Model Core Program Paper:

Prevention of Harms Associated with Substances

BC Health Authorities **BC Ministry of Healthy Living and Sport**

February 2009

This Model Core Program Paper was prepared by a working group consisting of representatives of the BC Ministry of Healthy Living and Sport and BC's health authorities.

This paper is based upon a review of evidence and best practice, and as such may include practices that are not currently implemented throughout the public health system in BC. This is to be expected, as the purpose of the Core Public Health Functions process—consistent with the quality improvement approach widely adopted in private and public sector organizations across Canada—is to put in place a performance improvement process to move the public health system in BC towards evidence-based best practice. Where warranted, health authorities will develop public performance improvement plans with feasible performance targets and will develop and implement performance improvement strategies that move them towards best practice in the program component areas identified in this Model Program Paper.

This Model Program Paper should be read in conjunction with the accompanying review of evidence and best practice.

Model Core Program Paper approved by:
Core Functions Steering Committee (February 2009)
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EXECUTIVE SUMMARY

This paper identifies the core elements that should be provided by British Columbia health authorities in the prevention of harms associated with substances.[1] It is intended, as part of the BC Core Functions in Public Health, to reflect evidence-based practice and to support continuous performance improvement.

A Working Group of representatives from the Ministry of Healthy Living and Sport, Provincial Health Services Authority, and regional health authorities worked together in the development of this paper. The Working Group highlighted that this program is in the early stages of development in many health authorities and requires strong coordination among local, regional, provincial and federal levels, as well as extensive support from the Ministry of Healthy Living and Sport.

Prevention of harms associated with substances is understood to include policies and practices that protect and improve health while also preventing or reducing the negative consequences associated with psychoactive substance use policies and programs. While unfamiliar and illegal drugs create much public concern and discussion, the literature indicates that tobacco and alcohol cause far more health problems at a population level.

The Working Group agreed that the goal of prevention strategies is to protect and improve health by minimizing the harms to individuals, families, and communities associated with psychoactive substances, while also recognizing their benefits in appropriate circumstances. The objectives of the program are to:

- Increase knowledge about psychoactive substances.
- Delay the onset of first use.
- Reduce problematic substance use.
- Reduce use to safer levels.
- Sustain and/or create environments that support health.

Integration of a number of fundamental concepts is necessary for a comprehensive approach to prevention of harms associated with substances. These are:

- Multi-disciplinary and multi-sectoral collaboration.
- Community development and community capacity building.
- Healthy public policy.
- A focus on positive protective factors.

[1] Includes alcohol, tobacco, prescription substances with reinforcing properties such as sleeping pills and pain medications, and illegal substances such as cannabis, cocaine, methamphetamines, ecstasy, and heroin.

- A focus on sub populations that are vulnerable to substance-related harms as well as on diverse groups with unique needs.
- A balance between universal initiatives to influence the population as a whole, and targeted initiatives focused on vulnerable sub-groups and diverse populations.

As well, health authority processes are required to support shared responsibility across disciplines and sectors including provincial ministries and their service delivery partners, school boards, social service agencies, local governments, and community organizations.

The major program components for prevention of harms associated with substances are described below, along with associated strategies for implementation of each component:

- Influence protective and risk factors at key life stages/transitions:
    - Adopt a comprehensive strategy to decrease substance use during pregnancy and reduce exposure of infants and young children to harmful substances.
    - Establish parental education and support programs.
    - Encourage and support positive school adjustment through a multi-components strategy in partnership with school boards, addressing the needs of teachers, parents, and children.
    - Encourage and support, in partnership with school boards and community groups, a smooth transition to independence and adult life and responsibilities through volunteering, mentoring, and community training programs.
    - Support mitigation of risk factors for adults and specific vulnerable sub-groups through programs to address broad social dimensions.
- Prevent, delay, and reduce alcohol, cannabis and tobacco use by children and youth:
    - Restrict access to alcohol and tobacco by minors.
    - Promote and support interactive and evidence-based educational support on alcohol, cannabis and tobacco for all schools.
    - Engage broad community participation in influencing social attitudes and responses to alcohol, tobacco and cannabis.
    - Encourage involvement of young people in recreational contexts where tobacco, alcohol and cannabis are not present.
- Reduce risky patterns of substance use:
    - Promote and support clear messaging that addresses safer substance use and reduces risk-taking.

  - Advocate for safer drinking and tobacco cessation programs among 19-24 year olds, for delivery through institutions that engage this age group.
  - Work with Aboriginal communities to facilitate safer drinking and tobacco cessation plans in their communities.
  - Support the use of brief interventions by health professionals and other professionals.
  - Promote and support prevention initiatives targeted toward older adults (65+) including screening, home visits as required, education for caregivers, and linkages with community groups.
  - Educate health care professionals on managing the safe use of psychoactive pharmaceuticals.

- Create safer contexts for substance use:
  - Promote and support evidence-based programs to increase safety and promote social and legal responsibility around licensed premises.
  - Support public awareness by partners to decrease impaired driving and associated harms.
  - Support public awareness/education and legislation to decrease harm from second-hand smoke.
  - Expand services to reduce harms associated with illegal drug use (i.e. improved access to needle and syringe distribution programs, multi-faceted support services, treatment and harms reduction programs in corrections facilities, supervised consumption sites, etc).

- Reduce discrimination and stigma
  - Develop regional strategies and plans to shift attitudes, address systemic inequities and remove barriers.
  - Focus on community-level strategies and partnerships to ensure approaches are shaped by the unique needs of the community and specific target groups.
  - Engage people who use substances to provide advice at all stages of planning and in delivery of services at all levels.
  - Enhance training and understanding of the issues among health care provider, as well as policy planners, employers, human resources personnel, emergency staff (e.g., police and other first responders) and social services.

- Surveillance,[2] monitoring and evaluation:
    - Gather, assess, and report statistics on the use and harm of tobacco, alcohol, cannabis, prescription psychoactive substances, and other substances.
    - Monitor vulnerable sub-populations taking into account the social, economic and environmental determinants of health.
    - Evaluate programs on prevention of harms associated with substances.

The program components and related strategies to prevent harms associated with substances, particularly influencing protective and risk factors at key life stages will also serve to support and strengthen concurrent prevention efforts in other core public health programs such as prevention of mental illness and healthy child and youth development.

Preliminary program indicators are suggested along with surveillance, monitoring and evaluation indicators related to prevention of harms associated with substances, as a basis for ongoing review and evaluation.

[2] Surveillance is the ongoing systematic collection of program data (not individual data) for the purposes of analysis and interpretation to assist in public health action including disease prevention, health promotion, program planning and evaluation (based on definitions in *Health Assessment and Disease Surveillance: A Review Of Best Practices.* Ministry of Health, 2006).

1.0 OVERVIEW/SETTING THE CONTEXT

As demonstrated in recent Canadian reports, public health needs to be better structured and resourced, in order to improve the health of the population. The Framework for Core Functions in Public Health is a component of that renewal in British Columbia. It defines and describes the core public health activities of a comprehensive public health system. This policy framework was accepted in 2005 by the then-Ministry of Health and the health authorities.

Implementation of core functions will establish a performance improvement process for public health, developed in collaboration between the Ministry of Healthy Living and Sport, the health authorities and the public health field. This process will result in greater consistency of public health services across the province, increased capacity and quality of public health services and improved health of the population. To ensure collaboration and feasibility of implementation, the oversight of the development of the performance improvement process is managed by a Provincial Steering Committee, with membership representing all health authorities and the ministry.

What are core programs? They are long-term programs representing public health services that health authorities provide in a renewed and modern public health system. Core programs are organized to improve health; they can be assessed ultimately in terms of improved health and well-being and/or reductions in disease, disability and injury. In total, 21 programs have been identified as "core programs"; the prevention of harms associated with substances is but one, and this "program" consists of a range of legislation, programs, initiatives and partnerships.

In a "model core program paper," each program will have clear goals, measurable objectives and an evidentiary base that shows it can improve people's health and prevent disease, disability and/or injury. Programs will be supported through the identification of best practices and national and international benchmarks (where such benchmarks exist). Each paper will be informed by an evidence paper, other key documents related to the program area and by key expert input obtained through a working group with representatives from each health authority and the Ministry of Healthy Living and Sport.

The Provincial Steering Committee has indicated that an approved model core program paper constitutes a model of good practice, while recognizing it will need to be modified to meet local context and needs. While health authorities must deliver all core programs, how each is provided is the responsibility of the health authority, as are the performance improvement targets they set for themselves.

It is envisioned that the performance improvement process will be implemented over several years. During that time the process will contribute to and benefit from related initiatives in public health infrastructure, health information and surveillance systems, workforce competence assessment and development and research and evaluation at the regional, provincial and national levels.

1.1 An Introduction to This Paper

This model core program paper is one element in an overall public health performance improvement strategy developed by the Ministry of Healthy Living and Sport in collaboration with provincial health authorities and experts in the field of prevention of harms associated with substances. It builds on previous work from a number of sources.

In March 2005, the then-Ministry of Health released a document entitled *A Framework for Core Functions in Public Health*. This document was prepared in consultation with representatives of health authorities and experts in the field of public health. It identifies the core programs that must be provided by health authorities, and the public health strategies that can be used to implement these core programs. It provides an overall framework for the development of this document.

The evidence reviews that have informed this paper include *Core Programs Evidence Review Paper on the Prevention of Harms Associated with Substances* (2006), prepared by the Centre for Addictions Research of BC for the Ministry of Healthy Living and Sport, and *Following the Evidence: Preventing Harms from Substance Use in BC*, (2006), also prepared by the Centre for Addictions Research of BC. These reviews identify research evidence related to local, regional and provincial prevention efforts which have demonstrated sustained benefits.

A Working Group for prevention of harms associated with substances was formed of experts from the Ministry of Healthy Living and Sport and the health authorities in January 2007. The group provided guidance and direction in the development of the model core program paper during meetings in January and July 2007, January and February 2008, as well as through telephone and e-mail discussions.

1.2 Introduction to Prevention of Harms Associated with Substances

It is important to acknowledge that substance use occurs along a spectrum from beneficial use through non-problematic, to problematic and dependent use. Problematic use includes episodic use that can have negative health consequences and chronic use that can lead to substance use disorders or other serious illness. For example, harms such as overdose can arise from a single instance of use, while others such as lung cancer and liver disease, result from hazardous use over a number of years. Harm can occur from adolescent substance use that leads to later problematic use or adult use that disrupts the development of children.

Social harms can also occur from problematic substance use, including family breakdown, child neglect, unstable housing, absenteeism, unemployment, financial and legal problems, and a significant level of drug-related criminal activity. In addition, harms originate from, or are exacerbated by laws and policies that fail to take into account unintended consequences. There is a growing body of scientific evidence indicating that many of the harms associated with psychoactive substances are due to the policy of prohibition of illegal substances and related enforcement practices (DeBeck, Wood, Montaner, & Kerr, 2006). From a health perspective, examples of unintended results can include: isolation and separation of people who use illegal drugs from health and prevention services including needle exchanges and treatment programs; heightened levels of violence; increased theft and property crime; a shift from smoking to

injecting illegal substances; and high-risk injecting behaviour (e.g. when under pressure, injectors are more likely to skip important safety steps in the injection processes) which can result in overdose events and deaths, and contribute to transmission of hepatitis C, HIV, and other infections (DeBeck et al., 2006). Non-health system consequences of prohibition (e.g., theft, property and violent crime, family and community disruption, incarceration, corruption) are beyond the scope of this paper.

Similarly, indiscriminate prohibition policies have an unintended impact on the social and cultural environment and contribute to prejudice and discrimination towards people who use substances. The resulting stigma can significantly heighten the harm experienced by people who use substances: attitudes of rejection, blame and devaluation within society, families and relationships can cause further social isolation and present significant barriers to recovery. This stigma also influences the allocation of resources and can result in low-priority, poorly-funded programs, and limited access to a range of necessary health care services (Mental Health Commission of Canada, 2007). A wide variety of measures are addressed in this paper to overcome these problems and to foster environments that reduce harm as well as enhance public safety.

While illegal drugs create much public concern and discussion, the literature indicates that legal substances such as tobacco and alcohol usually cause the greatest amount of individual and societal harm (Thomas & Davis, 2007). These are followed in terms of burden of disease, by prescription and illegal drug use (Ministry of Health, 2005). Substances that contribute to the greatest harms can be identified from the distribution of the burden of disease in BC:

- Tobacco use accounts for 12 per cent of the burden of disease.
- Alcohol for 10 per cent.
- Illegal substances 2 per cent.

Tobacco smoking is the number one cause of preventable death and disease in British Columbia. It accounts for 4,600 deaths per year (2006) (Centre for Addictions Research of BC [CARBC], Alcohol and Other Drugs [AOD] Monitoring Project). With respect to alcohol, adult consumption in BC increased by 8 per cent between 2002 and 2007 (CARBC, AOD Monitoring Project). During this time BC has seen an increase in the number of alcohol-related hospitalizations, chronic diseases and deaths (CARBC, AOD Monitoring Project). With respect illicit drugs, there were 378 deaths attributed to illicit drug use in 2006 in BC (CARBC, AOD Monitoring Project): poly-substance was common with two or more substances identified in 79.4 per cent of the deaths, and three or more in 34.5 per cent of the deaths (Buxton et al., 2008).

Significant harm can result from alcohol consumption by women during the childbearing years, placing them at risk for adverse perinatal and fetal outcomes. Fetal Alcohol Spectrum Disorder (FASD) is the leading cause of preventable developmental disability among Canadian children. The prevalence of FASD in BC has been estimated at 9.1 cases for 1,000 children, and 3.5 cases of Fetal Alcohol Syndrome (FAS) per 1,000 children. All current Canadian professional standards of practice recommend that there is no known safe level of alcohol consumption during pregnancy.

Also of major importance is the significant burden of morbidity and mortality associated with alcohol-related chronic disease and alcohol-related injuries. There is a growing body of evidence linking alcohol to chronic diseases including cardiovascular disease, some cancers, cirrhosis and mental disorders. There are also a variety of serious injuries associated with alcohol including falls, impaired driving, drowning, poisoning, and injuries resulting from violence and family abuse (Giesbrecht, N., Roerecke, M., & Rehm, J. (2005).

Prescription medications are also cause for concern: while they can provide important health benefits, they can also lead to significant harm. Problems related to medications can be due to a variety of inappropriate uses, such as under-treatment, over-treatment, use for reasons other than as prescribed, and adverse effects of the medication even if given according to recommendations. In BC, for example, it has been found that the pattern of utilization of benzodiazepines appears inconsistent with the recommendations of educational groups, regulators and manufacturers (Therapeutics Initiative, 2004). Approximately 170,000 people are receiving amounts incompatible with short-term or intermittent use and the two groups most vulnerable to adverse effects, women and the elderly, are the highest users (Therapeutics Initiative, 2004).

A Canadian cost study, based on 2002 data, estimated the overall social cost of harms associated with substances (excluding pharmaceuticals) to be $39.8 billion; tobacco accounted for about $17 billion (42.7 per cent of the total estimate), alcohol for about $14.6 billion (36.6 per cent) and illegal drugs, $8.2 billion (20.7 per cent) (Ministry of Health, Population Health and Wellness [PHW], 2006).

The rate of substance use (excluding pharmaceuticals) by British Columbians within a 12 month period (2004) were: 79.3 per cent alcohol use; 15 per cent tobacco use; 16.8 per cent cannabis use; 2.6 per cent cocaine/crack use; 0.8 per cent amphetamine/speed use; 1.1 per cent ecstasy use; 0.7 per cent hallucinogen use; overall 4 per cent used an illegal drug other than cannabis (Health Canada, 2004). In 2005, there were a total of 27,212 tobacco-related, 25,194 alcohol-related, and 4,817 illicit drug-related hospital discharges across British Columbia (CARBC & BC Mental Health and Addictions Research Network, 2007).

1.3 Linkages with Other Health Programs

There are strong linkages and collaborative relationships between the program to prevent harms associated with substances and many other health programs. It is important that the entire health care system and its community partners have a thorough understanding of the harms associated with substances, and a commitment to providing accessible supportive services to people who use substances. Primary care physicians are a key linkage in the provision of these services as well as health care providers in acute care and emergency care services, mental health and substance use treatment, child and youth mental health, and home and community care services.

With respect to public health, related core programs that require integration and coordinated measures include: the reproductive health and disability prevention program; the healthy living program (tobacco cessation); prevention of communicable diseases; prevention of chronic diseases, mental health promotion and prevention of mental disorders; healthy communities; and healthy child and youth development.

Key provincial government partners include the Ministry of Health Services, Ministry of Children and Family Development (the lead ministry for coordinating FASD prevention) and the Ministry of Public Safety and Solicitor General, which is responsible for police policy and the Crystal Meth Secretariat. On a community level, key partners include family and social service programs as well as police and justice system personnel.

2.0 SCOPE AND AUTHORITY FOR THE PREVENTION OF HARMS ASSOCIATED WITH SUBSTANCES

In order to implement the program for preventing harms associated with substances, there must be clarity on the roles and responsibilities of the Ministry of Healthy Living and Sport, the health authorities and other ministries and levels of government involved in this field.

2.1 National Roles and Responsibilities

Health Canada is responsible for providing leadership, coordination and research, on the prevention and treatment of harms associated with substances. It supports, along with the Canadian Centre on Substance Abuse (CCSA), the development of a national policy framework, the *National Framework for Action to Reduce the Harms Associated with Alcohol and other Drugs and Substances in Canada: Answering the Call* (CCSA, 2005), through a collaborative process with provinces and stakeholders. The Framework defines a comprehensive plan to clarify, enable and enhance planning and programs across the country. The CCSA has also recently developed *Reducing Alcohol-Related Harm in Canada: Towards a Culture of Moderation, Recommendations for a National Alcohol Strategy* (2007).

Health Canada also coordinates federal/provincial/territorial initiatives to advance best practices and collaboration across governments to prevent problematic substance use, and supports research, documentation and distribution of statistical and best practice information in partnership with other national agencies. For example, Health Canada played a central role in the 2004 Canadian Addiction Survey and its successor, the forthcoming Canadian Alcohol and Drug Use Monitoring Survey.

Other federal ministries that have a role in preventing harms associated with substances include: the Public Health Agency of Canada which has a role in developing public health policies, research, best practices, and knowledge exchange on harm reduction and related chronic disease prevention and injury prevention; and the federal Department of Justice which provides direction and coordination on enforcement strategies related to the use of illegal drugs in Canada.

Key national organizations that play a prominent role in prevention of harms associated with substances include: Joint Consortium for School Health, Canadian Centre on Substance Abuse, Canadian Community Epidemiology Network on Drug Use, Canadian Executive Council on Addiction, Canadian School Health Network, Canadian Substance Abuse Information Network, and the National Native Addictions Partnership Foundation.

2.2 Provincial Roles and Responsibilities

2.2.1 Ministry of Healthy Living and Sport Roles and Responsibilities

The mandate of the Ministry of Healthy Living and Sport is to

- Promote health and prevent disease, disability and injury.
- Protect people from harm.

- Facilitate quality opportunities to increase physical activity, participation and excellence in sport.
- Support the health, independence and continuing contributions of women and older people.

In its stewardship role, the Ministry of Healthy Living and Sport provides leadership, strategic policy direction, legislation and monitoring for public health and sports programs to support the delivery of appropriate and effective public health services in the province. The ministry has a role in addressing health inequalities, with a specific focus on the development of policies and programs to close the gap in Aboriginal health status. The Ministry works with the health authorities to provide accountability to government and the public for public health service outcomes.

In the area of prevention of harms associated with substances, the Ministry of Healthy Living and Sport is responsible for strategic planning, policies and legislation, in consultation with health authorities. Specifically, the ministry role is:

- Advising the Minister and other ministries on substance related policies, legislation, strategic directions, and priorities.
- Consulting and collaborating with health authorities, clinical and academic partners in the development of plans and strategies to outline provincial priorities and establish policies, best practices, and service frameworks on prevention of harms associated with psychoactive substances.
- Facilitating collaborative partnerships with other provincial Ministries and agencies, the federal government, and Federal/Provincial forums on the prevention of harms associated with substances.
- Providing leadership in provincial policy development and long-term planning for addictions and mental health treatment, rehabilitation, recovery services, and community reintegration through a continuum of services and supports.
- Facilitating appropriate policies and practices on the use and management of psychoactive pharmaceuticals in consultation with the BC College of Pharmacists and the BC College of Physicians and Surgeons.
- Developing, through a collaborative approach, a First Nations Health Plan with components related to reducing harms associated with substances.
- Supporting research on prevalence and estimated costs of harms associated with substances and innovative interventions such as supervised injections sites.
- Supporting knowledge exchange through the BC Partners for Mental Health and Addiction Information, and the Centre for Addictions Research of BC's Communications and Resources Unit.

2.2.2 Other Provincial Ministries Roles and Responsibilities

The Ministry of Healthy Living and Sport has a unique relationship with the Ministry of Health Services as they are the primary linkage to the regional health authorities and are responsible for service delivery of public health programs. The role and functions of the Ministry of Health Services are predominantly focused on: leadership for the delivery of health services and programs; funding and accountability for regional health authorities; ensuring long-term sustainability of the health care system; improved patient care; leadership, direction and support to health care service delivery partners; setting province-wide goals, standards and expectations for health care service delivery by health authorities; and management of the Medical Services Plan, Pharmacare, Ambulance Services, and BC HealthGuide self care program.

A number of other ministries have significant involvement in this field: the Ministry of Children and Family Development coordinates child, youth and family mental health and the Fetal Alcohol Spectrum Disorder provincial plan for British Columbia; the Ministry of Education facilitates school-based health promotion and prevention of harms associated with substances; and Ministry of Public Safety and Solicitor General leads policing and enforcement policies. The responsibilities of many other provincial ministries and agencies involved in this field are summarized in Appendix 3 for further information.

2.2.3 Provincial Health Services Authority Roles and Responsibilities

The Provincial Health Services Authority (PHSA) is responsible for ensuring that high-quality specialized services and programs are coordinated and delivered within the regional health authorities. PHSA operates eight provincial agencies including: BC Mental Health and Addiction Services, BC Children's Hospital, BC Women's Hospital & Health Centre, BC Centre for Disease Control, BC Cancer Agency, BC Renal Agency, BC Transplant and Cardiac Services BC.

One of PHSA's four key strategic directions is population and public health. A steering committee consisting of representation from all PHSA agencies and programs oversees population and public health activity across PHSA. Due to the provincial scope of PHSA's mandate, a dual role for PHSA is emerging: improvements aimed at streamlining population and public health activities within PHSA agencies and programs, as well as potential provincial coordination in areas such as surveillance, consistent messaging, expert advice, and supporting development of healthy public policy.

Key drivers for shaping PHSA's role in core programs are the needs of the regional health authorities, the Ministry of Healthy Living and Sport and the Ministry of Health Services. As PHSA's role evolves, the opportunity arises to develop mechanisms to convene and coordinate provincial dialogue; facilitate the identification of common needs and joint problem-solving; collaborate with and support regional and provincial partners to meet common needs; and jointly identify available resources for common initiatives.

In relation to preventing harms associated with substances, PHSA's activities include:

- The ACTNow BC, Healthy Choices in Pregnancy is offered through the PHSA to health and other service providers to counsel women about alcohol and other substance use in pregnancy.
- The BC Centre for Disease Control (BCCDC) coordinates the BC Harm Reduction Supply Services Committee, which establishes policies and priorities for harm reduction services in BC and oversees the distribution of supplies for needle distribution and collection, crack use supplies, and other harms reduction programs.
- The BC Centre of Excellence for Women's Health provides gender-based research and analysis.
- BC Women's Hospital and Health Centre operates the Fir Square Combined Care Unit which provides specialized care for substance-using pregnant women and substance-exposed babies.
- BC Mental Health and Addiction Services (BCMHAS) contribute to research and knowledge exchange on issues relating to harms associated with substances, including health promotion and prevention. It also leads implementation of a provincial plan to improve health literacy in mental health and addiction, oversees a Provincial Addiction Network composed of health authorities and other key stakeholders to improve the quality and accessibility of treatment and health promotion/prevention services, and oversees the delivery of a number of specialized mental health services, including children's mental health and the Provincial Youth Concurrent Disorders Programs, at the BC Children's Hospital.

2.3 Health Authorities Roles and Responsibilities

The role of health authorities is to identify and assess the health needs in the region, to deliver health services (excluding physician services and BC Pharmacare) to British Columbians in an efficient, appropriate, equitable and effective manner, and to monitor and evaluate the services which it provides. In the area of preventing harms associated with substances, regional health authorities are responsible for:

- Leadership in regional needs assessment, planning, policy development, partnerships, and workforce development in harms reduction.
- Delivery of programs including health promotion, public education, systematic screening, and outreach aimed at:
    - Influencing risk and protective factors at key developmental stages.
    - Preventing, delaying, and reducing alcohol, cannabis and tobacco use by children and youth.
    - Reducing risky patterns of substance use.

- Creating safer contexts for substance use.

- Community development/community capacity building to promote coordinated action plans involving primary health care physicians, schools, local governments, social service agencies, local media, workplaces and other community organizations; and
- Surveillance, monitoring, evaluation and performance improvement processes.

These programs and related strategies are described in detail in Section 5.0.

2.4 Local Roles and Responsibilities

Commitment and involvement at the local level is essential for the success of harms reduction initiatives—it is fundamental to ensuring that contracted agencies, local organizations and groups are empowered, knowledgeable, and organized to respond to local needs and priorities.

The *Public Health Act* strengthens the role and responsibilities of local government to address community public health encompassing not only zoning and facilities but also public health planning, health promotion and prevention of health problems. Local governments can exert important influence on public and community health policies, housing, social services, community safety, recreational services, development and zoning, licensing and by-laws. They are often more immediately affected by problematic substance use and bear the brunt of mounting costs for policing and enforcement (Ministry of Health, 2005b). Also, many community organizations and groups are involved in providing social support, recreation programs, faith services, and other supports that can have a significant positive impact on families and individuals experiencing the harmful effects associated with substances. Involvement of a wide range of faith communities, service clubs, recreation and leisure programs, private sector and non-government organizations are all important in providing health services and strong support for a coordinated, comprehensive community-wide approach to preventing harms associated with substances.

2.5 Aboriginal Communities Roles and Responsibilities

Also on a community level, it is essential that Aboriginal groups have full involvement in the planning and delivery of programs provided to people on First Nations reserves as well as Aboriginal people in other communities. Capacity building and partnership with Aboriginal communities can strengthen and support the shift toward self-government of the health care system and facilitate the management, planning and delivery of priority services to their own communities.

On a provincial level, through the signing of the *Transformative Change Accord*, the Leadership Council representing the First Nations of British Columbia, the Province of British Columbia and the federal government have agreed to a shared commitment to action on closing health, social, and economic gaps between First Nations and other British Columbians. The Accord specifies that “adult mental health substance abuse, as well as young adult suicide will be addressed through an Aboriginal Mental Health and Addictions Plan” as one of many actions to close health gaps between Aboriginal British Columbians and the general population by 2015. Further

work has resulted in a signed Tripartite First Nations Health Plan that commits the three parties to taking action on mental health and substance use among Aboriginal people. The success of these initiatives will require, in part, ongoing collaboration among various levels of government.

2.6 Legislation and Policy Direction

The overall legislative and policy direction for preventing harms associated with substances is derived from:

- Federal government *Tobacco Act* and related Regulations; *Controlled Drugs and Substances Act*; and International Conventions on Tobacco and Controlled Substances.
- The following provincial acts and regulations: *Public Health Act, Health Act,* BC *Liquor Control and Licensing Act*, *Liquor Distribution Act; Tobacco Sales Act; Tobacco Damages and Cost Recovery Act; Pharmacists, Pharmacy Operation and Drug Scheduling Act.*
- Provincial policy directional documents, specifically the *Every Door is the Right Door: a BC Planning Framework to Address Problematic Substance Use and Addiction* (2004), and *Harm Reduction: A British Columbia Community Guide* (2005); *Following the Evidence: Preventing Harms from Substance Use in BC.*
- *A Framework for Core Functions in Public Health* (March 2005).
- Specific policies/priorities that may be established by the health authority, the Ministry of Healthy Living and Sport or the provincial government.
- Local government by-laws and plans.

3.0 GOALS AND OBJECTIVES

The goal of the core program for prevention of harms associated with substances is to protect and improve health by minimizing the harms to individuals, families, and communities associated with psychoactive substances, while recognizing that substances have benefits in appropriate circumstances. The objectives of the program are to:

- Increase knowledge about psychoactive substances.
- Delay the onset of first use.
- Reduce problematic substance use.
- Reduce use to safer levels.
- Sustain and/or create environments that support health.

4.0 FUNDAMENTAL CONCEPTS

Integration of a number of fundamental, or cross-cutting, concepts is necessary for a comprehensive approach to prevention of harms associated with substances. These concepts are based on both the evidence and expertise of professionals in the field.

4.1 Harm Reduction

Harm reduction is a philosophy that guides policies and programs for those who use substances, with the goal of limiting the adverse health (e.g., HIV/AIDS, Hep C, overdose, etc.), social and economic consequences associated with such use. Harm reduction adopts a client-centred approach. It recognizes abstinence as a possible outcome for persons with addictions but the commitment to permanent abstinence is not a requirement for individuals to receive care or treatment. It respects self-determination and recognizes individuals' existing capacities, strengths and practices. Therefore, the participation of individuals recovering from addictions, clients presently using substances and those affected by others' alcohol/substance use are welcomed and valued in devising, implementing and evaluating interventions and programs (Fraser Health Authority, 2007).

4.2 Health Promotion

An approach based on health promotion principles is necessary to provide a broad range of strategies to influence attitudinal and behaviour change within the health authority itself and across the regional population. Health promotion research has shown that education and/or information by itself is not generally effective in facilitating changes in behaviour, rather a comprehensive range of sustained strategies are necessary including such measures as social marketing, advocacy, policy/legislation, skills development, as well as enforcement. Health literacy strategies are recognized as important in promoting access to, and understanding knowledge, and in shifting attitudes to support prevention, recognition, management, and professional help-seeking. (The dramatic reduction in tobacco use in BC over the past ten years is an excellent example of the deployment of health promotion measures in a comprehensive and planned approach.)

4.3 Multi-Sectoral Collaboration, Partnerships and Program Integration

Collaboration, partnership and integration of initiatives across a wide range of health programs and health professionals, and in multiple community settings is essential for effective delivery of this program. The high co-morbidity among substance use, mental disorders and their interrelatedness with physical illnesses and social problems demand integrated public health policies that target clusters of related problems, common determinants, early stages of multi-problem trajectories and populations at multiple risk (World Health Organization [WHO], 2004).

Public Health has a leadership role to play in preventing harms associated with substances; however, to make a real and lasting difference, collaborative and integrated solutions must come from the health system and other public systems, the private and voluntary sections, and different levels of government. Recent evidence and international experience shows that coordinated action across governments, sectors and diverse service systems is key. Public systems both

within and beyond the health sector are challenged to build their collective capacity to respond proactively to the substance use and mental health issues of the populations they work with or serve—whether they are students, children in foster care, people on income assistance, tenants of single room occupancy hotels, or parents expecting their first child.

Integrated planning and coordinated program delivery with the following key groups is necessary:

- Involvement of mental health and addiction professionals is fundamental to effective mental health promotion and mental disorder prevention.
- The involvement of primary care providers, acute care and emergency care practitioners, as well as residential care providers is also of primary importance.
- Integration/coordination with other related model core public health programs, especially the following:
  - Mental health promotion and mental disorders prevention.
  - Reproductive health and prevention of disabilities.
  - Healthy infant and early childhood development and healthy youth development.
  - Healthy living (healthy eating/weights, physical activity and tobacco cessation).
  - Healthy communities (healthy municipalities, health care facilities, workplaces and schools).
  - Prevention of violence and abuse.
  - Prevention and control of chronic diseases.
  - Prevention of unintentional injuries.
- On a community level it is important to collaborate with professionals in social services, mental health agencies, school boards, individual schools and other educational institutions, housing services, community recreation and sports, women's centres, transition houses, friendship centres, and multicultural and immigrant agencies. As well, coordination with local public safety, police and enforcement personnel is necessary.
- Collaboration and coordination with provincial partners includes:
  - Ministry of Children and Families Development (mental health services to children, youth and their families), Ministry of Education (program development in positive mental health, building resiliency, healthy sexuality, physical activity, healthy eating, etc.);

- Health professionals in PHSA for expert support and training in best practices, standards and guidelines.

4.4 Community Development/Community Capacity Building

Proactive community development and community capacity building is necessary to enhance understanding and encourage participation of key sectors including local governments, parents, schools, social service agencies, faith communities, workplaces, police, and other community organizations that can influence healthy lifestyles and positive behaviours.

Facilitation of community prevention is needed to support education and awareness, needs assessment, inventories of strengths, support for key partners, and development of local action plans.

4.5 Healthy Public Policy

Advocacy is essential to influence public policies that are instrumental in preventing harms. For example:

- The economic availability of alcohol and tobacco strongly affects the level of consumer demand (United States Department of Health and Human Services, 2000; Chaloupka, 1999). Effective strategies to reduce consumption can include: restricting price discounting and advertising at the retail level; restricting alcohol advertising to children/youth; promoting consumption of lower alcohol content and non-alcoholic drinks; promoting industry accords and community action projects to increase licensee accountability; promoting municipal alcohol policies; and promoting local zoning by-laws to limit liquor sales near schools.
- Policies governing the sale and use of psychoactive substances in communities require thorough analysis as they may contribute to harm by failing to take into account unintended consequences. As noted earlier, some harms associated with drugs are not simply a matter of individual use and choice, but a result of legislation and enforcement policies.

4.6 Discrimination and Stigma

Health authorities have a responsibility to address stigma (negative attitudes) and discrimination (negative behaviours) towards people with substance use problems and to become role models in their communities through organizational policies and practices which ensure their programs and services reflect positive, respectful, compassionate attitudes and behaviours towards those who use substances.

It is important to address stigma and discrimination as it results in exclusion from activities that are open to others (i.e., jobs, safe homes, health care services, acceptance from friends and family, etc.,) and internalization of the prejudice and discrimination by those who use substances (Centre for Addiction and Mental Health, n.d.). For example, studies reveal that stigma prevents people with substance use disorders from seeking help (e.g., less than 1/3 of people with

substance dependencies in Canada seek professional assistance) (Statistics Canada, 2003), and affects access to treatment as care providers themselves may have negative attitudes (e.g., more than 40 per cent of family doctors admitted in a recent US survey that they find the topic difficult to discuss with patients) (Johnson, Booth, & Johnson, 2005).

4.7 A Focus on Protective Factors

Factors that protect or strengthen individuals, families and communities to avoid harms associated with substances, have been shown to include: an easy temperament, social and emotional competence, healthy family attachment, school connectedness, participation in a faith community, and having a meaningful adult role model relationships during adolescence or a support relationship in adulthood (Loxley et al., 2004). Protective factors reduce vulnerability, promote resilience, prevent the occurrence of risk factors, or interact with risk factors to mitigate their harmful effects.

Literature on healthy youth development proposes a shift toward interventions that enhance and facilitate adaptive qualities in youth, and away from interventions that reduce risk factors and negative behavior (Saewyc & Stewart, 2007). Protective factors that buffer risky environments and lead to resilience among youth include the development of: competence across domains, confidence in oneself, connections to all elements of the community, character and moral commitment, and a sense of caring and compassion (Saewyc & Stewart, 2007). There is also evidence that healthy boundaries, constructive use of time, and social competencies are additional developmental assets (Search Institute, n.d.).

Key developmental stages are highlighted in the literature as opportunities to enhance protective factors and thus reduce vulnerabilities to problematic substance use. It is critical for people to adapt and succeed during these stages to achieve later health and social benefits that protect against problematic substance use and/or mental disorders (Toumbourou & Catalano, 2005). Key developmental stages include:

- The pre-natal/post-natal period.
- The transition to school.
- Adolescence and the transition to high school.
- Transition to independence (going to college or entering the work force).
- Transitions relating to family and occupation, including retirement (Loxley et al., 2004).

Many of the protective factors at key developmental stages that would reduce vulnerabilities will also be the basis for mental health promotion and other model core program areas. Investments in enhancing and facilitating adaptive qualities in youth will have substantial health promotion and prevention outcomes in numerous other health areas.

4.8 A Focus on Vulnerability

It is important to broadly define "vulnerable" populations to avoid a narrow view of those who are involved in risk behaviors. Frequently, analysis is restricted to only those who are engaged in risk behaviors such as injection drug use. However, that reflects a limited perspective as vulnerable populations in the context of problematic substance use can range from those who have never engaged in risk behaviors or do not perceive that their behaviour could put them at risk, to the traditional target population of people involved in commonly understood high-risk behaviours (Ministry of Health, 2007).

The evidence suggests that, for specific at-risk population sub-groups, a "determinants of health" approach enables targeted initiatives to mitigate the susceptibility to engaging in risky behaviours. A broad range of public health strategies (e.g., advocacy and collaboration initiatives with partners) can address social, environmental, and economic factors to overcome vulnerabilities that may result from factors such as low income levels, limited education and literacy, challenging family environments, gender inequities, and diverse cultural and ethnic backgrounds (Vancouver Coastal Health, n.d.). The evidence demonstrates that "risk" factors include genetic factors, parental substance use (pre- or post-natal), and early initiation of substance use, as well as more general "vulnerability" factors such as childhood trauma, inadequate income and/or housing (Loxley et al., 2004).

Table 1 provides a summary of both fixed and malleable risk and protective factors that influence development of mental disorders.

Table 1: Summary of Risk and Protective Factors That Influence Mental Disorders

Risk Factors		Protective Factors	
Academic failure and scholastic demoralization	Low birth weight	Ability to cope with stress	Problem-solving skills
Attention deficits	Low social class	Ability to face adversity	Pro-social behaviour
Caring for chronically ill or dementia patients	Medical illness	Adaptability	Safe and supportive communities
Chronic insomnia	Parental mental illness	Early cognitive stimulation	Self-esteem
Chronic pain	Parental problematic substance use	Exercise	Skills for life
Communication deviance	Perinatal complications	Feelings of security	Social and conflict management skills
Early pregnancies	Personal loss – bereavement	Feelings of mastery and control	Socio-emotional growth
Elder abuse	Poor work skills and habits	Good parenting	Social support of family and friends
Emotional immaturity and dyscontrol	Reading disabilities	Literacy	Stress management
Excessive substance use	Sensory disabilities or organic handicaps	Mental health promoting school and workplaces	
Exposure to aggression, violence and trauma	Social incompetence	Positive attachment and early bonding	
Family conflict or family disorganization	Stressful life events	Positive parent-child interactions	
Genetic risk factors	Substance use during pregnancy		
Loneliness	Exposure to childhood maltreatment		

Source: Adapted from Saxena, Jane-Llopis & Hosman (2006), based on extensive World Health Organization research and development.

Specific vulnerable and at-risk populations are discussed in the sections that follow.

4.8.1 Children and Adolescents

The evidence highlights the need to address child and adolescent development including differential gender impacts. Prevention of child abuse and all forms of childhood maltreatment, prevention of FASD and developmental harms is essential to ensure long term problems are avoided. In particular, the vulnerability of women and girls is significant with respect to their differing patterns in substance use, sexual exploitation, reproductive health, and the potential for fetal developmental harm (Saxena et al., 2006). As well, the greater propensity of males to engage in risk-taking behaviour, which leads to higher rates of injury and death, especially among young males, requires attention.

High risk youth are an important group requiring specific attention, including youth in care, street-entrenched youth, youth in active addiction, youth involved in sex work, HIV-positive youth, etc.) As well, youth in general are an important focus as delaying substance use is a critical harm reduction strategy. Youth who begin using substances prior to their 15th birthday, face a higher risk of poor health (Odgers et al., in press). As a result, universal interventions are

required to ensure that all children and young people, not just those at risk, are the focus of prevention efforts.

4.8.2 People Who Experience Violence and Abuse

Women's substance use is strongly associated with their experience of violence, abuse, assault and trauma. For example, alcohol problems are up to 15 times higher among women who are survivors of intimate partner violence than in the general population (Barron, 2005). Girls who experience physical and sexual abuse by dating partners are 2.5 time more likely to be smoking heavily within 30 days (Silverman et al., 2001). Mothers who have children with fetal alcohol syndrome have serious histories of abuse (Astley, 2004). In addition, studies of lesbian, gay and bisexual youth indicate that stigmatization and acts of psychological and physical abuse can lead to reduced self-esteem, social withdrawal and isolation, all of which are risk factors for substance use (Brown, Perlesz, & Proctor, 2002).

The effects of conflict and war trauma can span generations in refugees and war victims of physical or sexual abuse—most commonly, these involve post traumatic stress disorder, depression and anxiety, and are frequently associated with substances (Musisi, Mollica, & Weiss, 2005).

4.8.3 People Who Have Mental Disorders

It has been estimated that about 50 per cent of people with mental disorders have concurrent substance use disorders (BC Partners for Mental Health and Addictions Information, 2006). As well as drug and alcohol use, the rate of tobacco use is consistently high (e.g., tobacco use among people in BC with a diagnosed mental illness exceeds 70 per cent) (Johnson et al., 2006). The relationship is complex as problematic substance use may induce, worsen, or diminish psychiatric symptoms (Johnson et al., 2006).

4.8.4 Older Adults

Protective factors for older adults include social support—family, peers, informal relationships, more formal support groups, responsive health and social services such as respite care, and opportunities for new productive social roles. Risk factors include relationship loss and bereavement, chronic illness and caregiver burden, social isolation, and loss of meaningful social roles (Ministry of Health, PHW, 2007). Consumption of alcohol at unsafe levels, particularly with the use of medications, can adversely affect older adults' health. It may threaten the ability to live independently, increase the risk of falls, compromise mobility, and decrease cognitive ability (Spencer, 2001). Seventy-seven per cent of older adults (65+) consumed alcohol in the past year (2004), and about 10 per cent were "high risk drinkers (i.e., 4-5 drinks per day, at least one a month (Statistics Canada, 2004). The majority of older adults (84 per cent) also take some form of prescription or over-the counter medication, and many take more than one (Spencer, 2001).

4.8.5 Aboriginal People

A disproportionate share of the burden of substance use problems and mental health problems are borne by Aboriginal communities in BC. Aboriginal people who experience challenging social and economic situations are vulnerable to substance use. Research has shown that alcohol consumption is linked to the rate of suicide mortality, (Mann et al., 2008), a challenge in some Aboriginal communities particularly among youth. Although the majority of communities have found ways to successfully address these issues, others have not yet done so. Participation of Aboriginal people as full partners in the design and delivery of programs is necessary to ensure strategies are culturally sensitive and situated within an Aboriginal worldview in order to sustain long-term community-based change (Ministry of Health, PHW, 2007).

An Aboriginal mental health and substance use planning process is now underway through the Tripartite Process (discussed in 2.5); an Aboriginal-specific plan will be consistent with the 10 Year Plan to Address Mental Health and Substance Use in BC, and will build on the work already initiated by partner ministries in the development and implementation of Aboriginal-specific plans in their areas.

4.8.6 Diverse Cultural and Ethnic Groups

Persons or groups from diverse cultural or ethnic backgrounds may face risks due to conditions such as discrimination, marginalization, stigmatization, loss or devaluation of language and culture, and lack of access to culturally appropriate health care and services (Public Health Agency of Canada, 2004).

4.8.7 Gay, Lesbian, Bisexual and Transgendered People

Gay, lesbian, bisexual and transgendered people's experiences of sexual orientation and gender identity discrimination can create risks for substance use. For example, gay men and lesbian women report more psychological distress than heterosexuals (King et al., 2003) and higher rates of depression and suicide attempts (Cochran & Mays, 2000).

4.8.8 Marginalized Populations

Other diverse populations that have specific needs and require tailored strategies and outreach efforts include other individuals and groups who are marginalized and those who are unique because of religion or other elements of diversity.

4.9 Engagement

Engagement and involvement of those who are experiencing the harmful effects associated with substances is an important aspect of harms reduction. Outreach programs, needle exchange programs, education and referral services, are often the only links that drug users have to the health and social service system. Engagement with them provides a gateway to treatment services and increases the possibility that they will reduce drug use, re-engage in broader society and lead productive lives.

Also, drug users are the best source of information about their own drug use, and need to be empowered to join with service providers to determine the best interventions to reduce harms from drug use.

4.10 Universal and Targeted Initiatives

Effective prevention and harms reduction requires recognition that the bulk of preventable harms and costs to society is experienced by individuals with low- to average-risk, due to their greater numbers, rather than those at higher risk. In fact, the greatest burden of illness (both acute and chronic harms) related to alcohol, is generated by moderate drinkers. Generally, it is necessary to find a balance between universal initiatives focused on all ages and the population as a whole, and targeted interventions aimed at the smaller number of people most vulnerable to harms associated with substances (Stockwell et al., 2004). The evidence suggests that universal interventions that engage all members of society are required to impact legal drug use, while more targeted interventions are more likely to be beneficial for reducing harms from illegal drugs (Loxley et al., 2004).

Assessing regional and local needs to establish priorities is an important aspect of planning initiatives for both universal and targeted initiatives. In BC, based on analysis of interventions with the greatest potential for positive outcomes in relation to the burden of illness and patterns of substance use, targeted priorities for the province as a whole are:

1) Long term, dependent use of tobacco products;
2) Episodic or ‘binge’ use of alcohol, especially in settings with an injury risk;
3) Long term heavy use of alcohol with a particular emphasis on its role in chronic disease;
4) Injection of psychoactive substances, especially in unhygienic conditions and with unknown dosage;
5) Early use of alcohol or tobacco by adolescents (as delaying this type of use often delays subsequent illegal drug use, reduces the likelihood of addiction, and reduces the potential of other adverse consequences such as teen pregnancy, school failure, STIs, and criminal activity).

5.0 MAIN COMPONENTS AND SUPPORTING EVIDENCE

The major program components for health authority programs on preventing harms associated with substances are:

- Influence risk and protective factors at key developmental stages.
- Prevent, delay, and reduce alcohol, cannabis and tobacco use by teens.
- Reduce risky patterns of substance use.
- Create safer contexts for substance use.
- Reduce discrimination and stigma.
- Surveillance, monitoring and evaluation.

5.1 Introduction to Main Program Components

The main program components, and associated strategies for each program component, are based on international evidence on interventions with the most impact on preventing harms associated with substances, as presented in *Following the Evidence: Preventing Harms From Substance Use in BC* (Ministry of Health, 2006). While this document describes specific programs and strategies, it must be emphasized that, for the most part, these require collaborative planning and implementation with multi-disciplinary partners on a regional and a community level.

Health authorities must use their discretion in assessing which of these approaches are priorities for their region. This paper is intended to provide a framework for health authorities rather than specific, detailed or prescriptive solutions.

Additional information for planning and implementing proven initiatives is available in the evidence reviews that are noted in Section 1.1, as well as Ministry of Health documents: *Harm Reduction: A British Columbia Community Guide* (2005), and *Every Door Is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction* (2004). There are many examples of effective strategies in the literature, as well as many innovative and promising initiatives taking place in British Columbia. There is often no one "best practice" but rather practices that have been successful in other settings. The terms "promising practices", or "better practices" are preferred to reflect the evolving and developmental nature of performance improvement.

It should be noted that proposed strategies for each program component focus on primordial (upstream) and primary prevention/harms reduction. Early secondary prevention/harms reduction is included (early identification and early treatment) only where these have a major prevention focus. Treatment programs are not considered a public health function and are therefore not

included,[3] although it is recognized that a coordinated approach between prevention and treatment programs is essential.

Implementation strategies for each of the major program components are described in the sections that follow.

5.2 Influence Key Developmental Stages

A range of prevention strategies and services is necessary, in collaboration with government, school, and community partners, to address protective and risk factors at critical points across the lifespan. The strategies are:

- Develop and implement, through collaboration with Ministry of Children and Family Development, a comprehensive strategy to decrease substance use during pregnancy and reduce exposure of infants and young children to harmful substances, including:
  - Fetal Alcohol Syndrome Disorder (FASD) prevention strategies.
  - Community-based pregnancy support programs to assist expectant mothers.
  - Public information on the impact of alcohol, tobacco or other substance use on fetal development during pregnancy, with targeted strategies to address vulnerable and diverse populations.
  - Delivery of priority treatment services for pregnant women who drink.
- Provide parental education and support:
  - Identify, assess and/or screen young children and their families for risk factors associated with substances based on a postnatal risk assessment tool, screening during public health clinics, and/or referral from other sources such as physicians, day care providers, the justice system, MCFD, etc.
  - Provide pre- and post-natal regular and sustained home visiting by nurses for at-risk women having their first child, to promote positive health behaviours, competent care and personal development (e.g., on average 7-9 times prior to birth and about 25 times during infancy with linkages to appropriate health and social supports).
  - Promote and support universal parenting education, utilizing opportunities for contact at school transition points (i.e., entry into pre-school/kindergarten, middle school, high school).
- Encourage and support positive school adjustment through a multi-component strategy in partnership with school boards, addressing the needs of teachers, parents, and children, including:

[3] The *Framework for Core Functions in Public Health,* adopted by the Ministry of Health, defines the public health function of health authorities as primordial [upstream], primary, and early secondary prevention.

- Structured pre-school environments.
- Teacher training in effective classroom management designed to enhance teacher-student relationships and reduce negative school peer interactions (to reduce risk of social marginalization).
- Parenting courses to improve skills in healthy child/family relationships, parenting, and family support networks.
- Curriculum and classroom practices which support development of social and emotional competence to increase school retention rates.

- Encourage and support, in partnership with school boards and community groups, a smooth transition to independence and adult life and responsibilities:
  - Curricula resources to assist in preparing for transition to post-secondary education or the workforce.
  - Education and school support programs for pregnant students and young mothers.
  - Youth opportunities in volunteering and mentorship to develop employability skills and social responsibility.
  - Community supports and training programs that target young adults and address financial matters, positive relationships, and independent living.
- Promote opportunities with community and government partners, to address broad social dimensions that can mitigate risk factors among all age groups, and for specific vulnerable sub-groups:
  - Access to education and employment to address income inequalities for priority groups within the region.
  - Policies and services to improve access to psychosocial supports such as parenting support, crisis intervention, trauma and grief counselling.
  - Special attention for deprived neighbourhoods and communities for interventions related to key developmental stages.
- Develop strategies in collaboration with Aboriginal people, and/or multicultural groups, to address their community priorities and needs.

5.2.1 Summary of Supporting Evidence

The evidence strongly supports the above initiatives; for example, interventions at critical transition points in the life span are described as "protective" (Loxley et al., 2004), and programs targeted to vulnerable young women have reduced substance use by young mothers. The research also demonstrates that particular effort should be made to engage and retain parents seeking assistance in dealing with child-related problems (Toumbourou, Williams, Waters, & Patton, 2005).

The evidence is strong on the effectiveness of pre-natal and post-partum home visiting programs for new mothers at risk of adverse outcomes (i.e., first-time mothers, adolescents, low income etc.) (Olds, 2002). The Nurse Home Visiting Program with a nurse visiting 7 – 9 times prior to birth and 25 times during infancy showed fewer behaviour problems and less likelihood for participants to be involved in crime – for those families at greatest risk the effects were greatest (Waddell, Wong, Hua, & Godderis, 2004).

Evidence also suggests that strategies related to school adjustment have long-term effectiveness, including preparing children for transition, and providing support and education to parents (Olds, 2002). Similarly, Health Canada notes that complementary actions related to health, gender, income, and social policies that foster greater equity and healthier environments are needed to reduce harms associated with substances (Health Canada, 1986).

5.3 Prevent, Delay, and Reduce Alcohol, Tobacco and Cannabis Use by Children and Youth

Key strategies, in partnership with local governments, schools and other community organizations, to prevent, delay and reduce the use of alcohol, tobacco and cannabis, are presented. (NOTE: Although the use of other substances such as cocaine and crystal meth are of concern, the evidence notes that the greatest individual and societal harm in BC is caused by tobacco (12 per cent of the burden of disease) and alcohol (10 per cent of the burden of disease); illegal substances, with cannabis being the most common, contribute 2 per cent of the burden of disease. Strategies include:

- Restrict access to alcohol and tobacco by minors, including:
  - Enforcement to improve retailer compliance with age identification for tobacco and alcohol sales.
  - Media messages to increase public awareness of harms related to use of alcohol, tobacco or cannabis by minors, and or enforcement efforts.
  - Media and parent education strategies to increase supervised access to alcohol and tobacco in the home and social contexts.
- Provide, in partnerships with school boards, high quality, interactive and evidence-based education about alcohol, cannabis and tobacco in schools, including:
  - Learning resources on alcohol and cannabis for use in elementary and secondary school curriculum (for implementation in all grades).

  - Implementation of BC Tobacco Facts, and new alcohol and cannabis lessons in elementary and secondary school curriculum (Grades 4-10).
  - Teacher training to encourage interactive classroom teaching using the developed materials.
  - Advocacy for mandatory physical and health education in all grades.
- Engage broad community participation in influencing social attitudes and responses to alcohol, tobacco, and cannabis, including:
  - Community mobilization programs that aim to restrict the acceptance and use of alcohol, tobacco and cannabis by youth.
  - Strategies that identify and address environmental influences that undermine prevention efforts and reinforce problem behaviours.
  - Support for social marketing campaigns (developed by federal or provincial governments) utilizing mass media to reinforce the initiatives.
  - Safer partying initiatives.

5.3.1 Summary of Supporting Evidence

The above initiatives are based on research indicating that the younger a person starts using a substance, the more likely they are to have substance-related problems (such as chronic dependence) later in life. There is evidence for effectiveness of school drug education when this is properly implemented, that is, when programs are: supported by solid research and evaluation design including reinforcement on a regular basis; developed in consultation with youth: applied at pivotal stages in development; interactive and focused on skill development; targeted toward behavior change goals that are responsive to, and inclusive of, different cultural views and realities, etc (McBride, 2005). Community mobilization that aims to reduce perceived favourable community norms, along with integrated community programs, have demonstrated effectiveness in reducing initiation, escalation to regular use, and estimates of peer substance use (Toumbourou et al., 2005). Public awareness campaigns in the mass media on their own have been shown to have limited effect; however, media strategies appear to be effective when complemented by on-the-ground regulations and other interventions (Loxley et al., 2004).

The literature suggests that restricted access is generally associated with decreased use. For example, consistent enforcement of sales laws, coupled with media coverage, has been shown to be effective in reducing sales to minors, youth smoking and underage drinking (Grube & Nygaard, 2005). As well, integrated community programs have demonstrated effectiveness in reducing initiation, escalation to regular use, and estimates of peer substance use (Toumbourou et al., 2005).

5.4 Reduce Risky Patterns of Substance Use

Strategies should focus on collaborative approaches to reduce patterns of substance use associated with the highest risks, as follows:

- Promote and support clear messages that address safer substance use and inform risk-reducing choices:
  - Clear messages by media personnel and other professionals based on the spectrum of use model for both universal and targeted populations.
  - Low-risk drinking guidelines.
- Promote and support safer drinking and tobacco cessation programs among 19-24 year olds, with college, universities, and other institutions that engage with this age group, including:
  - Clear, publicized institutional policies on alcohol and tobacco.
  - Toolkit of materials to assist institutions in addressing smoking and binge drinking.
  - Campus alcohol policies, similar to municipal alcohol policies.
- Work with Aboriginal communities to support safer drinking and tobacco smoking cessation among Aboriginal people, through partnerships between Aboriginal communities and organizations and other levels of government, to mobilize strengths and resources and respond to the unique needs and realities in each community.
- Develop, promote and support implementation of brief interventions to address alcohol, tobacco, cannabis and other substances, including:
  - Patient screening for problems associated with hazardous substances, and brief intervention with individual follow-up and self-management materials by primary care physicians and other health care providers as appropriate.
  - Training on brief interventions and clear policies on their use in the workplace for employers and unions.
  - Training and educational support materials for brief intervention programs in all secondary schools.
  - Training on brief interventions by justice, corrections and related policy staff.
- Develop, promote and support prevention initiatives targeted toward older adults (65+) including:
  - Screening by health care providers for problems associated with alcohol use and prescription medications, followed by brief interventions and empathic support for positive change.

- Home visits by experienced counselors and nurses, as required, along with support, counseling and education for caregivers as necessary.
- Linkages with community groups to support social outings and recreational activities.

- Promote the development of programs that encourage the safer use of psychoactive medications, including:
  - Evidence-based interventions that improve prescribing practices among BC physicians (i.e. academic detailing, notification and feedback targeted to high-prescribing physicians, etc.).
  - Awareness strategies for health care professionals on alternatives to benzodiazepine prescriptions for sleep and anxiety problems as well as improved skill in managing benzodiazepine dependence.
  - Public information to improve consumer awareness and patient education on drug protocols and standards to enhance health literacy, self-management and the ability of patients to advocate for themselves.
  - Tools and systems to monitor specific harms and benefits of psychoactive medications.
  - Optimized access to, and delivery of methadone maintenance for opioid-dependent patients who are suited for it (i.e., effective dosages; interdisciplinary care; client-centred counselling; effective pain management for acute or chronic pain), and consider alternative pharmacotherapy be made available for opioid-dependent patients when indicated (i.e., bupronorphine when approved in Canada).
  - Continue support for research and pilots that explore innovative approaches to treating and reducing harms associated with opioid dependence, such as the use of injected diacetylmorhphine or injected hydromorphone with patients who have not responded to other treatment modalities, as studies by the North American Opiate Medication Initiative (NAOMI Study Team, 2008).

5.4.1 Summary of Supporting Evidence

Evidence highlights the effectiveness of brief intervention in primary care and hospital settings to address harms from alcohol and tobacco (Roche, 2004). Enough evidence exists to suggest these programs should be implemented and evaluated in other settings as well (Ministry of Health, 2006).

Statistics indicate that problematic patterns associated with substances are particularly common among the 19–24 age group. Implementation of clear policies and programs within institutions that service this group has shown significant impact (Ministry of Health, 2006).

Aboriginal people are an important target group as they have a high rate of tobacco use in BC (53 per cent), compared to the BC average (18.9 per cent), (BC Stats, 2004), higher rates of disease and lower rates of health status than the non-Aboriginal population (Provincial Health Officer [PHO], 2002). Evidence suggests that, in order to be successful, prevention and health promotion programming targeted to Aboriginal peoples must include their full engagement in the planning, implementation and evaluation phases (PHO, 2002).

Research indicates that traditional prevention and treatment programs are seldom appropriate or effective for older adults. Seniors are often reluctant to acknowledge a substance use problem or to seek help from specialized services. Alternative options are often indicated because of the unique issues and needs of this group. In-home services with an overall focus on quality of life and maintenance of independent living have been shown to be effective (Fraser Health Authority, 2007b; Spencer, 2001).

The evidence highlights the important health benefits but also potential significant harms from psychoactive medications, and suggests that both public awareness and professional practices are essential to minimizing the risk (Currie, 2003). Methadone maintenance is a very effective treatment for opioid dependence if it is done with appropriate management supports (Faggiano, Vigna-Taglianti, Versino, & Lemma, 2004; Mattick, Breen, Kimber, & Davolui, 2003).

5.5 Create Safer Contexts for Substance Use

Strategies to create positive, healthier environments to reduce the harms associated with substances include the following:

- Facilitate, in partnership with the police, local government and community organizations, evidence-based initiatives to increase safety and promote social responsibility around licensed liquor premises.
  - Municipal alcohol policies.
  - Training policies for all staff in licensed premises.
  - Active enforcement of regulations related to serving intoxicated or underage clients and related health and safety issues.
  - Limited liquor outlet density to reduce competition between establishments (which can result in cheaper alcohol and lax serving standards).
  - Public reports on serious alcohol-related harms associated with drinking at particular licensed premises.
- Encourage the police to implement actions to decrease impaired driving and associated harms, such as:
  - A highly publicized and visible system of random breath testing.
  - Public awareness of high-risk roads and intersections associated with a high incidence of harm.

- Promote and support public awareness and education strategies developed by partners to decrease harms from second-hand smoke, such as:
  - Social marketing campaigns to restrict the exposure of children and others to second-hand smoke in homes and private vehicles.
  - Tobacco-free school policies that meet legislative requirements.
  - Consistent and repeated messages from health care professionals and others that reinforce the risk and encourage behaviour change.
- Build on gains made in reducing harms associated with illegal drug use through partnerships to expand:
  - Needle and syringe distribution, distribution of safer crack use supplies, and recovery programs in both urban and rural settings.
  - Supervised consumption sites.
  - Primary response services that provide brief interventions and referrals to other services.
  - Multi-faceted support centres (i.e. sleeping quarters, inexpensive food, linkages to services) and multi-component systems (i.e., wet-damp-dry housing, contact centres, employability skills training and apprenticeship/experience programs).
  - Access to a range of treatment services, including methadone maintenance treatment.
  - Substance use services within all corrections facilities and programs, including treatment and harms reduction programs.

5.5.1 Summary of Supporting Evidence

The evidence shows that injuries account for a substantial portion of the harms related to alcohol and much of this related to the behaviour of young males in or about licensed premises, or as a result of service at licensed premises. The above strategies have shown effectiveness in reducing harms in these situations (Grube & Nygaard, 2005). With respect to impaired-driving, counter measures have demonstrated effectiveness and should be vigorously applied (Room, Babor, & Rehm, 2005).

Studies on needle distribution and collection programs have scientifically demonstrated that they reduce risks of contracting HIV and hepatitis C (Huo et al., 2005; Satcher, 2000). Studies have shown they can decrease the risk of contracting HIV by as much as 50 to 80 per cent (Givson et al., 2002). Outreach programs for people using illegal substances have been found to achieve the following outcomes: cessation of injecting, reduced injecting frequency, reduced sharing of needles and other injection equipment, increased disinfecting of needles, increased referrals and entry into treatment for substance dependence, and increased condom use (Coyle et al., 1999).

Insite, a supervised injection site operated by Vancouver coastal Health and the Portland Hotel Society, under a constitutional exception to the Controlled Drugs and Substances Act, has been subject to rigorous, independent third-party research and evaluation by the BC Centre for Excellence in HIV/AIDS. Research to date has shown that Insite: is leading to increased uptake into detoxification programs and addiction treatment (Wood, Tyndall, Lai, et al., 2006; Wood Tyndall, Zhang, et al., 2006; Tyndall et al., 2006); has not led to an increase in drug-related crime (rates of arrest for drug trafficking, assaults and robbery were similar after the facility's opening, and rates of vehicle break-ins/theft declined significantly) (Wood et al., 2007); has reduced the number of people injecting in public and the amount of injection-related litter in the downtown eastside (Wood, Kerr, et al., 2005); is attracting the highest-risk users—those more likely to be vulnerable to HIV infection and overdose, and who were contributing to problems of public drug use and unsafe syringe disposal (Wood, Tyndall, et al., 2005); reduced overall rates of needle sharing in the community, and among those who used the supervised injection site, 70 percent were less likely to report syringe sharing (Kerr et al., 2005); and Insite is preventing overdose deaths and reducing hospital visits (Milloy et al., in press).

A recent systematic review of the literature concluded that substance disorders are among the most prevalent mental disorders in the criminal justice system (Ogloff, Davis & Somers, 2005). Diversion of offenders with mental disorders is a necessary element of the criminal justice system, as research generally shows that a majority of them commit only low-level, non-violent offences (Adler, 2004). It is also noted that diversion must be supported by the availability of appropriate community-based services.

5.6 Reduce Discrimination and Stigma

Strategies to reduce the prejudice and discrimination and related stigma experienced by people who use substances should include the following:

- Develop regional strategies and plans to shift societal attitudes, address systemic inequities, remove barriers, improve the quality of life and the social integration of people who use substances:
    - Focus on community-level strategies to shift attitudes and behaviours.
    - Partner with local interested groups and organizations to ensure messages and approaches are shaped by the unique cultural needs of the community and specific target groups. This is particularly important for communities with a large Aboriginal population.
    - Utilize advisory committees which include a majority of people who use substances, along with community champions, representatives of multiple sectors and cultures, and researchers in the field.
    - Engage people who use substances to provide advice at each stage of the planning process and in the delivery of services.
    - Integrate human rights as a key element in the design of strategies.

    - Use the power of personal contact and storytelling to put a human face on the issues including opportunities for people in the community to have direct contact with those who use substances;

- Enhance training, awareness and understanding about substance use, addictions and concurrent disorders among health care providers, policy planners, employers, human resources personnel, emergency staff (e.g., police and other first responders) and social service personnel throughout the region.

5.6.1 Summary of Supporting Evidence

A number of international jurisdictions have placed a priority on addressing discrimination and stigma as a key factor in supporting the well-being of people who use substances. It is also increasingly being recognized by the federal and provincial governments and health professionals as a critical issue in Canada (Mental Health Commission of Canada, 2007). Although there is limited evidence on effective strategies to address this issue, international efforts provide valuable insight into what works and what does not. A Mental Health Commission of Canada review (2007) of the literature found emerging research agrees that: engaging service users at all levels of decision making and service delivery is essential; change is best accomplished at the local community level; repeated, direct contact with people with substance use problems disconfirms widely held prejudices and shifts changes in attitudes and behaviours; targeting behaviours not just attitudes is necessary; and a focus on rights and entitlements contributes to meaningful improvements. In addition, the literature notes that while large scale public education and social marketing initiatives may shift attitudes, they do not appear to be successful in changing behaviours (Ministry of Health, 2008).

Involvement of people who use substances is a major theme repeated in the literature: Friedman et al found that many people who use injection drugs are already actively playing a role in HIV prevention and care: they urge community members not to use drugs and urge other drug users to seek treatment. They are especially well placed to be health activists because they have insider knowledge and are often physically present when advice or assistance can usefully be provided (Friedman et al., 2004). As well as practical benefits, there are also ethical and human rights imperatives that require involvement of people who use substances in the decisions that affect their lives. Roy notes that it is imperative that persons who use drugs be recognized as possessing the same dignity as all other human beings (Roy, 1999). This is consistent with the United Nations International Guidelines on HIV/AIDS and Human Rights, which require that representatives of vulnerable groups, such as people who use drugs, be involved in consultations and in the planning and delivery of services (Office of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS, 1998).

5.7 Surveillance, Monitoring and Evaluation

Surveillance and monitoring assists in clarifying the prevalence and trends in harms associated with substances as well as the needs and priorities of vulnerable populations. Evaluation enables the assessment of program effectiveness. Health authorities should:

- Gather, assess and report statistical information from a range of sources to reflect current status and trends related to the use and harm of tobacco, alcohol, cannabis, and other psychoactive substances.
- Monitor characteristics of vulnerable populations within the health authorities, taking into account the social, economic, and environmental determinants of health.
- Collaborate with other health authorities, the Ministry of Healthy Living and Sport, community organizations, and academic groups to enhance monitoring and surveillance (including monitoring and reporting systems for injuries and viral infections associated with substances).
- Establish an evaluation framework for the program on prevention of harms associated with substances.

An innovative development in British Columbia for surveillance of substance-related harms is the Centre for Addictions Research of BC and the BC Mental Health and Addictions Research Network's BC Alcohol and Other Drug Monitoring Project. This pilot project aims to describe the main patterns of harms associated with substances in British Columbia and provide policy-makers, program developers and researchers with access to timely and accurate data on the epidemiology of harms associated with substances.

5.7.1 Summary of Supporting Evidence

It is recognized that performance of public health, and prevention programs in particular, are difficult to measure. It is nonetheless likely that we will be able to manage—and improve—core functions in public health if we can measure performance (Ministry of Health, 2005). A prevention information system capable of "telling us how well we are doing", is necessary for this purpose. As well, the public has a right to expect that the public health sector, along with the rest of the health care system, is paying attention to the quality and effectiveness of the interventions it undertakes, and is working to improve that quality (Ministry of Health, 2005).

6.0 INDICATORS, BENCHMARKS AND PERFORMANCE TARGETS

6.1 Introduction

It is important to define what one means by the terms *indicators*, *benchmarks*, and *performance targets*. An indicator is a measurement (usually numerical) of a factor which constitutes an important reflection of some aspect of a given program or service. Indicators need to be standard so that they can be compared across different organizational entities such as health regions. Benchmarks are reflective of "best" practices. They represent performance that health authorities should strive to achieve. Benchmarks are determined by: reviewing the literature; reviewing the best practice experience in other jurisdictions; or by determining "consensus" opinion of leading experts and practitioners in the field. Performance targets are locally determined targets that represent a realistic and achievable improvement in performance for a local health authority.

This section presents a number of key indicators or performance measures for a program on prevention of harms associated with substances. Suggested benchmarks can apply across the province, while other benchmarks may need to be modified to account for key variables such as geographic size or population demographics of the health authority.

As per the draft Public Health Logic Model, one can develop indicators related to the inputs, activities, outputs and outcomes (immediate, intermediate or final) of each of the respective components of the program on prevention of harms associated with substances. Thus, it is not necessary to only have outcome-related indicators and benchmarks. Furthermore, indicators need to be understood within a broader context. For example, a low per-capita cost for a specific program could reflect on the efficiency and effectiveness of a given program, or reflect a program that is under-resourced. It is recognized that programs to prevent harms associated with substances are complex, and that it may be difficult to link interventions with direct human health outcomes, particularly as initiatives involve multiple factors and multiple sectors, which all play a role in determining outcomes. In general, it is best to consider a number of indicators, taken together, before formulating a view on the performance in this area. Indicators and benchmarks work best as flags to indicate a variance from accepted norms and standards. Further investigation is usually required to determine the causes of any given variance from such norms or standards.

A health authority could establish its performance targets by assessing its current (and perhaps historical) level of performance, and then, based on consideration of local factors, determine a realistic performance target. This performance target would be consistent with the goal of performance improvement but would be achievable within a reasonable period of time. Initially, health authorities will set performance targets for a number of indicators. However, over time, and particularly if consistent data collection methods and definitions are applied, it would be realistic for health authorities to share information related to their targets and then develop a consensus approach to determine provincial benchmarks for these indicators. In other words, locally developed performance targets, over time, could lead to development of provincial benchmarks.

6.2 Indicators for the Program on Prevention of Harms Associated with Substances

The indicators considered the most significant in determining overall performance of strategies for the core program on prevention of harms associated with substances are included in Appendix 5, following the Logic Model (Appendix 4).

Health authorities will determine which indicators they consider the most important for their purposes and will focus their efforts on measuring these over time.

It is understood that some of the indicators may not be under the control or influence of health authorities, but these can, nevertheless, provide important information on trends and patterns that impact the program and planning priorities. Those indicators and benchmarks that can be influenced through the work of the health authorities, provide a basis for ongoing performance review and evaluation. In many cases, baseline data will need to be established to provide a basis for comparative analysis in future years. Benchmarks are currently not available but will be determined over time between the Ministry of Healthy Living and Sport and the health authorities. In addition, health authorities may wish to establish local or regional benchmarks and performance targets.

7.0 EXTERNAL CAPACITY AND SUPPORT REQUIREMENTS

7.1 Key Success Factors/System Strategies

The previous sections outlined the main components and best practices that health authorities could include in the program for preventing harms associated with substances. Successful implementation of effective strategies to prevent harms associated with substances will also depend on having in place key success factors/system strategies:

A number of success factors emphasized in the evidence have been highlighted in section 4.0 (i.e. multi-sectoral collaboration, community development, health promotion, healthy public policies, a focus on protective factors, a focus on vulnerabilities, and a balance of universal and targeted initiatives). Additional important factors include:

- Strong support from the Board and management of the health authorities, regarding the importance of preventing harms associated with substances in their regions and the role it plays in protecting the health of the population.
- Allocation, by the health authorities, of sufficient resources to deliver high quality programs.
- Well-trained and competent staff knowledgeable in the prevention of harms associated with psychoactive substances, substance dependence, and mental health issues, and with the necessary policies and equipment to carry out their work efficiently.
- Access to continuing professional development opportunities to enhance knowledge and skills in the prevention of harms associated with substances and to support implementation/uptake of best or promising practices and policies.
- An information system that provides staff with appropriate support, and provides management with the information it needs to drive good policy and practice decisions.
- High quality and competent management of the program for preventing harms associated with substances, including monitoring of performance measures.
- Clear mechanisms of reporting and accountability to the health authority and external bodies.

7.2 Intersectoral Collaboration and Coordination

As noted earlier, a program for preventing harms associated with substances does not exist in isolation and will not achieve optimum efficiency or effectiveness unless it works collaboratively with other key partners involved in this field. Intersectoral collaboration and coordination on the local and regional levels is essential to ensuring the active participation of those who can contribute to preventing harms associated with substances.

On the provincial level, the key linkages are the Ministry of Healthy Living and Sport and Provincial Health Services Authority (e.g. the British Columbia Centre for Disease Control, BC Mental Health and Addiction Services, and the BC Centre of Excellence for Women's Health). Other important linkages are with the Ministry of Children and Family Development, Ministry of Education, Ministry of Employment and Income Assistance, and Ministry of Public Safety and Solicitor General. At the regional and local level, it is essential to link with local governments and a wide range of local organizations and agencies involved in preventing and reducing the harms associated with substances.

7.3 Information Management

It is important for health authorities to review their existing information and monitoring systems with respect to their ability to measure and monitor performance indicators. It may be necessary to strengthen information management processes including:

- Establishing new policies and procedures for some activities to ensure that the necessary records are kept.
- Facilitating the process of recording, monitoring and reporting data to key decision-makers.
- Establishing key regional indicators, considering the importance of consistent and compatible reporting systems across the province.
- Developing baseline data where necessary to determine current levels, and thus provide a basis for calculating shifts and trends in the future.

Health authorities will also need to consider the impact of program monitoring, data collection and evaluation on resources, including program delivery, policy, and evaluation staff. Expertise will be needed in the fields of program monitoring, program analysis and program evaluation to ensure effective implementation and assessment of the core functions improvement process.

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GLOSSARY

This Glossary is based on the definition of terms used in the *10-Year Plan to Address Mental Health and Substance Use in BC* (2009). Given the inter-related nature of the core program on mental health promotion and prevention of mental disorders and the core program on prevention of harms associated with substances, the same Glossary is included in both model core program papers, to reflect ongoing efforts to integrate responses across these programs whenever warranted by the evidence.

Aboriginal
Canada's Aboriginal population is distinct and diverse. An Aboriginal person is identified in accordance to the *Constitution Act* of 1982, Part II, Section 35(2), as "the Indian, Inuit and Métis peoples of Canada." "First Nation" is the generally preferred term for Indian peoples of Canada. The term "Indian" is still used where referring to legislation or government statistics.

Source: Aboriginal Administrative Data Standard
http://www.cio.gov.bc.ca/prgs/Aboriginal_Administrative_Data_Standard.pdf

Acute Care
Acute care refers to short-term medical treatment, usually in a hospital, for patients having an acute illness or injury or recovering from surgery. Acute care is necessary treatment of a disease for only a short period of time in which a patient is treated for a brief but severe episode of illness. The term is generally associated with care rendered in an emergency department, ambulatory care clinic, or other short-term stay facility.

Addiction
Addiction is defined as a harmful behavioural preoccupation, generally accompanied by a loss of control, and a continuation of the behaviour despite negative consequences. Addictions may develop around a range of behaviours, including substance use. The World Health Organization stopped using the term "addiction" in 1964 and instead adopted "substance dependence" to describe this clinical condition. In BC we address "problematic substance use," which is understood to include a broader range of substance use behaviours or problems than just addiction, which refers to only the extreme end of the range of substance use behaviours and impacts. For instance, someone may be using a substance such as alcohol in a problematic way, for instance binge drinking or consuming a substance while pregnant, and not necessarily be addicted. Similarly, the term "alcoholic" is no longer used when referring to someone with an alcohol dependence problem. See also **Substance Use and Problematic Substance Use**.

Source: BC Partners for Mental Health and Addictions Information, Here to Help website
http://www.heretohelp.bc.ca/publications/factsheets/)

Another word for addiction is "dependence." There are two kinds of substance dependence:

- *Psychological dependence* occurs when a person feels he or she needs the drug to function or feel comfortable (e.g., needing to drink alcohol to feel relaxed in social situations, or needing to be high to enjoy sex). Some people come to feel they need a substance just to be able to cope with daily life.

- *Physical dependence* occurs when a person's body has adapted to the presence of a drug. Tolerance has developed, which means that the person needs to use more of the drug to get the same effect. When drug use stops, symptoms of withdrawal occur.

Source: Centre for Addiction and Mental Health. (2007). *Addiction: An Information Guide*. Toronto: Author.

Benchmark

A benchmark is a reference point or standard against which performance or achievements can be assessed. A benchmark refers to the performance that has been achieved in the recent past by other comparable organizations, or what can be reasonably inferred to have been achieved in the circumstances (OECD).

Source: World Health Organization. (n.d.) *Definitions.* Retrieved March 23, 2009, from http://www.who.int/hac/about/definitions/en/print.html.

Best Practices

Best practices represent proven methodologies for consistently and effectively achieving a business objective. Whereas a business process is simply a series of activities organized to achieve a specific business objective, a best practice is a business process with demonstrated ability to achieve superior results. There are various definitions of best practices. For example, best practices in health promotion are those sets of processes and activities that are consistent with health promotion values/goals/ethics, theories, beliefs, evidence and understanding of the environment and that are most likely to achieve health promotion goals in a given situation.

Source: Adapted from Ministry of Health. (2007, May). *Health Pathways Forward – A Strategic Integrated Approach to Viral Hepatitis in BC*. Victoria, BC: Author.

Burden of Illness

The WHO global burden of disease (GBD) measures the impact of a health problem using the disability-adjusted life year (DALY). This time-based measure combines years of life lost due to premature mortality and years of life lost due to time lived in states of less than full health. The DALY metric was developed in the original GBD 1990 study to assess the burden of disease consistently across diseases, risk factors and regions, and to predict the possible impact of health interventions.

Source: Phillips, C. & Thompson, G. (n.d.). What is a QALY?" *What is...? series, 1*(6). United Kingdom: Hayward Medical Communications. Retrieved March 23, 2009, from http://www.evidence-based-medicine.co.uk/ebmfiles/WhatisaQALY.pdf.

The economic burden of disease includes all of the direct health costs associated with treatment and care within the health care system, as well as the indirect costs, which—depending on the researchers—may include lost productivity, foregone earnings as a result of premature death, an economic valuation of the reduced quality of life, and other less easily quantifiable costs.

Source: Ministry of Healthy Living and Sport. Core Public Health Functions.

Capacity Building

An individual and organizational learning process that involves reflection, analysis, skill building, networking and action all aimed at increasing the knowledge, imagination, vision and impact of an organization and the individuals involved in it.

Source: Columbia University, Center for the Study of Human Rights & The Banyan Tree Foundation, May 2002.

Organizational capacity building refers to the process of ensuring an organization has the systems, physical assets, human resources, culture and ability to plan for the future while operating in the present. Institutional capacity building seeks to "…strengthen institutional development by strengthening links and the development of environments within which organizations exist."

Source: Green & Battcock, 2001.

Case Management

Case management assigns the administration of care for an outpatient individual with a serious mental illness to a single person (or team); this includes coordinating all necessary medical and mental health care, along with associated supportive services.

Case management tries to enhance access to care and improve the continuity and efficiency of services. Depending on the specific setting and locale, case managers are responsible for a variety of tasks, ranging from linking clients to services to actually providing intensive clinical or rehabilitative services themselves. Other core functions include outreach to engage clients in services, assessing individual needs, arranging requisite support services (such as housing, benefit programs, job training), monitoring medication and use of services, and advocating for client rights and entitlements. Case management is not a time-limited service, but is intended to be ongoing, providing clients whatever they need whenever they need it, for as long as necessary.

Source: Encyclopedia of Mental Disorders. (n.d.). *Case management.* Retrieved March 23, 2009, from http://www.minddisorders.com/Br-Del/Case-management.html.

Chronic Disease Management

Chronic disease management (CDM) is a systematic approach to improving health care for people with chronic disease. Health care can be delivered more effectively and efficiently if patients with chronic diseases take an active role in their own care and providers are supported with the necessary resources and expertise to better assist their patients in managing their illness.

Chronic disease management (CDM) is an approach to health care that emphasizes helping individuals maintain independence and keep as healthy as possible through prevention, early detection, and management of chronic conditions.

Chronic conditions impose challenges for those affected, their families and care providers. A patient's ability to follow medical advice, accommodate lifestyle changes, and access resources are all factors that influence successful management of an ongoing illness.

In a 2001 survey, BC physicians identified depression and dementia as two of eleven priority chronic diseases.

Source: BC Ministry of Health Services

Cognitive Behavioural Therapy
An evidence-based treatment mode that helps individuals gain insight into their current patterns of thinking and behaviour and learn healthier skills, habits and coping techniques. CBT is flexible and easily individualized. While it is useful in formal treatment settings, CBT is also an effective approach for brief interventions in various contexts. CBT has been associated with motivational interviewing, which attempts to meet the client where he/she is at and provide empathic support to help the client work through ambivalence and arrive at an action plan of his/her own choosing. CBT supports the client's sense of self-efficacy (one's confidence in being able to cope successfully and avoid setbacks or relapse) and should inform supports for self-management.

> Source: Ministry of Health Services. (2004, May). *Every door is the right door: A British Columbia planning framework to address problematic substance use and addiction*. Victoria, BC: Author.

Collaboration
Collaboration is a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own visions of what is possible. Collaboration involves joint problem-solving and decision-making among key stakeholders in a problem or issue.

In collaboration it is normal to have a lack of clarity about who is a stakeholder, disparity of power and/or resources among stakeholders, complex problems that are not well defined, scientific uncertainty, differing perspectives that lead to adversarial relationships, and dissatisfaction with previous and existing approaches and processes. Collaboration is a distinctly different process than coordination and cooperation. Collaboration is an emergent and evolving process of building substantive agreement. Coordination involves formalized, defined relationships among organizations. Cooperation involves informal trade-offs and agreements established in the absence of formal rules. Both coordination (formalized process) and cooperation (informal process) often occur as part of a collaborative process. Once initiated, collaboration creates a temporary forum within which participants can seek consensus about a problem, invent mutually agreeable solutions and develop collective actions for implementation.

> Source: Adapted from Gray, B. (1989). *Collaborating: Finding Common Ground for Multiparty Problems*. London: Jossey Bass.

Community
Aristotle defined community as a group of individuals bound together by natural will and a set of shared ideas and ideals and suggested that harmony underpins the concept of community (Aristotle, trans. 1980). In the intervening period the concept of community has become more sophisticated due to the changing nature of work, communications and increased social fluidity. People may work longer hours, or move more often, finding themselves living far from close relatives, and feeling like transient members of their residential neighbourhoods. But people still look for community, and many get that feeling from non-traditional sources such as the workplace, or through pursuit of other common interests (Rhodes et al., 2002).

There are a number of ways to categorize types of community, such as:

1. Geographic communities: range from the local neighbourhood, suburb, village, town or city, region, nation or even the planet as a whole. These refer to communities of location.
2. Communities of culture: range from the local clique, sub-culture, ethnic group, religious, multicultural or pluralistic civilization, or the global community cultures of today. They may include communities of need or identity, such as disabled persons, or frail aged people.
3. Community organizations: range from informal family or kinship networks, to more formal incorporated associations, political decision making structures, economic enterprises, or professional associations at a small, national or international scale.

Communities are nested, which means that one community can contain another—for example a geographic community may contain a number of ethnic communities.

> Source: Tropman J.E., Erlich, J.L., & Rothman, J. (2006). *Tactics and Techniques of Community Intervention*. Wadsworth Publishing.

Community Development
Community development, informally called community building, is a broad term applied to the practices and academic disciplines (e.g. environmentalists, social scientists) of civic leaders, activists, involved citizens and professionals to improve various aspects of local communities.

Community development seeks to empower individuals and groups of people by providing these groups with the skills they need to effect change in their own communities. These skills are often concentrated around building political power through the formation of large social groups working for a common agenda. Community developers must understand both how to work with individuals and how to affect communities' positions within the context of larger social institutions.

> Source: Federation for Community Development Learning. Retrieved on December 19, 2008.

Communities of Practice
The concept of a community of practice (often abbreviated as CoP) refers to the process of social learning that occurs, and shared sociocultural practices that emerge and evolve, when people who have common goals interact as they strive towards those goals.

... recently, Community of Practice has become associated with knowledge management as people have begun to see them as ways of developing social capital, nurturing new knowledge, stimulating innovation, or sharing existing tacit knowledge within an organization. It is now an accepted part of organizational development (OD). ... Communities of Practice offer a way to theorise tacit knowledge which cannot easily be captured, codified and stored.

The knowledge that is shared and learned in communities of practice is social capital. People connect at various levels and across departments, both internally and externally of the company or organization, without the constraints of a formal company structure. As people connect with

each other they are able to share their expertise and learn from other members. Benefits include problem solving, developing new capabilities, leveraging best practices, standardizing practices, time savings, increasing talent, and avoiding mistakes.

> Source: Adapted from Hildreth, P. & Kimble, C. *Knowledge Networks: Innovation through Communities of Practice*. New York: Idea Group Publishing. Retrieved December 19, 2008, from http://www.chris-kimble.com/KNICOP/Chapters/Introduction.html.

Concurrent Disorders
Concurrent disorders (CD for short) generally describes a situation in which a person experiences a psychiatric disorder and either a substance use disorder and/or a gambling disorder. It is important to keep in mind that there are many different kinds of problems that are covered by these various terms (psychiatric disorder etc); as a result, CD presents itself in many different forms. For example, someone living with schizophrenia who has problems with cannabis use has a concurrent disorder, and so does a person who has problems with alcohol use and has a clinical depression. Treatment approaches for each person would be different.

Other terms used over the years to describe the occurrence of both problems include: dual disorders, dual diagnosis, co-morbidity, and co-occurring substance abuse disorders and mental disorders. These terms will still be found in publications and on web sites. In Ontario and increasingly in BC, the term dual diagnosis applies to people with developmental disabilities and psychiatric disorders. In the United States and in the international literature, dual diagnosis and dual disorders are most commonly used; although recently the phrase "co-occurring disorders" has been used to refer to clients diagnosed with psychiatric disorders and substance use disorders.

> Source: Centre for Addiction and Mental Health, *Concurrent Substance Use and Mental Health Disorders: An Information Guide*, Retrieved December 15, 2008, from http://www.camh.net/About_Addiction_Mental_Health/Concurrent_Disordes/index.html.

Determinants of Health
"The range of personal, social, economic and environmental factors which determine the health status of individuals or populations. The factors which influence health are multiple and interactive. Health promotion is fundamentally concerned with action and advocacy to address the full range of potentially modifiable determinants of health - not only those which are related to the actions of individuals, such as health behaviours and lifestyles, but also factors such as income and social status, education, employment and working conditions, access to appropriate health services, and the physical environments. These, in combination, create different living conditions which impact on health.

> Source: World Health Organization Health Promotion Glossary, 1998.

Detox (see Withdrawal Management)

Developmental and Learning Disability
Developmental disability is a term used to describe life-long disabilities attributable to mental and/or physical or combination of mental and physical impairments, manifested prior to age

twenty-two. The term ... refer(s) to disabilities affecting daily functioning in three or more of the following areas:

- capacity for independent living
- economic self-sufficiency
- learning
- mobility
- receptive and expressive language
- self-care
- self-direction

Frequently, people with mental retardation, cerebral palsy, autism spectrum disorder, various genetic and chromosomal disorders such as Down's syndrome and Fragile X syndrome, and Fetal Alcohol Spectrum Disorder are described as having developmental disabilities. This use of the term is synonymous with the use of the term learning disability in the United Kingdom, and intellectual disability in Australia, Europe, Canada and elsewhere. Cognitive disability is also used synonymously in some jurisdictions.

Developmental disabilities are usually classified as severe, profound, moderate or mild, as assessed by the individual's need for supports, which may be lifelong.

There are many social, environmental and physical causes of developmental disabilities, although for some a definitive cause may never be determined. Common factors causing developmental disabilities include:

- Brain injury or infection before, during or after birth
- Growth or nutrition problems
- Abnormalities of chromosomes and genes
- Babies born long before the expected birth date - also called extreme prematurity
- Poor diet and health care
- Drug misuse during pregnancy, including alcohol intake and smoking.
- Child abuse can also have a severe effect on the development of a child, specifically the socio-emotional development.
- Diagnosis of an autism spectrum disorder

Developmental disabilities affect between 1 and 2 per cent of the population in most western countries, although many government sources acknowledge that statistics are flawed in this area. The worldwide proportion of people with developmental disabilities is believed to be approximately 1.4 per cent.

Source: Adapted from Inclusion International at http://www.inclusion-international.org/en/.

Dialectical Behavioural Therapy
Dialectical behavioural therapy (DBT) is a psychological method, based on Buddhist teachings, to treat persons with borderline personality disorder (BPD). Research indicates its application to also be effective in treating patients who represent varied symptoms and behaviours associated with spectrum mood disorders, including self-injury. DBT includes the following key elements: behaviourist theory, dialectics, cognitive therapy, and, DBT's central component, mindfulness.

Source: Linehan, M.M. & Dimeff, L. (2001). Dialectical Behaviour Therapy in a nutshell. *California Psychologist, 34*, 10–13.

Dual Diagnosis
Mental health issues, and psychiatric illnesses, are more likely to occur in people with developmental disabilities than in the general population. A number of factors are attributed to the high incidence rate of dual diagnoses:

- The high likelihood of encountering traumatic events throughout their lifetime (such as abandonment by loved ones, abuse, bullying and harassment).
- The social restrictions placed upon people with developmental disabilities (such as lack of education, poverty, limited employment opportunities, limited opportunities for fulfilling relationships, boredom).
- Biological factors (such as brain injury, epilepsy, illicit and prescribed drug and alcohol misuse).
- Developmental factors (such as lack of understanding of social norms and appropriate behaviour, inability of those around to allow/ understand expressions of grief and other human emotions).

These problems are exacerbated by difficulties in diagnosis of mental health issues, and in appropriate treatment and medication, as for physical health issues.

Source: Cooper, S. (2003, August). Classification and assessment of psychiatric disorders in adults with learning (intellectual) disabilities. *Psychiatry,* 2(8).

Evidence
Evidence consists of research and evaluation findings (including process, outcome and economic evaluations), needs assessments, specialist and community knowledge, as well as the lived experiences of patients, their families, community leaders and service providers. The nature of the evidence needed depends on what is meant by effectiveness. Effectiveness refers to the extent to which the intended outcomes of an intervention are achieved in accordance with stated values, and within the limited resources available.

Research, practice and policy have usually been constructed to affect the entire population without specific attention to differential effects on women and men or various subgroups such as Aboriginal men or teen girls. As such, evidence is usually lacking on the impact of population

level policies on many sub-populations, as well as for targeted approaches that address vulnerabilities specific to diverse groups of women and men.

Source: Ministry of Health Services, 2004.

Fetal Alcohol Spectrum Disorder

Fetal Alcohol Spectrum Disorder (FASD) is a term used to describe a range of disabilities that may affect people whose mothers drank alcohol while they were pregnant.

FASD is an umbrella term that covers several alcohol-related medical diagnoses. These include

- Fetal Alcohol Syndrome (FAS)
- partial Fetal Alcohol Syndrome (pFAS)
- alcohol-related neurodevelopmental disorder (ARND)
- alcohol-related birth defects (ARBD)

If women drink when they are pregnant, their babies may have brain damage. This means that children and adults who are affected may have a hard time learning and controlling their behaviour. For example, they may appear to learn how do to a new task one day, and not remember the next. Other common problems include having trouble:

- adding, subtracting and handling money
- thinking things through/reasoning
- learning from experience
- understanding consequences of their actions
- remembering things, and
- getting along with others.

Because of their disabilities, people who are affected by FASD may have special needs that require lifelong help - even throughout adulthood - regarding :

- handling money, such as paying rent and buying food
- learning from their experiences and making changes in their behaviour
- understanding consequences of their behaviour, or "cause and effect"
- interacting with other people socially, and
- keeping a job.

Affected people may develop mental health problems, have trouble with the law, drop out of school (or be disruptive in a classroom), (be) unemployed and/or may develop alcohol and drug problems. They may even be homeless.

Source: http://www.phac-aspc.gc.ca/fasd-etcaf/about-eng.php. Adapted December 16, 2008.

Harm Reduction
Harm reduction is an accepted, long-used public health practice. The International Harm Reduction Association describes harm reduction as "…policies and programs which attempt primarily to reduce the adverse health, social and economic consequences of mood altering substances to individual drug users, their families and communities, without requiring decrease in drug use" "Harm reduction is a term that covers activities and services that acknowledge the continued drug use of individuals, but seek to minimize the harm that such behaviour causes" (DrugScope, n.d.).

> Source: BC Ministry of Health. Healthy Pathways Forward – A strategic Integrated Approach to Viral Hepatitis in BC. May 2005, p. 4.

Harm reduction is any program or policy designed to reduce drug-related harm without requiring the cessation of drug use. Interventions may be targeted at the individual, the family, community or society. The primary focus of harm reduction is on people who are already experiencing some harm due to their substance use. Interventions are geared to movement from more to less harm. Examples of proven harm reduction programs are: server intervention programs which decrease public drunkenness; needle and syringe exchange programs which prevent the transmission of HIV among injection drug users; and, environmental controls on tobacco smoking which limit the exposure to second hand smoke.

> Source: CAMH, CAMH Position on Harm Reduction: Its Meaning and Applications for Substance Use. Retrieved from http://www.camh.net/Public_policy_papers/publicpolicy_harmreduc2002.html

Health Promotion
The World Health Organization (WHO) defines health as "…a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Health promotion is defined by WHO as '…the process of enabling people to increase control over, and to improve their health.' It involves the population as a whole in the context of their everyday lives, rather than focusing on people at risk for specific diseases, and is directed toward action on the determinants or causes of health. (WHO, 1986) It is a process, or a style of working, that uses a combination of strategies (building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, reorienting health services) to improve the overall health, well-being, and quality of life of the population and frequently focuses on the broader environmental, social, economic, political, and cultural conditions that determine health, using socio-political strategies to affect change.

According to the Ottawa Charter for Health Promotion, health promotion requires: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services.

Health promotion strategies encompass social marketing, self help, advocacy, public policy, legislation, community development and health education. In order to achieve health promotion objectives multiple strategies must be employed. Health promotion is not synonymous with health education; it is a much more complex set of actions to assist people to lead healthy lives.

> Source: Ministry of Health Services. (2004 May). Every door is the right door: A British Columbia planning framework to address problematic substance use and addiction.

Victoria, BC; Ottawa Charter for Health Promotion. November, 1986; Ministry of Healthy Living and Sport. Core Public Health Functions.

Inter-disciplinary
Inter-disciplinary practice can best be understood as part of a continuum from unidisciplinary practice to transdisciplinary practice:

- Unidisciplinary practice involves functioning in isolation from members of other disciplines.
- Intradisciplinary practice involves the contributions of different specialists within one discipline (such as physician consultations).
- Multidisciplinary practice refers to a clinical group whose members each practice with an awareness and toleration of other disciplines.
- Interdisciplinary practice is an integrated approach in which members of a clinical team actively coordinate care and services across disciplines.
- Transdisciplinary practice involves team members from different disciplines who share knowledge and skills; as a result, the traditional boundaries between professions become less rigid, allowing members of the team to work on problems not typically encountered or seen as the responsibility of their discipline.

Source: Ray, M.D. (1998). Shared borders: Achieving the goals of interdisciplinary patient care. American Journal of Health-System Pharmacy, 55(13), p. 1369).

Mental Disorder
The Diagnostic and Statistical Manual of Mental Disorders (DSM) is published by the American Psychiatric Association and provides diagnostic criteria for mental disorders. The DSM-IV organizes each psychiatric diagnosis into five levels (axes) relating to different aspects of disorder or disability:

- Axis I: clinical disorders, including major mental disorders, as well as developmental and learning disorders
- Axis II: underlying pervasive or personality conditions, as well as mental retardation
- Axis III: Acute medical conditions and physical disorders.
- Axis IV: psychosocial and environmental factors contributing to the disorder
- Axis V: Global Assessment of Functioning or Children's Global Assessment Scale for children under the age of 18 (on a scale from 100 to 1).

Common Axis I disorders include depression, anxiety disorders, bipolar disorder, attention deficit hyperactivity disorder (ADHD), phobias, and schizophrenia.

Common Axis II disorders include personality disorders: paranoid personality disorder, schizoid personality disorder, schizotypal personality disorder, borderline personality disorder, antisocial personality disorder, narcissistic personality disorder, histrionic personality disorder, avoidant personality disorder, dependent personality disorder, obsessive-compulsive personality disorder, and mental retardation.
Common Axis III disorders include brain injuries and other medical/physical disorders which may aggravate existing diseases or present symptoms similar to other disorders.

Source: American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 1994.

Mental Illness
Any of various conditions characterized by impairment of an individual's normal cognitive, emotional, or behavioural functioning, and caused by social, psychological, biochemical, genetic, or other factors, such as infection or head trauma. Also called emotional illness, mental disease; Also called mental disorder.

Source: http://www.answers.com/topic/mental-illness Retrieved December 14, 2008.

Mental Health Problem
Feeling sad or worried, having unusual thoughts or forgetful moments is most often normal. Everyone has these feelings and experiences at times. The distinction between normal emotions and thinking and a mental health problem is that a person with a mental health problem has:

- several symptoms
- symptoms that continue for a long time
- symptoms that cause distress and interfere with his or her ability to function in terms of self-care, work, leisure or relationships

For example, symptoms of depression may include loss of interest or pleasure in daily activities, irritability, loss of energy and change in appetite. For depression to be diagnosed, the symptoms must persist for at least two weeks, most of the day, almost every day (American Psychiatric Association, 2000). An older person with depression may not eat well and may lack proper nutrition, lose interest in hobbies and become isolated.

Mental illness impairs a person’s thoughts, mood and behaviour. It is caused by unregulated brain chemistry, sometimes complicated by life circumstances, such as trauma or abuse, which may trigger the illness. Research points to a genetic factor in disorders such as schizophrenia, bipolar disorder and major depression.

Mental illnesses tend to be episodic or cyclical; a person may have episodes of acute illness, but also long periods of wellness. The exception is dementia with a continuing decline of function. The presence and course of mental health problems in older persons vary considerably in terms of their general health, diet, care setting, access to social supports and other life factors.

A strong support network that offers security and a sense of control over circumstances may help a person with mental illness to cope with his or her symptoms. Older persons with dementia or other late-life problems are more likely to have a strong social support network than people with long-term chronic mental health issues, such as early-onset schizophrenia or bipolar disorder. By the time people with long-term severe mental illness reach old age, they often have little or no contact and support from family. This can result in poverty, isolation and hospitalization.

Source: http://www.camh.net/Publications/Resources_for_Professionals/Improving_Our_Response/what_mental_health_problem.html Retrieved December 16, 2008.

Neurological Disorder
A disturbance in structure or function of the central nervous system resulting from developmental abnormality, disease, injury or toxin.

Source: http://www.biology-online.org/dictionary/Neurological_disorder

Perinatal, Prenatal, Postnatal
Pertaining to or occurring in the period shortly before and after birth, variously defined as beginning with completion of the twentieth to twenty eighth week of gestation (prenatal) and ending 7 to 28 days after birth (postnatal).

Source: http://cancerweb.ncl.ac.uk/cgi-bin/omd?perinatal (Adapted. December 15, 2008)

Perinatal depression can occur from the time of conception to one year after childbirth. As many as one in five women in BC will experience significant depression in relation to her pregnancy and childbirth.

Source: *Addressing Perinatal Depression – A Framework for BC's Health Authorities*.

Population Health Approach
The population health approach aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, population health approaches examine and act upon the broad range of factors and conditions that have a strong influence on our health. Strategies are based on an assessment of the conditions of risk and benefit that may apply across the entire population, or to particular subgroups within the population. This approach recognizes that health is a capacity or resource rather than a state, a definition which corresponds more to the notion of being able to pursue one's goals, to acquire skills and education, and to grow. The population health approach does not diminish the importance of the health care system, genetics, or other individual factors (e.g. behavioural choices) that contribute to the health of Canadians, but includes additional factors, often systemic and the interactions among them.

Source: Frankish et al. 1996; Public Health Agency of Canada, n.d.

Prevention
Defined as "actions aimed at eradicating, eliminating, or minimizing the impact of disease and disability or, if none of these is feasible, retarding the progress of disease and disability" (World Health Organization).

Covers measures not only to prevent the occurrence of disease, such as risk factor reduction, but also to arrest its progress and reduce its consequences once established. Primary prevention is directed towards preventing the initial occurrence of a disorder. Secondary and tertiary prevention seek to arrest or retard existing disease and its effects through early detection and appropriate treatment; or to reduce the occurrence of relapses and the establishment of chronic conditions through, for example, effective rehabilitation. Disease prevention is sometimes used as a complementary term alongside health promotion. Although there is frequent overlap between the content and strategies, disease prevention is defined separately. Disease prevention in this context is considered to be action, which usually emanates from the health sector, dealing with individuals and populations identified as exhibiting identifiable risk factors, often associated with different risk behaviours.

For the purposes of prevention, risk may also be assessed from the population level to the individual level and appropriate strategies developed (e.g. universal, indicated, selective, and targeted).

Source: adapted from *Glossary of Terms used in Health for All* series. WHO, Geneva, 1984.

Primary Care and Primary Health Care Reform
Primary care is the health care provided at the first point of contact. It is considered to be the first-contact assessment of provision of continuing medical care through a broad scope of health services including diagnostics, treatment and management of health problems, promotion and prevention activities and ongoing support from professionals, family and community.

Primary health care reform is aimed at ensuring accessibility, public participation, health promotion, appropriate skills and technology and intersectoral cooperation. In British Columbia, eight priorities have been identified for improved primary health care: improved access to primary health care and primary maternity care, increased chronic disease prevention and enhanced management of chronic diseases; improved mental health care; improved coordination and management of co-morbidities; improved care of the frail elderly; and enhanced end of life care.

Source: http://www.bcresponsiblegambling.ca/responsible/faqs2.html

Psycho-social Rehabilitation
Psychosocial rehabilitation is the process of restoration of community functioning and wellbeing of an individual who has a psychiatric disability (been diagnosed with a mental disorder). Rehabilitation work undertaken by psychiatrists, social workers and other mental health professionals (psychologists and social workers, for example) seeks to effect changes in a person's environment and in a person's ability to deal with their environment, so as to facilitate improvement in symptoms or personal distress. These services often "combine pharmacologic treatment, independent living and social skills training, psychological support to clients and their families, housing, vocational rehabilitation, social support and network enhancement, and access to leisure activities. There is often a focus on challenging stigma and prejudice to enable social inclusion, on working collaboratively in order to empower clients, and sometimes on a goal of full psychosocial recovery."

Source: *Mental Health: A Report of the Surgeon General*, U.S. Surgeon General, 1999.

The Board of Directors of the United States Psychiatric Rehabilitation Association USPRA approved and adopted the following standard definition of psychiatric rehabilitation: Psychiatric rehabilitation promotes recovery, full community integration and improved quality of life for persons who have been diagnosed with any mental health condition that seriously impairs their ability to lead meaningful lives. Psychiatric rehabilitation services are collaborative, person directed and individualized. These services are an essential element of the health care and human services spectrum, and should be evidence-based. They focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice.

In British Columbia, psycho-social rehabilitation (PSR) services include rehabilitation services designed to assist persons with a severe mental illness and those with a concurrent substance use disorder in their recovery to effectively manage their illness and compensate for the functional deficits associated with the illness. People who receive PSR services are significantly more likely to be able to return to work or school or to resume a participating role in the community. The range of PSR services include:

- PSR assessment (vocational, educational, basic living skills, leisure);
- Supported work and employment, pre-employment and transitional employment services, self employment/ business enterprise
- Supported education, including English as a second language support
- Supported volunteer services, including therapeutic volunteer program
- Peer support
- Psycho-education support groups
- Clubhouse and drop-in programs
- Mental health and wellness programs (nutrition, physical exercise, smoking cessation)
- Community resources orientation, linkages and transition services
- Basic living skills, home and safety management, communication and building personal relationships
- Social recreational services, including supported leisure activities (e.g. community friends program)
- Consumer initiatives support
- Family support services

Psychotherapy

Psychotherapy is an interpersonal, relational intervention used by trained psychotherapists to aid clients in problems of living. This usually includes increasing individual sense of well-being and

reducing subjective discomforting experience. Psychotherapists employ a range of techniques based on experiential relationship building, dialogue, communication and behavior change and that are designed to improve the mental health of a client or patient, or to improve group relationships (such as in a family). Psychotherapy may be performed by practitioners with a number of different qualifications, including psychologists, marriage and family therapists, licensed clinical social workers, counsellors, psychiatric nurses, and psychiatrists.
Most forms of psychotherapy use spoken conversation. Some also use various other forms of communication such as the written word, artwork, drama, narrative story or music. Psychotherapy occurs within a structured encounter between a trained therapist and client(s). Purposeful, theoretically based psychotherapy began in the 19th century with psychoanalysis; since then, scores of other approaches have been developed and continue to be created. Therapy is generally employed in response to a variety of specific or non-specific manifestations of clinically diagnosable and/or existential crises. Treatment of everyday problems is more often referred to as counselling. However, the term counselling is sometimes used interchangeably with "psychotherapy".

Whilst some psychotherapeutic interventions are designed to treat the patient employing the medical model, many psychotherapeutic approaches do not adhere to the symptom-based model of "illness/cure". Some practitioners, such as humanistic therapists, see themselves more in a facilitative/helper role. As sensitive and deeply personal topics are often discussed during psychotherapy, therapists are expected, and usually legally bound, to respect client or patient confidentiality. The critical importance of confidentiality is enshrined in the regulatory psychotherapeutic organizations codes of ethical practice.

> Source: Frank, Jerome (1988) [1979]. "What is Psychotherapy?" in Bloch, Sidney (ed.). *An Introduction to the Psychotherapies*. Oxford: Oxford University Press. pp. 1–2. Adapted.

Substance Use and Problematic Substance Use

Substance use refers to the ingestion or administration of any substance that is psychoactive (i.e. alters consciousness). Psychoactive substances include alcohol, tobacco, caffeine, illegal drugs, some medications and some kinds of solvents and glues. The use of psychoactive substances is an almost universal human cultural behaviour and has been engaged in since the beginning of recorded human history. Substance use may range from beneficial to problematic, depending on the quantity, frequency, method or context of use. The use of an amount of a particular substance may be beneficial in certain people under certain circumstances, whereas a similar amount could be harmful to someone else under similar or different circumstances.

Problematic substance use refers to instances or patterns of substance use associated with physical, psychological, economic or social problems or use that constitutes a risk to health, security or well-being of individuals, families or communities. Some forms of problematic substance use involve potentially harmful types of use that may not constitute clinical disorders, such as impaired driving, using a substance while pregnant, binge consumption and routes of administration (i.e. ways of taking a substance into one’s body) that increase harm. Problematic substance use also includes “substance use disorders” (i.e. clinical conditions defined by medical diagnostic criteria, including dependence or “addiction”). Problematic substance use is not

related to the legal status of the substance used, but to the amount used, the pattern of use, the context in which it is used and, ultimately, the potential for harm.

Source: Ministry of Health Services. (2004 May). *Every door is the right door: A British Columbia planning framework to address problematic substance use and addiction*. Victoria, BC. p.83.

There are a variety of risk factors that contribute to problematic substance use, and if these factors act together, addiction may develop. Risk factors for problematic substance use include:

- a genetic, biological, or physiological predisposition
- external psychosocial factors such as community attitudes (including school), values and attitudes of peers or social group, and family situation
- internal factors such as poor coping skills and lack of resources

Degrees of Use
Substance use falls on a continuum based on frequency, intensity, and degree of dependency.

- Experimental: use is motivated by curiosity, and limited to only a few exposures.
- Social/Recreational: the person seeks out and uses a substance to enhance a social occasion. Use is irregular and infrequent, and usually occurs with others.
- Situational: there is a definite pattern of use, and the person associates use with a particular situation. There is some loss of control, but the person is not yet experiencing negative consequences.
- Intensive: also called "bingeing," the person uses a substance in an intense manner. They may consume a large amount over a short period of time, or engage in continuous use over a period of time.
- Dependence: can be physical, psychological, or both. Physical dependence consists of tolerance (needing more of the substance for the same effect) or tissue dependence (cell tissue changes so the body needs the substance to stay in balance). Psychological dependence is when people feel they need to use the substance in particular situations or to function effectively. There are degrees of dependence from mild to compulsive, with the latter being characterized as addiction.

Source: Here to Help website, What is Addiction Fact Sheet, http://www.heretohelp.bc.ca/publications/factsheets/addiction

Surveillance
Surveillance is an accepted epidemiological term which refers to the ongoing collection of epidemiological data, with real-time analysis (ODI/HPN paper 52, 2005, Checchi and Roberts).

Source: WHO. http://www.who.int/hac/about/definitions/en/print.html Retrieved November 25, 2008.

Systems
A system is an assemblage of inter-related elements comprising a unified whole. A sub-system is a system which is part of another system. A system consists of elements connected together to facilitate the flow of information, matter or energy—a group of interacting bodies under the influence of related forces. Applied to organizations such as the health system, systems theory suggests that specialty barriers can promote knowledge generation that is pursued in depth, but in isolation: "rather than getting a continuous and coherent picture we are getting fragments—remarkably detailed but isolated patterns" (Lazlo, 1996, p. 2). A systems approach attempts to look a range of different and interacting subsystems, and note their behaviour as a whole under diverse circumstances: this approach is especially valuable in understanding and addressing the many factors that influence population health, including individual and community vulnerability.

Target
An aspired outcome that is explicitly stated, e.g. achieve 90 per cent of timeliness of reporting, (J.M. Last, 2001).

> Source: WHO. http://www.who.int/hac/about/definitions/en/print.html Retrieved November 25, 2008.

To be effective a target should express an intended amount of measurable change to be achieved/accomplished over a specified period of time, in moving from a baseline measure to a benchmark, on a given indicator or measure.

Tertiary Care
Tertiary care is highly specialized medical care, usually provided over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities.

> Source: http://dictionary.reference.com/browse/tertiary+care& Retrieved December 16, 2008.

Vulnerable Populations
Individuals may be made vulnerable by a variety of circumstances such as: health status including the presence of chronic or terminal illness or disability; age; functional or developmental status; financial circumstances including access to food and shelter; ability to communicate effectively; personal characteristics; and, being part of a group that experiences stigma and discrimination. Poverty is one of the main causes of vulnerability in most parts of the world. Vulnerability can also be tracked along a life cycle continuum – from birth, youth and early adulthood through to old age. In general, populations are deemed to be vulnerable, while individuals may be deemed to be at risk.

Withdrawal Management
Withdrawal management refers to a group of treatment interventions with the primary purpose of supporting a person in overcoming physical and/or psychological dependence on a substance (also referred to as detoxification or "detox" when the treatment is provided in a residential facility or "daytox" when the individual receives treatment in the community). The immediate aims are to alleviate the physical symptoms of withdrawal, to achieve at least a temporary state

of abstinence from the substance(s) of dependence, and to treat any co-morbid physical or psychiatric conditions.

> Source: Adapted. Ministry of Health Services. (2004 May). *Every door is the right door: A British Columbia planning framework to address problematic substance use and addiction*. Victoria, BC. p.84.

Withdrawal, or detox, is the process of an individual's body adjusting to the absence of the alcohol or other drug that they used to use. Individuals may experience emotional as well as physical distress. Withdrawal management services can be provided in a variety of settings based on a comprehensive assessment of symptom severity to determine the appropriate level of care.

Home detox is an organized outpatient withdrawal management service provided in the person's home by trained clinicians who provide medical monitoring and evaluation of the withdrawal process and referral to other services. The use of a home detox program requires that the individual have a stable living environment with identified supportive persons to assist with the withdrawal management plan, and withdrawal symptoms that do not require high intensity monitoring and can be safely monitored at home with support from family members, a physician or a nurse.

Daytox services are planned, organized outpatient withdrawal management services consisting of regularly scheduled sessions with a semi-structured program with on-site monitoring by trained staff who provide medical monitoring and evaluation of the withdrawal process, recreational and educational activities, alternate therapies such as acupuncture, case management and referral to other services. Individuals using daytox services have withdrawal symptoms that do not require high intensity monitoring; have a stable living environment and transportation to attend the program; and can commit to several on-site treatment hours per week.

Supportive residential detox services are organized residential withdrawal management services monitored by competent, trained staff who provide medical monitoring and evaluation of the withdrawal process, recreational and educational activities, acupuncture and other alternate therapies, assessment and referral to other services.

Individuals requiring this level of care have symptoms which can be managed as required under nursing supervision with medical consultation provided by a physician. The individual typically does not have stable living environment or supportive person(s) and needs to be away from environment/activities that promote substance use. This level provides care for people whose psychological and behavioural symptoms would otherwise distract them from their recovery efforts.

Supportive residential settings are not suitable if the person has predicted complicated withdrawals; previous multiple seizures in each withdrawal episode; current nutritional disorders; current serious medical condition or current acute psychiatric condition.

A medically managed inpatient withdrawal management service is delivered by medical and nursing professionals, and provides for 24-hour medically directed care. Services are delivered under a defined set of physician-approved policies and protocols. Indications for intensive

inpatient services include that the client requires specific treatment for co-morbid general medical or clinical conditions; has a history of complicated withdrawal requiring intensive medical management; requires stabilization prior to protracted withdrawals (for example withdrawal from benzodiazepines); or the person is pregnant. An inpatient setting is not required if the person has no significant health risks, such as no history of previous multiple seizure; no complicated withdrawal predicted; or no, or stabilized, physical and psychiatric problems.

Source: *Youth Withdrawal Management: A Service Framework for BC Health Authorities*, BC Ministry of Health April 2008

APPENDIX 1: THE EVIDENCE BASE FOR A MODEL CORE PROGRAM FOR PREVENTION OF HARMS ASSOCIATED WITH SUBSTANCES

Taken from: ***Evidence Review: Prevention of Harms Associated with Substances*** **(2006), by the Centre for Addictions Research of BC, for the Ministry of Health, Population Health and Wellness.**

In 2006, the Ministry of Health and the Centre for Addictions Research of BC produced a document, *Following the Evidence: Preventing Harms from Substance Use in British Columbia*. The purpose of the evidence paper is to establish a common understanding and provide some priorities based on the best available evidence on how to address and prevent harms associated with substances. The evidence paper is for the government, non-government and private sectors, and those involved in community-based activity both locally and provincially. It speaks to the responsibilities of the health system and other public systems in British Columbia, including education, social services, police, courts, judiciary, victim services and corrections, including probation and parole. The paper is intended to guide the development of prevention services and activities to help ensure consistency across inter-sectoral approaches to psychoactive substance use. *Following the Evidence* articulates core concepts, guiding principles, key strategic directions and actions for British Columbia that are based on the best available evidence, and is meant to broaden the understanding of prevention, help provide access to what is known to be effective and draw attention to the variety of potentially successful prevention strategies.

Local and regional partners form much of the service delivery infrastructure for preventing harms from substance use. Together, they have the most immediate role to play as either direct providers or funders of health promotion, prevention, harm reduction, treatment and support services. The rich and complex web of inter-relationships that currently exists (and can be enhanced) among health, education, local government, social services, employment and enforcement partners at the regional and local level will form the foundation of an integrated and comprehensive response to preventing harms from substance use.

What follows is an evidence review paper on the prevention of harms associated with substances, focused on evidence of effective public health services at the health authority level. This in turn is meant to assist the health authorities to develop a “gap analysis” between what is provided and the set of functions or interventions that are recommended; this will, in turn, lead to the development of performance improvement targets and plans.

This evidence review paper adopts similar guiding principles contained in *Following the Evidence: Preventing Harms from Substance Use in British Columbia* (Ministry of Health 2006). It also follows the same strategic directions that international evidence suggests will have the most impact on preventing harms from substance use:

- Influencing developmental pathways and acknowledging that different life stages present differing risks and protective factors for harms.

- Delaying and preventing alcohol, tobacco and cannabis use among adolescents, a time of life when problematic patterns of use for these substances can lead to significant harms later in life.
- Reducing risky patterns of substance use, emphasizing interventions that can impact those types of substance use that have the greatest likelihood of causing harm.
- Creating safer contexts, which acknowledges that the setting or environment where substance use occurs can affect the risk of harms.
- Influencing economic availability, whereby pricing mechanisms can be used to influence the use of substances such as alcohol and tobacco.

Psychoactive substance use occurs in all societies, but the consequences of substance use vary depending upon the level and context of use, as well as individual susceptibility. Recent estimates for 2000 indicate that approximately 7 million deaths globally were associated with the use of psychoactive substances: 70 per cent due to long-term effects of tobacco, 25 per cent from problematic alcohol use and 5 per cent from illegal psychoactive substances. The overall direct and indirect impacts of alcohol and tobacco were almost equal and jointly accounted for 90 per cent of disability-adjusted-life-years due to problematic substance use, with illegal drugs accounting for the remaining 10 per cent (Rehm and Room 2005). In emerging economies, the impacts are greater for alcohol than tobacco. The overall impact of problematic substance use is greatest in the developed world but is still substantial elsewhere, especially in countries with emerging economies and longer overall life expectancy.

A recent Canadian cost study, based on 2002 data, estimates the overall social cost of problematic substance use to be $39.8 billion, representing a cost of $1,267 to every Canadian. Tobacco accounts for about $17.0 billion (42.7 per cent of the total estimate), alcohol accounts for about $14.6 billion (36.6 per cent) and illegal drugs for about $8.2 billion (20.7 per cent). The social costs included in the 2006 study include the direct costs of health care, enforcement, and research and prevention, and the indirect costs of lost productivity in the workplace or at home (Canadian Centre on Substance Abuse 2006). The focus of this evidence review paper is on how this great toll of death, injury and illness might be reduced for future generations by implementing effective prevention interventions.

Adolescence presents many concerns as young people test their limits and develop their own social networks, often in an attempt to express their independence. Many adults express concern about adolescent experimentation with psychoactive substances that are illegal. However, the most common patterns of risky substance use are usually with more familiar substances such as tobacco and alcohol. Furthermore, the use of these socially sanctioned substances has generated increasing concern, with evidence of increased “binge” drinking by teenagers in the United Kingdom, Europe, Canada and Australia, as well as relatively high levels of tobacco use in this age group (Hibell et al. 2004; Plant, Miller and Plant 2005; Chikritzhs, Pascal and Jones 2004; Adlaf, Begin and Sawka 2005). Also, in many countries there has been a marked increase in the use of cannabis, “party drugs” such as ecstasy, and injectable drugs such as heroin, cocaine and various amphetamine-type drugs over the past three decades (Adlaf et al. 2005).

Early use of psychoactive substances often predicts later problematic use, general health and mental health problems, and developmental delays in cognitive and emotional functions in young adulthood. Alcohol-related motor vehicle crash deaths frequently remain the leading cause of death among persons aged 15 to 24 years. Tobacco kills more people than all the other psychoactive substances combined, and uptake of tobacco smoking usually starts during the teenage years (Younie et al. 2005).

In many countries, significant investments have been made into prevention programs and their evaluation. Recent reviews of interventions for prevention of substance use and its harms (Stockwell et al. 2005; Loxley et al. 2004; Babor et al. 2003) have documented what can be learned from the global experience. These reviews have identified key elements that influence substance use patterns and contribute to or mitigate harms: the structure of the adult world that influences children and shapes their future patterns of substance use; recent contributions from research on brain development that isolate critical factors during pregnancy, birth, infancy and childhood that might be modified to reduce the risk of later behavioural problems, including those associated with substances; and a number of more general lessons and principles that underpin effective prevention that can be extracted from international experience of what works in certain settings or cultures. This brief review will try to summarize some of these lessons, identify some general principles and give a few specific examples of effective prevention practice that have been documented in different parts of the world; these examples may be of use to health authorities charged with the responsibility for developing and delivering an effective, integrated and comprehensive response to preventing harms from substance use.

APPENDIX 2: FOLLOWING THE EVIDENCE

Taken from: *Following the Evidence: Preventing Harm from Substance Use in BC* (2006), prepared by the Centre for Addictions Research of BC for the Ministry of Health.

Prevention of harms from psychoactive substances requires sustained effort by individuals, families, communities, governments and many other groups and organizations. This paper uses the best available evidence in population health and prevention to identify key strategic directions for action by ministries, health authorities, local governments, and agencies involved in the development of healthy public policy in British Columbia.

This prevention paper identifies five strategic directions that international evidence suggests will have the most impact on preventing harms from substance use. The first is influencing developmental pathways, which acknowledges that different life stages present differing risks and protective factors for harm. The second is delaying and preventing alcohol, tobacco and cannabis use during adolescence, when problematic patterns of use for these substances can lead to significant harms later in life. The third is reducing risk patterns of substance use, emphasizing interventions that can impact those types of substance use that have the greatest likelihood of causing harm. The fourth is creasing safer contexts, which acknowledges that the setting or environment where substance use occurs can affect the risk of harm. And the fifth is influencing economic availability, whereby pricing mechanisms can be used to influence the use of substances such as alcohol and tobacco.

Effective interventions to prevent harms related to substances extend beyond the responsibility of the Ministry of Health, its health authorities and the health care delivery system. The Ministry of Health will use this paper to inform efforts in creating partnerships with government, non-government and private sectors and those involved in community-based activity both locally and provincially, with the goal of protecting and improving the health of British Columbians by minimizing the harm to individuals, families and communities from psychoactive substance use.

APPENDIX 3: SUMMARY OF INITIATIVES IN OTHER BC MINISTRIES/AGENCIES IN PREVENTING HARMS ASSOCIATED WITH SUBSTANCES

Provincial ministries with responsibilities related to preventing harms associated with substances are:

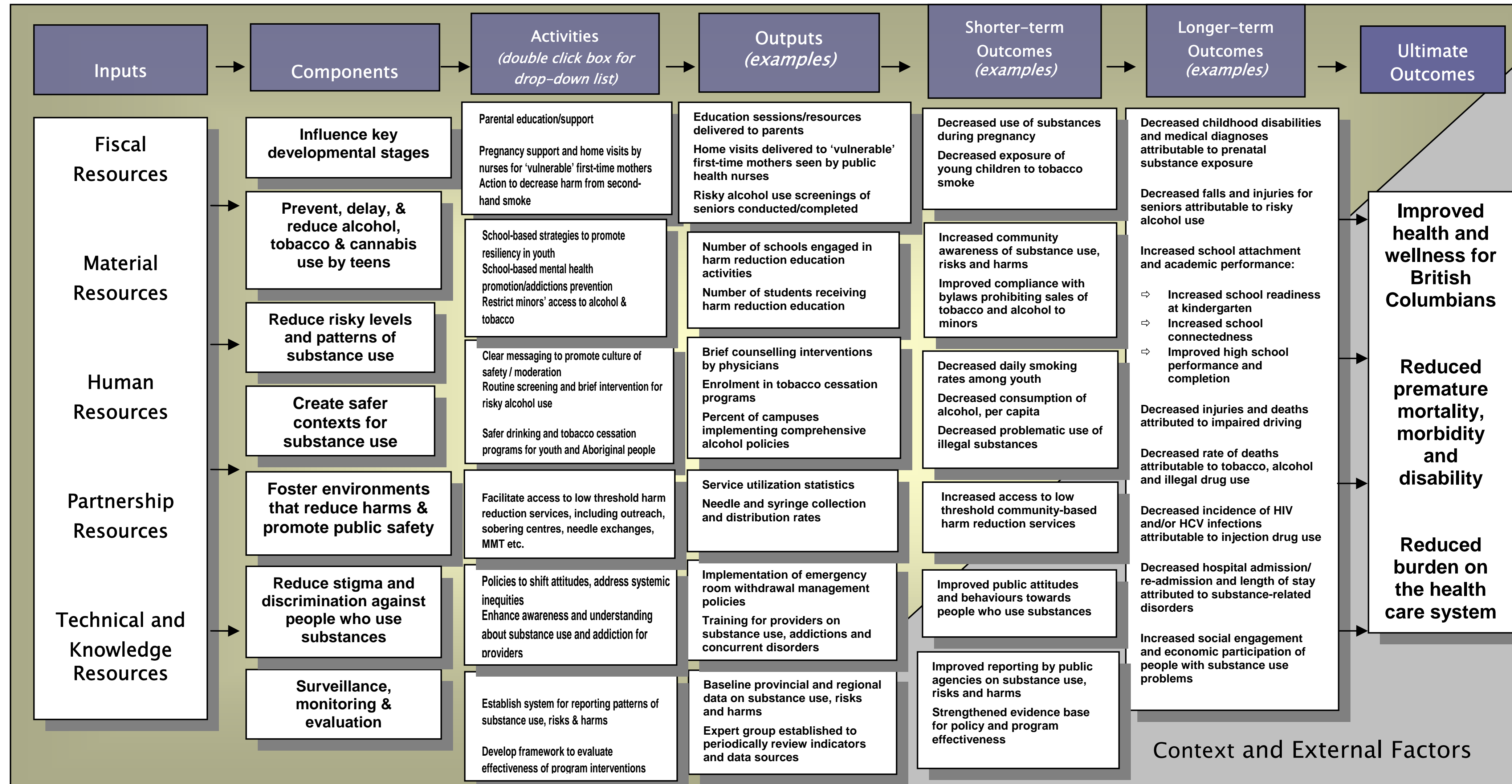
- Ministry of Children and Family Development is the lead ministry for: coordinating the Fetal Alcohol Spectrum Disorder provincial plan for British Columbia; child, youth and family mental health; and for services for youth with substance use disorders involved with the justice system.
- The Office of the Representative for Children and Youth monitors and investigates injuries and deaths, and recommends action to improve child/youth protection.
- Ministry of Employment and Income Assistance works to provide access to treatment for those with low incomes.
- Ministry of Education has a significant role in school-based health promotion and the prevention of harms associated with substances.
- Ministry of Public Safety and Solicitor General is responsible for policing and enforcement policies.
- As well, the Ministry of Public Safety and Solicitor General's Crystal Meth Secretariat coordinates response to crystal meth, educates the public, and partners with communities to establish effective strategies.
- The Ministry of Housing and Social Development supports housing for persons with special needs including individuals with mental disorders and/or substance dependence; the Ministry of Housing and Social Development also oversees the Liquor Control and Licensing Branch, which licenses the production of beverage alcohol and supervises the service of liquor in licensed establishments; the Liquor Distribution Branch manages the distribution, importation and retailing of beverage alcohol.

Provincial agencies:

- Insurance Corporation of BC plays an important role in preventing alcohol-related motor vehicle crashes.
- Centre for Addictions Research of BC at the University of Victoria is instrumental in research and analysis of effective best practices in harm reduction associated with substances.
- The Centre of Applied Research in Mental Health and Addiction at Simon Fraser University conducts research on enhancing the effectiveness, efficiency and quality of mental health and addiction services in BC.

APPENDIX 4: PREVENTION OF HARMS ASSOCIATED WITH SUBSTANCES LOGIC MODEL

Goal: To protect and improve health by minimizing the harm to individuals, families and communities associated with psychoactive substances while also recognizing their benefits in appropriate circumstances.



Note: Drop-down list of activities is only available on the electronic version of this document, available at http://www.phabc.org.

APPENDIX 5: INDICATORS ASSOCIATED WITH OUTCOMES IN REDUCTION OF HARMS ASSOCIATED WITH SUBSTANCES CORE PROGRAM LOGIC MODEL (DECEMBER 2008)

Shorter Term Outcomes	Shorter Term Outcome Indicator	Recent Data Examples	Data Sources	Comments/Data Specificity
Decreased use of substances during pregnancy.	Rates of use for different substances among pregnant women screened for all substance use.		Health Authority data	TBD.
Decreased exposure of young children to tobacco smoke.	Percentage of homes with young children exposed to smoking.	3.7% of children aged 0-11 were regularly exposed to smoke in the home. (2007)	CTUMS, BC Statistics	Provincial-level data available.
Increased community awareness of substance use, risks and harms.	Existence of publications containing information on problematic use of illegal substances or harms from such substances. (further TBD)	CAS 2004, CADUMS (in progress), Costs of Substance Abuse 2002.	Canadian Centre on Substance Abuse, Health Canada	Provincial-level data available, further TBD.
Improved compliance with bylaws prohibiting sales of tobacco and alcohol to minors.	Frequency of tobacco minor test shopping and compliance rates. Frequency of alcohol minor test shopping and compliance rates.	There was a compliance rate of 94% with respect to tobacco sales to minors. (2007)	Tobacco Enforcement Information System (TEIS) data. For alcohol, Liquor Control and Licensing Branch.	Address/postal code data available for tobacco contraventions.
Decreased daily smoking rates among youth.	Tobacco use over the past year for those aged 15-19.	12% of youth aged 15-19 were daily or occasional smokers. (2006)	CAS 2004, McCreary Center Society's Adolescent Health Survey, BC Statistics	Health Authority-level data available.
Decreased consumption of alcohol, per capita (litres)	Per capita consumption of alcohol in litres and type of beverage sold.	In British Columbia, the provincial per capita alcohol consumption was 8.92 L. (2007)	CARBC Alcohol and Other Drug Monitoring Project, BC Liquor Distribution Branch.	HSDA-level data available.
Decreased problematic use of illegal substances	Percentage of population reporting problematic use of illegal substances.	10.1% of past-year illegal drug users reported that drug use had a harmful effect on their health. (2004)	CAS 2004, CADUMS (in progress)	Provincial-level data available.

Shorter Term Outcomes	Shorter Term Outcome Indicator	Recent Data Examples	Data Sources	Comments/Data Specificity
Increased access and retention to community-based harm reduction and addiction treatment services.	Number of clients registered in methadone maintenance programs. Rates of needles and syringes distributed and collected, by region. Percent of those individuals requiring addictions treatment accessing services.	8985 patients registered in the methadone maintenance program. (2007) (Available in 2008)	BC College of Physicians and Surgeons BCCDC, Health Authority data CARBC Alcohol and Other Drug Monitoring Project	Methadone distribution from pharmacies can be identified. Postal codes from secondary harm reduction supply and distribution sites. TBD.
Improved public attitudes and behaviours towards people with substance use problems.	Opinion poll results reflecting attitudes towards people who use substances. (further TBD)	No statistics available specifically related to substance use.	CMA National Health Care Report Card (as a subset of mental illness)	Provincial-level data available.
Improved reporting by publicly-funded agencies on substance use, risks and harms.	A system is in place for regularly reporting on patterns of use and harms of alcohol, tobacco, and other substances. Further, there is evidence that the system is supporting policy and practice development.	Centre for Addictions Research of BC Alcohol and Other Drug Monitoring Project.	e.g. CTUMS, CADUMS (in progress), MSP, CCHS, Vital Statistics Agency, McCreary Center Society, Liquor Distribution Branch.	Variable specificities of data available.

Longer Term Outcomes	Longer Term Outcome Indicator	Recent Data Examples	Data Sources	Comments/Data Specificity
Decreased childhood developmental delays, disabilities and medical diagnoses attributable to prenatal exposure to substances	Outcome indicators for childhood developmental delays, disabilities and medical diagnoses attributable to prenatal exposure to substances are under development by staff responsible for the Reproductive and the Prevention of Disabilities & Healthy Infant and Early Child Development Core Programs.			
Improved school attachment and academic performance • Increased school readiness at kindergarten • Increased school connectedness • Improved high school performance and completion	(TBD: Reports from StrongStart BC, an early learning drop-in program) Positive response rate to questions regarding school connectedness Graduation and six-year completion rates by school district.	Newly-implemented program Adolescent Health Survey 93% of Grade 12 students (eligible to graduate) in BC graduated from high school. (2007)	StrongStart BC McCreary Centre Society B.C. Graduation reports, Ministry of Education	TBD. Data available by school district, for those districts participating. Data available by school postal code.

Longer Term Outcomes	Longer Term Outcome Indicator	Recent Data Examples	Data Sources	Comments/Data Specificity
Decreased injuries and deaths attributed to impaired driving.	Rates of impaired driving injuries and fatalities	104 deaths in alcohol-related motor vehicle collisions. (2005)	RCMP, Municipal police departments, PSSG, ICBC Motor Vehicle Branch, BC Vital Statistics	Provincial-level immediately available from report published by ICBC.
Decreased rate of death attributable to tobacco, alcohol and illegal drug use.	Number of deaths attributable to tobacco and rate per 100,000 people.	The rate of deaths attributable to tobacco in BC was 96.28 per 100,000 people. (2006)	CARBC Alcohol and Other Drug Monitoring Project, BC Vital Statistics	HSDA-level data available.
	Number of deaths attributable to alcohol and rate per 100,000 people.	The rate of deaths attributable to alcohol in BC was 19.48 per 100,000. (2006)	CARBC Alcohol and Other Drug Monitoring Project, BC Vital Statistics	Local health area-level data available.
	Number of deaths attributable to illegal drug use and rate per 100,000 people.	In BC, the number of deaths attributable to illegal drug use was 8.6 per 100,000. (2006)	CARBC Alcohol and Other Drug Monitoring Project, BC Vital Statistics	HSDA-level.
	Unintentional legal/illegal drug overdose deaths.	188 unintentional illegal drug overdose deaths. (2006)	BC Vital Statistics	Provincial-level data immediately available from Vital Statistics annual report
Decreased incidence of HIV and/or HCV infections attributable to injection drug use.	Incidence of Hepatitis C and HIV infection in those individuals with injection drug use as an identified risk factor.	91/395 (23%) of HIV cases reported in individuals where past injection drug use was recorded as a risk factor. (2007)	BCCDC	Provincial-level data immediately available.
Decreased hospital admission/ re-admission and length of stay for substance-related disorders.	Substance-related disorders as a proportion of total mental illness separations from general hospitals.	In BC general hospitals, 22.5% of mental illness separations were for substance-related disorders. (2006).	Canadian Institute for Health Information (CIHI)	Provincial-level data available.