population of 1,000.

3.9 Is the provision of bleach alone a sufficient response to the risk of HIV/HCV transmission via syringe sharing among prisoners?

No.

While very few prison systems have implemented syringe exchange programs, many have opted to provide bleach or other disinfectants to enable prisoners to clean syringes that are then to be reused. According to UNAIDS, the provision of full-strength bleach to prisoners as a harm reduction measure has been adopted in prisons in Europe, Australia, Africa, and Central America.¹¹³ In August 2001, it was reported that bleach was provided in 11 of 23 EU prison systems.¹¹⁴ In Canada, bleach is available as a harm reduction measure in the Federal, British Columbia, and Québec systems.¹¹⁵ However, while bleach is an important harm reduction option for injection drug using prisoners who must share injecting equipment, it is not an adequate substitute for the provision of needle exchange for injection drug users.

There are a number of reasons why this is true, the foremost being doubts about the efficacy of bleach in sterilizing syringes. While clearly a useful measure in *reducing* the risk of transmission of blood-borne

¹¹³ Joint United Nations Programme on HIV/AIDS (1997). p.6.

¹¹⁴ Stöver, H, von Ossietzky, C. (August 2001). *An overview study: Assistance to drug users in European Union prisons*. European Monitoring Centre from Drugs and Drug Addiction, Lisbon. p.24.

¹¹⁵ Lines (November 2003). p.18.

diseases, numerous scientific studies have cast doubt on the effectiveness of bleach in *eliminating* HIV¹¹⁶ and HCV¹¹⁷ in syringes. Many studies promoting the value of bleach as a harm reduction measure still conclude that access to sterile syringes is preferable to disinfecting previously used needles.¹¹⁸ There is also evidence that many injection drug users – as many as half or more in some studies – do not know or do not practice the proper method of using bleach for disinfecting needles.¹¹⁹ This further undermines the effectiveness of an already less-than-optimal HIV/HCV prevention measure. It has even been suggested that the reuse of an HIV contaminated syringe cleaned with bleach may actually *increase* the risk of HIV transmission.¹²⁰ Therefore, the provision of sterile syringes is clearly a more effective HIV/HCV prevention strategy than is providing only bleach.

As discussed in Section 3.6, prisons providing syringe exchange have also realized other health improvements in addition to a reduction in HIV and HCV transmission. These include a significant reduction in abscesses and other vein problems that results from reusing dull or damaged needles, as well as a decrease in fatal and non-fatal overdoses in some institutions. The provision of bleach alone does not offer these same health benefits.

Also, as explored in Section 3.1, the provision of needle exchange can significantly improve staff safety by reducing or eliminating the risk of accidental needle stick injury from hidden syringes during cell and personal searches. The provision of bleach alone does not offer this benefit for staff, as syringes are still considered contraband within the institutions and are therefore hidden rather than stored safely in visible areas.

In conclusion, bleach should be made available to prisoners as one option to enable injection drug users to reduce their risk of contracting HIV and HCV infection. Making bleach available is, however, not enough, and there are many additional benefits from establishing needle exchange programs in prisons.

¹¹⁶ Titus, S., Marmor, M., Des Jarlais, D., Kim, M., Wolfe, H., Beatrice, S. (July 1994). Bleach use and HIV seroconversion among New York City injection drug users. *Journal of Acquired Immune Deficiency Syndrome*. 1994 Jul;7(7):700-4.

¹¹⁷ Kapadia, F., Vlahov, D., Des Jarlais, D.C., Strathdee, S.A., Ouellet, L., Kerndt, P., Morse, E., Williams, I., Garfein, R.S. (2002) Does bleach disinfection of syringes protect against hepatitis C infection among young adult injection drug users? *Epidemiology*. 2002 Nov;13(6):738-41.

¹¹⁸ Kapadia, *et al.* (2002). See also Flynn, N., Jain, S., Keddie, E.M., Carlson, J.R., Jennings, M.B., Haverkos, H.W., Nassar, N., Anderson, R., Cohen, S., Goldberg, D. (July 1994). In vitro activity of readily available household materials against HIV-1: is bleach enough? *Journal of Acquired Immune Deficiency Syndrome*. 1994 Jul;7(7):747-53.

¹¹⁹ See Carlson, R.G., Wang, J., Siegal, H.A., Falck, R.S. (December 1998). A preliminary evaluation of a modified needle-cleaning intervention using bleach among injection drug users. *AIDS Education and Prevention*. 1998 Dec;10(6):523-32. See also McCoy, C.B., Rivers, J.E., McCoy, H.V., Shapshak, P., Weatherby, N.L., Chitwood, D.D., Page, J.B., Inciardi, J.A., McBride, D.C. (July 1994). Compliance to bleach disinfection protocols among injecting drug users in Miami. *Journal of Acquired Immune Deficiency Syndrome*. 1994 Jul;7(7):773-6. and Gleghorn, A.A., Doherty, M.C., Vlahov, D., Celentano, D.D., Jones, T.S. (July 1994). Inadequate bleach contact times during syringe cleaning among injection drug users. *Journal of Acquired Immune Deficiency Syndrome*. 1994 Jul;7(7):767-72.

¹²⁰ In a syringe cleaned with bleach, traces of bleach are likely to remain present even after flushing with water. Bleach contains free chlorine, a known oxidant, and in vitro laboratory studies have shown that low concentrations of oxidants can lead to both tissue inflammation and HIV-1 replication. Therefore, although not statistically proven, “[h]ypothetically, oxidant effects of the residual bleach in the bleach-cleaned syringes could enhance the possibility of infection by remaining HIV-1 contained in a contaminated syringe.” Contoreggi, C., Jones, S., Simpson, P., Lange, W.R., Meyer, W.A. (2000). Effects of varying concentrations of bleach on in vitro HIV-1 replication and the relevance to injection drug use. *Intervirology*. 2000;43(1):1-5.

3.10 Is the provision of methadone alone a sufficient response to the risk of HIV/HCV transmission via syringe sharing among prisoners?

No.

Methadone is a medically indicated treatment used internationally as an effective replacement therapy for opiates, and is an important harm reduction option for injection heroin and morphine users. Administered orally, methadone allows injection opiate users a valuable option for ending their reliance on illegal drugs, and ceasing injecting practices.

Methadone is a crucial element of a comprehensive harm reduction strategy, both in prisons and in the community, as it provides an important option for injection drug using prisoners who wish to stop using illegal drugs. However, despite its value, there are several reasons why methadone provision *in isolation* is not a sufficient response to the risk of HIV and HCV transmission in prisons via injection drug use.

The primary reason is that methadone – as a form of drug treatment – is of no benefit to those drug users who do not want to stop using illegal drugs. Injection drug users not wishing to access a methadone program will therefore continue to inject, and to share syringes when sterile needles are not available.

Methadone treatment is also only appropriate for drug users who are physically dependent upon opiates. Therefore, it is not an alternative for those who are occasional or recreational injection opiate users, who again will continue to inject and to share syringes where needle exchange is not provided. Even among those drug users who access methadone treatment, there will be a number who will continue to inject either sporadically or habitually, and will therefore share syringes where sterile ones are not available. This has been recognized by the Spanish government, and is cited as one of the reasons for allowing prisoners on methadone programs to also access needle exchange.¹²¹

Within prisons, barriers often exist to the optimal provision of methadone. As a medical therapy, a methadone program requires the involvement of a prison physician who is both trained in methadone provision and philosophically supportive of the use of substitution treatment. This is not always the case in many prisons, either in Canada or internationally. Additionally, because of the cost associated with the provision of this medical service, the number of methadone spaces is often limited, thereby creating a situation where some drug users will be excluded from accessing the program. Many of these users will therefore continue to inject, and to share needles where sterile ones are not available.

Finally, methadone is only a useful treatment for opiate dependency. It is not a harm reduction option for those who inject non-opiates, such as cocaine. Therefore, the availability of methadone does nothing to address the unsafe injecting practices of these drug users.

Therefore it is clear that the provision of methadone – while an essential element of a harm reduction strategy – is not in itself a sufficient response the risk of disease transmission via injection drug use in prisons. Furthermore, as examined in Section 3.9, the implementation of needle exchange in prisons has achieved other important benefits in the areas of prisoner health and staff safety that will be denied where syringe distribution programs are not available.

¹²¹ *Recomendaciones sobre los Programas de Intercambio de Jeringuillas (PIJ)*. Obtained from the Prisión Soto de Real: Madrid. Copy on file.

4. CONCLUSION—*Can prison needle exchange programs be implemented in Canada?*

Yes.

The international experience clearly demonstrates that syringe exchange programs can be safely and effectively established in Canadian prisons. There is also significant scientific evidence demonstrating the need for such programs, and national and international guidelines that outline the legal and ethical responsibility of Canadian governments to act to prevent the spread of HIV and HCV infection in prisons.

Sections 1.1—1.3 of this report outline what is known about rates of HIV and HCV infection and injection drug use in Canadian prisons. The results of these numerous studies clearly indicate the need for programs that reduce the risk of HIV and HCV transmission amongst injection drug using prisoners. Indeed, in many cases the rates of HIV and HCV infection and injection drug use in Canada are equal to or higher than those in countries that have implemented prison needle exchange.

Section 1.5 reviews the reports of numerous governmental and non-governmental bodies that have recommended the implementation of needle exchange programs in Canadian prisons. These include not only community-based AIDS organizations, but also working groups of the Correctional Service of Canada.

For example, in 1999 the *Final Report of the Study Group on Needle Exchange Programs*, prepared by a CSC working group established specifically to investigate this issue, recommended that the CSC Commissioner seek approval in principle from the Solicitor General of Canada to pilot test needle exchange programs in five federal prisons (one in each of the five CSC administrative regions), including at least one in a women's institution.¹²² Prisoners themselves have also expressed their support for the establishment of needle exchange programs. Most recently, a 2003 national survey of incarcerated women found that many identified the need for needle exchange programs within their institutions.¹²³

While Canadian governments have been reluctant to implement syringe exchange due to the expected objections of staff, the evidence in this regard is far from conclusive. For example, when researchers from the *Expert Committee on AIDS and Prisons* surveyed CSC staff attitudes towards HIV prevention initiatives, 15% of correctional officers and 31% of health care staff were in favour of making syringe exchange programs available to prisoners.¹²⁴ This survey was conducted ten years ago – before significant increases in HIV and HCV infection rates among prisoners and prior to the successful and safe implementation of prison needle exchange programs in other jurisdictions. It is therefore not unreasonable to expect the number of staff supporting the implementation of syringe exchange to be higher today.

Many Canadian jurisdictions have successfully introduced other harm reduction measures such as condoms and bleach in prisons in recent years. The implementation of these programs has been a success, despite initial concerns in some quarters that they would “send the wrong message” or lead to increases in violence and vandalism. This history should be instructive to those who now make the same claims to obstruct the implementation of prison syringe exchange.

It is also clear from the international evidence that funding in and of itself need not be a barrier to prison syringe exchange, as programs are operating in both well-resourced Western European prisons and poorly

¹²² Study Group on Needle Exchange Programs (October 1999). *Final Report of the Study Group on Needle Exchange Programs*. Correctional Service of Canada: Ottawa. Copy on file.

¹²³ DiCenso, *et al.* p.30.

¹²⁴ *HIV/AIDS in Prisons: Background Materials* (1994). Minister of Supply and Services Canada: Ottawa at 94.

resourced Eastern European prisons. Indeed, it can be argued that syringe exchange programs would quickly pay for themselves by preventing HIV and HCV transmission, thereby reducing the significant expense of providing medications to an increasing number of HIV and HCV infected prisoners. A recent Australian report concluded that money invested in syringe exchange programs in that country had resulted in a greater than fifteen-fold return in savings resulting from infections prevented over a 10 year period.¹²⁵ Some jurisdictions have also realized significant cost savings due to the decrease in abscesses and overdoses that resulted from the implementation of prison needle exchange.

As is also explored in Section 1.5, there are numerous Canadian and international instruments that detail the legal and ethical responsibility of Canadian governments to provide adequate standards of health care – including prevention programs – to people in prison.

Therefore, it is clear that prison syringe exchange programs are necessary, appropriate, and achievable within the Canadian context. The federal and provincial governments should act to immediately pilot test these programs, as recommended by CSC's 1999 *Study Group on Needle Exchange Programs*. The continued failure to do so is a failure to meet their basic ethical responsibilities to provide for prisoner and public health. As stated by UNAIDS,

There is no doubt that governments have a moral and legal responsibility to prevent the spread of HIV among prisoners and prison staff and to care for those infected. They also have a responsibility to prevent the spread of HIV among communities. Prisoners are the community. They come from the community, they return to it. Protection of prisoners is protection of our communities.¹²⁶

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¹²⁵ Australian National Council on Drugs.

¹²⁶ Joint United Nations Programme on HIV/AIDS (April 1996). Statement on HIV/AIDS in Prisons to the United Nations Commission on Human Rights at its Fifty-second session, April 1996

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TAKING THE PRINCIPLES OF EFFECTIVE CORRECTIONS SERIOUSLY IN CSC'S APPROACH TO THE REHABILITATION OF DRUG ABUSING PRISONERS

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INTRODUCTION

Research into “what works” in the rehabilitation of prisoners has identified several factors that contribute to effective reform of persons who have come into conflict with the law. Meta-analytic evaluative research by leading scholars now suggest that effective rehabilitation revolves around five principles: risk, need, responsivity, professional discretion, and program integrity (Andrews and Bonta, 1998). The purpose of this paper is to assess the relative progress that has been made on these five principles by the Correctional Service of Canada (CSC), and to make suggestions that will lead to a more effective approach to the rehabilitation of federal prisoners in Canada. The paper begins by presenting basic information about the principles of effective corrections. Next, it analyzes the relative attention that CSC has placed on the principles in its research since 1989. The paper then analyzes the relative progress made by CSC in implementing the “what works” principles, with particular emphasis on their application to programs directed at prisoners who misuse drugs and alcohol. Finally, the paper offers several recommendations designed to further improve CSC’s approach to the rehabilitation of prisoners.

BACKGROUND

Since the early 1990’s, the field of corrections has been experiencing a renaissance of sorts after a period of general disillusionment with rehabilitation that followed the publication of Martinson’s (in)famous “nothing works” article in the mid-1970’s (Cullen and Gendreau, 2000; Martinson, 1974). Over the last two decades, empirical research has repeatedly confirmed the failure of punitive “get tough” approaches to successfully deter criminal activity (Cullen and Gendreau, 2000; Gendreau, et al, 2000). At the same time, leading researchers in the field using the technique of meta-analysis have identified several principles that appear to produce meaningful declines in future criminal activity (Andrews and Bonta, 1998; Andrews, 1995). Collectively known as the “what works” principles, the best scientific evidence suggests that effective correctional rehabilitation is based on five principles: risk, need, responsivity, professional discretion, and program integrity. Each of these principles is discussed in greater detail below.

The Risk Principle

The risk principle suggests that effective correctional programs should accurately assess the offender’s risk of re-offending, and then provide services that correspond to their measured level of risk. In general, low-risk offenders should receive little or no programming, medium-risk offenders should receive moderate levels of intervention, and high-risk offenders should receive long-term, high-intensity treatment that includes on-going relapse prevention.

The Need Principle

The need principle states that in order to be most effective, correctional programming should target dynamic (i.e., changeable) factors present in prisoners that are known to contribute to criminal behavior.

The “major” dynamic criminogenic factors include: (1) anti-social/pro-criminal attitudes, values, beliefs and cognitive-emotional states, (2) pro-criminal associates and isolation from anti-criminal others, (3) antisocial personality factors such as impulsiveness, risk-taking, and low self-control; (4) educational/vocational achievement; and (5) family factors (Andrews and Bonta, 1998). The assessment of criminogenic needs in the federal correctional system in Canada is most often broken down according to the following functional areas: employment/education, marital/family, associates/social interaction, substance abuse, community functioning, personal/emotional orientation, and attitude (Taylor, 2001:16).

The Responsivity Principle

The responsivity principle suggests that, due to differences among prisoners, individuals will respond differently to different types and styles of programming. Responsivity considerations are divided into two main types: (1) general responsivity, and (2) specific responsivity (Andrews and Hoge, 1995:13; Andrews, Bonta, and Hoge, 1990). General responsivity suggests that the most effective rehabilitation programs for those who have come into conflict with the law are based on the cognitive-behavioral/social learning paradigm. According to Cullen and Gendreau (2000:145), cognitive-behavioral interventions are “well suited to altering the ‘criminogenic needs’—antisocial attitudes, cognitions, personality orientations, and associations—that underlie recidivism.” Specific responsivity relates to the need for rehabilitative programs to be sensitive to the individual characteristics of prisoners including: race, gender, age, cognitive ability, mental health, learning style, motivation for change, ability to function in groups, ability to deal with confrontation, etc. For example, prisoners who exhibit low levels of cognitive functioning will probably not respond well to programming that emphasizes higher-order thinking. These prisoners will be better served, at least initially, by programs that focus more on changing behavior rather than those that emphasize insight driven shifts in awareness.

The Principle of Professional Discretion

The principle of professional discretion states that along with attention to risk, needs, and responsivity, those charged with delivering rehabilitative programs must be sensitive to “moral, ethical, legal, and economic considerations, as well as to the uniqueness of individual offenders” (Andrews, 1995:13). According to this principle, the effectiveness of correctional programming can be increased by the prudent use of discretion by program staff based on these types of considerations. The principle of professional discretion focuses our attention on the fact that *the knowledge, experience, abilities and personal characteristics of correctional staff are just as important as the characteristics of prisoners served by them*. Important personal characteristics of staff that contribute to effective rehabilitation include: belief in the value of all human beings, belief in the ability of people to change and grow in maturity, the ability to be firm without abusing power, the ability to innovate and adjust program delivery to fit the individual needs and learning styles of offenders, etc.

The Principle of Program Integrity

This principle states that in order to ensure the ongoing effectiveness of programs, periodic assessments of actual program delivery and staff performance must be undertaken to make sure that the “what works” principles are correctly and consistently applied over time. Program integrity includes such activities as regular and intensive monitoring of actual program delivery, and regular, site-specific outcome assessments of programs and staff.

The Correctional Service of Canada (CSC) has worked hard over the last several decades to further our understandings of effective correctional programming through research, and to implement the principles

of effective corrections. In fact, CSC is recognized as a world leader in both correctional research and the delivery of research-based correctional programming (Weekes, Ginsburg and Chitty, 2001). The next section will comparatively assess the progress made by CSC in regards to researching and implementing the five principles of effective corrections.

A WHAT WORKS ASSESSMENT OF CSC'S RESEARCH REPORTS

It is possible to assess the attention that CSC has given the five “what works” principles in its research by analyzing the content of the research reports published on the Agency’s website (http://www.csc-scc.gc.ca/text/rsrch/reports/reports_e.shtml). From 1989 to 2002, CSC published a total of 117 reports on various topics related to corrections. The titles, tables of contents, executive summaries and conclusions of these reports were analyzed and then coded according to whether or not individual reports included significant discussions of any of the five principles of effective corrections. The criteria used for the coding process were as follows:

- *Risk*: Reports including significant discussions of: risk assessment/re-assessment, matching program intensity to level of risk, Statistical Information on Recidivism Scale (SIR and SIR-R1), predicting recidivism, Offender Intake Assessment (OIA), Community Risk/Needs Management Scale.
- *Need*: Reports including significant discussions of: criminogenic needs assessment/re-assessment, Level of Supervision Inventory (LSI), Computerized Lifestyle Assessment Instrument (CLAI), Offender Intake Assessment (OIA), Community Risk/Needs Management Scale (CRNMS), employment/education, marital family, associates/social interaction, substance abuse, community functioning, personal/emotional orientation, attitude.
- *Responsivity*: Reports including significant discussions of: gender, age, race, mental health, cognitive ability, cognitive-behavioral treatment approach, matching learning style of prisoners to program content, prisoner motivation for treatment, setting of treatment (i.e., community vs. institution).
- *Professional Discretion*: Reports including discussions of staff selection, training, and assessment.
- *Program Integrity*: Reports discussing the design, implementation and accreditation of programs, the monitoring of program delivery and performance, and the assessment of program outcomes.

For example, Research Report No. R-13 entitled “Conditional Release Supervision Standards: An Update on Training for Offender Risk/Needs Assessment” (1991) discusses efforts to implement and evaluate a training program for CSC staff regarding tools and procedures for assessing the risk and needs of prisoners. Thus, this report was coded as including risk, need and professional discretion (professional discretion was included due to the staff training component). Figures 1a and 1b below depicts the results of this coding process for all CSC research reports published between 1989 and 2002.

Figure 1a: Assessment of CSC Research Reports, 1989-2002

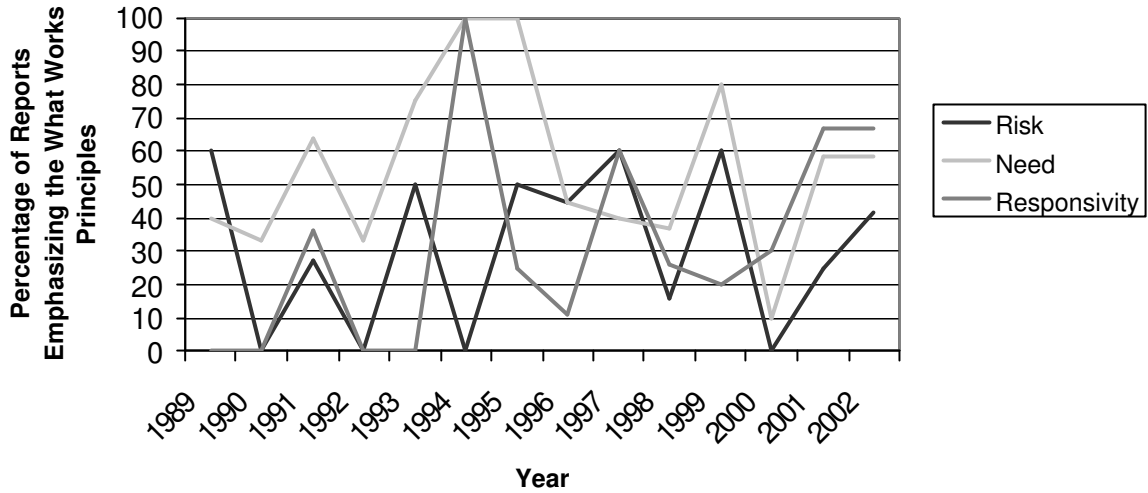
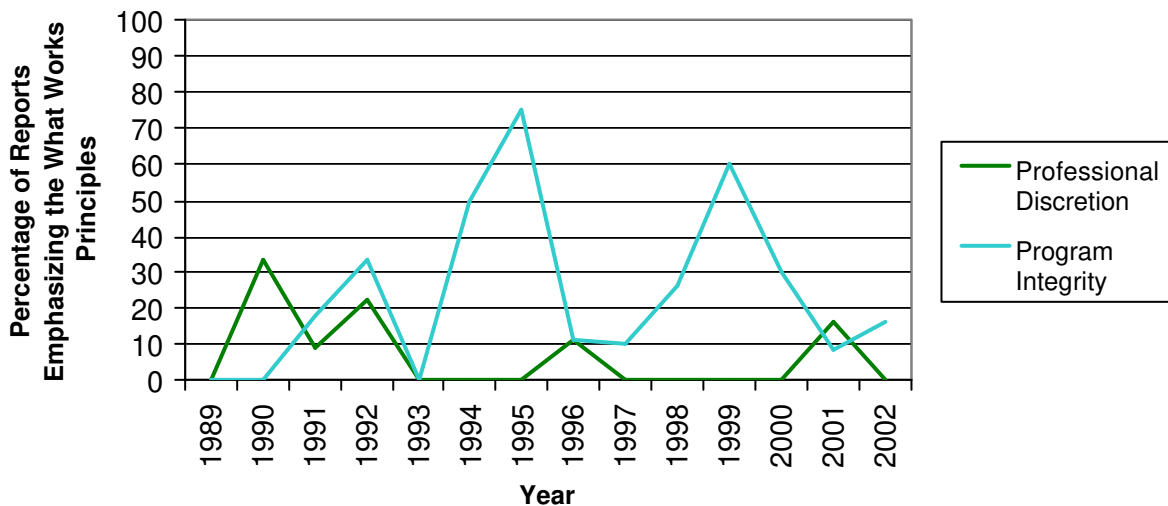


Figure 1a depicts the percentage of CSC research reports that included significant discussions of the risk, need, and responsivity principles between 1989 and 2002. As the graph suggests, CSC’s attention to these principles in its research reports has varied greatly with a noticeable peak in 1994-95 (for needs and responsivity). Overall, the need principle has received the most attention in CSC’s research reports appearing in an average of 55.23% of reports per year. The responsivity principle is next appearing in an average of 31.58% of reports per year, followed closely by the risk principle which appeared in an average of 31.01% of reports per year.

Figure 1b: Assessment of CSC Research Reports, 1989-2002



As Figure 1b depicts, the principles of professional discretion and program integrity have generally received less attention than the risk, need, and responsivity principles in CSC research reports. Overall,

the principle of program integrity has appeared in an average of 24.21% of reports per year while the professional discretion principle has appeared in an average of only 6.60% of reports per year. Once again, attention to these principles is somewhat uneven with noticeable peaks in 1995 and 1999 for the principle of program integrity. The principle of professional discretion appears to have cycled between periods of low attention (1990-92, 1996, 2001) and no attention over this time span.

The next section of this paper will explore the actual implementation of the five principles in CSC correctional programming with a particular emphasis on efforts to rehabilitate prisoners who misuse drugs and alcohol.

AN ASSESSMENT OF CSC'S EFFORTS TO IMPLEMENT THE "WHAT WORKS" PRINCIPLES

Implementation of the Risk and Need Principles

Risk and Need Assessment. Correctional Service Canada began work to standardize and modernize its procedures for assessing the risk and needs of prisoners in the late 1980's leading to the development and implementation of the Community Risk/Needs Management Scale (CRNMS) in 1990.¹ The CRNMS was a combined actuarial/clinical assessment process that allowed parole officers to assess the risk and needs of prisoners as they prepared to leave prison, and while they were under supervision in the community. Scores from the CRNMS were used to determine the frequency of contact a parolee were required to make with their parole officer while on conditional release, and for the assignment of community-based programming to address dynamic needs.

In 1994, CSC implemented the Offender Intake Assessment (OIA) process. The OIA is a comprehensive assessment process that combines actuarial data with non-actuarial information collected from sources external and internal to CSC (i.e., the police, the courts, probation officers, family members, employers and the prisoner) to generate a combined risk/needs classification score at the beginning of a prisoner's sentence. The OIA has two major components: static risk is assessed by the Criminal Risk Assessment (CRI) portion and dynamic criminogenic needs are assessed by the Dynamic Factors Identification and Analysis (DFIA) portion. Offender Intake Assessment ratings range from low risk/low need to high risk/high need, and information gleaned from the OIA process plays a major role in the creation of correctional plans of prisoners. As of August 1996, OIA ratings of federal prisoners in Canada were distributed as follows:

¹ The static risk assessment component of the CRNMS was derived from the Statistical Information on Recidivism (SIR) Scale which was originally developed at the Secretariat of the Solicitor General (now the Department of the Solicitor General of Canada) in the late 1970's and early 1980's (Nuffield, 1982). The dynamic needs assessment component of the CRNMS is based loosely on the Level of Supervision Inventory (LSI) developed by Don Andrews and his colleagues for the Ontario correctional system in the 1980's (Andrews and Robinson, 1984).

Table 1: Distribution of Risk/Need Levels of Federal Institutional Population At Admission (1996)

Risk/Need Level	Male Prisoners (N = 11,541)	Female Prisoners (N = 182)
Low Risk/Low Need	4.4%	26.4%
Low Risk/Medium Need	4.3%	13.7%
Low Risk/High Need	1.2%	4.4%
Subtotal	9.8%	45.5%
Medium Risk/Low Need	1.9%	4.4%
Medium Risk/Medium Need	20.3%	13.7%
Medium Risk/High Need	13.5%	12.1%
Subtotal	35.6%	30.2%
High Risk/Low Need	0.5%	1.1%
High Risk/Medium Need	8.5%	5.5%
High Risk/High Need	45.6%	18.7%
Subtotal	54.6%	25.3%

Source: Taylor, 1997

Outputs from the OIA are used to determine initial security ratings, institutional placement and programming needs while a prisoner is incarcerated. By 1998, the OIA had been applied to 93% of all CSC inmates representing 11,530 prisoners (Taylor, 1997).² The general validity of the OIA and the CRNMS have been confirmed repeatedly over time (Luciani, 1997; Motiuk, 1997a and b; Motiuk and Brown, 1993).³

In 1997, CSC's Task Force on the Reintegration of Offenders recommended that the Service review its needs assessment protocol to "*ensure that it identifies and prioritizes only those offender needs related to criminal behaviour*" (emphasis added; quoted in Brown, 1998). In response, CSC initiated a multi-year investigation that led to a major revamping of the risk/needs assessment processes. One of the most significant changes includes the integration of the OIA and the CRNMS into a single, full-sentence assessment process that includes continuous updating and monitoring of prisoners' risk and needs, both while incarcerated and while under supervision in the community. This change is now being implemented throughout the Service and will constitute a significant improvement of CSC's risk/needs assessment process.⁴

In recent years, CSC has further augmented its prisoner risk/need assessment process by using combined scores from the Custody Rating Scale (CRS), the SIR-R1, and the Offender Intake Assessment to create a Reintegration Potential (RP) score for each prisoner (Motiuk and Nafekh, 2001). The RP is calculated at the beginning of a prisoner's sentence and places them in a high, moderate, or low reintegration potential category. According to Motiuk and Nafekh (2001:11) the RP is producing "reintegration dividends" for the Service "by directing available programming resources and correctional controls to the level of

² CSC has also invested substantial resources in developing and implementing the Offender Management System (OMS) which is a computerized data management system that allow for the efficient use and sharing of information relevant to prisoner case management.

³ However, in Chapter 4 of its April 2003 Status Report, the Auditor General of Canada criticized CSC for not performing inter-rater reliability tests on its risk/need assessment instruments. See: Auditor General (2003).

⁴ The Service's new approach to institutional assessment/monitoring of risk and needs is detailed in Standard Operating Practices: 700-05: *Progress Monitoring in Institutions*. This is available online at: http://www.csc-scc.gc.ca/text/plcy/sop/700-05e_e.shtml

reintegration potential candidates present at the time of admission and encouraging greater efficiencies across offender management functions.”

Substance Abuse Needs Assessment. As indicated previously, CSC considers substance abuse to be a major dynamic criminogenic need.⁵ In response to the recommendations of the Task Force on Substance Abuse (CSC, 1990), which called for a “front end” method of screening prisoners for issues relating to substance abuse, CSC designed, tested and implemented the Computerized Lifestyle Assessment Instrument (CLAI). The CLAI is designed to collect information from inmates on the topics of physical and mental health, nutrition, drug and alcohol use, previous drug treatment experience, social functioning, criminal behavior, education, work and finances, and treatment motivation. Since the early 1990’s, the CLAI has been the principal tool for assessing drug and alcohol related problems of federal prisoners, and the instrument was favorably assessed for both validity and reliability in 1991 (Robinson, Porporino, and Millson, 1991).⁶ The CLAI is currently being revised and updated as the Computerized Assessment of Substance Abuse (CASA). The CASA will be shorter and easier to use than the CLAI, provide more focused information for assessing direct connections between a prisoner’s substance use and their criminality, include an assessment of motivation for treatment, and directly match the prisoner’s level of risk to appropriate intensity of treatment (Addictions Research Centre, 2003).

As the above discussion suggests, CSC has expended considerable effort over the last two decades to design, test, implement, revise, and update its risk/needs assessment processes, including tools and procedures for assessing the needs of prisoners with substance abuse problems. However, assessment is only the first step to implementing the risk and need principles. The next section of this paper looks at the actual implementation of programs designed to address the dynamic criminogenic needs of prisoners.

Implementation of Programs to Address Criminogenic Needs. Since the late 1980’s, CSC has invested considerable resources into designing, testing, implementing, and accrediting a wide-range of programs designed to address the criminogenic needs of prisoners. Table 2 lists CSC’s core correctional programs and the dynamic criminogenic needs they are designed to address:⁷

⁵ The identification of substance abuse as a major criminogenic need is somewhat controversial as meta-analytic research has documented only a slightly positive correlation between substance abuse treatment and reductions in recidivism. See Brothers, 2003 and Dowden, 1998.

⁶ The Dynamic Factors Identification and Analysis (DFIA) portion of the Offender Intake Assessment (OIA) process also includes questions designed to identify substance abuse needs of prisoners.

⁷ CSC incorporates the risk principle into its programming by adjusting the intensity and/or duration of its courses according to the assessed risk of the prisoner. For example, prisoners assessed as high and medium-risk in the area of family violence are directed to take courses that: (1) build awareness about domestic violence, (2) teach violence prevention skills, and (3) include relapse prevention or “booster” classes taken when the prisoner is on release in the community. Prisoners who are assessed as being low-risk in this area are directed to take only the awareness-raising component of the program.

Table 2: Core CSC Programs Directed at Dynamic Criminogenic Needs

Criminogenic Need	CSC Programs⁸
Substance Abuse	HISAP, OSAPP, Choices
Education/Employment	Adult Basic Education Program (ABE), Secondary Education, Post-Secondary Education, CORCAN, Vocational Education
Marital/Family	Living Without Family Violence Program, Parenting Skills Program
Associates/Social Interaction	Counter-Point, Leisure Skills Program, Violence Prevention Program
Community Functioning	Community Integration Program
Personal/Emotional Orientation	Counter-Point, Cognitive Skills Program; Anger and Emotions Management Program, Violence Prevention Program
Attitude	Counter-Point, Cognitive Skills Program, Anger and Emotions Management Program, etc.

In order to get an idea of the overall coverage of CSC's programming, it is useful to consider these statistics. In September 2000, CSC had a total of 23,304 prisoners under its jurisdiction, with 12,976 of incarcerated and 10,328 under supervision in the community. For the six-month period beginning September 1, 2000 and ending March 31, 2001, 25,826 program seats were available to prisoners inside CSC prisons, and an additional 7,621 seats were available in the community.⁹ The distribution of these program seats were as follows:

Table 3: Distribution of CSC Program Spaces (Sept. 2000 – March 2001)

Program	Institutional	Community	Completion Rate¹⁰
Substance Abuse	3,591	2,556	58%
Education	10,552	158	36%
Living Skills	5,904	2,202	78%
Other Personal Development	2,853	766	76%
Aboriginal ¹¹	1,050	190	52%
Sex Offender	948	954	66%
Family Violence	645	369	70%
Violence Prevention	283	100	67%
Counterpoint (community only)	N/A	326	54%
Total	25,826	7,621	

Source: Weekes, Ginsburg and Chitty, 2001

⁸ This is not an exhaustive list of all CSC programming. The Service also has core programming for sex offenders, for example, and regional/local programs directed at addressing specific criminogenic needs. See Table 4.

⁹ Many offenders are enrolled in more than one program at a time. This explains the provisioning of 33,447 program seats for approximately 23,000 prisoners.

¹⁰ Completion rate indicates successful completions of all program requirements. These data are for FY 2000-2001.

¹¹ Approximately 18% of federal offenders are of aboriginal descent. To put this into perspective, only about 2.8% of the Canadian population is aboriginal. Research has documented that programming designed specifically for aboriginals is more effective with first nation peoples than "standard" programming. Given the fact that there are approximately 4200 aboriginal prisoners in the federal correctional system, the number of aboriginal-specific program seats appears to be quite low.

Two observations stand out from Table 3. First, it is apparent that CSC's education programs constitute a substantial proportion of the programming offered in prison, accounting for over 40% of all institutional program seats. Second, the distribution between institutional and community programming is uneven with 77% offered inside prison, and only 23% offered in the community. This distribution is particularly significant when one considers that 55% of prisoners under CSC jurisdiction were incarcerated and 45% were on supervision in the community during this time period.

Programs for Substance Abusing Prisoners. CSC has two major programs directed at the issue of substance abuse: the Offender Substance Abuse Pre-Release Program (OSAPP), and Choices. In accordance with the risk principle, prisoners who are assessed with severe and intermediate substance abuse problems are directed to take OSAPP while they are incarcerated, and then Choices (which includes a relapse prevention component) when they are in the community.¹² Prisoners who are assessed to have low severity substance abuse problems are directed to take only the Choices Program once they are released into the community. However, in 2001 researchers analyzing the CLAI scores of prisoners enrolled in OSAPP found that nearly 1/3 of the program enrollees were assessed as either having low-severity substance abuse needs, or no substance abuse problems at all (Weekes, Ginsburg and Chitty, 2001:22). *This constitutes a major contravention of the risk principle and is an indication that a substantial portion of substance abuse programming in prisons is being used inappropriately by CSC.* It is also evidence of what may be a tendency of risk-averse case managers and parole officers to "over program" offenders who admit to using illicit substances regardless of whether their substance use is directly connected to their criminality or not. This issue will be further discussed in the conclusion of this paper.

In its most recent status report, the Auditor General (2003) reviewed CSC's implementation of its correctional programming and found a major shortfall/underutilization of programs based in the community. For example, CSC data indicate that in 2001, only 45% of prisoners with moderate or severe substance abuse problems on conditional release in the community were enrolled in the Choices Program. This finding is echoed by Weekes, Ginsburg and Chitty (2001:23) when they state that the "...Choices Program continues to be grossly under-utilized despite the fact that it is an accredited program with demonstrated effectiveness."¹³ CSC has responded to this problem by increasing spending on community programs from \$11M in 1998, to \$16M in 2002, and by creating the four-year, \$1.6M Effective Community Corrections initiative. While these responses are laudable, the Auditor General's 2003 status report indicated that community program availability and utilization continues to be a major problem today. In the words of the Auditor General: "We expected far more progress in this area" (Auditor General, 2003 at paragraph 4.74).

To summarize, it is apparent that CSC has expended considerable effort over the last two decades to research and apply the risk and needs principles in its efforts to rehabilitate prisoners, including those who

¹² A comprehensive outcome assessment of the OSAPP Program in 1999 revealed that the Program was 50% more effective with prisoners in the intermediate-need category than those assessed as having high substance abuse needs (T3 Associates, 1999). In response, the Service designed, piloted, and is now implementing the High Intensity Substance Abuse Program (HiSAP) for prisoners with severe substance abuse needs (Eno, et al., 2001:45). Data from CSC's Pacific Region indicates that up to 37% of prisoners with substance abuse issues are in the "high-need" category. This is further evidence of CSC's commitment to implementing the risk and need principles.

¹³ To be fair, the underutilization of community-based programs has many possible causes and not all of these factors are under the control of CSC. The Auditor General identified the following issues related to this problem: (1) programs are long and start dates are fixed, (2) many programs are offered only during the day (which can interfere with prisoners who are employed), (3) many programs are concentrated in larger urban areas, (4) prisoners often move to new locations where programs are not available, and (5) there may not be enough prisoners to warrant offering a program.

have substance abuse problems. While there are remaining issues relating to ensuring that prisoners are given programming that corresponds to their assessed levels of criminogenic risk/need, and to provisioning programming in the community, CSC should be commended on its efforts in these areas. The next section of this paper will assess CSC's efforts to implement the responsivity principle.

Implementing the Responsivity Principle

Issues relating to responsivity have long been recognized as important in determining the effectiveness of correctional programming (Andrews, 1980). However, until very recently, the responsivity principle has received much less attention than either the risk or need principles.¹⁴ This is true in terms of both research and practice (Preston, 2000; Kennedy, 2000; Serin and Kennedy, 1997; VanVooris, 1997). Bonta (1995) describes the responsivity principle this way:

The basic assumption underlying the responsivity principle is that offenders are not all the same. Although various categorizations attempt to minimize offender differences (such as referring to offenders by a number), individual offenders can still be identified by their intelligence, communication style, and emotionality. These characteristics also influence how offenders respond to efforts to change their behavior, thoughts, and attitudes.

The responsivity principle is normally broken down into two types: general responsivity and specific responsivity (Andrews and Hoge, 1995:13). The principle of general responsivity suggests that the most effective correctional programming is based on the cognitive-behavioral paradigm because this approach is well suited for addressing the factors that underlie criminal behavior. Specific responsivity relates to the need for programs to be delivered in ways that match the personal characteristics of individual prisoners. Characteristics associated with specific responsivity include: race, gender, age, cognitive ability, mental health, motivation for treatment, learning style, ability to function in groups, ability to handle confrontation, etc.

Implementing General Responsivity. Most of CSC's core programs, including those directed at prisoners with substance abuse problems, now employ accepted cognitive-behavioral techniques such as pro-social modeling, graduated practice, role-playing, reinforcement, concrete verbal suggestions, and cognitive restructuring. According to Cullen and Gendreau (2000:145), cognitive-behavioral interventions are "well suited to altering the 'criminogenic needs'—antisocial attitudes, cognitions, personality orientations, and associations—that underlie recidivism." The superior effectiveness of the cognitive-behavioral approach for the rehabilitation of prisoners has been repeatedly confirmed in meta-evaluations (Dowden and Andrews, 1999; Dowden, 1998; Lipsey, 1995). Indeed, the effectiveness of the cognitive-behavioral approach appears to hold with prisoners that vary by gender, race, age, and many other specific responsivity characteristics, confirming its classification as a "general" responsivity factor (Cullen and Gendreau, 2000:150).

While it is encouraging that CSC's programs are now universally grounded in the cognitive-behavioral paradigm thus satisfying the principle of general responsivity, it is important to recognize that the effectiveness of this approach is still significantly affected by specific responsivity factors such as cognitive ability, learning style, and mental health. In this regard, one of the most important benefits of the cognitive-behavioral approach is that its delivery can be adjusted to emphasize either behavioral change or cognitive change. At a recent "what works" conference sponsored by the Solicitor General of

¹⁴ VanVooris (1997) writes: "As [the risk, need, and responsivity] principles take hold in correctional service delivery and research arenas, we see most efforts devoted to the first two principles.... But while these commendable advances promote the development of classification systems...as well as specific assessments of criminogenic needs, *the costs of ignoring the responsivity principle should not be understated*" (emphasis added).

Canada,¹⁵ Paul Gendreau stated that the cognitive behavioral paradigm can really be viewed as a continuum of approaches because it is possible to adjust its delivery to emphasize particular components. For example, prisoners who are deficient in cognitive ability will most likely respond better to programming that stresses behavioral change through pro-social role modeling and graduated practice, while prisoners who are capable of more advanced thinking will likely be more responsive to programming that emphasizes cognitive restructuring. Of course, in order to capitalize on the variability of the cognitive-behavioral approach *program officers must be trained to accurately assess prisoners for qualities that may affect program responsiveness and be given the discretion and resources required to tailor program delivery to match the individual characteristics/abilities of prisoners.*¹⁶ It is also important that class sizes are manageable so that program officers can give the prisoners the individualized attention they need to maximize treatment gains. Finally, the program officer or contract worker must be willing to expend the substantial energy and creativity needed to tailor treatment down to the individual level. This relates directly to a need for staff members having a genuine, deep-seated desire to assist prisoners, which is in turn derived from service providers being committed and emotionally invested in their work. This issue is related to the topic of “Staff Values and Commitment” discussed below.

Another factor that can be considered a general responsibility issue is the location or environment where programs are administered. Empirical research continues to confirm that programs delivered in the community produce greater reductions in recidivism than those conducted inside prisons. Cullen and Gendreau (2000:150) write that “this finding may be attributed to the difficulties of delivering services within institutions, but it may also reflect the benefits of working to change offenders while they are living in, and are affected by, their ‘natural’ social environment.”¹⁷ Of course, it is not reasonable to expect that all programming will be delivered in the community, as time constraints alone require that some programs must be delivered within institutions. However, the superior effectiveness of community-based programming is justification for increasing their availability and use whenever possible. From this perspective, the under-provisioning and underutilization of CSC’s community-based programs discussed above is particularly troubling, especially when combined with the finding that up to 1/3 of prisoners enrolled in the institutionally-based OSAP Program were not assessed as requiring that level of intervention. The logical response to this problem would be to shift the resources currently being used inappropriately for treatment inside CSC’s institutions and make them available for expanding the availability of the Choices Program in the community.

Implementing Specific Responsibility. Since the mid-1990’s, CSC has dedicated considerable resources to researching, designing and implementing versions of its programs tailored to specific responsibility characteristics. The issues of gender-specific programming, in particular, has benefited from this process.

¹⁵ “What Works in Conditional Release and Community Reintegration,” A Solicitor General Canada Conference, Montreal, Quebec, March 3-4, 2003.

¹⁶ According to VanVooris (1997), “classification for purposes of responsibility or differential treatment enjoys a long tradition in corrections which predates the current generation of risk assessment models. At the core of this tradition are psychological and personality-based typologies that classify offenders according to cognitive complexity...or criminal personality types (such as the...Client Management Classification system). These systems were more widely used from the 1960’s to the mid-1980’s than they are today.” In fact, CSC uses a version of the Client Management Classification system in its Case Management Strategies (CMS). The CMS system has been used by CSC since the mid-1980’s, however, it was negatively assessed by parole and case management officers in 1990 for creating “busy work” without adding significantly to the successful management of prisoners. See: Andrews, et al., 1990).

¹⁷ At the “What Works in Conditional Release” Conference cited in footnote 13, sociologist Jim Austin made this point more simply by stating: “It’s tough to implement ‘great’ programs in prison. Whenever possible we should do them in the community.”

Thus, there are now gender specific programs to address substance abuse, sexual offending, and other criminogenic needs (Fortin, 2003; Hume, 2001; CSC, 2001:39; Eppercht, 2000; Ellerby and Ellerby 2000; Bloom, 1999). By comparison, CSC has not been as effective in implementing programs designed for aboriginals, young offenders, prisoners with mental disorders, and older prisoners.¹⁸ Implementing specialized programming based on specific responsivity considerations is often a problem due to the small number of prisoners that fall into some of these groupings. The high costs associated with researching, piloting and implementing specialized correctional programs can sometimes not be justified given the small numbers of prisoners who will be served by them. This highlights the inherent trade-off between effectiveness and efficiency in the implementation of correctional programming. A system that is perfectly effective/responsive would seek to rehabilitate the maximum number of offenders regardless of cost considerations. A system that is perfectly efficient would ensure that the costs per prisoner rehabilitated were minimized.¹⁹ In the real world, trade-offs between effectiveness and efficiency are reconciled by creating a system that delivers a “reasonable” level of effectiveness at a “reasonable” cost. What is defined as reasonable in these contexts depends on many variables including, ultimately, the overall support for prisoner rehabilitation in society.

Prisoner motivation for treatment is another issue related to specific responsivity. It has long been recognized that motivation to change is one of the most significant determinants of successful rehabilitation, especially in regards to substance abuse (Miller, 1985). CSC’s core substance abuse programs (OSAPP and Choices) have explicit motivational components built into them, however, the Service has just begun to implement assessments of prisoner motivation and techniques for stimulating prisoner motivation more broadly outside of its substance abuse programming (Stewart and Cripps-Picheca, 2001; Preston, 2000). For example, all new programs implemented by CSC now have “front end” motivational enhancement modules based on the technique of motivational interviewing (Stewart and Cripps-Picheca, 2001). While these changes are welcomed improvements that will likely increase the effectiveness of CSC’s programming over time, the importance of motivation as a specific responsivity factor makes it imperative that *all existing CSC programs be restructured to include program specific assessments of motivation and components explicitly designed to reduce prisoner resistance to change.*

As the above discussion suggests, CSC has indeed begun the process of implementing the principle of responsivity in its correctional programming. While this principle has not benefited from the same attention given to the risk and need principles, all of the Service’s programs are now grounded in the cognitive-behavioral approach, CSC has developed and implemented programming that is gender and race specific, and it is beginning to broadly implement motivational components into in correctional programming. However, issues involving the “staff side” of responsivity, the location of treatment (institution vs. the community), programming for aboriginals, juveniles, the mentally disordered, and elderly offenders still remain. Staff related responsivity factors, such as assessment, training, and commitment, are discussed in the next section.

¹⁸ CSC does have a version of its drug rehabilitation programming specifically designed for long-term/older offenders. In addition, the Service has conducted/published research investigating the special programming needs of these groups. For juveniles see: *Forum on Correction Research*, Volume 11, No. 2. For mentally disordered prisoners see: *Forum on Corrections Research*, Volume 6, No. 2 and Volume 14, No. 2. For older/long-term prisoners see: *Forum on Corrections Research*, Volume 4, No. 2 and Volume 12, No. 3. *The Forum* is available online at: http://www.csc-scc.gc.ca/text/pblct/forum/index_e.shtml

¹⁹ The law of decreasing returns derived from the bell curve of treatability means that the marginal costs of treatment increase for each successive prisoner rehabilitated. This leads to the “problem of the last 1%” where the costs associated with rehabilitating the prisoners that fall at the extremes of the treatability distribution increase exponentially.

Implementing the Principle of Professional Discretion²⁰

The “what works” assessment of CSC’s research reports presented above reveals that the principle of professional discretion received the least amount of attention of the five principles; appearing in an average of only 6.6% of research reports per year. The principle of professional discretion suggests that even when the risk, need, and responsivity principles are fully applied, those charged with delivering rehabilitative programs must be sensitive to “moral, ethical, legal, and economic considerations, as well as to the uniqueness of individual offenders” (Andrews, 1995:13). In other words, the principle of professional discretion focuses our attention on the fact that *the values, knowledge, capabilities and commitment of staff are just as important as the characteristics of prisoners who are served by them*. The following sections discuss the issues of staff assessment, staff training and staff values/commitment.

Staff Assessments. An important component to the successful implementation of the principle of professional discretion is the assessment and selection of competent staff. In January 1999, CSC promulgated specific rules and procedures for assessing and hiring program delivery staff in *Commission Directive 726* and *Standard Operating Practices 726*, both titled: “Management of Correctional Programs” (CSC, 1999a and b). *SOP 726* states that: “All program officers shall...possess particular knowledge, experience, ability and personal suitability (these qualifications will be assessed in the staff/contractor selection process and will be monitored throughout program involvement)” (CSC, 1999b). In addition, the *SOP* states that: “[Program] evaluations shall be conducted in order to determine...whether offenders view the program/deliverers as effective and suitable for their need” (CSC, 1999b).

In September 1999, Appendix A: “Standards for National Substance Abuse Programs” was added to *SOP 726*.²¹ The purpose of Appendix A is to “provide standards for all programs under the Substance Abuse menu and provide more explicit direction for quality assurance staff on how to evaluate compliance with standards” (CSC, 1999c). Appendix A is a lengthy document that includes detailed instructions on the implementation of CSC’s core substance abuse programs including criteria and procedures for assessing program staff. Topic relevant to staff assessment include: Selection of Regional Trainer, Quality Assurance of Regional Trainers (assessed every two years), Certification Process (OSAPP and Choices), and Program Officer Quality Assurance (assessed annually). To provide an example of the level of detail provided in these performance criteria, Appendix A lists the personal characteristics of effective substance abuse program officers as:

- Above average verbal skills.
- Ability to relate positively and empathetically to offenders, but to do so while maintaining a position of authority such that the relationship he/she establishes does not compromise agency rules and regulations.
- Sensitivity to group dynamics and ability to stimulate groups and promote interest and high activity levels while maintaining adequate discipline and control.
- Ability to confront clients without demeaning them.
- Above average interpersonal skills and, in particular, the social/cognitive skills he/she wishes clients to acquire:

²⁰ The author realizes that the operationalization of the principle of professional discretion in this paper is somewhat broader than its typical use. For conceptual convenience, this research places all concerns relating to staff values, training, and assessment in this principle. This includes the “staff side” of the specific responsivity, a highly neglected topic in both research and practice (Preston, 2000:25).

²¹ In December 2000, a second appendix (Appendix B) was added to *SOP 726* which set out similar detailed standards for CSC “living skills” programs including: the Cognitive Skills Training Program, the Anger and Emotions Management Program, the Living Without Violence in the Family Program, the Parenting Skills Program, the Leisure Education Program, and the Community Integration Program.

- social perspective-taking (empathy vs. egocentricity),
- effective problem-solving,
- well-developed values,
- rational and logical reasoning,
- Successful experience in managing groups of poorly motivated individuals who may be passively or aggressively hostile or critical.
- Humility, willingness to consider views (of both clients and program delivers) which may not reflect their own.
- Enthusiasm (CSC, 1999b).

While it is likely that substance abuse program staff selected on these criteria will indeed be able program deliverers, a review of the staff assessment procedures in Appendix A suggest that criteria relevant to the principle of specific responsivity are not explicitly included. For example, one of the central tenets of the principle of specific responsivity is that in order to maximize program effectiveness, the learning styles of prisoners and the teaching styles of staff should be “matched” as closely as possible. The first step in this process is the accurate assessment of prisoner learning styles and staff teaching styles, but it does not appear as though CSC has any objective or standardized procedure for conducting these types of assessments, or for explicitly matching staff and prisoners based on such assessments. Thus, it is difficult to see how the principle of specific responsivity can be appropriately implemented under the current staff assessment system.²²

Staff Training. The issue of staff training is also thoroughly set out in CSC’s Standard Operating Practices. Section A of Appendix A sets out detailed training standards for substance abuse program deliverers under the topics of: Training of Regional Trainers, Training of Program Officers, Site Certification Process (for OSAPP and Choices), Program Officer Certification Process, Refresher Training, Continuing Education, and Staff Awareness Training.²³ The training for substance abuse program delivery staff includes a 10-day initial training session, a review of videotapes of the delivery of two full programs, follow-up training, refresher training (for those who with substandard performance evaluations or staff who don’t deliver a program for 12 months or more), continuing education (also for those who have had substandard performance reviews), and annual staff awareness training. To provide an example of typical training requirements, during follow-up training substance abuse program officers are assessed according to the following criteria:

- Knowledge and understanding of the skills and course content.
- Implementation of the program as directed in training.
- Integrity of program objectives.
- Following procedure and delivery schedule.
- Interaction with the group.
- Ability to motivate the group.
- Delivery technique.

²² This also points to a need to expand prisoner risk/need assessments to include criteria directly related to specific responsivity, such as learning style. At the present time, there are no objective or standardized ways of conducting these assessments.

²³ Appendices A and B of *SOP 726* include systems for tracking compliance with each of their major provisions based on a three-point scale: 0 for noncompliance, 1 for partial compliance, and 2 for substantial compliance. Although these data have ostensibly been collected since early 2000, this author could find no published account of how well Service staff have performed with regards to the assessment or training provisions of *SOP 726*.

- Facilitation skills.
- Modeling skills and attitudes consistent with program.
- Enthusiasm.
- Reception to feedback.
- Preparation and Organization.
- Presentation style.
- Personal attributes while coaching.

A review of the criteria used to assess the training of program delivery staff indicates that the criteria place a strong emphasis on the ability to follow program structure, to control and motivate the group and to follow program delivery schedules. From a “what works” perspective, what is missing are skills related to the correct application of the responsivity principle. Namely, training of program officers to accurately assess prisoners according to specific responsivity factors, training on how to innovate and tailor program delivery according to individual specific responsivity characteristics of prisoners, etc.²⁴ There are, of course, inherent tradeoffs between strict adherence to established program guidelines and the need to adjust program delivery according to the responsivity principle, but it is troubling to this author that there appears to be little explicit attention to specific responsivity in program officer training. It is possible that issues related to this principle are included in the topics of “delivery technique,” “facilitation technique,” “presentation style,” and “personal attributes while coaching,” but the importance of the responsivity principle in effective correctional programming suggests that this issue should be given more explicit attention in program officer training. Further, if program officers are not given the discretion and time/resources required to innovate and adjust program delivery at the individual level,²⁵ it will be difficult to effectively implement the principle of specific responsivity into CSC correctional programming.²⁶

While it is encouraging to see detailed criteria for staff assessment and training being implemented with regards to those involved in the delivery of correctional programs, including those directed toward

²⁴ Under the topic of Program Officer Training – OSAPP in Appendix A, the criteria “Program Matching, Assessment, and OSAPP Screening Criteria” are listed as part of the initial training of program delivery staff. However, this topic does not appear to address issues related to specific responsivity, but instead the assessment of level of substance abuse need and the matching of program intensity to that need. Thus, these criteria relate to the risk and need principles, and not to specific responsivity.

²⁵ Under the topic of “Group Size and Cohesion,” *SOP 726* states: “Group size shall be linked to program intensity, characteristics of participants and experience of deliverers. Group size should normally be no less than 8 and no more than 12” (these limits are set at 4 and 10 for the OSAPP and Choices programs) (CSC, 1999b, emphasis added). However, Appendix A states that: “The optimal size for any National Substance Abuse Program, including the maintenance component, is 8 offenders” (CSC 1999b, Appendix A, Section 12). These requirements appear to be contradictory. On the one hand, the policy states that optimal group size will be based on the individual characteristics of attending prisoners and on staff experience. On the other hand, the criteria state that the optimal class size is 8 prisoners. If optimality is based on criteria that vary according to the individual characteristics of prisoners, groups of 8 prisoners will not always produce the most effective learning environment. Of course, the designation of “optimal group size” by CSC includes efficiency and cost considerations in addition to those related to responsivity and effectiveness. It is important to recognize, however, that optimality based on effectiveness/responsivity will not always be the same as optimality based on efficiency.

²⁶ Theoretically speaking, there are basically two ways to deal with specific responsivity issues. The first is to design, pilot, and implement programs with particular responsivity characteristics in mind. This is what CSC has done with regards to its aboriginal and gender specific programming. The other option is to train staff to tailor delivery of “core” programming so that it is sensitive to specific responsivity issues. The high costs associated with the first approach suggest that in cases where small numbers of prisoners will be served, it may be more cost effective to train program staff so they can effectively implement the responsivity principle in standard programs rather than create stand alone specialized programming.

substance abuse, it is problematic that similar standards and procedures have not yet been implemented for other staff involved in the management/rehabilitation of prisoners. On this point, the most recent Status Report of the Auditor General discusses concerns related to the training of CSC institutional parole officers. To quote from the report:

In 1996 we found that training for parole officers was inadequate. We noted that many had not received the eight-day orientation training for parole officers until after they had started the job. By 1999, the Service indicated that it was now providing parole officers 10 days of orientation training, and more of them were participating. [However] our [2003] fieldwork found that many new parole officers still do not receive orientation training before they start the job. A recent review by the Service showed that 20 percent of parole officers appointed in the last year did not receive orientation training and an additional 15 percent did not receive it in the time required. These results clearly indicate the need for substantive improvement. [Further], parole officers in the community told us that the 10 days of orientation training did not cover all the areas of their jobs adequately. Only the last two days of the course dealt with community supervision, and the content was considered superficial. Correctional Service's national headquarters has not given the regions detailed guidelines for structured on-the-job training, and we found that training on the job is uneven. ...Only some offices provide structured training; most training on the job is provided by the more experienced parole officers (Auditor General, 2003).

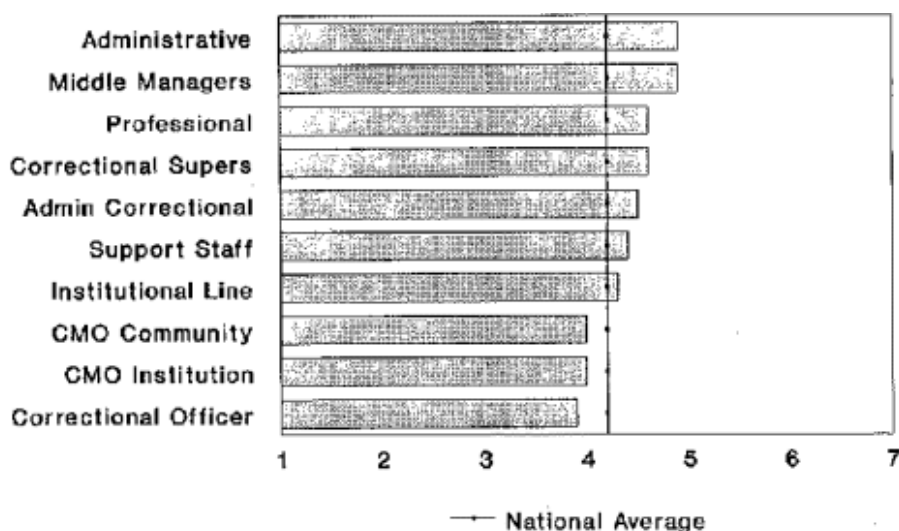
The Auditor General also found that the turnover rate for parole officers was high, and that this negatively affected the ability of the Service to provide effective supervision/rehabilitation of prisoners. On a more positive note, the Auditor General states that: "...senior [CSC] management recently approved five additional days of development each year starting in 2003-2004. The Service has also increased its funding for staff training and it will provide added specialized training online to enhance the present orientation training for parole officers" (Auditor General, 2003). One must wonder, however, why it has taken since 1996 for the Service to implement upgraded training for parole officers and, given the effort put into setting out and implementing detailed assessment and training criteria for program delivery staff since 1999, why similar standards have not yet been implemented for parole officers and other staff involved in the rehabilitation/management of prisoners?

The Importance of Staff Values and Commitment. The importance of staff values and commitment relate to the role that these personal characteristics play in enhancing employee motivation, willingness to learn and innovate, job satisfaction, job performance, enthusiasm, creativity, etc. Given that the rehabilitation of prisoners is one of the two main "corporate objectives" of the Correctional Service Canada (the other being public safety), the monitoring of staff values and commitment related to this goal is an important part of ensuring the Service's overall effectiveness (Tellier, Milento, Dowden and Veung, 2001). Indeed, research by Canadian scholars confirms the importance of congruence between personal and organizational values for the overall effectiveness of correctional officers (Larivière, 2002; Simourd, 1997).

Although recent data are not available, findings from a Service-wide investigation of staff values and commitment conducted in the early 1990's indicated that, while there is general acceptance for CSC "corporate objectives" (including prisoner rehabilitation), this support is significantly correlated with both position and job classification as depicted in Figure 2.²⁷

²⁷ The study was based on a randomized sample of 684 CSC staff who completed both group-administered questionnaires and personal interviews. Although senior managers were excluded, the sample was constructed to represent the major occupational groupings within the service from all regions including national headquarters. See: Robinson et al., 1992.

Figure 2: Average Commitment Scores by Job Categories (c. 1991)



Source: Robinson et al., 1992

Figure 2 indicates that support for CSC corporate objectives (including prisoner rehabilitation) is highest among administrative staff, middle managers and professionals (i.e., nurses, program staff, etc.), and lowest among front-line correctional officers (who scored 3.8 out of 7). In general, the “average” commitment score of 4.2 would seem to indicate only moderate support for CSC corporate objectives throughout the organization. Of particular concern for this analysis, however, is the relatively low commitment scores of both institutional and community parole officers (CMO Institution and CMO Community) as these staff occupy central roles in the prisoner rehabilitation/reintegration process. Given these findings, it is surprising to this author that the issue of staff commitment has received very little attention by CSC in the decade since these data were collected.²⁸

The one recent CSC initiative where staff values and commitment do appear to play a significant role is the correctional officer (CO) hiring initiative launched in September 1998 (Tellier, Milento, Dowden and Veung, 2001). As part of this large-scale hiring process, CSC collected data to assess the value sets of the CO recruits in order to facilitate the hiring of individuals whose personal values more closely matched CSC corporate objectives.²⁹ A review of the criteria used in this assessment, however, suggests that values related to prisoner rehabilitation do not seem to figure very prominently. For example, the value that appears to be most closely related with rehabilitation is termed “respect.” In the study, respect “...refers to the ability of recruits to acknowledge, appreciate and understand differing beliefs of those they interact with, as well as respecting Canadian law, authority and the Mission of CSC. Examples include the recruits’ abiding to the rules, supporting leaders and authority figures, allowing differences of opinion, supporting the rights of others, and endorsing the rule of law” (Tellier, Milento, Dowden and

²⁸ The topic of staff assessments is a politically sensitive one and this may partially explain why CSC has not given more attention to this issue. At the recent “What Works in Conditional Release Conference” mentioned previously, David Perry, who is involved in a large-scale effort to restructure/upgrade the parole system in the United Kingdom, stated that parole staff are often reluctant to submit to these types of exercises because we are essentially “assessing them on the same criteria that we assess offenders.” I believe the controversy inherent in this approach speaks for itself.

²⁹ In addition, the values of the new recruits hired under this initiative will be re-assessed during their training, and again after twelve months of working on the job, in order to track how they may change over time.

Veung, 2001:3). While some of these values can indeed be related to support for prisoner rehabilitation, it is troubling that the value assessment process included in the CO hiring initiative did not include more explicit criteria related to this important CSC corporate objective. Further, the rather limited scope of this initiative (i.e., focused only on correctional officers hired since 1998) means that it will likely translate into only marginal improvements in overall staff commitment in the short to medium-term.³⁰ Clearly, if CSC is serious about addressing the issue of staff values and commitment, a broader initiative will need to be implemented.

This section has reviewed the progress that CSC has made implementing the principle of professional discretion. While there is some evidence that CSC has begun to address issues related to this important principle of effective corrections, there is also much to be done. In particular, criteria relevant to the “staff side” of responsibility need to be explicitly included in the assessment and training of all staff involved in prisoner rehabilitation, and methods of objectively assessing and tracking the values and commitment of staff to CSC’s corporate objectives (including prisoner rehabilitation) need to be expanded Service-wide. On a more practical level, given the fact that detailed performance data have been collected on all program officers since the promulgation of Appendix A of *SOP 726* in 1999, it is imperative that CSC collate and publish this information as soon as possible in order to facilitate independent assessments of the Service’s performance and to promote public accountability.

Implementing the Principle of Program Integrity

In assessing CSC’s efforts to implement the principle of program integrity, it is important to recognize that this principle was added to the “what works” criteria in the mid-1990’s and, therefore, CSC has had less time to implement it into its operations (Bonta, 1997). By way of review, the principle of program integrity suggests that in order to ensure the ongoing effectiveness of programs, periodic assessments of program design and actual program delivery must be undertaken to make sure that the principles of effective corrections are correctly and consistently applied at all delivery sites over time.

All of CSC’s national programs now have built in evaluation components that allow for the collection of both qualitative and quantitative data to assess their adherence to the principles of effective corrections. Indeed, *Commissioner’s Directive 726*, “The Management of Correctional Programs,” states that: “Evaluations, by specific program areas, shall be conducted on a five-year cycle unless a program has been accredited” (CSC, 1999a). Overall program evaluations are conducted in order to determine:

- if the program is meeting its objectives within the established budget;
- if the objectives remain valid;
- if the program is cost effective;
- the program’s strengths and weaknesses;
- whether the referral criteria remain appropriate;
- if the program is based on the latest scientific knowledge;
- if the program addresses factors that contribute to criminal behavior;
- if the program has the characteristics research indicates are essential to program success;
- if the program has a research component;
- if the program has an impact on CSC’s activities and operations;
- if the program is suitable for offenders with special needs/characteristics;

³⁰ An analysis of demographic variables collected during the correctional officer hiring initiative revealed that the new recruits included fewer women and were, on average, less educated than those hired before 1998. Since support for rehabilitation is generally higher among women and those with post-secondary education, these trends do not bode well for increasing support for prisoner rehabilitation among correctional officers at CSC.

- whether the program is having an effect on reducing the risk to the public; and
- whether the offenders view the program/deliverers as effective and suitable to their needs (CSC, 1999b).

In order to monitor program integrity, CSC evaluates programs on both the micro and the macro levels. On the macro-level, CSC convenes international accreditation panels on five-year intervals to review program design and assist in the development of program implementation guidelines, and the Service conducts generalized statistical evaluations to determine overall program effectiveness. On the micro-level, the CSC accredits programs at the site level and conducts annual performance reviews of program delivery staff. Each of these topics is discussed in greater detail below.

National Program Accreditation. An important part of CSC’s efforts to implement the principle of program integrity is the creation of an independent review process to validate that its programs embody the principles of effective corrections. In order to facilitate this goal, CSC assembles International Experts Panels (IEP’s) with expertise in specific areas (e.g., sex offender treatment, substance abuse treatment, etc.) to review the design of its core correctional programs. In addition to assessing and accrediting CSC’s core programs, the IEP’s also review and approve implementation guidelines and assessment criteria set out for each program in the appendices to *SOP 726* which are used in the site accreditation process (see below). Additionally, in order to assure that its programs continue to be based on “state of the art” knowledge, each program is re-accredited by the IEP on approximately five-year intervals (CSC, 1999a). Table 4 below depicts the status of CSC’s IEP program accreditation process as of September 2003.

Table 4: International Experts Panel Accreditation of CSC’s National Treatment Programs

Program	Date Reviewed	Outcome	Due for Re-review	Scheduled for Re-Review (tent.)
Cognitive Skills	June 1998	Accredited	June 2003	February 2004
Anger and Emotions Management	June 1998	Accredited	June 2003	February 2004
High Intensity Substance Abuse	March 2002	Conditional Accreditation for 1 Year	March 2003	December 2003
OSAPP (including Long Term)	August 1998	Accredited	August 2003	December 2003
Choices	August 1998	Accredited	August 2003	December 2003
ITPVO – High Intensity Violence Program (Regional Health Centre, Pacific)	June 2000	Not Accredited	Must be re-evaluated to see if is should be brought forward again or replace by national program.	
National Violence Program	June 2000	Accredited	June 2005	June 2005
Persistently Violent Offender	June 1999	Accredited	Discontinued and replaced by the National Violence Program.	
La Macaza – High	October 2001	Conditionally	October 2003	Spring 2004

Intensity Sex Offender Program (Regional Headquarters, Quebec)		Accredited for 2 years.		
High Intensity Sex Offender (Regional Treatment Centre, Ontario)	August 2000	Not Accredited; came forward again in October 2002 and was accredited.	October 2007	October 2007
IITPSO-High Intensity Sex Offender (Regional Health Center, Pacific)	November 1998	Not Accredited	Must be re-evaluated to see if is should be brought forward again or replaced by national program.	
Clearwater – High Intensity Sex Offender (Regional Psychiatric Centre, Praries)	November 1998	Accredited with conditions.	November 2003	Spring 2004
Moderate Intensity Sex Offender	June 2000	Accredited	June 2005	June 2005
VISA – Low Intensity Sex Offender (Regional Headquarters, Quebec)	October 2001	Conditional Accreditation for 2-years.	October 2003	Spring 2004
Low Intensity Sex Offender	August 2000	Accredited	August 2005	August 2005
Challenge – Low Intensity Sex Offender (Regional Treatment Centre, Atlantic)	August 2000	Not Accredited	Must be re-evaluated to see if is should be brought forward again or replaced by national program.	
Northstar – Low Functioning Sex Offender (Regional Health Centre, Pacific)	November 1998	Not Accredited	Must be re-evaluated to see if is should be brought forward again or replaced by national program.	
High Intensity Family	March 2001	Accredited	March 2006	March 2006
Moderate Intensity Family	March 2001	Accredited	March 2006	March 2006
CERUM	October 2002	Not Accredited	Is supported to come forward again.	Spring 2004

Source: CSC Performance Assurance Sector.

As Table 4 suggested, CSC's core national programs have fared very well in the IEP accreditation process, while several of its regional/local programs have not. This outcome is fueling a trend whereby CSC's accredited national programs are replacing non-accredited regional and local programs. While this

trend can be viewed as generally positively, it is important that CSC ensure that the “top down” standardization of its programs does not detract from the Service’s ability to develop innovative programs and practices that may be directed from the “bottom up.” On this point, it is important to recognize that evaluations based on *outcomes* rather than on *process* are essential to the identification of effective localized practices that could be redirected back into national programs.

Evaluating Overall Program Effectiveness. The overall effectiveness of CSC’s programs is evaluated infrequently through statistical outcome assessments that most often document the effects of specific programs on future offending (recidivism). Table 5 lists the results of CSC’s program effectiveness studies undertaken since the mid-1990’s.

Table 5: CSC Program Effectiveness Studies

Criminogenic Need	Study Title	Design/Sample	Results
Substance Abuse	"An Outcome Evaluation of CSC Substance Abuse Programs: OSAPP, ALTO, and Choices Executive Summary" (T ³ Associates, 1999).	Compared a sample of male federal offenders who participated in OSAPP with a matched sample of offenders. Follow-up period of 1 year.	2,432 offenders completed OSAPP and showed a 14% reduction in re-admissions (from 49% for the benchmark group to 42% in the program group) and 31% reduction in new convictions (from 21.9% for the benchmark group to 15.2% in the program group).
Education	"A Two Year Follow-Up of Federal Offenders Who Participated in the Adult Basic Education (ABE) Program" (R. Boe, 1997, CSC Research Report R-60).	Compared a sample of male federal offenders who participated in ABE with a national sample of paroled offenders. Follow-up period of two years.	718 paroled offenders who completed ABE-8 program had a 7.1% reduction in re-admissions (from 24% for the benchmark group to 22.3% for the program group). 74 paroled offenders who completed ABE-10 program had a 21.3% reduction in re-admissions (from 24% for the benchmark group to 18.9% in the program group).
Employment	"Prison Work Programs and Post-Release Outcome: A Preliminary Investigation" (L. Motiuk and R. Belcourt, 1996, CSC Research Report R-43).	Compared a sample of male federal offenders who participated in CORCAN with a national sample of paroled offenders. Follow-up period of 1.5 years.	52 paroled offenders who participated fully in the prison industries program (CORCAN) had a 27.8% reduction in re-admissions (from 26.6% for the benchmark group to 19.2% in the program group).

Personal/Emotional	"The Impact of Cognitive Skills Training on Post-release Recidivism among Canadian Federal Offenders" (D. Robinson, 1995, R-41)	Compared a sample of federal offenders who completed Cognitive Skills Training with offenders who remained on the waiting list without programming.	1,444 offenders who completed cognitive skills training demonstrated an 11% reduction in re-admissions to prison and 20% reduction in new convictions.
	"Anger Management Programming for Federal Inmates: An Effective Intervention" (C. Dowden et al, 1999, R-82)	Compared a matched sample of male federal offenders to an untreated comparison group. Matched on age, risk and major offence. Average follow-up period of 1.5 years	56 higher risk offenders completed the Anger Management program and showed a 69% reduction in non-violent recidivism (from 39.3% for the benchmark group to 12.5% in the program group) and 86% reduction in violent recidivism (from 25% for the benchmark group to 3.6% in the program group).
Sex Offenders	"Applying the Risk Principle to Sex Offender Treatment" (A. Gordon and T. Nicholaichuk, 1996, FORUM, 8(2)).	Compared treated male sex offenders with a national sample of sex offenders. Follow-up of two years.	80 higher risk sex offenders on the Clearwater Unit program showed a 58.9% reduction in sexual recidivism (from 14.6% for the benchmark group to 6.0% in the program group).
	"A Multi-Year Multi-Modal Review of Sex Offender Programs in Federal Corrections" (L. Motiuk, 1998, 17 th Annual Research and Treatment Conference for the Association for Treatment of Sexual Abusers).	Compared treated male sex offenders with a national sample of all released sex offenders. Follow-up of three years.	210 treated sex offenders showed a 50% reduction in sexual recidivism (from 6% for the benchmark group to 3% in the program group).

Source: Motiuk, Boe, and Nafekh, 2002.

As Table 5 suggests, CSC appears to have devoted significant resources to assessing the outcomes of some of its core correctional programs in the 1995-1999 time period, but has not completed a major program outcome evaluation since that time. Given the central importance of outcome evaluations to the principle of program integrity, it is surprising that CSC has not given more consistent attention to this issue. More importantly, while program-level statistical evaluations such as these are useful for validate the overall effectiveness of treatment programs, *it is also important that regular, site-specific outcome evaluations occur to verify the effectiveness of programs delivered in specific locations and by specific staff.* That is, while it is significant that CSC employs advanced statistical analyses to generate overall outcome effectiveness evaluations of its programs, it is troubling that it does not conduct regular, site-specific outcome evaluations to add specificity to its performance assessments.

Program Site Accreditation. In order to assure program integrity in each of its facilities, CSC has developed procedures for accrediting program delivery at the site level. The criteria for site accreditation are set out following extensive consultation with program staff and are approved as appendices to *SOP 726, "The Management of Correctional Programs,"* by the same International Experts Panels (IEP's) that accredit CSC's programs at the national level. In 1998, the OSAPP, OSAPP Long, Choices, Cognitive Skills/Cognitive Skills Booster, and Anger and Emotions Management/Anger and Emotions Management

Booster programs were accredited by the IEP, and site implementation guidelines for these programs were added as Appendices A and B to *SOP 726*. Between November 1998 and November 2001, CSC conducted site evaluations of 37 male prisons and 19 parole districts across all five regions. The outcome of CSC's site accreditation efforts are depicted in Tables 6 and 7 below:

Table 6a: Percentage of Institutions Receiving 3-Year Program Accreditation as of Nov. 2001

CSC Region	OSAPP	OSAPP Long	Cognitive Skills	Anger Management	Avg.
Atlantic	100	50	100	100	87.50
Quebec	10	0	90	80	45.00
Ontario	88	0	88	66	60.50
Prairie	100	25	100	66	72.75
Pacific	83	33	83	66	66.25
Avg.	76.20	21.60	92.20	75.60	66.40

Table 6b: Percentage of Parole Regions Receiving 3-Year Program Accreditation as of Nov. 2001

CSC Region	Choices	Cognitive Skills	Cognitive Skills Booster	Anger Management	Anger Management Booster	Avg.
Atlantic	80	0	60	0	0	28.00
Quebec	100	0	0	0	0	20.00
Ontario	60	40	40	40	0	36.00
Prairie	75	25	50	50	0	40.00
Pacific	33	0	33	0	0	13.20
Avg.	69.60	13.00	36.60	18.00	0.00	27.44

Source: CSC Performance Assurance Sector

The low overall accreditation percentages depicted in Tables 6a and 6b are due mainly to the fact that site accreditation was temporarily suspended in November 2001 pending a review and standardization of the accreditation process. Thus, a substantial proportion of sites have never been assessed for accreditation. In total, only 2.70% of CSC institutional programs and 7.37% of parole region programs were assessed as "not accredited" by November 2001.³¹ The site accreditation process is set to resume under the new, standardized criteria in early 2004 (Hooper, 2003). Inasmuch as the accreditations granted in the 1998-2001 time frame were limited to 3-years, the site accreditation process will need to be repeated for all sites and regions when it resumes under standardized guidelines in 2004.

Evaluating Program Delivery Staff. In regards to the evaluation of program delivery staff, Appendix A of *SOP 726* states that the performance of all substance abuse program facilitators will be evaluated by regional trainers annually. Those who do not meet basic minimum standards are directed to take refresher training or, in extreme cases, may lose their certification to deliver programs. Program officer evaluations consist of reviewing videotaped sessions of actual program delivery, monitoring of compliance with

³¹ These numbers were calculated as follows: A total of 37 institutions were assessed over 4 programs, and only 4 program sites were "not accredited" $4/(37 \times 4) = 2.70\%$. Amazingly, Warkworth Institution in Ontario accounted for 3 of the 4 negative institutional program assessments. A total of 19 probation regions were assessed over 5 programs and a total of 7 regional programs were "not accredited" $7/(19 \times 5) = 7.37\%$. The Southern and Manitoba Parole Districts in the Prairie Region, and the Vancouver Parole district in the Pacific region, accounted for 6 of the 7 negative parole program assessments.

program implementation standards and the evaluation of written reports (CSC, 1999a). In addition, “Prior to commencement of each program, the facilitator shall be instructed by the regional trainer as to which sessions shall be videotaped. As a minimum requirement, for each Substance Abuse Program delivered by each facilitator, three program sessions shall be videotaped” (CSC, 1999b, Appendix A, Sections 7.2 and 7.4).³² While these types of assessments will ensure that program staff follow implementation guidelines set out for specific programs, they do not provide information regarding their effectiveness in producing desired program outcomes. The site-specific outcome evaluations mentioned previously would assist CSC in identifying specific staff that are not meeting minimum outcome performance criteria.

The program and staff evaluation practices discussed above demonstrate that CSC has begun implementing procedures for monitoring the integrity of its core rehabilitative programs, especially since the promulgation of *SOP 726* in 1999. Although this author could find no published account of actual performance data collected through the evaluative components of *SOP 726*, the Service should be commended on its recent efforts to monitor program integrity, staff competency, and overall program effectiveness. Given the significant attention that CSC has placed on monitoring the performance of its core programs and program delivery staff, however, it is perplexing that similar efforts have not been directed at monitoring the performance of other CSC staff involved in the management and rehabilitation of prisoners. In particular, the central role that both institutional and community parole officers play in the rehabilitation of prisoners warrants that they be trained and assessed at the same level as program delivery officers.³³ Additionally, while it is true that CSC’s efforts to accredit the design and implementation of its programs will further goals related to program integrity, *it is imperative that the Service also conduct regular site-specific outcomes assessments of programs and staff* so that it can be more specific in the identification of sites that may not be achieving minimum *outcome* performance standards. Outcome assessments conducted at this level will allow the Service to identify problems that may not be found in the broader efforts to accredit program design and implementation standards discussed above. Site-specific outcomes assessments will also allow the Service to be more efficient in the use of resources devoted to performance enhancement as it can direct these resources at specific problem sites.³⁴

This paper has reviewed the Correctional Service of Canada (CSC’s) efforts to conduct research on and implement the principles of effective corrections. Generally speaking, this analysis reveals that CSC has devoted significant resources toward furthering our understandings of “what works” in correctional rehabilitation, and toward translating these understandings into good correctional practices. Thus, the Service appears to indeed be worthy of its reputation as one of the most progressive and innovative correctional services in the world. There are, however, several areas where the Service could improve on these excellent efforts. Recommendations relevant to each of the major principles of effective corrections are presented below:

³² Appendix B of *SOP 726* sets out similar evaluation procedures for CSC’s core “living skills” programs and staff. See Footnote 19 for more information on the programs covered under Appendix B.

³³ James Bonta of the Solicitor General’s office is currently conducting a “what works” assessment of probation in Manitoba and will be publishing the results from this study in the Fall of 2003. At the “What Works in Conditional Release” Conference mentioned previously, Dr. Bonta reported preliminary findings from the study which suggest that probation staff in Manitoba appear to be effectively applying the what works principles about 50% of the time in their interactions with prisoners.

³⁴ At the “What Works in Conditional Release” conference mentioned previously, David Perry described the significant efforts currently being implemented in the United Kingdom to increase the performance of its parole system. These efforts include the regular site specific monitoring of program delivery and outcomes. This approach is useful for identifying sites and staff that are not meeting minimum *outcome* performance criteria. In cases where problems sites/staff are identified, “performance enhancement teams” are sent out to help increase performance.

RECOMMENDATIONS

The Risk/Need Principles

- *Recommendation R/N1*: Following the work of Weekes, Ginsburg and Chitty (2001) in the area of substance abuse programs, CSC should use actuarial data collected on prisoners to cross-validate that all prisoners are enrolled in programs that correspond to their assessed level of risk.
- *Recommendation R/N2*: Following the recommendation of the Task Force on the Reintegration of Offenders (1997), CSC should work to increase the ability of its risk and need assessment procedures to: (1) identify which prisoner needs are directly connected to their criminality, and (2) prioritize rehabilitative programming based on findings from (1). This recommendation should be especially applied to assessing prisoners with substance abuse issues to ensure the appropriate use of substance abuse programming.
- *Recommendation R/N3*: CSC should study the feasibility of explicitly incorporating assessments of learning style and other factors that may affect responsivity into its prisoner assessment protocols. This will facilitate, among other things, the effective matching of prisoners with the teaching styles of program officers, as suggested by the Responsivity Principle.

The Responsivity Principle

- *Recommendation RE1*: CSC should seek to increase the availability and utilization of community-based programming whenever possible. While some of the factors causal to the underutilization of community-based programming are out of CSC's control, the Service could, based on the findings of Recommendations R/N 1 and 2 above, redirect programming resources being used inappropriately in the institutions to expand the availability of community-based programs by offering them in more locations, conducting more programs in the evenings and on weekends, and delivering programs to smaller groups of prisoners when necessary.
- *Recommendation RE2*: CSC should devote resources to researching and implementing staff assessment and training protocols related to the implementation of the Responsivity Principle. These include:
 - Assessments of program officer teaching style to allow for the effective matching with prisoner learning styles.
 - Training of program officers in the assessment of prisoners for factors related to specific responsivity, including: mental disorders, cognitive functioning, age, etc.
 - Explicit training of program officers on techniques for adjusting program delivery based on specific responsivity characteristics.
- *Recommendation RE3*: CSC should, as quickly as is feasible, restructure all of its core correctional programs to include program-specific assessments of motivation and components explicitly designed to reduce prisoner resistance to change.³⁵

The Principle of Professional Discretion

- *Recommendation PD1*: CSC should work to extend the staff assessment and training protocols designed for program officers to other staff significantly involved in the management and rehabilitation of prisoners. In particular, the standards and protocols set out in the Appendices of

³⁵ According to Dr. John Weekes, CSC is now actively working to implement this recommendation throughout its menu of programs.

SOP 726 should be appropriately modified and applied to both institutional and community parole officers.

- *Recommendation PD2*: CSC should continue its recent efforts to assess staff values and commitment and, eventually, extend these efforts to all staff involved in the management/rehabilitation of prisoners. In addition, CSC should design these assessments to include criteria explicitly related to the corporate goal of prisoner rehabilitation.
- *Recommendation PD3*: Once accepted staff value/commitment assessment procedures are established out of Recommendation PD 2, CSC should make these assessments a permanent part of all hiring and promotion decisions.
- *Recommendation PD4*: CSC should collect, analyze and make public the program and program officer performance monitoring data collected based on the Appendices of *SOP 726*. These data could be presented in summary form in the Service's Annual Report.

The Principle of Program Integrity

- *Recommendation P11*: CSC should augment its current program/program staff performance assessments with regular, site-specific *outcome assessments* to assist in identifying locations and staff that may not be meeting minimum outcome performance criteria.

CONCLUSIONS

In reviewing CSC's efforts to research and implement the principles of effective corrections, several issues were uncovered that merit further consideration. First and foremost, it appears as though CSC has placed great emphasis on researching and implementing programs/procedures related to the "prisoner-side" of corrections. Although these efforts are laudable and have no doubt increased the effectiveness of CSC's efforts to rehabilitate those who have come into conflict with the law, the Service has not given the same level of attention to issues related to the "staff-side" of corrections. Many of the recommendations listed above relate to the need to take the staff side of effective corrections seriously and this involves improving efforts to implement the Responsivity, Professional Discretion and Program Integrity Principles.

Second, it is clear from this analysis that the area of substance abuse appears to be a something of a test bed for innovations within the Service. For example, it was the first area to have specific implementation guidelines set out explicitly as an Appendix to *SOP 726*. Also, the new substance abuse assessment instrument (CASA) incorporates some very innovative components related to assessing prisoner motivation and for directly linking substance use to the prisoner criminality. Thus, many of the recommendations listed above relate to expanding these innovations from the substance abuse domain to the other need domains within the Service.

Third, one of CSC's main two goals is public safety. However, in this review several conditions were uncovered that could be indicative of the fact that CSC makes decisions that *seek more to protect itself and its staff from liability rather than to maximize public safety*. As an example, consider the fact that 1/3 of the prisoners assigned to take OSAPP for substance abuse problems were not assessed as needing that level of treatment (Weekes, Ginsburg and Chitty, 2001). One of the potential costs associated with such misapplications of the Risk Principle include the fact that over-programming has been shown to *increase* recidivism in some instances. Thus, misapplying programming in this way actually has the potential to *decrease* the Service's ability to enhance public safety. One explanation for this observed misapplication of the Risk Principle is that risk-averse case managers and parole officers are over-programming prisoners

who admit to using drugs and alcohol without verifying that the prisoner's drug and/or alcohol use is directly connected to their criminality. This follows from the mindset of many who work in the enforcement/corrections sector that "all drug use is abuse." What is needed from the perspective of effective corrections is a more discerning approach to prisoner risk/need assessment that allows for the direct linking of need to criminality. While efforts to upgrade CSC's substance abuse assessment instrument via the CASA appear to be working toward this goal, this author recommends that all of CSC's assessment protocols should be upgraded as well to make them more discerning in this way.

To conclude, it is clearly the case that CSC has earned its reputation as one of the most innovative and progressive correctional organizations in the world. The recommendations derived from this paper will help the Service continue in this excellent legacy by further improving the application of the principles of effective corrections.

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