Appendix E: Environmental Scan

Substance Use in Toronto: Issues, Impacts & Interventions

An environmental scan prepared for the Toronto Drug Strategy Initiative

March 2005

TORONTO

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Introduction

In January 2004, the City of Toronto began a two-year process to develop a comprehensive drug strategy based on four key components, or pillars: prevention, harm reduction[i], treatment and enforcement. Toronto has many services and responses that span these areas. However, there is not a unifying framework or strategy to guide or co-ordinate these efforts even though they often share similar goals. The Toronto Drug Strategy Initiative aims to develop a co-ordinated and comprehensive response to substance[ii] use issues in our city – one that balances public health with public order.

The City of Toronto has broad-based social, economic and environmental plans, which set out the principles, goals and strategies for municipal action in each of these areas. Similarly, the Toronto Drug Strategy will provide a broader, strategic context within which the City and its institutional and community partners can make informed decisions about substance use and ensure the best use of resources. The Federation of Canadian Municipalities recommends that all cities have a co-ordinated local drug strategy. Toronto is fortunate in that it does not have the concentrated, open drug scenes of other cities. However, the use of drugs, alcohol and other substances is a serious issue for individuals, families and communities across our city. It is an issue that often evokes strong feelings and opinions as it strikes at the heart of our personal values and beliefs.

> *Toronto City Council has made a commitment to improving the health and well-being of the people of our city.*
>
> **City of Toronto, Social Development Strategy, 2001**

What is the story of substance use in Toronto? This report attempts to tell this complicated tale starting with an overview of who uses what kinds of substances and why, as well as the impact of substance use on individuals and communities. An overview of existing programs and responses is provided and barriers to service and service gaps are identified. Best practices are reviewed, as are international and national drug policies and their impact on local drug policy. Finally, we look to the experience of other cities to see what can be learned by their efforts and successes.

The purpose of this report is to provide a solid foundation of knowledge and understanding upon which to build Toronto's Drug Strategy. It is an ambitious task, but we are not starting from scratch. Considerable work has been done in the area of substance use, both in Toronto and elsewhere. We will draw from the wealth of evidence-based policy and research, using the pieces most relevant to our city. Information is presented at a general level only; it is not a detailed review.

There are limitations in a report of this nature. For some issues, little to no research has been done and so information is not readily available. Data are not always collected as frequently or in the way we might like. It is also sometimes difficult to reach marginalized groups and so their issues are not always well reflected in the scientific literature. In this report, we use a range of data sources including government, academics, institutions, community-based and user-generated research. Input gathered from key informants is also included, a list of whom can be found in the appendix.

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i Based on a Toronto City Council resolution in June 2001, harm reduction in this report is defined as a holistic philosophy and set of practical strategies that seek to reduce the harms associated with substance use without requiring abstinence.

iiSubstances for the purposes of this report refers to the full range of psychoactive drugs including alcohol, illicit drugs, prescription drugs, solvents, etc. Tobacco is not included as comprehensive strategies are already in place.

Profile of substance use in Toronto

This section provides a general overview of who uses what kinds of substances. The reasons that people use and do not use alcohol and drugs are described, and a brief overview of both the legal and illegal drug trade is provided. There are still gaps in our knowledge of substance use and this is reflected in the sometimes uneven level of information provided.

I. Who uses substances?

Information on rates of substance use comes mainly from general population surveys. While this is the best data available, it is important to note the **limitations**. Specifically, rates of use tend to be under-reported as some people choose not to reveal their use, particularly of illegal substances. Population surveys also don't tend to reflect the experience of vulnerable or high- risk groups, such as street-involved people, for whom rates of use are much higher and the impacts more severe.

General use

The reality is that most people in our society use substances of one kind or another. The type and amount of substances used may differ but the majority of people use something – from caffeine to tobacco to alcohol to cannabis and other drugs. **Alcohol is the most widely used psychoactive drug**. In Toronto, 78% of adults (18 years and over) reported using alcohol, according to the latest survey, comparable to province-wide rates.[1] Of this group, 15% report drinking at "harmful or hazardous levels."[2]

The same survey found that fewer adults use cannabis than alcohol – 15% of Toronto's adults reported use in the previous year.[3] However, use of **cannabis seems to be on the rise**, or at least the reported use. These rates compare with national trends that reveal a significant increase over the previous decade. The *2004 Canadian Addiction Survey* found that 14% of Canadians reported using cannabis in the past year, almost double the rate reported in 1994.[4] This rise in reported use may reflect changing attitudes among Canadians about cannabis.

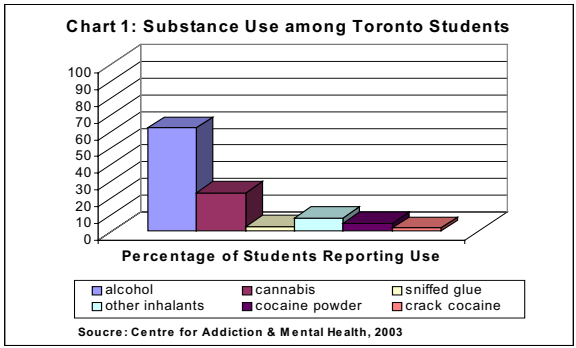
> *Cannabis sativa…has been cultivated for centuries for industrial and medicinal use, and for its "psychoactive" effects. Marijuana, hashish and hashish oil all derive from the cannabis plant.*
>
> **Do you know…Cannabis, CAMH, 003**

Two percent of Canadians admit to using **other drugs,** specifically cocaine, crack cocaine, ecstasy, LSD and other hallucinogens, speed/amphetamines, and heroin.[5] It is interesting to note that while most Canadians say they are not current users of illicit drugs, many have tried them at some point in their lives, men more often than women. Over 10 million people, or 40% of Canadians, said they have tried cannabis at least once. Use of other illicit drugs ranges from 11% for cocaine or crack cocaine to 13% for LSD, speed and heroin combined.[6]

Overall, rates of substance use are lower in Toronto than elsewhere in the province. This has been attributed to what is called the "**healthy immigrant effect**" due to the high number of newcomers coming from cultures where substance use is less common. This "effect" tends to disappear in future generations. In addition, there are some **gender differences** related to substance use. For example, more men than women use illicit drugs. For women, alcohol is the most common substance used.[7] Except for cannabis, lifetime use of illicit drugs is rare among women.

Substance use by youth

The Centre for Addiction & Mental Health has conducted biennial surveys of Ontario junior high and high school students since 1977 to monitor patterns of alcohol and drug use among these youth. The 2003 survey notes the following trends for students in Toronto, as noted in Chart 1:[8]



- **Use of alcohol** has grown steadily among students over the past five years. Of those surveyed, 62% said they had used alcohol at least once in the previous year – up 6% from the 2001 and 1999 surveys.
- 18% of students surveyed reported **binge drinking** (more than five drinks on one occasion). Province-wide this number is much higher at 27%, a particular concern given the health and safety risks associated with binge drinking.
- About 14% of licensed students said they **drove under the influence of cannabis**, another high-risk activity.
- 23% of surveyed students had used **cannabis** in the previous year – the highest reported rate since 1979.
- About 3% of Toronto students said they had sniffed glue; 8% had used other types of inhalants. **Inhalant use** was particularly popular among younger students – grades 7 and 8. This type of use tends to stop as they get older.
- About 5% of students said they had used **cocaine powder** in the past year. Trend data show a slight rise in use over the last decade**.** Reported use of **crack cocaine** by students remains at 2%.
- Stable or decreasing use of **ecstasy and GHB** follows similar trends in other jurisdictions.

You can find the *CAMH Monitor* and *Ontario Student Drug Use Survey* reports on the Centre for Addiction & Mental Health's web site at www.camh.net.

Tobacco and alcohol are often viewed as **"gateway"** drugs to cannabis, which in turn leads to use of other illegal drugs such as heroin or cocaine. However, the research does not bear this out. While it is true that users of these types of illegal drugs also tend to use cigarettes, alcohol and cannabis, the opposite is not true. The majority of

people who use alcohol, tobacco and cannabis never use other illegal substances. Although some studies have found an association with increased risk of progression to other drugs, researchers maintain that the progression is by no means inevitable and no study has been able to isolate a causal link.[9] [10]

While the trends of substance use among youth are of concern, it is important to note that many young people try alcohol or illicit drugs without becoming frequent or problem users. Research shows that experimentation with drugs and alcohol is in many respects part of "normal" adolescent development and usually declines as youth reach their mid-to-late 20s.[11] This "maturing out" process tends to correspond with the adoption of adult roles and responsibilities.[12]

Groups at high-risk for substance use

There is a wide range of health, social, economic and situational conditions that place some people at particular risk for substance use. Some of the most vulnerable groups are noted below.

- **Youth who are homeless** tend to use substances at significantly higher rates than do youth who live at home. This is not surprising given the risks associated with living rough on the street and the high proportion of street youth that have experienced early family chaos, physical, sexual and emotional abuse and the effects of parental substance use.[13] A recent Toronto study found that 84% of street youth used cannabis and 83% used alcohol. Use of crack cocaine and prescription pills was also high at 60% and 41% respectively. These youth also tend to use more frequently; 72% used daily and usually more than one substance at a time.[14]
- Overall rates of substance use for **adults who are homeless** are not available, but we do know it is an issue for some. In one Toronto study, 44% of the homeless people who participated said they had used drugs in the previous month.[15] Another local study found that 85% of homeless people who were using had been using their drug of choice for at least five years, 65% had been using for 10 or more years.[16]
- **Lesbian, gay, bisexual and transgendered** youth and adults have higher than average rates of substance use and this is often related to life experiences of homophobia and transphobia.[17] Alcohol and other drugs also play a large role in the socialization of LGBT youth in clubs in urban settings, as well as in facilitating entry into the community.
- **Aboriginal people** across the country have been found to be at particularly high risk for substance use and injection drug use.[18] In Ontario, Aboriginal people have significantly higher rates of substance use than the general population. In addition, 80% of Aboriginal people who use alcohol are likely to be using other substances.[19] A 1996 study found that Aboriginal people 15 years and older were almost three times more likely than non-Aboriginals to have used cannabis or hashish in the previous year. They were three and a half times more likely to have used LSD, speed, cocaine, crack or heroin and 11 times more likely to have sniffed solvents or aerosols.[20]
- There is limited information on the number of people with **concurrent** disorders (both mental health and substance use issues) although they are recognized as a high-risk group. Data collected from the Centre for Addiction & Mental Health

and community mental health service providers found between 18-25% of people had a concurrent disorder.[21] Of this group, proportionately more were between the ages of 25 and 44 and the majority were men. It is important to note that these data only reflect people who are in the treatment system. Rates are likely higher for marginalized groups such as people who are homeless.

- **Sex workers** tend to have higher rates of substance use issues than the general population.[22]
- People in **detention centers, jails and prisons** report high rates of substance use. National data indicate that at least seven out of 10 people in the federal correctional system have "engaged in problematic use of alcohol and other drugs" in the year prior to their incarceration.[23] For people in Canada's federal prisons, about 51% are estimated to have issue with alcohol; 48% with drugs other than alcohol.[24] Statistics aren't available on substance use in Ontario or Toronto correctional facilities. But anecdotal reports from service providers who work with prisoners indicate significant rates of use citing prison "culture" as a key reason.

The above information provides a brief sketch of what we know about people who use alcohol and other drugs. However, there is much that we don't know, especially about people who never come in contact with the service system. This includes, for example, people who have the resources to acquire and use drugs in privacy. This **"hidden" form of substance use** is also a concern and can be dangerous in cases of illness or overdose if no one is there to assist. We know that many people use substances without their family or friends ever knowing.

II. What types of substances do people use?

The *2004 Drug Use in Toronto* report concludes that for the general population of Toronto, the most frequently used legal substances continue to be **alcohol** and **tobacco.**[25] Trends in the use of **other drugs** in Toronto include:

- ***Cannabis*** is the most frequently used illicit drug, as discussed in the previous section.
- ***Cocaine powder*** has enjoyed a resurgence in popularity. Cocaine is a powerful stimulant and there are many physical problems associated with its use, including a strong potential for misuse and interaction with other substances.

Cocaine is a stimulant drug. Stimulants make people feel more alert and energetic. Cocaine can also make people feel euphoric, or "high".

Do you know Cocaine, CAMH, 2003.

- ***Crack cocaine*** is used by about 1% of adults in Toronto. However, it is considered to be the most popular street drug used in Toronto. Similar to trends seen in other North American cities, local studies confirm that crack is the most popular recreational drug among poor, homeless or otherwise disenfranchised people in Toronto.[26] One study of people who are homeless, found that 74% used crack as well as high levels of alcohol and cannabis (65% and 62% respectively).[27] Crack cocaine or a combination of crack, alcohol and cannabis were the main drugs used by this group.
- ***Heroin*** use remains at about 1% among adults in Toronto using this drug over their lifetime. However, like cocaine, heroin is more prevalent among homeless or street-involved youth and adults.

Heroin belongs to the opioid family of drugs. Also in the opioid family…morphine and codeine, which are natural products of the opium poppy; and "synthetic" opioids, such as Demerol and methadone.

Do you know Cocaine, CAMH, 2003.

The *2004 Drug Use in Toronto* report also highlights some **newer trends** in drug use including the following:

- ***Designer drugs*** (a.k.a. chemical drugs, club drugs, or rave drugs) are produced by chemically altering and combining existing drugs or substances (e.g., GHB and ecstasy). These drugs are designed to provide a specific, often unique combination of physical and psychoactive effects.
- ***Oxycodone hydrochloride*** is a narcotic pain reliever manufactured as Percocet, Percodan and Tylox. A relatively new and longer-lasting oxycodone product, OxyContin, is an oral timed-release form of the drug. Reports of increased use of oxycodone, especially OxyContin, have been noted across North America over the past two years.
- ***Methamphetamine*** (a.k.a. meth, crystal, speed, crank, ice) is a powerful, chemical stimulant produced in underground laboratories in Canada and the U.S. Increases in methamphetamine use have been associated with serious health problems across North America over the past decade.
- ***DXM*** *(dextromethorphan*) is a cough suppressant available by prescription or over the counter. Taken as recommended it is generally considered safe. However, some people consume DXM in considerably higher doses in order to experience hallucinations and dissociative effects.

You can find the *2004 Drug Use in Toronto* report on Toronto Public Health's website at www.city.toronto.on.ca/health/rgdu/rgdu_2004.htm

People also misuse **prescription drugs**, sometimes mixing them with alcohol or other drugs (rates of prescription drug misuse could not be obtained in time for the printing of this report). Prescription drugs that are misused include over-the-counter drugs, like DXM described above, as well as drugs that are marketed illegally. Combination or poly-drug use is common; more details of which can be found in Section V of this chapter. Use of **steroids** and other substances has also emerged as a growing issue in the world of sport as some athletes strive to be more competitive. The group most at risk is young men between the ages of 15 and 30 who are involved in sport or work in a field where a muscular appearance and strength work in their favour.[28]

There are also new substances that we need to learn more about, some of which are introduced in Canada by other cultures**. Khat**, for example, is a mild stimulant that is usually chewed and, although illegal in Canada, it is legal in several African countries and Britain.

III. Why do people use substances?

Throughout history, people of all cultures, income levels and religions have used a wide range of psychoactive substances. Why do people use substances such as beer, wine, or even cocaine or heroin? The reasons are as varied and complex as human nature and include **individual and broader societal factors**.

Of course, one of the main reasons that people use substances is for **pleasure** and to enhance social interactions. A group of friends may meet at a pub after work or gather at someone's home for a wine tasting. This same pleasure principle also applies to illicit drugs.

Substances have been used throughout the ages as part of **religious and spiritual practices**. For example, wine is used as part of the communion ceremony in some Christian traditions and is also a part of some Jewish prayers. Tobacco is considered sacred by many Aboriginal peoples and is used in traditional ceremonies and practices.

Psychoactive substances help people to **cope with chronic illness**. In addition to prescription pain medications, the use of cannabis for medical purposes is now legal in Canada on a limited basis. For people suffering from some chronic or terminal illnesses, cannabis has been effective as an anti-nauseate (to counter the effects of HIV/AIDS antiviral medication) and as an appetite stimulant (to help with the potentially dangerous loss of appetite experienced by some people with HIV/AIDS). Some prisoners with chronic illness turn to illicit drugs when they cannot get appropriate or needed pain medication.

People also use substances to **cope with stress, trauma or hardship –** some as a form of **self-medication**. Poverty, homelessness, lack of education, family dysfunction and parental substance use, mental health issues and a history of child abuse are all factors that place people at higher risk of using substances.[29] A recent Toronto study of injection drug users found the majority had experienced emotional, physical or sexual abuse.[30] Research has made strong links between the use of crack cocaine and family breakdown and childhood exposure to violence.[31] [32] For people who are homeless, alcohol and other drugs are sometimes used to help survive life on the streets. Some drugs numb their pain while others help keep them awake and vigilant of the many dangers on the street. People suffering from post-traumatic stress disorder (people fleeing war-torn countries, for example) may turn to alcohol or other drugs to escape those memories.

For some people there is a strong link between **sex**, **alcohol and drugs**. Substances are used in the ritual of dating and to enhance sexual experiences as they can lower people's inhibitions. Some drugs, such as crack cocaine, increase the users sexual appetite; although for this drug it seems to hold true more for men than for women, who often have the opposite reaction.[33] In addition, for some people who become addicted to drugs a vicious cycle can ensue – sex is exchanged for the drugs which then precipitate the need for more drugs and hence more sexual trades.

The reasons that **youth** use substances are more complex than traditionally thought. For some youth, the reasons are similar to those for adults: for pleasure and social enjoyment or to relieve stress or escape emotional pain. But youth also use substances to show independence, to signal entry into a peer group and to satisfy curiosity.[34] For some youth, use is driven by a desire to get intoxicated – a familiar phenomenon in college and university campuses

Substance use among **Aboriginal people** has been linked with the considerable social disadvantages experienced by these groups, including poverty, low education, unstable family structure, physical abuse and poor social support networks.[35] These factors are further exacerbated by discrimination, the after-effects of residential schools and barriers to health care such as the lack of culturally appropriate services.[36]

The role of cultural differences also applies to **immigrant newcomers.** This group often experiences social and economic inequities such as unemployment, underemployment and racism, which are additional stressors to the settlement and

adaptation process and may contribute to substance use. A Toronto study on substance use among Afghan, Pakistani and Russian communities highlights the following issues:[37]

- Burdened with problems of poverty, unemployment and racism, men experienced depression, health and mental health issues and sleeplessness, which in turn lead to substance use as a way to cope with these issues.
- Loneliness, isolation, separation from family members, lack of family control, and the challenges of integrating into a new culture and society were identified as factors leading to substance use in order to reduce the associated stress, tension, depression and anxiety.
- Youth must contend with peer pressure and the struggle to "fit in" to a new society. Some youth reported suffering from depression due to the difficulties in adjusting to a new life and finding new social networks.

When does use become problematic? Generally speaking, substance use becomes a problem when it begins to have **negative effects** on a person's health, safety, relationships, education or employment. For families or communities, substance use becomes a problem when it starts to affect their lives. This can range from coping with the erratic or destructive behaviour of an alcoholic spouse, to residents being disturbed by rowdy patrons leaving a neighbourhood bar or being exposed to open drug dealing.

For some people, **the problem is the substanc**e being used. Alcohol is legal and therefore its use is largely socially acceptable for those of legal age. Alcohol-related issues are linked mainly to behaviours such as binge drinking, violence or driving while impaired. However, the use of illegal substances is often viewed as problematic regardless of whether there are any negative behaviours for the individual or the community because of that use.

The impact of social attitudes on substance use

Attitudes change as society evolves and this holds true for views about substance use as well. This change is well illustrated in the case of tobacco. **Tobacco** has been a legal substance for many years and at one time was even promoted as a socially desirable and glamorous activity. But as the health risks of smoking became better known, government policies and programs began to discourage people from smoking. While tobacco continues to be a legal substance, most people now view smoking as problematic.

Over the last four decades, **recreational cannabis** use has evolved from a practice that was popular only within certain marginalized groups or subcultures, to one that is now broadly established throughout society. This more generalized use, particularly among the middle class, has resulted in more tolerant attitudes by law enforcers and the general public alike. As a "tolerable deviance," cannabis use has seemingly become more of a personal lifestyle choice now that it is part of mainstream society.[38]

IV. Why people choose not to use substances

Some people choose not to use substances at all. Again, the reasons for this choice are diverse and are influenced by many factors in a person's life. For some, choice relates to the legal status of the drug. They may drink alcohol but would never consider using illicit drugs because they are **illegal**.

For some, choosing not to use relates to their **religious or spiritual practice**. For example, some Muslims refrain from using specific substances because their religion forbids it. **Negative exposure** to substance use by others may also affect a person's decision to use. For example, a child who has grown up with an alcoholic parent may avoid drinking because he or she has personally experienced the destruction that alcohol can cause.

For **youth**, choice may involve a decision not to use or to delay use until they are older. The presence of what are called "**protective factors**" increases resiliency, helping youth with this decision-making process. Protective factors are attributes or skills that protect, buffer against, or reduce the effect of exposures to risks that children and youth may encounter. Examples of protective factors include social and problem-solving skills, flexibility, positive family bonding, involvement in community and/or peer group activities. One of the most critical factors that protects youth from risk-taking behaviour, such as substance use, is having a supportive and caring relationship with an adult.[39] Research shows that even when faced with risks, such as pressure to try cigarettes, alcohol or other drugs, a young person may not succumb because of these protective factors.[40]

> *The focus on risk and protective factors has been among the most important developments in substance abuse prevention theory and programming in recent years.*
>
> **U.S. Department of Health and Human Services**

V. How people use substances

There are several ways to ingest alcohol and other substances. The **most popular form of use is oral**, but substances can also be smoked, snorted, sniffed, inhaled or injected. A new and legal method of taking alcohol that is popular in bars in Britain and the United States is AWOL, or Alcohol With Out Liquid. A shot of alcohol is poured into a vaporizing machine, which creates a mist of alcohol and oxygen that is then inhaled. Users of AWOL say it increases the intensity of the high without the added calories of the liquid. AWOL is currently not available in Canada.

Injection is one of the quickest and most direct ways to get high. There are an estimated 10,000 to 18,000 injection drug users in Toronto.[41] Determining the exact number of people who inject drugs is difficult as it is an illegal activity and many people will not admit their use. In Toronto, **the most frequently injected drug is believed to be cocaine**. This finding is reflected in an ongoing study of injection drug users in Toronto in which the vast majority (79%) of people were injecting cocaine.[42] The next most frequently injected drug was crack cocaine at 63%. This latter number is significantly higher than for the other three cities being studied.[43]

Poly-drug use is common in Toronto**,** referring to the use of more than one substance at a time. Combinations include alcohol, illicit and prescription drugs. Factors influencing this use include the growing availability of prescription drugs, the club-drug culture where a wide array of drugs are available at one time and the use of different substances to enhance effects or counteract the negative effects of other drugs.[44] A recent Canadian study of illicit opioid users found high rates of poly-drug use.[45] Opioid use in this study was not limited to heroin, but included a wide variety of prescription opioids including diverted methadone. Opioid users also regularly used cocaine, crack cocaine or opioid/cocaine combinations.

In Toronto, **popular drug combinations** include:[46]

- *Alcohol and designer drugs* such as GHB, GBL, and Ketamine.
- *Opiates and cocaine*, which are known *as "*speedballs."
- *Trail-mix,* which is a blend of methamphetamine, ecstasy, Ketamine and Viagra.
- *Salad bowl*, which is a combination of randomly obtained pills, often taken with alcohol.

In addition to potential dangers of mixing various drugs together, the use of drugs can lead people to engage in **other risky behaviours** as described below.

- Aggressive public education and police enforcement campaigns have reduced the incidents of **drinking and driving**, but many people continue to engage in this risky activity. A recent student survey found that 30% of Toronto students had been in a car with a driver who was under the influence of alcohol.[47] Male drivers are more likely than females to drink and drive (20% vs 8%).[48] The vast majority of substance-related vehicle accidents involve alcohol, but impairment due to use of other drugs is also a concern. It is a criminal offence to drive while impaired by any drug; however, the police do not have the authority or ability to test for **drug impairment**, as they do for alcohol-related driving offences.[49] The potent combination of cannabis and alcohol is a particular concern.[50] Proposed changes to the criminal code mean that drivers suspected of being high on over-the-counter, prescription or illegal drugs could be required to give police saliva, urine or blood sample on demand.[51]
- A Canadian study looking at patterns among injection drug users of **injecting practices, HIV-testing behaviours** and **sexual behaviours** found high rates of sharing needles and other injecting paraphernalia by multiple people and high rates of sexual activity.[52] All of these factors increase the potential spread of blood-borne viruses and sexually transmitted diseases. Another study found that many injection drug users are involved in unprotected sex and that condom use with regular and casual partners was low.[53]
- Cocaine and crack cocaine users tend to have a **high injection rate** due to the short duration of the high – as often as 20 times a day.[54] Therefore, depending on their injection practice, the availability of new syringes and other paraphernalia, there can be an increased risk of disease transmission.
- Studies have found that women often depend on their male partners for their drugs and are often the **secondary user** after the man has injected.[55] Sharing needles in this way places women at higher risk for acquiring communicable diseases. It is also not uncommon for women, especially poor or marginalized women, to exchange sex for drugs or money, again placing them at further risk of infection or disease.

A recent study by the AIDS Committee of Toronto looked at the use of party drugs in Toronto's gay dance club scene. A key finding of the report was that poly-drug use was associated with **high-risk sex**. However, it is important to note that overall study participants who said they had unprotected sex had a low commitment to safer sex even in absence of drug use.[56] It is not known if a similar effect is true among heterosexuals who are active in the club scene.

VI. How people get legal and illegal substances in Toronto

Legal substances

Legal substances are controlled and regulated under Canada's *Food & Drug Act*. Prescription drugs are prescribed by physicians and dispensed by pharmacists. However, there is also an illegal trade in prescription drugs, although we do not have a clear picture about the extent of this problem. In Ontario, **access to alcohol** is controlled under the *Liquor Control Act* and regulated through the Alcohol & Gaming Commission. In Ontario, the government sells alcohol through LCBO, beer and wine stores. Despite regulation, youth under the legal drinking age can still get access to alcohol. In the most recent student survey, 62% of students said that it was easy or very easy to get alcohol.[57]

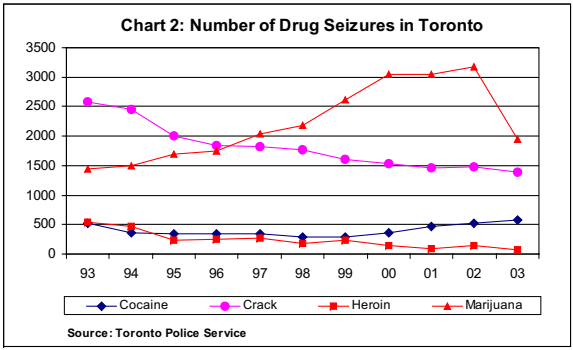
While alcohol is a legal substance, police do make **seizures of illegal alcohol**. The vast majority of these incidents involve the smuggling of alcohol from the United States. Spikes in this type of crime are usually associated with increased taxation of alcohol in Canada as happened, for example, in the early 90s.

Illegal substances

In Canada, the *Controlled Drugs & Substances Act* controls the importation, traffic and use of narcotics and other illicit substances while allowing for their medicinal use where appropriate.[58] The act also prohibits the unauthorized possession of equipment (i.e., drug paraphernalia) intended for ingesting drugs into the human body, or meant for the production of such substances, if it contains traces of a prohibited drug.[59]

As a large urban centre, **Toronto is a "user" market** with illicit drugs coming in for consumption. However, it is also a large **"trans-shipment" hub** with supplies of drugs moving through the city to other parts of the province and the country. It is impossible to determine with any accuracy the amount of drugs coming into or through Toronto at any given time. However, the *2004 Drug Use in Toronto* report documents key trends in drug seizures in the city, as seen in Chart 2.[60]

- **Cannabis** accounted for 43% of all drug seizures in 2003. Seizures increased between 1996 and 2002 to over 3,100 but decreased in 2003 to 1,947. However, while the number of seizures has decreased, the quantity of seizures has increased significantly – from 577,537 grams to over three million grams.
- **Crack cocaine** is second only to cannabis in terms of illegal substances seized by police, accounting for 30% in 2003. Powder cocaine accounted for about 12% of all seizures in 2003.
- **Cocaine seizures have been on the decline** since the late 80s. Similarly, the number of crack cocaine seizures has dropped since a peak in 1992. Seizures of heroin peaked in the early 90s. Since then, the number of **heroin** seizures continues to fall, accounting for only about 2% of the total number of drug seizures in 2003.



These drug seizure statistics need to be understood in context. In large part they **reflect the amount and type of police resources** that are targeted to this activity. For example, in recent years, marijuana grow-operations have been a key enforcement focus of the Toronto Police Service. As a result, seizures of cannabis have increased considerably. In addition, drugs seized within the boundaries of Toronto do not tell the whole story. Drug seizures at **Pearson International Airport** and in the surrounding jurisdictions must also be considered. For example, in 2003 the RCMP seized 7, 207 grams of heroin, 417,420 grams of cocaine and 736, 635 grams of marijuana at the airport.[61]

The RCMP also reports that the trafficking and use of **synthetic drugs** (such as ecstasy) are growing in Canada. At one time these drugs were mainly associated with raves and nightclubs. However, use of synthetic drugs is expanding from these venues into more mainstream use. In addition, while youth remain the main users of synthetic drugs, more adults are now using them.[62]

Drug dealing in Toronto

Drug dealing happens **throughout the city** and tools such as cell phones help to keep much of it out of sight. Dealers with cell phones and cars are highly mobile and often deliver to people's homes or to a pre-arranged meeting place on the street. The internet is also useful for organizing and executing low-key drug deals. There are areas of the city that have more visible and active areas for dealing, especially in the downtown core. However, this activity often involves dealers coming in from other parts of the city. Buyers as well come downtown from all over Toronto to "shop" for drugs.

Traditionally, drug traffickers have co-existed in relative harmony due to the **free-market status** of Toronto. No one entity or family controls or tries to control the total city market as is the case with organized crime in some U.S. cities. Crime groups in Toronto can act autonomously without paying "homage" or "respect" monies to any controlling group. Some criminal groups or gangs do try to control a relatively small territory for their drug trafficking efforts using violent force if necessary. Some groups also control the availability of particular substances. For example, cocaine found in Canada almost exclusively comes from Brazil, Venezuela

or Colombia. Criminal groups from those countries can affect the availability and therefore the price of this drug on the streets of Toronto. On the other hand, heroin in Toronto primarily comes from processing laboratories in China, Laos and Thailand. The product is shipped directly to Canada, some of which is intended for Toronto and surrounding area. The remainder, and probably the majority, is sent to the United States.

Similar to the alcohol industry, the illicit drug trade is a **sophisticated marketplace.** Some traffickers consciously introduce drugs through the use of strategic marketing techniques. For example:

- Putting happy faces and identifiable logos on ecstasy or MDMA pills
- Putting PCP and Methamphetamine in ecstasy tablets
- Lacing marihuana joints with crack cocaine (called Coca Puffs)
- Reducing the street price of heroin to compete with crack cocaine
- Popularizing the smoking of heroin

Depending on the type of substance, it seems to be **fairly easy for young people to get illicit drugs** in Toronto. The Centre for Addiction and Mental Health's 2003 survey of junior high and high school students found:[63]

- 44% of students surveyed said it was easy or very easy to get cannabis;
- 21% said it was easy/very easy to get ecstasy;
- 20% said it was easy/very easy to get cocaine;
- 33% said that someone had tried to sell them drugs; and
- 31% had witnessed drug selling in their neighbourhood.

Drug dealers

The illegal drug trade is made up of many players. The big money is made by a relatively small group of global traffickers. Conducting research on the dynamics of the drug trade is difficult because of its illegal and dangerous nature. But, we know that dealers are not always motivated by the same things or play the same roles. **Some dealers do not use drugs themselves** and indeed may never come in contact with the end user. These people are primarily motivated by profit and often use street-level dealers to actually distribute the drugs.

Some people deal drugs only on a short-term basis, perhaps to pay their way through school or to get out of a bad financial situation. However, profit is not the only motivation for selling drugs. Some people **sell drugs in exchange for drugs** to use themselves. In Toronto's crack cocaine market these sellers are called "flexers." Flexers do not see themselves as dealers per se but rather as go-betweens from dealers to users. A Toronto study into the local crack cocaine market found that poor, unemployed and homeless people are particularly vulnerable to being drafted into this trade, their knowledge of street culture being an advantage to finding crack buyers.[64] Crack is also a relatively cheap drug and so is used more frequently than other drugs by people who are homeless or poor.

The dynamic between users and their dealers is often complex. Some users are abused or victimized by their dealers who exploit their addiction. Others build trusting relationships with their dealers. Some dealers closely monitor the quality of the drugs they sell and warn people of highly potent or contaminated drugs that may

be circulating on the streets. Some users even receive "credit" privileges if they are long-term customers.

Buying clubs

In Toronto, as elsewhere, there are also **buying clubs**, which sell cannabis to people who are chronically ill, but who have not been granted legal sanction to use cannabis for medical purposes. These buying clubs are therefore illegal and sometimes closed down by the police.

Effects and impacts of substance use

I. What are the health and social impacts of substance use?

There are many health and social consequences to using alcohol and other drugs and people experience them to greater or lesser degrees. This section provides a brief overview of some of the main impacts.

Disease, physical injury and disability

The health effects of alcohol use are well studied and publicized. **Long-term alcohol use** can lead to serious problems such as hypertension, heart disease, acute alcohol poisoning, respiratory system disease, brain damage, liver disease, and premature death. Alcohol is also a significant risk factor for cancer, and research has found that about 10% of cancer deaths in Ontario are attributable to alcohol.[65] **Short-term effects of alcohol** use include a substantial number of injuries such as falls, drowning, motor vehicle collisions, and related disabilities.

The health effects of **cannabis** continue to be a topic of debate. The 2002 report of the Special Senate Committee on Illegal Drugs concluded that cannabis is less harmful than alcohol and therefore should be governed by the same sort of regulations as tobacco.[66] A recent review of research looking at the **adverse effects of cannabis** use concludes that there is an emerging, yet difficult to quantify, link between cannabis intoxication and motor vehicle accidents.[67] A highlighted study in the review found that above-limit alcohol levels were found in 26% and that cannabis was found in 10% of injured drivers. The review also reports an increased risk of airways cancer in long-term heavy cannabis use, but little evidence of lasting cognitive impairments. Another trend noted in the review is an *association* between maternal cannabis use and developmental problems in their children.

The use of **other drugs** also has the potential for a number of serious health issues, including:

- The transmission of **HIV and Hepatitis C** (HCV), which are two of the most serious public health risks associated with injection drug use. A recent study of injection drug users in four cities across Canada found that in Toronto, 54% of users were HCV positive and 5% were HIV positive. Compared to the other cities (Regina, Sudbury and Victoria), overall Toronto had the lowest rates of infection. However, these infection rates are still considered unacceptably high.[68] Toronto's proactive needle exchange practice has been credited with helping to keep infection rates down.
- A study of people using illegal opiates (e.g., heroin) compared social, health and drug use characteristics. The research found that this group regularly used more than one drug at the same time – usually a variety of illicit opiates and cocaine or crack. They also reported high levels of **physical illness** (for example, infectious disease) and **mental health issues** such as depression.[69]
- Whether smoked or injected, use of crack cocaine presents a number of health and safety risks, including **compulsive use and addiction**, the spread of infections such as HIV and Hepatitis C, cardiac problems, seizures and even death.[70]

- An issue of considerable debate at the moment is the question of the potential for disease transmission among people who smoke crack. Specifically, the question is can **blood-borne diseases** be spread through the sharing of crack pipes among users with burnt or cracked lips. Unfortunately, to date little research has been done to examine this issue.

Overdose and death

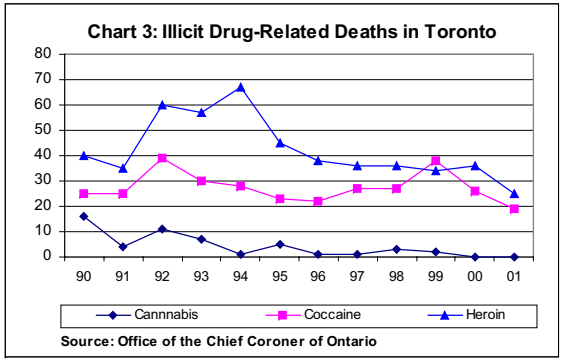
For people who use illicit drugs, **overdose** is a major cause of illness and death. Research shows that most illicit drug users experience nonfatal overdoses. A Canadian study of illicit opiate (e.g., heroin) users linked several factors with overdose episodes.[71] A key factor was homelessness, which was also identified as a powerful social determinant of poor health outcomes. Exposure to drug treatment within the previous year was also a contributing factor to drug overdose (primarily detox and methadone treatment). This surprising connection may be due to a lower drug tolerance resulting from treatment or the potentially toxic combination of prescription and non-prescription drugs.[72]

Of course, the most extreme impact of substance use is death. The latest nation-wide data on **deaths** attributable to substance use in Canada is for 1995.[73]

- **Tobacco** accounts for the vast majority of Canadian deaths due to substance use (34,728 people).
- 6,503 Canadians died because of **alcohol** consumption. Motor vehicle accidents, liver cirrhosis and suicide accounted the largest number of alcohol-related deaths. In the most recent traffic injury research in Ontario, 6% of drivers killed in crashes had been drinking, and more than 15% had impaired ability with alcohol over the legal limit.[74]
- 804 deaths were attributed to **illegal drugs.** Suicide and opiate poisoning accounted for the majority of those deaths.

Chart 3 shows key death trends in Toronto due to illegal drug use, as reported in the *2004 Drug Use in Toronto* report.[75]

- After a spike of 38 **cocaine-**related deaths in 1999, the number of people in Toronto who died because of cocaine fell to 19 in 2001.
- The late 80s/early 90s saw an increase in **heroin-**related deaths peaking at 67 deaths in 1994. The number of deaths has continued to decline since that time to a reported 25 deaths in 2001.
- **Cannabis** is generally not considered to be a lethal drug. In the 49 drug-related deaths between 1986 and 1998 in which cannabis was present, it was never the sole cause of death.



Drug contamination

Because of the illegal and therefore unregulated nature of the illicit drug trade various hazards related to these substances are possible including:

- **Contamination** – residue from the production process or contaminants that are unintentionally incorporated during the production or distribution process may cause poisoning;
- **Adulteration** – dilutents (bulking/cutting agents) and other substances deliberately added during the production or distribution process can result in poisoning;
- **Dosing/purity errors** – uncertainty about the strength/purity of illicit drugs means that estimation of amounts used is uncertain and – especially when drugs of unexpected purity become available – can result in unintentional overdose.[76]

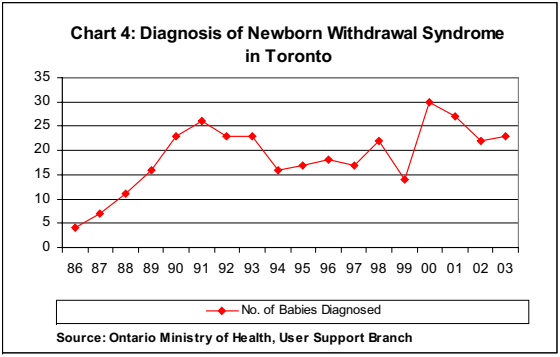
In Toronto, as elsewhere, more drugs are produced by "**underground chemists**," which increases the danger of drug contamination. Examples of recent incidents in Toronto include strychnine poisoning, potentially from adulterated crack cocaine and suspected contamination of cocaine, resulting in painful effects including severe burning sensations in the head, neck and face.[77]

Neonatal impacts

Drinking during pregnancy can result in a range of conditions, which are collectively known as **fetal alcohol spectrum disorder** or FASD. FASD crosses all racial, ethnic and socioeconomic barriers, although preliminary research suggests rates may be higher in some Aboriginal communities. The effects of FASD can last a lifetime and include intellectual deficits and learning disabilities, hyperactivity, inability to manage anger, etc.[78] These conditions lead to the potential for early school drop out, alcohol and drug use, homelessness, trouble with the law, etc.[79]

Drug use during pregnancy may also lead to **newborn drug withdrawal syndrome**, which is associated with central nervous system irritability, seizures and gastrointestinal problems that can last for up to six months. Chart 4 shows the number of infants born in Toronto over the last eighteen years who were diagnosed with

newborn drug withdrawal syndrome. Trends reflect increased recognition of the syndrome by physicians, as well as actual patterns of incidence.



Loss of housing

Even if people have a stable lifestyle and source of income, they may be at **risk of eviction** by landlords who will not tolerate people who are actively using substances, especially illicit drugs. In this way, finding and keeping stable, permanent **housing is a key issue** for users. A study of the health and social conditions of people using illegal opiates (e.g., heroin) found that the majority of this group did not have permanent housing and often relied on semi-legal or illegal activities for income.[80] In Toronto, housing stability is further exacerbated by a serious lack of affordable housing. Once a person has lost his or her housing, it can be very difficult to find another place to live. In a housing market where landlords can afford to be choosy, someone who has just been evicted or is suspected of using drugs will be hard pressed to find a home.

Stigma and discrimination

A key issue for users, service providers, advocates and policy makers is the stigma attached to people who use drugs, especially illicit drugs. This has significant consequences as people **internalize these negative perceptions**. When people are made to feel unworthy or vilified by the rest of the community, they are more likely to withdraw, making it even harder for them to find their way back. A vicious cycle is created as the more marginalized that people become because of this social rejection, the more society condemns them, which in turn fuels their marginalization, and so on.

Attitudes also differ according to the substance being used, even among users themselves. People who only smoke cannabis are viewed less harshly than those who use other drugs such as cocaine or heroin. People who inject drugs are viewed more harshly than those who don't. Heroin and cocaine, as drugs that are more expensive and used by more affluent users, have more "cachet" than cheaper drugs like crack cocaine. Crack users tend to be the most vilified group even by other users. "Crack head" is a commonly used derogatory term reserved for the lowest kind of drug user. People of all income ranges smoke and inject crack cocaine, but because it is cheap

and readily available it is often associated with people who are poor, homeless or otherwise street-involved.

Gender is also an issue as **women** who use alcohol or drugs are often perceived more negatively than men**.** This may be rooted in a perception that substance use impairs their ability to be caregivers and mothers, viewed by some as a primary role for women. In this way they are seen as more "sick and deviant" than men who use drugs or alcohol.[81]

Drug users can also feel stigmatized by health and social service providers. The roots of this stigma go back to the notion of the "junkie" formed in the late 19th century and to the misguided belief that **people with addictions are weak-willed** and could stop if they really wanted to. A study looking at the experience of people in methadone treatment found significant issues of stigma stemming from the lack of acceptance of methadone as a normal therapy for a bonafide medical condition (opiate addiction).[82] Some opiate users view methadone as an inferior, even harmful drug that dulls the senses and is even harder to kick than heroin.[83] People often feel they need to conceal the fact they are in treatment out of fear of losing their jobs or being rejected by family or friends.[84] They often fall into a pattern of voluntary social segregation enduring lives filled with anguish, shame, stress, and the constant fear of public exposure of their "dirty secret."[85]

> *People who use illegal drugs are viewed as deserving of punishment rather than in need of care, treatment and support.*
>
> **Canadian HIV-AIDS Legal Network**

Impacts for high-risk groups

There are a number of groups for whom the effects and impacts of substance use can be more severe, as highlighted below:

- **Women** experience more severe impacts to their physical health and in a shorter period of time by intense substance use than men do.[86]
- A recent Toronto study found that **homeless women** between the ages of 18 and 44 were ten times more likely to die than women in the general population.[87] For these women, the most common reasons for death were drug overdose and HIV/AIDS.
- The impact of substance use on people who are **homeless** is considerable. Active use can limit a person's access to much needed health care, treatment services, shelters and housing programs that usually do not allow people to use on the premises. A Toronto study found that this group is very vulnerable to falling into a pattern of long-term homelessness, or unstable housing with recurring short periods of homelessness.[88]
- People who use drugs and are **lesbian, gay, bisexual or transgendered** often experience the effects of systemic and individual discrimination through homophobia and transphobia resulting in higher rates of disease and poor health status.[89]
- **Aboriginal people** are five times more likely than Caucasians to have HIV or AIDS.[90] Aboriginal people are also over-represented among groups most vulnerable to HIV, such as sex-trade workers and prisoners.[91]

- **People in prisons** (both federal and provincial) have higher rates of both HIV-infection and Hepatitis C than the general population.[92] Studies on provincial prisons in Ontario, B.C. and Quebec found HIV rates 10 times higher than for the general population.[93] Many people come to prison already infected with HIV or Hepatitis C, but the likelihood of further spread of these diseases is high due to unsafe sex practices and injection drug use while incarcerated. And, of course, these concerns continue when the person is released back into the community.

> …prisoners come from the community and return to it… what is done or not done in prisons … has an impact on the health of all…
>
> **Canadian HIV-AIDS Legal Network**

Some positive impacts of substance use

Along with the negative, it's important to acknowledge the positive aspects of substance use. The effects are not all bad. For example, research on the **benefits of moderate drinking** has received considerable attention in recent years. A Canadian study found that alcohol prevented 7,400 deaths in 1992 largely due to the beneficial impact of alcohol use on ischaemic heart disease and stroke.[94] Of course, it is important to remember that overall, more lives are lost than saved because of alcohol.

The **medical use of cannabis** has proven beneficial for people suffering from chronic pain. Cannabis can help to relieve pain and anxiety and stimulate the appetite to help ensure people get the nutrition they need to heal or stabilize their health. Cannabis also aids with restorative sleep.

Finally, many would argue that as a **coping or self-medicating strategy** for severe trauma or abuse, substance use has kept some people alive until they can find other ways to deal with their pain.

II. What are the economic impacts of substance use?

The United Nations Office on Drugs and Crime estimates that the global illicit drug industry is worth about 8% of all international trade.[95] Measuring the impact of substance use on the Canadian economy is a difficult task. However, researchers have calculated that substance use has an estimated $18 billion impact nation-wide.[96] This includes costs to government and society as a whole. **Tobacco** was found to have the greatest economic impact, accounting for about $10 billion in the year studied (1992; an updated study will be released in 2005). **Alcohol** accounted for $7.5 billion, or 41% of the total costs. The economic impact of **illicit drugs** was estimated at $1 billion.

The study looked at a broad range of areas including costs to the health care system, the workplace and the criminal justice system. It is important to note that this research is focused on estimating costs, not to providing a cost-benefit analysis. Key findings include the following:

- ***Health care costs***
  The greatest economic impact of substance use among the general population is on health care, estimated at over $4 billion**.** Health care services include general and psychiatric hospital stays, ambulance services, treatment, residential, ambulatory and outpatient care and prescription drugs.
- ***Law enforcement costs***
  Considerable costs were also associated with the enforcement of Canada's drug laws, estimated at close to $1.8 billion. This included activities related to alcohol

and illegal drugs only. Areas of law enforcement studied included policing, the court system, corrections including probation, and Customs & Excise. The vast majority of enforcement resources are spent on alcohol-related activities ($1.4 billion); enforcing illegal drugs is estimated at $400 million.

- ***Labour force costs***
  About $20 million in losses were attributed to the workplace. This includes the cost of employee assistance programs to support people experiencing problems with substance use and health promotion programs. A small amount was attributed to drug testing in the workplace. The majority of these expenses are directed to alcohol-related issues.

While impossible to measure, we must acknowledge the **loss of potential** experienced by people who are incapacitated by their substance use. Some people consume alcohol and/or other drugs and live happy, productive lives. But, this is not true for everyone, especially for people who lack the financial, health or social resources necessary to succeed in our society. We all need to feel useful, to be able to **make a contribution** to our families, our communities and even to ourselves. People who have become socially excluded or marginalized because of their substance use often lose this capacity. They may lose their jobs and have great difficulty re-entering the workforce. Finding employment or even volunteer opportunities when you are actively using psychoactive substances can be a tremendous challenge.

III. What are the criminal impacts of substance use?

Throughout history the legal status of drugs has changed. Now a legal substance, alcohol was once illegal during the prohibition years of the early 1900s. Conversely, heroin and cocaine were legal substances at one time. The legal status of drugs also differs from one country to another. For example, khat, a mild stimulant that is usually chewed, is legal in several countries including Somalia, Ethiopia and Britain. In these countries, khat can be legally imported, distributed, used and exported. However, in the 1990s, Canada classified khat as an illegal substance.[97] The legal status of substances shapes how they are used, regulated and sold. It also affects the nature of the relationship between drugs and crime.

The relationship between substance use and crime

There are several dimensions to this issue. One relates to the role of the substance itself in a person's decision to commit a crime as well as its effect on a person's behaviour (e.g., violence). Another is the role of crime as a means of obtaining drugs to use. Finally, there is the presence of criminal activity, which is inherent in a drug market that is illegal and unregulated.

A Canadian study found a **strong relationship between crime and alcohol and drugs**.[98] Rates of alcohol and other drug use and dependency were high among people in prison, and these substances were frequently involved during the commission of their crimes. The study explored the causal links between the substance use and the crimes committed. In other words, would the person have committed the crime if they had not been under the influence of drugs. The study estimated that the proportion of relatively serious-crimes inmates attributed to the use of psychoactive substances was between 40-50%. Of this amount, an estimated 10-15% of crimes were causally linked to the use of illicit drugs, 15-20% to alcohol only and 10% to 20% to a combination of alcohol and illicit drugs. In addition, a significant proportion of crimes were committed for the purpose of obtaining drugs or

alcohol for personal use including thefts (46%), robberies (41%) and breaking and entries (36%).

There is considerable research demonstrating the connection between alcohol and violent crime. Between 40% and 45% of perpetrators of violent crimes in Canada were found to have been drinking when they committed their crime.[99] Research also indicates a strong link between those who drink regularly and the likelihood of committing acts of violence.[100] Limited research has been done on the presence of **alcohol in non-violent crime**, although what has been done shows rates lower than for violent crime.[101]

A recent Toronto-based study on youth violence found that substance use was very common among **weapon-involved youth**.[102] Moreover, the majority of youth who dropped out of school or who were detained for possession of weapons reported heavy use of illicit drugs (mainly cannabis). A smaller proportion of youth in this study reported binge drinking. Weapon-involved youth in the detainee and dropout samples are more involved in drug selling than students were. In addition, a greater proportion of detainees were involved in what are considered to be the more dangerous drug markets of cocaine and crack cocaine selling.

It is important to note that **most crime associated with illegal drug use is non-violent.**[103] This is not to say that the crime that is involved does not have serious or detrimental effects on the communities experiencing that crime. However, analysis of drug-related crime reinforces the complex nature of factors at play including individual, situational and environmental circumstances.[104] These factors shape the way communities experience the harms associated with substance use and vary according to the substance used. For example, there is significant evidence that shows the links between alcohol and violence, but that the use of opiates may actually inhibit violence.[105] The one drug that has shown a connection to violence similar to that for alcohol is cocaine.[106] Other relevant factors that shape the relationship between drugs and crime include current unemployment rates, the prevalence of domestic violence and the level of social supports that exist within the community.[107]

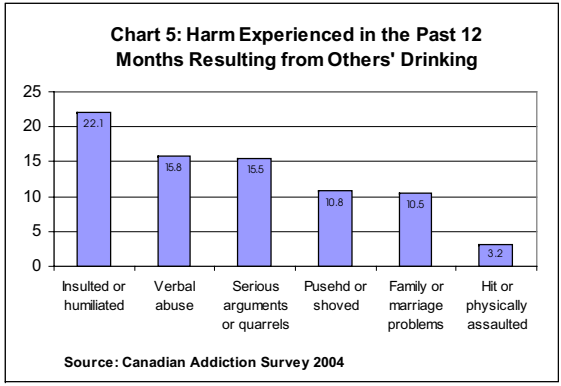
As noted above, the very **nature of illegal drug markets** creates high-risk environments that promote crime and violent interactions that affect both those involved and the broader community. However, evidence suggests that it is not the use of substances but the context (i.e., policies, profits and prohibitions) that is the best predictor of violence and of fear and threat experienced by the community.[108] An example of this is illustrated in a local study exploring the crack cocaine market, which found considerably lower levels of violence in Toronto markets than in similar American cities, despite comparable patterns of use.[109]

IV. What are the family and community impacts of substance use?

Family impacts

Substance use can have serious consequences not only for the individual who is using but also for his or her family. When someone in a family experiences problematic substance use the whole family can suffer. Issues involve ongoing stress in dealing with the dysfunctional behaviour of the user – they may become **disruptive, abusive or even violent**. For example, we know that while alcohol is not the cause of abuse, it can increase the severity of assaults in intimate relationships.

People with problematic alcohol or drug use may lose their job or become seriously ill or incapacitated by their substance use, creating an **economic as well as emotional burden** for both the user and the caregiver. As we know, **families break up** because of substance use, the long-term effects of which can be significant for all concerned especially for children.



The *2004 Canadian Addiction Survey* found that one in 10 survey respondents who were 18 years or older reported that someone's drinking was responsible for **family and marriage problems**. Physical altercations were reported less frequently, but are still significant as 11% of participants said they were pushed or shoved. Another disturbing trend that emerged from the survey was an increase in harms associated with being a passenger with a drunk driver, which rose from 7% to 17% over a decade.[110]

The chaotic use of drugs and alcohol by adults who are role models, parents and future parents has some very obvious and direct negative effects on children and on unborn children in terms of early infant development. Research shows a strong link between parental substance use and the **neglect of children**. Children whose parents abuse substances tend to have low self-esteem, poor performance in school, and are at risk for substance use themselves.[111]

A study of homeless youth in Toronto found that a major reason that young people leave home is **excessive alcohol use by their parents.**[112] Conversely, substance use by adolescents can also cause considerable stress and tension among family members. This can be particularly problematic when the youth and the parents have grown up in different cultures.

Community impacts of substance use

In addition to individuals and families, **communities and neighbourhoods are also negatively affected** by substance use. This includes local tenants, residents and business owners. Issues related to **alcohol use**, for example, arise from people leaving local bars and clubs. While the majority of people may at worst be loud and

obnoxious, others may vandalize property or become physically violent with each other or with bystanders.

Neighbourhoods with concentrations of **illegal drug use and drug dealing** also suffer negative impacts. Drug-related issues can include prostitution and violence. Local residents may fear personal harm and vandalism of their property because of this activity. A common issue related to street-level drug use is the discarding of drug-related paraphernalia such as needles, syringes and crack pipes. Some city parks are struggling with how to deal with this litter, which can pose serious health and safety concerns for children and adults who want to use these public spaces. Needle exchange programs have helped reduce the amount of discarded needles in Toronto as people learn how and where to dispose of syringes safely.

Communities are also affected by the presence **marijuana grow-ops**, many of which are located in residential areas. Between 2000 and 2002, the number of grow-ops in Ontario was estimated to have increased by 250 percent.[113] Grow-ops can pose serious health and safety threats to the community and to the police. This includes the threat of fire due to growing practices and violence from the growers/dealers involved. People, including children, who live in grow-ops also face health risks from the mould that is sometimes associated with marijuana cultivation and the chemicals used to foster plant growth.[114]

Table 1 provides data on "**public disorder**" **offences** in Toronto between 1998 and 2002. These offences are identified as having a significant impact on a community's environment and perception of public safety. It is fair to assume that some of these crimes involved the use of alcohol or other drugs. However, the nature and extent of that involvement is not known. In other words, some of the break-and-enter or theft crimes may have involved or been motivated by the need to buy alcohol or drugs, but this data does not document how frequently this happens.

Table 1: City of Toronto, Public Disorder Offences

Type of Offence	1998	1999	2000	2001	2002
Mischief	20,053	17,556	17,106	18,100	17,291
Consume liquor in public place	3,326	3,869	4,481	3,495	4,236
Drunk-intoxicated in public place	2,501	2,789	3,549	3,635	3,291
Cause disturbance	296	300	333	320	364
Trespass or prowl by night	215	192	204	244	221
Prostitution	2,447	2,133	1,263	1,171	1,135
Drug	6,956	8,961	10,558	9,333	9,196
Breaking & entry	20,305	17,629	15,636	16,132	15,782
Vehicle theft	15,189	14,693	13,954	14,020	12,954
Theft from vehicle	26,885	23,473	21,240	21,015	21,015

Source: Toronto Police Service, Environmental Scan Update 2003.

Alcohol-related offences include drinking or being drunk in a public place. As noted in Table 1, the incidence of these types of crimes has steadily increased between 1998 and 2002. The number of **drug offences** has decreased slightly – from 9,333 in 2001 to 9,196 in 2002. These offences mainly involve possession of illegal substances,

possession for the purposes of trafficking and trafficking. Most offences involve simple possession often laid as an accessory charge to the main crime the person was arrested for. The number of **people arrested/charged** for drug offences also dropped by 15%, down from 3,743 people in 2001 to 3,181 in 2002. However, over the past five years, drug offences and arrests have increased 32% and 8% respectively.

Additional information on the relationship between substance use and crime can be found in the previous section on criminal impacts of substance use.

Programs and interventions

I. Existing substance use programs and interventions in Toronto

This section describes the range of programs, services and responses that are currently available in Toronto dealing with substance use issues and is organized according to the key areas of prevention, treatment, harm reduction and enforcement. This information does not represent an inventory of individual programs, which is beyond the scope of this report, but rather is intended to provide an overall picture of the types of responses that are in place.

Prevention services

There is a wide range of community-based groups across Toronto that deliver drug prevention activities - from small, independent, grassroots agencies and groups to larger, more established institutions. These groups deliver diverse prevention programming that includes **education,** but also extends to **skills development** and **community capacity building -** activities aimed at building the resiliency of people and communities to guard against substance use. Funding for these programs comes from the municipal and federal governments as well as from the United Way and foundations.

Toronto Public Health (TPH) advocates, develops policy and delivers prevention and health promotion programs focused on the spectrum of substance use from alcohol and tobacco, to illicit drugs such as crack cocaine and heroin. Programs are delivered in **various settings** including schools, community, and workplaces and range from targeted interventions that work with specific individuals and groups (e.g., at-risk youth) to broader ones that focus on the city's entire population.

Public Health works with the two major **school boards** in Toronto (Toronto District School Board and the Toronto Catholic District School Board) on programs aimed at increasing student knowledge and awareness of drugs, building skills and supports, and reducing harms associated with drug use. TPH provides support and resource materials to Toronto elementary, junior and secondary schools and partners with the **Toronto Police Service** and **the RCMP** on specific drug prevention activities.

The **Centre for Addiction & Mental Health** provides a range of comprehensive health promotion strategies involving various populations, (youth, diverse communities) settings (school, workplace) and intersectoral partnerships. Strategies include public education aimed at eliminating stigma and providing current and accurate information about alcohol, drugs and mental health issues. Public policy development and advocacy related to substance use and mental health issues are also key areas of focus.

Treatment services

The treatment system in Toronto is a mix of hospital providers, such as the Centre for Addiction & Mental Health, and a broad range of community-based service providers, some of which are affiliated with hospitals. **Withdrawal management** (detox) services help people go through withdrawal of alcohol and/or other drugs. Services are provided in non-medical centres but all have medical supervision through an affiliated hospital. **Assessment and referral** services help link people to

the appropriate services. **Case management** services link people with a primary worker who provides ongoing assessment and adjustments of the client's treatment and discharge needs. **Residential treatment** programs provide structured short-term and long-term treatment and/or rehabilitation services in a peer environment**. Residential supportive treatment** provides housing and related recovery/support services for people who need a stable, supportive environment prior to, during, or following treatment, which is accessed elsewhere. **Outpatient and community-based treatment** services provide lifestyle and personal counselling to help people manage their substance use and related issues. **Community medical/psychiatric treatment** programs provide non-residential support for people with concurrent disorders (both a mental health and a substance use issue) through structured day or evening programs. **Methadone maintenance** treatment is also available for people using opiates (e.g., heroin).

Table 2: Number of Treatment Beds in Toronto

Type of Treatment	Spaces for Men	Spaces for Women	Spaces for Youth
Withdrawal Management (detox)	120	16	0
Residential Supportive Treatment	46	9	0
Residential Treatment	210	57	0

Source: Ministry of Health & Long-Term Care.

Specific treatment programs are also targeted to the diverse range of people affected by substance use including: people with HIV/AIDS, opiate users, Aboriginal people, francophones, women, ethnocultural communities, people who are homeless, older adults, gay, lesbian and bi-sexual people, youth, families, and people with concurrent disorders, disabilities or acquired brain injury.

Harm reduction services

A range of government, institutional and community-based organizations deliver harm reduction services across the city. Unlike other parts of the service system, such as the treatment sector, harm reduction services do not have a formal or established service infrastructure. For the most part harm reduction programs are delivered within an agency's overall range of services (for example, a needle exchange program in a community health centre). Harm reduction is also applied as a philosophy or model of service delivery within established services.

Toronto Public Health funds and/or delivers a wide range harm reduction activities. Services include **needle** and **condom distribution, a low-threshold met**hadone **maintenance program**, HIV and Hepatitis C testing, immunizations, mobile outreach teams, counselling and referrals, and sexual health programs. In addition, funding is provided through **AIDS prevention grants** and the **Drug Prevention Grants Program** to support community groups targeting AIDS and drug prevention and education activities by reducing risk behaviours in drug

The City's Shelter, Housing and Support Division also provides harm reduction services to people who are homeless through various shelter programs such as the

managed-alcohol program at Seaton House and The Lounge program at Women's Residence. Funds are also allocated to community-based agencies for a range of harm reduction services and activities including **outreach, shelters, drop-ins and housing programs.**

A wide range of **community-based agencies** across Toronto provide harm reduction services such as needle exchange and condom distribution. In recent years, a number of community health agencies and street outreach services began to distribute **"safer crack use kits"** out of concern for the health risks associated with smoking crack. Harm reduction services also provide information and referrals to other services such as counselling, treatment, withdrawal management, education and skill-building, medical and dental services, legal services, employment services and housing support.

Enforcement services

Community policing is a key aspect of how the Toronto Police delivers its service in the city. Community policing involves local community and police partnerships working to address issues in the following **four key areas**:

- enhancing public safety,
- maintaining order,
- preventing crime, and
- enforcing laws.

The current areas of priority focus for the Toronto Police Services are **drug enforcement and education,** youth violence and victimization of youth, and community safety and satisfaction.

The Toronto Police Service (TPS) has taken a **tiered approach** to tackling illegal drug issues with an emphasis on street-level trafficking. There are components of TPS drug interdiction that work on the middle and high-end drug traffickers. Just about every part of the TPS deals with some aspect of the illicit drug trade during investigations and appropriate action is taken. TPS is also involved with permanent joint forces operations with the RCMP, the OPP and regional police forces in York, Peel and Durham.

The criminal justice system, including the courts, correctional facilities and probation and parole services, deals with the variety of crimes associated with substance use. Some specific programs related to drug issues include the **Toronto Drug Treatment Court**, which diverts non-violent drug offenders to treatment and other support services as an alternative to incarceration. More details on the Drug Treatment Court are provided in the Best Practices part of this report. The **Gladue (Aboriginal Persons) Court** at Old City Hall works to address the over-representation of Aboriginal people in the criminal justice system. Under this court, Aboriginal people with serious substance use issues are sometimes provided with a treatment plan put together by the Native Court workers from Aboriginal Services of Toronto. This often involves getting people to appropriate treatment outside of Toronto.

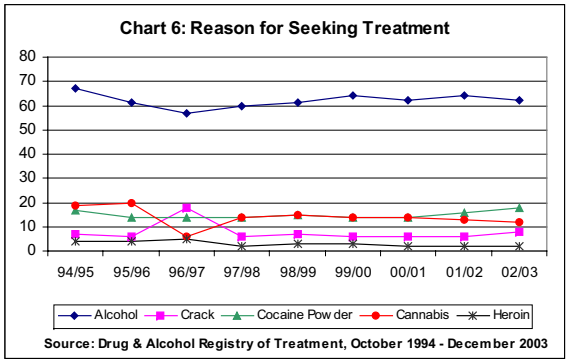
II. Trends related to service use in Toronto

This section provides an overview of what we know about how people use services and programs related to substance use. Unfortunately, information on service use is not available in every area, but available data for treatment and harm reduction services are described below.

Treatment services

Ontario's main referral system for addiction treatment services is the Drug and Alcohol Registry of Treatment, or DART. In Toronto, the Centre for Addiction & Mental Health and the Metro Addiction Assessment Referral Service (MAARS) are also significant referral sources. Information collected in Toronto about people seeking treatment for alcohol and other drug use reveals the following relatively stable patterns over the last 10 years (see also Chart 6). [115]

- **Alcohol** is the most commonly used substance for which people seek treatment.
- **Cocaine** is the most common illicit drug for which people seek treatment, followed by **cannabis.**
- There has been little change in the number of people seeking help for **heroin** over the last few years. About 5% of people report heroin use as the reason for treatment.



We also have some information about **people who use treatment services** in Ontario (not Toronto specific), gathered through the Drug and Alcohol Treatment Information System or DATIS, including:[116]

- Youth and older people are under-represented in the treatment population.
- Some modest increases in the number of youth in treatment likely reflect the addition of some new youth programs in the early 90s.
- Most people are in treatment for alcohol only (40%) or combined alcohol-drug (22%) issues, although there is an increasing involvement of drugs other than alcohol, such as cannabis.

- Problems with cocaine use remain high in the treatment system (23%). Of interest is the high rate of people who said they had problems with cannabis (29%).
- A high percentage of people were unemployed (23%), disabled (11%) or not in the labour force (15%). This suggests the need for employment supports and a better understanding of the role of employment for people dealing with substance use issues.

Research on **how people find their way into the treatment system** highlights some key areas for consideration.[117] People are supported or pressured by friends and family to seek treatment. Also, the broader systems of health, social and correctional services are a main referral source. The relationship between the criminal justice system and the treatment system is of particular concern given the considerable number of people who could potentially be diverted into treatment. In addition, referrals from the community health and other psychiatric services tend to be quite low, which is a concern given the significant number of people with concurrent disorders (i.e., both an addiction and a mental health issue). We know from best-practice studies that these two systems need to collaborate more effectively to ensure this population has access to services.

It is important to note that **treatment is not a panacea** and in many respects we are still figuring out what works best for which people. Fewer than 10% of people who use substances will consider entering an abstinence-based program. which constitutes the vast majority of treatment programs. [118] In addition, one-third of participants leave treatment against the advice of treatment staff. We do not have good information as to why this is the case, but researchers speculate it is due to:[119]

- a disparity between what the person needs/wants and what the services provide,
- an appropriate "shopping for services" on the part of the client, or
- an expected part of the process of struggling to give up an addiction.

The rise in heroin-related deaths in the early to mid-1990s prompted greater access to **methadone maintenance treatment** across the province**.** Physicians need to be licensed in order to dispense methadone. There are no longer any limits as to the number of patients doctors can treat at any one time. As of October 2001, there were 6,751 people on active methadone treatment in Ontario, compared with 975 people prior to 1996. In Toronto, 66 physicians are licensed to provide methadone maintenance treatment.[120]

Harm reduction services

System-wide data on the provision of harm reduction services for people who use drugs or alcohol are not readily available. The most comprehensive data collected relate to needle exchange programs across the city. Services are administered by Toronto Public Health and provided through 28 contracted agencies. Services are available through mobile vans, drop-in health services and street outreach. Information on the use of **needle exchange and associated support services** in Toronto for 2003 is as follows:

- Total number of contacts (not individuals): 8,150 male and 5,630 female.
- The majority of people served are between the ages of 31 and 40.
- 311,365 needles were given out; 192,859 needles taken in.

- 71,344 condoms were handed out.
- 255 vaccines were provided for Hepatitis A, B and influenza.
- 240 tests were done for HIV and Hepatitis B and C.

III. Barriers to using services and supports in Toronto

The previous section discussed some of what we know about people who use services. However, many more people rarely or never come in contact with the treatment system. There are many reasons people do not use services including individual choice, the type and way existing treatment services are delivered, and the fact that some needed services are simply not available. Examples of barriers to using services that people in Toronto experience are described below. The barriers are not intended to be an exhaustive list. They were identified through the input of key informants and the research and literature reviewed for this report.

- **Accessing the treatment/referral system** is difficult for some people. The procedure for seeking treatment in Toronto is confusing for some clients and even for service providers. Areas that need clarification include the requirements for initial assessment, expected waiting times and specific information on the availability of residential services, withdrawal management services and follow-up support.[121] Long waiting lists and intake procedures also mean that treatment options are not necessarily available when people want and need them. Collect calls from people in jails and prisons are often refused, making it very difficult for people to arrange treatment for when they are discharged.

- **Attitudes about treatment.** For some people the type of treatment that is available does not work for them. As an example, a study of opiate users found that although methadone treatment has been available in North America for decades, only a small proportion of opiate users (about 25% in Canada) receive methadone treatment.[122] Many users have tried this form of treatment, often multiple times, but leave to resume using illicit opiates. The reasons for this illustrate the complex nature of drug use:
  - People may have a higher preference for heroin as their opiate of choice and find methadone (a synthetic opiate) as less desirable due to perceived adverse side effects and the potential for addiction.
  - Methadone's lack of or negative psychoactive effect means other illicit (enhancer) drugs are needed to get the desired psychoactive sensations or to balance methadone's undesired ones.
  - The injection aspect of heroin use seems to be an important factor as some users appear to be as much addicted to the needle as to the effects of the drug. Methadone is taken orally and so cannot fulfill this need.
  - Perception that the way methadone programs are delivered is punitive and controlling.

- **Methadone treatment.** Some people receiving methadone treatment would also like to benefit from other kinds of treatment. Ironically, this form of treatment can preclude people from accessing other forms of drug treatment. Some programs will not admit people who are in methadone therapy as they are still viewed as actively using. People interviewed for this report talked about the "liquid handcuffs" that methadone can represent.

- **Discrimination.** Those who are socially marginalized, such as people who are homeless, sex workers and people who are transgendered, sometimes have a difficult time using existing services due to experiences of discrimination and a perception that staff and other residents do not understand their particular needs or issues. Discrimination based on other identities, such as gender, race, culture and ability, intersect to further compound these barriers.
- **Lack of culturally appropriate services** is an issue for newcomers and a significant barrier to seeking help.[123] A review of Canadian research looking at treatment use and health promotion in ethno-cultural communities identified barriers of language incompatibility and lack of translation supports, as well as significant mistrust of mainstream services stemming from experiences of discrimination.[124] Services based on Western concepts of substance use and family structure failed to consider that what constitutes a "drug" and appropriate consumption are varied and culturally determined.
- **Geography** is a problem for people who live outside the downtown core of Toronto. The majority of services for people who use substances are located downtown and are therefore not available to people in their own communities.
- **Fear of losing children** to child welfare services is an issue for women, particularly women who are homeless and pregnant while using substances. This fear often prevents women from approaching treatment and other health care services. This issue is compounded for young women who are homeless and are therefore even more vulnerable. An estimated 50% of young women living on the streets of Toronto become pregnant while they are homeless.[125]

IV. Gaps in substance use programs and interventions

In addition to service barriers, there are significant gaps and inefficiencies in the continuum of services and resources available and in addressing the needs of diverse populations who use substances, as described below. These gaps are not intended to represent an exhaustive list. They reflect issues identified by key informants and through the research and literature reviewed for this report.

- **Lack of effective prevention programming.** A lot of existing prevention programming is ineffective for a variety of reasons. For example, reduced funding for both schools and public health has reduced the level of prevention programming in Toronto schools. Many of the programs that are available are ineffective and not based on best-practice research. Reaching children and youth at a young age is critical to instil accurate messages about the potential harms of substance use and to help develop good life skills, such as decision making. One challenging aspect of prevention is how to talk to youth about the dangers of driving under the influence of cannabis and other drugs without being seen to be condoning use of illegal drugs.
- **Lack of treatment options.** There is general agreement that there are not enough treatment options in Toronto. Research has shown that the characteristics of drug users can differ substantially between cities and therefore treatment options must be designed to meet local needs.[126] Gaps in treatment services in Toronto include:
  - Residential treatment, especially for youth – currently there are no such services for youth.
  - Longer-term treatment options.

- Withdrawal management programs (detox), especially for women, youth and Aboriginal people.
- Services where women can bring their children (e.g., on-site child care).
- Culturally appropriate services for both Aboriginal people and ethno-cultural groups. (Currently, Aboriginal people who desire traditional forms of treatment are sent to centres outside Toronto. Efforts are underway to re-establish a traditional withdrawal management centre in the city.)
- Treatment programs with economic development component to help people with skills development and training.
- Harm reduction-based treatment programs.
- Discharge planning for people leaving treatment programs.

- **Lack of services for people with concurrent disorders (both an addiction and a mental health issue).** This group often has a difficult time using existing services. Addiction services often do not have the expertise to work with people with mental health issues and vice versa. In addition, people are often told to resolve their substance use before they can be seen by mental health workers, or to resolve their mental health issues before they can be helped with their substance use. Historically, these parts of the service sector have not worked together, although this is slowly starting to change. This is critical to ensuring this high-risk group of people do not continue to fall through the cracks.

- **Lack of day programs.** We all need occupations for our time whether they are paid or unpaid, employment or leisure. Financially stable people tend to have a wide range of pursuits and activities to occupy their work and leisure time. People who are not working and/or who are struggling on a limited income tend to have fewer resources for activities to engage their time. Day programs offer important opportunities to help enrich and stabilize people's lives in part by giving them something to do. Art or music classes can help people develop their creative potential (sometimes even for income generation) and job-readiness and educational classes help people build their skills and confidence. In addition, feeling part of a regular community of friends or co-workers helps to build confidence and reduce social isolation.

- **Lack of case management services**. This type of approach involves a designated case manager to co-ordinate programs, services and resources for the client, which helps to ensure that people, especially vulnerable groups such as youth, do not get lost or fall through the cracks.

- **Lack of post-treatment programs**. Once a person is finished a treatment program they are often left on their own. However, some people need and want longer-term support to help get them back on their feet. For example, education and employment training programs can help people make the transition from treatment back into the labour force. People may also want individual or group counselling to deal with issues that were created or even masked by the substance use.

- **Lack of discharge planning for people leaving prisons**. Very few supports exist in jails regarding discharge planning, particularly for people serving short-term sentences or who are in remand custody (awaiting trial). People often lose their jobs and housing while in jail and have a difficult time stabilizing their lives after their release, especially people with substance use or other health issues.

The consequence for many of this group is homelessness as they are discharged from prison to the street.

- **Lack of harm reduction and/or treatment services in prisons.** Health services are inconsistently delivered across the provincial and federal prison system. Treatment options for people in prison are very limited. For example, methadone therapy is available only to inmates who are already receiving methadone at the time of incarceration. In addition, people do not always get the appropriate dosage of methadone. Health and research advocates are pushing for needle exchange services in prisons in an effort to reduce the spread of HIV and Hepatitis C.

- **Lack of housing options.** Affordable housing and the critical role it plays in both the prevention of substance use and the stabilization of people who use substances was a strong theme emerging from the key informant interviews and focus groups done for this report. The evaluation of the Homelessness Pilot Project for ex-residents of Tent City found that housing stability was strongly associated with reduced substance use. By the third interview 70% of participants reported using less alcohol and drugs than they had at Tent City.[127] In addition, there is a need for harm reduction housing where people who are actively using drugs don't live in fear of eviction because of their substance use. Research has shown the critical role that housing and other forms of social support plays in helping to reduce health risks for illicit drug users, including the risk of drug overdose.[128]

> *The best method of harm reduction is housing.*
>
> **Ex-resident of Tent City**
> **From Tent City to Housing**

- **Lack of 24-hour outreach and basic needs services.** Active drug users who are homeless or otherwise living in poverty consistently identify the need for practical, basic supports such as needles, alcohol swabs, clean water, condoms, and good, nutritious food – on a 24-hour basis. Some outreach workers, community health centres, and drop-in centres do provide these supports, but most are not offered around the clock and services are not offered equitably across the city. Users in areas outside the downtown core are particularly underserved.

- **Lack of support in emergency rooms.** Emergency room staff are often the first people to see the effects of contaminated drugs as people come in ill or suffering from overdose. As we know, hospitals continue to struggle to deliver services with inadequate resources. Part of the impact is a lack of staff in emergency rooms who can support users beyond their immediate health crisis to make sure they are linked to the health and social services they need. In addition, there are no formal connections between emergency rooms, the police or community health and social service providers to spread the word about problem drugs as they get identified.

- **Lack of drug surveillance and early warning systems.** Incidents of drug contamination in Toronto, as well as other jurisdictions, underscore the need for drug testing and timely information sharing in instances of drug contamination and other emergency situations. Professionals in the area of health care, treatment, police, public health and related fields have endorsed the idea of creating a system to formalize such information sharing. In addition to identifying local emergent dangers, data regarding potential antidotes could also be made available through such an information system.

- **Lack of focus on what works.** Some people working in the area of substance use are reluctant to let go of traditional approaches even in the face of evidence that shows they are not effective. For example, research has consistently shown that education alone does not prevent substance use and yet these approaches continue to be funded and operated. We need to focus on strategies that work, recognizing that these approaches may challenge our traditional attitudes and beliefs about substance use.

V. Best practices related to substance use

This section of the report provides an overview of current thinking on best practices in the areas of prevention, treatment, harm reduction and enforcement. Some new and emerging practices, which are showing signs of promise, are also discussed.

Best practices in prevention

Prevention refers to interventions that promote health, prevent or delay the onset of substance use, and prevent or reduce the harms associated with substance use. The three main types of prevention that fall along a continuum are *universal, selective* and *indicated. Universal* prevention targets the whole population, *selective* prevention focuses on sub-groups who may be at greater risk, and *indicated* prevention targets high-risk groups or people already using substances. **A comprehensive prevention strategy** includes a combination of all these approaches.

Significant research has been done in the area of substance use prevention. Based on this knowledge, we have learned a great deal about **<u>what doesn't work</u>**, including:

- A **focus only on education** or raising awareness of substance use issues. This approach has met with limited success as changes in knowledge and understanding do not necessarily translate into changed attitudes or behaviours.[129] This is a critical point prevention is more than just education.

> *When kids are told that illegal drugs, including marijuana, are extremely dangerous and addictive, and then learn through experimentation that this is false, the rest of the message is discredited. Honest drug education is one key to ensuring that individuals know how to make informed decisions.*
>
> **Canadian HIV-AIDS Legal Network**

- Programs that use **scare tactics or fear-mongering** and those that take hard-line approaches (victim-blaming, zero tolerance, etc.) have little to no effect.[130]
- Strategies that deal with personal issues alone (e.g., self-esteem, values) are questionable.[131]
- **One-time programs** (e.g., one-session workshop) done in isolation have limited impact.[132]

That being said, we also know a lot about **<u>what does work</u>**. Generally speaking, prevention programs need **comprehensive and integrated** approaches that have the following characteristics:

- Clear and realistic goals and practical principles.
- **Start prevention programming as early as possible**. Start in early childhood and continue through to adolescence and adulthood to reinforce messages across the life-span.[133] [134]
- **Recognize the continuum of drug use** and therefore the need for a range of strategies from prevention to harm reduction.

- **Recognize the determinants of health**[iii] as they relate to a person's choice to use substances and the status of these determinants as representing the "best predictors of substance use."[135] Effective strategies must be tied to these determinants (e.g., housing, income, food, safety) and the range of social and economic conditions that expose people to various risks. Strategies must also focus on a combination of individual action, structural change, social/environmental supports.[136] [137]
- Use a **range of health promotion strategies** (e.g. skill-building, education/awareness-raising, policy development, advocacy, providing environmental supports, social marketing, and community capacity building).
- Balance policies aimed at reducing both the supply and the demand for drugs.
- **Focus on policy/legislation change**. Examples of alcohol-related policy measures include graduated licensing for young/new drivers, low blood-alcohol content limits for drivers, and minimum drinking age laws.[138] [139] The most effective intervention to prevent and/or reduce alcohol-related problems is to control alcohol consumption by reducing the availability of and access to alcohol. Limiting or reducing the per capita consumption of alcohol reduces the risks of alcohol-related problems across the entire population. Strategies that strengthen public controls (e.g., government monopoly) on the availability, sale, promotion, consumption and distribution of alcohol are particularly effective.[140] [141]
- **Target multiple levels of influence** (e.g., individuals and policy makers) in multiple settings (e.g., school, community, home).[142] [143] For example, Toronto's Municipal Alcohol Policy aims to reduce problems related to alcohol abuse by using strategies such as policy and enforcement, education and awareness, skill-building (e.g., server intervention training), and providing environmental supports (requiring provision of food and non-alcoholic drinks). Such policies are effective, especially when used in combination with other policies and legislation such as increasing the minimum drinking age, restricting access and availability to alcohol in public locations, and ensuring training for servers (e.g. SmartServe program).
- **Involve/engage target groups** in all aspects of a program from planning through to implementation and evaluation.[144]

Prevention **strategies for youth** warrant additional consideration because adolescence brings with it the normal developmental period of experimentation and challenging authority. There is also a tendency for multiple risk factors to occur simultaneously for youth. For example, youth who engage in risky activities such as unprotected sex often will try other risky behaviours such as driving while impaired. Therefore, additional prevention efforts should focus on:

- **Increasing protective factors and building resilience.** Effective programs focus on both risk and protective factors and emphasize increasing protective factors and building resilience (e.g., by increasing development assets, promoting social bonding, etc.) at individual, family, peer, school and community levels. Protective

> *Resiliency is the capability of individuals, families, groups, and communities to cope successfully in the face of significant adversity or risk.*
>
> **Canada's Drug Strategy: Resilience: Relevance to Health Promotion**

iii The *Ottawa Charter for Health Promotion* defines "determinants of health" as the fundamental conditions and resources for health, specifically: peace, shelter, education, food, income, a stable eco-system, sustainable resources and social justice and equity.

factors (e.g., social and problem-solving skills, flexibility, positive family bonding, involvement in community and/or peer group activities, etc.) help buffer against or reduce the effect of exposures to risks. Having a supportive and caring relationship with an adult has been shown to be one of most important factors that protect youth against taking risks.[145] [146] [147] [148]

- **Building life skills.** Life-skills building strategies (e.g., coping skills, decision-making skills, communication skills, and conflict resolution) that address multiple risks at the same time increase the likelihood that youth will be able to deal effectively with situations presenting potential risk.[149]
- **Addressing cultural and social norms.** Prevention programs that are based on social/peer influence models and that focus on social and cultural norms (i.e., address the social and physical environment related to drug use) can be very effective. Programs need to recognize and address all the factors that influence youth (peers, the media, social pressures, etc.). "Families/caregivers and peers have the most influence on this age group's decision making". Approaches that address these influences show the most promising results for behaviour outcomes.[150] [151] [152]
- **Using peer-based strategies.** Peer-based programming (e.g., peer modelling) has been found to be particularly effective in changing social norms and building development assets. Peer-based programs and strategies can assist in changing social norms by promoting prevention and harm reduction messages and also in building assets among peers.[153] [154] [155] [156]

Best practices in treatment

Treatment refers to the wide range of services and supports that help people **to deal with their substance use and lead healthier lives**. Specific types of treatment include outpatient and peer-based counselling, methadone maintenance programs, daytime and residential treatment, withdrawal management (detox), housing support and ongoing medical care. Treatment approaches may also differ according to the specific population they are geared toward and the philosophy of the service provider.

The majority of treatment programs require abstinence. If clients are found to be using whatever substance(s) they are in treatment for they may be asked to leave the program until such time as they can stop using. In recent years, some treatment services have begun to look at how they can incorporate harm reduction philosophies and practices into their programs. This is a challenge both philosophically (some believe that the main goal should be to stop using and abstinence is the first step) and programmatically (delivering effective programs where some people are using and others want to be out of that environment).

Developing treatment programs that work for people is, of course, a critical component of a comprehensive drug strategy. This is underscored by the fact that fewer than 10% of people who use substances will consider entering an abstinence-based program.[157] An overview of effective treatment approaches is outlined below, including those aimed at specific groups.

- **Methadone maintenance treatment (MMT)**

  MMT involves the medical prescription of methadone, a long-acting synthetic opioid used to alleviate the symptoms of opioid (e.g., heroin) withdrawal. Methadone blocks the euphoric effects of other opioids making it less likely that people will either use illicit opioids or overdose. Methadone is also a much

longer-acting drug than other opioids; usually one daily dose prevents the onset of withdrawal symptoms.[158] Methadone is prescribed by licensed doctors to be taken either in their office, at a local pharmacy or, after a period of time, at the person's home. MMT is most effective as part of a comprehensive set of services, including medical care, counselling and support, mental health services, health promotion, disease prevention and education and links with other community-based supports and services.[159]

Opinions differ on the role of MMT and how it should be delivered but there are some key features that increase the likelihood of people staying in treatment and improving their health over the long term. A continuum of program options is needed that includes low-threshold programs that may serve as a bridge to higher-threshold programs and services focused on meeting the longer-term needs of clients.[160] Programs must also be flexible enough to meet the needs of diverse opiate users – from pregnant women, Aboriginal people, people who are employed to people who are homeless.[161]

Methadone treatment has proven effective for many opiate users. Some recognize that methadone is the best (albeit only) available pharmacological treatment option available in Canada and credit it with saving their lives, their families and their jobs. Some people also appreciate the structure and regularity this form of treatment can give to their daily lives.[162]

- **Low-threshold methadone maintenance**

  Low-threshold methadone programs are designed to attract opiate users who do not use traditional treatment programs or who have been discharged from other treatment programs because they are not able or willing to stop their drug use.[163] While the goal of high-threshold programs is ultimately abstinence, low-threshold programs seek to keep users in treatment and work towards reducing the harms associated with drug use.[164] These programs have few admission criteria and do not expel people who continue to use drugs. A recent Toronto study found a significant drop in HIV-related risk behaviours (sharing needles and other drug paraphernalia, etc.) and overall use of both alcohol and drugs among people in low-threshold methadone programs.[165] About 50% fewer clients were using drugs 12 months after treatment. Participants also reduced illegal behaviours and said they felt their mental health had improved as had their family and social relationships.

- **Treatment for women**

  Historically, treatment programs have been designed for men, creating what is termed a "male norm bias," which in turn has judged women who require treatment more harshly and has limited the exploration of gender-specific treatment approaches.[166] Research into this area concludes that for treatment programs to be effective for women they should:[167]

  Few treatment services provide childcare, and in some cultures it is very difficult for women to leave their homes and family responsibilities to seek treatment.

  United Nations Office on Drugs and Crime

  - be gender specific, incorporating a women-centred approach;
  - provide a variety of interventions, including harm reduction;
  - address all aspects of women's lives, including practical needs such as child care;

- support and encourage connections between women;
- be supportive, egalitarian and non-hierarchical;
- support empowerment for women;
- be client-driven and based on client strengths;
- facilitate education and awareness of clients;
- be family-focused and community-based.

Effective treatment approaches for women should address physical health issues, personal issues, interpersonal issues and relapse prevention management.

- **Treatment for Aboriginal people**

  Aboriginal communities are particularly concerned with getting services for youth who may be survivors of physical, emotional and sexual abuse. Key to meeting the needs of this group are services that maintain the autonomy of each Aboriginal community rather than being absorbed into larger mainstream addiction services.[168]

Effective treatment strategies include:

- services that reflect and respect Aboriginal cultures;
- both traditional healing practices and the best approaches to be found in non-Aboriginal services;
- access to a full range of treatment approaches including harm reduction;
- involve Aboriginal people directly in planning, developing and implementing treatment services.[169]

- **Treatment for people with concurrent disorders**

  People with concurrent disorders have both an addiction and a mental health issue. Historically, this group has been neglected, abandoned by the mental health system that won't help them until they stop using and the addiction treatment system that won't help until they get their mental health issues under control. Attention is finally starting to focus on this very marginalized and high-risk group of people.

  There is very little published information on concurrent disorders that goes beyond an assessment of the many challenges and barriers to systems integration. Community agencies, planners and policy makers have been stuck in the single-problem mode of thinking because of the long-established barriers between the treatment systems for mental health and substance use.[170] These barriers came about as a result of separate training and development in the two fields and competing perspectives.

  Two key areas of best practice for concurrent disorders are as follows.[171]

  - *Program integration*: Mental health and substance use treatments must be brought together by clinicians/support workers, or a team of clinicians/support workers, in the same program, to ensure that the individual receives a consistent explanation of illness/problems and a coherent prescription for treatment rather than a contradictory set of messages from different providers.

- *System integration:* The development of enduring linkages between service providers or treatment units within a system, or across multiple systems, to facilitate the provision of service to individuals at the local level. Mental health treatment and substance use treatment are, therefore, brought together by two or more clinicians/support workers working for different treatment units or service providers.

- **Treatment for drinking drivers**

  The Province of Ontario now requires all convicted impaired drivers to complete a remedial measures program, called *Back on Track*, in order to be eligible for licence reinstatement at the end of their period of mandatory licence suspension. The program is offered at 28 sites across Ontario and consists of an assessment, an education or treatment component and a 6-month follow-up interview. The education program focuses on how alcohol and other drugs affect driving performance and safety, the legal and personal consequences of an impaired driving conviction, and ways to avoid drinking and driving in the future. The treatment program helps participants learn about and take responsibility for alcohol and drug use and its consequences, commit to reducing or stopping problem use of alcohol and other drugs, avoid drinking and driving. In Toronto, *Back on Track* is offered through the Centre for Addiction & Mental Health.

  Back on Track is based on the best available evidence on the most effective programs for drinking drivers. Results to date have been positive including: a 97% completion rate, high levels of client satisfaction and effectively assessing subsequent alcohol-and drug-related problems within an impaired-driving population.

New and emerging treatment approaches

New treatment approaches are being tried all the time, both in Canada and around the world. Many have yet to be rigorously evaluated but reports of early success suggest the need for a closer look. Of particular interest to Toronto is some of the work being done for crack cocaine, given the high rate of use in our city. Cocaine is one of the hardest drugs to treat as there is no known substitution therapy, such as methadone, which has proven successful with heroin.

- **Prescription heroin**

  Prescription heroin is being studied in the North American Opiate Medication Initiative (NAOMI). The Canadian Institutes for Health Research (CIHR) is funding Toronto, Vancouver and Montreal to do a national study in Canada. To date, no American researchers have been able to secure support or funding to participate in this study. The research will determine whether heroin is more effective than methadone in getting users who have proved resistant to other therapies to stop using. It will also look at whether providing free heroin will reduce a user's incidence of homelessness or contacts with the criminal justice system.

  Heroin is prescribed in the treatment of addiction in several European countries including Switzerland, Holland and Germany. Britain is an international anomaly in that heroin has been prescribed to treat people with addictions since the early 1920s. It was considered an effective treatment approach to help people lead normal lives. The government recently approved limited expansion of this

program because of its potential impact on reducing crime as well as improving the health of patients.[172] About 450 people receive prescribed heroin in Britain.

In 1994, Switzerland initiated a research study of prescribed heroin in several cities. Controversial at the time, the program soon expanded to other parts of the country after studies showed significant improvements in the health of users and lower rates of drug-related crime. Ongoing government funding is supported by Swiss voters who have been convinced by the results. Heroin prescription is now an ongoing, government-funded program available in all Swiss cities and most major towns.

- **Harm reduction psychotherapy**

  In recent years, therapists in New York and San Francisco have worked to develop this new approach, which is a marriage of the principles of harm reduction and therapeutic practice. This form of treatment grew out of concerns about people whose issues were so complex that they were rejected by or unable to participate in ongoing treatment programs. Harm reduction psychotherapy helps people to understand better their relationship with drugs or alcohol and provides people with practical tools to gain control over their substance use at their own pace, whether or not their goal is abstinence.[173] This approach introduces to the field of illicit drug treatment the idea of "managed use." It challenges the medical disease model of addiction in which person is deemed to be "ill" because of their substance use, and the goal of treatment is to help them end that addiction. However, the user retains the label of addict, albeit recovering addict, for the rest of his or her life.

- **Acupuncture**

  Sometimes referred to as "acudetox," this form of treatment has been used in Hong Kong since 1972 to treat the symptoms of drug withdrawal. New York City's Lincoln Hospital advanced its use in North America during the 1970s. Over 2,000 clinics in diverse settings world-wide now use this form of treatment based on a protocol developed by the National Acupuncture Detoxification Association. Acupuncture offers people a non-medical support for withdrawal from alcohol, heroin, cocaine and other drugs. It has also been found to be useful for relapse prevention and has proved successful in the treatment of resistant clients.[174]

  Acupuncture works best as part of a comprehensive approach to treatment that includes counselling, education, case management and medication therapy. Acupuncture is not a "magic bullet" and rarely alleviates all symptoms of withdrawal, but for many it has been shown to make symptoms more manageable.[175] Health centres in Toronto, such as Toronto-Western Hospital, do use acupuncture to treat withdrawal symptoms.

- **Crack cocaine study**

  The U.K. has developed a national crack cocaine strategy in response to growing use throughout Britain. In March 2003, as part of that strategy, the National Treatment Agency announced a pilot project involving 11 high-risk cities to try a new approach to treating crack cocaine use. This research constitutes the largest study of crack cocaine in Europe and is based on a belief that this form of addiction can be treated. The pilot involves the use of a comprehensive staff-training package, a range of new tools and materials to enable drug workers to

work better with people who use crack and the identification of "good" practice. Research results are expected in Spring 2005.

Best practices in harm reduction

While there is no one agreed-upon definition of harm reduction, Toronto City Council has adopted the following definition: **"a holistic philosophy and set of practical strategies that seek to reduce the harms associated with drugs."** Harm reduction applies to drug policies, programs, or strategies that try to reduce the harms related to drug use while at the same time not requiring abstinence. It is viewed by many as an achievable, pragmatic approach that accepts that abstinence is not a realistic goal for some people, particularly in the short term. Harm reduction strategies are used throughout the world and have proved successful at reducing overdose, overdose deaths and the spread of communicable diseases such as HIV/AIDS and Hepatitis C; at helping to connect people to health and social services; and at reducing the use of drugs in the street.

Effective harm reduction policy and practice is characterized by flexibility, a health promotion approach, non-repressive legislation, and law enforcement based on community policing as part of a comprehensive and multi-faceted strategy.[176] Evidence-based research has found that strategies such as needle exchange/distribution, substitution treatment and peer outreach are the most effective in reaching drug users and reducing the spread of public health diseases.[177]

An international review of harm reduction programs concludes that good practice has the following elements:[178]

- an early start;
- community involvement at all stages;
- a comprehensive range of well co-ordinated, user-friendly and flexible services;
- ready access to condoms and sterile injection equipment;
- broad geographic range;
- gender and ethnic sensitivity;
- respect for human rights;
- adequate coverage and sustainability;
- a supportive environment; and
- assessment, evaluation and monitoring.

- **Needle exchange program (NEP)**

  Needle exchange or distribution programs are probably the best-known form of harm reduction. The spread of HIV/AIDS among injection drug users in the 1980s prompted the widespread introduction of needle exchange programs throughout North America, Europe and Australia.[179] **Prevention of blood-borne diseases** such as HIV and Hepatitis C is the main goal of NEPs. The core services provided by NEPs aim to increase the number of needles and syringes in circulation and encourage their return and safe disposal, although NEPs typically provide a broader range of services to their clients.[180]

  Key outcomes of NEPs include decreased risk behaviours (i.e., needle sharing) and reduced levels of HIV infections.[181] Research has also found that NEPs increase the likelihood that injection drug users will become involved in

treatment and prevention interventions.[182] NEPs are also cost effective because they help defray the significant health care costs for people with infectious diseases such as HIV and Hepatitis C.[183]

A new area of controversy is the need for **NEPs in Canadian prisons** to help reduce the risk of disease transmission from needle sharing. Rates of HIV and Hepatitis C have been found to be much higher in prison populations than in the general public.[184] Since 1992, needle exchange programs have been implemented in prisons in six European countries including Switzerland, Germany and Spain.[185] The Canadian HIV/AIDS Legal Network recently conducted a comprehensive review of the evidence and legal basis for prison needle exchanges.[186] Among its findings, the review found that prison NEPs reduce risk behaviours and the spread of infectious disease, do not increase drug consumption or injecting and do not endanger staff or other prisoners. The review recommends the establishment of NEPs in federal and provincial prisons, echoing the voices of many other groups including the Ontario Medical Association.

- **Consumption rooms**

  Drug consumption rooms (supervised injection sites or inhalation rooms) **are legally sanctioned low-threshold facilities** that allow the consumption of pre-obtained drugs under supervision in a non-judgmental environment. Consumption rooms evolved from efforts to reduce public nuisance associated with open injection drug use and to provide a clean and protected environment for users to reduce the transmission of blood-borne viruses and the risk of overdose.[187] They are often characterized as a "middle ground" between public health and public order concerns as they have played an important role in the management of open drug scenes and the provision of harm reduction services.[188] Consumption rooms operate as **part of a comprehensive, effective response** to illicit drug use.

  There are 40 to 50 legal supervised injections facilities (SIFs) world-wide, located in Australia, Austria, Germany, Luxembourg, the Netherlands, Norway, Spain and Switzerland.[189] In September 2003, the first North American SIF was opened in Vancouver as part of a federally funded research trial. Definitive outcome research is not yet available on SIFs. However, observations and studies in Switzerland, the Netherlands and Germany suggest that SIFs reduce risks and harms associated with injection drug use, including high-risk behaviours (e.g., needle sharing, improper syringe disposal) and contribute to a decline in criminality and public order issues (e.g., open drug use, discarded syringes in public).[190] Preliminary research on Vancouver's SIF had similar results, including reduced public injection drug use and public syringe disposal.[191] The collection and evaluation of data on health outcomes for users are ongoing and will be reported throughout the research trial.

  SIFs are not surprisingly an **area of some controversy**. Some groups, such as the International Narcotics Control Board, oppose SIFs as violating international drug conventions that limit the use and possession of illicit substances to medical and scientific purposes. Countries in favour of SIFs argue the matter is one of interpretation. In Canada, health policy and research experts have called for pilot supervised injection facilities in cities like Vancouver, Montreal, Toronto and Ottawa where health concerns related to injection drug use continue to be of serious concern.[192] They recommend that any such trial be subject to rigorous evaluation to inform the basis for any long-term policy decisions.

- **Alcohol and harm reduction**

  Harm reduction strategies can also be very effective in addressing alcohol-related problems (e.g. strategies promoting responsible drinking policies/programs (e.g., the Low Risk Drinking Guidelines and Municipal Alcohol Policies), alcohol-server intervention training, and shelter-based alcohol harm reduction programs or "wet-shelters."[193] A recent literature review found a substantial body of evidence-based research demonstrating the effectiveness of harm reduction approaches for alcohol use. The research found that providing a **choice of goals within a continuum** or stepped model of intervention increases people's commitment to treatment and improves their feelings of success in meeting their goals. The review also refutes claims that a harm reduction model of treatment either encourages use or promotes underage drinking. In fact, prevention programs aimed at youth and young adults that use a harm reduction approach were found to have significant reductions in both the consumption and consequences associated with alcohol use.[194]

- **Peer groups and networks**

  Involving people who use or have used drugs or alcohol in planning, implementing and evaluating policies and programs intended to serve them **is critical**. Groups and networks of users have been formed to provide people with a stronger voice to effect change.[195] The two active peer networks in Toronto are Finally Understanding Narcotics (FUN) and the Toronto Harm Reduction Task Force Peer Network.

  Peers, as they are often called, also help with the delivery of services, such as providing outreach services. In 1991, the first peer group in Toronto was started by Toronto Public Health's *The Works* program for injection drug users. This program as well as other needle exchanges across the city support and encourage the involvement of peers to help deliver their programs. Some countries fund user groups directly to deliver programs. Since the late 1980s, the Australian government has funded several groups to deliver needle exchange, peer education on health issues, safer injecting methods, overdose and adverse drug reactions.[196] Peers are viewed as a credible source of information and referral to other users and provide valuable links to social, health and treatment services.[197]

  > *Peer work is about improving your understanding of drug use, extending that knowledge back out into the community and using your past experiences in a positive, pro-active way.*
  >
  > **Toronto Harm Reduction Task Force, Peer Manual.**

  The Toronto Harm Reduction Task Force Peer Network recently produced the *Peer Manual: A Guide for Peer Workers and Agencies*. This practice-based guide has proved very popular, and requests for the document have come from around the world. In 1986, the peer group, Finally Understanding Narcotics (FUN) produced a safer-injecting video called FIT, which they marketed successfully around the world. The video is still actively in use.

New and emerging practices in harm reduction

- **Safer crack use kits**

  The distribution of safer crack use kits has emerged as a street outreach practice in Toronto in **response to growing health concerns** for people who smoke crack. These kits contain various items to help prevent disease transmission, burns and other crack-related harms. For example, the pipes included with the kits have

many advantages; they do not heat up quickly and therefore will not burn users' fingers or lips. Burns and cuts from self-made crack pipes like ginseng bottles, aluminum cans, plastic bottles, and inhalers are a prime route for potential disease transmission.

Some community-based street outreach services distribute these kits in Toronto. Workers stress the value of the kits as a tool to connect with a group of users who are often difficult to reach. Funding is provided through a patchwork of private donor sources, although community groups continue to advocate for stable and increased government funding for this harm reduction service. The Winnipeg Regional Health Authority funds the distribution of safer crack use kits to users in their community; the City of Ottawa plans to begin distribution in April 2005.

- **Harm reduction housing**

  Harm reduction housing is a relatively new approach aimed at **stabilizing active substance users** who are at particular risk of losing their housing because of that use. The PHS Community Services Society in Vancouver operates this type of housing and has found it to be very successful in stabilizing the lives of some of the most marginalized groups of drug users in the Downtown Eastside of that city.

  Service providers in Toronto have been advocating for harm reduction housing here. One study recommends a multi-pronged, multi-disciplinary approach that would incorporate the following elements:[198]

  - Tenants may use drugs and/or alcohol, and abstinence from drugs and/or alcohol is not a criterion for admission, nor is continued use after admission grounds for eviction.
  - Safe, respectful and appropriate behaviour is the primary concern of the housing staff and other residents, and as a consequence admission and tenancy criteria will focus on these issues instead of the use of substances.
  - The provision of supplies and services needed for safer drug use either on-site or nearby.

Best practices in enforcement

Enforcement recognizes the need for public order and safety by targeting organized crime, drug dealing, drug houses, problem businesses involved in the drug trade and by improving co-ordination with health services and other agencies serving drug users.

Effective policing and criminal justice work is not only about getting tough on crime. It also means being visible, understanding the community and its issues and creating long-term relationships with residents, knowing about available resources for substance use (like treatment and referral services) and when to use them, and co-ordinating efforts with other agencies.

- **Health and Enforcement in Partnership**

  Health and Enforcement in Partnership (HEP) is a Canada Drug Strategy initiative supporting the **collaboration between health/social agencies and the police/justice system**. The project focuses on developing solutions to problems of alcohol and drug use. HEP is lead by a steering committee made up of representatives from the Canadian Centre on Substance Abuse, Health Canada,

Alberta Alcohol and Drug Abuse Commission, National Advisory Commission on AIDS, Correctional Services Canada, Canadian Association of Chiefs of Police, Royal Canadian Mounted Police, Department of Solicitor General and Department of Justice. HEP encourages partnerships between police, addictions and health professionals. Projects include drug awareness videos, programs for street youth, pre-charge diversion options for young offenders and referral programs.

HEP has recognized the **Merseyside model in England** as an effective collaboration between police and health officials in dealing with drug issues in that community. HEP attributes the success of this model directly to the co-operation between police and health officials. Police are active participants on regional health committees and rely on the expertise of local health authorities for ongoing internal police training. Police refer drug users who are arrested to treatment services and support the work of needle exchanges by limiting surveillance of these programs and not prosecuting for possession of needles. Police focus on drug trafficking but rely on cautioning and diversion for simple drug possession.[199] The Merseyside model is discussed further in the section of this report looking at how other cities respond to drug issues.

- **Intersectoral collaboration**

  Police in Toronto and across Ontario are using a **collaborative approach to deal with marijuana-grow operations**. Under this approach, police work with what are referred to as the "Big Five" – political leaders, media (because of the power of communication), appropriate departments within social and government agencies and the community (both business and residents). In Toronto, partners include the Insurance Bureau of Canada, Toronto Hydro, Canada Mortgage & Housing Corporation, municipal by-law officials, Toronto Public Health, real estate authorities, child welfare agencies and the police, who work together to ensure that all aspects are being addressed.

  As an example, police work with local public health and child welfare services to address the issues of young children living in marijuana grow-operations. This kind of environment can put children and adults at significant risk of respiratory problems from mould and mildew. Physical-safety issues are also a concern as many residence/grow-operations are being looked after by adults who are often being paid to tend the operation for an organized crime group who wants the place to appear that it is a regular residence occupied by a normal family. Residences are often re-wired to bypass the hydro meter so that detection of ultra high levels of hydro power is harder to detect, leaving hydro authorities victims of theft.

  Police have found that if they only use a criminal justice approach, an investigation may take months or even years to conclude. A collaborative, problem-solving approach allows them to address the problems faster and more effectively thereby preventing further victimization (health and safety issues, theft of hydro, etc.).

- **Drug treatment courts**

  Established in December 1998, the Toronto Drug Treatment Court provides **voluntary, court-supervised treatment** for people who use cocaine and/or opiates. Non-violent offenders charged with possession of, or trafficking in, small quantities of crack cocaine or heroin, or with prostitution-related offences

are eligible to participate in the program. Rather than incarceration, offenders receive a non-custodial sentence upon successful completion of the program.

Close ongoing collaboration between the court, the community, and the treatment system is a hallmark of this program. By helping people to stay engaged in treatment, the program aims to **reduce relapse rates** for substance use **and related criminal behaviour**, and to improve social stability. Toronto's Drug Treatment Court has received international attention and other countries, such as Jamaica, are basing their programs on this model.

As with other responses to drug issues, drug treatment courts don't work for everyone. However, the Toronto Drug Treatment Court has proved successful for some drug users. Of the 77 people who have graduated from the program, only three have been convicted of criminal code offences since graduation. Drug use of both graduates and those who do not complete the program decreases over their period of involvement in the program. Graduates must be free of both cocaine and heroin use for at least four months and of marijuana use for at least one month prior to graduating. Graduates report improvements in their overall health and psychological well-being, anxiety, depression, and self-control. There have been four pregnant women in the program and all have had babies born free of drugs.

New and emerging practices in enforcement

- **Drug recognition experts**

  The RCMP is providing specialized training to police officers across the country to be drug recognition experts. These officers are trained to determine whether a person is impaired using a 12-step standardized procedure that involves observing visual clues (eyes, divided-attention abilities, psychomotor skills) and vital signs; questioning; and taking urine or saliva samples for analysis.

  Officers will be able to determine impairment by both alcohol and other drugs. Previous breath testing techniques only allowed testing for alcohol. This new training for officers will be applied in a number of situations other than assessing for impaired driving. Officers can better determine whether intoxicated prisoners need medical attention; judge whether those who have been sexually assaulted are victims of a date-rape drug; determine if - people who are giving statements are impaired and assess whether people who are on parole have violated conditions forbidding alcohol and/or drugs.

International conventions, legislation and policy

I. International conventions

The production, distribution and consumption of substances, whether legal or illegal, are complex global issues extending far beyond the borders of Toronto. Understanding the impact and interplay of this global environment on the local level is therefore useful context in thinking through a municipal drug strategy.

Canada is a signatory to **three key international treaties** relevant to psychoactive substances: the *Single Convention on Narcotic Drugs* (1961), the *Convention on Psychotropic Substances* (1971) and the *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (1988). Collectively, these treaties form the basis for the international prohibition of the production, trafficking and possession of illicit drugs. This includes controlling the availability of drugs for legitimate medical and scientific purposes (although these terms are not defined). It is up to each country to create the necessary legislative and regulatory measures to establish the controls within their own jurisdiction to meet the commitments of treaties. The three conventions recognize the particular features of national, legal and judicial systems and specify that the measures adopted by a country will respect these systems.[200]

> *The attempt to eliminate both the supply and the consumption of drugs in our society has failed.*
>
> **Frankfurt Resolution: The Manifesto of the European Cities Movement Against Prohibition**.

The **International Control Board** (INCB) is an independent, quasi-judicial body that monitors government compliance with international drug conventions. There is **increasing tension** between some domestic drug policies and the strict interpretations of the conventions held by the INCB and prohibition-oriented countries.[201] This is the result of nations, primarily European, who are promoting more pragmatic strategies to address illegal drug issues. Some drug policy experts view the drug conventions as contrary to evidence-based research on effective responses to drug use. In addition, some argue they contradict human rights conventions to which Canada is also a signatory. Part of the challenge is that the conventions were drafted before harm reduction measures were widely accepted and are therefore not specifically accommodated for.

The INCB has stated that harm reduction programmes could play a part in a comprehensive, drug demand reduction strategy.[202] However, there has been **considerable controversy** about two specific types of harm reduction measures that fall within the purview of the drug conventions: the provision of illicit drugs under medical supervision (for example, prescription heroin), and measures that make the use of illicit drugs safer (for example, supervised injection sites).[203] It has been argued that each country should decide how to interpret the treaties to allow measures of either type. However, with respect to the first category, the INCB has campaigned against maintenance on heroin (but not on other opiates). With respect to strategies aimed at making the use of illicit drugs safer, the INCB has voiced strong objections to "safe and sterile injection rooms."[204]

As it stands, a country must be willing to endure open diplomatic criticism from the INCB if they hold a contrary interpretation of these measures. Vancouver recently came under fire for opening North America's first supervised injection site. However,

there are signs of change on the international front as much of Western Europe is moving away from the largely criminalizing approaches required under these drug conventions.[205] Europe is an important funder of drug control bodies and therefore the shift in European attitudes will likely affect the tenor of political debate on these issues over the long term.[206]

II. Canadian drug policy and legislation

Drug policy is an area of **considerable debate** especially as it relates to illegal drugs. Some support the legal prohibitionist approach that focuses efforts and resources on reducing the supply of drugs and penalizing those who use or sell drugs illegally. Others take a more pragmatic, public health-oriented approach, which recognizes that drugs will likely always be with us and that some people cannot or will not stop using them. Under this approach, drug policies should focus on reducing the harms associated with drug use as well as on supporting efforts to prevent use.

In the late 1980s, it looked as though Canadian drug policy was heading towards significant change. Canada had chosen a system of legal repression through the establishment of the *Narcotic Control Act* in 1961, which emphasized prohibition as the main response to drug control.[207]

However, in 1987 the federal government announced a redirection of its drug policy efforts by shifting more toward the principles of "harm reduction" and a "balance of demand and supply reduction" measures. The government announced that this drug-policy overhaul would include a new drug law that would form the "legal backbone" of its new policy framework.[208] However, this draft Bill C-85 differed little from Canada's traditional prohibitionist legislation and at any rate did not pass. Future iterations of similar "new" drug laws were proposed in subsequent parliaments. Bill C-7 suggested minor changes such as reduced penalties for first-time cannabis offenders in an attempt to be more in line with public opinion. Drug policy experts from across Canada strongly criticized the draft bill specifically in the areas of drug scheduling, cost-effectiveness and the effects of drug-user criminalization.[209] Bill C-7 died with the dissolution of parliament in February 1996 but was resurrected in its same form and finally passed as Bill C-8 later that year.[210]

Proponents of harm reduction often work around existing legislation. For example, the U.S. federal government does not support or fund harm reduction initiatives, but some states have responded on their own to the needs of drug users through more practical approaches such as needle exchange programs. Europe (Switzerland, Germany, the Netherlands, etc.) and Australia for some time now have supported and promoted harm reduction systems from an "un-legalistic" perspective, practising change despite the law, rather than through or against the law.[211] These systems have started to reduce the "harm" by ignoring what they view as inappropriate drug laws. A key challenge in the ongoing debate on drug policy in Canada is to show that harm reduction is primarily built on common sense and a rational, humanistic approach to drug issues.[212]

A significant area of policy debate in Canada and elsewhere relates to **cannabis**. While the possession and use of cannabis is still illegal under the *Controlled Drugs & Substances* Act, there are now exceptions under this law:

- In July 2001, "Canada became the first country in the world to legalize the use of cannabis by people suffering from terminal illnesses and chronic conditions."[213]

- In May 2003, the Cannabis Reform Bill (C-38) was tabled in the House of Commons. Under the proposed legislation cannabis possession remained illegal, but possession of 15 grams or less was decriminalized and a charge for small amounts of cannabis was punishable by fine. The proposal included tougher penalties for growers. The Ontario Court of Appeals amended the bill's proposed decriminalizing possession of 15 grams to 10 grams or less.[214] However, Bill C-38 died with the dissolution of the federal government in July 2004.
- The federal government reintroduced legislation in November 2004 to decriminalize small amounts of marijuana. Under this new Bill C-17, possession of small amounts (under 15 grams) is punishable by a fine instead of a criminal charge. A companion bill, C-16, was also put forward to address drug-impaired driving. This bill sets out the conditions under which the police can demand blood or urine samples from people they suspect of driving while intoxicated.[215]

III. Government strategies on substance use

This section provides a brief overview of Canadian government drug strategies and initiatives. This information is useful for Toronto to consider as it develops its own drug strategy to ensure that our efforts are "in sync" with the directions of other levels of government.

Canada's Drug Strategy

In 1987, the federal government released the **Canada Drug Strategy**, which focused on public education, treatment and rehabilitation, and enforcement. The announcement included $210 million in new spending over five years. Phase II of the Drug Strategy was launched in 1992 with the announcement of another $270 million over five years. Less than half of this second round of funding was allocated due to a program review. At the end of Phase II in 1997, the Drug Strategy was again renewed but prevention activities were not funded. In addition, enforcement efforts were funded at 65% of previous levels.

In 2002, reports from the Auditor General, a Senate committee and a parliamentary committee called for stronger leadership, for a rebalance of activities dealing with drug supply and demand and for an increase in emphasis on prevention, treatment and rehabilitation, and harm reduction. May 2003 brought another **"renewal" of Canada's Drug Strategy**. The focus now is "to have Canadians living in a society increasingly free of the harms associated with substance abuse." The strategy is to use a "balanced approach" to address both the demand and supply (prevention, treatment, harm reduction and enforcement). Another $245 million in renewed funding over five years is broken down as follows:

- Health Canada: $121million
- Department of Justice: $47 million
- Solicitor General: $62 million
- Foreign Affairs and International Trade: $3 million.

National framework for action on substance use initiative

On the heels of renewing Canada's Drug Strategy, Health Canada and the Canadian Centre on Substance Abuse began cross-country consultations to gauge interest in longer-term collaboration to develop and implement a **national framework for**

action on substance use. Consultations have been conducted with officials from provinces, territories, municipalities, the voluntary sector, professional associations, law enforcement agencies and the private sector.

Key themes emerging from these discussions include:

- The need for a paradigm shift in "order to frame substance abuse as first and foremost a health and social issue rather than a criminal one, and to dedicate funds accordingly."
- The need to work collaboratively, establishing vertical and horizontal partnerships to break down silos of all kinds.
- The need to "address the root causes of addictions and problematic use of alcohol and substances" to understand how "personal, family, community, social and economic issues," such as abuse, trauma, poverty and inadequate housing, impact use.
- The need for "new, potent and holistic models" to substance use, with most participants advocating looking "outside the box," including "strategies that push the boundaries of harm reduction, address larger societal issues, mental health issues and co-occurring problems."
- The need for "enforcement and justice interventions in partnership with health and to develop and fund socially relevant policing strategies" was stressed by most participants who fell in the middle of the spectrum of opinions voiced on law enforcement.[216]

The timing of this national initiative works well for the Toronto Drug Strategy Initiative. It is important for Toronto to integrate its strategy with what is happening at the provincial and federal levels as well as to have the opportunity to collaborate with other municipalities doing similar work.

Provincial responses to substance use

Currently, the Province of Ontario does not have a co-ordinated policy or strategy on substance use. In 1993, the NDP provincial government introduced *Partners in Action: Ontario's Substance Abuse Strategy.* The report articulated a policy framework with a 10-year plan to reduce substance abuse and thereby help to build healthier communities.[217] The subsequent Conservative government failed to implement this framework.

In 1996/97, as part of a larger health system restructuring exercise, the **Ontario Substance Abuse Bureau** commissioned restructuring studies in each of Ontario's six health planning regions. This review looked at how to make the best use of addiction treatment resources (as opposed to prevention) and how to structure services to best meet the needs of the clients. The 1999 report of this review, *Setting the Course: A Framework for Integrating Addiction Treatment Services in Ontario,* recommended actions to:

- improve the quality of addiction services,
- increase capacity of the system,
- co-ordinate services, and
- make better use of existing resources. (Provincial funding for addiction treatment services has not increased in over ten years.)

Strategies were directed to government, district health councils, addiction services and others, toward creating a more "client-centered" approach to care. The framework promotes a "stepped" approach that provides people with more choice and easier access to the services they need.[218] Implementation committees made up of representatives from across the treatment system were set up to oversee the rollout of the *Setting the Course* plan, including one for Toronto. In March 2000, flowing from directions proposed in *Setting the Course*, a province-wide Residential Working Group released a report recommending actions to strengthen the sector including harm reduction approaches, flexible lengths of stay, and the types of resources and geographical considerations needed relative to particular target populations.[219] Other parts of the sector, such as Withdrawal Management Services (detox), are also in the process of reviewing and redesigning the way they deliver services.

Public health is another important source of strategic action regarding substance use. The *Health Protection & Promotion Act* directs local public health units to undertake health promotion and disease/injury prevention. In this program area the Ministry of Health sets out mandatory service guidelines with a goal to "reduce disability, morbidity and mortality caused by motorized vehicles, bicycle crashes, alcohol and other substances, falls in the elderly and to prevent drowning in specific recreational water facilities."[220] Ministry targets for the year 2010 include:

- reducing the rate of alcohol and other substance-related injuries or deaths by 20%;
- reducing the percentage of adults who drink more than two drinks a day by 20%; and
- reducing the rate of illicit substance use and non-medical use of drugs and other psychoactive substances by 20%.

The provincial **AIDS Bureau** funds organizations and initiatives across the province to operate HIV/AIDS education and support/practical assistance programs for gay men, hemophiliacs, Aboriginal communities, street youth, women, children, deaf people, culturally and linguistically diverse groups and people who use injection drugs. They also fund anonymous and prenatal HIV testing and various research initiatives. In addition, the HIV/IDU Outreach Program funds outreach workers to provide prevention education to injection drug users at risk for HIV infection and support to people living with HIV. The *HIV/AIDS Strategy for Ontario to 2008* proposes a comprehensive approach to fighting HIV, which takes into account factors that put people at risk of infection and disease, the increasing complexity of client needs, existing services and the need for new leadership. Recommended strategies include extending the availability and range of harm reduction and treatment options for people at risk, including injection drug users.

Federation of Canadian Municipalities, Municipal Drug Strategy Initiative

In 1999, prompted by municipal leaders, the Federation of Canadian Municipalities began the Municipal Drug Strategy project to complement national efforts under Canada's Drug Strategy. **A Model Municipal Drug Strategy** was developed to support and mobilize a municipal-level response to substance use. Key recommended elements of a Municipal Drug Strategy are:

- municipal leadership,
- a municipal drug policy,

- a plan tailored to meet local needs,
- organization, co-ordination and leadership.

Specific strategy components recommended for a Municipal Drug Strategy are:

- prevention and drug demand reduction,
- rehabilitation (a continuum of services including harm reduction, housing, employment, etc.),
- law enforcement.

Key learnings from this approach, which was piloted in nine Canadian communities, include:

- Leadership and co-ordination are critical, as is a flexible structure and transparent process.
- Clear goals, objectives, roles and responsibilities must be articulated.
- Effective partnerships are key to any community mobilization effort, as is the availability of a solid information base to inform the community, guide decision making, and encourage widespread support for the initiative.
- Key community players, including municipal leaders and those representing major institutions, need to be involved.
- Adequate resources must be committed, including a dedicated project co-ordinator.[221]

City of Toronto drug policy

The City of Toronto does not have a comprehensive municipal drug policy or strategy, hence the need for the current **Toronto Drug Strategy Initiative**.

The City does have a **Municipal Alcohol Policy**, the goal of which is to promote the health and safety of people at events on City property. The policy describes what a person or group holding an event on City property must do to prevent alcohol-related incidents. The policy also works to protect people from liability and to promote low-risk drinking. The City also delivers and funds a range of drug prevention and harm reduction initiatives throughout Toronto, primarily through Toronto Public Health and Community & Neighbourhood Services.

In addition, the **Toronto Police Service** addresses issues related to substance use through their four key roles in the community including enhancing public safety, maintaining order, preventing crime as well as enforcing laws.

Additional details on these responses can be found in the Programs & Services chapter of this report.

Examples of how other cities respond to substance use issues

This section provides a brief summary of strategies and approaches to substance use issues in five selected cities in Canada, the United States, Australia, Britain and Europe. The Toronto Drug Strategy Initiative advisory committees selected the cities as a representative sample of relevant approaches. Examining how other cities have tackled the complex issue of substance use provides useful learning for the City of Toronto as it develops its own strategic responses.

I. CANADA: Vancouver

As a major seaport, Vancouver is a key entry point in North America for drugs. In the late 1980s and 1990s, the Downtown Eastside area of Vancouver became an enclave of open drug use. An increase in the purity of heroin in 1992 and the introduction of cheap cocaine and crack cocaine in the early 1990s had a devastating impact on the community.

Overdose deaths in B.C. rose from 39 in 1988 to 331 in 1993. Of the latter, 201 of those deaths occurred in Vancouver, primarily the result of illicit drugs. In addition, reported HIV infection cases reached 587 in 1992.[222] The situation became extreme enough for the City of Vancouver to declare a public health emergency in 1997. Since that time the City has taken a strong leadership role, bringing together the relevant stakeholders to address this tragic health crisis. In Vancouver it is estimated that alcohol dependence affects over 12,000 people and that there are about 9,000 injection drug users in the city (about 4,000 in the Downtown Eastside). [223]

Overview of Vancouver's drug strategy/approach[224]

- Vancouver's **Four Pillars Drug Strategy** is a council-approved, co-ordinated, comprehensive approach that balances public order and public health in order to create a safer, healthier community.
- In 1997, the City of Vancouver created the Coalition for Crime Prevention and Drug Treatment (now called the Four Pillars Coalition) – made up of business, government, non-profit organizations and advocacy groups – to engage the community in addressing Vancouver's drug problem and drug-related crime.
- In 2000, then-Mayor Philip Owen released *Framework for Action: A Four Pillar Approach to Vancouver's Drug Problems*, which outlined this integrated approach as a way to address Vancouver's drug problems, particularly in the Downtown Eastside.
- To build support and get input on the four pillars, the City released papers and held community forums. The City also worked with the federal and provincial governments to create the Vancouver Agreement. The Vancouver Coastal Health Authority and the Vancouver Police are also signatories to this agreement.
- The **Vancouver Agreement** is an urban development agreement for the whole city, with a first focus for action on the Downtown Eastside. The agreement commits all parties to working together on concrete actions for change. The agreement acknowledges that a comprehensive drug strategy must be linked to housing, employment, and social and economic development.

- No one agency is responsible for implementation of Vancouver's drug strategy. It is a co-operative project that relies on the co-ordinated efforts of the Vancouver Agreement, the City of Vancouver, Vancouver Coastal Health, the B.C. government, Health Canada, the Vancouver police department and the community, within their areas of responsibility.

Key impacts/achievements of the Vancouver strategy

- In November 2003, the Mayor's Four Pillars Coalition sponsored a community symposium to begin the process of developing a comprehensive, evidence-based **prevention strategy** for the City of Vancouver. A draft strategy is being developed.
- The Vancouver Foundation created the new **Four Pillars Fund**, a permanent endowment fund to help organizations working with addictions in the Downtown Eastside, in partnership with the City of Vancouver.
- Researchers in Vancouver, Toronto and Montreal are funded by the Canadian Institutes for Health Research (CIHR) to participate in the **North American Opiate Medication Initiative (NAOMI)**. Vancouver is the first city to begin this study in which prescription heroin, along with methadone, will be provided to drug users to determine whether pharmaceutical heroin will improve the health and quality of life of injection drug users, reduce homelessness or reduce users' contacts with the criminal justice system.
- Vancouver now has **24-hour-a-day access to needles** – through low-threshold peer-based needle exchange, mobile needle exchange and needle exchange attached to primary health care services.
- **PHS Community Services Society** provides some of the most innovative harm reduction programs in the world. PHS operates affordable housing programs for traditionally "hard to house" people who have substance use and/or mental health issues. They provide a range of onsite support services to their tenants and maintain a "no eviction" policy. PHS also supports small business ventures for this population as well as drop-in, health and banking services. [225]
- The Vancouver Police Department has re-deployed officers to the Downtown Eastside as part of a **City-wide Enforcement Team** strategy to end the worst of the open drug scene and restore public order to a community in distress. Police have made it clear that their goal is to target drug dealers – not users – and to work with Vancouver Coastal Health to help users access primary health care and addiction treatment services.
- Vancouver opened Insite, North America's first **supervised injection facility**, in September 2003. Vancouver Coastal Health and PHS Community Services Society co-operate the site. Health Canada funds the three-year pilot study, the research component of which is being led by the B.C. Centre for Excellence in HIV/AIDS. The one-year evaluation of the project shows positive results:[226]
  - A high volume of use – about 600 injections are supervised daily.
  - 68% of clients lived in the Downtown Eastside; 35% within three blocks of the site.
  - Over 100 overdose incidents have occurred at the site but there have been no deaths.

- Client satisfaction is high with 63% of users rating the overall quality of the site as "excellent" and 32% rating it "good."
- In the last six months, 262 referrals were made to addiction counselling; 78 to detox.

II. AUSTRALIA, Sydney

- Prior to 1960, there was limited use of illicit drugs in Australia. Growth in use of cannabis and heroin occurred in the 1960s when many U.S. soldiers came on leave during the Vietnam War.
- Australia is vulnerable to trafficking arising in South-East and South Asia when there is prolonged glut of opium and Australia is the nearest wealth market to exploit.
- Sydney's King's Cross area has been the epicentre of Australia's sex and illicit drug trades for many years. Since the early 1970s, heroin has become increasingly available in this area, injected by drug users who often became homeless thus creating an open drug scene in the area.
- Since the early 1990s, a growing number of commercial sex establishments in King's Cross, which had previously rented rooms to street-based sex workers, started to rent these same rooms for the purpose of injecting drugs. They operated as a quasi-supervised injection facility (SIF) providing clean injecting equipment and checking the rooms, calling ambulances if someone overdosed.
- Years of debate about SIFs ensued, but it was a civic disobedience exercise in 1999 where a mock SIF was operated in a church-run facility that put SIFs on the agenda.
- The Uniting Church of Australia was invited by the government to apply for a licence to operate a SIF. The community was consulted and the site opened on May 6, 2001.

Overview of Sydney's drug strategy/approach

The City of Sydney supports a comprehensive approach to dealing with substance use issues, including harm reduction. In 2001, the City developed an action plan to respond to the problems associated with the use of drugs. The strategy promotes initiatives to address illegal drug use that facilitate partnerships between government, business and community groups, and police aimed at reducing drug-use harms for city users. They also strive to provide addicts with health and related services and ongoing support that assist in diverting them from the crime cycle.

Key initiatives and impacts of Sydney and other Australian approaches

- Attitudes of the police and many in the community have changed considerably in recent years. Following a six-month trial of a formal cautioning program in one police district for possession and use of cannabis, this policy has now been adopted state-wide and has greatly reduced the court load. Similar programs have been used with other illicit drugs.

- The Capital City Lord Mayors of Australia have unanimously supported fresh approaches to drug policy, realizing that prohibition is no more effective against the illicit drugs than it was against alcohol in the United States in the early 1900s.
- Methadone treatment is linked with a significant reduction in crime and drug overdose deaths.
- In May 2001, Sydney's Medically Supervised Injecting Centre (MSIC) opened as the first such facility in the English-speaking world. It is a scientific trial aimed at reducing public health and public order issues arising from open injection drug use. An evaluation of the first 18 months of the program found that it had successfully engaged injection drug users.[227] Referrals were being made to treatment, particularly for frequent users of the site. However, it should be noted that the majority of people used the site infrequently. It was concluded that a number of heroin overdoses that were managed at the MSIC may have been fatal had they occurred elsewhere. However, they could not prove a reduction in infectious disease incidents. There were no increases in crime or drug-related loitering, and community support for the program increased after it was up and running.

III. UNITED STATES, New York City

- New York City, particularly the Washington Heights section of Manhattan, is the main distribution centre for retail and wholesale cocaine and heroin through the northeast U.S. and is a significant point of distribution for locations across North America. Much of the heroin seized in the U.S. is seized in or destined for NYC. In addition, a significant portion of cocaine imported into the U.S. comes to or through New York.
- The sale of diverted prescription drugs on the street is growing. Most of the locations where pills are sold are within two blocks of treatment facilities.
- Methamphetamine is viewed as an emerging or growing problem, particularly among gay men.
- Ecstasy has become an established drug of choice in NYC clubs. Seizures of ecstasy have skyrocketed from 225,000 pills in 1997 to over 2 million in 2001, an increase of 912%.
- A 2003 survey of NYC high school students found that 30% had tried cannabis at least once; down from 34% in 2001.
- An estimated 50% of the approximately 200,000 injection drug users in NYC are HIV positive.

Overview of New York City's drug strategy/approach

- In 1979, the Bureau of Alcoholism Services was established to plan, fund and monitor alcohol services in New York City. Similar responsibilities for drug use services were managed directly by the State. In 1994, the agencies were combined and the City became the lead jurisdiction.
- From 1995-2001, much of the focus was on addiction, with resources directed to overseeing the City's addiction initiatives while moving towards a prevention agenda.

- In 2002, the addiction services merged with the health department and education efforts were expanded to promote greater awareness of alcohol and substance use issues and to highlight the availability of community-based services. The NYC Board of Education is the largest provider of school-based prevention and intervention programs.
- While the U.S. federal government does not fund or support harm reduction practices, a number of these programs operate at the community or state level. As one example, in 1992 needle exchange programs were finally legalized in New York City.
- New York's treatment service system is large and diverse. Services include adolescent programs, prevention, outreach and education programs; integrated primary health care, mental health and substance use services to accommodate individuals and families with multiple needs; hospital methadone programs, and a community residential program for methadone clients.
- The New York Police Department works to eliminate drug gangs and individuals who control drug operations. They are part of a task force with federal and state investigators targeting middle- and upper-level drug traffickers and importers. There is also a Narcotics Control Unit in the housing department that addresses drug trafficking in city-owned buildings.[228]

Key initiatives and impacts of the New York approach

- **Buprenorphine,** a new treatment for opioid dependency, is the alternative treatment now preferred following the U.S. Federal Drug Agency's approval in October 2002. Certified physicians prescribe buprenorphine to treat heroin and other forms of opioid dependence. Compared with methadone, buprenorphine has a lower risk for misuse and dependence, fewer side effects, and a longer duration of action. In addition, because of burenorphine's ceiling effect, an overdose is less likely than with methadone or other opioids.
- **Drug Treatment Alternative-to-Prison** (DTAP) is the first prosecution-run program in the country to divert prison-bound felony offenders to residential drug treatment. This program is based on the premise that defendants will return to society in a better position to resist drugs and crime after treatment than if they had spent comparable time in prison. DTAP targets drug-addicted defendants arrested for non-violent felony offenses who have previously been convicted of one or more non-violent felonies. Defendants entered into DTAP have their sentences deferred while undergoing 15 to 24 months of intensive drug treatment. As of May 20, 2004, approximately 1,984 defendants had been accepted into the DTAP program; 388 were still in treatment; and 756 had completed the program and had their charges dismissed.[229]
- **Active community participation** in the planning process is considered key to user-friendly services. Input is generated from substance users, family members, community residents and interested professionals. As part of their citizen participation structure, the NYC Federation of Mental Health, Mental Retardation and Alcoholism Services has councils in each of the city's five boroughs that help inform the Bureau of Alcoholism Services and the public about the costs of alcohol and substance abuse and the availability and efficacy of treatment. These advisory bodies work with the Bureau to identify community needs, determine planning priorities, establish the necessary inter-program linkages and advocate for effective prevention and treatment efforts.

IV. ENGLAND, Merseyside

Overview of Merseyside's drug strategy/approach

In the early 1980s, Merseyside became a center for harm reduction policy due to an epidemic spread of drug use, particularly heroin, and increased rates of HIV infection. Three key factors led to the creation of the **Mersey Model of harm reduction** as it is known.[230] One was the establishment of local drug dependency clinics in the mid-80s. Prior to this, outpatient treatment was limited to a few psychiatrists who still practised the old British system, which allowed the prescription (in certain cases) of illicit drugs. To this day, injectable opiates are prescribed on a take-home basis in Merseyside. A second factor was that in 1986, the Mersey Regional Drug Training and Information Centre started one of the first needle exchange programs in the U.K. The third key element was the co-operation of local police, who agreed not to place drug services under surveillance and began referring to drug services those users who had been arrested, a policy known as "cautioning."

Harm reduction services in Merseyside include needle exchange, counselling, prescription of drugs (including heroin) and employment and housing services.

Key impacts/achievements of the Merseyside strategy

- A key reason for the success of the Mersey Model is that many levels of service and a wide variety of agencies are involved. Services are integrated so that drug users can get help when they need it.[231]
- The Mersey HIV prevention strategy for injection drug users has also proved effective. Contacts with drug users have increased steadily over time and anecdotal evidence suggests that the number of drug-related health problems have decreased. In addition, risk behaviours such as the sharing of needles have also declined.[232]
- Drug-related crime dropped in many parts of the region, whereas the national rate increased.[233]

Examples of best practices in Merseyside

- **HIT**, formerly the Mersey Drug Training and Information Centre, was established in 1985 to reduce drug-related harm. Based in Liverpool, the organization has gained an international reputation for developing, advocating and implementing a pragmatic and effective approach to drug use. HIT delivers effective interventions on drugs, community safety and other public health concerns. They produce publications, run mass-media campaigns, deliver training and organize conferences. They work in partnership with individuals, community groups and health, social care and criminal justice agencies at a local, national and international level. HIT's recent work includes providing information about drugs and the law, sexual health, safer injecting and HIV protection, safer clubbing, young people and alcohol and overdose prevention.
- **Police practise of "cautioning"** where the offenders are taken to the police station, their drugs are confiscated, the incident recorded, and they are given a formal warning that if they are again found in possession of illicit drugs they will be prosecuted. The drug users are then given information about available services in the area, including needle exchange. If found in possession a second or third time,

the offenders are sent to court, where they may be fined for small quantities or sentenced for possession of large amounts. About 50% of drug possession incidents are dealt with by cautioning in Merseyside compared to about 25% in the rest of the U.K.[234]

V. GERMANY, Frankfurt

Frankfurt is seen as an international leader in the area of addressing problematic drug use. During 1970s and 1980s, Frankfurt had a large, open drug scene in a small downtown park near its main train station with as many as 5,000 people using drugs at any one time. The HIV infection rate was as high as 25% among injection drug users. Overdose deaths rose from 31 in 1985 to an alarming 147 in 1991. Traditional enforcement efforts aimed at dispersing this open drug scene met with limited success and so the City of Frankfurt looked to new approaches, including harm reduction.

Overview of Frankfurt's drug strategy/approach

- Frankfurt, like most large German cities, uses a **comprehensive harm reduction approach**.[235] Their strategy is based on what has been termed "the Four Pillar approach," which recognizes that prevention, treatment, harm reduction and enforcement are needed to effectively address substance use issues. Drug use is viewed as a serious health concern for the population and measures are developed aimed at benefiting both the individual user and the broader community.
- The key lever to action on drug issues in Frankfurt is a group known as **Monday's Round**, which started in 1989. This high-profile group was chaired by the mayor and included representatives from the health authority, the school system, police, the court system, social services and the community service sector. The local business community was also involved and funded some of the initial steps to develop their drug aid plan. The group originally met once a week and over two years developed a co-ordinated plan of action.
- The Mayor of Frankfurt also met with mayors of surrounding municipalities informing them of Frankfurt's strategy and encouraging them to start caring for their own drug users.
- Monday's Round continues to meet every two weeks to address new and emerging issues, recognizing that drug issues are an ongoing reality of urban life.
- Another group, **Friday's Round,** also met once a week during the early days of Frankfurt's drug response planning. This group had similar membership to Monday's Round but included the staff responsible for the actual implementation. Friday's Round now meets only about four times a year as the service co-ordination and communication links are so well established.
- The City of Frankfurt also has a **Drug Policy Co-ordination Office** to support ongoing co-ordination and policy development.

Key components of the Frankfurt approach[236]

- The police closed the affected park's open drug scene using a **comprehensive harm reduction approach**. The police said they would no longer tolerate open drug use but referred users to the new harm reduction services that had been set up. This included a 300-bed shelter facility with onsite support programs.

- Setting up a **low-threshold methadone** program in 1991 was considered key to stablilizing many drug users. Previously, methadone was prescribed only in life-threatening situations.
- Between 1994 and 1996, four **supervised injection sites** were opened in an attempt to erode further the open drug scene and bring more users in contact with health and other support services.
- In 1997, a **Crack Street Project** began as the first interdisciplinary project involving doctors, social workers and youth welfare workers. Recently, OSSIP, the Offensive, Social Work, Safety, Intervention and Prevention project, began. OSSIP is an intensive outreach support program for street involved drug users. Five agencies contribute staff time to the project including the police, health and social workers.
- In 2000, a national **heroin prescription** program was set up, moving towards the legal ability to use heroin as part of a treatment regime.
- Frankfurt's drug aid system is now comprehensive and includes crisis and survival services, counselling centres, youth services, child care and family services and school-based prevention and support services.

Key impacts/achievements of the Frankfurt strategy[237]

- Open drug use dropped from 1,500 to under 200 throughout Frankfurt.
- Drug **overdose deaths declined** from a high of 147 in 1991 to 28 in 2002 (mostly heroin).[238]
- HIV rates among injection drug users dropped from 24% to 14%.
- **Auto-theft rates were reduced** by 36%, break-ins by 13%, grievous bodily harm incidents by 19% and police-registered first-time consumers of illicit drugs dropped by 39%.
- Police are now better able to separate the addicted dealers and the non-addicted dealers. They direct their energy toward the middle- and higher-level drug dealers and importers of illicit drugs, while also helping the system to ameliorate conditions at the street level.
- **Drug-related court cases were reduced**. Drug courts had been introduced in the mid-1980s and people sentenced to three years or less could choose treatment such as methadone.

Examples of best practices in Frankfurt

- Frankfurt's approach to **multi-sectoral collaboration** has become a model for other cities. Monday's Round has received international attention as an effective way to build co-operation among prevention, treatment, harm reduction and enforcement stakeholders.
- Frankfurt has two **multi-service drug aid centres** specifically targeted to the needs of drug users.
    - *Eastside* is a large facility located outside the downtown core. Onsite services include medium-term shelter beds (six months to a year), emergency overnight shelter (up to four weeks), a safe injection site and a contact café (counselling/support). Next door is a dedicated medical clinic that provides primary health care as well as methadone and other types of

substance use treatment. Eastside also has work-training programs, a print shop, carpentry shop and a laundry business. These programs allow users to gain skills and confidence, which in turn help to stabilize their lives.

- *Elbestrasse* is located downtown. This centre provides needle exchange, a supervised injection room, medical and methadone clinics, counselling services, an inhalation room, contact café and daytime and overnight shelter beds.

- **Consumption rooms**. Frankfurt has four consumption rooms. All four offer supervised injection facilities and one, Elbestrasse, as noted above, also has an inhalation room for people who smoke crack cocaine. Non-profit groups operate these services. Programs offered range from needle and condom distribution, supervision while injecting, crisis intervention services, day and night shelter beds and food programs. Referrals are also made to detox and treatment programs. There have been more than a million injections in these programs and to date there has not been a fatal overdose. The local police support the programs and work with staff to keep the use of drugs low key and out of site. Police are called if drug dealers enter the building.

List of key informants

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