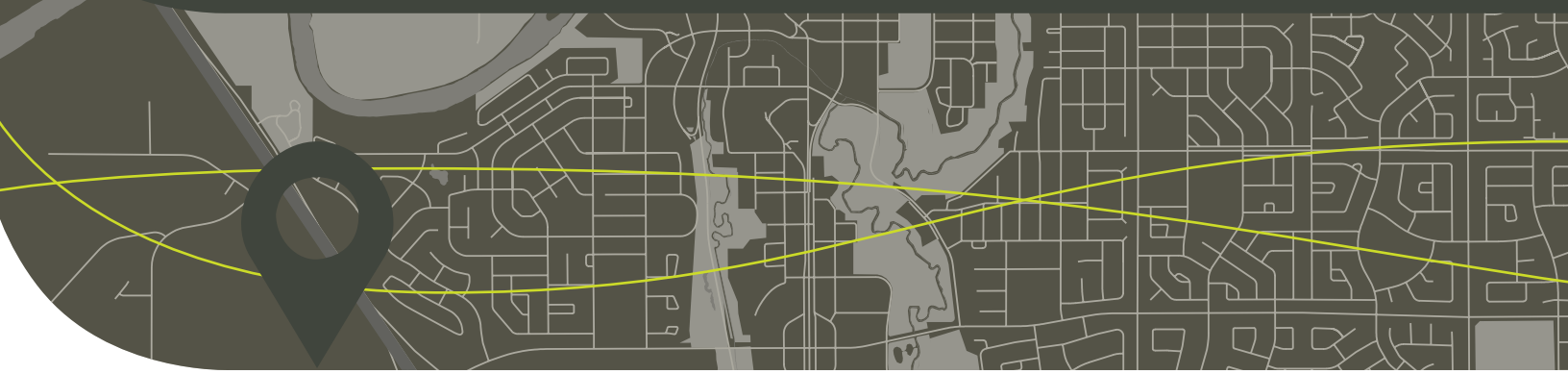
OUR VISION: *A HEALTHY AND VIBRANT RED DEER WHERE PEOPLE ARE THE PRIORITY.*

THE RED DEER

ALCOHOL & DRUG **STRATEGY REPORT**



CAAC | Central Alberta Addictions Consortium

THE CITY OF Red Deer

ACKNOWLEDGEMENTS

The Central Alberta Addictions Consortium and The City of Red Deer would like to thank the following community stakeholders for contributing their time, resources and expertise to the development of *Red Deer's Alcohol and Drug Strategy*. Our deepest appreciation goes out to all who took the time to help make this a truly 'made-in-Red Deer' strategy.

- Red Deer Downtown Business Association
- CAANS Next Step Peer Support Group
- Red Deer College
- Central Alberta FASD Network
- Red Deer Youth and Volunteer Centre
- Red Deer Public Schools
- Central Alberta Child and Family Services
- Alberta Health Services, Red Deer Regional Hospital

Central Alberta Addictions Consortium Members:

- Brian Einarson, Community Facilitator, (Ret.) The City of Red Deer, Social Planning Department
- Christine Stewart, Programs Manager, McMan Youth, Family and Community Services Association
- Darcie Gellner, M.D., C.C.F.P. (E.M.), Citizen at Large
- David Radcliffe, Citizen at Large
- Jason Taylor, Community Facilitator, The City of Red Deer, Social Planning Department
- Jennifer Vanderschaeghe, Executive Director, Central Alberta AIDS Network Society
- Kath Hoffman, Executive Director, Safe Harbour Society
- Marion McGuigan, Executive Director, Canadian Mental Health Association, Alberta Central Region
- Patrick McNulty, Manager, Alberta Health Services, Addictions Services – Red Deer
- Robecca Chahine, Chief Executive Officer, Vantage Community Services
- Sgt. Tom Kalis, Royal Canadian Mounted Police, Red Deer City
- Supt. (Ret.) Warren Dosko, Royal Canadian Mounted Police, Red Deer City
- Tanya Schur, Executive Director, Red Deer Native Friendship Society

TABLE OF

CONTENTS

"Stories are highlighted throughout in these quotation boxes. They paint a picture of some of the ways stigma, discrimination and shame surround substance use. When we take the time to listen to people's history we open a door to understanding. Jodi Picoult says it very well in her book, The Storyteller. She says: "Sometimes all it takes to be human again is someone who can see you that way, no matter how you present on the surface."

EXECUTIVE

SUMMARY

The Central Alberta Addictions Consortium is pleased to present the Red Deer Alcohol and Drug Strategy.

In response to growing concerns surrounding the negative impacts of substance use in our community, Red Deer City Council identified the need for a made-in-Red Deer, community-driven response to this issue. This document is intended to provide an evidence-base for a broad, dynamic and evolving community conversation about our shared approaches to the harms of substance use in Red Deer, along with actions needed to begin addressing existing gaps in our service continuum.

This local initiative is informed by the four-pillar approach to drug policy, which includes prevention, treatment, harm reduction and enforcement practices. This strategy provides recommended actions to achieve the outcomes identified under each of the four pillars and to meet the needs of our community.

The Central Alberta Addictions Consortium is a Red Deer-based coalition made up of representatives from the RCMP, Alberta Health Services, municipal government, not-for-profit organizations, and involved citizens focused on supporting coordinated and collaborative approaches to the delivery of addictions services in the region and advocating for education, awareness and evidence-informed practices in meeting community needs.

In order to begin this work, a vital first step will be working with The City of Red Deer to establish a Leadership Committee to oversee and initiate detailed discussions among key stakeholders moving forward. Indeed, leadership at all levels will be required to address the community needs outlined in this report.

As part of this work, the Consortium consulted with community members and service providers in order to get a sense of the issue from a broad community perspective. Through these consultations, we learned that Red Deer is an engaged and caring community that values comprehensive responses to the harms of substance use. The need for leadership on this issue was another prominent theme in these consultations, as we seek to support evidence-informed practices and to reduce stigma surrounding this complex community issue.

Though there remains a divide between general public awareness and the current science surrounding substance use and related harms, Red Deer has a clear opportunity to engage all stakeholders in this conversation to promote well-rounded and effective local approaches.

Without doubt, we are all responsible for co-creating an ever-safer, ever-healthier Red Deer. Brief case examples throughout this strategy demonstrate the complexity of this issue and the need for a collaborative approach.

Red Deer has a proven track-record as an innovative, creative and driven community. Red Deer's Drug and Alcohol Strategy will further demonstrate how our community embraces innovative practices to respond to critical community concerns.

INTRODUCTION

Society's use of alcohol and other drugs is more complex now than ever before.

Early traumatic experiences can powerfully impact the likelihood of substance use and mental health issues in a person's life, and it is now widely accepted that "exposure to chronic and serious early stressors creates an exaggerated stress response in the brain and body that, over time, may erode the solid foundation on which mental health develops."[1]

While evidence shows that certain socioeconomic and demographic characteristics such as poverty, abuse or mental illness may increase the risk of harmful substance use, this issue pervades all levels of society.

There are an abundance of factors that influence the ways in which communities understand and respond to substance use and its impacts. Cultural traditions and attitudes around the use of substances can also differ greatly. The methods used to mitigate the harmful impacts of substance use are even more diverse and touch upon many political, legal and social views, as well as scientific understandings.

To effectively develop an alcohol and drug strategy that is comprehensive and that encompasses all facets of substance use, we must first understand the context of substance use and its impact on individuals, families and the community as a whole.

Research on the subject continues to provide new insights to help inform our responses; yet the issue remains a highly charged one, wrought with conflicting perspectives. As a result, the inherent complexity surrounding the harms of substance use will require approaches that respect individual and cultural realities. There is no easy answer and no one-size-fits-all approach to this issue. Our response as a community to the harmful effects of substance use will require creativity, resourcefulness, patience, compassion, intentionality and leadership if it is to be effective.

> "I'm respected in the business community, and for all intents and purposes, I look like an ideal community citizen. What they don't know is that I have so much shame surrounding my addiction to alcohol that I've stopped drinking booze and switched to mouthwash. Why, you ask? I don't want to be seen going into the liquor store as often as I need to now. No one thinks twice if they see you going into a grocery store."

1 http://www.health.alberta.ca/documents/Creating-Connections-2011-Strategy.pdf - Accessed March 28, 2014

PURPOSE

This document has been prepared to provide an evidence-base for a comprehensive, dynamic and evolving community conversation about our shared responses to key issues related to substance use in Red Deer, along with actions needed to address the harmful effects of alcohol and drug use in our community.

In addition to supporting an increased awareness of the root causes of substance use, the information and recommendations in this report will enhance opportunities to foster healthy lifestyles and reduce the harms of substance use among citizens.

RED DEER'S ALCOHOL AND DRUG HISTORY

The City of Red Deer's Safety Charter identifies the development of a local alcohol and drug strategy informed by the four-pillar model as a key goal to better understand emergent issues, possible strategies and responsibilities for community stakeholders throughout the city.

In response to growing concerns about the negative impacts of illicit drugs and addictions in our community, Red Deer City Council voted to support the Vienna Declaration on June 13, 2011. In 2012, The City of Red Deer appointed the Central Alberta Addictions Consortium as the Advisory Committee on the development of an Alcohol and Drug Strategy. The Central Alberta Addictions Consortium is a Red Deer-based coalition focused on supporting coordinated and collaborative approaches to the delivery of addictions services in the region and advocating for education, awareness and evidence-informed practices in meeting community needs.

The Consortium then set forth to gather the pieces of information necessary to establish a clear picture of alcohol and drug use in Red Deer, beginning with a series of community consultations. In addition to qualitative community input, available quantitative data pertaining to drug and alcohol use prevalence, support services and the related costs to society was used to inform the environmental scan. The Consortium also participated in a series of facilitated workshops to finalize the key components that would make up the *Red Deer Alcohol and Drug Strategy*.

The Vienna Declaration was drafted by a team of international experts and initiated by several of the world's leading HIV and drug-policy scientific bodies. The Vienna Declaration is a statement seeking to improve community health and safety by calling for the incorporation of scientific evidence into drug policies.

THE CURRENT

SCIENCE OF **ADDICTION**

Like all behaviours, addiction and the harmful use of substances are influenced by brain architecture. The environments we are exposed to as children, particularly exposure to toxic stress, even prenatally, can cause brain architecture to develop in ways that shape how vulnerable we are later in adolescence and adulthood to physical and mental health outcomes, including addiction.

While significant advancements have been made surrounding our understanding of addictions, a good deal of work remains to be done to advance educated understandings of the nature of addiction.

In 2010, the Alberta Family Wellness Initiative (AFWI) of the Norlien Foundation partnered with Alberta Health Services and the Government of Alberta to collaborate toward a transformation in knowledge about early brain development and addiction in an effort to support informed policy and decision-making throughout the province. As it is succinctly noted in the AFWI's Sharing the Brain Story report:

> *[R]esearch, policy, and practice depend upon public awareness, perception, and support. But while scientific knowledge about early childhood development, child mental health, and addiction has advanced dramatically in recent years, very little of this knowledge has percolated into public discourse. The public still has foggy, often misguided, notions of how the brain develops; what, if anything, can be done to promote healthy development; and who is responsible for doing it. Likewise, under-developed notions about the nature of addiction and what causes it restrict how the public and policy makers think about what can be done to address the problem and who is responsible for doing it.*[2]

In addition to sharing the science of early brain development and its influence on mental health and substance use outcomes, we must encourage comprehensive and holistic understandings and approaches to truly make progress on this front. Dr. Gabor Mate illustrates this point concisely:

> *We need to avoid the trap of believing that addiction can be reduced to the action of brain chemicals or nerve circuits or any other neurobiological, psychological or sociological data. A multileveled exploration is necessary because it's impossible to understand addiction fully from any one perspective, no matter how accurate. Addiction is a complex condition, a complex interaction between human beings and their environment. Addiction has biological, chemical, neurological, psychological, medical, emotional, social, political, economic and spiritual underpinnings. Addiction is "all about" many things.*

Widespread education on the underlying factors surrounding substance use will be required to avoid reenacting the same responses that have slowed progress on this issue historically – approaches that address the symptoms of mental health and addiction problems, but fail to address the root contributors to such issues.

***Red Deer's Alcohol and Drug Strategy* will act as yet another tool to support evidence-based practices and as a foundation that builds a comprehensive view of alcohol, drug use and mental health issues in the community.**

For readers interested in further information on the current science of addiction and early brain development, here are a couple of helpful and informative links here:

http://www.albertafamilywellness.org/resources/video/how-brains-are-built-core-story-brain-development

https://www.youtube.com/watch?v=yCzXbsGAXiI

http://www.albertafamilywellness.org/resources/publication/sharing-brain-story-afwis-knowledge-mobilization-strategy

2 Walters. Alberta Family Wellness Initiative. Sharing the Brain Story: Knowledge Mobilization Strategy -Transforming Research, Policy, and Practice in Alberta (2013). Calgary, AB, Canada: Norlien Foundation. Pg 8

COMMUNITY CONSULTATIONS

For both The City of Red Deer and the Central Alberta Addictions Consortium, hearing from service users, citizens, businesses and service providers about the harmful impacts of substance use continues to be of the utmost importance. First-hand perspectives on the harmful effects of substance use and our collective responses to these issues are critical in ensuring the creation of a community-driven, culturally-appropriate strategy.

The City of Red Deer, in partnership with the Central Alberta Addictions Consortium, engaged in a community consultation process to gather perspectives on the development of the *Red Deer Alcohol and Drug Strategy.* The consultation was composed of a one-day community event, as well as six focus groups with stakeholders considered to have key insights or experience related to substance use and related services.

The public event, held on May 16, 2013, offered an opportunity for the community to provide input and suggestions for inclusion in the development of the strategy. Approximately 100 attendees gathered for a presentation from Donald MacPherson, Director of the Canadian Drug Policy Coalition. This was followed by group discussions and a question-and-answer period with a panel of experts. Recommendations from the community regarding alcohol and drug use in Red Deer covered a variety of topic areas:

Awareness and Stigma Reduction

Participants discussed reducing the focus on the individual and emphasizing substance use as a community issue. This is necessary in order to overcome the stigma directed toward people who use substances. Broad-level community engagement and education were identified as being critical to facilitating this change.

Community and Compassion

Participants expressed the need for all community members and stakeholders to actively come together to foster integrated and intergenerational community involvement. This will assist in building protective factors and community resiliency to support all members of the community affected by alcohol and drug use.

Political Involvement

Participants emphasized the need for increased political advocacy by all stakeholders. Educating, engaging, lobbying and gaining support from political leaders at all levels is critical to creating change in both policy and legislation.

Policy and Legislation

Participants discussed issues of decriminalization versus enhanced enforcement. Participants identified a link between the criminalization of drugs and stigmatization of users. The majority of participants felt that decriminalizing the possession of small amounts of certain drugs would allow for a better use of resources.

Holistic Approach and Collaboration

Participants recognized the importance of a broad range of service options along the continuum of substance use. Participants emphasized prevention-focused efforts and supporting increased resilience, as these are seen as critical in reducing downstream interventions or enforcement practices. Collaboration will be vital to driving meaningful change and the provision of comprehensive supports.

In the six facilitated focus groups, 57 individuals represented the following organizations, among others:

- Central Alberta AIDS Network Society: Next Steps Peer Support Group
- Central Alberta's Safe Harbour Society for Health and Housing
- McMan Youth, Family and Community Services Association
- Red Deer Downtown Business Association
- Red Deer Native Friendship Society
- Red Deer Regional Hospital

The City of Red Deer's Social Planning department provided Community Facilitators to conduct the focus groups, and participants were invited to provide their thoughts and feedback on a proposed strategy. To a large extent, the ideas and themes gathered from the community conversation overlap with those identified through the focus group consultations with stakeholders.

In addition to a broad range of existing positive outcomes seen in the community, participants prioritized the following service gaps:

- **Safety and Justice**
- **Funding**
- **Program and Services**
- **Awareness and Education**[3]

The insights gained through community consultation have contributed to the development of this strategy and will ensure that this truly is a made -in-Red Deer approach.

> "I am a doctor at a local walk-in clinic. I'm trying to stay compassionate when it comes to drug addicts. I understand mental health and how people "can't help" what is happening to them, but when it comes to drug use, it still looks like a choice to me. It's frustrating to see people who are addicted in the clinic. It's hard not to be mad at them because they could stop. People can stop. Yet, when I'm doing their histories and examining their bodies, I start to imagine what their lives might be like. I know they aren't having any fun. I know they are killing themselves slowly. I see their families with them and see the hurt and confusion that surround them. No one would choose this. Here they are in front of me and how am I helping? Does my energy reveal my contempt? As a doctor who treats pain, how deep is theirs? Have we really looked for it or do we just see this surface symptom? How can I help best?"

3 Schmitt-Boshnick, M. Community Consultation Report for a Drug and Alcohol Roadmap for a Healthy Community. City of Red Deer, September 2013.

GUIDING

PRINCIPLES

The following Guiding Principles capture both community sentiments and the collective knowledge and aspirations of addictions service leaders in the community. These principles will guide community stakeholders in implementing the recommendations of this strategy and working to address the harmful effects of alcohol and drug use in the community.

Relationships

Community connections not only nurture broad and comprehensive understandings of an issue, but also ensure that a community's assets and services are integrated, seamless and operating as efficiently as possible for the benefit of individuals and the community as a whole.

Pragmatism

Supports to individuals and families must recognize that change is a process, and the process of addiction is complex. Approaches must be sufficiently flexible to empower those affected by alcohol and drugs toward positive behavioral changes by meeting them where they are at, and doing what works for them.

Respect

Respectful client-centered service provision is vital, as is the need to ensure that all perspectives on issues related to alcohol and drug use are heard. There are a wide array of beliefs and perspectives regarding services and policies related to substance use, and the respectful exchange of ideas should be valued.

Cultural Relevance

Approaches, programs and services must take cultural realities, customs and other factors into consideration in order to be effective and impactful.

Well-being

Approaches, strategies and services must enhance the holistic well-being of individuals, families and the community at large. Holistic well-being includes physical, socioeconomic, mental/emotional and inter-relational health, as well as the broader environmental, economic and social well-being of the community.

Evidence-Informed Practice

Research and evidence-informed approaches that will achieve positive outcomes for individuals and communities will be supported and used. The results of programs and services will be measured to ensure shared learning and enable reproduction of successful strategies.

Innovation and Creativity

Our ability to effectively respond to issues related to substance use will depend on our ability to think 'outside the box' and develop creative approaches that work for our community.

THE FOUR-PILLAR APPROACH AND

RECOMMENDATIONS FOR RED DEER

The four-pillar approach to drug use was first implemented in a number of European countries in the 1990s, followed by several Canadian communities, in 1997.[4] This approach, composed of the prevention, treatment, harm reduction, and enforcement pillars, supports a comprehensive and multi-system approach to addressing this issue.

The four-pillar approach has since been incorporated into international, national, provincial and municipal responses and strategies related to drug and alcohol use. The pillar of Harm Reduction has been eliminated from the federal government's *National Anti-Drug Strategy*, but even so, all four pillars continue to be supported as best-practice approaches to this issue. Because of this demonstrated best practice, the *Red Deer Alcohol and Drug Strategy* supports the four-pillar model as the foundation for moving forward.

The following is a brief description of each of the four pillars, with supplementary links for further information. After a description of each pillar, key recommendations under each pillar are identified, as well as recommendations related to leadership and implementation moving forward.

> "I am a mother who lost her daughter to cancer. Throughout that entire nightmare, I had tremendous support and love wrapped around me, and it helped me so much as I let her go. Now I have a son I'm losing to addiction, and I feel very alone. This is such a different process, but it can have the same result. I'm terrified to lose him but hesitant to talk to people about it. When I talked to my friends about my daughter's cancer, I knew what their reaction would be. I knew they would embrace me. If I talk about my son and even only give them a glimmer of an idea of what we're going through, there is a good chance they will tell me to kick him out or to stop talking to him. They may even wonder what I've done to contribute to his addiction. No one blamed me for my daughter's cancer. I'm ashamed of this addiction, of what people will think of us when they find out. I told my friends every component of my daughter's journey and very little of my son's. I am ashamed that I am ashamed of him."

4 City of Vancouver, "Four Pillars Drug Strategy". July, 2004. Retrieved on January 27, 2014. Pg. 1. (http://www.mayorsinnovation.org/pdf/briefing_book_012706/dcp3.pdf), pg. 3

PREVENTION

Prevention refers to those strategies, services and programs that are intended to prevent harm related to substance use while respecting the important role played by abstinence-based and early-stage prevention approaches (education, asset development, etc.). Prevention methods also recognize that experimentation with substances does occur and that people require information to do so as safely as possible. Further:

> *The prevention of problematic substance use contributes to the public good by reducing costs to society, as well as harm to individuals and communities. Important prevention goals include stopping or delaying the onset of substance use among youth and addressing the underlying causes of drug use, not just the drug use itself.*[5]

Prevention initiatives attempt to prevent the harms associated with the use of legal substances, such as alcohol, prescription drugs, as well as substances such as cocaine, heroin, and marijuana.

http://www.albertafamilywellness.org/resources/video/brain-hero

Recommendations

Increase the community's understanding of alcohol and drug use, reducing the level of stigma and discrimination that surround people with an addiction, striving to prevent the harms of substance use through the following actions:

1. Implement and evaluate a broad-based community education campaign on early brain development, root causes and the critical role toxic stress plays in our understanding of addiction.
2. Increase resiliency for children and families by ensuring education and supports are available.
3. Increase evidence-based alcohol and drug prevention programming for youth in the Red Deer school systems and broader community.
4. Increase workplace addiction-related health and safety education and informing policy on the impacts of drug testing within human resources.
5. Simplify and increase access to addiction and mental health information, including peer support group meetings in Central Alberta.
6. Enhance the level of dialogue between sectors and institutions in order to access and share local alcohol and drug data.

5 City of Vancouver, "Four Pillars Drug Strategy". July, 2004. Retrieved on January 27, 2014. Pg. 1. (http://www.mayorsinnovation.org/pdf/briefing_book_012706/dcp3.pdf), pg. 3

TREATMENT

The treatment pillar is intended to capture a broad range of community-based medical and counselling interventions, outreach support and other bio-psychosocial programs that work with individuals experiencing difficulties related to their use of psychoactive substances and to support positive behaviour change.

While the common conception of treatment brings to mind an abstinence model, treatment can also support developing the capacity to make healthy choices that do not demand total abstinence; for example, controlled drinking programs. In addition, feeling connected is critical for both the prevention and treatment of addiction. Our cultures are our roots, our places of refuge, our heritage and where we feel we belong, and these are the very cornerstones in the prevention and treatment of addiction.

> "My brother is in jail. He got busted for crack again. I don't know what happened to him. He used to be so nice to me and let me hang out with him and his friends. We used to play road hockey all the time. Then he started partying, and he hasn't ever stopped. I can't bring my friends over any more because of all the fighting with Mom and Dad and him. All my friends know about it, and I just wait for them to say something to me. I'm so mad; I never thought I'd be ashamed of him."

Recommendations

Enhance community treatment resources that support individuals and families toward healthy and rewarding lives through the following actions:

1. Increase the diversity and number of treatment options in the community, not only for those who are addicted, but for those around them. This includes appropriate capacity for shelters working with intoxicated people and medically supported detox spaces for youth and adults.
2. Increase cultural programming for Aboriginal people and newcomers to Canada.
3. Increase addiction supports within the Red Deer school systems.
4. Support affordable, accessible and local access to residential treatment for both youth and adults.
5. Support long-term assisted living and palliative care supports for people with an active addiction.

HARM REDUCTION

Harm reduction involves an achievable, pragmatic approach to alcohol and drug issues, and seeks to reduce the individual and societal harms associated with substance use. Harm reduction seeks to mitigate harm while still allowing for the possibility that total abstinence may not be an option for everyone and that some level of use may simply be a reality based on where a person is at in their readiness for change. Harm reduction ensures access to services and supports at all points along the continuum of use.

Harm reduction methods have attracted intense public and governmental scrutiny over the years. The fundamental premise of not requiring a change in drug use per se, but working to reduce the harms related to substance use, is difficult for many to reconcile with the goal of safer, healthier communities. Yet the philosophy of harm reduction pervades health promotion methods and benefits citizens from all walks of life. In Red Deer, we want to work toward saving lives and reducing the harms related to substance use, and we believe harm reduction initiatives will greatly contribute to our overall success as a community.

http://www.youtube.com/watch?v=ta2Jmy1ZFXM

Recommendations

Work to reduce the harms of alcohol and drug use in Red Deer through the following actions:

1. Increase safety programming for people who inject, inhale or drink substances, as well as maintenance programs to help with withdrawal as people minimize their use.
2. Increase overdose-prevention and awareness programming.
3. Increase harm reduction programming in prenatal programs.
4. Implement a safer partying program/awareness campaign directed at young adults.
5. Increase the variety of Housing First options in the community.

COMMUNITY SAFETY

The pillar of community safety is recognized as an integral component of a holistic approach to responding to the harmful effects of drug and alcohol use. "Community safety" is included with the term "enforcement" to represent this pillar and the range of interventions that seek to address the crime and social disorder related to drug and alcohol use. This pillar represents all components of the broader criminal justice system, including police, the courts, parole/probation, crime prevention and community-driven initiatives intended to enhance community safety and mitigate social disorder.

Red Deer Police and Crisis Team: http://vimeo.com/75507516

National Film Board of Canada, "Through a Blue Lens": https://www.youtube.com/watch?v=gwFRsfATaag

Recommendations

Work to reduce drug trafficking in the community, as well as alcohol and drug-related incidences, and support appropriate diversion to treatment options through the following actions:

1. Increase the coordinated approach between police and community stakeholders in addressing alcohol and drug related crime.

2. Prioritize enforcement resources on organized crime (drug production and trafficking) within the RCMP.

3. Continue to support and evaluate Community Response Unit (CRU) and Police and Crisis Team (PACT) Programs in Red Deer.

4. Increase programs that divert people from the justice system to appropriate health supports. This includes incorporating alcohol and drug related cases into diversion programs.

5. Implement a drug court.

"As a homeless addicted person in Red Deer, I walk around with my head down most of the time. I feel invisible mostly. I usually have a wide berth, no problems with crowds around me. People usually even cross the street to stay out of my way. I grew up in Red Deer, so did my dad and his dad. Until I started using, it was a community that I felt I belonged to. Now the community I "belong" to is full of many people as sick as I am. The old community that walks around me all day doesn't want me in it anymore. I read the papers; I know I am one of those eyesores in the downtown. People hate the sight of me. I can feel it coming off of them as they look at me. I want to laugh and tell them, "Hey, I used to be just like you." I made a lot of money in the oil patch; I had all the toys, the fancy truck, the quad, the boat, granite countertops even. I got in debt over my head and started drinking all the time instead of just on the weekends. I didn't know how to keep it all going. The debt weighed heavy on my shoulders constantly. A little bottle of pills seemed to lighten the load for a while, but now they are the heaviest load I walk with. I lost everything: my family, all the toys, and all the friends I had to enjoy them with me. Everything is gone. The community that welcomes me now keeps me sick and the other wants to keep me hidden. Where do I go?"

IMPLEMENTING THIS

STRATEGY

Improving the lives of Red Deerians will rely on Red Deer's support of best practice approaches and widespread understanding of this critical issue.

Leadership at all levels will be required to address the community needs outlined in this strategy. In addition, the implementation and follow-up work related to the recommendations in *Red Deer's Alcohol and Drug Strategy* will require financial and human resources support from leaders across sectors to ensure that this strategy is a living one; a strategy that will result in measurable outcomes into the future.

In recognition of jurisdictional boundaries and responsibilities shared by a number of sectors and stakeholders, we understand the distinctive role of the municipality in providing leadership and support for community stakeholders to work toward a healthier, safer community.

Indeed, effecting change to improve the wellbeing of all community members requires an integrated, multisystem effort, which is driven, maintained and monitored by strong leadership at all levels.

This report calls on The City of Red Deer to participate in the establishment of a Leadership Committee to initiate discussions and bring key stakeholders together around *Red Deer Alcohol and Drug Strategy* recommendations. It will also be vital that this committee regularly checks in with the community and key stakeholders on the progress being made.

> "I was addicted to pain killers for 15 years, but I've been clean for the past five. Things are finally starting to turn around for me, and what happens but I get a kidney stone! The pain was unbearable, and while I was in emergency, the doctors refused to give me anything for it. I had been honest about my medical history, and they didn't want me to become addicted again. I tried to explain that it is not the substance that made me addicted, it was all the stress in my life. No one could hear me. Once that addict label was attached to my chart, I was alone with my pain once again."

STIGMA, DISCRIMINATION AND

SHAME

It is not uncommon to hear friends, family, colleagues, or even ourselves use terms like 'those people' to describe particular groups of people when speaking of a given issue. As with mental illness, substance use and dependency is possible within all of our families and neighbourhoods; no socioeconomic or demographic group is immune. Yet our concerns about community safety or acceptable behaviour can sometimes be misdirected toward an easily identifiable group: 'those people'. Often, those who are most visibly affected by a complex issue, such as substance use or mental health problems, are the recipients of generalizations or derogatory comments. For some, it may be a community's homeless or street-involved population; for others, it might be young people or those living on lower incomes that are 'the problem', or 'those people'. While this is common in many communities, pointing to a group or subpopulation as 'the problem' is not an accurate representation of the issue.

Throughout this report, an intentional attempt has been made to use evidence-informed and non-stigmatizing language that respects the fundamental human rights of all citizens, including people who use substances. The importance of words and language around this issue is paramount. Value-laden and judgmental language does little to assist the community in determining the approaches that will ensure our community is a healthy, vibrant, and inclusive one that embraces progress and compassion. Encouraging the use of evidence-informed and non-judgmental language will support a greater understanding of the issue at-hand.

Through this strategy, we strive to shift the conversation around the harmful effects of substance use away from one of judgment or oversimplification to one of understanding and shared responsibility.

APPENDIX A

DRUG AND ALCOHOL POLICY OVERVIEW "AT A GLANCE"

There is nothing simple about drug policy in Canada.

Substance use, and the harms related to it, is a complex subject, with implications and relevance in both health and criminal justice contexts, among others. Complicating things further are the different jurisdictional boundaries between governments in Canada. The provision of health care services is predominantly considered to be a responsibility of the provinces, while criminal law falls under federal jurisdiction. Municipalities are empowered to pass bylaws respecting "the safety, health and welfare of people and the protection of people and property," and are generally responsible for maintaining safe and viable communities.[6] Such jurisdictional priorities and responsibilities between levels of government influence the policy and legislative environments at each respective level. As the Canadian Drug Policy Alliance's Getting to Tomorrow: A Report on Canadian Drug Policy report states:

> *Canadian drug policy is a multi-jurisdictional matter. The federal government, the provinces, provincial health authorities, municipal governments, and police all play a role in deciding which issues will be a priority, how drug use issues will be understood and approached, how the illegal drug trade can be limited, and how public funds will be allocated. Drug policy decisions also cut across a number of other policy areas including policing, justice, lawmaking, the use of military force, interpretation of law and the decisions of judges. And elements of drug policy are also found in public policy areas such as health, housing, social assistance, education and immigration and citizenship..*[7]

The four-pillar approach to drug policy recognizes that prevention, treatment, harm reduction and community safety are symbiotic and mutually necessary components of a comprehensive service continuum and multi-level response to the harmful effects of substance use. While jurisdictional and political implications, the availability of fiscal and human resources, and other factors can play a role in what appear at times to be varying priorities at different levels of government, efforts to support evidence-based practices that respect human rights must be supported at all levels.

Organizations, experts and countries around the world are reevaluating the 'war on drugs' approach to the control of illicit substances as evidence emerges regarding the human and economic costs of criminalizing policies. A steady reliance at the federal level in Canada upon enforcement-based methods has drawn scrutiny from leading drug and public health policy bodies, such as the Canadian Drug Policy Alliance and the Canadian Public Health Association. Provincially, the Government of Alberta and Alberta Health Services continue to support evidence-informed public health approaches, such as harm reduction and early childhood development strategies, as best practices and important pieces of this complex puzzle.

Ultimately, this strategy reinforces Red Deer City Council's endorsement of the Vienna Declaration and the importance of evidence-based practices and comprehensive approaches to substance use based on the four-pillar approach to drug policy in ensuring the health and safety of Red Deerians into the future.

6 Province of Alberta. Municipal Government Act: Revised Statutes of Alberta, 2000. Division 1, section 7 (a). http://www.qp.alberta.ca/documents/Acts/m26.pdf - accessed May 23, 2014.
7 Connie I. Carter & Donald Macpherson. Canadian Drug Policy Coalition: Getting to Tomorrow (2013). Pg 15

DRUG POLICY OVERVIEW

The following section will explore some of the nuances surrounding drug policy at the international, national, provincial and municipal levels.

International Drug Policy

In 1961, in an attempt to consolidate multiple multilateral treaties related to the control of narcotic substances, the Economic and Social Council of the United Nations convened a conference of international government and non-government representatives for the adoption of a single convention on narcotic drugs. The Single Convention would "reduce the number of international treaty organs exclusively concerned with the control of narcotic drugs, and to make provision for the control of the production of raw materials of narcotic drugs."[8]

The Single Convention lays out the schedules of controlled substances, as well as responsibilities of member states to pass domestic laws and regulations, and penal provisions, to ensure compliance with the Convention and supports provided to ensure this, as well as strict exceptions for medical and scientific uses of narcotics. The treaty focuses on cutting off the supply of illicit narcotics through focusing on producers and traffickers and takes a generally prohibitionist stance to illicit drug use and production.

Then, in 1971, the Economic and Social Council of the United Nations convened a conference of international government and non-government representatives for the adoption of a convention on psychotropic drugs. The implementation of the provisions contained within the Convention on Psychotropic Substances reflects and supplements the provisions of the Single Convention on Narcotic Substances.

In 1988, the UN General Assembly requested the Commission on Narcotic Drugs develop a convention against illicit traffic in narcotic drugs, taking into consideration "various aspects of the problem as a whole and, in particular, those not envisaged in existing international instruments."[9] The 1988 Convention encourages extensive information sharing and cooperation between member state policing organizations in the effort to combat illicit trafficking of narcotic and psychotropic drugs.[10]

The three aforementioned Conventions, or treaties, establish the legal framework and responsibilities of signatory states to "regulate the production, possession, sale and use of controlled psychoactive substances".[11] The UN Drug Conventions establish measures for the control of both the international trading of identified substances, and domestic drug laws.[12] Importantly, the "great many countries that became signatories to these conventions must in particular forbid any domestic market in prohibited substances and make possession of such substances a criminal offense."[13] The only exclusions to the regulations laid out in the Conventions apply to authorized scientific or medical research.[14]

While these treaties focus on the creation and enforcement of laws intended to control the supply and demand of illicit substances, the Canadian Drug Policy Coalition points out that "drug control cannot operate in isolation from international law including human rights law; nor can it be unconnected from the concerns of public health or medical ethics."[15] There appears to be a growing sentiment in the international community in favour of exploring alternative evidence-based approaches, reevaluating the 'war on drugs'-based strategies that have characterized international drug policy for the past half-century. The Getting to Tomorrow report states:

8 United Nations (1961). Single Convention on Narcotic Drugs.
9 United Nations (1988). Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. http://www.unodc.org/pdf/convention_1988_en.pdf Accessed April 2, 2014
10 Ibid
11 Global Initiative for Drug Policy Reform. "Conventions". http://reformdrugpolicy.com/beckley-main-content/conventions/ Accessed April 4, 2014
12 Ibid
13 Ibid
14 Ibid
15 Connie I. Carter & Donald Macpherson. Canadian Drug Policy Coalition: Getting to Tomorrow (2013). p. 67.

> *Some countries do not suppress socially and culturally embedded uses of controlled drugs like cannabis, opium and coca leaf chewing. Other governments have introduced pragmatic measures based on public health that focus on reducing the harms associated with drugs (i.e. needle exchanges, etc.) . . . and a number of governments have introduced de-penalization or decriminalization of some or all drugs to move away from the mass incarceration of people who use drugs.*[16]

The release of the inaugural report from the Global Commission on Drug Policy in 2011, a diverse "19-member panel, including current and former heads of state . . . criticized global prohibition and recommended that policies be based on evidence of what works to protect the health and safety of citizens."[17] Recently, in May of 2014, the London School of Economics issued a report endorsed by multiple Nobel Prize winning economists condemning the 'war on drugs' as an international policy strategy. The report's opening statement reads as follows:

> *A major rethink of international drug policies is under way. The failure of the UN to achieve its goal of 'a drug free world' and the continuation of enormous collateral damage from excessively militarized and enforcement-led drug policies, has led to growing calls for an end to the 'war on drugs'. For decades the UN-centered drug control system has sought to enforce a uniform set of prohibitionist-oriented policies often at the expense of other, arguably more effective policies that incorporate broad frameworks of public health and illicit market management. Now the consensus that underpinned this system is breaking apart and there is a new trajectory towards accepting global policy pluralism and that different policies will work for different countries and regions.*[18]

Drawing upon this information, it is clear that change is afoot in the international arena surrounding drug policy. Movement in support of evidence-informed public health and human rights-based approaches is occurring in light of the challenges faced by 'war on drugs'-focused approaches. To be sure, changes at the international level may set the stage for subsequent stages among states and their domestic governments, which may have an impact on the community of Red Deer down the road.

National Policy Overview

In 1987, the Progressive Conservative government of the day introduced Canada's National Drug Strategy, acknowledging substance use as a health issue while still confirming the enforcement-based approaches adopted historically in Canada since the Opium Act in 1908.[19] As described on the Parliament of Canada website:

> *Efforts to control and regulate psychoactive substances have . . . relied on legislation to ban the production, distribution and use of illicit drugs. The legislation used has included the Opium and Drug Act, the Narcotic Control Act, the Food and Drug Act and the current Controlled Drugs and Substances Act.*[20]

In 1992, Canada's National Drug Strategy was approved, calling for a balanced approach to efforts aimed at reducing the supply and demand for illicit substances through a focus on the four-pillar approach including prevention, treatment, harm reduction and enforcement-based strategies.[21] Then, in 1997, under the Chretien government:

> *[t]he Controlled Drugs and Substances Act was introduced and remains the current legislation for controlling the use of illicit drugs. In 2001, the Auditor General published a report on the federal government's role in the area of illicit drugs . . . Canada's Drug Strategy was renewed in 2003. It 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.*[22]

As noted above, Canada's federal drug control laws are contained within the Controlled Drugs and Substances Act. As noted by the Canadian Foundation for Drug Policy, the Act is "[t]he most important federal statute dealing with illicit drugs . . . [and] governs six common offences such as possession, trafficking, cultivation, importing or exporting and 'prescription shopping'.[23] "The Act lays out exemptions for law enforcement personnel and medical practitioners, administration and compliance standards, and punishments for possession, trafficking, exportation and production of each category of controlled substances. Further, the Act "serves as the implementing legislation for the Single Convention on Narcotic Drugs, the Convention on Psychotropic Substances, and the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances."[24]

The Government of Canada under Prime Minister Stephen Harper then introduced the National Anti-Drug Strategy on October 4, 2007, with three main priorities to "prevent illicit drug use, treat illicit drug addiction, and combat illicit drug production and distribution."[25]

Noticeably absent in the National Anti-Drug Strategy was the pillar of harm reduction, as well as any funding for harm reduction programming or services such as needle and syringe distribution programs, methadone treatment, and supervised injection facilities. Also absent is any clear targeting of approaches for the harms arising from the use of legal substances. such as alcohol, tobacco, or prescription pharmaceuticals.

On March 13, 2013, Bill C-10 received royal assent in Canada's Parliament, "to amend the Controlled Drugs and Substances Act 1 (CDSA) to provide for minimum penalties for serious drug offences, such as dealing drugs for organized crime purposes or using a weapon or violence" when involved in drug-related activities.[26] Importantly, the bill contains provisions for exceptions to be made by the courts in the imposition of mandatory minimum sentences upon the successful completion of a Drug Treatment Court program, or a drug treatment program.

A 2008 evaluation of the Anti-Drug Strategy was conducted by the federal government, containing reference to the discord between federal and provincial approaches to addressing the harms of substance use. The report recognizes that "the provinces' focus on substance abuse in general rather than abuse of illegal drugs, support harm reduction, and take a more holistic approach to substance use issues (for example, many provinces have integrated or are integrating mental health and addictions)'".[27]

National drug policy in Canada has mirrored the generally prohibitionist, enforcement-oriented approaches, to greater or lesser extents, seen at the international level to managing the manufacturing, distribution and use of illicit and licit substances. Recognizing that the pillar of enforcement is undoubtedly a critical element in a comprehensive response to addressing the harms of substance use, it will be important for stakeholders at all levels to monitor the evidence around the benefits and consequences to communities, families, and individuals, of this shift in federal policy" has been identified as a cumbersome sentence, and this has been suggested instead: "National drug policy in Canada has mirrored the generally prohibitionist, enforcement-orineted approaches seen at international levels. These focus, to greater or lesser extents, on managing the manufacture, distribution and use of illicit and licit substances. While recognizing that the pillar of enforcement is a critical element in a comprehensive plan addressing the harms of substance use, it will be important for stakeholders at all levels to monitor the evidence around the benefits and consequences to communities, families and individuals of this federal policy shift

Provincial Policy Overview

In 2011, the Province of Alberta and Alberta Health Services launched Alberta's Addiction and Mental Health Strategy and Creating Connections: Alberta Addiction and Mental Health Action Plan 2011–2012. The strategy and its associated action plan lays out broad directions for addiction and mental health priorities within the province of Alberta and informs the overarching legislative, policy, strategic and performance management direction for addiction and mental health services in the province.[28]

In recognition of the substantial changes that have occurred related to the amalgamation of the province's nine regional health authorities, as well as the Alberta

15 Connie I. Carter & Donald Macpherson. Canadian Drug Policy Coalition: Getting to Tomorrow (2013). p. 67.
16 Ibid
17 Ibid
18 London School of Economics. Ending the Drug Wars: Report of the LSE Expert Group on the Economics of Drug Policy. Pg 6. May 2014
19 http://www.parl.gc.ca/About/Parliament/LegislativeSummarie
20 LegislativeSummaries/bills_ls.asp?ls=c10-04&Parl=41&Ses=1#a2 – Accessed March 17, 2014
21 Ibid
22 http://www.parl.gc.ca/About/Parliament/LegislativeSummaries/bills_ls.asp?ls=c10-04&Parl=41&Ses=1#a2 – Accessed March 17, 2014
23 http://www.cfdp.ca/sen8ex1.htm - Accessed March 18, 2014
24 http://en.wikipedia.org/wiki/Controlled_Drugs_and_Substances_Act - Accessed March 14, 2014
25 Ibid
26 http://www.parl.gc.ca/About/Parliament/LegislativeSummaries/bills_ls.asp?ls=c10-04&Parl=41&Ses=1#a2 – Accessed March 17, 2014
27 Ibid
28 Government of Alberta. Creating Connections: Alberta's Addiction and Mental Health Strategy. September, 2011, p. 3

Mental Health Board, the Alberta Alcohol and Drug Abuse Commission, and the Alberta Cancer Board into a single health authority, Alberta Health Services and the Government of Alberta (Alberta Health and Wellness) issued the report, stating:

> *The purpose of the Strategy is to transform the addiction and mental health system in Alberta. The ultimate goal is to reduce the prevalence of addiction, mental health problems and mental illness in Alberta through health promotion and prevention activities and to provide quality assessment, treatment and support services to Albertans when they need them.*[29]

The strategy establishes a foundational acknowledgment of the many issues often at play surrounding mental health and addictions and that a complex interplay of "genetic, biological, personality and environmental factors"[30] influence an individual's pattern of substance use.

The five strategic directions identified in the strategy are as follows:

1. Build healthy and resilient communities
2. Foster the development of healthy children, youth and families (includes seniors)
3. Enhance community-based services, capacity and supports
4. Address complex needs
5. Enhance assurance

As stated in the report, "[f]or each strategic direction, major priorities and key results are identified and recommended initiatives are developed."[31] The Strategy also identifies three priority populations, including clients/patients with complex needs; those living in rural and remote areas; and targeted sub-populations such as children and families, First Nations, Métis and Inuit peoples, seniors, individuals involved with justice, and families at risk.

The Harm Reduction for Psychoactive Substance Use policy confirms Alberta Health Services' commitment to harm reduction as an important component of the continuum of care when working with those using psychoactive substances. The key elements of the policy outline the role of harm reduction in the continuum of care, the need for harm reduction initiatives to be evidence-based and quality assured, and the need for the provision of current and accurate information about harm reduction principles and practices to health service providers and the general public. Further, the policy supports access to "non-judgmental harm reduction services and supports needed to improve the health of individuals that use psychoactive substances" and reinforces the importance of collaboration and practical solutions to reducing harms from psychoactive substance use.[32]

As the above examples of provincial policy direction in Alberta illustrate, there is a clear focus at the provincial level on public health and human rights-based approaches. Alberta Health Services' Harm Reduction for Psychoactive Substance Use policy ensures that harm reduction as an evidence-informed intervention has a critical role to play in effective, pragmatic and compassionate approaches to substance use. As well, the Creating Connections report provides a comprehensive view of addictions and mental health issues and related services, and offers an opportunity to move toward an integrated service system throughout the province.

Municipal Policy Overview

The City of Red Deer policies and bylaws related to the harms of substance use generally aim to ensure the safety of citizens, public places and property and to mitigate social disorder – powers bequeathed to municipalities under the provincial *Municipal Government Act*. Red Deer City Council has the responsibility and authority to pass bylaws for municipal purposes respecting:

a) The safety, health and welfare of people and the protection of people and property
b) People, activities and things in, on or near a public place or place that is open to the public
c) The licensing of businesses

29 Ibid
30 Ibid
31 http://www.health.alberta.ca/documents/Creating-Connections-2011-Strategy.pdf - Accessed March 28, 2014
32 Alberta Health Services (2013). Harm Reduction for Psychoactive Substances. https://extranet.ahsnet.ca/teams/policydocuments/1/clp-harm-reduction-for-psychoactive-substance-use-policy.pdf - Accessed April 4, 2014

As such, and due to concerns raised in the community regarding vandalism, litter, noise, and violence, among others, City Council has passed the following bylaws in an attempt to ensure that adverse impacts on the community related to the use of drugs or alcohol are minimized. The Late Night Clubs Bylaw, the Drinking Establishment Licensing Bylaw, and the Smoke Free Bylaw are examples of bylaws intended to address potential health and social disorder issues related to the use of certain psychoactive substances and to establish controls for the sale and public use of those substances.

For more information on City of Red Deer Bylaws, please visit http://www.reddeer.ca/city-government/bylaws.

Following the completion of The City of Red Deer's Crime Prevention and Policing Study, in 2004, which resulted in a comprehensive strategy and implementation plan for the future direction of the RCMP and crime prevention initiatives for the community, The City endeavoured to evaluate the implementation of the study and investigate other possible policing models through the *Crime Prevention and Policing Study Update and Policing Service Model Review*. In recognition of the shared desire for a safer community, and that crime prevention too is a shared responsibility among all community members, The City of Red Deer engaged local citizens and stakeholders around strategies to make the community a safer place for all. The report provides recommendations with respect to crime prevention and policing strategies and the most effective policing service model for Red Deer.[33] The *Red Deer Crime Prevention and Policing Model Review* and its associated recommendations are relevant to the *Red Deer Alcohol and Drug Strategy*, largely within the pillar of enforcement/community safety in Red Deer. Perhaps most importantly, the report places significant emphasis on inclusive and community-based crime prevention responses, which utilize our community's resources at all levels.

Red Deer's Alcohol and Drug Strategy will set a precedent for the community in terms of establishing a comprehensive, community-based, and evidence-informed set of strategies that recognize and support efforts to enhance community safety, as well as prevention, treatment and harm reduction services in the city.

Not unlike what we are seeing in the areas such as housing and homelessness, municipalities are being increasingly compelled to take on a greater role to address issues traditionally assumed to be outside of their jurisdiction. It is not uncommon to see modern municipalities develop multi-faceted plans and strategies to address the harms of substance use. Cities such as Toronto, Vancouver, Thunder Bay, and the Waterloo Region have taken the initiative to get a better grasp on issues that are affecting the health and safety their communities and are pioneering the way forward looking for ways to improve citizen health and protect human rights.

Again, the *Red Deer Alcohol and Drug Strategy* supports Red Deer City Council's endorsement of the Vienna Declaration and the importance of evidence-based practices and comprehensive approaches to substance use based on the four-pillar approach to drug policy

The City of Red Deer has a key role to play, particularly as a leader and advocate for evidence-informed policies and practices at the local level, as well as ensuring a safe community for all residents. But The City of Red Deer is only one of many stakeholders whose commitment will be needed to give this strategy life and to move our community toward enhanced well-being for everyone.

33 Ibid

APPENDIX B

ENVIRONMENTAL SCAN

Introduction

Over the last two decades, many communities, including Red Deer, have become increasingly concerned about the harmful effects of substance use. Despite the growing concern, there is still much to learn about the actual extent, nature and impact of alcohol and drug use in mid-size cities such as Red Deer. There is a need for more reliable and valid information about alcohol and drug use over time and associated health and social impacts. Access to quality evidence and information will inform what prevention, harm reduction, treatment and enforcement strategies need to be employed to reduce harmful effects on the community.

The use of alcohol and psychoactive, or mood-altering, substances can cause harm to the health of individuals, families and communities. Recent Canadian data confirm the very high population burden. In 2012, 78.4 per cent of Canadians reported drinking alcohol in the past year, and the prevalence of past-year cannabis use among Canadians aged 15 years and older was 10.2 per cent. In Alberta, among people who consumed alcohol over the past 12 months, 11.9 per cent exceeded the guideline for chronic effects[1] and 8.8 per cent exceeded the guideline for acute effects. In Red Deer, police records and homeless counts revealed significant levels of alcohol and substance use.

Given the complex set of factors that influence patterns of substance use, such as family, peer, biological and environmental factors, as well as the impacts of associated interventions, local strategies informed by the community context are needed if they are to be effective.

In response to the growing concerns about substance use, the Province launched Alberta's Addiction and Mental Health Strategy ("Strategy") and Creating Connections: Alberta Addiction and Mental Health Action Plan 2011–2012 ("Action Plan"). The Strategy and its associated Action Plan lay out broad directions for addiction and mental health priorities within the province of Alberta and inform the overarching legislative, policy, strategic and performance management direction for addiction and mental health services in the province (Wiled et al, 2014).

The overarching aim of the strategy is to "transform the addiction and mental health system in Alberta," with the goal of "...reducing the prevalence of addiction, mental health problems and mental illness in Alberta through health promotion and prevention activities and to provide quality assessment, treatment and support services to Albertans when they need them," (p. 3). Key strategies identified to support this overall purpose include (1) building healthy and resilient communities; (2) fostering the development of healthy children, youth and families; (3) enhancing community-based services, capacity and supports; (4) addressing complex needs; and (5) enhancing assurance. The Strategy also identifies three priority populations, including clients/patients with complex needs; those living in rural and remote areas; and targeted sub-populations such as children and families, First Nations, Métis and Inuit peoples, seniors, individuals involved with justice, and families at risk.

While this is an incremental step forward, it does not address the whole spectrum of alcohol and drug use. More importantly, it does not address the local peculiarities of some mid-size cities such as Red Deer. Further, the plan does not maximize the role of local action that can be undertaken to reduce the harmful effects of alcohol and other substance use in the community.

The Central Alberta Addictions Consortium will spearhead this local action in Red Deer. This environmental scan is intended to assist this group with this very important work as the basis of evidence-informed practice.

Objectives of the Environmental Scan

The objectives of this environmental scan are to:

1. Examine the prevalence of alcohol and other substance use and misuse in various sub-populations in terms of geography, demographics and specialized populations.
2. Examine the causes and risk factors for alcohol and other substance use and misuse in terms of individuals, family, peer and environmental factors.
3. Identify the impact of alcohol and other substance use and misuse of the individual, family and the community as whole
4. Identify the most promising and best practices that are relevant and applicable to the context of Red Deer to inform local strategies.

Methodology

The approach to this environmental scan was secondary study[2] through a literature review. Begley (2008) asserted that secondary research is a valid method of conducting research[3] and should be used if sufficient primary research has already been conducted. Brereton et al (2007) observed that the accumulation of evidence through secondary studies can be very valuable in offering new insights or in identifying where an issue might be clarified by additional primary studies. Begley (2008) further noted that it may be unethical to conduct further study in the same area if there is already available evidence to answer the research question. In this case, the work of Wild et al (2014) for the central zone of Alberta Health Services, which includes Red Deer, qualifies within this context.

Given that there were already population surveys, police reports and service utilization available, it was appropriate that this scan adopt this approach. Secondly, the basic premise for the selection of the secondary analysis approach was to allow this scan to combine data from multiple data sources to increase not only the reliability of the information but to draw on all relevant available data to provide the bigger picture for the scope of this study. The literature was qualitative synthesis within the context of systematic review. Formal qualitative synthesis is the process of pooling qualitative and mixed-method research data and then drawing conclusions regarding the collective meaning of the research (Bearman and Dawson, 2013), while systematic literature reviews are primarily concerned with the problem of aggregating empirical evidence that may have been obtained using a variety of techniques, and in (potentially) widely differing contexts (Brereton et al, 2007)). The rationale for this literature review method was to allow for the use of data from multiple research methods and summarize them for each section of this scan without statistically combining them as the case might be in systematic review alone.

There were two stages involved in carrying out the review: literature identification and data extraction. After establishing the inclusion and exclusion criteria as a systematic review requires, a search was conducted of web-based/electronic archives of publications related to alcohol and other substance misuse, including population surveys, research and evaluation studies, and current best practices and recommendations. Other information gathered included research-based books and articles, government reports and publications, and information/discussion papers by relevant agencies and associations. For quality assessment, each of these studies was assessed based on their strength and weakness of the primary study and the relevancy of their outcomes to the topic of alcohol and other substance misuse in Red Deer. The data from the primary studies included the bibliography, descriptions of the study setting, as well as the limitations of each study.

Research Questions

1. What is the extent and nature of alcohol and other substance use in mid-size cities such as Red Deer?
2. What is the prevalence level among different sub-populations based on geography and demographic characteristics?
3. What are the causes or risk factors associated with the patterns of alcohol and other drug use?
4. What is the impact of alcohol and other substance use in terms of individual, family and community?
5. What strategies can be used for prevention, harm reduction, and treatment for alcohol and other drugs?

Red Deer Community Profile

Social and health policies regarding drug and alcohol issues are often broadly applied without consideration for the unique situation of an individual community (Mitchell & Schmidt, 2011). However, for the approaches to be

1 In November 2011, the Canadian federal, provincial, and territorial health ministers received Canada's Low-Risk Alcohol Drinking Guidelines, which consist of five guidelines and a series of tips. The first two guidelines apply to all Canadians and address long-term (chronic) effects (guideline 1) like liver disease and certain cancers, and short-term (acute) effects (guideline 2) such as injuries and overdoses. People who drink within the low-risk alcohol drinking guidelines consume no more than the recommended quantity of alcohol within the number of days specified, whereas those who exceed the guidelines consume more alcohol than recommended within the stated timeframe

2 Secondary research refers to studies where previously collected data are used or previously published research findings are presented to answer research questions.
3 The research papers summarized in the review are referred to as primary studies.

effective, it is important to obtain specific information about the local community so that resources can be directed appropriately. Further, given that family, peer and environmental factors play an important role in substance use patterns, understanding the social and economic context of a resource-based community is critical for formulating community strategies (Marsh and Dale, 2007; Parkins & Angell, 2011). Red Deer's community profile provides a pathway for an evidence-informed approach to reducing the harmful impacts of alcohol and other substance misuse in the community.

Red Deer is located midway between, and within 150 kilometers of, both Calgary and Edmonton along the Queen Elizabeth II Highway in central Alberta, Canada. Red Deer has a land area of 104.29 square kilometers. According to The City of Red Deer's Municipal Census (2013), the population of the city stood at 97,109 as of April 2013, indicating an increase of 5,232 new residents or 5.7 per cent over the previous census of 2011. Red Deer also has one of the youngest populations in Canada. The median age in Red Deer was 34.7 years in 2011. In comparison, the median age of Alberta was 36.5 years and 40.6 years for Canada as a whole. The percentage of children aged 0 to 14 was 18.3 per cent, and the percentage of the working age population (15 to 64) was 71.3 per cent. The percentage of the population aged 65 and over in Red Deer was 10.4 per cent. In terms of family structure, 66.8 per cent of census families were married couples in 2011, while 15.8 per cent were common-law-couples and 17.4 per cent were lone-parent families.

In the 100 years since the inception of Red Deer as a municipality, the multicultural nature of our community has developed and grown significantly. Data from the National Household Survey (NHS) shows that 4,590 people had indicated an Aboriginal identity in 2011, representing 5.2 per cent of Red Deer's total population. Over the years, most immigrants were from continental Europe, the United States and Asia. However, recent trends suggest that immigrants are coming from across the globe to live and work in Red Deer, from countries such as the Philippines, Afghanistan, Mexico, India, China, South Korea, Nigeria and Pakistan .The immigrant population constituted approximately 10 per cent of the population of Red Deer between 1981 and 2011. That is, at any point in time, one out of every 10 people in Red Deer is an immigrant. Currently, the percentage of those born in the province is at 57.4 per cent, while those born outside of Alberta constitute 31.9 per cent of the population; those born outside Canada are at 10.7 per cent.

Education is said to be the 'greatest equalizer,'[4] as it improves the quality life of individuals and brings broad societal benefits, such as maintaining positive and cohesive social environments. In 2011, 57.4 per cent of the 58,795 adults aged 25 years and over in Red Deer had completed some form of post-secondary education; of that population, 19.7 per cent had a university certificate or degree. An additional 22.6 per cent had a college diploma and 15.1 per cent had a trade certificate. The share of the adult population that had completed a high school diploma as their highest level of educational attainment was 25.3 per cent; 17.2 per cent had completed neither high school nor any post-secondary certificates, diplomas or degrees.

Red Deer has a diversified economy ranging from oil and gas, manufacturing, agriculture and agriculture processing centers, broad-based retail and wholesale services, as well as a vibrant tourism sector. While the global recession led to lower economic growth, higher unemployment rates and a weaker housing market, Red Deer still fared better compared to several other mid-size cities in Canada, which is reflected in local economic and housing indicators.

In terms of labour force employment by industry, 13.5 per cent of Red Deer's total labour force is engaged in retail trade; 12.2 per cent in health and social assistance; 8.9 per cent in mining, oil and gas extraction; 8.8 per cent in construction; and a further 7.6 per cent in manufacturing, reflecting the diversity of the local economy. The number of self-employed people in Red Deer amounted to 4,850 or 9.8 per cent of all total employed workers. Since 1981, the employment rate in Red Deer has consistently exceeded 65 per cent of the active labour force. At the end of December 2013, the unemployment rate of Red Deer was 2.7 per cent, indicating recovery from the 2008 financial crisis. This lower unemployment rate has led to increased immigration into the community coupled with increasing incomes.

There has been general growth in individual, family and household income over the years in constant dollar, which is reflected in the median incomes. This has resulted in the upward mobility of income for various individuals, families and households to higher income brackets, reducing the concentration of people in the lower bottom of the income scale. The median after-tax income of economic families in Red Deer in 2010 was $75,533; the median income for couple families was $83,141, and for lone-parent families, $43,167. For persons not in economic families (persons living alone or with non-relatives only), the median after-tax income was $30,215. Families come in different sizes, and larger families may have benefited from pooling of resources and economies of scale. In Red Deer, based on their after-tax income adjusted for family size, 56.4 per cent of the population was in the top half of the income distribution, below the rate of 60.1 per cent in Alberta. The percentage of the population in the lowest income decile group sits at 8.9 per cent, which was similar to that in Alberta (8.4 per cent). The percentage of the population in the highest decile group was 12.8 per cent, lower than in Alberta (17.1 per cent).

Housing market indicators are reflected in vacancy rates, average rents and house prices. The average cost of a dwelling in Red Deer was $328,127 in 2011. The homeownership rate in Red Deer was 67.5 per cent, while 32.5 per cent were tenant households. Households in Red Deer that paid 30 per cent or more of household total income toward shelter costs represented 26.5 per cent of non-farm, non-reserve households with total income greater than zero. As of October 2013, the average rent for a two bedroom apartment was $937, representing a 7.5 per cent increase over the previous year, and the vacancy rate was 1.7 per cent, indicating slight improvement of over the previous years of 1.5 per cent (Statistics Canada, 2013.

Substance Use in Canada

Data on alcohol and drug use behavior provides an understanding of the complex causes underlying substance use prevalence levels and approaches for prevention and intervention. Using different 'indicators' or 'predictors' of alcohol and substance use that are available in all areas stemming from a variety of sources, including population surveys, administrative data, police records and service records from multiple service agencies, this scan reveals differing prevalence levels in terms of geography, sex, age, ethnicity and specialized populations.

According to Statistics Canada (2014), beer and liquor stores and agencies sold $21.4 billion worth of alcoholic beverages during the fiscal year ending March 31, 2013, up 2.2 per cent from the previous year. While this should not be equated with data on consumption, the Canadian Alcohol and Drug Use Monitoring Survey (CADUMS) does provide some measure of consumption. In 2012, 78.4 per cent of Canadians reported drinking alcohol in the past year, a rate similar to that reported in 2011 (78.0 per cent). There was, however, a decrease in reported past-year alcohol use among youth 15 to 24 years of age, from 82.9 per cent to 70.0 per cent in 2012. Similar to previous years, in 2012, a higher percentage of males than females reported past-year alcohol use (82.7 per cent versus 74.4 per cent, respectively), while the prevalence of past-year drinking among adults aged 25 years and older (80.0 per cent) was higher than among youth (70.0 per cent).

Among people who consumed alcohol in the past 12 months, 18.6 per cent (representing 14.4 per cent of the total population) exceeded guideline 1 for chronic effects and 12.8 per cent (9.9 per cent of the total population) exceeded guideline 2 for acute effects. A higher percentage of males than females drank in patterns that exceeded both guidelines. The chronic-risk guideline was exceeded by 21.2 per cent of male drinkers and 15.9 per cent of female drinkers, while the acute-risk guideline was exceeded by 15.8 per cent of male drinkers and 9.7 per cent of female drinkers. The guidelines were exceeded by youth aged 15 to 24 years at higher rates than among adults aged

4 The quote is from 18th-century educator Horace Mann often called the father of American public school education in United States

25 years and older. One in four (24.4 per cent) youth drinkers versus 17.6 per cent of adult drinkers exceeded the guideline for chronic risk, while the acute-risk guideline was exceeded by 17.9 per cent of youth drinkers and 11.9 per cent of adult drinkers.

In terms of drugs or psychoactive pharmaceutical use, the prevalence of past-year cannabis use among Canadians aged 15 years and older was 10.2 per cent in 2012, largely unchanged from 9.1 per cent in 2011, but lower than in 2004 (14.1 per cent). There was an increase in past-year cannabis use among adults aged 25 years and older to 8.4 per cent in 2012, from 6.7 per cent in 2011, and no change from 2011 among youth aged 15 to 24 years. However, the prevalence of past-year cannabis use among youth (20.3 per cent) remains higher than that of adults (8.4 per cent). Youth initiated cannabis use at an older age in 2012 than in 2011 (16.1 versus 15.6 years). Use of at least one of five illicit drugs excluding cannabis [cocaine or crack, speed, ecstasy, hallucinogens (including salvia) or heroin] was reported by 2.0 per cent of Canadians and is not different from 2011 (1.9 per cent).

The reported rate of such use by males (3.1 per cent) was almost triple that reported by females (1.1 per cent), while the rate of use by youth (6.5 per cent) was five times higher than that reported by adults (1.2 per cent). Although the overall rate of psychoactive pharmaceutical use among Canadians aged 15 years and older was unchanged between 2012 (24.1 per cent) and 2011 (22.9 per cent), the rate of such use among youth increased to 24.7 per cent in 2012 from 17.6 per cent in 2011. Use of psychoactive pharmaceuticals was similar between youth aged 15 to 24 years and adults aged 25 years and older (23.9 per cent), while prevalence was higher among females (26.7 per cent) than males (21.3 per cent).

Substance Use in Alberta

Beer and liquor stores and agencies sold $2.4 billion worth of alcoholic beverages during the fiscal year ending March 31, 2013, up 6.1 per cent from the previous year (Statistics Canada, 2014). In terms of consumption 76.2 per cent of Albertans reported drinking alcohol in 2012; this was lower than the rate of use in 2011, which was 80.0 per cent. Among people who consumed alcohol over the past 12 months 11.9 per cent exceeded the guideline for chronic effects and 8.8 per cent exceeded the guideline for acute effects. In 2011, 19.9 per cent exceeded the guideline for chronic effects and 14.2 per cent exceeded the guideline for acute effects.

In one of the most comprehensive studies on estimating the prevalence of addiction and substance use in Alberta, Wild and colleagues went beyond anecdotal observations to collect systematic empirical data on unmet population need, service capacity, and costs in their 2014 study "Gap Analysis of Public Mental Health and Addictions Programs (GAP-MAP) in Alberta." Using the Alcohol Use Disorders Identification Test (AUDIT), a 10-item self-report used to identify hazardous and harmful drinking, the study revealed that a total of 8.5 per cent of respondents met AUDIT criteria for alcohol problems, while 12.6 per cent of males were "problem drinkers" compared to 4.3 per cent of females. The 18 to 34 year age category reported the highest level of harmful consumption at 12.9 per cent; for the age group 35 to 54, that number was 8.1 per cent; and 4.1 per cent for the 55-plus age group. This is consistent with other population survey estimates. The researchers recruited a large random sample of Alberta adults and reported that 15 per cent of drinkers met criteria for alcohol problems.

There exist similar patterns for other illicit drugs and psychoactive pharmaceutical drugs as well. Overall drug use in 2012 was 12.1 per cent, compared to 12.0 per cent in 2008 and 8.4 per cent in 2011. The prevalence of past-year cannabis use among Albertans aged 15 years and older was 11.4 per cent. In terms of illicit drugs (cocaine/crack, speed, methamphetamine/crystal meth, hallucinogens, ecstasy, and heroin) the use for the previous year was 11.6 per cent. Again, there exist greater variations between males and females as well as between adults and youth regarding the use of cannabis. The average age of initiation for cannabis use among youth 15 to 24 years of age has remained unchanged over the past seven years at approximately 15.6 years of age.

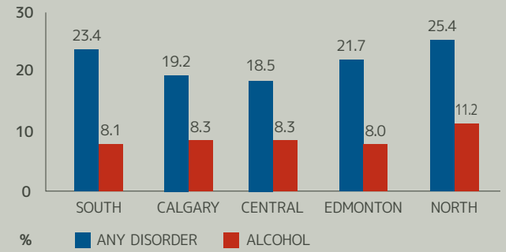
Wild and colleagues (2014) revealed that, among their respondents, 3.0 per cent of Alberta adults, or over 91,000 people, were diagnosed with a mental health problem; and 1.9 per cent, or 51,000 people, were diagnosed with an addiction.

The GAP-MAP prevalence estimates were generally consistent with previously available Alberta data. Slomp and colleagues (2009) analyzed physician billing data and reported that the past-year physician-treated prevalence rate of mental disorders, including substance use disorders, in the Alberta adult population was 18 per cent. Callaghan and Macdonald (2009) reviewed drug-related national and provincial hospital separation data between 1997 and 2005 and reported that Alberta rates for hospital separations related to all drugs studied (alcohol, cocaine, cannabis, methamphetamine, and opioids) were above the national average. These results were consistent across all time points studied.

Substance Use in Red Deer and Area (Central Zone)

There were no specific results from the CADUMS study for Red Deer; however, the population survey for Alberta Health Services—Central Zone and police reported data were used to ascertain the scope of the issue in Red Deer. Bright and Ritter (2011) observed that there is a lack of data available in a concise, accessible form that maps trends in illicit drug crime offences for different types of drugs. However, if available, trends in arrests for alcohol and illicit drug crime, by drug type, are a useful source of information for assessing prevalence levels in the community. Rosenfeld and Decker examined arrest data for cocaine, heroin, and marijuana in major United States cities and concluded that arrest data are valid and reliable indicators of the prevalence of drug use (Rosenfeld and Decker, 1999). Trends over time in the number of illicit drug arrests may reflect changes in the prevalence of drug use and/or trends in law enforcement activity and focus related to drugs. Specifically for Red Deer, alcohol-related incidents tracked by the Royal Canadian Mounted Police (RCMP), as wells as drug enforcement incidents, provide some insight in local prevalence levels.

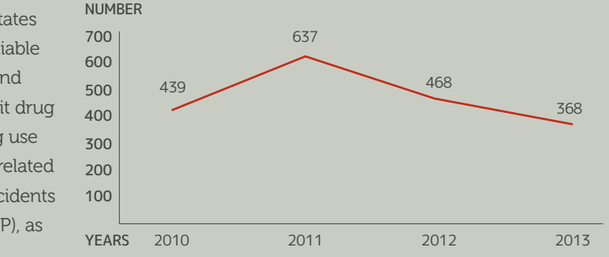
Figure 1: Prevalence of past-year addiction and mental health problems among Alberta adults by Zone



Source: Wild et al. (2014) Gap Analysis of Public Mental Health and Addictions Program

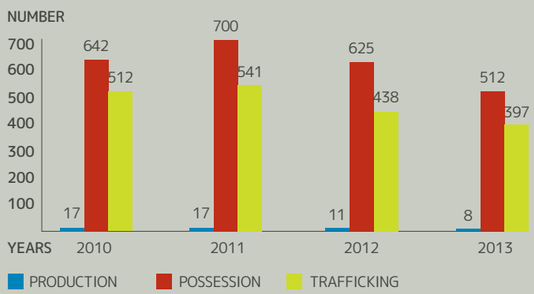
Data from the RCMP Detachment revealed that there were 439 alcohol-related incidents in 2010. Alcohol related issues peaked in 2011, at 637 reported cases, but have since declined in 2012 and 2013, as shown in Figure 2. In 2009 alone, the RCMP reported that 769 people were arrested or ticketed for operating a motor vehicle under the influence of alcohol, and of those, 246 were charged. In 2011, a total of 1,100 people were arrested or ticketed for driving under the influence of alcohol, for which 248 were charged. In 2013, a total of 800 were arrested or ticketed, and 158 were charged (RCMP, 2014). While not all the impairment incidences have directly resulted in accidents, it raises the potential risks of driving accidents, serious injuries and fatalities.

Figure 2: Alcohol Related Incidents based on Liquor Law Violations, Red Deer, 2010-2013



Source: Red Deer RCMP, Municipal Detachment Profile, 2014.

Figure 3: Illicit Drug Enforcement for Production, Possession Trafficking and Other Drugs, Red Deer, 2010-2013



Source: Red Deer RCMP, Municipal Detachment Profile, 2014.

Similarly, police drug enforcement data also reveals the prevalence of various illicit drugs in the community. The RCMP data allows four types of activities to be recorded for each offense in terms of production, possession, trafficking and other, as shown in Figure 3. The incidents involving drugs most often reported involved possession, followed by trafficking, with production and other drug incidents being the least reported offence. The number of possession incidents is overrepresented in the data from 2010 to 2013, recording 700 different incidents in 2011 as the highest over the period.

The proportion of drug incidents involving possession decreased from 625 in 2012 to 512 in 2013. The number of trafficking has varied over the years; from a high of 541 in 2011, the number reduced by 36 per cent to 397 in 2013. Incidences related to production of drugs were 17 in 2011, but has gradually declined roughly by half to 8 in 2013. All other types of drug activity have stayed fairly consistent over the years. The most common drugs found by the RCMP were cannabis, cocaine, ecstasy, heroin and methamphetamine. In 2011, there were 67 reported cases of impaired driving under the influence of a drug; that number declined to 47 in 2012 and further decreased to 43 in 2013. The drug data does not distinguish between prescription drugs arrests, by type of drugs commonly obtained through prescription, and the number of dosage units seized per year.

Aboriginal Citizens and Substance Use in Red Deer

Aboriginal people constitute one of the fastest growing groups in Canada. In Red Deer, the Aboriginal population increased by 27.5 per cent between 2006 and 2011. In 1996, 2,075 people reported Aboriginal identity, representing 3.5 per cent of the total population. This figure rose to 2,675 in 2001, indicating a 28.1 per cent increase and accounting for 4.0 per cent of Red Deer's total population. In 2006, the population increased to 3,600, constituting a 34.6 per cent increase and 4.4 per cent of the total population. In 2011, the National Household Survey (NHS) shows that 4,590 people had indicated an Aboriginal identity, representing 5.2 per cent of Red Deer's total population.

In Canada, the proportion of Aboriginal people who live in cities now exceeds the proportion in rural and remote communities. Today, more than half of all Aboriginals Canadians live in cities (Statistics Canada, 2008). That said, we know little about the factors that support Aboriginal health and well-being. Extensive investigations into Aboriginal health inequalities consistently identify alcohol and other substance use issues as one of the Aboriginal population's major health concerns (Brady 2004 and Orford et al., 2005). Compared to the general population, Aboriginal peoples are at higher risk of death from alcoholism, homicide, suicide and pneumonia; however, accurate prevalence data based on clear diagnostic criteria are not available (MacMillan, 1996). Prevalence has thus been based on indirect estimates, such as mortality rates due to causes that are known to be alcohol or drug related.

According to the Alberta Addiction Mental Health Research Partnership Program (2014), rates of heavy drinking (having five or more drinks on one occasion at least once a month over the past year) were also higher for Aboriginal people in Alberta compared to non-Aboriginal (33.4 per cent versus 19.9 per cent). Martin and colleagues (2011) found that Albertan Aboriginal patients had higher all-cause and HIV-related mortality rates, compared to other HIV patients. Injection drug use was the most common source of exposure in this group, and Aboriginal patients were significantly more likely to have been infected with HIV through injection drug use. Currie and colleagues revealed that illicit and prescription drug use disorders are two to four times more prevalent among Aboriginal peoples in North America (Currie et al., 2013).

Closer to Red Deer, in 2013, Currie and colleagues conducted a study of adults who self-identified as Aboriginal, Métis or Inuit and lived in Edmonton, Alberta—home to the second largest Aboriginal population in Canada. Their study revealed overall that 62.5 per cent participants reported 12-month illicit drug use, most typically cannabis (56.1 per cent), cocaine (32.5 per cent), and hallucinogens (14.6 per cent).Cannabis was used most frequently, with 16.2 per cent reporting daily or almost daily use and another 8.7 per cent reporting weekly use. In terms of prescription drug use, one-in-four (24.8 per cent) of participants reported prescription drug misuse in the past year (13.8 per cent opiates, 6.0 per cent sedatives/tranquilizers, and 4.6 per cent stimulants). Most (56.5 per cent) who used prescription drugs did so over one drug-class, while 24.7 per cent did so over two drug-classes, and 18.8 per cent across all three drug-classes examined.

In terms of broader ethnicity and focus on youth, Duff and colleagues (2011), using data derived from the Vancouver Youth Drug Reporting System, observed significant differences in the prevalence of substance use for white and Aboriginal youth compared to Asian youth, including Chinese, South, and Southeast Asian youth. White and Aboriginal youth consistently reported higher lifetime prevalence rates than Asian youth for all four-drug categories. Aboriginal participants appear to be especially vulnerable, particularly in relation to cannabis and 'club drug' use, with an odds ratios of 15.38 and 9.74, respectively. The value of exploring ethno-cultural differences in young people's substance use surely lies in the promise of developing more culturally sensitive prevention, harm reduction, and treatment strategies (Duff et al, 2011).

Homeless Citizens and Substance Use

High prevalence of substance use and misuse among the homeless sub-population has been well documented. While estimates of alcohol and drug use rates among the homeless vary considerably, there is agreement among experts that individuals with substance use disorders are more prevalent in the community samples of the homeless population than the general housed population with risk prevalence ratios of one to two (Booth et al, 2002) The problem is further compounded by the fact that few homeless individuals with substance disorders obtain treatment or any help from formal treatment organizations or locations. Substance use in terms of homelessness is mutually reinforcing: substance use can lead to homelessness, and homelessness can also lead to substance use (Didenko and Pankratz, 2007).

In Red Deer, the homeless Point in Time Count revealed that nearly three out of every four respondents said that they had an addiction, and the situation was more pronounced among the homeless population that were unsheltered. More than half (59 per cent) of homeless youth reported an addiction. Aboriginal homeless respondents were also significantly more likely to report having an addiction compared to the non-Aboriginals represented in the homeless count (Red Deer Point in Time Count, 2012).

Associated Risk Factors and Predictors and the Prevalence of Alcohol and other Substance Use

Like any social phenomena, it can be difficult to distinguish cause and consequence of substance use. For instance, for people who are distressed or alienated, heavy drug involvement can be a way to manage the negative effects, bond with others, and/or experience an alternative source of reward. On the other hand, excessive substance use also results in emotional distress (Marsh & Dale, 2005). Research indicates that certain risk factors are associated

with a higher likelihood that an individual will develop a substance use problem, but in each case, the impact of particular risk factor may vary.

The risk factor notion is one often used to understand susceptibility to infectious and other types of diseases and has been used widely by epidemiologists. Although the analogy between an infectious disease and substance use is not perfect, it provides an important technique and conceptual tool to understand the multiple causes and predictors of substance use (Newcomb et al, 1986). These factors were found to be associated with use, frequency of use, and the level of use.

These risk factors can also predict the prevalence of substance use in the community. DeWit and Beneteau (1996) asserted that social isolation from one's relatives or friends is an important predictor of substance use and may be particularly salient in cultural groups that place a lot of emphasis on close family relations. Addressing the issues of substance use requires a greater understanding of the associated risk factors. Since it has become difficult to determine prevalence levels, predictors could be useful gauges of the scope of the issue in the community.

Utilizing these two components of substance use information can be critical to developing effective strategies. For the purposes of this scan, alcohol and substance use is considered in the context of individual, family, peer and broader environmental risk factors of substance use, as well as predictors of prevalence.

Individual

People who use substances excessively often highlight the importance of emotional distress in their drug use. Some controlled substance users are more likely to report using drugs out of curiosity and to have fun. Excessive drug users often report being motivated to relieve personal distress, cope with negative emotions (anger, loneliness, frustration, stress and boredom), or to improve self-concept. Jacobs and Gill (2001) revealed that there were significant differences in the rates of attempted suicide observed when comparing abusers and non-abusers. In the past month, substance abusers experienced significantly greater amounts of depression (28.8 per cent versus 7.6 per cent for non-abusers) and trouble controlling violent behavior (22.7 per cent versus 5.3 per cent for non-abusers). Substance abusers were also more likely to be extremely bothered by the presence of a psychological problem than non-abusers (substance abusers at 39.0 per cent versus non-substance abusers at 25.9 per cent). Even among individuals, certain sub-populations demonstrate greater vulnerability than others within the same socio-cultural and family context. This illustration recognizes the individual as a key contributor to alcohol and drug use.

Family and Developmental Factors

Early experiences with parents and caregivers influence a child's sense of security and identity, how they feel about themselves and others, and their ability to regulate their emotions (maintain positive affect and reduce negative affect). Children of parents with alcohol addiction, for example, show higher rates of alcoholism than children who do not have parents with an alcohol addiction (Moss, 2013). Parental sensitivity and responsiveness leads to secure attachment, whereas consistent neglect, unresponsiveness, over-stimulation or abuse from caregivers leads to insecure attachment. Securely attached adults have a balanced perspective in relation to attachment experiences and are self-confident and comfortable with intimacy and tend to form secure, stable and satisfying long-term relationships.

Breckenridge et al (2012) noted that a significant proportion of adults who are subjected to abuse in childhood may, as a result, experience social, emotional and psychological problems of a serious and disruptive nature when they are adults. Their research, as well as previous bodies of work, links child abuse with poor physical and mental health outcomes across the lifespan, including increased risk for diabetes, lung disease, heart attack and stroke, depression and anxiety, smoking, and hazardous alcohol and drug consumption. Essentially, childhood experiences of rejection, neglect, abuse or an atmosphere in which they feel frightened or unloved leaves people with high levels of psychological distress. They are often anxious and fearful and frequently become untrusting and suspicious of others. They often feel alienated from society and find it difficult to form meaningful human connections. Many of those who have experienced physical or sexual abuse frequently live with very distressing symptoms of PTSD, such as nightmares and flashbacks of the abuse. Under these circumstances, drug use is an attractive option for feeling good, bonding with others, dulling internal pain and a sense of alienation, or temporarily forgetting the past.

Peer

For those whose home life is unrewarding or abusive, and those who find little security and affiliation within conventional social networks, drug-using peer networks can provide powerful sources of support and reward (Brown, 1991 cited Marsh and Dale, 2005). For some young people, the motivation to seek out a group of heavy drug-using peers may arise from the perception of being rejected by non-drug-using peers, family and school (Kaplan, Martin, and Robins, 1984 cited Marsh and Dale, 2005). For others, it may arise out of admiration for heavy drug users and the desire to become part of a cool, glamourous group.

Broader Societal Influences

Previously, risk factors were largely focused on the individual and the family as the main triggers for alcohol and drug use. Subsequent research has however established that immediate environments are not all alike and that certain outside conditions might make a person more or less likely to use alcohol and other drugs, thus the focus on broader societal influences. Gorman and Labouvie (2000) cited several demographic and socioeconomic factors, such as age, race, poverty, unemployment, education, income levels, residential instability, and local housing market indicators, as key influencing risk factors that dictate prevalence levels of substance use in any community. Drawing on the relationship between social-contextual factors and alcohol and polydrug use among college freshmen, Simons et al (2005) observed that students who have experimented with alcohol and drug use prior to entering college may be more likely to engage in social and recreational activities where alcohol and drugs are available.

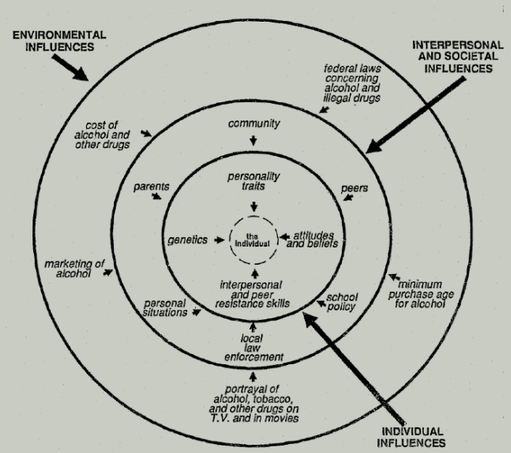
Further, Draus (2009) underscores this connection to environmental factors in describing the linkages between slow-motion disaster, structural vulnerability, collective susceptibility, and substance abuse with specific reference to the city of Detroit. Draus (2009) contends that Detroit continues to suffer from a slow-motion disaster caused by the long-term collision between corrosive structural processes, counterproductive social policies, and vulnerable populations. Draus (2009) identified illicit-drug markets and substance abuse in Detroit as 'one particular effect of this ongoing crisis-level situation, which is now a contributing factor as well.' With particular relevance to Red Deer, Parkins and Angell (2011) identified five factors associated with the susceptibility of substance use in resource-based communities such as Red Deer based on their study of Town of Hinton in Alberta:

> (1) an economy based on multiple divergent sectors, which gives rise to income disparity and social inequality; (2) a highly transient population, which results in social distancing and lack of social support; (3) shift work, which prevents opportunities for consistent and productive family and community relationships; (4) high incomes, which lead to material competition and financial stress; and (5) a culture of entitlement, which produces certain expectations and perceived privileges among some workers and their families.

They observed that the community is based on a number of economically divergent sectors; that is, some sectors are high paying, such as the natural-resource sectors, while others offer relatively low pay (for example, the service sector). This type of economic structure has resulted in a social structure that is characterized by growing income disparity and tightly knit social groups, which has decreased the overall level of social cohesion within the community. What is significant for Red Deer is that both family and individual factors still play a larger role in terms of risk factors despite environmental factors. A thorough analysis of individual and family context and

broader environmental factors contributing to substance use for each community is critical to developing more comprehensive approaches that will address the issue in any community.

Factors that Influence Alcohol and Other Substance Use



Source: Adopted from US department of Health and Human Services, 1989

The Impact and Harmful Effects of Substance Use

To effectively develop a drug strategy that is comprehensive and encompassing of all facets of substance use, it is important to understand the impact of substance use on individuals, families and the community as a whole. At the individual level, it has been observed that substance use is related to a range of adverse social and physiological effects (Merline et al., 2004). They are most often a contributory factor in unsafe sexual practices, the commission of violent crimes and domestic disputes, child abuse, suicides and suicide attempts, automobile injuries, fatalities, and self-inflicted wounds. It is also associated with liver damage, various forms of cancer, and psychological impairments such as depression and dementia diseases.

Plitt and colleagues (2010) reported a 23.9 per cent HIV-positive prevalence rate for injection drug users in Edmonton, which was the highest of all Canadian cities participating in the federal government's surveillance program for injection drug use (the national rate was 13.2 per cent). In 2011, 1.8 per cent of Canadians aged 15 years and older reported experiencing at least one harm in the past year due to their illicit drug use, a rate that is significantly lower than in 2004 (2.8 per cent). Youth 15 to 24 years of age were approximately five times more likely than adults aged 25 years and older to report harm due to drug use, with 5.8 per cent of youth reporting such harm, compared to 1.1 per cent of adults. The most common harmful effects of substance use cited in the study were to physical health; friendships and social life; financial position; home life or marriage; work, studies, or employment opportunities; legal problems; difficulty learning; and housing problems.

Family members or friends may also be harmed by risky or violent behaviour resulting from substance use, as well as emotional distress and financial hardship. Employers are affected by absenteeism and lost productivity. According to the National Institute on Drug Abuse (NIDA), the average cost of drug abuse per employee annually is $10,000 due to employee turnover, Workers Compensation claims, absenteeism, employee theft, violence on the job, and the use of health care benefits are all factors in this equation. The average cost of a Workers Compensation claim is $1,574 and the average cost of a lost time claim is $5,574 (Workers Compensation Board Alberta, 2008).

Table 1: Total cost of AHS direct addiction services by services type

SERVICE TYPE	DOLLARS $	PERCENTAGE
RESIDENTIAL AND DETOX SERVICES	31,083,765	48.23%
OUTPATIENT SERVICES	31,521,847	48.91%
OPIOID DEPENDENCE PROGRAM	1,841,821	2.86%
TOTAL	64,447,433	100%

Modified and adapted from Wild et al. (2014)

For the community as a whole, the effects of substance use present significant health, social and economic costs. The overall cost of substance abuse for Alberta is $4.4 billion ($1,414 per capita). Of that total, $1.6 billion was spent on alcohol and $1 billion was spent on illegal drugs; 63 per cent of the $4.4 billion was attributed to productivity losses as well as when factoring the direct health cost, law enforcement cost and millions in lost productivity (Cost of Substance Abuse in Canada, 2002.; Roth, 2012.) Drug use may also lead users to commit crimes due to the immediate result of drug intoxication. Of equal significance are the human and social impacts associated with harmful alcohol and drug use that cannot be monetized (Smythe and Caverson, 2008).

Service Gaps

The community context, prevalence levels and related impacts of alcohol and other drug issues present a challenge for service delivery. Gorman and Labouvie (2000) emphasized that addressing this issue is complex, as need is comprised of both "met" demand (i.e., those clinical "cases" who actually received treatment during a specific period of time), and "unmet" demand (i.e., those cases who could have appropriately entered treatment, but did not). The number of individuals falling within the latter category is very difficult to assess using epidemiological surveys, not least because exact standards defining a clinical case in need of treatment are uncertain, and many individuals underreport drug-related behaviors on questionnaires.

In the area of prevention, these matters are further complicated as individuals tend not to seek out such services in the first place, and therefore the very notion of demand becomes problematic. Additionally, developing criteria and survey items to identify those individuals in need of prevention services would be even more complicated than it is in the case of treatment-needs assessment (Gorman and Labouvie, 2000). This assertion is supported by Wild and colleagues (2014), who, when they observed that problem drinkers were significantly more likely than those without alcohol problems to be interested in accessing brief self-help interventions, suggested that there may be a large, unserved group of drinkers who would be interested in accessing these self-help interventions. This is important, given that most problem drinkers in Alberta report not receiving any alcohol-related health services, and that brief alcohol interventions delivered to the general drinking public are effective strategies for reducing alcohol consumption. Therefore, both prevention and intervention strategies would have to consider the scale of unmet need, as well as the availability and accessibility of services to meet this demand.

Rush and colleagues (2010) reported that unmet service needs were greatest for those with pure substance-related disorders. Albertans who experienced past-year addiction and mental health disorders reported substantially higher unmet needs for all types of services, compared to the provincial rate and to those who did not meet criteria for addiction and mental health problems. Wild et al (2014) reported that respondents with a diagnosed addiction were most likely to have received hospital care and harm reduction services (17 per cent and 7 per cent, respectively). As of March 31, 2012, a total of 2,859 beds were allocated for specialty addiction treatment (n = 830 beds, 29 per cent of total bed capacity). In terms of service accessibility, although most publicly funded programs and services for addiction and mental health problems in Alberta provide counselling, the vast majority of qualified counsellors operate privately, outside the system of publicly funded care (Moulding et al., 2009). What is evident is that most of those in need are unlikely to seek help, but more likely to self-manage their substance issues.

Approaches to Addressing Alcohol and Substances Use

The associated risk and predictors points to the complexity of the issue and the fact that there cannot be a one-size-fits-all approach to addressing alcohol and other substance use in the community. Most communities have focused their strategy on what has been termed "the Four Pillar approach," which recognizes that prevention, treatment, harm reduction and enforcement as the linchpins needed to effectively address substance use. However, these four

pillars alone may not be adequate to address the host of the issues or the specific needs of a particular sub-population.

As Munro and Allan (2011) noted, most approaches to intervention are individualized, locating the problem and the solution in the substance user. When problematic use is common within a family and community, individual treatment is likely to be ineffective. The development of family-focused intervention with culturally appropriate services is however, more effective for certain sub-populations.

This means a more systematic approach with sub-elements under these key pillars will be the most appropriate. Because the risk and predictors of alcohol and substance use come from multiple sources and across various sub-populations, demographic groups and socioeconomic context, strategies require a variety of approaches, all of which should be integrated across community institutions and stakeholder groups. These pieces must be brought together in the form of a comprehensive strategy that works with every part of the community, providing many approaches and addressing the needs of all populations. Because one aspect alone cannot work in isolation and one strategy may not work for all population groups, there must be a continuum of clear, concise, and unambiguous strategies under each of the pillars. Additionally, depending on the community context and prevalence of issues, there may be particular focus in one area than the other, as demonstrated in the drug strategies of Vancouver, Canada; Sydney, Australia; and Liverpool, England.

Limitations

The current study is affected by the same limitations associated with the use of multiple data sources collected using multiple methodologies and under different context that should be considered in the utilization of the work by the Central Alberta Addictions Consortium.

Population Surveys

Reliance on self-reporting of substance use may be associated with lower than actual estimates of prevalence. Dependence captures only a small and very specific aspect of alcohol- and drug-related problems. This analysis does not cover the vast array of other difficulties that can result from alcohol and illicit drug consumption. For several reasons, this analysis likely underestimates substance dependence rates. Survey respondents may provide answers that are socially acceptable. Some who had used alcohol or drugs may not have reported doing so, or may have underreported the frequency. Illicit drug dependence was determined based on several drugs combined, not for specific drugs. This grouping may mask important differences, as different drugs may result in different levels of dependence.

Police Reported Data

An increase in the number of arrests for illicit drug crime may signify an increase in prevalence with an associated increase in dealing. Alternatively, the increase could simply reflect increased efforts by law enforcement agencies to detect individuals who are using and/or dealing, without any underlying prevalence change. A third possibility is that changes in arrest rates may reflect issues that are not related to illicit drugs; for example, a greater focus by law enforcement on other crimes.

References

Alberta Addiction Mental Health Research Partnership. (2014, April 14). Health indicator profile, by aboriginal identity and sex, age-standardized rate, four year estimates, Canada, provinces and territories, occasional (rate). Retrieved from CANSIM table 105-0513.

Bearman, M., & Dawson, P. (2013). Qualitative synthesis and systematic review in health professions education. Medical Education, 47(3), 252-260. doi:10.1111/medu.12092

Begley, C. (2008). Approaches to research. In Nursing research: Designs and methods (pp. 13-22). Philadelphia: Churchill Livingstone.

Booth, B.M., Sullivan, G., Koegel, P., & Burnam, A. (2002). Vulnerability factors for homelessness associated with substance dependence in a community sample of homeless adults. Journal of Drug and Alcohol Abuse, 28(3), 429-452. Retrieved from http://informahealthcare.com/doi/abs/10.1081/ADA120006735?journalCode=ada

Brady, M. (2004). Indigenous Australia and alcohol policy: Meeting difference with indifference. Sydney: University of New South Wales Press.

Breckenridge, J., Salter, M. & Shaw, E. (2012) Use and abuse: understanding the intersections of childhood abuse, alcohol and drug use and mental health, Mental Health and Substance Use, 5(4), 314-327, DOI: 10.1080/17523281.2012.703224

Brereton, P., Kitchenham, B. A., Budgen, D., Turner, M., & Khalil, M. (2007). Lessons from applying the systematic literature review process within the software engineering domain. The Journal of Systems and Software, 80(4), 571-583. Retrieved from www.elsevier.com/locate/jss

Bright, D, & Ritter (2011). Australian Trends in Drug User and Drug Dealer Arrest Rates: 1993 to 2006–07. Psychiatry, Psychology and Law, 18 (2) 190–201.

Callaghan, R. C. & Macdonald, S. A. (2009). Changes in the rates of alcohol- and drug-related hospital separations for Canadian provinces: 1996-2005. Canadian Journal of Public Health, 100, 393–396.

Cunningham, J. A., Wild, T. C., Cordingley, J., van Mierlo, T., & Humphreys, K. (2010). Twelve-month follow up results from a randomized controlled trial of a brief personalized feedback intervention for problem drinkers. Alcohol & Alcoholism, 45, 258–262.

Currie, C. L., Wild, C. T., Schopflocher, D. P., Laing, L., & Veugelers, P. (2013). Illicit and prescription drug problems among urban aboriginal adults in canada:the role of traditional culture in protection and resilience. Social Science & Medicine, 88, 1-9. Retrieved from www.elsevier.com/locate/socscimed

Dewit, D. & Beneteau, B. (1996). Predictors of the Prevalence of Alcohol Use and Related Problems among Francophones and Anglophones in the Province of Ontario, Canada. Journal of Studies on Alcohol and Drugs, 59: 78-88. Retrieved from http://www.jsad.com/jsad/article/Predictors_of_the_Prevalence_of_Alcohol_Use_and_Related_Problems_among_Fran/486.html

Didenko, E. and Pankratz, N. (2007). Substance Use: Pathways to homelessness? Or a way of adapting to street life, Visions: BC's Mental Health and Addictions Journal, 4(1), 9-10. Retrieved from http://www.heretohelp.bc.ca/.

Draus, P.J. (2009). Substance abuse and slow-motion disasters: The case of Detroit. The Sociological Quarterly, 50, 360_382.

Duff, C., Puri, A. & Chow, C. (2011). Ethno-Cultural Differences in the Use of Alcohol and Other Drugs: Evidence from the Vancouver Youth Drug Reporting. Journal of Ethnicity in Substance Abuse, 10, 2-23. doi: 10.1080/15332640.2011.547791.

Gorman, D.M, & Labouvie, E. (2000). Using Social Indicators to Inform Community Drug and Alcohol Prevention Policy. Journal of Public Health Policy, 21(4), 428-446.

Health Canada. (2014, April). "Canadian alcohol and drug use monitoring survey, 2012. website: http://www.hc-sc.gc.ca/hc-ps/drugs-drogues/stat/_2011/summary-sommaire-eng.php

Jacobsen, L., Southwick, S., and Kosten, T. (2001). Substance use disorders in patients with posttraumatic stress disorder: A review of the literature. American Journal of Psychiatry, 158, 1184 – 1190.

MacMillan, H.L, MacMillan, A. B, Offord D. R, Dingle J.L. (1996). Aboriginal health. Canadian Medical Association Journal, 155, 1560-1578.

Marsh, A., & Dale, A. (2007). Risk factors for alcohol and other drug disorders: A review. Australian Psychologist, 40(2), 73-80. doi:http://dx.doi.org/10.1080/00050060500094662

Marsh, A & Dale, A. (2005) Risk factors for alcohol and other drug disorders: A review, Australian Psychologist, 40(2), 73-80

Merline, A., O'Malley, P., Schulenberg, J., Bachman J., & Johnston, L. (2004). Substance Use Among Adults 35 Years of Age: Prevalence, Adulthood Predictors, and Impact of Adolescent Substance Use. American Journal of Public Health, 94(1) 96-102.

Mitchell, J., & Schmidt, G. (2011). The importance of local research for policy and practice: A rural Canadian study. Journal of Social Work Practice in the Addictions, 11(2), 150-162. doi:10.1080/1533256X.2011.570621

Moss, H B. (2013). The Impact of Alcohol on Society: A Brief Overview, Social Work in Public Health, 28(3-4), 175-177, DOI: 10.1080/19371918.2013.758987

Moulding, R., Grenier, J., Blashki, G., Ritchie, P., Pirkis, J. & Chomienne, M.H (2009) Integrating Psychologists into the Canadian Health Care System: The Example of Australia. Canadian Journal of Public Health, 100(2)145-47. Retrived from journal.cpha.ca/index.php/cjph/article/download/1773/1957

Munro, A., & Allan, J. (2011). Can family-focussed interventions improve problematic substance use in aboriginal communities? A role for social work. Australian Social Work, 64(2), 169-182. doi:10.1080/0312407X.2010.508841

Orford, J., Natera, G., Copello, A., Atkinson, C., Mora, J., Velleman, R., et al. (2005). Coping with alcohol and drug problems: "The experiences of family members in three contrasting cultures. East Sussex: Routledge.

Leah, J. M., Houston, S., Yasui, Y., Wild, T.C & Saunders, D. (2011). All-cause and HIV-related Mortality Rates Among HIV-infected Patients After Initiating Highly Active Antiretroviral Therapy: The Impact of Aboriginal Ethnicity and Injection Drug Use. Canadian Journal of Public Health. 102(2), 90-96. Retrieved from journal.cpha.ca/index.php/cjph/article/download/2034/

Parkins, J., & Angell, A. (2011). Linking social structure, fragmentation, and substance abuse in a resource-based community. Community, Work & Family, 14(1), 39-55. doi:10.1080/13668803.2010.506030

Plitt, S. S., Gratrix, J., Hewitt, S., Conroy, P., Parnell, T., Lucki, B., Pilling, V., Anderson, B., Choudri, Y., Archibald, C. P., & Singh, A. E. (2010). Seroprevalence and correlates of HIV and HCV among injecting drug users in Edmonton, Alberta. Canadian Journal of Public Health, 101, 50–55.

Roth, P. (2012, November 8). Alcohol misuse costs alberta $1.6 billion per year according to Dr. James Talbot, chief medical officer of health. Edmonton Sun.

Rosenfeld, R. & and Decker, S. (1999). Are arrest statistics a valid measure of illicit drug use? The relationship between criminal justice and public health indicators of cocaine, heroin, and marijuana use. Justice Quarterly, 16(3) 685-699. doi:10.1080/07418829900094311

Rush, B. R., Urbanoski, K. A., Bassani, D., Castel, S., & Wild, T. C. (2010). The epidemiology of co-occurring substance use and other mental disorders in Canada: Prevalence, service use, and unmet needs. In J. Cairney & D. Streiner (Eds.), Mental Disorder in Canada: An Epidemiological Perspective (pp. 170–204). Toronto: University of Toronto Press.

Slomp, M., Bland, R., Patterson, S., & Whittaker, L. (2009). Three-year physician treated prevalence rate of mental disorders in Alberta. Canadian Journal of Psychiatry, 54, 199–202.
Statistics Canada. (2014, April). Control and sale of alcoholic beverages, for the year ending march 31, 2013. website: http://www.statcan.gc.ca/daily-quotidien/140410/dq140410a-eng.pdf

Simons, L., Klichine, S.,Lantz , V., Ascolese, L., Stephanie Deihl, S., Schatz, B & Wright, L. (2005). The Relationship Between Social-Contextual Factors and Alcohol and Polydrug Use Among College Freshmen, Journal of Psychoactive Drugs, 37(4), 415-424, DOI: 10.1080/02791072.2005.10399815

Smythe, C., & Caverson, R. (2008). Alcohol, other drugs & related harms in Ontario a scan of the environment a background document to support the development of an Ontario drug strategy Retrieved from Ontario Centre for Addiction and Mental Health website: http://www.camh.ca/en/hospital/Documents/www.camh.net/Public_policy/Public_policy_papers/HEP env scan January 2008.pdf

Statistics Canada. (2008). Aboriginal peoples in Canada in 2006: Inuit, Métis and First Nations, 2006 census (Catalogue no. 97-558-XIE). Ottawa, ON: Statistics Canada.

The City Of Red Deer. (2013, June). 2013 Municipal census report. website: www.reddeer.ca/media/reddeerca/about-red-deer/statistics-and-demographics/Census-2013-Results.pd

The City of Red Deer. (2012). Red deer point in time [pit] homeless count 2012 . Retrieved from The City of Red Deer website: http://www.homelesshub.ca/sites/default/files/1304710 - November- Approved Red Deer PIT Final Report - 1.pdf

Wild, T. C., Wolfe, J., Wang, J., & Ohinmaa, A. (2014). Gap analysis of public mental health and addictions programs (gap-map)final report . Retrieved from University of Alberta website: http://www.health.alberta.ca/documents/GAP-MAP-Report-2014.pdf

Wild, T. C., Cunningham, J. A., & Roberts, A. B. (2007). Controlled study of brief personalized assessment feedback for drinkers interested in self-help. Addiction, 102, 241–250.

Workers Compensation Board. (2008). Drug and Alcohol Usage Statistics: Worker's Compensation Statistics: Provincial Synopsis, 2008. http://www.wcb.ab.ca/

APPENDIX C

ADDICTIONS SERVICES AND RESOURCES IN RED DEER

The following list is not exhaustive. There are a myriad of services that are provided that do not specifically target people who use alcohol and drugs but do provide support services. This list provides a starting point of referral for the key addiction and mental health services in Red Deer.

Prevention Services in Red Deer

Alberta Health Services, Addictions and Mental Health
www.albertahealthservices.ca
Telephone 403-340-5274
24 hour help line 1-866-332-2322

Central Alberta Sexual Assault Centre
www.casasc.ca
403-340-1124

McMan Youth, Family and Community Services
www.mcman.ca
403-309-2002

Vantage Community Services
vantagecommunityservices.ca
403-340-8995

Red Deer Public School System
www.rdpsd.ab.ca
403-343-1405

Red Deer Catholic School System
www.rdcrd.ab.ca
403-343-1055

Safe Harbour Society
www.safeharboursociety.org
403-347-0181

Treatment Options in Red Deer

Alberta Health Services – Addictions and Mental Health
www.albertahealthservices.ca
Telephone 403-340-5274
24 hour help line 1-866-332-2322

McMan Youth, Family and Community Services
www.mcman.ca
403-309-2002

Vantage Community Services
vantagecommunityservices.ca
403-340-8995

Red Deer Native Friendship Society
www.reddeernativefriendship.com
403-340-0020

Safe Harbour Society
www.safeharboursociety.org
403-347-0181

Harm Reduction

Canadian Mental Health Association – Central Alberta
www.reddeer.cmha.ca
403-342-2266

Central Alberta AIDS Network Society
www.caans.org
403-346-8858

Vantage Community Services
vantagecommunityservices.ca
403-340-8995

Safe Harbour Society
www.safeharboursociety.org
403-347-0181

Enforcement/Community Safety in Red Deer

Central Alberta Crime Prevention Centre
Crime Prevention Through Environmental Design via:

City of Red Deer
www.reddeer.ca
403-342-8111

Royal Canadian Mounted Police
www.reddeer.ca
403-406-2300

SeCure Consulting
www.targetcrime.ca
403-392-8088

X-Cops
403-358-5517

Community Response Unit (C.R.U.)
www.reddeer.ca
403-406-2300

Crime Reduction Initiative
www.reddeer.ca
403-309-8500

Police and Crisis Team (P.A.C.T.)
www.reddeerpcn.com
403-406-2505

GLOSSARY AND IMPRORTANT TERMS

We recognize that the words we use can shape our understandings, stereotypes, assumptions and reckoning on a given subject, and it is for this reason that the Central Alberta Addictions Consortium offers the following explanations.

Psychoactive Substance – A substance that, when ingested, affects mental processes (e.g. cognition or affect). This term and its equivalent, psychotropic drug, are the most neutral and descriptive terms for the whole class of substances, licit and illicit (including controlled drugs like alcohol, tobacco and prescription drugs). The term does not necessarily imply abuse or dependence.[34]

Stimulant – Stimulant drugs increase central nervous system activity, decrease appetite, and may produce temporary sensations of increased well-being. Some common psychoactive drugs that fall into this category are caffeine, tobacco, cocaine/crack, ecstasy, methamphetamine and Ritalin.

Depressant – Depressants decrease central nervous system activity and are often used for their sedative, anxiety-reducing, and pain-relief/anesthetic properties. Some common depressant drugs include alcohol, benzodiazepines, and opioids such as OxyContin, heroin and morphine.

Marijuana - While marijuana is commonly understood as a depressant drug due to its apparent sedative properties, it also produces increased stimulation of the central nervous system and in some users may have hallucinogenic effects.

Hallucinogen – Hallucinogens are drugs that produce auditory or visual hallucinations. Common hallucinogens include magic mushrooms, LSD or PCP. Hallucinogens may also produce both stimulant and depressant effects on the central nervous system.

Inhalants - Inhalants are substances (household, industrial or medical products) that produce chemical vapors that are inhaled to produce mind-altering effects. Inhalants produce effects similar to alcohol intoxication, including lightheadedness, slurred speech or dizziness and can produce long term health problems or death.

Harm Reduction - "Those policies, programs and practices that aim primarily to reduce the adverse health, social or economic consequences of use of legal and illegal psychoactive substances without necessarily reducing consumption. ... A harm reduction approach to substance use accepts that abstinence may not be a realistic goal for some people."[35]

Tolerance - As the body adapts physically to the presence of a particular psychoactive substance, higher amounts of the substance are required to achieve the desired feeling, sensation, mood, etc. As it is noted by Dr. David A. Cook, in the 2004 Alberta Alcohol and Drug Abuse Commission paper, "Addiction and Medications":

> There is now evidence that if drugs that mimic the neurotransmitters are administered repeatedly, the ability of the normal neurotransmitter to provide a sense of reward becomes suppressed. This means that the desired sensation can only be achieved by administration of the drug, often in ever-increasing amounts.[36]

Withdrawal Syndrome - As the body adjusts to the presence of a substance, its ability to function 'normally' without it, once removed, causes symptoms of withdrawal (sweating, headache, seizures and sometimes death).

Physical Dependence - As noted in the above explanation of tolerance and withdrawal, physical or tissue dependence is marked by the phenomena of tolerance and withdrawal, wherein 'normal' physical functioning requires taking the substance to mitigate withdrawal symptoms.

Psychological Dependence - This may be characterized by preoccupation with using a substance, cravings to use and the feeling that one needs to use the substance to feel normal.

An apt summary of these points can be taken again from Dr. Cook, who writes that when an individual:

> [D]evelops a craving for a drug, this is referred to as psychological dependence. In its mild form, it is called habituation, and the use of tea or coffee provides an illustration. When the psychological dependence becomes more severe, we speak of addiction. Prolonged use of some drugs leads to a situation where the body needs the drug to function properly, and the patient will become sick or even die when the drug is stopped abruptly. This used to be called physical dependence, but we tend now to talk about such drugs as producing a withdrawal syndrome or abstinence syndrome. Both medical and recreational drugs can produce a withdrawal syndrome . . . Finally, when the individual needs increasing doses of the drug to produce the same effect, that agent is described as producing tolerance.[37]

Continuum of Use and the Process of Addiction

As it is noted earlier in this report, a person's pattern of use or relationship with a particular psychoactive substance can remain constant over time, or may progress through stages, from experimental use through to dependence, and can be influenced by socioeconomic, biological, psychological and other personal factors.

Movement through the stages in the continuum of use is not necessarily sequential or linear; one may experiment with a substance and never use it again; use a substance socially with no difficulty; or move quickly from experimentation through to dependency in very little time. Simply put, "[d]rugs produce effects that may be experienced as pleasurable, and some individuals will then continue to seek out that drug to regain the pleasure they experienced;" factors that can influence one's choice to continue using or not using a substance include "the personal characteristics of the user, the society in which the individual lives and the pharmacological effects of the drug on mood and thought."[38]

34 `Alberta Health Services, 2013. Harm Reduction for Psychoactive Substance Use Policy, pp 1-3.
35 Ibid

36 Cook, David A (Alberta Alcohol and Drug Abuse Commission). Addiction and Medications, 2004. Pg 8.
37 Cook, David A (Alberta Alcohol and Drug Abuse Commission). Addiction and Medications, 2004. Pg 8.
38 Ibid

CAAC | Central Alberta Addictions Consortium