An Environmental Scan of Thunder Bay

Issues, Impacts, and Interconnections of Substance Use

A background paper prepared for the Thunder Bay Drug Strategy Project, March, 2010.

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Scope & Limitations:

The intention of the following paper is to provide as current and accurate a picture as possible of the issues, impacts, and interconnections of substance use in Thunder Bay while also considering the broader context. When attempting to compile a comprehensive paper on such a broad and complex subject, it is difficult to determine what information to include and what can reasonably be left out. There is a plethora of existing literature that provides information about substances of use, the various pathways to addiction, and so on; while it is important to understand the terminology, processes, and various theories as they pertain to substance use, such topics are beyond the scope of this paper. Also, individuals with an interest in this topic will already have a breadth of knowledge about substance use issues. That being said however, it is also recognized that not everyone involved with the Thunder Bay Drug Strategy Project has such a breadth of knowledge and therefore some additional information is provided for such readers. Thus, while the following may not necessarily be 'new' information for all readers, attempts have been made to create a comprehensive and useful document. For the sake of simplicity, the term 'substance use' will largely be used throughout, and is meant to encompass all psychoactive substances, whether they be legal or illegal, including alcohol. While the term 'substance use' does not necessarily imply problematic use, in the context of this paper, it is meant to pertain to a range of use, which could also include problematic use.

The report first looks at the international context of substance use, which is presented to add to our understanding of this complex subject. The national and provincial landscapes are also considered and noteworthy is their divergent perspectives on drug policy. Next, the local context is examined; areas of enforcement, health, youth, human and social impacts of substance use, and the types of addictions treatment available in our community are highlighted. The social determinants of health/mental health in the context of Thunder Bay are also discussed as a reminder that while these may not be 'direct' substance use issues, they are interrelated and applicable all the same. Some apparent strengths and gaps in Thunder Bay surrounding the issue of substance use are also provided, although by no means are meant to be exhaustive. In the last section is a more inclusive list of programs, activities and services currently available in Thunder Bay to address substance use issues (but again, may not be exhaustive).

It should be recognized that any study, report, or research project can never be truly free from a certain extent of bias. While this author has attempted to keep her own biases in check, it should be acknowledged that this paper was written through the lens of someone who believes in a biopsychosocial model of addiction, sees substance use as primarily a health matter rather than an enforcement issue, and that the causes and impacts of substance use relate to larger social, economic, cultural, and political concerns. This writer also has personal experience in the realm of substance use and has studied the topic for numerous years.

Attempts were made to make all information in this report as current as possible, where possible. However, due to a lack of recent comprehensive studies in some areas and time constraints, some data provided may not be entirely up to date. Much of the information on local resources was taken from internet websites, thus if the site had not recently been updated, the information in this report will likely reflect that. Many thanks go out to the individuals who forwarded information to assist with the drafting of this paper and especially to Patty Hajdu for instilling her trust in me to undertake this important piece of work.

On a final note, while this report is largely 'problem-focused' it is not meant to suggest that the situation in Thunder Bay is bleak and hopeless, or that the current systems that are in place are inherently flawed. There are many things that the community of Thunder Bay is doing right in relation to addressing the harms associated with substance use. However, in a largely problem-focused and reactive society, it seems that in order to draw attention to the need for change, evidence regarding the scope and depth of the issue is necessary.

Stephanie Hendrickson

The International Context:

Substance use in Canada, including in Thunder Bay, is connected to a range of complex global issues that ultimately impact upon our community. Therefore, it makes sense to examine the global context when considering possibilities for the creation of an innovative local drug strategy.

With today's ever-growing global economy, assets and goods can be transferred more easily than ever before, which along with contributing to other types of business and trade, also adds to the sophistication of the drug trafficking industry worldwide.[1] The drug trade is a multi-billion dollar business with no limits on where its products can permeate. While the City of Thunder Bay may not be a main entry point in North America for illegal drugs like the seaport city of Vancouver, Thunder Bay is nonetheless the geographic centre of Canada, considered to be a regional hub, and is the "Gateway to the Great Northwest."[2] Thunder Bay joins the east and west of Canada and is located on the Trans Canada Highway - one of, if not the most-travelled highway in the country.

Canada is a member of three key international treaties that pertain to the production, distribution and consumption of both legal and illegal substances: the *Single Convention on Narcotic Drugs* (1961) aims to combat drug abuse by coordinated international action;[3] the *Convention on Psychotropic Substances* (1971) establishes controls over a number of synthetic drugs according to their abuse potential (while still taking into account their therapeutic value)[4] and the *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (1988) provides measures against drug trafficking.[5] These are all UN treaties monitored by The International Narcotics Control Board (INCB).

In its latest annual report (2008) the INCB noted key challenges that the international drug control conventions were facing. Chief among their concerns were health-related challenges, legal challenges, the challenge of drug abuse prevention, and the challenges of globalization.[6] Some of the challenges being faced at the international level are the very same challenges that we are dealing with currently in the community of Thunder Bay. In February of 2010, the INCB board issued a warning stating that prescription drug abuse is growing around the world. In Canada, it is estimated that 1 to 3 percent of the population currently abuses prescription opioids.[7]

Another consideration when looking at the international picture is to consider where the drugs that end up in our city are actually coming from. It has been shown that Canada is the world's third-highest consumer of prescription opioids; there are also strong correlations between medical availability and prescription opioid abuse, as well as treatment and mortality indicators.[8] Thunder Bay has been experiencing an increase of such issues, especially regarding prescription opioids such as OxyContin and Percocet.

OxyContin is a product of the pharmaceutical company Purdue Pharma, headquartered in the United States. OxyContin first hit the market in 1996, and was first deemed to be a

[1] An Environmental Scan prepared for the Toronto Drug Strategy Initiative. (2005).
[2] City of Thunder Bay Website. (2009).
[3] United Nations Office on Drugs and Crime. (2010).
[4] International Narcotics Control Board. (2010).
[5] Ibid.
[6] The international drug control conventions: history, achievements and challenges. (2008).
[7] The Vancouver Sun. (24 Feb., 2010). U.N. narcotics board warns of prescription drug abuse.
[8] Fischer & Rehm. (22 Feb., 2010). Scientific Conclusions of Drug Policy and the Public Good.

'miracle drug' because it was supposed to be more effective and less addictive than other pain relievers. Approximately ten years after OxyContin was added to drug formularies, current and former executives of Purdue Pharma pleaded guilty to charges of misleading the public about the safety of the drug. The case brought against Purdue Pharma resulted in one of the largest fines to ever be imposed on a drug company – 634.5 million dollars.[9] When OxyContin was first being marketed, the company claimed that it was less addictive than other painkillers and therefore had less potential for abuse; today it is widely known that such claims could not be further from the truth. Oxycodone is extremely potent and thus has a high potential for abuse and dependency, especially when altered from its pill form.

The concern surrounding the non-medical use of such substances is complex, since drugs such as prescription opioids are not only legally prescribed medications for legitimate pain relief, but they are also aggressively marketed by large pharmaceutical companies. Our own national policies here in Canada also pose barriers to addressing what many see as a pressing issue. Looking at the national context, which includes Canada's National Anti-drug Strategy, sheds light on some of these barriers.

The National Picture:

National Anti-drug Strategy (2007)

The National Anti-Drug Strategy replaced Canada's former Drug Strategy in 2007. Canada's first federal drug strategy, introduced in 1987, acknowledged that substance abuse was primarily a health issue.[10] In 2003, Canada's Drug Strategy was described as, "an initiative to reduce the harm associated with the use of narcotics and controlled substances and the abuse of alcohol and prescription drugs."[11]The strategy aimed to address the underlying factors associated with substance use and abuse.

With the introduction of the new National Anti-Drug Strategy in 2007, the acceptance of substance abuse as being primarily a health issue was lost, along with the notion that the reduction of harm should be the primary purpose of national drug policy. While acknowledging that generous federal funding through Health Canada has enabled the City of Thunder Bay to have the opportunity to develop a community-specific municipal drug strategy, it is nonetheless necessary to draw attention to the fact that Canada's current National Anti-Drug Strategy is not only lacking a focus on reducing the harms caused by substance use, but is missing the harm reduction pillar entirely. Harm reduction has been described as being "any program or policy designed to reduce drug-related harm without requiring the cessation of drug use."[12] The harm reduction philosophy has wide-ranging applicability and in its basic premise is something that we all practice in our day-to-day lives, through the use of things like seatbelts or designated drivers, for example.

Under the National Anti-Drug Strategy there are three specific areas of focus: prevention, treatment, and enforcement. The strategy's explicit aim is to, "take action against illicit drugs to contain the growth in supply and demand."[13] The current national strategy focuses on illicit drugs and places an emphasis on issues pertaining to youth. While it is certainly vital to focus on prevention strategies aimed at youth and to tackle

[9] Medical News Today. (15 May, 2007).
[10] Legislative Summary. (2009). Library of Parliament.
[11] Ibid.
[12] CAMH. (2002). CAMH and Harm Reduction.
[13] Government of Canada. (2007). The National Anti-Drug Strategy.

issues associated with the large-scale trafficking of illegal drugs, the National Anti-Drug Strategy has been criticized for ignoring the importance of harm reduction as being part of a comprehensive approach.[14] The National Anti-Drug Strategy is led by the Department of Justice rather than Health Canada, which signifies the shift to an emphasis on supply reduction and punishment instead of demand reduction and decreasing the harms associated with substance use.

In addition to the loss of the harm reduction pillar (which equates to a loss of funding for harm reduction initiatives) the National Anti-Drug Strategy has also been criticized for its sole focus on illicit drugs to the exclusion of alcohol, prescription drugs, or the abuse of other legal substances such as solvents.[15] Meanwhile, it has been reported that OxyContin has surpassed heroin in popularity among intravenous drug users in Toronto, and has also overtaken crack cocaine as Ottawa's most commonly abused drug.[16] In the community of Thunder Bay, we are also experiencing myriad problems that pertain to legal drugs, namely alcohol and the non-medical use of prescription opioids. It is therefore imperative that the impact of these substances not be ignored. Internationally renowned researchers of *Drug Policy and the Public Good* also support the notion that differential drug use patterns and needs require locally differentiated interventions.[17] The aim of the Thunder Bay Municipal Drug strategy will thus need to be innovative and somewhat divergent from the National Anti-Drug Strategy.

The Controlled Drugs and Substances Act (CDSA):
In Canada, the Controlled Drugs and Substances Act enforces the control of certain drugs, their precursors, and other substances; drugs are categorized by schedules,[18] for example:

Schedule I – Opium poppy, its preparations, derivatives, alkaloids and salts (cocaine is also in this schedule)
Schedule II – Cannabis, its preparations, derivatives and similar synthetic preparations
Schedule III – Amphetamines and lysergic acid diethylamide (LSD)
Schedule IV – Barbiturates, their salts and derivatives (including benzodiazepines)
Schedules V and VI - contain precursors required to produce controlled substances
Schedules VII and VIII - contain amounts of cannabis and cannabis resin required for charging and sentencing purposes.

There are currently no mandatory prison terms under the CDSA (which the Conservative government is currently trying to amend), but the most serious drug offences have a maximum penalty of life imprisonment.[19] The offences in the Act include possession, "double doctoring," trafficking, importing and exporting, and the production of substances included in the schedules of the CDSA.[20] The punishment for the offence depends on which schedule the drug in question applies to.[21]

[14] CAMH. (2008). The National Anti-Drug Strategy: A CAMH Response.
[15] Ibid.
[16] CBC. (3 Mar., 2010). OxyContin more abused than crack: rehab centre.
[17] Fischer & Rehm. (22 Feb., 2010). Scientific Conclusions of Drug Policy and the Public Good.
[18] Department of Justice Canada. (1996, c.19). Controlled Drugs and Substance Act.
[19] Legislative Summary. (2009). Library of Parliament.
[20] Ibid.
[21] Ibid.

Bill C-15:
In accordance with the federal government's National Anti-Drug Strategy, Bill C-15 was put forward in 2009; it died with the recent proroguing of parliament, but the Conservatives have stated their intent to reintroduce the bill in its original form (i.e. without the amendments that were suggested in 2009). This bill would largely impact how drug offences are defined and prosecuted in Canada. The purpose of Bill C-15 is to amend the Controlled Drugs and Substances Act and to make "related and consequential amendments to other Acts."[22] This bill would impose mandatory minimum sentences for serious drug offences, including possession for the purpose of trafficking, production, and importing/exporting.[23] The bill would also increase the maximum penalty for cannabis production and reschedule certain substances from Schedule III of the CDSA to Schedule I.[24] The term 'serious,' however, is quite subjective and thus requires further examination.

Some implications of this bill would include: people caught growing one or more marijuana plants could be sentenced to a minimum of six months in jail; if plants are grown on a property that belongs to another person or in an area where it may present a hazard to children, minimum jail time is nine months.[25] Bill C-15 also includes trafficking provisions that require mandatory imprisonment of at least two-years for any person found to have trafficked drugs on "school grounds."[26] As a consequence of this, youth could find themselves in contact with the law more frequently, and subsequently having to deal with the implications of having a criminal record at a young age. Concern has also been raised regarding the definition of trafficking in the CDSA and what the implications of this new legislation could be. Under the CDSA, "traffic," in to respect substances included in Schedules I to IV means: "to sell, administer, give, transfer, transport, send or deliver the substance."[27] "Trafficking" then, could apply equally to those who sell a large amount of what they have produced for profit, as to those who give a small amount to friends for free.[28]

Critics of the bill such as the Centre for Addiction and Mental Health suggest that mandatory minimum sentences are not an effective response to illegal substance use and are encouraging the conservative government to reconsider their approach. Others agree that this bill is based on the U.S.'s 'war on drugs' ideology, which has not been successful in decreasing drug use and crime, but instead has resulted in bringing prison populations to the point where, in the United States, one in one-hundred adults is in prison, and one in thirty-one adults is under some form of correctional control.[29]

There is a call for policies based on evidence rather than ideology. Authors of *Drug Policy and the Public Good* concluded in their extensive international analysis that there is virtually no scientific evidence that supports repression (supply control) and enforcement efforts as an effective solution to the 'drug problem.'[30] The researchers suggest that the same standards need to be established for enforcement efforts as those that apply to treatment, prevention and other public health measures.[31] The other pillars

[22] Legislative Summary. (2009). Library of Parliament.
[23] Ibid.
[24] Ibid.
[25] Pablo, Carlito. (2009). Bill C-15 could fill Canadian prisoners with drug offenders.
[26] Legislative Summary. (2009). Library of Parliament.
[27] Canadian Civil Liberties Association. (2009). Submissions of the Canadian Civil Liberties Association Re: Bill C-15.
[28] Ibid.
[29] The Pew Charitable Trusts. (2001). One in 31: The Long Reach of American Corrections.
[30] Fischer & Rehm. (22 Feb., 2010). Scientific Conclusions of Drug Policy and the Public Good.
[31] Ibid.

largely rely on best practices and evidence-based interventions, but enforcement does not seem to follow the same principles.

It is reported that in 2006–2007, about half of all drug-related court cases were stayed, withdrawn, dismissed or discharged, due to resolution discussions, lack of evidence, or referral to court-sponsored diversion programs.[32] If Bill C-15 were to pass, it is feared that Canada's prison population would increase exponentially. This bill will likely be reintroduced with a new name in the near future. At a time when countries around the world are enacting what have been referred to as 'radical' drug policy reforms (e.g., Mexico has decriminalized the possession of small amounts of most illicit substances), Canada seems to be moving backwards when it comes to drug policy by choosing to follow old U.S. models, which have proven to be ineffective.

Sentencing Drug Users to Prison:
Sentencing people with substance use issues to prison makes little sense from a public health perspective. Firstly, it is no secret that drug use continues even when people are incarcerated: just because people are behind bars, it does not mean that they are automatically abstinent. In fact, a survey by Correctional Services Canada (CSC) showed that 38% of prisoners have used illicit drugs while in custody; 11% of which used injection drugs.[33] Research has actually shown that IV drug-use patterns are similar whether a person is in prison or not.[34]

Prison populations also have a disproportionate number of individuals with infectious diseases: rates of Hepatitis C (HCV) and HIV/AIDS are said to be 10 to 20 times higher in prison populations when compared to the general population.[35] Further, without the provision of harm reduction measures (and more than simply supplying inmates with bleach for syringes, which some prisons currently do) more people are leaving prison being infected with a disease than they did going in. Data has shown that among newly-admitted prisoners, the HCV infection rate in males is 9%, and in females, 31%; the prevalence rate in the general prison population is 27% for males, and 36% for females.[36] HIV/AIDS incidence rates similarly increase from the time individuals are admitted to prison compared to later on in their sentence.[37]

There are currently more than 60 prisons worldwide that have prison needle-exchange programs, including Europe, Asia and the Middle East.[38] Evaluation of these programs have consistently shown that prison needle-exchange programs do not lead to an increase in drug use, and the programs have not resulted in the syringes being used as weapons.[39] Considering that 90% of prisoners return to society, it does not seem to make sense on either a moral or financial level to send people, which already tend to suffer from addiction and mental health issues, back to the community sicker than when they entered prison.[40] The act of sentencing drug users to prison also means that individuals will not likely receive the treatment needed in order to be able to examine their substance use problem.

[32] Legislative Summary. (2009). Library of Parliament.
[33] Picard, Andre. (Feb., 2010). The lack of needles and the damage done. Globe & Mail.
[34] Ibid.
[35] Ibid.
[36] Ibid.
[37] Ibid.
[38] Ibid.
[39] Ibid.
[40] Ibid.

The Provincial Picture:

Ontario does not currently have a fully-developed drug strategy in place, although a provincial level drug strategy framework has been drafted. The provincial drug strategy framework puts forward a comprehensive approach to alcohol and legal/illegal drugs, promotes a coordinated and balanced approach to health and safety, embraces a multi-sector perspective, and has the goal of providing a common frame-of-reference for provincial priorities.[41] A provincial framework would encompass all four pillars (prevention, treatment, harm reduction and enforcement) and focus on harmful substances as a whole: alcohol and other drugs, both licit and illicit.

At the provincial level, work is also being done to implement a ten-year mental health and addictions strategy. Treatment and mental health professionals alike have long since recognized that these two issues are inextricably linked. *Every Door is the Right Door* is a discussion paper that was put forward in 2009 by former Minister of Health and Long-Term Care Daivd Caplan; the strategy is now being carried forward by the new minister Deb Matthews. The aim of this strategy is to transform mental health and addiction services in Ontario to better meet the needs of individuals, and to identify ways to create the necessary conditions to foster optimal health and wellbeing in communities.[42] The *Minister's Advisory Group on Mental Health and Addictions* is expected to release their final report of recommendations sometime in 2010; the results will come out of hearings that were held with consumers/survivors, providers, experts, government and other interested parties.[43]

Municipality of Thunder Bay Drug Policy:

Currently, a comprehensive drug strategy or policy does not exist for the City of Thunder Bay. Work is underway to produce a community-specific strategy aimed at meeting community needs and concerns. The strategy aspires to be evidence-based, not ideologically-driven and focuses on the pressing needs as identified by our community. The strategy involves the collaboration of community leaders, treatment professionals, individuals in recovery, concerned citizens, and other professionals, working toward a common vision and goal of improving the health, safety and wellbeing of all citizens.

[41] Caverson, Reggie. (2008). Developing an Ontario Drug Strategy: progress, challenges & implications.
[42] Ministry of Health & Long-Term Care. (2010). Minister's Advisory Group on Mental Health and Addictions.
[43] Ibid.

Societal Views of Addiction:

There are a range of models and perspectives used when it comes to attempting to explain the etiology of addiction. Knowledge of such models is important as they largely guide policy, programs and services, and societal beliefs surrounding addiction and individuals who suffer from addiction.[44] While each model is not necessarily mutually exclusive, some of the common addiction models are grouped into the following: the moral model, psychological models, family models, the disease model, biological models, sociocultural models, and multicausal or biopsychosocial models.[45] Three of the most common are briefly discussed below.

Moral Model:

Proponents of the moral model see addiction as being a result of personal choice and consequently, that individuals engaging in addictive behaviours are capable of making alternative choices. The moral model guides approaches that tend to place an emphasis on punishment. While present-day scholars generally discredit this model, the concept that addiction is a sin or moral weakness continues to influence public policy.[46] This model appears to continue to persevere in the U.S. and more recently in Canada, as indicated by the implementation of the National Anti-Drug Strategy and the recently proposed bill (C-15) that would, for the first time in Canadian history, impose mandatory minimum sentences for drug-related offences.

Disease Model:

In the context of the disease model, addiction is viewed as a primary disease; one that is progressive, chronic and incurable.[47] For this reason, this model contends that the goal for the addicted person needs to be abstinence. This approach is also somewhat controversial. While equating addiction with disease removes the moral stigma associated with addiction and emphasizes the need for treatment of the illness, opponents of this model argue that the progression of addiction through the proposed stages does not always occur, and that the disease concept may promote the idea for some individuals that since addiction is a disease, they are powerless over it, and thus are not responsible for their behaviour.[48] This approach is that taken up by groups such as Alcoholics Anonymous.

Biopsychosocial Model:

In contrast to the traditional theories, biopsychosocial models have been developed to explain the complex interaction between the biological, psychological, and social aspects of addiction. This is the model that is most widely endorsed by treatment researchers because it can most adequately explain the complex nature of addiction.[49] It is considered to be a much more holistic model and usually also includes the facet of spirituality. Since its conception other researchers have expanded the concept of the biopsychosocial model to reflect the multiple pathways to addiction: genetic predisposition, learned behaviour, the need for self-medication, and the impact of one's family.[50] The study of epigenetics has also emerged, which considers the ways in which a person's genes are actually shaped by the environment s/he is immersed in.

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[44] Capuzzi & Stauffer. (2008). Foundations of Addictions Counselling.
[45] Ibid.
[46] Ibid.
[47] Ibid.
[48] Ibid.
[49] Sunshine Coast Health Centre. (2009).
[50] Ibid.

ISSUES, IMPACTS & INTERCONNECTIONS OF SUBSTANCE USE:

Substance use is linked and interconnected to a multitude of issues. The complexity of this topic cannot be understated. The following submission is by no means exhaustive, but is meant to be a starting point for discussion about the local needs/issues in Thunder Bay.

Connections Between Substance Use and Crime:

Connections between substance use and crime are well established. Research has shown that a large amount of offences are committed by people who are under the influence of drugs and/or alcohol. Many crimes, such as property crimes in particular, are often committed as a means to obtain money to purchase drugs, and a large amount of the individuals who are incarcerated in Ontario report current problems with alcohol (42%) and drugs (45%).[51] Drug offences have also shown to be linked to organized crime, gang activity, and prostitution. The possession and trafficking of drugs is merely the tip of the iceberg when it comes to the enforcement-related implications of substance use; for example, alcohol use is correlated with domestic violence, a large-scale issue in itself.

Law Enforcement Costs:

The estimated annual policing costs in Ontario attributed to alcohol are $811 million and account for 30.8% of all crimes.[52] Policing costs associated with illegal drugs are $603 million per year (22% of all crimes).[53] A statistic provided by local enforcement officials indicates that 1 million dollars in Thunder Bay is spent per year on policing costs pertaining to the arrests of intoxicated persons alone.

The Drug Policy and Public Policy Group, which consists of scholars from around the world, proposes that recognition of the cost-benefit limits and other counterproductive results of trying to repress the drug problem are needed.[54] They suggest that the saved resources from enforcement efforts could be spent in the other pillars of prevention, treatment and public health measures.

Drug Offences:

According to Statistics Canada, in 2007, the total number of police-reported drug offences in Thunder Bay was 355, with a large percentage of arrests being related to cannabis (254/355), followed by cocaine (54/355); heroin accounted for only one arrest in 2007, and 'other drugs' accounted for 46 out of the 355 offences.[55] The category 'other drugs' includes, "all other illicit drugs not otherwise stated, e.g. crystal meth, ecstasy, "date rape" drugs, LSD, barbiturates, chemical precursors, etc.[56]

The overall rate of drug offences, according to the most recent data available, has officially gone down in Thunder Bay. In 2002, Thunder Bay had the highest rate of drug offences in the country with a rate of 571 per 100,000, topping even Vancouver. In 2007, the rate was down to 289.7 per 100, 000 population, putting Thunder Bay at the 17th highest rate out of 28 Canadian cities.[57]

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[51] Caverson, Reggie. (2008). Developing an Ontario Drug Strategy: progress, challenges & implications.
[52] Rehm et al. (2002). The Costs of Substance Abuse in Canada.
[53] Ibid.
[54] Fischer & Rehm. (22 Feb., 2010). Scientific Conclusions of Drug Policy and the Public Good.
[55] Dauvergne, Mia. (2009). Statistics Canada.
[56] Ibid.
[57] Statistics Canada. (2007). Police-Reported Drug Offences by census metropolitan area.

However; the same *Juristat* (Statistics Canada) report showing that the rate of drug offences in Thunder Bay had decreased also declared that in 2007, the police-reported rate of drug offences nationally had reached its highest point in 30 years.[58] Interesting, is that in the "Notes" section of this report it is revealed that, "Beginning in April 2008, the Incident-based Uniform Crime Reporting Survey began capturing information on two new types of drugs: methamphetamine (crystal meth) and methylenedioxyamphetamine (ecstasy).[59] The following question may then be raised: would adding two new classes of drugs to the reporting practices not dramatically impact the overall statistical rate of drug offences?

Thus, a note of caution is warranted when looking at official police-reported drug offences and statistics in general for that matter. The problem with statistics is that they can be interpreted in a number of different ways. Does the drop in the rate of drug offences in Thunder Bay mean that less people are using and selling drugs? Does it mean that the local police are not doing their jobs efficiently? There are many variables that could be contributing to the apparent drop in drug offences in Thunder Bay, just as the apparent increase nationally may not be attributable to an actual increase in drug use or drug crimes, but rather to a different way of recording and classifying drug-related offences.

Drop in Reported Drug Offences in Thunder Bay:
When considering the reported drop in Thunder Bay drug-related offences, certain questions need to be raised. Firstly, it is not entirely clear if arrests related to licit drugs such as OxyContin and other prescription pills are included in the national statistics. In fact, prescription opioids are not at all mentioned in the *Juristat* report (and an email sent to Statistics Canada requesting clarification was not answered after two-plus months). These legal drugs that can be used illegally (by being sold, "double-doctoring," etc.) pose challenges to law enforcement, since by and large prescription drugs are obtained through legal (although at times questionable) means. The possession of a licit drug is legitimate if the holder has a prescription and is not carrying an excessive amount. This creates what has been described as somewhat of a grey area for law enforcement: generally, individuals need to be caught selling prescription pills, or found with a large quantity of pills in order to be charged with possession and/or trafficking.

When thinking critically about the apparent drop in drug-related offences then, it is important to question whether this actually indicates a drop in drug use and drug trafficking, or perhaps merely a shift in the primary substances being used. It is not unlikely that an increase in the use of prescription opioids may, at least in part, account for the lower rate of nationally reported drug-related offences in Thunder Bay.

Local Enforcement Concerns:
Various local sectors have identified that there is a serious drug (and alcohol) issue in Thunder Bay, including City Police officials. Thunder Bay's Chief of Police has acknowledged in the media that there are prescription and intravenous drug use problems in the community.[60] There have been numerous drug store robberies and attempted robberies in the city in efforts to obtain prescription drugs. In addition, there have been incidences of people driving vehicles into local beer stores in order to obtain alcohol (at least twice in the past six months alone); this has become such an issue that

[58] Dauvergne, Mia. (2009). Statistics Canada.
[59] Ibid.
[60] CBQ FM Radio. (15 Oct., 2009). Great Northwest News hour 2.

these establishments are considering adding concrete barriers to their storefronts in an effort to prevent this from happening in the future. Just recently, there was a drug bust in which $30,000 worth of Oxycodone was seized.[61] In addition to the pills and $7,000 cash that were found at the scene, $50,000 was also seized from a safety deposit box,[62] indicating this was a fair-sized operation. This is just one example of the many drug busts that have occurred recently in the city of Thunder Bay.

Law enforcement officials in Thunder Bay assert that marijuana possession and sales, and cocaine possession and sales, continue to be local trends in drug trafficking. A newer trend that law enforcement is seeing however, is that prescription drugs are increasingly becoming the drug of choice to sell, for numerous reasons: 1) There is a big profit margin to be made on prescription pills that are largely covered by health insurance; 2) prescription pills are accessible; and 3) there are sources out there that are supplying prescription pills in large amounts.[63] From April 2008 to March 2009, 44,300 grams of prescription narcotics were seized in Thunder Bay.[64] The highly addictive nature of these substances contributes to their high demand, and the fact that pills are easy to conceal also poses challenges to law enforcement.

According to local police officials, there are several harmful impacts of illicit drug trafficking; it is correlated to violent crime (e.g. competition between rival dealers, robberies to obtain funds for purchases) and it is also highly correlated to property crimes (e.g. break and enters), as mentioned previously.[65]

Community Policing:
A shift in Community Policing recently occurred in Thunder Bay. At one time, there were seven Neighbourhood Policing stations located throughout the city, primarily in areas that were recognized as being in need of a greater police presence; however, it has been announced that neighbourhood policing through these locations will soon cease to exist and instead, local Community Policing will be moving towards a 'foot patrol' approach. The Beat Patrol Program will have six designated officers and provide permanent coverage in the downtown north- and south-cores. Chief of Police Bob Herman has also stated that there will be a 'Focused Enforcement Team' put into place to address specific problems within neighbourhoods and the downtown cores. [66]

Intoxicated Arrests:
Arrests associated with alcohol use are indisputably high in Thunder Bay. The arrest of intoxicated persons is the number one reason for arrest in our city and comprises about half of all arrests.[67] In a recent presentation to City Council, the Chief of Police made connections between poverty and substance abuse, stating that the two fuel crime and disorder, increase stress on families and individuals, and directly impacts the amount of calls to police for service. The arrest rate in Thunder Bay for intoxicated persons is an overwhelming 2,608 per 100,000, which is the highest in all of Ontario.[68] For comparative reasons, a list of Ontario arrest rates for intoxicated persons per 100,000 population is provided below:

[61] The Chronicle Journal. (18 Mar., 2010). Pills, cash seized, 2 women arrested.
[62] Ibid.
[63] Inspector with Community Police Services. (Mar., 2010). Addictions and the Impact on Policing and the Community.
[64] Ibid.
[65] Ibid.
[66] Chief of Police Bob Herman. (25 Mar., 2010). TBT News.
[67] Ibid.
[68] The Chronicle Journal. (12 Feb., 2010). P. A-6.

Thunder Bay	2,608
Timmins	969
North Bay	731
Guelph	627
Windsor	408
Barrie	399
Kingston	385
Sudbury	279

According to police officials, 96% of these arrests are adults and 73% are male. From an enforcement perspective the significance of this issue is that officer time taken to deal with both public intoxication and mental health issues is increasing annually and impacts on the ability of the police to address other core policing functions.[69] The Chief of Police has suggested that the police cannot address this complex issue alone, and that money is needed in our community for treatment, diversion, and mental health.[70]

Withdrawal Management Concerns Across Multiple Sectors:
The issue of high rates of intoxicated individuals resulting in police intervention has contributed to the notion that Thunder Bay is lacking in the amount of withdrawal management beds necessary to accommodate people needing a place to go while intoxicated. While it is widely agreed that more withdrawal management beds in Thunder Bay are needed, treatment professionals may disagree that adding more detoxification beds is the panacea to this widely acknowledged and publicized issue.

Balmoral Centre has a total of 7 beds available for crisis withdrawal management.[71] These beds are often full and it has been said that Balmoral Centre regularly operates at over 100% capacity. It is estimated that Balmoral Centre unavoidably turns away about 1000 people per year, largely due to a lack of available beds.[72] One of the purposes of the Balmoral Centre is to provide a safe environment for individuals withdrawing from alcohol and/or drugs;[73] however, the assumption or idea behind this is that the person *wants* to withdraw: all services offered are voluntary.

The fact is that many of the individuals that end up spending the night in jail, in the emergency department of the hospital, or at the local detoxification centre, are chronically publicly inebriated and either homeless or under-housed. Individuals arrested for public intoxication generally spend between 6 and 14 hours in a jail cell, and it is not uncommon for chronic alcohol users to be back at the police station 2-3 hours after their release.[74] While such individuals make up a relatively small portion of the population, this group utilizes a disproportionate amount of community resources and tax-payer dollars through the use of emergency and hospital services, emergency transportation, detoxification services, court, and jail services. Individuals that make up this segment of the population are often involved in the 'revolving door syndrome' of service systems, are homeless or under-housed, and unable to sleep at one of the few shelters in Thunder Bay due to their intoxicated state.

[69] Chief of Police Bob Herman. (2010). Presentation to City Council.
[70] CBQ FM Radio. (15 Oct., 2009). Great Northwest News hour 2.
[71] CAMH Opiate Project. (2009). A Discussion Paper: Opioid Abuse Issues and Treatment Needs in Thunder Bay.
[72] Inspector with Community Police Services. (Mar., 2010). Addictions and the Impact on Policing and the Community.
[73] St. Joseph's Care Group. (2010). Withdrawal Management Programs.
[74] Inspector with Community Police Services. (Mar., 2010). Addictions and the Impact on Policing and the Community.

In the same way that many police officers and ED personnel have expressed that these individuals should not be spending the night in a jail cell or in the ED, it is also questionable as to whether a withdrawal management centre is the most appropriate place for such individuals.

In recognition of issues such as that described above, some cities have taken innovative steps to try and alleviate this problem. For example, in Minneapolis MN, a project named Anishinabe Wakiagun ("The People's Home") was put into place. This development provides 40 units of affordable and supportive-housing for low-income, chronic-stage alcoholic Native American homeless men and women.[75] The project does not demand sobriety of its residents, but alcohol and drugs are not permitted on the property; tenants have access to a meal program, social and health services and recreational activities, and residents are encouraged, but not required to participate in the offered programs.[76] These types of developments have shown to be effective in numerous studies. One study done on Anishinabe Wakiagun and The Glenwood (also in the U.S.) showed that there were significant reductions in emergency room use (26%), jail (41%), and detoxification facilities (32%).[77]

These types of initiatives are controversial, however cost-benefit analyses have indicated that it may be less expensive to offer harm reduction services to this segment of the population, rather than to continue to rely heavily on community resources. Research from the National Institute of Alcohol and Drug Abuse indicates that **less than 5% of the population** with this type of profile ever become abstinent for the remainder of their lives.[78] Thus, the question should be raised if it makes sense to continue to keep doing things the same as way we have been in Thunder Bay, or to try a different approach; one that is evidence-based and has proven to make a difference in relation to both financial and quality of life indicators.

Impaired Driving Charges in Thunder Bay:
Ontario toughened its impaired driving laws in May 2009 when the legal limit was reduced from a blood alcohol concentration not exceeding 0.08 to a blood alcohol concentration not exceeding 0.05.

The following are impaired driving statistics for the year of 2008, and from January 1st to September 30, 2009:[79]

Jan 1, 2008 - Dec 31, 2008	160 impaired charges
Jan 1, 2009 - Sept. 30, 2009	117 impaired charges

While these statistics do not tell us much in isolation, it will be interesting to examine the finalized statistics from 2009, to see if there was an impact of the new legislation on impaired driving charge rates in Thunder Bay.

[75] Anishinabe Wakiagun. (Not dated). Website.
[76] Ibid.
[77] Downtown Emergency Service Centre. (13 Dec., 2005). Seattle Press Release. DESC celebrates opening of new housing for homeless alcoholics.
[78] Ibid.
[79] Statistics provided by Thunder Bay Police Services. (2010).

Health and Substance Use:
There are many health-related impacts of substance use, such as accidental injury, chronic illness, injuries as a result of violence, self-harm, overdoses, mental health complications, etc.

Health Care Costs in Ontario:
Besides the indirect costs of productivity losses, the biggest single direct cost associated with substance use is direct health care costs (followed by direct law enforcement costs).[80] Health care costs in Ontario attributed to alcohol, which include intentional/unintentional injury, chronic disease, infectious disease, and addiction, are $1.16 billion; health care costs attributed to illegal drugs are $373 million.[81] Alcohol is said to be Ontario's number one drug problem and alcohol-related injury accounts for $440 million of health care costs in Ontario each year.[82] Also noteworthy is that it is estimated that 40-60% of suicide victims are intoxicated at the time of death.[83]

Thunder Bay Regional Health Sciences Centre (TBRHSC) Statistics:
In 2008/09, there were a total of 1,659 visits to the Emergency Department (ED) for substance abuse conditions in Thunder Bay.[84] The two leading substance abuse conditions resulting in ED visits were alcohol (75.5%) and opioids (11.8%).[85] The average ED length of stay for substance abuse-related visits was 4.9 hours compared to the provincial ED length of stay of 6.4 hours.[86] On average, there was a 1.1 hour wait for assessment by a physician, and just 5% of substance abuse patients were admitted to the hospital as an inpatient[87] while 78.2% of substance abuse clients were discharged home with no supports.[88] The average age for substance abuse patients was 36.7, and 11.2% of substance abuse patients were under 18 years of age.[89]

Hepatitis C in the District of Thunder Bay:
Hepatitis C (HCV) is a serious chronic disease with significant long-term complications. The Thunder Bay District has the second highest prevalence rate of HCV in all of Ontario after Kingston (which also has a large federal prison population that significantly impacts the city's prevalence rate).[90] Certain subpopulations have extremely high rates of HCV: injection drug use is by far the most common route of infection.[91] In 2007, 80% of new HCV cases in Ontario were among injection drug users.[92] While the Hepatitis C incidence rate is dropping in Ontario overall, cases are actually increasing in Thunder Bay. In 2007, there were 136 new confirmed cases, or 87.7 per 100, 000 population.[93]

Invasive Group A Streptococcal Disease (IGAS):
Over the period of 2007-2009, there was a large outbreak of IGAS in Thunder Bay and the surrounding district, which resulted in 14 deaths. This two-year long outbreak had a

[80] Rehm et al. (2002). The Costs of Substance Abuse in Canada.
[81] Ibid.
[82] Ibid.
[83] Ibid.
[84] Profile Communities Local Data. (31 Mar., 2010) Mental Health and Addictions Quality Improvement Forum: Toronto.
[85] Ibid.
[86] Ibid.
[87] Ibid.
[88] Ibid.
[89] Ibid.
[90] Thunder Bay District Health Unit. (2010).
[91] Ibid.
[92] Ibid.
[93] Ibid.

rate that was approximately 9 times the expected rate. The population group most affected by IGAS had similar characteristics to those who are at an increased risk of contracting HCV: street-involved injection drug users were over-represented, as were Aboriginal individuals and those who were under-housed.[94]

Street Outreach Nursing:
In response to community needs, a street nursing program was put in place through the Thunder Bay District Health Unit.

The Street Outreach Nursing Program provides street-level services aimed at assessing and addressing the needs of the street-involved population. Services are free, confidential and include:

- Counseling and Referral to Services
- Harm Reduction Services
- Infectious Disease Follow-Up
- STI (Sexually Transmitted Infections) Testing and Treatment

In 2009, the Street Nursing team saw a total of 435 clients. There were slightly more male service-users (183/435) than female service users (145/435). Street Nursing data shows that the most serviced population group were males aged 50-59, followed by females aged 30-39. The most common risk factor appeared to be homelessness or being under-housed. The services provided in order of frequency were vaccinations, STI testing, treatment, wound care, and referrals.[95]

Ontario Opioid Overdose Study:
A study released from the Canadian Medical Association in December 2009, shows that opioid-related deaths in Ontario have increased markedly since 1991; a significant portion of this increase is associated with the introduction of oxycodone and from 1991 to 2004, opioid-related deaths doubled from 13.7 per million to 27.2 per million.[96]

Prescriptions of oxycodone increased by 850% between 1991 and 2007; the addition of oxycodone to the Ontario drug formulary is associated with a 5-fold increase in oxycodone-related deaths and a 41% increase in overall opioid mortality.[97] The majority of deaths were determined to be unintentional (54.2%), death was determined suicide in 23.6% of cases, and was unable to be determined in 21.9% of cases.[98] Health care services were commonly used in the month before death: 66.4% had visited a physician in the month before death and 56.1% had filled a prescription for an opioid in the month before death, which suggests missed opportunities for prevention/intervention.[99]

Of the 3,406 deaths from 1991-2004, the median age was 40 and 67% were men.[100] The analysis in this study strongly supports the researchers' hypothesis that increased rates of opioid prescriptions contribute significantly to morbidity and unintentional opioid-related death.

[94] Thunder Bay District Health Unit. (2010).
[95] Ibid.
[96] Irfan A. Dhallla MD MSc, et al. (2009). Canadian Medical Association Journal.
[97] Ibid.
[98] Ibid.
[99] Ibid.
[100] Ibid.

The authors of the study provided numerous recommendations regarding the prescribing practices of this potent drug. They suggest that a general increase in awareness among doctors may help to reduce the undesirable health consequences of opioid prescribing. They also suggest specific intervention practices that could be put into place, such as:

- Real-time electronic databases accessible to physicians and pharmacists that would make it harder for people to "double-doctor" and possibly reduce the risk of harmful drug interactions.[101]
- More education for pharmacists and doctors about the relative potency of different opioids, the use of physician-patient contracts in opioid prescribing, outpatient care of opioid-dependent individuals, and education about the potential interaction of opioids with other central nervous system depressants.[102]
- In some instances, doctors could use urine toxicology assays when prescribing opioids to help identify illicit drug use and drug diversion;[103] and lastly,
- Formulary restrictions could be used to deter the prescribing of pharmaceuticals with a high potential for abuse.[104]

There is nationwide concern surrounding the prescribing practices of prescription opioids and work is currently underway to develop comprehensive guidelines in order to provide procedures for doctors to follow when considering whether or not to prescribe narcotic medications to patients.

The non-medical use of prescription drugs has shown to cross all socioeconomic levels and to affect all age groups. However, information from the Canadian Centre on Substance Abuse indicates that, in general, adolescents, older adults, women and Aboriginal people are at elevated risk to abuse prescription drugs.[105] Considering the large proportion of aging citizens and growing Aboriginal population, it seems imperative that steps be taken in Thunder Bay to guard against this growing issue.

National Opioid Use Guideline Group (NOUGG):
NUOGG was established in 2007, as a response to the perceived need for national standards for regulators of prescription opioids.[106] As a result, The Colleges of Physicians and Surgeons from each province are now collaborating on an initiative designed to produce and implement a national consensus guideline on opioid use.[107] The initiative's goal is to, "assist doctors to effectively manage patients with chronic non-cancer pain, and prescribe opioids in a safe and effective manner."[108] The new guidelines for doctors should be released in 2010.

Workplace Safety and Insurance Board (WSIB):
In the past, Thunder Bay was commonly described as having a dominantly 'blue-collar' or industrial type of workforce. Jobs that require a high degree of physical labour also put workers at an increased risk for work-related accidents and injuries. There are copious anecdotal reports from community members that an increased number of

[101] Irfan A. Dhallla MD MSc et al. (2009). Canadian Medical Association Journal.
[102] Ibid.
[103] Ibid.
[104] Ibid.
[105] Canadian Centre on Substance Abuse. (2005). Substance abuse in Canada: Current challenges and choices.
[106] Carol, Angela qtd. in Klich, Barbara. (2010). Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain.
[107] Ibid.
[108] Ibid.

injured workers are becoming dependent on prescription opioids through the medication of pain that resulted from a work-place injury/accident. Action taken to address this issue by WSIB supports these anecdotal reports:

In 2007, WSIB began noticing trends in the use of prescription opioids by injured workers, showing that 40% more workers have been prescribed narcotics compared to 10 years ago and there have also been 100% more narcotic prescriptions over that same period of time.[109] It was found that since 2006, the doses prescribed by physicians have also increased. As a result of this information, WSIB implemented a Narcotic Strategy effective February 16, 2010.[110] For new injuries or a recurrence of injury under the new strategy, WSIB will initially only allow prescriptions for short-acting narcotics, and for a maximum of 12 weeks.[111] Long-acting drugs will not be allowed at all during this period, as it is the opinion of WSIB that there are other milder drugs available that workers can use for pain relief.[112] After 12 weeks of ongoing narcotic use, WSIB clinical staff will review the worker's case regarding the ongoing use of narcotics.[113] The stated goal of WSIB's new Narcotics Strategy is appropriate pain management aimed at improving workers' functioning, quality of life, and support to a safe and sustained return to work.[114]

Is Prescription Opioid Use an 'Epidemic' in Northwestern Ontario?
The situation regarding the use, abuse, and trafficking of prescription opioids has been described by many as being epidemic in Thunder Bay and Northwestern Ontario. While it is hard to get a completely accurate picture of the scope of this issue, numerous sources support this widespread perception:

The Chiefs of Matawa First Nations declared a state of emergency in June 2009 for their communities, with some communities indicating over 60% of their population is misusing opiates. Unfortunately, this situation only seems to have since gotten worse.

Despite the challenges posed to enforcement surrounding the task of investigating the trafficking and possession of 'legal' drugs, seizures of large amounts of prescription pills by City Police and the Combined Forces Organized Crime Unit have been in the news frequently. Many of these drugs have been intercepted at the Thunder Bay International Airport where they were headed to northern communities and reserves. With the large quantities of pills that are being confiscated by enforcement officials and the increase in the frequency of individuals seeking assistance for opioid dependency issues, one can only wonder about the true volume of these drugs that are flowing through our city. The drug-trade is an extremely lucrative business for large-scale dealers, and for others, selling one's medication may be seen as a necessary means to supplement a low-income.

In Thunder Bay, the street price of OxyContin is reported to be about 1 dollar per milligram; one OxyContin 80 mg pill can therefore be sold for $80 on the street. Thus, a prescription for 30 pills could net a person $2400. When these same pills make their way into northern communities and reserves their price increases significantly. In light of the

[109] WSIB. (2010). Enhanced narcotics management for injured workers.
[110] Ibid
[111] Ibid.
[112] Ibid.
[113] Ibid.
[114] Ibid.

current economic climate of Thunder Bay, it is easy to see the attraction for people to engage in the 'drug-trade.' There are many anecdotal reports that elderly retirees (among other population groups of course) are increasingly choosing to sell their prescriptions as a means of supplementing their fixed low-incomes.

Balmoral Centre & Opioids:
In addition to crisis withdrawal management, Balmoral Centre offers "day detox" services, pre-treatment stabilization services (8 beds available), and facilitates access to treatment services.[115]

Staff has acknowledged that unique challenges have arisen with more cases of people seeking assistance with opioid withdrawal, one being that the length of withdrawal tends to be longer than it is for other substances, which results in individuals needing to stay longer in withdrawal crisis beds, creating what has been described as a 'bottle-neck' in the movement of clients to stabilization beds.[116] This in turn results in an increase in the number of clients that the centre is unable to admit due to a lack of beds.[117]

Of the 1,363 people admitted to the Balmoral Centre between January 1, 2008 and December 31, 2008, 313 men and 136 women identified opiate abuse as an issue (33% of all admissions).[118] During the same period, the centre was unable to serve 927 people and again 33% of those the centre was unable to serve identified opiate abuse as an issue.[119] The reasons why individuals were unable to be admitted were that either all beds were full or no opiate beds were available.

Referrals are regularly made from TBRHSC to Balmoral Centre (626 annually, resulting in 398 admissions).[120] Balmoral Centre was unable to serve 228 of the referrals in 2008, due to a lack of available beds or a lack of available opioid beds, or because medical clearance was required; of these referrals, 46% identified opioid abuse as an issue.[121] Since Balmoral Centre is a non-medical withdrawal management service, in the past all medically compromised clients have needed to be referred to Thunder Bay Regional Health Sciences Centre (TBRHSC). This resulted in 369 people being transferred from Balmoral to TBRHSC annually.[122] Within the past year a part-time nurse practitioner was able to be recruited by the centre and it has been estimated that 50% fewer clients have needed to be transferred to the emergency department as a result.

Still of a concern is that methadone maintenance clients are largely unable to get their doses administered at the site, and if clients need other medications dispensed in daily increments this is also a barrier to receiving treatment.

Methadone Maintenance Treatment:
Methadone is not a cure for opiate dependence; it is a form of treatment and can be considered a harm reduction or secondary prevention measure.[123] Methadone Maintenance Treatment is recognized by Health Canada as a best practice in the

[115] CAMH Opiate Project. (2009). A Discussion Paper: Opioid Abuse Issues and Treatment Needs in Thunder Bay.
[116] Ibid.
[117] Ibid.
[118] Ibid.
[119] Ibid.
[120] Ibid.
[121] Ibid.
[122] Ibid.
[123] CAMH (2009). Do you know … methadone.

treatment of opioid dependence, and is one of the most evidence-based treatments that exist.[124]

Ideally, treatment with methadone provides people with the medical and social support they need to stabilize and improve their lives; research has strongly identified case management and counselling as important adjuncts to MMT,[125] unfortunately however, clients are not always able to receive these services. The length of MMT is indefinite, ranging anywhere from one year to the rest of a person's life. MMT has been compared to the treatment of diabetes in that a person will always need to take his or her insulin. However, ending treatment *is* possible by tapering the dose over time in order to ease withdrawal. Some take the approach that once a person has been stabilized and has his or her life in order, methadone may no longer be necessary.[126]

Thunder Bay is fortunate to be able to offer methadone maintenance treatment from three clinics; however the system is not perfect.

Lakeview Methadone Clinic:
The Lakeview Methadone Clinic provides community-based treatment for persons with opioid dependence. The service's approach to the treatment of addiction utilizes the benefits of medication, substance abuse counselling, family support/counselling, and community-based resources in a multi-faceted approach.[127]

Lakeview Clinic is an outpatient methadone program of Northwestern Concurrent Disorders and part of St. Joseph's Care Group. The clinic currently has about 75 clients, with 40 on the waitlist, and has not had any new intakes in over a year. The standstill regarding intakes has been attributed to a lack of doctors meeting the legislative requirements to dispense methadone. In Canada, doctors are required to apply to Health Canada to be exempted under Section 56 of the *Controlled Drugs and Substances Act* before they are allowed to prescribe methadone.[128] It is reported that Lakeview Clinic hopes to be able to recruit 1-2 more doctors by April or May of 2010.[129]

Ontario Addiction Treatment Centres (OATC):
OATC is the country's largest network of (recently accredited) methadone clinics. Currently, two clinics operate in Thunder Bay at north- and south-ward locations[130] (there is also work underway to open a third clinic in the near future). As of February 2010, the south side clinic reported an enrolment of 486 clients, with three clinical case managers on staff; the north side clinic had 309 clients with three clinical case managers on staff.[131] It is reported that the south side clinic had 60 people waiting to get into the program; it takes an estimated 3-4 weeks to see a counsellor and up to 2 weeks to see the doctor.[132] The north-side clinic did not have a waitlist as of February 2010, because the clinic had been capped after reaching the maximum amount of clients they could serve. This cap is reportedly being removed by the end of March 2010.[133] The south side clinic does 60 intakes per month and the north side clinic has done 5 intakes under

[124] Health Canada. (2002). Best Practices, Methadone Maintenance Treatment.
[125] Ibid.
[126] CAMH. (2009). Do you know … methadone
[127] St. Joseph's Care Group: Lakeview Methadone Clinic. (2010).
[128] Methadone Maintenance Treatment. (29 Jan., 2008). Health Canada.
[129] Information provided by Lakeview Methadone Clinic. (Feb., 2010).
[130] Ontario Addiction Treatment Centres. (2010). Website.
[131] Information provided by OATC. (Feb., 2010).
[132] Ibid.
[133] Ibid.

emergency circumstances (e.g. for opioid-dependent pregnant women).[134] Until recently, the combined 4 prescribing physicians for the two clinics were all based in Southern Ontario and provided support to clients primarily via teleconference, while making periodic visits to the community. The clinics have now been able to obtain the service of an 'in-house' physician on a part-time basis, whom is available to see methadone maintenance clients weekly.

Needle-Exchange Programs:
Thunder Bay is also fortunate to have a needle exchange program: Superior Points. The Superior Points Harm Reduction Program provides clean needles and harm reduction services through street outreach. Services are free, confidential and include:

- Needles/Syringe Exchange
- HIV and AIDS Education
- Counseling and Referral to Services
- Condoms
- Sterile Water
- Hepatitis C Prevention Information
- Presentations to the Public and Organizations

Needle exchange programs have shown to be effective in reducing the spread of blood-borne diseases (HIV/AIDS, HCV) among injection drug users. Studies demonstrate that needle exchange programs do not lead to increased drug use.[135] These programs have also been proven to be cost-effective and shown to contribute to community safety by reducing the number of publicly discarded needles and syringes.[136] An additional positive aspect of needle-exchange programs is that by the nature of these outreach services, an entry point can be provided for people interested in addiction treatment programs.[137]

Superior Points indicates that we have the third highest rate of needle exchanges in Ontario. This high rate is said to be largely due to the number of individuals who have progressed to taking prescription opiates via injection. From 2003 to 2004, there was a 44% increase in needles collected by the program and a 54.7% increase in needles given out.[138]

[134] Information provided by OATC. (Feb., 2010).
[135] Alberta Alcohol and Drug Abuse Commission. (2007). Harm Reduction Policy Background Paper.
[136] Ibid.
[137] Picard, Andre. (Feb., 2010). The lack of needles and the damage done. Globe & Mail.
[138] Superior Points. (2009). Thunder Bay District Health Unit.

The following table compares the needle exchange statistics of Thunder Bay to other cities in Ontario. In 2005, Thunder Bay both took in and gave out the most needles, and also had the highest needle return rate. Primary drugs of choice in Thunder Bay were reported to be cocaine, crack, opiates, OxyContin, morphine, and inhalants.[139]

Site	Total # of needles taken in (2005)	Total # of needles given out (2005)	Return Rate	Primary drugs of choice
Thunder Bay	550,223	590,609	93.2%	Cocaine, crack, opiates, oxycontin, morphine, inhalants
Toronto	323,192	526,809	61.3%	Cocaine, opiates, amphetamines
Kingston	389,500	475,000	82%	Cocaine, morphine, meth, opiates, crack cocaine
Ottawa	283,332	308,140	79%	Cocaine, morphine, crack, heroin

From 2005 to 2007 there was a decrease in the number of needles collected and given out; this is said to be primarily due to a shift in the drug of choice and the opening of more methadone clinics in Thunder Bay.

	2005	2006	2007
Needles In	550,223	495,725	398,541
Needles Out	590,609	525,722	410,544

Superior Points provides the following data:
In 2009, a total of 1,967 clients used their services, with almost an equal split between male and female service users. Counseling was done by staff in 752 instances and was primarily in reference to personal issues (315), drug issues (209), and sex-related issues (147). Superior Points made a total of 3,343 referrals in 2009. Referrals were listed in the "other" category for the majority of cases (3,098); clients were also referred for medical reasons (136), for additional support (59), and for legal/police-related issues (50).[140]

[139] Superior Points. (2009). Thunder Bay District Health Unit.
[140] Ibid.

Mental Health and Substance Use:

Substance use and mental health concerns are interrelated and often linked. It is estimated that 1 in 5 Canadians will suffer from an addiction or mental health issue in their lifetime and the World Health Organization has suggested that depression will be the most prevalent illness worldwide by 2020.[141]

According to the Centre for Addiction and Mental Health, a person with a mental health problem (most commonly anxiety or a mood disorder, such as depression) has a higher risk of having a substance use problem and vice versa.[142] When both a mental health issue and substance use issue are present in the same individual, it is often referred to as a concurrent disorder.[143]

Statistics show that many people suffer from concurrent disorders:

- About 30% of people with mental illness have a substance use disorder;
- About 53% of people with a substance use disorder have a mental illness as well;
- About 47% of people with schizophrenia have a substance use disorder;
- About 53% of people with bipolar disorder have a substance use disorder as well.[144]

Many people ask whether substance use leads to, or causes, mental health issues. There is no simple answer to this question because each individual's situation is different. Some people may begin to use substances in an attempt to 'self-medicate' their mental health issue;[145] substances can also cause changes in people's mental health, greatly impact upon their lives and cause relationships to suffer,[146] possibly leading, or contributing to, the development of a mental health issue. Unfortunately, the best answer is that the interconnections between substance use and mental health concerns are complex with many variables to consider. There may be genetic/biological factors that lead to mental health and substance use problems, or there may be an emotional or physical trauma that leads to a concurrent disorder[147] (or a combination of these factors).

Dually diagnosed individuals often have complex needs that require flexible and integrated treatment methods and services. It has been said that "for a client to present with a single addiction, without a coexisting addiction or addictions, or without a coexisting psychiatric disorder or disorders, would be the exception rather than the rule."[148] People who misuse substances tend to have a substance of choice, but it is also common for poly-substance use to occur, which can also compound mental health issues.

[141] Pringle, Valerie. (22 Mar., 2010). Mental Health & Stigma.
[142] Bartha, Christina MSW, RSW, et al. (2004). CAMH Concurrent Substance Use and Mental Health Disorders: An Information Guide.
[143] Ibid.
[144] St. Joseph's Care Group. Mental Health and Addictions Outreach Programs. (2010). FAQ for Northwestern Ontario Concurrent Disorders Program.
[145] Ibid.
[146] Ibid
[147] Ibid.
[148] Capuzzi & Stauffer. (2008). Foundations of Addictions Counselling.

Local Emergency Department Mental Health Data (TBRHSC):
Local statistics show that of the 3,518 emergency department (ED) visits for mental health in 2008/09, anxiety (22.7%) and depression (16.8%) were the leading conditions resulting in patient visits.[149] The average ED length of stay for mental health was 4.2 hours compared to a provincial length of stay of 7.6 hours; 8.4% of mental health patients were admitted as an inpatient to the hospital and 51.3% of patients were discharged home with no supports.[150] The average age for mental health patients was 37.8, and 14.5% of mental health patients were under 18 years of age.[151]

Local Community Mental Health Services Data:
In 2008/09, data shows that there were 23,597 service recipients for community mental health programs (the data reported is for total service recipients, not individuals).[152] Recipients of services primarily sought assistance for mood disorders (36%); 12% sought assistance for schizophrenia or other psychotic disorders, another 12% for anxiety disorders, and 16% fell into the 'other' category.[153] The presenting issues being addressed in order of frequency were problems with: 'other' issues (36%), substance abuse (29%), educational/occupational/employment issues (24%), and specific symptoms of serious mental illness (19%).[154] Service recipients were male in 52% of cases and female in 48% of cases; 37% were between ages 35-54, 25% were between ages 25-34, and 13% were between ages 55-64.[155]

<u>Examples of Local Services that Address Concurrent Disorders:</u>

- Sister Margaret Smith Centre - Concurrent Disorders Program
- St. Joseph's Health Centre - Northwestern Ontario Concurrent Disorders & Outreach to Recovery (ACT)
- Canadian Mental Health Association - Crisis Response
- Alpha Court Community Mental Health Services - G.A.P.P.S., Rapid Response Outreach Program
- Thunder Bay Counselling Centre - Concurrent Disorders Case Management Program
- TBRHSC – Assertive Community Treatment (ACT) Teams (2)

Stigma:
With both addiction and mental health issues comes an enormous amount of stigma. Stigma results in people being marginalized and discriminated against on both an individual level and by the larger society; it impacts upon peoples' access to services and the quality of treatment received through some services. Stigma prevents many people from seeking help, leaving them and their families to suffer in silence.

Diagnosis may be seen as both a blessing and a curse to individuals suffering from a mental health condition/addiction. On the one hand, a diagnosis may result in a person becoming eligible for a much-needed program or service, and diagnosis may also offer a

[149] Profile Communities Local Data. (31 Mar., 2010). Mental Health and Addictions Quality Improvement Forum: Toronto.
[150] Ibid.
[151] Ibid.
[152] Ibid.
[153] Ibid.
[154] Ibid.
[155] Ibid.

degree of relief to a person who may finally be able to name and better understand what he/she is experiencing. However, the diagnosis of a mental health *disorder* and/or addiction also results in the labelling and categorization of people, leading to judgements based on stereotypes. The issue of stigma is huge and not easy to address: eradicating stigma involves somehow changing the attitudes and perceptions of the larger society and fostering an understanding about mental health and addiction issues.[156] Ironically, stigma can also prevent people from accessing and seeking help from the very services that were designed to assist them.[157]

Youth and Substance Use:

Thunder Bay youth have a significantly higher incidence of substance use as compared to youth in other parts of Ontario.

- **Cannabis** use among youth in Thunder Bay is significantly higher than the provincial average (32.6% vs. 25.6%);
- **Alcohol** use among Thunder Bay youth is also higher (64.4% compared to 58.2% provincially), as is the incidence of **binge-drinking** (29.9%) compared to the rest of the province (24.7%).
- **OxyContin** use is higher for Thunder Bay youth (3.1% reporting use vs. 1.6% of their provincial counterparts);
- **Cocaine** use is also higher for Thunder Bay youth (4.1% vs. 2.6%).

  The above data is from the OSDUHS Report (2009) and NWOSDUS (2009). Percents are based on substances used in the past year (2009).

According to the most recent Ontario Student Drug Use and Health Survey, students in Northern Ontario continue to be above average for alcohol use, binge drinking, cigarette smoking, cannabis use, salvia use, non-medical stimulant use, and non-medical OxyContin use.[158] Interesting to note is that while Thunder Bay youth have a lower incidence of overall reported opiate-use (14.4% compared to 17.8% provincially), Thunder Bay youth have a higher incidence of OxyContin use than their provincial counterparts.[159]

Substance related mental health disorders have also shown to be higher in our region for both adolescent (14 to 19), males (33% as compared to 21% provincially) and females (18% as compared to 12% provincially). Illicit drug use was reported by 35% of youths.[160]

Natural Helpers Peer Mentor Surveys:

From 2007-2009, drug use placed in the top three concerns (out of a list of 25 identified concerns) for youth in local high schools. Youth report that they feel concerned that drugs are very easy to access in school and that it affects the functioning and health of their peers.[161]

[156] Minister's Advisory Group. (2009). Every Door is the Right Door.
[157] Janzen, Liz. (22 Feb., 2010). CAMH webcast. Drug Policy and the Public Good.
[158] OSDUHS Drug Use Report. (2009).
[159] Northwestern Ontario Student Drug Use Survey. (2009).
[160] The Northern Ontario Child and Youth Health Report. (Jun., 2003).
[161] Natural Helpers School Wide Surveys. (2007-09).

Results from Street Involved Survey (funded by the DSCIF: Ontario Region-2004)
The Street Involved Drug Use Survey questionnaire was administered by street involved youth to their peers in order to determine the extent of drug use among street-involved and at-risk youth under age 24 living in the District of Thunder Bay. Results from the 313 questionnaires completed indicated 98.4% reported drug use over the previous 12 months, with 30% reporting injection drug use. Thirty eight per cent (38%) of drug users who did not have a history of injection drug use indicated they knew an injection drug user. This fact, combined with the proportion of individuals who shared their drug works (74.8%), and the 63.3% who indicated they did not always use a condom when sexually active, compounds the risk of contracting and spreading infectious disease.

Impact of Substance Use on Social Service Agencies:
Social service agencies such as Dilico Children and Family Services, Children's Aid Society and Ontario Works indicate that they are seeing a large increase in families that have been affected negatively by a member misusing prescription opiates, leading to financial and personal stress and the inability to parent or maintain employment; however, substance use in general, greatly impacts upon these services.

Children's Aid Society:
In 2009, is it estimated that 75-80% of 700 referrals for investigations/assessments for protection services were impacted by substance abuse issues, meaning that it was either the primary or secondary reason for referral; this equates to between 500 and 560 families seen at intake being impacted by substance abuse.[162]

In addition, at any given time last year Children's Aid Society was involved with nearly 300 ongoing protection cases, and again 75-80% of such cases would be relatable to the impact of substance use, with another 200 to 240 families being involved with the agency due to substance abuse being the primary or secondary concern.[163]

The agency also has approximately 250 children in care, which would come from the above mentioned family constellations.[164] Consequently, it is estimated that nearly 200 children are living apart from their families due to substance abuse being a primary or secondary issue.[165] A source at CAS maintains that substance abuse is a key issue for our population and that in a world where there were no substance abuse issues, the need for child welfare services would change dramatically.

Thunder Bay Counselling Centre (TBCC):
In 2009, a total of 787 individuals had an alcohol and drug assessment at TBCC (119 were under the age of 18).[166] In that same year, 467 individuals participated in community treatment and 282 individuals were involved in intensive case management services.[167]

[162] Information provided by Children's Aid Society. (Feb., 2010).
[163] Ibid.
[164] Ibid.
[165] Ibid.
[166] Information provided by Thunder Bay Counselling Centre. (Feb., 2010).
[167] Ibid.

Reported Problem Substance Use (TBCC):
In 2009, alcohol was the primary reported problem substance of use among clients at a rate of 64%; a provincial comparison to open admission addiction agencies shows that this rate was 21% higher at TBCC.[168] The second most frequent problem substance reported was cannabis (38%) and was 7% higher in comparison to other provincial agencies.[169] Opiates were reported to be a problem substance among 33% of clients compared to 13% in other Ontario agencies.[170] Cocaine/crack was also reported a problem in 33% of cases at TBCC, which is 7% higher than provincial counterparts.[171]

Other substances tracked were other stimulants (ecstasy, crystal meth, and methamphetamine) with 6% reporting these as being problem substances of use (2% higher than other provincial agencies), and benzodiazepines were reported to be problem substances for 3% of individuals, which is the same percentage as for the rest of the province.[172]

Break Down by Gender:
When broken down by gender, TBCC statistics show that women were more likely to report opiates and other stimulants as problem substances of use and men were more likely to report alcohol, cannabis, and cocaine/crack as problem substances of use.[173] Men and women equally reported benzodiazepines as being problem substances.[174]

Youth Problem Substance Use:
Youth accounted for more of the statistics related to problem substances used in the categories of cannabis and other stimulants.[175]

Addiction Services Initiative – Ontario Works & TBCC:
The current caseload of the ASI program is approximately 250 clients and the most-serviced age group is 25-34.[176] Members of Ontario Works staff expressed that they were surprised to discover how quickly clients responded to the newly offered service (implementation began in 2002), and also at the amount of Ontario Works clients who came forward and indicated that substance use was an issue for them.[177]

Sister Margaret Smith Centre (SMSC):
In 2008 and 2009, a total of 2,215 individuals were served at SMSC. It is reported that 60% of clients were male; 40% were female. Adults aged 25-54 accounted for the majority of clients served at 67%; youth 24 years of age and under accounted for 23% of the clients served; and older adults represented 10% of clients served.[178]

[168] Information provided by Thunder Bay Counselling Centre. (Feb., 2010).
[169] Ibid.
[170] Ibid.
[171] Ibid.
[172] Ibid.
[173] Ibid.
[174] Ibid.
[175] Ibid.
[176] Ontario Works ASI in Partnership with TBCC. (5 Mar., 2010). Building Bridges V.
[177] Ibid.
[178] Information provided by Sister Margaret Smith Centre. (Mar., 2010).

Substance Abuse & Mental Health Treatment Services – Thunder Bay:
Thunder Bay is fortunate in being able to provide a range of treatment options to those seeking assistance with substance use issues. The following are available in Thunder Bay: residential (inpatient) treatment for men, women and youth, community (outpatient) treatment, various networks of support groups, pre-treatment programming, post-treatment (aftercare) programs, methadone maintenance treatment, case management services, [179] and more. Nonetheless, there are gaps in services, barriers to accessing some services (e.g. waitlists, admissions criteria, transportation/childcare issues, etc.), and some services that simply do not exist that could be beneficial to people suffering from addiction and/or mental health issues.

Data from 2008/09 shows that the highest percentage age group of clients accessing community substance abuse treatments was 16-24 (24.7%) and 35-44 years (24.4%).[180] Leading presenting problem substances were alcohol (77.6%), cannabis (35.5%), cocaine (23.5%), and prescription opioids (23%).[181] Most clients were self-referred to treatment services (34.8%), 20.5% were referred from the legal system, and .6% from a hospital.[182]

* *

Some of the currently available addiction and mental health services have already been discussed, more are presented here, and a more comprehensive list of agencies, committees, groups and addictions/mental health service providers is included at the end of this report.

Thunder Bay Integrated Addiction Services:
Thunder Bay Integrated Addiction Services is a group of service providers that work together and share information with each other and with other agencies to better support clients in developing plans of care regarding choices and decisions pertaining to substance use. These agencies could be said to make up the 'core' of Thunder Bay's treatment system. Thunder Bay Integrated Addiction Services includes the following agencies:

Thunder Bay Counselling Centre Addictions Services:
Substance use services include: Alcohol and Other Drugs Program that offers assessment and community treatment, Addiction Services Initiative which provides outreach services to Ontario Works clients, and the Pregnancy and Health Program which supports women who are pregnant or parenting.[183] Recently, TBCC has also been able to offer case management services to MMT clients through a part-time position.

St. Joseph's Care Group – Addictions and Mental Health Services:
St. Joseph's Care Group offers a range of services in relation to addiction and mental health issues: [184]

[179] CAMH Opiate Project. (2009). A Discussion Paper: Opioid Abuse Issues and Treatment Needs in Thunder Bay.
[180] Profile Communities Local Data. (31 Mar., 2010). Mental Health and Addictions Quality Improvement Forum: Toronto.
[181] Ibid.
[182] Ibid.
[183] CAMH Opiate Project. (2009). A Discussion Paper: Opioid Abuse Issues and Treatment Needs in Thunder Bay.
[184] St Joseph's Care Group. (2010).

- Withdrawal Management (Balmoral Centre)

Sister Margaret Smith Centre:

- Adult Substance Abuse and Problem Gambling Programs (assessment and treatment planning, community treatment groups, ongoing support groups, individual counselling, intensive residential treatment)
- Youth Addiction Programs
- Older Adult Programs
- Specialized Programs
- And more ….

Alpha Court Community Mental Health Services:

Alpha Court offers the following programs which are staffed by mental health professionals:[185]

- Community Mental Health Program
- G.A.P.P.S. (Getting Appropriate Personal and Professional Supports)
- Homelessness Initiative Program (HIP2)
- Ooshke Bemahdesewin Mental Health Program
- RROS (Rapid Response Outreach Services)

Crossroads Centre Inc.:

Crossroads Centre provides abstinence based recovery support services (including a transitional housing component) to individuals with substance abuse disorders. There are two different categories of programs at the centre: Pre-Treatment and Post-treatment. Pre-Treatment Services focus on assisting clients in stabilizing to attend treatment. Post-Treatment Services are designed to assist clients in making the transition to an independent, substance-free lifestyle.[186]

Children's Centre Thunder Bay – New Experiences Program:

The New Experiences Program is a community based resource and treatment model established to deliver and promote a spectrum of addiction and mental health treatment interventions.[187] The program asserts that a range of interventions is key to recognizing the cultural diversity of youth and expand existing treatment options to accommodate youth who do not engage in current modes of treatment. [188]

The New Experiences Program:

- Provides assessment, case management, treatment, group work, aftercare and counseling for youth with dual disorders and their families.
- Establishes coordinated care planning and linkages with services for youth with dual disorders.
- Provides consultation to existing children's mental health and addiction programs.

Dilico Addiction Services:

Adult Residential Treatment Centre: Dilico provides a clinically based approach to treatment for alcoholism and drug dependency. The program is a 5-week co-ed program that combines cultural teachings, clinical counselling, and a 12-step recovery program.

[185] Alpha Court. (2010).
[186] Crossroads Inc. (2010).
[187] Children's Centre Thunder Bay. (2010).
[188] Ibid.

Youth Outreach Workers (YOW):
YOW Services works with other community programs and agencies to link at-risk youth with existing supports and resources in the community. Youth are empowered to find opportunities and solutions to issues related to housing, employment, and education,[189] for example.

Ontario Works – Addiction Services Initiative (ASI):
This initiative aims to provide employable Ontario Works recipients with appropriate treatment options and supports to assist with their path to recovery.[190] The initiative consists of the collaboration of Ontario Works agents and addiction treatment providers, and has resulted in the creation of a Community Outreach Team with intensive case management of Ontario Works participants to support them to economic self-sufficiency. The ASI team consists of three Ontario Works Addiction Counsellors (with one located in Manitouwadge), three Community Addiction Outreach Counsellors, and one Assessment Counsellor.[191]

Human and Social Impacts of Substance Use:

The human and social impacts of substance use on individuals, families, and the larger community are not only complex but also largely immeasurable. A few of these impacts have already been discussed, however there are many more.

Human and social impacts of substance use include, but definitely are not limited to: stress/anxiety, depression, poverty, food insecurity, domestic violence, child maltreatment and/or neglect, crime and violence, lack of safety/security, family breakdown, stigma, isolation, suicide, mental health issues, homelessness, criminalization, emotional suffering (guilt/shame), unemployment, unsafe sexual practices, chronic illness, etc.

Such factors have the potential to either contribute to, or be the result of substance use, illuminating what many refer to a vicious cycle. The use of substances may offer temporary release from stress and an escape from difficult conditions, but in the long run tends to intensify the factors that lead to its use in the first place, making problems worse for individuals and further contributing to the addictive cycle.[192] The human and social impacts of substance use are better understood when examined through the lens of the social determinants of health.

The Social Determinants of Health:

There is now an evidence-base indicating the need to look at the bigger picture of health overall and to examine factors previously considered to be outside of the traditional realm of the health care system. It is being recognized more than ever that at every stage of life, health is determined by complex interactions between social and economic factors, the physical environment and individual behavior.[193]

[189] Dilico Anishnabek Family Care. (2010).
[190] Ontario Works ASI in Partnership with TBCC. (5 Mar., 2010). Building Bridges V.
[191] Ibid.
[192] World Health Organization. (2003). Social determinants of health: the solid facts.
[193] Public Health Agency of Canada. (2010).

"The social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics." (World Health Organization)

The social determinants of health are not only useful in helping to develop an understanding of some of the contributing factors leading to individual substance use, but they also help to foster an understanding as to why substance use is such a complex issue, both to prevent and to treat. Any strategy that does not consider the wider socioeconomic issues that interconnect with substance use-related problems will not be comprehensive or effective in dealing with the multiple factors associated with substance use.

The social determinants of health are presented here as a reminder of the systemic and large-scale issues that need to be addressed in order to improve many social problems, including addiction/mental health issues (and also how people with addiction/mental health issues are treated in our society). However, as large as these issues seem, this does not mean that things cannot be done at the grassroots or local level to improve the lives and wellbeing of our citizens and reduce the harms associated with substance use. For example, efforts that work towards improving the inclusion of certain population groups can improve people's overall health and also reduce the risks associated with substance use: there is evidence that social support and community belonging are equated with healthier people.

<u>The World Health Organization's Drug Policy Perspective:</u>
According to the World Health Organization, the use of alcohol and drugs is influenced by the larger social setting. Drugs are often used to numb the pain associated with harsh economic and social conditions. Alcohol dependence leads to downward social mobility, and alcohol dependence and drug use are both connected to markers of social and economic disadvantage.[194] Productivity losses as a result of alcohol use are said to be 7.13 billion dollars per year in Canada and accounts for 49% of total alcohol-related costs.[195] This is the largest financial cost associated with substance use. In being consistent with the social determinants of health, the following policy implications have been put forward by the World Health Organization:

• Work to deal with problems of both legal and illicit drug use needs not only to support and treat people who have developed addictive patterns of use, but also to address the patterns of social deprivation in which the problems are rooted.[196]

• Policies need to regulate availability through pricing and licensing, and to inform people about less harmful forms of use, to use health education to reduce recruitment of young people and to provide effective treatment services for addicts.[197]

• None of these will succeed if the social factors that breed drug use are left unchanged. Trying to shift the whole responsibility onto the user is clearly an inadequate response. This blames the victim, rather than addressing the complexities of the social

[194] World Health Organization. (2003). Social determinants of health: the solid facts.
[195] Rehm et al. (2002). The Costs of Substance Abuse in Canada.
[196] World Health Organization. (2003). Social determinants of health: the solid facts.
[197] Ibid.

circumstances that generate drug use. Effective drug policy must therefore be supported by the broad framework of social and economic policy.[198]

In short, it is evident that the World Health Organization endorses a public health-centred approach aimed at reducing the harms associated with both illegal and legal substance use, while also recognizing the importance of addressing other socioeconomic issues.

Canada & the Social Determinants of Health:
The Public Health Agency of Canada lists a total of twelve social determinants of health:[199]

- Income and Social Status
- Social Support Networks
- Education and Literacy
- Employment/Working Conditions
- Social Environments
- Physical Environments
- Personal Health Practices and Coping Skills
- Healthy Child Development
- Biology and Genetic Endowment
- Health Services
- Gender
- Culture

Social Determinants of Health/Mental Health – In the context of Thunder Bay:
The following is not inclusive of all of the recognized social determinants of health, but considers key issues of particular relevance to Thunder Bay.

Income and Social Status:
It goes without saying that a sufficient income is required in order to be able to obtain adequate food, shelter, clothing, and other supports for participation in the community. Without an adequate income people are not able to participate or meaningfully engage in the community. Evidence indicates that the degree of control people have over their life circumstances (in which income plays a big part) is a key influence on health. A number of studies have shown that limited options and/or poor coping skills for dealing with stress increase vulnerability to a range of diseases (including addiction) through pathways that involve the immune and hormonal systems.[200]

Economic Issues in Thunder Bay:

Poverty:
Poverty negatively affects the health and mental health of individuals; it entails deprivation, anxiety/stress, insecure housing, etc. One of the most comprehensive studies to date on poverty in Thunder Bay sheds light on the economic situation locally. In 2001, approximately 17, 000 or 14% of the population lived below the low income cut-off, which is the most widely used and accepted measure in Canada to gauge what is

[198] World Health Organization. (2003). Social determinants of health: the solid facts.
[199] Public Health Agency of Canada. (2010).
[200] Ibid.

considered living in economic hardship or poverty.[201] At the time of the writing of the report, the low income cut-offs in Thunder Bay were:

1 individual $17,895
2 individuals $22,276
3 individuals $27,386
4 individuals $33,251
5 individuals $37,711

*The low income cut-offs have increased slightly over the years due to changes in the cost of living, but not significantly.

The Face of Poverty in Thunder Bay:
Results from *Poverty in Thunder Bay* showed that in 2001:

- 40% of the Aboriginal population in Thunder Bay were poor
- 12% of women in Thunder Bay were poor
- 16% of children (age 9-14) and youth (age 15-24) in Thunder Bay were poor[202]

Note: According to the 2001 Census (the data used in the *Poverty in Thunder Bay* report), the CMA population of Thunder Bay was 121,986. The Aboriginal population comprised a relatively large portion of the population at 8,205.[203]

Is the Situation Improving?
Statistics show that the number of people living in poverty was only slightly improved five years later, with just under 16, 000 people, or 13% of the Thunder Bay population living below the low income cut-off (based on the Census Metropolitan Area population of Thunder Bay in 2006, which was 122, 907).[204]

While the statistics indicate a slight improvement in the reduction of poverty, the Lakehead Social Planning Council cautions that it is important to note that due to the timing of the 2006 Census, the above data would not capture changes that have occurred in Thunder Bay in the past 4 years; particularly the sharp decline of the forestry industry and the additional out-migration that has been a result of these job losses in our community.[205]

Unemployment:
The unemployment rate in Thunder Bay currently sits at 8.1% (February, 2010). In the past year Thunder Bay's unemployment rate has fluctuated between 7.2 and 8.9%.[206]

Our city has seen the closure of many of our staple industries over the past ten years resulting in an enormous amount of job losses, particularly in pulp and saw mills, the grain handling industry, trucking companies, and other woodlands jobs.

A human resource manager with Abitibi-Bowater (currently the only running pulp mill in Thunder Bay) provides the following information:

[201] Poverty in Thunder Bay – A Statistical Reference. (2006).
[202] Ibid.
[203] Ibid.
[204] Statistics Canada Community Profiles. (2006). Thunder Bay.
[205] Social Profile for Thunder Bay. (2009). Lakehead Social Planning Council.
[206] Human Resource Services Development Canada. (Feb., 2010).

- 10 years ago there were 4 pulp mills in Thunder Bay; at present, there is only 1 and it is running at reduced operation.
- 10 years ago there were 3 saw mills in Thunder Bay; at present, there is only 1.
- Total job losses in the mills are estimated at **2,100**.
- Total losses of woodlands and trucking jobs are estimated at **700**.
- Some estimates put spin-off job losses as high as 2 ½ to 3 times that of actual mill workers, which would mean that all jobs lost due to the mill closures would be about **5,250**.
- This equates to approximately 137 million dollars of lost wages per year in the City of Thunder Bay.

Figures for the grain handling industries also indicate significant job losses:

- Of 1,200 jobs available in the year 2000, there were approximately 200 left in 2010: **1000** jobs were lost over the last ten years. These are twenty-dollar an hour jobs; thus combined lost wages could be as much as 34 million dollars per year.[207]

The decline of these industries has impacted individuals, families, local businesses, and the community as a whole. While many workers may have been able to obtain alternative employment in the city, many have not, and others have found it necessary to leave Thunder Bay entirely in order to seek employment elsewhere in order to support themselves and their families. Unemployment is an issue that interconnects with many other related concerns. In relation to substances, individuals many turn to alcohol or other drugs as a means of coping with their job loss; for others, in times of a bleak economy, they may be driven to engage in the drug-trade as a means of employment or source of income.

Ontario Works (OW) and the Ontario Disability Support Program (ODSP):
According to the Thunder Bay District Social Services Administration Board, the Ontario Works' caseload was 2,696 as of December 2009 (up from 2,506 in June 2006).[208] In 2008, the annual income for a single person receiving Ontario Works was $7,352, including all tax credits, which would be $10,000 less than the low income cut-off for a single person living in Thunder Bay.[209] In 2008, the income for a single person on the Ontario Disability Support Program was $12, 647, including all tax credits: over $5,000 less than the low income cut-off for a single person living in Thunder Bay.[210]

[207] Information provided by an official with the Grain Handlers Union. (Feb., 2010).
[208] Thunder Bay District of Social Services Administration Board. (2009).
[209] National Council of Welfare Reports. (2008).
[210] Ibid.

Housing:

Adequate housing is a fundamental human right and is protected under the Universal Declaration of Human Rights; it provides physical and mental wellbeing, aids in development, provides dignity, and raises overall quality of life.[211] Without adequate housing people face instability, being under-housed or homelessness. Individuals in such circumstances need to focus their time and energy on getting their essential daily needs met, such as eating and finding a safe place to sleep, and are therefore largely unable to focus on higher order needs like personal development and securing stable employment, which even then may leave a person earning wages that would leave them below the low income cut-off. As figures and anecdotal evidence tells us, adequate and affordable housing is not available to all in Thunder Bay.

Rent Costs:

Broken down by area, Northward and Southward average rents differ slightly, with the Southward being somewhat lower.

Private Apartment Average Rents by Zone and Bedroom Type – Thunder Bay CMA **(2005)**				
	Bachelor	1 Bedroom	2 Bedroom	3 Bedroom
Southward	$409	$527	$654	n/a
Northward	n/a	$586	$719	n/a

* CMHC 2005 (Poverty in Thunder Bay Report)

The average rental prices in Thunder Bay have risen slightly over the years, although they remain among the lowest in the province.

Private Apartment Average Rents by Zone and Bedroom Type – Thunder Bay CMA **(2009)**				
	Bachelor	1 Bedroom	2 Bedroom	3 Bedroom
Southward	$484	$573	$697	$831
Northward	$474	$643	$778	$896

*CMHC 2009 Rental Market Report Thunder Bay CMA

It is interesting to note that neither single recipients of Ontario Works nor ODSP are able to afford even a bachelor apartment at the average rental cost based on shelter allowances provided through these social assistance programs. Ontario Works allows $364 per month for shelter costs, and ODSP $454 per month.[212]

A single person receiving OW social assistance would have approximately $100 to last them the entire month after paying the average rental cost on a bachelor apartment, assuming they had *no* other bills to pay. The issue of food security, another determinant of health, would come into play here as well. Our local food system has proven to be inadequate and despite the strong support of the community through donations many individuals still go hungry. Many see food banks as a ‘band-aid’ solution that does not address the underlying or root causes of poverty.

[211] Poverty in Thunder Bay – A Statistical Reference. (2006).
[212] Ministry of Community and Social Services. (2009).

Social Housing:
The Thunder Bay District Housing Corporation is designed to assist individuals with low incomes by providing rent geared to income housing. There were **3,784** rent geared to income units under the Central Housing Registry in 2004.[213] As of December 31, 2004, the total number of eligible applicants on the Central Housing Registry Waiting List was **1,260**.[214]

More recent data shows that there are a total of **4,300** social housing units under the Housing Services Division.[215] The current waitlist sits at approximately **1,226**.[216] Thus, despite the addition of 500-plus units over the past five years, the waiting list for social housing has only marginally decreased (by about 30 individuals/families), indicating an increasing need for low income housing in Thunder Bay. Thunder Bay Social Services suggests that some of the factors contributing to the increased demand for housing are: "increased migration of aboriginal people, low wage service sector jobs, fewer programs for persons with mental health issues, and a general decline in the natural resources industry, particularly in mining and forestry."[217]

Wait Times:
There are many variables that come into play when trying to determine how long the 'average' wait time will be for an individual or family to be placed in a social housing unit. It depends on the type of accommodation an individual/family needs (e.g. one-bedroom, two-bedroom, no stairs, etc.), the area(s) of town in which the individual/family is willing to live, and the level of perceived urgency. People considered to need housing as soon as possible are placed on an 'Urgent List' and are given priority of receiving placement options before other people that may have been waiting for a longer period, but are not deemed to be in a crisis state. It is interesting to learn that being homeless is not considered a matter of priority that qualifies someone to be placed on the 'Urgent List.'

Social Housing Trends in Thunder Bay:
According to workers with Thunder Bay District Housing there are certain trends in Thunder Bay. Firstly, workers affirm that issues of substance use and drug dealing are increasingly impacting upon their work with clients, especially in certain areas of the city.[218] Workers also acknowledge being familiar with the practice of people selling their prescription medication as a means to supplement their low-incomes, and state that this is becoming more common even among senior clients. One worker conveyed that the loss of community policing stations in certain areas of the city has had negative impacts, and expressed the hope that their reinstatement would be considered.

Other trends in Thunder Bay are: the large out-migration of young people due to changes in the economy and seniors accounting for a higher proportion of our population.[219] Yet, despite the large senior population in the city, the highest demand for social housing is not among seniors, but rather middle-aged, single people, and persons with disabilities.[220] The following represents the combined portfolio of all housing providers participating in the Central Housing Registry (2005):

[213] Poverty in Thunder Bay – A Statistical Reference. (2006).
[214] Ibid.
[215] Thunder Bay District Social Services Department. (2010).
[216] Thunder Bay District Housing Corporation . (24 Mar., 2010).
[217] Thunder Bay District Social Services Department. (2005). Community Housing Plan. P. 4.
[218] Ibid.
[219] Ibid.
[220] Thunder Bay District Housing Corporation . (24 Mar., 2010).

Seniors' Units	1,759
One-Bedroom Non-Senior Units	572
Two-bedroom Non-Senior Units	583
Three-bedroom Non-Senior Units	730
Four-bedroom Non-Senior Units	117
Five-bedroom Non-Senior Units	23

Community Housing Plan (2005). District of Thunder Bay Social Services Department.

Noteworthy is that there were three times more units available for seniors than one-bedroom units for non-seniors (the type of unit in the highest demand). Thus, it is evident that the types of units available under the Central Housing Registry do not reflect the needs of the individuals requiring social housing assistance. Since the release of the Community Housing Plan in 2005, steps have been taken to address this issue. In an innovative approach, Thunder Bay District Housing changed the age of eligibility for some senior housing units to age 50, down from 60. This allowed for single people over the age of 50 to gain access to available housing units that had previously been designated for 'seniors,' but were not in high demand.[221] However, despite these efforts, one-bedroom single units remain in the highest demand and therefore have the longest wait times.

Poverty Trap?

Social housing rental charges are based on 30% of the household's gross monthly income starting at $85.00 per month and for tenants who are in receipt of Ontario Works or Ontario Disability Support Program benefits, rent is charged based on provincial social assistance scales.[222] Concern has been raised about the so-called 'poverty trap' that can inadvertently result from people becoming involved with the social housing system. For instance, if a person on Ontario Works who resides in a rent geared to income unit is able to find employment and increase their income level; their rent would also increase to reflect the 30% rental formula. If the person's income were to increase significantly upon gaining employment, this would not be much of an issue; however, more likely than not, a person coming off of social assistance would not immediately be earning a wage that most people would consider adequate. The result would be that the person, who was paying $85/month for rent while on social assistance, would need to spend more of their (still low) income on housing.

In short, as individuals in social housing make more money (even if it's not a significant amount), their rent goes up. Therefore, a person may be no better off, or only marginally better off financially if they are employed rather than receiving social assistance. In light of the way the system is currently set up, what is intended to be a stepping stone to help people reach a point of financial security, stability, and responsibility, may actually provide a great disincentive for people to get off of social assistance. Individuals or families may find themselves largely in the same situation, whether they are working or not, due to the increased amount of their income required for rent.

[221] Thunder Bay District Housing Corporation . (24 Mar., 2010).
[222] Thunder Bay District Social Services Department. (2005). Community Housing Plan.

Native People of Thunder Bay Development Corporation:
This corporation's mandate is to purchase and rent homes to Aboriginal families and Senior Citizens and to provide a support service to those tenants.

- **249 units**

It reportedly may take 6 months to a year for accepted applicants to be placed in a subsidized unit.[223]

Shelters:
Thunder Bay has five temporary shelters, which are able to provide a combined 177 beds a night. There are 114 permanent beds per night available for men and 53 permanent beds per night available for women (and children). There are just 10 permanent beds a night in our city available for youth (5 male, 5 female). Thunder Bay does not currently have any youth-specific shelters or damp/wet shelter options (shelters that would accept individuals under the influence of alcohol or allow alcohol consumption on-site).

Thunder Bay Shelter House:
Beds Available:
Men: 27
Women: 5
Youth: 10 (5 female, 5 male)
Total: 42

*If necessary, Shelter House can provide for up to 18 more sleeping spots.

Salvation Army Men's' Residence (Booth Centre):
Beds Available:
Men - Hostel: 17
Men - Residential: 25

John Howard Society:
Beds Available:
Men: 45 (approximately)

Faye Peterson Transition House:
Beds Available:
Women: 24

Beendigen Inc.:
Beds Available:
Women and children: 24

It is important to note that not everyone is eligible for assistance through these shelters. For instance, Faye Peterson Transition House is for women and children who have left abusive situations, as is Beendigen Inc. for Aboriginal women and children, and John Howard Society is largely for individuals recently released from correctional centres.

[223] Native People of Thunder Bay Development Corporation. (2010).

Social Supports, Social Environment & Inclusion:

The Public Health Agency of Canada asserts that:

The array of values and norms of a society influence in varying ways the health and well being of individuals and populations. In addition, social stability, recognition of diversity, safety, good working relationships, and cohesive communities provide a supportive society that reduces or avoids many potential risks to good health.[224]

It is not merely on a subjective level that the City of Thunder Bay does not live up to this statement. One of our largest and steadily-growing population groups consistently faces the effects of historic and systemic racism in our city.

Aboriginal Peoples and Thunder Bay:

From 2001 to 2006, the Aboriginal population in Thunder Bay had grown from 8,205 to 10,055, an increase of 23%.[225] These numbers continue to rise: the Aboriginal population is young and growing with 48% of Aboriginal peoples in Thunder Bay under age 25, compared to 28% of the non-Aboriginal population.[226] In 2006, the Aboriginal population made up 8% of the city's total population,[227] although other sources suggest that currently, it is more likely about 15%.

Unfortunately, Aboriginal peoples and visible minorities face both overt and systemic racism in Thunder Bay. Diversity Thunder Bay's 2001 study concluded that in addition to the occurrence of individual racist attitudes and actions in our city, institutional practices and societal structures disadvantage certain population groups and give privileges to others.[228] Racism in Thunder Bay affects social cohesion, hinders cooperation and impacts quality of life and participation in the community.[229]

The most common sites where racialization was found to occur in Thunder Bay were in retail establishments, police services, the employment sector, and schools, including post-secondary institutions. In the study, racism was strongly viewed by participants as being a community issue, not a personal one (by 79% of respondents).[230]

- 73% of Aboriginal respondents strongly agreed with the statement that, "People of my race have been discriminated against."[231]
- 76% of Aboriginal respondents had observed incidents of racism occur.[232]
- 56% of Aboriginal respondents had experienced discrimination based on race.[233]

Social supports and the social environment, such as the community one lives in, are critical components of one's overall health. Social support networks can be vital in helping people resolve issues and deal with adversity, as well as in maintaining a sense

[224] Public Health Agency of Canada. (2010).
[225] Aboriginal Population Profile for Thunder Bay. (2006).
[226] Ibid.
[227] Ibid.
[228] Diversity Thunder Bay. (2001). A Community of Acceptance: Respect for Thunder Bay's Diversity.
[229] Ibid.
[230] Ibid.
[231] Ibid.
[232] Ibid.
[233] Diversity Thunder Bay. (2001). A Community of Acceptance: Respect for Thunder Bay's Diversity.

of mastery and control over life circumstances.[234] It has been shown that the importance of social support also extends to the broader community and is "reflected in the institutions, organizations and informal giving practices that people create to share resources and build attachments with others."[235]

A report examining the demographic and socioeconomic characteristics of the Aboriginal population living in Thunder Bay indicates issues of systemic inequity (from 2006 census data):

- The unemployment rate for the Aboriginal core working age population (aged 25-54) in Thunder Bay was higher than that of the non-Aboriginal population (13% compared to 5.2%).[236]

- Aboriginal people who worked full-time full-year in 2005 continued to earn less than their non-Aboriginal counterparts and the gap is not closing. Aboriginal people in Thunder Bay working full-time full-year earned 87% of what their non-Aboriginal counterparts were earning in both 2000 and 2005.[237]

- Six in ten off-reserve First Nations and Métis adults in Ontario reported that they had been diagnosed with at least one chronic condition; most commonly, arthritis or rheumatism, respiratory problems, high blood pressure, heart problems or effects of a stroke.[238]

- Aboriginal youth aged 15 to 24 in Thunder Bay had lower school attendance rates than their non-Aboriginal counterparts (65% versus 73%).[239]

Since the release of the Diversity report in 2001, some work has been done to address issues of racism in Thunder Bay, such as efforts to implement diversity into local police services through policy reviews and analyses of bias and barriers.[240] However, as the more recent statistics above indicate, the issue of racism in Thunder Bay still negatively impacts a large portion of our population. Community awareness needs to be raised, education about the historic and systemic nature of racism against Aboriginal people needs to be disseminated, and further efforts need to be taken to address these inequalities.

[234] Public Health Agency of Canada. (2010).
[235] Ibid.
[236] Statistics Canada. (2009). Aboriginal Population Profile for Thunder Bay.
[237] Ibid.
[238] Ibid.
[239] Ibid.
[240] Northern Ontario Symposium on Diversity Awareness and Race Relations. (2-3 Feb., 2007).

The causes, impacts, outcomes, and interconnections of substance use have been studied and analyzed at great length and there is a vast amount of literature on the subject. Most people accept (and if not, they may be in denial) that we will never live in a society free of psychoactive substances and people who use them. The fact is that substances themselves do not *cause* addiction; although it is true that certain substances have a greater potential for abuse.[241] Addiction is complex and can result from a number of different yet interconnected factors including genetics, environment, social learning, and traumatic events, such as a history of abuse, etc.[242] As long as there are social, environmental, and economic conditions that drive people to need, or want, to alter their states of consciousness, there will be work to be done in the area of mental health and addictions. The social determinants of health tell us what issues need to be addressed if we desire a truly healthy community made up of healthy community members, but these goals, while important to continue to work towards, also need to be supplemented with smaller-scale changes that can be made at present in order to improve the wellbeing of citizens in Thunder Bay and address the harms associated with substance use.

Apparent Gaps in Thunder Bay:

- A place for intoxicated homeless or under-housed people to go in order to get off of the street (e.g. wet/damp shelter or 24-hour damp drop-in/sobering-up centre)
- A youth-specific shelter or more shelter spaces designated for youth
- Shelter space/transitional housing for women
- Transitional/Supportive housing
- Sufficient amount of withdrawal management beds
- Withdrawal management services for youth - age16 and under
- Medical withdrawal management services
- Mental health emergency department/Systemic issues in ED pertaining to mental health and substance abuse
- Withdrawal management equipped to assist opioid dependent clients
- Availability of adequate subsidized housing
- An awareness and measures to address racism, discrimination and stigma
- Lack of doctors meeting the requirements to dispense methadone
- Insufficient amount of family doctors in general
- Lack of case management for substance using clients
- Lack of treatment options/Drug-specific treatment
- Long waitlists for some programs/services
- Lack of coordination among service providers
- Clients/Consumers not being aware of what services are available and/or how to go about navigating service systems

[241] Gourlay, Douglas MD. (Not dated). Universal precautions in pain management – A rational approach to management of chronic pain.
[242] Ibid.

STRENGTHS – What We Are Doing Well:

- Sister Margaret Smith Centre – Youth Treatment – based on harm reduction and strengths perspective
- Dilico - Youth Outreach Workers, culturally appropriate services
- TBDHU - Street Nursing Outreach, Superior Points
- Thunder Bay Integrated Addiction Services
- Availability of Methadone Maintenance Treatment
- AIDS Thunder Bay –Injection Drug Use Outreach (IDUO) Program (Peer Support)
- Concurrent Disorder Services (e.g. Alpha Court)
- Collaborating on a Municipal Drug Strategy for Thunder Bay

Examples – What Other Municipalities are Doing to Address Substance Use Issues:

At the provincial level, the Municipal Drug Strategy Coordinators Network of Ontario has been established with the mission "to build and enhance collaborative actions across Ontario for effective development and implementation of local and provincial drug strategies that promote health and reduce the harm of alcohol and other drugs for individuals, families and communities."[243] It is increasingly being recognized that differentiated interventions are necessary to address differential drug use patterns and needs. More and more cities across Ontario and across the country are working towards implementing community-specific strategies to address the harms associated with substance use.

The Toronto Drug Strategy – A comprehensive approach to alcohol and other drugs:
The Toronto Drug Strategy was passed in full by Toronto's City Council in 2005.[244] The strategy was formulated through a collaboration of Toronto Public Health, community groups, and other stakeholders.[245] The Toronto Drug Strategy takes a four pillar approach that includes actions in prevention, harm reduction, treatment and enforcement. The strategy was constructed in such a way as to balance public order and public health interests.

The key recommendation that came out of the Toronto Drug Strategy report was the importance of putting an Implementation Committee in place to ensure that the ideas proposed in the Drug Strategy report were not made in vain, and also to have a group dedicated to keeping abreast of emerging issues requiring response.[246] Another key recommendation was that the Toronto Drug Strategy should be co-ordinated with other related municipal initiatives in order to "transform the traditional silo-based approaches into a more horizontal-model based on collaboration and progressive problem-solving."[247] The Thunder Bay Drug Strategy project could learn from this approach; for

[243] Four Pillars Across Canada. (2008). Quarterly Update.
[244] CAMH. (2005). CAMH Commends Passage of Toronto Drug Strategy.
[245] Ibid.
[246] The Toronto Drug Strategy. (2005).
[247] Ibid. P. 14.

example, a partnership that seems like it could be a natural fit is the newly emerging *City of Thunder Bay Community Safety Council*. Other cities have also found benefits in this approach, such as Waterloo, Ontario, in which the city's drug strategy is connected to their *Community Safety and Crime Prevention Council.*

Some of the other recommendations that came out of the Toronto Drug Strategy were working to prevent the misuse of prescription drugs, decriminalizing small amounts of marijuana, and an expansion of harm reduction and outreach programs,[248] along with many others.

In 2008, The Toronto Drug Strategy released a status report. The strategy has been successful in forming the *Toronto Drug Strategy Implementation Panel*, numerous working groups, and establishing dedicated staff support through the *Toronto Drug Strategy Secretariat,* Liz Janzen, of Toronto Public Health.[249] At a recent conference at CAMH, Janzen provided another update on the strategy's work. One of the strategy's working groups is looking at ways to address stigma, which is a significant barrier to people accessing services. The Toronto Harm Reduction Task Force is also currently working on an overdose prevention strategy that will hopefully involve a peer-based program where Naloxone can be distributed to opiate injection drug users.[250] Since the Toronto Drug Strategy was passed, a Safer Crack Use Program, which had previously been a user-based initiative only, has become a city-funded and recognized program, despite some resistance.[251] Janzen credits the passage of the Toronto Drug Strategy for the fact that these programs have even been considered at the city level.

<u>Waterloo Region Integrated Drugs Strategy</u>:
As mentioned, the Waterloo Region Integrated Drugs Strategy is a project that is connected to the *Waterloo Region Community Safety and Crime Prevention Council*. This strategy also incorporates a four pillar approach and recognizes that issues related to drugs and alcohol cross multiple sectors and impact the community as a whole. The strategy emphasizes broad-based planning for this complex issue and identifies the importance of community capacity building, addressing perceptions and stigma, and inter-sectoral collaboration.[252] A locally produced film called "In the Mind's Eye," provided a real glimpse into issues of substance use and addiction, and has lead to several initiatives, including planning for an Overdose Prevention and Intervention Program that will likely include the provision of Naloxone/Narcan for people dependant on opiates[253] (much like the plan of the Toronto Drug Strategy). This innovative strategy is truly forward in its thinking: working towards a balance of public health and crime prevention through the fostering of healthy a community and collaboration across sectors.

[248] The Toronto Drug Strategy. (2005).
[249] The Toronto Drug Strategy Status Report. (2008).
[250] Ibid.
[251] Ibid.
[252] Waterloo Crime Prevention Council. (2009). Integrated Drugs Strategy.
[253] Four Pillars Across Canada. (2008) Quarterly Report.

An Exciting Opportunity!

The fact that Thunder Bay is now engaged in the creation of an innovative community-specific drug strategy is very exciting. Despite the political, ideological, and funding-related challenges, municipal drug strategies have shown to have real potential in creating change at the community level. Many strategies are adopted and approved by City Councils and therefore carry significant weight when it comes to the priority of implementation. Inter-sectoral collaboration is already reaching new levels in Thunder Bay as is evident by the Drug Strategy Steering Committee and its diverse membership. With committed individuals, the Thunder Bay Drug Strategy can also be a success and provide a roadmap for where we want to go in the future and how we plan to get there.

Programs, Services and Activities that address Substance Issues in Thunder Bay

Submitted by Patty Hajdu

Health Promotion and Prevention/Education

CHILDREN & YOUTH

St. Joseph's Care Group

- YES Group (Youth Education Screening) provides program geared to those youth pre-contemplating using substances
- Educational Sessions/Outreach Program to schools or community
- Annual "I Know Drugs Aren't Cool" presentations to Grade 5/6

Thunder Bay Youth Coalition

- Provides opportunities for youth engagement through Youth Week and other coordinated activities.

Natural Helpers

- Trains youth to provide support to their peers and refer their friends for issues that need adult support. Currently runs in 5 local high schools. (4 Public, 1 Separate)

School Boards

- Work in partnership with prevention agencies to provide substance and alcohol information to youth in their schools.

Confederation College

- Health Promotion activities for and by students on a variety of substance use issues.

MULTIPLE AGE GROUPS

Drug Awareness Committee (DAC)

- Members conduct awareness campaigns and facilitate environmental supports such as peer mentor programs. Also conduct advocacy on alcohol and substance related issues and legislation.

Thunder Bay District Health Unit

- Conducts awareness campaigns and facilitate environmental supports such as peer mentor programs. Also conduct advocacy on alcohol and substance related issues and legislation. Works in partnership with the DAC.

FOCUS/NorWest Community Health Centres

- Alcohol and Substance Abuse Prevention Program uses education, skills building for youth and provision of healthy alternative activities. Facilities Strengthening Families for the Future in partnership with other community agencies.

Centre for Addiction and Mental Health

- Regional Consultant supports community initiatives in prevention by assisting in program design, policy development, implementation, evaluation, training, and information seminars.

Anishinawbe Mushkiki

- Health Promotion/prevention activities through programming for both children and adults.

Thunder Bay Indian Friendship Centre

- Health Promotion and community development activities through programming a variety of programming.

Treatment Services

CHILDREN & YOUTH
INPATIENT

- **St. Joseph's Care Group 10 BEDS**
- **Thunder Bay Regional Health Sciences Centre Child and Adolescent Mental Health Services**
- **Ka-Na-Chi-Hi Solvent Treatment Centre**

OUTPATIENT

- **Children's Centre Thunder Bay**
- **Thunder Bay Counselling Centre**
- **Dilico Anishinabek Family Care**
- **Lakehead University Counselling**
- **Alateen**

ADULT
INPATIENT

- **St. Joseph's Care Group 40 beds**
- **Balmoral Withdrawal Management Centre 15 beds**
- **Dilico Anishinabek Family Care In Patient**
- **Thunder Bay Regional Health Sciences Centre Mental and Addiction Services 30 beds**
- **Teen Challenge 6 beds**
- **Three C's 12 beds**
- **Crossroads Centre 40 beds**

OUTPATIENT

- **St. Joseph's Care Group**
- **Dilico Anishinabek Family Care**
- **Thunder Bay Regional Health Sciences Centre Mental and Addiction Services**
- **Thunder Bay Counselling Centre**
- **Ontario Addictions Treatment Centres**
- **Beendigen**

- **AA/NA/Alanon**
- **John Howard Society**
- **Redwood Park**
- **Thunder Bay Indian Friendship Centre**
- **BISNO – Healthy Lifestyles Group**

St. Joseph's Care Group
Sister Margaret Smith Centre
- Older Adult program
- Youth Treatment: 10 beds In Patient, 6 Day Patient
- Adult Treatment: 40 beds
- In Patient and Out Patient Services

Balmoral Withdrawal Management Centre
- 15 bed, non medical withdrawal management services
- Recovery Group (outpatient support)

Outreach Services
- Advocacy, treatment and support
- *Lakeview Methadone Clinic*
- Outpatient methadone treatment for opiate users

Interagency Addictions Committee
- Coalition of treatment providers that meet frequently to discuss treatment issues, gaps and news in Thunder Bay.

Dilico Anishinabek Family Care
- Adult Inpatient Treatment Centre and Aftercare Program
- Youth Outreach Program (YOW): counselling and referral to services for at-risk youth

Thunder Bay Regional Health Sciences Centre
- Mental Health and Addictions Unit

Children's Centre Thunder Bay
- Group and individual treatment, family services
- New Experiences Program

Thunder Bay Counselling Centre
- Substance Use assessments
- Treatment Planning and referral services
- Outpatient treatment, education and support groups
- Walk-in Counselling Services

Teen Challenge
- 6 bed, inpatient program, one year in length. Abstinence Based

Three C's Reintroduction Centre
- 12 bed supportive housing that provides long term care for substance dependent adult males.

Crossroads Centre

- 40 bed residence to provide support for adult men and women in early stages of recovery from substance abuse.

Ontario Addiction Treatment Services

- Outpatient methadone treatment for opiate substance users.

Ka-Na-Chi-Hi Specialized Solvent Abuse Treatment Centre

- Long-term residential treatment centre for First Nation males ages 16 to 25 who are chronic solvent abusers

AA/NA/Alanon

- Support groups for alcohol and substance users and their families that advocate a 12 step, abstinence approach.

Beendigen Inc.

- Provision of NNADAP worker who supports individuals dealing with substance and addiction issues. Referrals, counselling, group programs, creation of aftercare treatment plans.

John Howard Society of Thunder Bay

- Individual and group counselling and support for men who have been involved with the justice system.

Lakehead University

- Counselling for university students with substance use concerns

Redwood Park Opportunities Centre

- *Celebrate Recovery* 12 step recovery program

Thunder Bay Indian Friendship Centre

- Outpatient Treatment/Aftercare programs, programs that support wellness and recovery

Enforcement

Thunder Bay Police Force

- Neighbourhood policing with focus on developing programming and crime prevention.
- Facilitates and participates on the Integrated Gang Unit, monitors and apprehends gang members, provides community education on gang behaviour.
- Crime Stoppers: engages community in providing tips to apprehend individuals that have committed crimes.

Ontario Provincial Police: Drug Enforcement Section

- Works in conjunction with municipal police services, OPP regions, as well as national and international agencies to apprehend organized drug traffickers, locally and on a global basis.

- Provides community education through outreach to youth and participation on community initiatives that work to prevent substance misuse.

The Combined Forces Organized Crime Unit

- Consists of members from The Thunder Bay Police Service, The O.P.P. - Organized Crime Enforcement Bureau, The R.C.M.P., The Nishnawbe-Aski Police Service and The Anishinabek Police Service.

RCMP: Drug Section

- Works to identify, target, investigate, disrupt, and dismantle the international, national, regional, and local drug trafficking organizations that are having the most significant impact in Canada
- Prevents the importation, production, traffic and use of illicit drugs

Anishinabek Police Services

NAPS Nishnawbe–Aski Police Services

- Member of the Regional Integrated Gang Unit
- Apprehension and deterrence of drug traffickers targeting First Nations Communities in the Nishnawbe–Aski area.

Ontario Courts of Justice

Justice Canada

Secondary Prevention (Harm Reduction)

Thunder Bay District Health Unit

- *Superior Points Needle Exchange*
  Provides pick up and dispensing of clean needles, referral to services and support to people using substances.
- *Street Nursing Outreach*
  Provides primary care and medical testing to individuals

Aids Thunder Bay: Injection Drug Use Outreach Program

- Provides access to an injection drug use outreach worker in partnership with Superior Points

Addiction Services Initiative: Ontario Works

- Case Management for people with substance use issues that are employable.

Dilico Anishnabek Family Services: Youth Outreach Program (YOW)

- Counselling and referral to services for at-risk youth

Bibliography:

1. An Environmental Scan prepared for the Toronto Drug Strategy Initiative (2005). Substance Use in Toronto: Issues, Impacts, and Interventions. <http://www.toronto.ca/health/drugstrategy/pdf/tds_appendix_e.pdf>
2. City of Thunder Bay Website (2009).
3. United Nations Office on Drugs and Crime (2010). <http://www.unodc.org/unodc/en/treaties/single-convention.html>
4. International Narcotics Control Board (2010). <http://www.incb.org/incb/convention_1988.html>
5. Ibid.
6. The international drug control conventions: history, achievements and challenges (2008). <http://www.incb.org/pdf/annual-report/2008/en/AR2008_Chapter_I.pdf>
7. The Vancouver Sun. (24 Feb., 2010). U.N. narcotics board warns of prescription drug abuse.
8. Fischer & Rehm (22 Feb., 2010). Scientific Conclusions of Drug Policy and the Public Good. CAMH Webcast: TSM # 10552774
9. Medical News Today (15 May, 2007). <http://www.medicalnewstoday.com/articles/70753.php>
10. Legislative Summary (2009). Library of Parliament. LS-634E Depuis & Mackay.
11. Ibid.
12. CAMH (2002). CAMH and Harm Reduction: A Background Paper on its Meaning and Application for Substance Use Issues.
13. Government of Canada: The National Anti-Drug Strategy (2007). <http://www.nationalantidrugstrategy.gc.ca/nadssna.html>
14. CAMH (2008). The National Anti-Drug Strategy: A CAMH Response.
15. Ibid.
16. CBC (March 3, 2010). OxyContin more abused than crack: rehab centre.
17. Fischer & Rehm (22 Feb., 2010). Scientific Conclusions of Drug Policy and the Public Good. CAMH Webcast: TSM # 10552774.
18. Department of Justice Canada (1996, c.19). Controlled Drugs and Substance Act.
19. Legislative Summary (2009). Library of Parliament. LS-634E Depuis & Mackay.
20. Ibid.
21. Ibid.
22. Ibid
23. Ibid.
24. Ibid.
25. Pablo, Carlito (2009). Bill C-15 could fill Canadian prisoners with drug offenders. Straight.com - Vancouver's Online Source. <http://www.straight.com/article-209473/bill-c15-could-fill-prisons>
26. Legislative Summary (2009). Library of Parliament. LS-634E Depuis & Mackay.
27. Canadian Civil Liberties Association. (2009). Submissions of the Canadian Civil Liberties Association Re: Bill C-15. <http://ccla.org/wordpress/wp-content/uploads/2009/04/2009-04-23-ccla-submission-re-bill-c-15-final-draft.pdf>
28. Ibid.
29. The Pew Charitable Trusts (2009). One in 31: The Long Reach of American Corrections.

30. Fischer & Rehm (22 Feb., 2010). Scientific Conclusions of Drug Policy and the Public Good. CAMH Webcast: TSM # 10552774.
31. Ibid.
32. Legislative Summary (2009). Library of Parliament. LS-634E Depuis & Mackay.
33. Picard, Andre (Feb., 2010). The lack of needles and the damage done. Globe & Mail.
34. Ibid.
35. Ibid.
36. Ibid.
37. Ibid.
38. Ibid.
39. Picard, Andre (Feb., 2010). The lack of needles and the damage done. Globe & Mail.
40. Ibid.
41. Caverson, Reggie (2008). Developing an Ontario Drug Strategy: progress, challenges & implications.
42. Ministry of Health & Long-Term Care. Minister's Advisory Group on Mental Health and Addictions. <www.health.gov.on.ca/english/public/program/mentalhealth/minister_advisgroup/minister_advisgroup.html>
43. Ibid.
44. Capuzzi & Stauffer. (2008). Foundations of Addictions Counselling. Pearson Education: USA.
45. Ibid.
46. Ibid.
47. Ibid.
48. Ibid.
49. Sunshine Coast Health Centre (2009). <http://www.sunshinecoasthealthcentre.ca/biopsychosocial.html>
50. Ibid.
51. Caverson, Reggie (2008). Developing an Ontario Drug Strategy: progress, challenges & implications.
52. Rehm et al. (2002) The Costs of Substance Abuse in Canada.
53. Ibid.
54. Fischer & Rehm (22 Feb., 2010). Scientific Conclusions of Drug Policy and the Public Good. CAMH Webcast: TSM # 10552774
55. Dauvergne, Mia (2009) Statistics Canada-Catalogue no. 85-002-X Juristat, vol. 29, no. 2.
56. Ibid.
57. Statistics Canada (2007). Police-Reported Drug Offences by census metropolitan area. <http://www.statcan.gc.ca/daily-quotidien/090513/t090513d3-eng.htm>
58. Dauvergne, Mia (2009) Statistics Canada-Catalogue no. 85-002-X Juristat, vol. 29, no. 2.
59. Ibid.
60. CBQ FM Radio (15 Oct., 2009). Great Northwest News hour 2 (CBQ-FM). CBQ FM Radio. Thunder Bay. Ref# 13589FC-1.
61. The Chronicle Journal (18 Mar., 2010). Pills, cash seized 2 women arrested.
62. Ibid.
63. Inspector with Community Police Services (Mar., 2010). Addictions and the Impact on Policing and the Community.

64. Ibid.
65. Ibid.
66. Chief of Police Bob Herman (25 Mar., 2010).TBT News.
67. Ibid.
68. The Chronicle Journal (12 Feb., 2010). P. A-6.
69. Chief of Police Bob Herman (2010). Presentation to City Council.
70. CBQ FM Radio (15 Oct., 2009). Great Northwest News hour 2. (CBQ-FM). CBQ FM Radio. Thunder Bay. Ref# 13589FC-1.
71. CAMH Opiate Project (2009). A Discussion Paper: Opioid Abuse Issues and Treatment Needs in Thunder Bay.
72. Inspector with Community Police Services (Mar., 2010). Addictions and the Impact on Policing and the Community.
73. St. Joseph's Care Group (2010). Withdrawal Management Programs. <http://sjcg.net/services/mental-health_addictions/mha-gambling/widthdrawal-management/main.aspx>
74. Inspector with Community Police Services (Mar., 2010). Addictions and the Impact on Policing and the Community.
75. Anishinabe Wakiagun (Not dated). <http://www.aicdc-mn.org/node/23>
76. Ibid.
77. Downtown Emergency Service Centre (13 Dec., 2005). Seattle Press Release. DESC celebrates opening of new housing for homeless alcoholics.
78. Ibid.
79. Statistics provided by Thunder Bay Police Services (2010).
80. Rehm et al. (2002) The Costs of Substance Abuse in Canada.
81. Ibid.
82. Ibid.
83. Thunder Bay District Health Unit (2009).
84. Profile Communities Local Data (31 Mar., 2010). Mental Health and Addictions Quality Improvement Forum: Toronto.
85. Ibid.
86. Ibid.
87. Ibid.
88. Ibid.
89. Ibid.
90. Thunder Bay District Health Unit (2009).
91. Ibid.
92. Ibid.
93. Ibid.
94. Ibid.
95. Irfan A. Dhallla MD MSc, Muhammad M. Mamdani Pharm MD MPH, Marco L.A. Sivilottie MD MSc, Alex Kopp BA, Omar Qureshi MD, David N. Juulink MD PhD (2009). Prescribing of opioid analgesics and related mortality before and after the introduction of long-acting oxycodone. Canadian Medical Association Journal. DOI:10.1503/cmaj.090784.
96. Ibid.
97. Ibid.
98. Ibid.
99. Ibid.
100. Ibid
101. Ibid.

102. Irfan A. Dhallla MD MSc, Muhammad M. Mamdani Pharm MD MPH, Marco L.A. Sivilottie MD MSc, Alex Kopp BA, Omar Qureshi MD, David N. Juulink MD PhD (2009). Prescribing of opioid analgesics and related mortality before and after the introduction of long-acting oxycodone. Canadian Medical Association Journal. DOI:10.1503/cmaj.090784.
103. Ibid.
104. Ibid.
105. Canadian Centre on Substance Abuse (2005). Substance abuse in Canada: Current challenges and choices.
106. Carol, Angela qtd. in Klich, Barbara (2010). Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain. <http://www.oma.org/pcomm/OMR/jul/09occupationalday.asp>
107. Ibid.
108. Ibid.
109. WSIB (2010). Enhanced narcotics management for injured workers. <http://www.wsib.on.ca/wsib/wsibsite.nsf/public/WorkersNarcoticsStrategy>
110. WSIB (2010). Enhanced narcotics management for injured workers. <http://www.wsib.on.ca/wsib/wsibsite.nsf/public/WorkersNarcoticsStrategy>
111. Ibid.
112. Ibid.
113. Ibid.
114. Ibid.
115. CAMH Opiate Project (2009). A Discussion Paper: Opioid Abuse Issues and Treatment Needs in Thunder Bay.
116. CAMH Opiate Project (2009). A Discussion Paper: Opioid Abuse Issues and Treatment Needs in Thunder Bay.
117. Ibid.
118. Ibid.
119. Ibid.
120. Ibid.
121. Ibid.
122. Ibid.
123. CAMH. (2009). Do you know….methadone.
124. Health Canada (2002). Best Practices: Methadone Maintenance Treatment.
125. Ibid.
126. CAMH (2009). Do you know … methadone <http://www.camh.net/About_Addiction_Mental_Health/Drug_and_Addiction_Information/methadone_dyk.html>
127. St. Joseph's Care Group (2010). Lakeview Methadone Clinic. <http://www.sjcg.net/services/mental-health_addictions/outreach/lmc.aspx >
128. Methadone Maintenance Treatment (29 Jan., 2008). Health Canada.
129. Information provided by Lakeview Methadone Clinic (Feb., 2010).
130. Ontario Addiction Treatment Centres (2010). <http://www.oatc.ca/>
131. Information provided by OATC (Feb., 2010).
132. Ibid.
133. Information provided by OATC (Feb., 2010).
134. Ibid.
135. Alberta Alcohol and Drug Abuse Commission (2007) Harm Reduction Policy Background Paper.
136. Ibid.

137. Picard, Andre (Feb., 2010). The lack of needles and the damage done. Globe & Mail.
138. Superior Points (2009). Thunder Bay District Health Unit.
139. Superior Points (2009). Thunder Bay District Health Unit.
140. Ibid.
141. Pringle, Valerie (22 Mar., 2010). Mental Health & Stigma Presentation. Valhalla Inn; Thunder Bay, ON.
142. Bartha, Christina MSW, CSW, O'Grady, Caroline P.RN, MN, PhD, Parker, Carol MSW, CSW & Skinner, W.J. Wayne MSW, RSW (2004). CAMH Concurrent Substance Use and Mental Health Disorders: An Information Guide.
143. Ibid.
144. St. Joseph's Care Group. Mental Health and Addictions Outreach Programs (2010). FAQ for Northwestern Ontario Concurrent Disorders Program. <http://www.sjcg.net/services/mental-health_addictions/outreach/faq-nwocdp.aspx>
145. Ibid.
146. Ibid
147. Ibid.
148. Capuzzi & Stauffer (2008). Foundations of Addictions Counselling.
149. Profile Communities Local Data (31 Mar., 2010). Mental Health and Addictions Quality Improvement Forum: Toronto.
150. Ibid.
151. Ibid.
152. Ibid.
153. Ibid.
154. Ibid.
155. Ibid.
156. Minister's Advisory Group (2009). Every Door is the Right Door: Towards a 10-Year Mental Health and Addictions Strategy: A discussion paper.
157. Janzen, Liz (Feb. 22, 2010). Drug Policy and the Public Good. CAMH webcast: TSM # 10552774.
158. OSDUHS Drug Use Report (2009).
159. Northwestern Ontario Student Drug Use Survey (2009).
160. The Northern Ontario Child and Youth Health Report (Jun., 2003).
161. Natural Helpers School Wide Surveys (2007-09).
162. Information provided by Children's Aid Society (Feb., 2010).
163. Information provided by Children's Aid Society (Feb., 2010).
164. Ibid.
165. Ibid.
166. Information provided by Thunder Bay Counselling Centre (Feb., 2010).
167. Ibid.
168. Ibid.
169. Ibid.
170. Ibid.
171. Ibid.
172. Ibid.
173. Ibid.
174. Ibid.
175. Ibid.

176. Pudas, Melissa & Sacino, Kirsten (5 Mar., 2010). Ontario Works Addiction Services Initiative in Partnership with Thunder Bay Counselling Centre; Building Bridges V: Northwestern Ontario Concurrent Disorders Conference.
177. Ibid.
178. Information provided by Sister Margaret Smith Centre (Mar., 2010).
179. CAMH Opiate Project. (2009). A Discussion Paper: Opioid Abuse Issues and Treatment Needs in Thunder Bay.
180. Profile Communities Local Data (31 Mar., 2010) Mental Health and Addictions Quality Improvement Forum: 2010.
181. Ibid.
182. Ibid.
183. CAMH Opiate Project (2009). A Discussion Paper: Opioid Abuse Issues and Treatment Needs in Thunder Bay.
184. St Joseph's Care Group (2010). Adult Addiction Programs. <http://sjcg.net/services/mentalhealth_addictions/mha-gambling/adult/main.aspx>
185. Alpha Court (2010). <http://www.alphacourt.ca/ >
186. Crossroads Inc. (2010). <http://www.crossroadscentre.ca/>
187. Children's Centre Thunder Bay (2010). <http://www.childrenscentre.ca/newexp.html>
188. Ibid.
189. Dilico Anishnabek Family Care (2010). <www.dilico.com>
190. Pudas, Melissa & Sacino, Kirsten (5 Mar., 2010). Ontario Works Addiction Services Initiative in Partnership with Thunder Bay Counselling Centre; Building Bridges V: Northwestern Ontario Concurrent Disorders Conference.
191. Ibid.
192. World Health Organization (2003). Social determinants of health: the solid facts. 2nd edition/edited by Richard Wilkinson & Michael Marmot.
193. Public Health Agency of Canada (2010).
194. World Health Organization (2003). Social Determinants of health: the solid facts. 2nd edition/edited by Richard Wilkinson & Michael Marmot.
195. Rehm et al. (2002). The Costs of Substance Abuse in Canada.
196. World Health Organization (2003). Social Determinants of health: the solid facts. 2nd edition/edited by Richard Wilkinson & Michael Marmot.
197. Ibid.
198. World Health Organization (2003). Social Determinants of health: the solid facts. 2nd edition/edited by Richard Wilkinson & Michael Marmot.
199. Public Health Agency of Canada (2010).
200. Ibid.
201. Brotchi, Karli. (2006) Poverty in Thunder Bay – A Statistical Reference. Thunder Bay Economic Justice Committee.
202. Ibid.
203. Ibid.
204. Statistics Canada Community Profiles - Thunder Bay (2006). <http://www12.statcan.ca/census-recensement/2006/dp-pd/prof/92 591/index.cfm?Lang=E>
205. Social Profile for Thunder Bay (2009). Lakehead Social Planning Council. <http://www.lspc-circ.on.ca/pdfs/SocialProfile.pdf >
206. Human Resource Services Development Canada (Feb., 2010). <www.hrsdc.gc.ca>
207. Information provided by an official with the Grain Handlers Union (Feb., 2010).

208. Thunder Bay District of Social Services Administration Board (2009). <http://www.tbdssab.on.ca/Ontario_Works/Statistics.htm>
209. National Council of Welfare Reports (2008). <http://www.ncwcnbes.net/en/home.html>
210. Ibid.
211. Brotchi, Karli. (2006) Poverty in Thunder Bay – A Statistical Reference. Thunder Bay Economic Justice Committee.
212. Ministry of Community and Social Services (2009). <http://www.tbdssab.on.ca/Ontario_Works/Statistics.htm>
213. Brotchi, Karli. (2006) Poverty in Thunder Bay – A Statistical Reference. Thunder Bay Economic Justice Committee.
214. Ibid.
215. Thunder Bay District Social Services Department (2010). <http://www.tbdssab.on.ca/Ontario_Works/Statistics.htm>
216. Thunder Bay District Housing Corporation (24 Mar., 2010). Personal Communication.
217. Thunder Bay District Social Services Department (2005). Community Housing Plan. P. 4. <http://www.tbdssab.on.ca/Assets/TBDSSAB+Folder/_assets/docs/tbdssab_housing/2290.pdf>
218. Ibid.
219. Ibid.
220. Thunder Bay District Housing Corporation (24 Mar., 2010). Personal Communication.
221. Ibid.
222. Thunder Bay District Social Services Department (2005). Community Housing Plan. <http://www.tbdssab.on.ca/Assets/TBDSSAB+Folder/_assets/docs/tbdssab_housing/2290.pdf>
223. Native People of Thunder Bay Development Corporation (2010). <http://www.nptbdc.org/>
224. Public Health Agency of Canada (2010).
225. Statistics Canada (2009). Aboriginal Population Profile for Thunder Bay. Catalogue no. 89-638-X no. 2009001.
226. Ibid.
227. Ibid.
228. Diversity Thunder Bay (2001). A Community of Acceptance: Respect for Thunder Bay's Diversity.
229. Ibid.
230. Diversity Thunder Bay (2001). A Community of Acceptance: Respect for Thunder Bay's Diversity.
231. Ibid.
232. Ibid.
233. Ibid.
234. Public Health Agency of Canada (2010).
235. Ibid.
236. Statistics Canada (2009). Aboriginal Population Profile for Thunder Bay. Catalogue no. 89-638-X no. 2009001.
237. Ibid.
238. Ibid.
239. Ibid.
240. Northern Ontario Symposium on Diversity Awareness and Race Relations. (2-3 Feb., 2007). North Bay, ON.

241. Gourlay, Douglas MD, FRCPC, FASAM (Not dated). Universal precautions in pain management – A rational approach to management of chronic pain. Wasser Pain Management Centre; Centre for Addiction and Mental Health. Toronto; Canada. <http://www.thci.org/opioid/mar05docs/Gourlay.pdf>
242. Ibid.
243. Four Pillars Across Canada (2008). Quarterly Update. Vol. 2. No. 1. <http://vancouver.ca/fourpillars/documents/FourPillarsAcrossCanadaUpdateJanuary2009.pdf >
244. CAMH (2005). CAMH Commends Passage of Toronto Drug Strategy.
245. Ibid.
246. The Toronto Drug Strategy (2005). <http://www.toronto.ca/health/drugstrategy/pdf/tds_appendix_e.pdf >
247. Ibid. P. 14.
248. The Toronto Drug Strategy (2005).
249. The Toronto Drug Strategy Status Report (2008).
250. Ibid.
251. Ibid.
252. Waterloo Crime Prevention Council (2009). Integrated Drugs Strategy. <http://www.preventingcrime.net/main.cfm?id=51A4A830-B6A7-8AA0-6B87BAD6181FD9EF>
253. Four Pillars Across Canada (2008) Quarterly Report. Vol. 2. No. 1. <http://vancouver.ca/fourpillars/documents/FourPillarsAcrossCanadaUpdateJanuary2009.pdf >