



Centre for Addiction and Mental Health  
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## **Centre for Addiction and Mental Health**

Submission to

### **The Senate Special Committee on Illegal Drugs**

June 2002

*A PAHO/WHO  
Collaborating Centre*

*Un Centre collaborateur  
OPS/OMS*

*Affiliated with the  
University of Toronto*

*Affilié à l'Université  
de Toronto*

## **Background to CAMH**

The Centre for Addiction and Mental Health (CAMH) was created in 1998 through the successful merger of the Addiction Research Foundation, the Clarke Institute of Psychiatry, the Donwood Institute and the Queen Street Mental Health Centre. The Centre is a teaching hospital fully affiliated with the University of Toronto and is a World Health Organization Centre of Excellence. It is the largest mental health and addiction facility in Canada.

The Centre brings together internationally recognized biological, clinical and social research with pre-eminent treatment facilities, a range of professional training and a province-wide network of community program staff. As a result, we have a unique capacity to focus our research agenda on the most pressing needs and to translate new knowledge into action. With clinical expertise in both addictions and mental health, the Centre is also in a unique position to demonstrate a collaborative, interdisciplinary approach to prevention, care, education and research.

The Centre is committed to providing comprehensive and well-coordinated care for all people with mental illness and substance abuse problems. The Centre advocates for services that are accessible, effective and adequately funded for all people needing help. We are also working towards the elimination of the stigma that is faced by those with mental illness or substance abuse problems.

## **Introduction**

We are very pleased to have the opportunity to meet with you today as you work to fulfil your important mandate. Although this is not the first time the issues before us have been debated, we commend the Senate for its desire to move public policy into line with the most current research, knowledge and experience, and the slowly evolving opinion of the Canadian public. Through your work we may yet see the kind of reform that we have been seeking since this process began in 1972 with the LeDain Commission.

Today we hope that we can help add some additional information to the substantial body of evidence that has been brought to you so far, which on the subject of cannabis has been so well synthesized in the Discussion Paper you released last month.

## **CAMH Cannabis Position**

Two years ago the Centre for Addiction and Mental Health adopted a public policy position supporting the removal of criminal sanctions for the possession of small amounts of cannabis for personal use. We did this after careful consideration of the social and policy research and analysis conducted by our scientists Pat Erickson, Eric Single, Reg Smart, Harold Kalant and Benedikt Fischer, and their many years of experience with a broad sample of cannabis users. We reached the conclusion that the current sanctions exact a disproportionately heavy cost on individual users and society relative to the dangers of the drug itself, and are ineffective in deterring use. What we have recommended is that possession be decriminalized and converted into a civil offence under the federal Contraventions Act.

That is not to say that CAMH in any way supports or encourages the use of cannabis or any other psychoactive substances. Rather, we accept that a certain level of substance use is

inevitable in society, and believe that its dangers can most effectively be addressed through a public health approach. In previous testimony, the elements of prevention, treatment, enforcement and harm reduction were identified as the four pillars of the strategy that have been adopted in Vancouver as a basis for combating their significant drug problem. We also believe that each of these four elements have a role to play in a balanced response to substance use problems. We will later address each of these aspects in turn.

Cannabis is not a benign drug. Though most use is sporadic and casual, and therefore not a substantial health risk, of the 4,810 clients admitted to our Addictions Program between December 1, 1996 and March 31, 1999, 9.5% report cannabis as their primary problem substance for which they are seeking treatment.

Cannabis use poses a special risk for those who suffer from concurrent mental health and addiction problems, as their psychiatric symptoms may be exacerbated by the effects of the drug. Of the clients of the Concurrent Disorders Treatment Program, cannabis use is reported by 10.4% as their primary problem substance.

Although we recommend people not use cannabis, when use has become a problem, we encourage them to seek treatment. Our treatment approach is based on a harm reduction philosophy that focuses on reducing the adverse health and social consequences of substance use. The CAMH Addictions Program offers withdrawal management, assessment and case management, out patient, day treatment and residential programs for a variety of substance use problems. We also provide specialized programs for women, youth, older persons, family members and those with co-occurring mental health and addiction problems. Clients are matched with the programs that will be least intrusive and most effective in meeting their needs.

We have found that treatment for both the general and concurrent disorders population is associated with significant decreases in substance use and related problems. A recent study of treatment outcomes showed that in the 90 days prior to the 2-month follow-up to treatment, 60% of clients reported being abstinent or having reduced the use of their problem substance by at least 50%; this result remained stable at the 6- month follow up.

Without revisiting territory that has been extensively covered by some of our scientists and many of the other experts who have appeared before you, CAMH weighs in with the considered opinion that the current approach to cannabis use as a preponderantly criminal justice issue has proven ineffective and costly. As we can see from the Centre's most recent Ontario Student Drug Use Survey, cannabis use among young people is growing despite existing criminal sanctions. While approximately 7% of Ontarians have used cannabis in the past year, the figure is 23 to 44% among students. The OSDUS also shows that the prevalence of cannabis use exceeds that of tobacco among students from Grades 7 to 12 (29.8% vs 23.6%), a good indication that other forces are at play in their decision to use, and that laws and other forms of moral disapproval have little influence on those decisions. Given that offences related to cannabis account for the largest proportion of the \$400 million spent annually by the criminal justice system, and are overwhelmingly committed by young men for whom the threat of criminal sanctions has been ineffective, it follows that we should redirect our resources to where they can have more impact.

CAMH is heavily involved in public education and prevention activities, the production of public information materials and the development of education programs, both for the public and specialized audiences, including educators and students. CAMH works with communities throughout Ontario to design evidence-based approaches to support health and prevent illness.

Accurate information is a key component of any public education and prevention campaign which helps people to make healthy lifestyle decisions. As part of a more comprehensive strategy, we agree with the RCMP in its presentation to you that we need a national prevention program, with adequate resources to sustain and extend these efforts.

For cannabis this more comprehensive approach should include enforcement mechanisms, such as fines, to convey the message that we as a society prefer to have some control over the use of substances that can sometimes pose a threat to the individual and/or to the common good.

One of the messages we would like to emphasize is our serious concern in the addictions treatment community about the lack of investment in the services we provide. Although this is a provincial funding issue, it is indicative of a broader systemic problem that requires a federal investment through a coordinated national drug strategy.

### **Beyond Cannabis – Elements of a Broader Harm Reduction Approach**

Although the primary focus of this committee is on cannabis, a too long outstanding public policy issue in need of resolution, we believe that any proposals you put forward should be couched in a more general framework of substance use, and that some of the most pressing issues we must face are related to the use of other substances.

Although a proportion of our clients come to us to seek treatment for their cannabis use, alcohol and cocaine are by far more problematic substances whose use is reported by 46.6% and 20.2% of our clients respectively. The use of these and other drugs continues to exact a heavy cost on users and society and must be addressed by a comprehensive strategy, based, we believe, on the philosophy of harm reduction.

While the concept and practice of harm reduction is gaining acceptance it still provokes some debate. The concept can also be applied in many different ways, and is often unknowingly practiced by those who are simply adapting their treatment approaches to meet the current needs of their clients. Given the diversity of approaches to harm reduction within the Centre itself, CAMH determined to seek internal consensus for a working definition of harm reduction that would help guide our diverse activities in preventing and responding to addiction problems. As a result the Centre has recently produced a background paper that presents some of the evidence supporting a harm reduction approach as well as the areas in which more needs to be done.

In the CAMH definition, “Harm reduction is any program or policy designed to reduce drug-related harm without requiring the cessation of drug use. Interventions may be targeted at the individual, the family, community or society.” You will have received our paper and may want to question us on the details later, but for this record I will outline the guiding principles that we have adopted as pertaining to all harm reduction efforts:

### **Harm Reduction Guiding Principles**

**Pragmatism:** Harm reduction accepts that some level of substance use in society is inevitable and normal, though this view varies according to culture and cultural values. Harm reduction seeks to reduce the more immediate and tangible harms rather than embrace a vague, abstract

goal related to some future ideal like a drug free society.

**Focus on harms:** Harm reduction focuses on reducing the harmful consequences of substance use without necessarily requiring any reduction in use, mindful of the fact that harms may related to the health, social, or economic factors that affect the individual, community and society as a whole.

**Prioritization of goals:** Harm reduction strategies prioritize each user's goals with an emphasis on those that are immediate and achievable. The eventual goal may be abstinence but does not have to begin this way. Where community and individual goals appear to conflict, there is an attempt to reconcile them.

**Flexibility and maximization of intervention options:** Harm reduction initiatives are flexible in design in recognition of individual differences and how individual goals may change. They provide a maximum range of options for intervention, such as diverting users to alternative community-based measures and a variety of treatment options such as drug substitution, drug maintenance and interventions that adopt safer methods of use.

**Autonomy:** The substance user's decision to use is acknowledged as a personal choice, for which they take responsibility. The user is an active participant in managing their addictions, illustrated by the fact that many harm reduction programs have originated with users themselves. Reintegration into the community is emphasized over stigmatization and social exclusion.

**Evaluation:** CAMH supports responsiveness and innovation in program and policy design as well as evaluations of their effectiveness. Programs and policies should have clear mission statements and goals and identify what " harms" are being addressed. Both the health and functioning of the individual and the net impact on harm indicators in the community are important indicators of the success of harm reduction.

Although the research base is growing in support of a broad range of various harm reduction approaches, gaps continue to exist in the scientific evaluation of controversial programs that present strong indications of success, such as safe crack kits. What we need is an unbiased, pragmatic commitment to reducing harm in whatever manner proves most effective. An investment in the trial and evaluation of programs that prove effective will pave the way for the eventual acceptance of programs like syringe and needle exchange.

From the discussions seeking consensus on this issue among CAMH staff from a broad range of programs and activities, it was clear that based on their shared values of client-centred care and partnership in treatment, harm reduction is one option for clients among others on a broad spectrum of approaches that include programs with an abstinence-based philosophy.

Although the most obvious difference between an abstinence and a harm reduction approach is the lack of insistence that drug use cease as a condition of entering and remaining in treatment, harm reduction does not preclude abstinence as an eventual goal of any treatment approach. Contrary to popular belief, most drug users would not choose the path to addiction again, but specific personal, physiological and social circumstances may make abstinence an unrealistic goal at a particular time.

## **Attitudes Toward Substance Abuse**

We believe that one obstacle to a greater emphasis on treatment is a prevailing stigma regarding substance users among the public but also among many physicians. Psychoactive substance use has an enormous impact on public health and well-being. In Canada in 1992 substance use exacted \$19 billion dollars from the economy.

As a first point of contact for many drug users, family physicians can have a major impact on addressing substance use. To further our understanding of why opiate dependent persons face barriers in accessing appropriate health care through their family doctors CAMH undertook the Opiate Dependent Attitude Study. Our results supported previous studies that showed that physicians have negative attitudes to alcohol and drug users. As a result they do not diagnose and treat substance use with the same frequency, accuracy and effectiveness as they treat other chronic illnesses. This attitude has led to their reluctance to learn about and treat drug and alcohol related problems resulting in late diagnosis of these conditions and an inability to engage patients into treatment. Of 73 respondents to our survey, 40 reported that the survey did not apply to them or that they were not qualified to answer, which speaks to their inability to diagnose presenting symptoms or ask appropriate questions. Those who did respond to the survey revealed a marked pessimism about treatment outcomes. Given what we know about treatment results, the outcome of this survey reveals a strong need to educate primary care physicians in the diagnosis and care of substance abuse problems.

In the public's perception, cases of heroin addiction may be the most dramatic and hopeless cases of substance abuse imaginable, a view sustained by images from films like *Midnight Cowboy*. Indeed, heroin addiction can wreck the lives of users and their families, and cause social havoc when users commit crimes to sustain their expensive habit. An intervention that has had good success for a significant number of heroin users is methadone maintenance, a drug substitution program that provides users with an alternative to heroin that is convenient to use with a stable dose over time, produces no intoxication or euphoria, does not result in lethargy or impairment, decreases craving and drug seeking, and has few side effects.

## **The Evidence is Clear**

A study from the CAMH Methadone Maintenance Program showed the following data: Before entering treatment, 97% of heroin users were still actively using heroin. In six months, the percentage still using dropped to 67%. From 6 months to 4.5 years, 23% of program participants were still using. Beyond 4.5 years, only 8% of those in the program were still using heroin. The remainder had chosen of their own volition to cease their use of their substance of choice at points in their lives when they felt strong enough to do so, similar perhaps to the rest of us when we decide to quit smoking over and over again until it sticks. For heroin users for whom it works, methadone provides them with the conditions that helps them stabilize their physiological functioning to the degree that they can get the rest of their lives in order: finding housing and employment, normalizing their relationships to family, friends and the community, eliminating their need to resort to criminal activity to finance an expensive habit, all factors that benefit not only the individual but society at large. The crime days per treated heroin user per year in one city with a methadone maintenance program dropped from 282 to 37 six months after the program was introduced. In another city the figure dropped from 189 to 14.

A study published in May 2001 in the American Journal of Public Health shows that drug users who attend methadone maintenance programs have significantly lower rates of mortality from either overdose or natural causes.

The economic benefits of methadone maintenance programs are also indisputable. Where methadone costs \$5,000 per client each year, incarceration costs approximately \$50,000. Despite its benefits, resources are needed to establish more programs to meet existing needs. The depth of the problem can be illustrated by the stories of two women, one who deliberately became pregnant and another who deliberately contracted HIV in order to jump to the head of the waiting list for treatment, such was their desperation and assessment of the harms with which they had to deal.

Investment in evaluation of harm reduction programs may be hampered by the continued fear that these approaches condone and support continued drug use among borderline criminal populations. In reality what they offer is a crucial first point of contact with empathic front line caregivers who are able to win their trust and then encourage users to accept further support from a health system they have previously rejected. A therapeutic alliance then has clients and therapists agree on a treatment approach as they progress through agreed upon and successive goals toward the highest level of recovery the client is able to achieve. The endurance of this relationship through the ups and downs of the process has proven to be an important motivator for positive change. Clearly this approach needs to be incorporated into the training of family physicians who are need these resources to enable them to successfully identify and manage their patients drug use issues.

### **Emphasis on Youth**

Much of this current debate is driven by a concern for young people and the effects our public policies and the implicit messages they convey may have on their short and long term health and well being. We have seen that a prohibitionist response does not work for adolescents who have a developmental need to take risks, assert their autonomy, develop values independent of their parents and other authorities, find acceptance in a peer group, seek excitement and satisfy their curiosity.

Taking a pragmatic approach to this generally understood phenomenon, harm reduction avoids taking a uniform stance that substance use is bad, but instead focuses on getting accurate and unbiased information on the harm of use to potential users, in order to help them make informed decisions about whether to use, and if they choose to use, what precautions to take to minimize their risk. Young people do not trust authorities they believe provide misleading information on substance use and its dangers when it contradicts their own experience or those of their peers.

Drug use also correlates with the social and mental health problems of vulnerable children who turn to drugs as a coping mechanism against circumstances beyond their control. From their perspective as well as in the context of drug use in general, it is a fact that deficits in the broader determinants of health such as employment, housing, social and income support, create the conditions for general social decline of which drug abuse is one outcome. Clearly there is a need for a broader social policy to address these needs which is beyond the scope of this committee's mandate.

So what can be done to address what are complex and deep-rooted problems?

## Prevention

CAMH participated in producing the document *Preventing Substance Use Problems Among Young People: A Compendium of Best Practices*, which was published by Health Canada in 2001. Written in response to the increase in substance use among adolescents, the compendium examines a number of successful, evidence-based prevention strategies, principles and programs for youth. It is these kinds of programs, which, when combined with other efforts in a public health approach, may best meet the needs of young people facing difficult choices in establishing healthy lifestyles.

To give you a sense of best practices that are recommended, the investigators found that programs were most effective that adhered to certain principles. Briefly stated:

1. In **Building a Strong Framework**, programs must be tied to complementary efforts in the community and have sufficient duration and intensity to meet the needs of children at various ages and stages of risk.
2. To assure **Accountability**, programs should address their sustainability from the beginning, set clear goals and incorporate an evaluation component.
2. **Understand and Involve Young People** to effectively respond to their needs and perceptions at various stages, involving them in program design and implementation
4. **Create an Effective Process** by developing credible messages, provide for interactive skill development and competent, empathic teachers.

A number of programs CAMH has developed or been engaged in have been described in the compendium for adhering to the principles just described.

*The Student Alcohol and Drug Use Policy and School Curriculum Resources* addresses prevention of drug use among students from Grades 1 to 10.

*Opening Doors* is directed to youth in the transition year of Grade 9 who are at risk of developing problem behaviours. The goal is to prevent or reduce a variety of problems including substance use, truancy, violence and other anti-social behaviours. Short term goals include improvements in academic achievement and positive attitudes toward school, increases in self-concept and perceived competency. Results of the provincial outcome study indicated significant reductions in frequency of drinking, cannabis use, and non-prescription tranquilizer and sedative use; less supportive attitudes toward alcohol, tobacco and cannabis use and risky drinking behaviour.

The *Harm Reduction for Rural Youth* project, involved youth members on a project team that received training in conducting a needs assessment and implemented a survey in their high school. It identified the issues of concern to students and the mechanism by which they wanted to learn about them. The students developed a magazine including factual information about alcohol and other drugs, as well as tips for safe use. The findings from this project and recommendations for developing effective youth-led projects are captured in the handbook entitled "Freedom to Act" produced by CAMH.

*Let 'Em Go* is another resource for youth service providers or peer leaders that provides information on coordinating youth driven projects. This handbook describes the experiences of

using a harm reduction approach with street involved youth. The youth led a research and development project that resulted in the production of a video that explores the realities of life on the street and suggests ways to reduce drug related harm.

**First Contact** is a brief treatment protocol directed at youth between the ages of 14 -25 who are using substances. The manual presents a motivational counselling approach to help youth examine their drug use, look at the pros and cons of changing, identifying situations that put them at risk, and develop strategies to deal with these situations. A clinical evaluation study of First Contact was conducted at the Centre for Addiction and Mental Health; at six-month post-treatment, clients reported significant reductions in drug use and significant reductions in negative consequences related to drug use.

The interplay between mental health and substance use and abuse is increasingly becoming more evident in clinical practice and research. According to the 1999 Ontario Student Drug Survey roughly one in three students report elevated psychological distress, with one in two females students reporting a moderate risk for depression. Using a participatory qualitative research approach CAMH sponsored a province wide project entitled VALIDITY (Vibrant Action Looking into Depression in today's Young Women) which examined depression in young women. Fear of rejection, judgement and negative reactions by others was an overwhelmingly frequent response from focus group participants as barriers to seeking help. From youth self reports we know that youth often use substances including cannabis to cope with mental health issues.

Early identification and treatment of young children and youth that have mental health problems may help to prevent later substance use and abuse. The reverse is also true: those who have a substance use problem should be thoroughly assessed to determine if they have co-occurring mental health problems.

The compendium also includes a number of prevention programs from other countries that have been scientifically evaluated. Additional Canadian programs are included that have been shown to adhere to the principles described above. As with other harm reduction interventions, innovative programs should be encouraged and supported, with an evaluation component that will allow us to adopt the most effective strategies for addressing the harms associated with substance use.

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