◄► CONTENTS

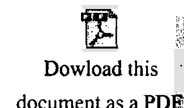
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TABLE OF CONTENTS

0 EXECUTIVE SUMMARY

1 A "SNAPSHOT" of British Columbia

2 HISTORY OF ALCOHOL AND DRUG SERVICES (ADS) in BC*

3 A BUSINESS CASE for Investing in Prevention and Treatment

4 "The DISCONTINUOUS CONTINUUM": ADS in BC
4:1 Prevention and Education
4:2 Intervention and Treatment

5 BC Government: REVENUES AND ADS EXPENDITURES
5:1 Revenues from Drinking, Smoking and Gambling
5:2 ADS Expenditures through MCF

6 The NON-PROFIT, FUNDED AGENCIES, MCF and ADS
6:1 Comments/Concerns by the Non-Profits
6:2 Other Issues
6:3 Complementary Role of the Non-Funded Organizations

7 CONCLUSIONS and RECOMMENDATIONS re SAPAC-BC

8 APPENDICES:
Appendix 1 - BC's Addiction Services as seen by MCF
Appendix 2 - Prevention
Appendix 3 - Education

* Alcohol and Drug Services (ADS) presently called Addiction Services by MCF

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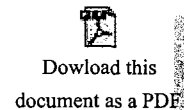
The case for an independent SUBSTANCE ABUSE PREVENTION and ADDICTIONS COMMISSION for British Columbia



0) EXECUTIVE SUMMARY:

Background:

This discussion paper makes a case for a SUBSTANCE ABUSE PREVENTION AND ADDICTIONS COMMISSION for British Columbia, or (SAPAC-BC).

It recommends that the Government of British Columbia reconsider the integration of the province's alcohol, drug and gambling services (ADS) within the programs of the Ministry for Children and Families (MCF).

It contends that the ministry's focus on children and/or families in crisis renders about 90% of British Columbians invisible when it comes to alcohol, drug and gambling prevention and treatment services.

Rationale:

Despite the best efforts of the dedicated people working both within and outside of government, these crucial policies and services cannot be realistically formulated and/or successfully delivered under the present system.

Approximately 15% of BC's present alcohol, drug and gambling services are provided "direct" through the provincial government, with 85% delivered "indirectly" through about 200 funded, non-profit agencies as well as volunteer services.

Service providers complain that under the existing system ADS suffers from having a very low priority and profile, no clear provincial strategy, a lack of focus and leadership, inadequate consultation and coordination, inconsistent and unreliable funding, miniscule prevention efforts, and little or no research. In short, they contend that present ADS are ineffective within a ministry that has "more pressing" priorities.

Whatever the causes, vital alcohol, drug and gambling services are being smothered and lost, becoming even less effective at a time when they are needed most.

A separate body with a strong mandate is the recommended solution.

Recommendations:

We propose the establishment of an arms-length Commission. It should be as independent as possible from day-to-day politics. We suggest it could be called the Substance Abuse Prevention and Addictions Commission (SAPAC-BC).

SAPAC's goal, as with MCF's today, would be to oversee and to ensure the provision of a continuum of services: from education and prevention through to intervention and treatment. It would have the added advantages of having the profile, the mandate and the resources to get the job done.

We see the Commission as a visible, pro-active and credible body.

It would be given the responsibility to help British Columbians make healthier choices in their non-use or use of alcohol, tobacco, drugs and gambling. It would take the lead role, with appropriate partnerships when possible, in providing effective public awareness and information campaigns, particularly for younger British Columbians.

Its mandate should be legislated. It should be provided adequate resources to establish a realistic and comprehensive long-term plan, to provide leadership and coordination in carrying out that plan, to undertake and gather quality research, and be seen as a value-added public resource in a well-functioning provincial system.

It would not be some remote body, off on its own. The Commission would collaborate with and coordinate the full range of affected interests, from the various affected government ministries, to service providers and volunteers, to research interests, to potential partnerships, to clients and, particularly, to youth.

In keeping with recommendations by the Seaton Commission and others, SAPAC-BC should provide greatly increased priority and funding for education and prevention efforts. One-third of the new Commission's budget and focus should be on prevention. The increased funding for prevention and education should be additional, not taken from already-stretched existing funding for treatment.

A case could be made to have this new Commission most closely associated with the Ministry of Health. However, given the beleaguered state of health services today, and the absolute imperative that SAPAC-BC be highly visible

and credible in order to be effective, we believe that a separate Commission is essential.

As well, while understanding that successful programs to reduce abuse and addiction take consistent application over time, and believing that the new body would work best without having to contend with day-to-day politics, the Commission would provide annual opportunities to have its strategy and effectiveness reviewed by the Legislature or a Legislative Committee.

Extent of Use:

Whether we use them or not, alcohol, tobacco and other drugs are a big part of our lives. So is gambling. Who among us has not experienced an alcohol or drug or gambling "problem" within our family, or our circle of friends or associates?

There are lessons we try as a society to incorporate into our own lives, and to pass on to our children, on activities such as using a substance or playing the lottery. For instance: There's nothing wrong with abstinence. Delay first use. Learn about any substance before you even consider putting it into your body. Learn what's involved in any activity before you decide whether to participate. Make good choices. If you decide to do something, be responsible, be moderate, and stay in control. Stay aware of what you're doing, and if you think you've got a problem, change your behaviour, or get some help.

Most British Columbians are "users" of something. The main recreational drugs of choice for adults are alcohol, tobacco and marijuana. Almost 2.24 million British Columbians admit to drinking alcohol, at least occasionally. Roughly 750,000 British Columbians admit they still smoke cigarettes. Over 350,000 admit they smoke marijuana, despite social and legal discouragement. As for non-recreational use, over 450,000 daily use prescription medicines. When it comes to gambling, over 2.1 million British Columbians buy lottery tickets, and over 180,000 visit casinos, at least occasionally.

While most British Columbians do not presently have serious or chronic problems with alcohol, drugs and gambling, too many do. At least 10% of our population could be considered "at risk" or worse and in need of some form of counseling or treatment, with 2.5% chemically dependent or otherwise addicted.

In addition, of the 90% presently not considered at serious risk, many have significant problems that are directly or indirectly caused by their inappropriate use of alcohol and other drugs. These range from health concerns, to associated crime, to family and relationship issues, to productivity, both in the workplace and the school setting.

Education and prevention aim to provide credible information and social skills that help British Columbians make good choices and avoid problems through use or abuse. Treatment responds to problems, with efforts to assist recovery. Obviously, it's better to help someone avoid getting a problem than having to help someone recover after they've got the problem.

To the extent that the provincial government has assumed the leadership role in this health and social issue, it has attempted to provide for a "continuum" of alcohol, tobacco, drug and gambling services.

But with the exception of admitted cigarette smokers, there are more British Columbians engaged in a wider variety of substance use, and abuse, than ever before. "First use" is beginning at a younger and younger age.

As a society, we've been unable to respond in a clear, credible and effective way. Our present and our potential problem is massive. Our response has been woefully inadequate, and dangerously invisible to most British Columbians.

Costs of Abuse:

The cost of substance abuse - including tobacco - to the British Columbia taxpayer, and to business, is staggering. Conservative estimates provided by the major 1996 study by the Canadian Centre for Substance Abuse (CCSA) and Ontario's Centre for Addictions and Mental Health (CAMH) put the annual costs of substance abuse to British Columbia at over $2.25 billion, or about 2.6% of the Gross Provincial Product (GPP) back in 1992.

The same CCSA/CAMH study estimates that tobacco use accounts for 49.2% of total substance abuse costs in BC, alcohol for 41.6%, and illicit drugs for 9.2%.

Substance abuse leads annually to 45% of all deaths by drowning, 45% of all motor vehicle accidents and 50% of all motor vehicle deaths. More telling, an incredible 21% of total morbidity (disease/suffering) was due to the abuse of tobacco, alcohol and illicit drugs.

Regrettably, BC leads the nation in a number of key categories. Our mortality (death) rate for alcohol-related disorders is the highest in Canada. So is our rate of HIV per capita. So is our number of deaths per capita due to illicit drug use. So is our cost of illicit drug use to our GPP, estimated at 0.24%.

Our Youth:

More important, how are we doing with the younger generation?

We need look no further than the latest McCreary Centre Society survey of 26,000 students taken here in British Columbia last year.

Of our 17-year-old students, 80% admit having tried alcohol recently and, of those, 44% having been binge drinking at least once in the last month. Of the same 17-year-olds, admitted experimentation with marijuana has risen by 50% in the last five years, to 58%. Among 13-year-olds, the number admitting to trying marijuana has doubled in the last five years to 20%.

MCF's own "Measuring Our Success" (1999) reports that the percentage of children and youth in BC who smoke regularly or consume alcohol has risen significantly in the last 5 years and is well above the national average.

More of our young people are using more drugs, beginning at a younger age.

Prevention and Treatment are Cost-Effective:

When it comes to devoting the necessary resources at the earliest possible stages for prevention and treatment, the question is not whether we can afford to, but whether we can afford not to. Or to paraphrase former provincial Chief Coroner Vince Caine: Pay now, or pay more later!

By almost every measure or study, education/prevention/intervention and treatment are the most cost effective, and socially beneficial, routes to a healthier society with less substance abuse and addiction.

Reducing demand is fundamental, and the keys here are prevention and treatment.

Prevention is cost effective because it reduces the number of new cases of abuse or addiction. According to Prevention Source BC (PSBC), with comprehensive and long-term prevention (involving schools, communities and families), the cost savings range from estimates of $4 to $65 per dollar spent, depending on the study and the substance. Potential savings would seem to be greatest by reducing tobacco and alcohol abuse.

Treatment is cost effective. For instance, a RAND Study (Massing, 1994) compared the effectiveness of four types of drug control in reducing cocaine consumption. The four areas were domestic law enforcement (arresting and imprisoning buyers and sellers), interdiction (stopping drugs at the border), source control (attacking the drug trade abroad), and drug treatment.

The RAND study showed that treatment was seven times more effective than law enforcement, 10 times more effective than interdiction, and 21 times more effective than attacking drugs at their source.

The Alberta Alcohol and Drug Abuse Commission (AADAC) estimates that every $1 invested in substance abuse treatment saves or returns $7.14 after one year through increased productivity and savings in such areas as health and justice system costs.

Similarly, James Langenbucher at Rutgers University showed that treatment for addictive disorders drives down demand for health care and promotes more efficient use of the health care system by patients and their families.

Additionally, significant financial savings also result from the positive effect treatment of the abusers has on their families. Spouses and children are heavy users of health care, with up to four times more than the norm. In one study, the health system use by family members, after their alcoholic relative received appropriate treatment, fell by 50%. Of the total decline, nearly two-thirds was attributable to decreased system use by family members.

The Government Gets Revenues:

The provincial government does well when it comes to revenues. The province takes in almost $1.7 billion from taxes on tobacco, sales of liquor, and gambling. This includes profits from government liquor stores, social services taxes on beer and wine store sales, the tax of 10% per drink sold in licensed establishments, and its share of proceeds from legal lottery and gambling activities.

That $1.7 billion represents roughly 8% of annual gross revenues to the provincial government.

And Invests in Prevention and Treatment Services (ADS):

The provincial government provides alcohol, drug and gambling prevention and treatment services, in partnership with volunteer, non-profit and other service providers.

In addition to the general costs absorbed through our universal health and social assistance systems, MCF targets roughly $60 million dollars annually towards alcohol, drug and gambling abuse prevention and treatment.

The $60 million MCF spends on prevention and treatment services represents less than 4% of the almost $1.7 billion in provincial revenues provided through legal sale and tax on alcohol, tobacco and gambling.

But We're Not Getting the Job Done:

While fully acknowledging the best of intentions in attempting to rationalize alcohol, drug and gambling services within MCF, the experiment has been a failure. Our desired continuum has become discontinuous.

While the vast majority of British Columbians do not now have serious or chronic alcohol, drug or addiction problems that today require treatment, we are not devoting adequate attention and resources to help prevent them from joining the 10% now at risk or already chemically dependent or addicted.

British Columbians are facing a major and worsening challenge. What we're trying to do -reduce abuse -- isn't working. There is a better way.

Conclusions:

Our basic message is simple. As a society, we should:

- take a more pro-active role to raise awareness, and to provide British Columbians with more credible information and skills to help them make appropriate and responsible choices in their non-use or use of available alcohol, tobacco, drug or gambling activities;
- provide appropriate and timely intervention when our fellow citizens develop alcohol, tobacco, drug use or gambling problems; and,
- reduce the stigma of addiction and take better advantage of a range of evidence-based treatment methods to help the disordered individuals, and their families, become healthier, with the consequent reduction in economic and social costs.

We believe a new, independent body would achieve the best results. It must have a strong mandate and adequate resources. It would provide visible leadership, while ensuring the efficient coordination and the effective delivery of alcohol, tobacco, drug and gambling services.

Appropriate services - from education and prevention through to intervention and treatment -- should be readily available to those British Columbians who want to maintain or restore their personal health.

The "SAPAC" Paper is a Collaborative Effort:

A Commission, along the lines of SAPAC, has been recommended often before.

This recommendation is consistent with the 1991 Seaton Royal Commission on Health Care and Costs, position papers prepared by the BC Medical Association's Committee on Addiction Medicine, by the Association of Substance Abuse Programs in BC (ASAP-BC), by several other studies prepared for government over the last 10 years, such as former provincial Chief Coroner Vince Caine's 1994 Report and former provincial Health Officer John Millar's 1998 Report, and by the overwhelming majority of service providers consulted in preparation of this discussion paper.

The paper also concludes that it would be beneficial to have a regular outside assessment of how effectively the province is progressing with its alcohol, drug and gambling services. The Kaiser Youth Foundation has agreed to work with the BC Medical Association's Committee on Addiction Medicine and other key stakeholders to prepare and publish this regular, perhaps biennial, review of alcohol, tobacco, drug and gambling services in British Columbia.

This overview and critique is put forward by a cross section of professionals and organizations working in the field. It has been assembled by the Kaiser Youth Foundation, working in collaboration with: Dan Reist and the Association of Substance Abuse Programs in BC (ASAP-BC); Dr. Ray Baker of the BC Medical Association's Committee on Addiction Medicine; Art Steinman and Alcohol-Drug Education Service (A-DES); Colin Mangham and Prevention Source BC (PSBC); Ross Ramsey of Optima Humanus; forensic psychiatrist Dr. Maelor Vallance; Sgt. Chuck Doucette (RCMP Drug Awareness Service), and many others.

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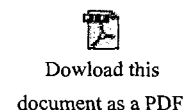

1) A SNAPSHOT of British Columbia*

*(Unless otherwise noted, polling percentages are from The Canadian Profile on Alcohol, Tobacco and Other Drugs, published in 1999 by the Canadian Centre on Substance Abuse and Ontario's Centre for Addiction and Mental Health)

The social costs of substance abuse, and various addictions from chemical dependency to gambling, are well known to professionals in the field.

What may not be fully appreciated in the broader population is the staggering cost of substance abuse -- including tobacco - to the Canadian taxpayer and to Canadian business.

The 1996 study by the Canadian Centre for Substance Abuse and the Centre for Addiction and Mental Health used conservative estimates in concluding the cost at roughly $18.4 billion, or about 2.7% of the Gross Domestic Product in 1992. The study took into account such "direct" costs as health care, losses in the workplace, administrative costs such as social welfare payments and workers' compensation, research and prevention costs, law enforcement costs, fire or traffic accident costs, and "indirect" costs such as losses due to morbidity (disease/suffering), mortality (death) and crime.

The study estimated that tobacco use accounts for 51.8% of Canada's total substance abuse costs, alcohol use for 40.8% and illicit drug use for 7.4%.

For British Columbia, the comparable numbers are roughly 49% for tobacco, 42% for alcohol and 9% for illicit drug use.

The CCSA/CAMH study put British Columbia's costs of substance abuse during 1992, the year of the data analyzed, at over $2.4 billion, or 2.6% of BC's Gross Provincial Product.

More telling, an incredible 21% of total morbidity among Canadians was due to the abuse of tobacco, alcohol and illicit drugs.

And, regrettably, British Columbia leads the nation in a number of key categories. BC's mortality rate for alcohol-related disorders is the highest in Canada. BC's rate of HIV per capita is the highest in Canada. BC's number of deaths per capita due to illicit drug use is the highest in Canada.

As well, the cost of illicit drug use to the province's GPP is also highest in the country, estimated at 0.24%. While the costs of illicit drug use are significant, it is noted that the same CCSA/CAMH study estimated that the abuse of tobacco and alcohol accounted for over 90% of the overall costs of substance abuse.

A snapshot overview of British Columbians would show, not surprisingly, that all mature British Columbians are exposed to opportunities to use alcohol and drugs. Unfortunately, this availability is occurring at a younger and younger age.

For the purpose of the following we assume an overall provincial population of four million people, with three million being the number of British Columbians 19-years or older.

Among adults, roughly 78% (an estimated 2.34 million British Columbians) drink alcohol. A quarter of these (585,000) "at least occasionally" consume more than the guidelines for "low risk" drinking. 2.5% meet the criteria for alcohol dependence. 14% count themselves as former drinkers. 7% profess to be lifelong abstainers. Interestingly, while 10% report "problems" with their own drinking, 58% of British Columbians have problems with "someone else's" drinking.

In the early '70's, well over half of British Columbians smoked cigarettes. Today, a quarter (750,000) admit they still do, of which 48% (360,000) would be considered nicotine dependent. 35% count themselves as former smokers. Roughly 40% are considered non-smokers, having smoked less than 100 cigarettes in their lifetimes.

At least 12% (360,000) admit to using marijuana over the last year, while 35% (over one million British Columbians) admit to having tried it at least once.

On admitted illicit drug usage over a lifetime, British Columbians lead the nation in marijuana (35.4%), cocaine (8.1%), LSD, Speed and/or Heroin (10.4%), and "any one of the five previously mentioned" (36.6%), according to the CCSA/CAMH study. Admitted usage during the preceding year showed British Columbians at 11.6% for marijuana, 1.2% for cocaine, 1.6% for LSD, speed and/or heroin, and 11.8% for any one of the five.

Among youth, substance use has increased while the age of first use has dropped.

In BC, the legal age to drink is 19. The legal age to purchase cigarettes is also 19. There is no legal age to purchase or to use marijuana.

However, according to the RCMP, the average age for first use of tobacco is 10. For alcohol, 12. For marijuana, 12.

Over 40% of 13-year-olds have tried alcohol, which rises to over 80% by the age of 17. Of young people that drink, 44% have been "binge" drinking (five drinks or more over a two hour period) within the last month.

At least 45% of young people admit to having tried cigarette smoking.

The latest McCreary Centre Society survey indicates admitted marijuana use has risen significantly over the past five years among high school students, with 20% of 13-year-olds and 58% of 17-year-olds admitting they have tried the drug. Roughly speaking, marijuana use among youth has risen by over 50% in the last five years, doubling among 13-year-olds.

Having laid out these statistics, it is important to note that the vast majority of adult British Columbians do not experience chronic or on-going problems with alcohol and/or drug abuse.

The majority of British Columbians successfully determine their own levels of appropriate non-use or use of alcohol, cigarettes and other drugs. However, excluding cigarette smokers, at least 10% (300,000) might be considered "at risk" or worse, with at least 2.5% (75,000) chemically dependent in some form.

However, one of the principal concerns identified in preparing this paper is that we are not doing enough to help educate and prevent the 90% that do not have major problems with substance abuse from sliding into the group of 10% that are at risk or worse. British Columbians of all ages are not provided with sufficient information on improving their personal health, on making good choices while reducing the risks of substance abuse.

Abstinence is great. Delaying first use is important. But are we doing a good job of providing British Columbians, particularly younger British Columbians, with realistic and credible education and prevention information and skills development to help them to make good choices of what substances to use or not to use, or how much?

We believe the answer is no!

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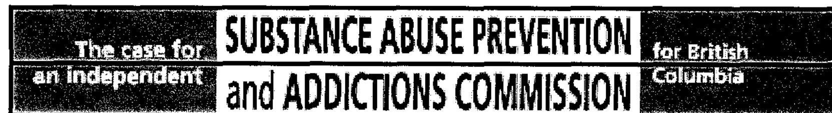

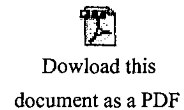

2) HISTORY OF ALCOHOL AND DRUG SERVICES (ADS) in BC*

*Although presently known as Addiction Services by MCF, these are referred to as Alcohol and Drug Services (ADS) for the purpose of this paper.

After decades of benign neglect of those citizens with drug and alcohol problems, governments finally, in the 1950's, began to play a complementary role to assist the non-profit, religious and charitable agencies that had been shouldering the bulk of assistance efforts.

However, from the beginning the provincial government's alcohol and drug services (ADS) have been inconsistent, under-funded and nomadic, having been shuffled in and out of a variety of different government ministries and agencies.

In 1952, the Health and Auxiliary Department of Greater Vancouver requested that the provincial government study the extent of alcoholism in British Columbia.

In 1953, the Alcoholism Foundation of British Columbia (AFBC) was formed through a financial contribution from the province. In 1955, the AFBC opened an outpatient treatment centre in Vancouver.

Also in 1955, the Narcotics Addiction Foundation (NAF) was incorporated under the provincial Society Act.

The provision of alcohol services through AFBC and the provision of drug services through NAF resulted in a duplication of services and competition for scarce resources. This was frustrating to clients, many of whom had problems with both alcohol and drugs, as well as to service providers.

This led, in 1973, to the passing of the Alcohol and Drug Commission Act for the establishment of a single system to provide all substance abuse services in the province. This Commission got off to a fairly good start but, over time, lost its effectiveness and credibility and was deemed "too political" by many service providers in the field.

In 1982, the Alcohol and Drug Commission was disbanded, primarily as a result of the controversy over the Heroin Treatment Program and methadone maintenance. At that time, Alcohol and Drug Programs (ADP) was formed and located within the Ministry of Health.

In 1985, The Kaiser Youth Foundation was founded to promote healthy lifestyles and prevent substance abuse, particularly among youth. In its early days The Foundation worked closely with the provincial government and originally had three provincial ministers (the Social Resources Committee of Cabinet) on the Board of Directors.

As it evolved, The Kaiser Youth Foundation chose to pursue a more independent course, although continuing to work closely with the province on certain projects and programs. A most notable success is the Kaiser Directory of Addiction Services, published in partnership with MCF.

In 1987, the province received the Jansen report, on liquor policies for British Columbia, and the Ryan report, on alcohol and drug abuse in the work place. Both recommended significant increases in funding for addiction services. Also, the 1987 Sullivan Commission on Education recommended the inclusion of a comprehensive school health program, to include A&D, within the curriculum.

In 1988, following the Jansen and Ryan reports, the province moved ADP to the Ministry of Labour and Consumer Services. The government also added $60 million, spread over three years, to the ADP's annual budget of $26 million.

With the additional funding, new prevention and treatment services were developed largely by non-profit, community agencies under contracts with ADP, resulting in roughly 85% of BC's ADS being delivered by the contracted sector, or funded agencies.

In 1991, the Seaton Royal Commission on Health Care and Costs made its recommendations. Included in these was Seaton's call for the establishment of an independent and appropriately funded alcohol and drug Commission.

In what has proven to be a lingering truth almost 10 years after its 1991 report was released, The Seaton Royal Commission concluded that the system of care is not designed for a comprehensive attack on substance abuse.

Concerns most often expressed back then included:

- the location of ADP (Alcohol and Drug Programs) within the wrong Ministry;

- the lack of a clear legislative mandate for ADP;
- the lack of clear goals and a comprehensive plan to guide program development and service delivery;
- perceived adversarial relationships among ADP, its agencies and private contractors;
- staff reductions; and,
- difficulties suffered by the funded agencies because of uncertainty with one-year funding and short-term contracts.

The Seaton Royal Commission concluded that what was needed was leadership and direction.

Seaton also concluded that contract agencies should continue to be used, but stability of funding should be ensured.

Another concern of Seaton, and others, has been to determine the best structure and mandate under which alcohol and drug services would be defined and delivered.

Seaton pointed out that in previous experimentation by other provinces with the focus, structure and location of substance abuse agencies, two approaches have predominated:

The first is to integrate alcohol and drug programs and services within various existing government ministries.

Integration was tried in the early 1970's in Quebec in response to the generally well-received Castonguay Report. Quebec integrated a sizable and respected substance abuse agency into a number of ministries.

However, when that system proved inadequate and Quebec tried to reestablish an autonomous agency in the mid 1980's, it was impossible to identify the alcohol and drug resources that, by that time, had been blended into various ministries and budgets.

The second approach is to establish a strong, autonomous or semi-autonomous organization linked to government, generally through the health ministry, but at arms-length.

Autonomy was declared to be the preferred option by the Seaton Commission.

Today, the Alberta Alcohol and Drug Abuse Commission (AADAC) and the Alcoholism Foundation of Manitoba (AFM) are two examples of semi-autonomous agencies.

For example, AADAC acts as a province-wide agency providing leadership in treatment and education about addictions. It has not been integrated and regionalized within regional health authorities. It acts as a coordinating agency, as a resource for information and training, as a partner in providing treatment programs, and provides awareness, education and prevention programs. It maintains an arms-length relationship with the Alberta government. The Board has province-wide representation, and provides overall policy direction for the Commission.

Another approach is a combination of the two.

With the pressure on governments to combine and integrate programs with the goal of achieving cost savings and other efficiencies, many Canadian provinces are today attempting to rationalize the provision of ADS through regional health structures. In Ontario, it is the Ontario Substance Abuse Bureau of the Ministry of Health's Centre for Addiction and Mental Health that administers the funding for addiction services. In Quebec, it is now the Ministry of Health and Social Services that provides addiction services through regional administrations.

For British Columbia, Seaton, in his 1991 Royal Commission, and others since that time, have concluded that the preferred solution would be an independent Commission. Seaton also recommended that "at least one-third" of the resources of this new alcohol and drug Commission be devoted to prevention.

Despite these specific ADS recommendations, the government of the day chose not to follow the Seaton recommendations and not to establish an independent A&D Commission.

Instead, ADP was moved back into the Ministry of Health in 1992.

Also in 1992, in the wake of the Seaton Commission, the service providers formed an association to provide a voice and policy recommendations on behalf of the non-profit sector. This was known as the Association of Substance Abuse Programs in British Columbia (ASAP-BC).

Following the death of five-year old Matthew Vaudreuil at the hands of his mother while supposedly under the care of provincial child protection services, the Gove Inquiry was conducted in 1995.

The Gove report led to the creation of the Ministry for Children and Families (MCF). ADP was moved into this new Ministry in 1997 and became Alcohol and Drug Services (ADS), which were to be integrated into the Ministry's overall delivery of a range of services.

Once again, it was a move made with the best of intentions.

However, with each move, ADS have been forced to take on the priorities of the new ministry, rather than developing and pursuing its own strategy for helping British Columbians achieve healthier lifestyles with reduced substance abuse and addictions.

Unfortunately, under MCF, this dilution and lack of visibility has become, once again, the unintended consequence of the latest move of ADS from one home to another.

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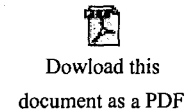

3) A BUSINESS CASE for Investing in Prevention and Treatment:

The premise is simple. Beyond the human damage to addicts and their families, there is the cost to society. Reduced addiction and abuse means a healthier society.

In terms of the social safety net, it's a case of: "Invest now to save taxpayers' money later. Pay now, or pay more later."

There are two main approaches to reducing the social costs of alcohol, drug and gambling abuse and addiction: reduce the demand and/or reduce the supply.

Reducing supply is outside the scope of this paper, which stresses the importance of reducing the demand. That means increased education, prevention, intervention and treatment.

Improved education and prevention programs reduce the number of British Columbians who might otherwise develop substance abuse problems that require treatment. Treatment reduces costs to society that would otherwise have been incurred by the individuals with the disorder, by their families, and by society.

A RAND Study (Massing, 1994) compared the effectiveness of four types of drug control. The four areas were domestic law enforcement (arresting and imprisoning buyers and sellers), interdiction (stopping drugs at the border), source control (attacking the drug trade abroad), and drug treatment. The study devised a financial formula with over 70 variables, and looked at how much the government would have to spend on each approach to reduce cocaine consumption by one percent.

The RAND study showed that treatment was seven times more effective than law enforcement, 10 times more effective than interdictions, and 21 times more effective than attacking drugs at their source.

When it comes to dollars invested in addictions treatment, the generally accepted rule of thumb in the field is that for every $1 invested by the system, $7 dollars are saved.

For prevention, the rule of thumb is more wide ranging. Preventing British Columbians from falling into prolonged or chronic substance abuse or problem gambling results in cost savings that otherwise would have to be absorbed because of lost productivity and increased use of our health, criminal justice and social assistance systems.

Prevention is cost effective because it reduces the number of new cases of abuse or addiction. Cost saving estimates for comprehensive and long-term prevention (involving schools, communities and families) run from $4 to $65 per dollar spent, depending on the study and the substance. For instance, potential savings would be greatest by reducing tobacco and alcohol abuse.

The cost of substance abuse to British Columbia according to the CCSA/CAMH study -- including tobacco, alcohol and drugs - was estimated at over $2.25 billion, or roughly 2.6% of the gross provincial product.

While illicit drug use was a small percentage of the total costs of substance abuse, it is illustrative of the kinds of costs society now absorbs as a result. The CCSA/CAMH study estimated the cost of illicit drug use alone at 0.24% of British Columbia's GPP.

The Millar Report estimated just the direct costs of illicit drug use to the BC government at over $95 million annually.

Direct health care costs cited by Millar included hospitalization, residential care, co-morbidity, prescription drugs, ambulatory care, non-residential care and other health care costs. Direct law enforcement costs included police, courts, corrections, and customs and excise.

The $95 million estimate by Millar did not include indirect considerations such as costs related to unemployment and lost productivity, which lead to the need for income assistance, unemployment benefits and other social assistance. Income assistance alone was estimated to cost as much as $67 million annually. Nor did Millar's $95 million estimate include costs to society resulting from criminal activity, such as theft and property damage.

The Alberta Alcohol and Drug Abuse Commission (AADAC) 1997-98 Annual Review points out that addictions treatment has been shown to result in increased productivity as well as reduced costs for health, crime and family problems.

AADAC estimates that every $1 invested in a substance abuse treatment program will produce savings of $7.14

after one year.

Similarly, James Langenbucher's team at Rutgers University showed that treatment for addictive disorders drives down demand for health care and promotes more efficient use of the health care system by patients and their families. Langenbucher's findings in his 1994 paper "Offsets are not Add-Ons: The Place of Addictions Treatment in North American Health Care Reform" is summarized below:

The Cost-Offset Effect:

Health economists call it a cost-offset effect, the reduction in the future burden of medical services, and medical costs, that can be attributed directly to treatments applied now. Medical services that generally produce attractive cost-offsets include inoculation procedures and well-baby visits, early detection programs such as cancer screens, and other preventive or primary care.

British Columbia's prevention campaigns have their own success stories. These would include reductions in drinking and driving, the greater use of seatbelts, and improved dental health, as just three examples. However, there are other opportunities crying out for improved prevention campaigns, such as reducing and trying to eliminate Fetal Alcohol Syndrome (FAS), a disastrous condition that is entirely preventable.

Langenbucher and others show a prime potential source of cost-offsets is addictions treatment. Addictions treatment significantly reduces overall health care utilization by alcoholics, drug addicts and even their family members. By the most conservative standard, treatment that addresses excessive drinking and drug use drives down the demand for health care.

The Cost-Ramping Profile of Addictions:

Langenbucher pointed out that one of the most frustrating characteristics of alcohol and other drugs users is their frequent failure to take steps to protect or restore their health, and their susceptibility to a variety of injuries and illnesses. Treatment focused on the drinking or drug use is too often not sought, too hard to access, or overlooked by their medical professionals. Offered instead are the urgent, specialized, expensive and increasingly fruitless medical services necessary to treat the physical consequences of addiction. In this way, alcohol and other drug abusers consume a disproportionate share of the health care budget, staying in the hospital longer, being readmitted more often, driving up costs for other consumers, and overloading an already strained delivery system.

The health care costs of alcoholics rise gradually. This positively accelerating cost curve is the "ramping" or peaking common to the health care histories of patients with chronic diseases. Starting from a cost level already twice that of nonalcoholic patients, care demands of alcoholics ramp-up sharply as they approach a medical crisis. These may take the form of repeated visits to the family doctor, to the emergency room or the specialist's office, or to the hospital with increasingly severe complaints or loss of function.

If a patient's drinking or drug use is not recognized, then lengthy, unsuccessful and frequent care episodes become common. The abuser's medical problems require a constantly high level of care, because the essential irritant of the gastric, cardiac, neurological or other malady - drinking and/or drug use - keeps the patient symptomatic and complaining.

Cost-Offset Effects:

Treatment for excessive drinking and other drug use, rather than the "surrogate diagnoses" of alcohol- and drug-related disease, can help bring health care costs in line. With patients who have received treatment, their use of health care falls dramatically, immediately, and converges eventually to near the norm. Studies have shown even more impressive cost savings, which pay for addictions treatment within two or three years. These cost savings are equal for males and females, and are most marked in youngest patients with the most prominent polysubstance abuse patterns. Only in the minority of cases, where the patient is no longer physically resilient, does significant shrinkage of health care use not occur, although there is a cost-offset effect when their chronic medical problems are no longer exacerbated.

Collateral Cost-Offsets:

Additional savings are found in collateral cost-offsets, or reduced use by spouses and children when alcohol- or drug-addicted family members receive treatment. Spouses and children are also heavy users of health care, with up to four times the norm. Given their large numbers, collateral family members may represent one of the largest health care cost savings opportunities attributable to providing treatment for addictive disorders.

The amount of health care used by the rest of the family members converges to normal levels when the substance abuser gets treatment. In one study, the health care claims of family members, after their alcoholic relative received appropriate treatment, fell by 50%. Of the total decline in health care costs, nearly two-thirds was attributable to decreased claims by family members. The potential savings are enormous, because the family members are a much larger group than the alcohol and drug abusers themselves.

Langenbucher et al conclude that addictions treatment causes sharp reductions in medical care use and encourages more appropriate use when services are needed, by patients and by their family members. Addiction treatment is

emphatically not an expensive add-on to an already strained system. It is an important cost-saving component of health care reform from which society will reap large benefits immediately and recurrently.

In summary, there is a solid business case to be made for early, effective and efficient prevention and treatment programs.

Effective prevention programs can help keep people from using, and from abusing. This has marked benefits in maintained or increased productivity at work and within a healthier home.

Effective treatment can help reverse the decline in the disordered individuals' health, and the negative consequences to their families, while saving costs that would otherwise need to be absorbed by our social safety net in health, justice and other expenditures.

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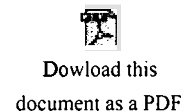

4) The "DISCONTINUOUS" CONTINUUM: ADS in BC

In response to the Seaton Commission, the Ministry of Health did attempt to develop an alcohol and drug "continuum of care" with various components.

Similarly, when BC's alcohol and drug programs were moved into the Ministry for Children and Families, it continued efforts intended to provide a "continuum" of complementary services - from education and prevention, through intervention and treatment.

The goals are basic. Educate about use, and prevention of abuse, whether it be alcohol, drugs or gambling. Intervene, within social limits, in a timely fashion. Have counselling and treatment readily available for those in need, whether for the individuals with the "problem" or those close to them, particularly those willing to seek help. Provide a "continuum" of services.

4:1 Prevention and Education* (Please see Appendix II for Prevention, and Appendix III for Education)

Prevention:

We're just not getting the message out, either to our young people or, for that matter, the overall population. The continuum should begin with services and programs to support and educate those that are not using. There should have been sufficient education about the potential consequences, harm and risks associated with use well before an individual progresses from non-use to use.

While the vast majority of our population, both young and old, are not abusers or addicts, they are not receiving the education necessary to help them make healthy lifestyle choices regarding drug use. It often appears that the continuum starts with intervention and treatment, and, when prevention is provided, it is often relapse prevention.

The School Based Prevention Program (SBPP), initiated and funded by ADS, was designed to: increase the mean age of onset of substance use; decrease substance use by youth; reduce the proportion of youth at high risk for substance misuse; decrease the negative consequences of substance abuse in youth; and, increase the proportion of youth abstaining from substance use.

As McCreary and other polls point out, the numbers don't show a high success rate. As well, this program seems to have lost the leadership and support that was previously being provided by head office. Many prevention field workers expressed the view that they "feel like orphans," disconnected from the basic ADS program with little support or supervision.

Other prevention concerns expressed by service providers include: unrealistic prevention targets set by the province without any additional resources provided; a general lack of overall plans and realistic goals; inadequate training for prevention workers; "seconding" prevention workers to other jobs in the ADS field; lack of effective community prevention programs, and; the lack of funding "prevention" receives in the scramble for scarce alcohol and drug dollars from government.

Prevention is a key to developing healthy living practices. Only prevention reduces the number of new cases, of substance abuse, whereas treatment can only hope to reduce the number of existing cases of substance abuse.

Any prevention program, to be successful, must be credible, well communicated, and reinforced over time. That's not happening in British Columbia. The resources and the priority devoted to prevention are, to be kind, miniscule.

Education:

While obviously not part of MCF's mandate, education is included in this paper because the school years provide a special opportunity to provide students realistic and credible information about the importance of making healthy choices in life, and the consequences that can result otherwise. The provincial education system should play an integral part in promoting a healthier society, and a Commission should work with educators to help provide the programs and initiatives needed.

The most beneficial opportunity to promote healthy lifestyle choices concerning substance non-use, or use, is near the beginning of the school years, by providing young people with credible education and social skills development before they are called on to make their own decisions about use. BC's educational system (K-12) offers an under-used opportunity to deliver comprehensive, ongoing prevention programs.

While there has been some progress providing substance abuse education through the province's Career and

Personal Planning (CAPP) program, and some ADS funding contracts for educational programming with a variety of agencies including A-DES and Prevention Source BC, it's only a drop in the bucket.

"Substance Abuse Prevention" is today allocated only 1/18th of whatever time is dedicated for CAPP, and this varies from district to district. As well, much of what is available is delivered after children have already begun making potentially harmful choices. With the age of first use dropping younger and younger, it's too often the case that by the time many students are beginning their classroom education about substance use and abuse, they're already using. It's a case of too little, too late.

In addition to insufficient time devoted to substance abuse education and prevention, other concerns expressed include: inadequate expertise or training for teachers faced with teaching substance abuse prevention; inconsistent resource materials; too heavy a reliance on stand-alone speakers; inconsistent follow-up and reinforcement; not enough "attitude and skills" development to help young people make good choices when confronted with opportunities to participate in alcohol and/or drug use, and; an inability to provide a credible education and prevention program for those students who have moved beyond society's "abstinence" and "delay first use" targets into experimenting with substances that they should not use because they are too young or because the substances are illegal.

In general, our educational efforts are fragmentary and inadequate. Efforts are dissipated and inconsistent from school district to school district, and region to region. Prevention and education help stop abuse before it happens. We are not devoting either the resources or the priority to helping stop abuse before it starts!

4:2 Intervention and Treatment

Intervention:

Intervention is a delicate subject that involves the balancing of personal freedoms against the interests of families or the community affected by someone's behaviour. Effective intervention requires a broad network of coordinated professionals trained and empowered to identify people "at risk" and to assist people in finding appropriate resources. For addiction services, this might include health care professionals, teachers, social workers and staff in community programs.

Some estimates indicate that fewer than 5% of people with substance abuse problems are "identified" or "intervened" through their contact with the health system. The BC Medical Association sees this failure to take advantage of the contact of substance abusers with their family doctor, or their local hospital, as a wasted opportunity. Other wasted opportunities are equally obvious.

The BC Medical Association's Committee on Addiction Medicine, among others, would like to see the family doctors and hospitals' admitting personnel taking greater advantage of their opportunities to intervene with "obvious" drug abusers. The high rates of accidents, absenteeism and sick benefit claims by untreated alcoholics and addicts in the workforce negatively impact not only on the affected individual, but their families, their colleagues and the community.

The question of intervention - when, how and by whom - is an area requiring much better definition in the development and administration of an effective substance abuse prevention and treatment continuum. Developing a more effective "intervention" link in the continuum chain will require some clarity to be established around strategies such as the "war-on-drugs" and the "harm reduction" approach, as well as understanding and dealing positively with the public's perceptions regarding addictions.

It will also require an investment in training professionals outside the narrower addictions field to recognize and respond to addiction indicators. Efforts in the past have again been fragmentary, and the responsibility of various agencies and ministries.

Treatment:

Treatment is an area that consumes the major part of the provincial ADS budget.

Any new body charged with developing and administering the ADS program in this province should undertake a total review of "treatment" as far as availability, effectiveness and cost. This should be done within the context of best practices using national and international standards.

To do this effectively, the province would need to develop a research capacity and collection capability that is currently unavailable, and would be welcomed by those in the field.

When substance dependent individuals take advantage of treatment, study after study shows "marked reductions in health care use....marked reductions in health care use by family members....marked reductions in workplace accidents, absenteeism and sickness claims.....and marked reductions in criminal justice activity after treatment for alcohol/drug addiction."

The study cited most often is the Rutgers University Centre on Alcohol Studies "Socioeconomic Evaluations of Addiction Treatment" (1993). This review determined that for every dollar spent on addictions treatment, between

7-10 dollars were ultimately recovered through savings in other health care spending, absenteeism, accidents, welfare and criminal justice costs.

The challenge is to target resources most effectively to ensure the treatment system can deliver these cost benefits.

Changes in priorities have often been introduced from the top down and without proper attention to managing change. The managers of the system often have little or no expertise in addictions or in treatment. As a result, the system continues to fragment.

Taking note of the experience in other jurisdictions that have attempted to combine treatment philosophies, particular care should be taken to allow for both the "abstinence-based" and the "harm reduction" approaches to be used. One should not preclude the other, nor should one take precedence over the other. In BC, however, the approaches often seem to have been pitted against each other, rather than being seen as parts of the same continuum. These differences in approach and philosophy have, through inadequate coordination, resulted in further fragmentation of the system of care.

In short, British Columbia's attempt to provide an appropriate "continuum of services" for the users and abusers of alcohol, drugs and gambling is today a broken chain.

Inconsistent and under-funded education and prevention efforts. Wasted opportunities for intervention. Fragmented components for counselling and treatment. Inadequate data-collection and research capacity on which to base good decisions. Waiting lists for counselling and for treatment.

The province's ADS continuum, despite the best of intentions, has become a "discontinuous" continuum.

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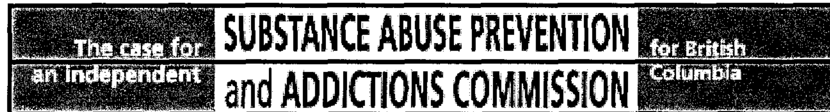

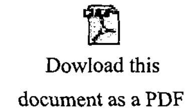

5) BC Government: REVENUES and ADS EXPENDITURES

5:1 Revenues from Drinking, Smoking and Gambling:

The province receives a significant share of revenues from the drinking, smoking and gambling activities of British Columbians.

The amount of tax and other dollars pouring into government coffers from smoking, drinking and gambling, which are legal, is substantial, almost reaching $1.7 billion annually, and growing.

The $1.7 billion was roughly 8% of the province's gross revenues of some $20.7 billion for fiscal '99.

ALCOHOL, TOBACCO AND GAMBLING REVENUES (Fiscal '99 in millions of dollars)	
LIQUOR:	
Liquor Control Board Profits	$615.855
Social Service Tax (10% per drink, wine & beer stores, etc)	$180.000 (est)
	$795.855
TOBACCO/CIGARETTES:	
Tobacco Tax	$505.111
	$505.111
GAMBLING:	
BC Lottery Corporation	$369.420
Horse Racing	3.843
	$373.263
Fiscal '99 Revenue	**$1.674 Billion**

5:2 ADS Expenditures through MCF:

Other ministries, through such programs as crime prevention through the Attorney General or medical and hospital care through Health, play an indirect role in the provision of alcohol, drug and gambling services.

For example, while tobacco must be considered a drug subject to abuse and addiction, the $5 million Tobacco Reduction Strategy now underway is a specific campaign developed and operated through the Ministry of Health.

However, with the exception of tobacco, primary ADS are provided through the Ministry for Children and Families (MCF). (See" Appendix One" for Ministry of Children and Families and ADS)

MCF spends roughly $60 million annually trying to provide a "continuum" of ADS. This ranges from health promotion and education of those choosing not to use drugs through to a range of treatment services for those with serious dependency.

While the province takes in almost $1.7 billion as its share of these legal smoking, drinking and gambling activities, the province spends less than four percent of this income promoting healthy abuse-free lifestyles and providing

intervention and treatment for those in need.

The $60 million is not spent evenly over the continuum.

In-field service providers estimate that at least 90% is spent on less than 10% of the provincial population, primarily on treatment for people with serious dependency problems.

Consequently, in-field workers also estimate that less than 10% is actually applied to their efforts to provide the remaining 90% with appropriate education to help develop healthy life styles and other skills to prevent this vast majority of British Columbians from becoming "problem" drinkers, "problem" smokers, "problem" drug users, or "problem" gamblers.

The Ministry for Children and Families provides ADS through two, sometimes complementary, sometimes competing, arms:

- Policy and Program Development is managed through the Assistant Deputy Minister (ADM) of Policy Division, and
- Program Funding is managed through the ADM of Regional Operations and the 11 MCF Regional Executive Directors, known as REDs.

The ADM of Regional Operations and Performance Management at MCF oversees program spending through Regional Operating Agencies and the 11 Regional Executive Directors.

However, if power is control of the purse strings, power over ADS is in the hands of MCF's Assistant Deputy Minister of Regional Operations.

Recently, MCF has been working with selected regional health boards to explore whether the health boards could better administer some ADS programs.

The estimate for the ministry's basic program spending on ADS, both for the 15% of services provided directly by MCF and the 85% of services provided by funding some 200 non-profit organizations, was approximately $55.4 million for fiscal '99.

MCF contracts with organizations such as Alcohol-Drug Education Service (A-DES) and Prevention Source BC (PSBC) to provide prevention and education materials and services. As well, MCF-funded services providers are expected to devote up to 25% of their time to prevention efforts.

MCF provides some clinical services, while contracting with the non-profits for the rest. Clinical services include: l) outpatient services; 2) withdrawal management services (detox); 3) intensive non-residential (day/evening/weekend) programs; 4) residential treatment facilities, and; 5) supportive recovery services.

MCF directly operates 15 of 130 "out patient" services, with 115 operated through grants to non-profits. MCF directly operates 2 out of 12 "withdrawal management" (detox) centres, with 10 operated through grants to non-profits. As well, MCF provides grants to 11 residential centres operated by non-profits, and to 20 supportive recovery services operated by non-profits.

MCF estimates that approximately 42,000 British Columbians use this range of services annually.

The non-profits were asked to accept a 1.5% reduction in ADS grants in '99, which for most followed several years of zero increases in funding from the government.

In May of 1999 the MCF minister announced that $9.25 million was being committed to provide addictions counsellors, day treatment programs, and 75 new alcohol and drug treatment beds and other services for youths.

For the purpose of this paper, we have assumed expenditures by MCF at roughly $60 million annually, plus or minus, for alcohol, drug and gambling services in 1999.

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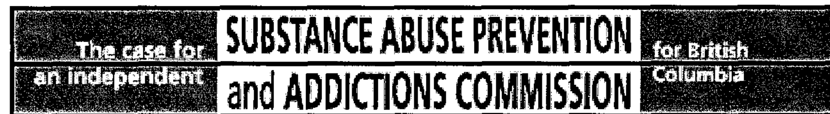

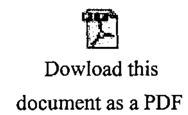

6) THE NON-PROFIT, FUNDED AGENCIES, MCF AND ADS:

BC's current alcohol and drug services consist of a few services provided "directly" by provincial government, and an estimated 200 non-profit, government-funded agencies which "indirectly" provide a similar or complementary range of services.

With less than 15% of the drug and alcohol services being provided "directly" through the government, the province relies heavily on this ADS system of non-profit agencies to " indirectly" deliver the bulk of the roughly $60 million in services.

The non-profits provide assessment, counselling, outpatient services, detox services, day treatment, residential treatment, and supportive recovery services.

These services are provided free with the exception of residential treatment, for which clients are charged between $1,000-$1,200 per month for in-patient treatment. Subsidies of up to 100% are offered for those on social assistance, or low-income qualifiers. However, these funds are administered differently from region to region, and are often used up well before the year end.

The supportive group recovery homes and residential treatment centres are primarily abstinence-based, using a variety of modalities and philosophies of treatment. Usually the client must be drug-free for a period of time before being accepted into residential treatment. These centres offer psychosocial treatment only. They do not have the capacity to offer treatments to clients with additional, often significant, medical or psychiatric conditions.

6.1 Comments/Concerns by the Non-Profits

While quick to acknowledge the dedication and sincerity of the MCF efforts, professionals from the "indirect" ADS field are virtually unanimous in their frustration at the present state of ADS in British Columbia.

The Association of Substance Abuse Programs (ASAP-BC) has drafted a position paper with a series of comments and recommendations, including its call for the provincial government to establish an autonomous Alcohol and Drug Commission.

ASAP members contend that:

- ADS programs, generally, lack leadership and focus, and are grossly under-funded,
- MCF has little commitment to providing ADS for adults who do not have children, or families, "in crisis,"
- the MCF focus on social work and families in crisis means that over 90% of the provincial population is virtually invisible to the ministry when it comes to providing ADS,
- this focus means that ADS cannot be properly provided through the MCF ministry,
- British Columbia's ADS system is being systematically dismantled in the name of integrated services, which have not been achieved,
- the stated goal of MCF to "enhance prevention and early intervention" services has not happened because MCF is a social work ministry without a health or ADS focus,
- education and prevention efforts are miniscule in relation to what's needed,
- ADS prevention efforts are dissipated and inconsistent from school to school, and region to region, particularly as some school based prevention workers are moved out of their schools and into communities,
- there is no province-wide prevention plan or goals in place,
- previous prevention resources and programmes have disappeared,
- gaps in the province's intervention and treatment capabilities are resulting in wait lists that prevent clients

who need help from entering into appropriate treatment during their "window" of readiness,

- there is limited recognition of addiction services within the MCF regional management structure as ADS are usually just a small part of a manager's concern,
- the MCF managers rarely have a full understanding of the addictions field, and are changed so often they rarely become sufficiently knowledgeable,
- clients, service providers and others directly involved in the field often feel left out of the planning and decision making,
- ADS "indirect" service providers are not only not consulted but, in some regions, not even officially informed of decisions about changes that affect their operations and programs,
- the focus of MCF is regulatory, and addiction services are often viewed as primarily an assessment service to be used in making regulatory decisions,
- within MCF the therapeutic nature of treatment is not well understood and is being compromised,
- staff who were once seen as addiction specialists are now expected to function as generalists,
- without even minimal retraining, staff trained to provide therapy to adults are now asked to assist youth,
- ADS' inclusion within a ministry that focuses on child protection presents a perceived barrier to some potential clients who fear that the admission of substance abuse might result in the removal of their children,
- while MCF has targeted monies at developing some new programs, resources for existing programs are being consistently eroded,
- residential treatment facilities are being asked to collect 1/3 of their funding requirements through user fees, which is creating significant barriers to potential clients while creating further instability for the service providers,
- the residential user fee was being increased last year, while the ADS subsidy to cover this cost for people in need has been capped and is administered differently from region to region,
- budgets have been frozen for the past five years, and contracts were cut another 1.5% last year, and
- the constant state of flux has made the old, one-year contracts seem like a model of stability by comparison.

Concludes ASAP: "The experiment to integrate alcohol, drug and gambling services within the Ministry for Children and Families has been a complete failure."

6:2 Other Issues:

A Commission would be useful in ensuring a coordinated and collaborative approach to addressing all forms of substance use, abuse and addiction, plus problem gambling. This would, ideally, include tobacco reduction and cessation programs.

A Commission could also play a role in helping to resolve a number of other issues and questions of concern in the field. It could be positioned to review and comment, when appropriate or requested by government, on the effectiveness of current policy and/or to suggest changes for consideration by elected policy makers in pursuit of a healthier society.

By way of example, while health and social services are the domain of the province, and criminal law is the domain of the federal government, this Commission could review and comment on the effectiveness of our present responses to substance abuse related crime, punishment and opportunities for treatment.

The RCMP estimates that 80% of all crime is directly or indirectly related to substance use or abuse, and that more than 50% of federal inmates committed their crime under the influence of a drug. The BC Medical Association estimates that 60% of people incarcerated in provincial corrections facilities suffer from substance abuse disorders.

These are the same people seen in physicians' offices, hospitals and social agencies. They cost various ministries great amounts of money due to the medical, social, criminal, vocational, and psychological consequences of their abuse.

Since incarceration provides a relatively stable period in the life of the addicted person, is that time being used for appropriate therapy? Is the prison system the most effective form of incarceration for British Columbians who commit illegal acts because of substance abuse problems? Is there a role for special courts and programs to deal with drug offenders?

Another concern is the apparent move towards pay and benefit packages for non-profit employees comparable to their counterparts within the provincial government. This could represent a fundamental change in the traditional budgeting requirements of the non-profit agency.

Many non-government service providers contend that the never-ending difficulties in obtaining consistent funding from government, coupled with the lowered morale that accompanies their perception that ADS are disappearing amidst other MCF activities, threaten the future viability of many non-profit agencies.

For decades, the province has relied on "indirect" ADS being provided through the efforts of non-governmental or funded agencies, usually at a cost considerably less than if the same services were being provided "direct" through the provincial government.

Some non-profits believe their inability to pay salaries and benefits comparable to union rates and benefits available at nearby facilities are contributing significantly to high staff turnover at non-unionized, non-profit agencies.

For obvious reasons, many of the non-profit employees are interested in an implied assurance from government that funding would be increased to bring a new union member's pay and benefits package into line with those working in government.

Some non-profit agencies have deliberately encouraged unionization, believing it the only way to get additional funds to pay their employees acceptable salaries. This is attractive for service providers looking for wage, benefit and pension improvements, along with something resembling job stability.

A new Commission would be positioned to help clarify and recommend a course of action for these and other issues relating to the overall focus and delivery of abuse and addictions policies and programs.

6:3 Complementary role of the Non-Funded Organizations

While this paper has focused on the direct and indirect ADS services provided through the provincial government and the non-profit agencies, it should be remembered that the non-funded volunteer and the private sectors make substantial contributions to alcohol, drug and gambling services in British Columbia.

6:3:1 AA and other Self-Help, 12-Step programs:

Many British Columbians attempting to recover from alcohol and other types of addiction disorders use the 12-step, abstinence based, self-help programs derived from the original Alcoholics Anonymous (AA).

These 12-step groups cover a variety of problems, ranging through cocaine use, adult children of alcoholics, co-dependence, compulsive gambling and other addictions.

Regular meetings are available, and participants determine their own levels of attendance, ranging from one or more per day, to every other day, to once a week, etc. The participants maintain strict anonymity. Their doors are open to any who choose to attend. Their goal is to "attract" new participants by example, rather than to "promote" their activities.

These 12-step programs such as AA are self-funding, and receive no government financial assistance. Because of the anonymity, the number of British Columbians using the AA-type programs is not estimated.

6:3:2 Private Sector service providers:

These organizations are run as private, for-profit facilities.

The main private facility is Edgewood, a residential treatment centre located near Nanaimo. The cost to clients is $125 per day. It has a bed capacity of 67, and the program runs on average between 6-7 weeks.

Anecdotal information would suggest that a sizeable number of British Columbians who have access to the necessary financial resources are going outside the province to residential treatment establishments. For instance, some residents of the northeast Peace River area go for treatment in Edmonton, some residents of the east Kootenays travel to Calgary, while others travel to such well-known American treatment centres as Betty Ford in California, Hazeldon in Minnesota, or Sierra Tucson in Arizona.

6:3:3 Employee Assistance Programs (EAPs):

Employee Assistance Programs (EAPs), also known as Employee and Family Assistance Programs (EFAPs), are worksite-based programs that assist employees and their families who are affected by substance abuse problems or a wide range of other personal problems. Today's EAPs also assist employees and their family members with legal, family, emotional, marital and other personal, health and work-related problems.

Some EAP practitioners are now qualified to refer their EAP clients directly to the services offered through MCF's addictions services. To qualify, practitioners must become members of and be trained through the Employee Assistance Professionals Association or the National Assessment and Referral Service Coordinators Society. Those not qualified by either EAPA or NARSC may refer their clients to addiction services outpatient services, where MCF addiction services will provide case management.

6:3:4 Non-Funded, non-profit service providers:

These organizations receive no funding from government. Clients may, however, cover costs of care through money received from social assistance.

Examples of these are Miracle Valley, Harbour Lights, the Union Gospel Mission Recovery Program and most of those identified as "transitional living" agencies in the 1999 Kaiser Directory of Addiction Services.

The Salvation Army runs Harbour Lights and Miracle Valley. Harbour Lights has 31 beds for males, is a 90 day program and costs $536 per month. The Union Gospel Mission has 25 male beds, runs for 3 months and costs $450 per month.

The transitional living agencies average between 8 - 20 beds, and cost approximately $400 - $500 per month.

These non-funded organizations are vital players in the province's efforts to reduce abuse and assist recovery from addictions.

The provincial government and any new Commission should recognize and encourage the continued and expanded contribution to be made by the 12-Step programs and other mutual support groups, the private sector service providers, the Employee Assistance Programs (EAPS), the volunteer and other service providers as beneficial and integral parts of an overall solution.

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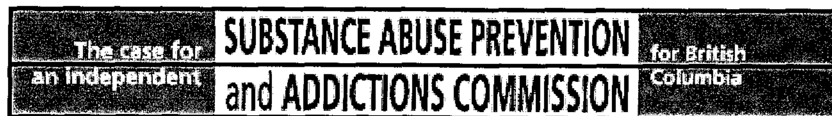

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7) CONCLUSIONS and RECOMMENDATIONS re SAPAC-BC:

BC's alcohol, drug and gambling education/prevention and intervention/treatment efforts cannot get the job done under the present system.

Dollars spent wisely and up-front on prevention and treatment result in dollars saved that otherwise would be called upon down the line. We can do a better job to effectively provide these important services than we're doing today. ADS must be delivered efficiently at the community level, but at the same time be part of a provincially-led and coordinated system that ensures access to the full range of services for all British Columbians.

It was on this rationale that the Seaton Commission concluded that the best alternative is to establish an independent British Columbia Drug and Alcohol Commission, with a clear mandate and sufficient resources.

That's what has been consistently recommended by, among others, the Seaton Royal Commission on Health Care and Costs (1991), the Cain Report (1994), the Millar Report (1998), the BC Medical Association's Sub-Committee on Narcotics Harm Reduction (1998), the Association of Substance Abuse Programs in BC (ASAP-BC) and now, by this discussion paper.

In keeping with Seaton, this paper recommends the establishment of a SUBSTANCE ABUSE PREVENTION and ADDICTIONS COMMISSION (SAPAC-BC).

SAPAC-BC should be a separate agency, linked to government through Order-In-Council appointments to a Board of Directors.

Should SAPAC be placed under the umbrella of the Ministry of Health, it should be at arms-length, and be as independent as possible, taking into consideration that elected politicians in the provincial Legislature must vote the funds necessary for the Commission to carry out its mandate and the Commission must be accountable.

There should be direct communication between the chairperson of the board and the minister. The Chief Executive Officer should "confer" not "report to" the Deputy Minister of Health and the Assistant Deputy Ministers.

SAPAC's mandate should be established through an Act of the Legislature.

SAPAC should have objects of incorporation that are broad in design and include prevention, treatment, research, health education, training and development.

And, as recommended by Seaton, it should be clearly separate from Liquor Control and Licensing, and the Liquor Distribution Branch.

Additional SAPAC responsibilities should include:

- the development of a comprehensive, strategic plan for the reduction of substance abuse,
- the development of information systems to support evidence-based decision making,
- the establishment of a research and development institute to be used as a provincial resource, and to work with similar institutes in other jurisdictions, and
- the development of a needs-based budget for alcohol, drug and gambling services with sufficient resources to address the needs in an efficient way.

Given these conclusions, the Kaiser Youth Foundation and the collaborators to this paper undertake to:

1. PROMOTE THE ESTABLISHMENT OF AN INDEPENDENT, APPROPRIATELY-FUNDED SUBSTANCE ABUSE PREVENTION AND ADDICTIONS COMMISSION, which could be known as SAPAC-BC, along the lines recommended by the Seaton Royal Commission on Health Care and other reports;

2. Push to ensure that SAPAC's first budget has sufficient funds added to existing ADS funding to ensure that AT LEAST ONE-THIRD OF SAPAC-BC FUNDING IS DEDICATED TO INCREASED EDUCATION AND PREVENTION EFFORTS, and;

3. Work with the BCMA's Committee on Addiction Medicine and other key stakeholders to PREPARE AND PUBLISH A REGULAR, PERHAPS BIENNIAL, AUDIT OR REPORT ON ALCOHOL, DRUG AND GAMBLING SERVICES IN BRITISH COLUMBIA, identifying all types of addictive disorders while documenting the:

- Incidence and prevalence of addictive disorders;
- Availability of effective means of prevention and treatment;
- Gaps in education and prevention services,
- Gaps in intervention and treatment services,
- Social costs (health, lost productivity, crime, incarceration, etc.);
- Government revenues from, and expenditures on, alcohol, drug and gambling services, and;
- Savings in health, insurance and other costs as a result of reduced rates of substance abuse.

An arms-length, visible and responsible Commission is needed because the present system doesn't work, and simply shunting ADS back to another ministry would only serve to repeat the same problem.

We believe that a Commission must be separate and at arms-length in order to be efficient and effective. It should be a visible, pro-active, responsible and credible body.

With a legislated mandate and adequate resources, SAPAC would establish a realistic and comprehensive strategy, provide strong leadership and coordination, ensure services are available to all British Columbians, and undertake and gather quality research.

SAPAC should initiate credible public information campaigns, with sponsoring partners where appropriate, targeting those who use as well as those who abuse. As well, it should have its strategy and its effectiveness reviewed annually.

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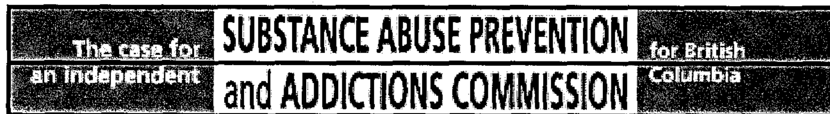

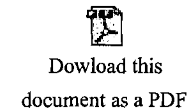

Appendix 1:

"Any time a person's use of a particular substance, be it tobacco, alcohol or drugs, including across-the-counter or prescription drugs, or a particular activity, such as gambling, causes personal, career, social, physical or spiritual problems, it is abuse."

A former head of ADS in BC

BC's ADDICTIONS SERVICES AS SEEN BY MCF*

*(This Appendix provides a review of these alcohol, drug and gambling services provided by MCF, as quoted from the Ministry's statements)

ADS and Ministry for Children and Families:

Addiction Services provides a range of substance misuse and problem gambling services through a combination of government and non-government organizations in all regions of the province. Services are delivered along a continuum, ranging from Prevention to Clinical services.

Prevention Services Overview:

Prevention Services are offered through every outpatient clinic, which devotes 25% of all resources to prevention activities. Utilizing the Prevention Planning model, a community consultation-planning model, prevention workers assess, plan and evaluate prevention initiatives. A major initiative occurs each November with participation in the National Drug Awareness Week strategy. Significant support to prevention services is also provided through Prevention Source BC.

Clinical Services Overview:

Clinical services operate by integrated case management through five different components, organized into a provincial System of Care, with annual admissions of approximately 42,000. Clinical services include:

1 Outpatient Services
2 Withdrawal Management Services (detoxification)
3 Intensive Non-Residential (Day Treatment) Facilities
4 Residential Treatment Facilities
5 Supportive Recovery Services

Clients enter the System of Care through Outpatient or Withdrawal Management Services. Through comprehensive assessment, the case manager matches the client to the best available treatment option to meet the individual's need.

Clinical Services - Specifics:

1 Outpatient Services:

Provides assessment, individual, family and group treatment, case management and follow up. (Also provides community prevention services).

- 130 centres throughout all regions of the province
- 15 centres operated directly by MCF employees
- 115 by community-based non-profit societies
- 36 are specialized youth services, the remainder serve all ages, including youth
- average annual admissions: 21,000 adults, 3,700 youth

2 Withdrawal Management (Detoxification)

A range of services including support and supervision (medical and non-medical) to minimize negative physical effects of withdrawal from mood altering and addictive substances

- 12 centres throughout the province, some serving more than one region
- 2 centres operated by MCF
- 10 by community non-profit societies
- Vancouver region funds a specialized youth detox program through a partnership between Downtown Eastside Youth Activities society and Family Services. An average of 15 youth per month admitted to the program.
- Annual admissions: 14,000 adults, 250 youth

3 Intensive Non-Residential (Day Treatment) Services

Intensive group counselling and education at least three times per week for those experiencing serious substance misuse related problems. May involve therapeutic work during week, evening and/or weekend sessions over a period of weeks. These programs serve persons whose living arrangements and living situation are stable enough to support intensive treatment on an outpatient basis

- 16 programs for women will be funded in 1999/2000. Women's programs are all based on a DEW-W (Day Evening Weekend for Women) program developed and piloted in BC and now used in other provinces
- 3 programs for youth will be funded in 1999/2000 (1 program is for both male and female youth)
- most regions of the province will have day treatment programs offered at least once this year. Coast Garibaldi and Peace Laird Regions do not, at this time, have capacity to offer day treatment programs
- most day treatment programs run for 3 - 6 weeks and serve 8 - 10 people at a time.

4 Residential Treatment Facilities:

Short term intensive group counselling and education for adults and youth whose substance misuse has been very harmful and whose living arrangements do not provide the stability to support attending treatment in a non-residential setting

- 11 centres across the province
- all 11 regions served
- some serve a specific client group
- 2 are for women only (Aurora Centre in Vancouver and Peardonville House in Abbotsford
- 1 is for women and their pre-school children (Peardonville House in Abbotsford)
- 2 are for youth only (Exodux and Peak House in the Lower Mainland area)
- 2 offer an Aboriginal focus (Round Lake in Armstrong, and Kakawis, which is designed for the whole family, on Meares Island)
- clients must be referred by ADS workers or approved referral agents, all of whom provide ongoing case management services
- annual admissions: over 3,300 adults, 220 youth

5 Supportive Recovery Services:

Safe, structured drug-free housing which is provided to support those who have been living in unstable, non-supportive situations while they are undergoing addictions treatment

- 20 centres are funded by contract with Alcohol and Drug Services
- at any other time, 2 - 5 others are funded on a per diem basis in order to make the most efficient use of limited funds
- most centres are gender specific: two are co-ed (Turning Point in Vancouver and Streetlink in Victoria)

Problem Gambling Program Overview:

The Problem Gambling Program was established in the fall of 1997 with the initiation of the Problem Gambling Help-Line and counselling services in all regions, with specialists for target groups of Youth, Aboriginal people and Multicultural populations. Provincial consultants for Seniors and for Women were also established. Telephone clinical counselling was made available, accessed through the Help-Line. The Problem Gambling Program has a budget of $2 million, and will be evaluated by Treasury Board spring of 2000.

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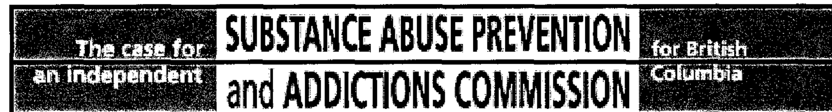

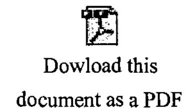

Appendix 2:

PREVENTION

Prevention is the process of reducing substance abuse, or the problems occurring from substance abuse.

First, only prevention reduces the incidence (the number of new cases) of substance abuse problems. Treatment in any form can only hope to reduce the prevalence (number of existing cases) of misuse. Without prevention, there will always be more cases to replace those we have been able to help.

Second, the scope of the problem is severe. Substance misuse contributes hugely to other problems, such as physical and emotional health problems, abuse, family breakdown, violence and crime.

Third, the solution to substance abuse problems is a preventive one. As in the case of many chronic diseases such as cardiovascular disease and cancer, the key solution to substance misuse is prevention.

Fourth, prevention is cost effective, compared to treatment and to coping with the aftermath of substance abuse. Cost saving estimates for comprehensive and long term prevention (involving schools, communities and families) run from $4 to $65 per dollar spent, depending on the study and the substance addressed. For instance, potential savings would seem to be greatest by reducing tobacco and alcohol use and abuse.

Finally, there is a strong human imperative to emphasize prevention. To simply wait for individuals or families to come forward and seek information and counsel means that the years of pain, suffering and other negative impacts would just continue.

Prevention includes many strategies employing a range of activities in public awareness, education, skills development, social marketing, community action, policy, and laws and regulations.

These all work together, over time, to shift attitudes, awareness, knowledge and behaviour in ways that lead to reduced risk of substance misuse. The key is effort over time. Efforts must be maintained for months and years. Unfortunately, shifting funding structures and priorities have prohibited this from happening.

Prevention Source BC describes at least three classes of prevention:

Primary prevention involves preventing or delaying the onset of substance use, and is best targeted at children and young teens. For example, a school-based program teaching refusal skills to pre-teens.

Secondary prevention, or early intervention, includes preventing problems from progressing by intervening in the process of substance use. For example, having an awareness program for heavy drinking teens, or encouraging family doctors or emergency ward workers to take the opportunity to intervene with obviously drug-dependent clients.

Harm reduction strategies are prevention efforts that focus on reducing the problems associated with substance abuse without primary regard for consumption itself. An example here would be a needle-exchange program for intravenous drug users, such as that run in downtown Vancouver where 2.5 million needles are handed out annually.

Not even the most optimistic prevention worker in the field would suggest that even 10% of current ADS finds its way into prevention efforts. This despite the Seaton Commission's recommendation, and others including the federal government's drug strategy, that at least one-third of the ADS budgets should be dedicated to prevention.

The Seaton Commission cited four accepted public health strategies that must "work in concert" for successful prevention efforts: 1) control (the availability of drugs and alcohol); 2) influence (modifying people's attitudes and behaviour); 3) competency development (helping people make responsible decisions), and: 4) environmental design (creating environments more conducive to healthy behaviour).

Seaton also pointed out that the system must respond to a variety of community concerns, rather than view addictions through a single lens.

To be effective, the system must bring together and coordinate programs within health promotion, education, social planning, community policing and treatment, to name but a few.

For prevention efforts to be successful, any new ADS structure needs: stability over time to enable primary and

reinforced teaching messages; a stable and adequate prevention budget; a strong base of research, current knowledge and evidence-based theories, and; the detachment of prevention from treatment.

Following receipt of the Jansen and the Ryan reports in the late '80's, the Ministry for Labour and Consumer Services assumed responsibility for Alcohol and Drug Programs, along with its responsibilities for the Workers' Compensation Board, the Drinking and Driving Counter Attack and the Liquor Distribution Branch.

The Ministry announced a major thrust towards the prevention of substance abuse under a new "Community Awareness and Action" Plan.

Previously the government had spent only 14% of A&D funds on prevention and enforcement, with 86% going to treatment. However, the federal National Drug Strategy was recommending that at least one-third be spent on prevention. The province committed to spend 36% on prevention at that time.

One part of the provincial strategy was the TRY ("The Responsibility is Yours") program. TRY was a mixed media campaign to inform individuals, families and communities, as well as specialized target groups, that alcohol and drug abuse can be prevented. This $5.4 million campaign involved TV, radio, bus boards, print, buttons, posters, etc.

A TRY booklet was delivered to every household in BC, along with community centres, health professional offices and schools. As well, innovative print and video resources for high-risk young, Indo-Canadians, Chinese Canadians, ESL instructors and others were developed under TRY. All these are long since out of print, and yet demand for these and additional materials has grown.

In addition to the TRY campaign, a 24-hour toll-free alcohol and drug information referral service was initiated.

Substantial grants were made available to communities through the Community Action Program (CAP). These CAP grants focused on local initiatives on prevention programs through to treatment. In 88/89, $900,000 was given out by the province. In 89/90, this was increased to $2.2 million.

As well, attempts were made to extend school-based prevention services, first used in the Vancouver School District, to the rest of the province. This effort was in support of the Ministry of Education's efforts at substance abuse prevention.

By the fall of 1991, the School Based Prevention Project (SBPP) had placed 18 prevention workers in selected middle, junior and secondary schools across BC. In 1992, an additional 20 SBPP workers were added. The addition of six more in the fall of 1993 raised the total number of prevention workers to 44, working in 57 schools in 37 school districts.

Two groups were targeted: youth aged 12 years or older in the school system, and; parents, teachers and administrators.

Based on a "community participation" philosophy, the goal of SBPP was to involve youth, parents and the school community to promote health by preventing substance use. The Ministry of Health provided structure and personnel for the program, but schools and communities planned and directed the specific activities of the SBPP in their areas. Ongoing training was provided for the school-based prevention workers and their supervisors. Support services were provided for people in the field. In 91/92, 175 schools received grants. In 92/93 each school could access up to $2,000 in grants.

From 1989 through 1993, prevention services played an important role in the alcohol and drug continuum. The central office at the Ministry of Health was providing full or partial funding for prevention projects such as prevention pamphlets and newsletters, the Kaiser Directory of Addiction Services, fellowships for research in the addiction's field, KID'S ZONE (an educational TV program), a "Peers Helping Peers" training book, "Thanks for Caring" (on fetal alcohol syndrome prevention), a traveling "drug awareness" theatre project, the TRY line, etc.

One of the major thrusts during this period was the development of a clearinghouse to provide prevention information throughout the province.

Through a contract with Alcohol - Drug Education Service (A-DES), the BC Prevention Resource Centre was created. Over the years, this expanded and in 1996 became known as Prevention Source BC (PSBC), presently funded with about $400,000 annually through MCF and the Ministry of Health.

Prevention Source BC's mandate was to provide prevention training and materials to prevention workers. PSBC's services now include an up-to-date website, assistance in planning prevention programs, and prevention information on alcohol, drug and tobacco use that is available to school-based prevention workers and others in the field.

The SBPP was the primary prevention thrust of Prevention Services until 1997 when it moved into the Ministry for Children and Families.

Since that time, all 5 of the ADS prevention services personnel located at MCF's central office have left the government's ADS. Other than the 24-hour help line, Prevention Source BC and the school based prevention workers, there have been few, if any, additional initiatives taken in the prevention field since the early '90's.

In-field workers claim severe deficiencies in planning, establishment of goals, resources, training, community development programs, and evaluation.

In addition, many of the school-based prevention workers now complain that they are being taken away from "prevention" work in order to perform other ADS services such as intervention and treatment.

The result is that workers in the field confess to "feeling like orphans" with direction often coming from people who have little or no understanding of the prevention field.

Perhaps the greatest loss during the erosion of prevention services has been the evaporation of prevention funding to communities, such as the Community Action Programs (CAP grants). As well, the social marketing thrust of the TRY campaign has been lost.

At present, all that remains at MCF's head office is a vacant slot for a single Prevention Consultant to initiate and co-ordinate the ministry's overall prevention efforts. The previous occupant of this slot also had broad responsibilities extending beyond prevention.

While current MCF policy requires that all outpatient programs dedicate 25% of their resources towards community-based prevention programs, that just isn't happening and the "25%" target is regarded as little more than a joke to those in the field.

According to one non-profit service provider: "About 10 years ago the government decided that treatment agencies should also 'do' prevention. So they tacked on an order that 10% of all clinical time should go toward a very broadly defined 'prevention' target. No new $'s were provided. Over the years the 'prevention target' has been increased to 25% - 33%, but no additional dollars were ever provided to fund prevention activities."

The end result is that, at present, British Columbians of all ages are provided with very little primary or secondary alcohol and drug prevention. What is provided varies widely from region to region and school to school. And there is very little overall central direction and funding support.

The new Substance Abuse Prevention and Addictions Commission (SAPAC-BC) should be mandated to ensure that additional funds are committed to prevention efforts, with a target of "at least one-third" of ADS budget being dedicated to prevention.

In addition, SAPAC should ensure prevention is provided sufficient infrastructure to reach not only the primary target of youth, but also the broader population of British Columbians, in an organized, effective and on-going campaign to encourage healthier living habits that targets those that use as well as those that abuse.

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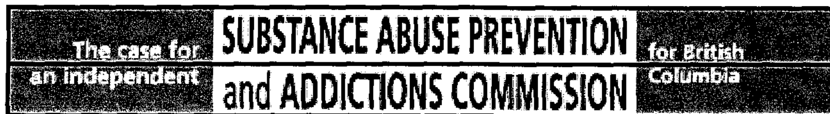

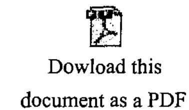

Appendix 3:

EDUCATION

While education is not within MCF's mandate, a new Commission must work with the Ministry of Education to ensure our school system becomes part of the solution to substance use, misuse and abuse.

One older British Columbian recalls her only in-school alcohol and drug education as "something called Guidance that we did in a classroom during PE (Physical Education) when we couldn't get gym time." There's greater recognition of the importance of substance abuse prevention efforts today. But then, there are more drugs being used today, and they're more readily available than in the old days.

In recent years, the Ministry of Education has included substance abuse prevention education as a mandated part of the curriculum. The province's effort to organize substance abuse programs in the schools began to take form in 1988, when the Ministry of Education began standard review and revisions to the provincial Health-Guidance curriculum. The review was influenced by the '86 Sullivan Report on Child Abuse in BC, the '87 inter-ministry AIDS Report, and the '88 Royal Commission on Education.

One result was the establishment of a Provincial Advisory Committee, which involved 20 community organizations, including the Kaiser Youth Foundation, professional associations and government agencies. This Committee and other input led to the establishment of a "Learning for Living" Program, which comprised seven content areas: 1) Career Development; 2) Mental Well-Being; 3) Traffic Safety; 4) Child Abuse; 5) Family Life, including sex education; 6) Fitness and Nutrition, and; 7) Substance Abuse Prevention.

Pressure from parents and teachers contending that the Learning for Living program did not provide sufficient preparation for post-graduate living resulted in the then minister restructuring and renaming the program "Personal Planning" (PP) for kindergarten through grade seven, and "Career and Personal Planning" (CAPP) for grades eight through 12.

This mandated, comprehensive school health program has three main elements, each supposed to receive one-third of whatever time is allocated to the PP or CAPP curriculum. These three PP/CAPP elements are: 1) Career Development (formerly one of seven content areas); 2) Personal Planning (preparing personal learning plans along with goals and intended study habits), and; 3) Personal Development.

The six content areas to be covered in Personal Development include: 1) Healthy Living; 2) Mental Well-Being; 3) Family Life, including sex education; 4) Safety and Injury Prevention; 5) Child Abuse Prevention, and; 6) Substance Abuse Prevention.

As can be seen from the description of these changes, "Substance Abuse Prevention" now receives only one-sixth of one-third of whatever time is allocated to CAPP. This compares poorly with the one-seventh of teaching time under the former Learning for Living program for substance abuse prevention.

Regardless of the importance of the other CAPP subject areas, devoting only one-eighteenth of PP or CAPP teaching time to substance abuse prevention is obviously inadequate, particularly given poll data showing increased use of various substances at younger and younger ages.

Researchers claim that for a school health program to be effective it should receive between 50-75 hours of instruction, with the study material reinforced from year to year. Very few BC schools devote 50-75 hours to CAPP. The result is that, at most, students might receive two or three hours of teaching on substance abuse prevention.

Developed by A-DES for grades six and seven, "Making Decisions" is an example of programs that are devoting more realistic time to this area.

A Ministry of Education-approved drug education program, "Making Decisions" is now in 300 schools, and roughly 750 classrooms, and provides eight hours of interactive learning. Teacher training is available, along with parent education. "Making Decisions" is locally developed and part of the Ministry of Education's "Grade Collection".

As well, the RCMP is providing the Drug Abuse Resistance Education (DARE) program. It insists on being provided with adequate time before it will attempt its teaching program. Developed and run by the RCMP for use in grade schools' primary prevention efforts, DARE insists on a signed contract providing for at least 16 hours of teaching time for each class before it will begin.

While "Making Decisions" and DARE have been successfully employed in some schools, schools generally are not

allocating sufficient hours for substance abuse education and prevention. Having access to only one-eighteenth of perhaps two CAPP hours per week just doesn't get the prevention job done.

In summary, concerns about alcohol/drug education provided in BC schools include:

- inconsistent teaching of PP and CAPP across the province,
- teachers having to teach sensitive areas such as substance abuse prevention with inadequate expertise or training,
- insufficient time and re-enforcement devoted to substance abuse prevention as part of overall education,
- inconsistent resource materials available,
- too much "single issue" teaching, where teachers bring in stand-alone speakers dealing with only one topic,
- not enough "attitude and skills" development to help young people make good choices when confronted with opportunities to participate in alcohol and/or drug use,
- not enough connection between the course content and the skills developed, and the transference of these skills across content areas, and
- inability to provide a credible education and prevention program to those students who have moved beyond the "abstinence" and "delay first use" themes on to experimenting with substances that they should not use because they are too young or because the substances are illegal to use at any age.

A new Substance Abuse Prevention and Addictions Commission (SAPAC-BC) should be mandated to collaborate with the Ministry of Education to ensure the appropriate educating of teachers followed up with appropriate "in service" training, the provision of consistent materials, and the setting aside of adequate classroom time to properly provide, and subsequently reinforce, substance abuse education and prevention to students.

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