

The Central Okanagan Framework for Action



A Four Pillar Approach to Problematic Drug Use and Related Issues in the Central Okanagan

Prepared by:

Robert James
Coordinator/Consultant
Central Okanagan Four Pillars Coalition
January 22, 2005
ISBN 0-9737592-0-8

Produced with funding support from:



Health
Canada

Santé
Canada

Table of Contents

Table of Contents	3
List of Charts and Tables	4
Mayors' Messages	5
Executive Summary	7
Background	10
What is a Four Pillar Approach?	11
Prevention.....	11
Treatment	12
Enforcement	12
Harm Reduction.....	12
Separate Responsibilities, Shared Accountability	13
Federal Government	13
Provincial Government	14
Municipal Governments.....	14
Non-Governmental Stakeholders	15
Global, National and Regional Context.....	16
Drug use – Who, What and Why	18
Why People Use Drugs	18
Youth and Drugs	20
The Social Costs of Drugs	23
Enforcement Costs	23
Healthcare Costs	24
The Four Pillars Experience Elsewhere.....	26
Europe	26
The United States	27
Vancouver.....	27
A Central Okanagan Framework for Action.....	29
Public Perceptions	29
Action No. 1: Regional Drug Policy Coordinator	30
Prevention: Managing the Future	31
Action No. 2: Community Capacity Building	31
Anti-Drug Education Strategies	32
Action 3: Expansion of D.A.R.E.....	33
Action 4: Enhanced Drug Education	33
Action 5: Harm Reduction Education	34
Alternatives to Drug Use	34
Action 6: Recreational, Social & Cultural Alternatives	35
Program Awareness and Accessibility.....	35
Action 7: Making Alternatives to Drug Use Accessible	35
Action 8: Drug-related Information Line	35
Underlying Factors	36
Action 9: Addressing Causal Factors.....	36
Community Environment	37
Action 10: Urban Renewal.....	37
Treatment: Building a Continuum	38
Treatment Coordination.....	38
Action 11: Coordinated Planning and Implementation.....	38
Treatment Capacity and Issues	39
Action 12: Improving Treatment Capacity	40
Youth Addiction Services.....	40
Action 13: Increasing Youth Addiction Services Capacity.....	41
Adult Addiction Services	41
Action 14: Increasing Adult Addiction Services Capacity.....	41

Action 15: Adult Residential Treatment Capacity.....	42
Action 16: Funding Supportive Recovery Housing.....	42
Action 17: Supporting Methadone Treatment Programs.....	43
Aboriginal Services	43
Action 18: Improved Aboriginal Addiction Services	43
Enforcement: Ensuring Public Security.....	44
Managing the Load	44
Action No. 19: RCMP Special Projects Team.....	44
Criminal Justice.....	45
Action No. 20: Effective Application of Legislation	45
Policing the Community.....	46
Action No. 21: Protective Detention.....	46
Communications and Relations	47
Action No. 22: Professional Courtesy and Interaction	47
Harm Reduction: Taking the Next Steps	48
Popular Misconceptions	48
Shelter Needs – Emergency and Longer Term	49
Action No. 23: Short-term shelter pilot project.....	49
Action No. 24: Youth shelter and drop-in facility	50
Action No. 25: Low-income Housing Projects.....	50
Preventing Harm to Others	51
Action No. 26: Improved Needle Drop Box Services	51
Public Education.....	52
Action No. 27: Public Education.....	52
Public Health.....	52
Action No. 28: Public Health Outreach	53
Conclusion	54
Bibliography	55
APPENDIX ONE: SUMMARY OF GOALS AND ACTIONS	60
APPENDIX TWO: KANDU REPORT.....	79
APPENDIX THREE: EXISTING HARM REDUCTION STRATEGIES.....	81
APPENDIX FOUR – EXISTING TREATMENT PROGRAMS	84
APPENDIX FIVE – ADS CONTINUUM OF CARE	85
APPENDIX SIX: GROUPS AND AGENCIES CONSULTED.....	87
APPENDIX SEVEN: STEERING COMMITTEE & SUBCOMMITTEES.....	88
APPENDIX EIGHT: SUMMARY OF TREATMENT SERVICE PROVIDER FOCUS GROUP INPUT.....	89
APPENDIX NINE: PUBLIC INPUT	93

List of Charts and Tables

Figure 1: Percentage of Canadians who have used illicit drugs	17
Figure 2: Admissions to community addiction services for amphetamine misuse.....	17
Figure 3: Low-Income Housing Deficit - Kelowna, 1999/2000.....	19
Figure 4: Average rents and units vacant by type - Kelowna	20
Figure 5: Number of Homeless in Kelowna - on street and in total	20
Figure 6: Age at onset of substance misuse	21
Figure 7: Substance use history of inmates	23
Figure 8: BC methamphetamine-related deaths	24
Figure 9: Impact of harm reduction programs on street drug scene	26
Figure 10: Service Accessed by InSite Users.....	28
Figure 11: Existing Adult Treatment Capacity	42

Mayors' Messages

The Central Okanagan is faced with an issue that unfortunately is not unique - the tragedy of drug addiction. Recognizing that enforcement alone will not address this societal problem, Kelowna has taken a proactive approach with the Four Pillars Coalition. We have seen the success of this strategy in other communities and other countries, and we feel this four-pronged approach focusing on **treatment, prevention, enforcement and harm reduction** is the most comprehensive.

The Central Okanagan Four Pillars Coalition, with countless hours of consultation and public input, has developed this Framework for Action. On behalf of Kelowna City Council, I encourage you to read this document, absorb its contents and raise your hands to be part of the solution. We as a community need to join together to gain control of this problem, to help and protect our neighbours, our friends and our family members from the effects of drug abuse.

Let's create a made-in-Kelowna solution. We need to **prevent** the use of drugs through education; **treat** those who are already addicted; **enforce** public order and safety, and encourage **harm reduction** for those unable to stop their drug use.

I sincerely thank the members of the Central Okanagan Four Pillars Coalition for their time, their expertise and their compassion. This document, the *Central Okanagan Framework for Action*, will prove to be an invaluable tool as our community moves forward to deal with the issue of drug abuse.

While there is no "quick fix", I hope this will prove to be a long term strategy to reduce the dire social problem of drug abuse in our community.

Yours truly,



Mayor of Kelowna

The District of Lake Country is located in the Okanagan Valley, between the cities of Kelowna and Vernon, with picturesque treed hillsides overlooking Okanagan, Kalamalka, and Wood Lakes. The District is comprised of the communities of Winfield, Oyama, Carr's Landing and Okanagan Centre, has a population of approximately 10,000 people and contains both urban and rural land use.

We are pleased to say that we have the finest soccer fields in the Okanagan Valley and a very active parks and recreation program that includes parks, beaches, an arena and curling facility, and skateboard park. The Lake Country Community Complex, the Creekside Theatre, and the Lake Country Senior Citizens' Activity Centre are facilities made available for use by the public.

The community-wide increase in problematic drug use threatens the safety and security of our residents, and must be taken extremely seriously. We feel strongly that the enjoyment of all that Lake Country has to offer must be preserved and protected. The District of Lake Country therefore supports the four pillar approach of prevention, treatment, enforcement, and harm reduction outlined in the Framework for Action. We are pleased to have provided financial support, in conjunction with other levels of government, for development of the Framework for Action.

We would like to thank all who contributed to this worthwhile report for their hard work and dedication. There is hope that, with a strong framework for *action*, we can work toward positive solutions to drug problems which we experience both locally and nationally.

Yours truly,



Rolly Hein
Mayor of Lake Country

Executive Summary

The Central Okanagan Framework for Action (COFA) is an urgent appeal to the entire community – residents, businesses, service providers, drug consumers, government agencies, elected officials at all levels of government – to come together and implement a coordinated, comprehensive response to problematic drug use in the Central Okanagan.

In any discussion, terminology is important. In this document, the term “problematic drug use” is used to refer to the entire range of potentially harmful behaviours or use patterns related to drug use (family violence, sexual abuse, drug use during pregnancy, etc.), up to and including actual dependency or addiction. Even non-addicted drug users are considered problematic drug users if their behaviour or use patterns put them, or others, at risk. When the comments made in this Framework refer specifically to addictions or addicted individuals, those terms will be used.

This framework is based on the **Four Pillar** approach to problematic drug use, a model that has been followed to great effect around the world for decades. The approach balances prevention, treatment, enforcement and harm reduction initiatives, within a single coordinated community drug strategy. Briefly, the four pillars are as follows:

Prevention involves educating people (non-users, non-addicted drug users, addicted and problematic drug users, and their friends and family) about the dangers of drug use. It builds awareness about why people misuse drugs and tells what can be done to avoid drug use, addiction or worsened addiction.

Treatment consists of a continuum of interventions and support programs designed to help problematic drug users make healthier life decisions.

Enforcement is primarily concerned with the maintenance and enhancement of public order and safety, and targets the activities of those drug-involved individuals who are a threat to either.

Harm reduction focuses on decreasing the negative consequences of drug use for individuals and communities alike. Not all drug users are ready or able to stop using drugs right now; until they are, it is the goal of harm reduction to make sure that they do as little damage to themselves and others as possible.

The **purpose** of this Framework is to:

- Describe the nature and extent of issues related to problematic drug use in our community;
- Identify initiatives currently in place to address problematic drug use; and,
- Suggest actions that can and should be taken to reduce the impact of problematic drug use on individuals and the community.

Drug use is increasingly common throughout the Central Okanagan, and Statistics Canada research suggests the region could be home to more than 1200 drug-addicted individuals. Contrary to popular belief, the vast majority (up to 80%) of drug-addicted individuals are not homeless; rather, they are distributed throughout all parts of society, regardless of age, gender, ethnicity, income and social standing. The same is true of the thousands of “recreational” drug users who, while not clinically addicted and not included in these estimates, remain at risk of overdose, HIV/AIDS, hepatitis C, injury, death, and other drug-related harms. The actions identified in this Framework must be construed and implemented in such a manner as to make them effective for all drug users, not just those we can readily see.

That being said, drug use is still most obvious and most easily studied at the street level, and much of the data in this Framework comes from this source. In addition, as a consequence of their circumstances, street level and homeless drug users are generally more at risk of drug-related injury or illness, and accordingly have the greatest need for immediate treatment. Increasingly, crack cocaine and crystal methamphetamine are the drugs of choice in the community. A November 2004 survey by Kelowna Area Network of Drug Users showed that

crack was favoured by 29% of active drug users and crystal methamphetamine (CMA) by 26%. The increased prevalence of CMA is of great concern, as its addictive qualities are difficult to overcome; up to 47% of youth who abandon or fail to complete treatment programs are CMA users. Area youth addiction service providers report that many of their clients became drug-involved at a very early age, with 20% misusing substances when they were between 8 and 10 years of age. Tragically, youth often resort to crime to support their drug consumption, with studies showing that up to 17% of street youth trade sex for drugs.

Drugs have a significant economic impact as well. It is estimated that at least 70% of the Central Okanagan's annual policing budget is spent on drug-related crime – about \$8.6 million in 2004. Healthcare costs are enormous as well. It is estimated that up to 85% of all Emergency Room admissions are drug related, and that the annual cost of providing healthcare to untreated injection drug users alone is \$4.5 million. Equally troubling, yet far more difficult to quantify, is the economic cost to the community from flight of legitimate businesses from the area's downtown cores, reduced tourism, and loss of potential investment capital due to the presence of an open drug scene in our urban centres.

More than 90% of those surveyed by the Central Okanagan Four Pillars Coalition see drugs as a growing threat to their community, with many describing the increase in drug activity as either "significant", "major" or "out of control". Hundreds of residents offered suggestions as to how the problem might best be addressed; some of the more common themes included the need for:

- A coordinated, community-wide approach to drug misuse and related issues;
- More effective prevention programs;
- Shorter wait times for entry into treatment programs;
- 24/7 availability of treatment and harm reduction services;
- Stable, long-term funding for anti-drug initiatives;
- More services for youth, women and Aboriginal persons;
- Greater police presence in the downtown cores;
- Enforcement focussing on dealers, rather than users; and,
- More stringent and consistent sentences for drug dealers.

The **four main goals** identified through the community consultation process during the creation of this Framework are:

1. **Greater Coordination and Cooperation:** Define and implement a coordinated response to problematic drug use, and to ensure the continued relevance of that response through ongoing research and consultation.
2. **Improved Public Health:** Address drug-related health and welfare issues through effective prevention, treatment and harm reduction activities.
3. **Enhanced Quality of Life:** Improve the social and economic quality of life for the community, by reducing the negative effects of problematic drug use.
4. **Restored Public Order:** Restore public order, by aggressively targeting drug-related threats to public safety and security in the Central Okanagan.

This Framework includes a series of **28 specific actions** that respond to these goals, namely:

1. Regional Drug Policy Coordinator (p.27)
2. Community Capacity Building (p.28)
3. Expansion of D.A.R.E. (p.30)
4. Enhanced Drug Education (p.30)
5. Harm Reduction Education (p.31)
6. Recreational, Social and Cultural Alternatives (p.32)
7. Making Alternatives to Drug Use Accessible (p.32)
8. Drug-related Information Line (p.33)
9. Addressing Causal Factors (p.33)

10. Urban Renewal (p.34)
11. Coordinated Planning and Implementation (p.35)
12. Improving Treatment Capacity (p.37)
13. Increasing Youth Addiction Services Capacity (p.38)
14. Increasing Adult Addiction Services Capacity (p.38)
15. Adult Residential Treatment Capacity (p.39)
16. Funding Supportive Recovery Housing (p.39)
17. Supporting Methadone Treatment Programs (p.40)
18. Improved Aboriginal Addiction Services (p.40)
19. RCMP Special Projects Team (p.41)
20. Effective Application of Legislation (p.42)
21. Protective Detention (p.43)
22. Professional Courtesy and Interaction (p.44)
23. Short-term Shelter Pilot Project (p.46)
24. Youth Shelter and Drop-In Facility (p.47)
25. Low-Income Housing Projects (p.47)
26. Improved Needle Drop Box Services (p.48)
27. Public Education (p.49)
28. Public Health Outreach (p.50)

For each of these actions, the Four Pillars Steering Committee has identified potential lead and partner agencies. In many cases, the identified agencies operate in related fields and/or offer similar or complementary services; some, particularly government ministries, bear specifically defined legislative responsibility for some or all elements of the action. For the most part, however, these lead and partner agencies were identified because they have expertise and/or resources that can help ensure its successful implementation, and because they are natural stakeholders in the areas affected by the action.

The approach described in the following pages balances the need for restored public order with the need for improved public health. Acting on this Framework will require financial support from all levels of government, the ongoing support and cooperation of key stakeholders, and widespread support from the entire community.

A qualified consultant will provide costs estimates related to the development and implementation of selected actions following completion of a review (currently underway). The final phase of this project involves the negotiation and implementation of a Kelowna Agreement that will detail how funding and operational responsibilities for each of the listed actions will be apportioned among the three levels of government involved.

Background

In May 2003, the AIDS Resource Centre (now the Living Positive Resource Centre [LPRC]) and the Okanagan Aboriginal AIDS Society facilitated screenings of the film **Fix – The Story of an Addicted City** throughout the Okanagan. Fix graphically depicts Vancouver’s Downtown Eastside drug scene and shows that community’s efforts to address the situation. The City of Vancouver had, for many years, dealt with drugs and drug-related issues using an almost entirely enforcement-based approach, a process that one police officer in the film derided as “shovelling water”. The film shows how, in 2002, Vancouver came to realize that a more effective way of reducing the potential harm to all of its citizens was to develop and implement a “Four Pillar” approach to problematic drug use, similar to programs used successfully for decades in Europe and elsewhere.

The film played to large audiences from Salmon Arm to Oliver, and was held over several days to satisfy public demand in Kelowna. Building on the success of these presentations, the LPRC, Okanagan Aboriginal AIDS Society (OAAS), NOW Canada and the Okanagan Boys and Girls Club approached Kelowna Mayor Walter Gray, asking that he assist them in focusing public attention on the issue of drug use in the Central Okanagan.

On November 26th 2003, Mayor Gray and the above agencies hosted a forum on Community Safety and Harm Reduction, with keynote presentations by former Vancouver Mayor Phillip Owen and Sgt. Doug Lang of the Vancouver Police Service. Over 200 concerned residents, representatives of community organizations, service providers, local politicians, police and members of the drug-involved community attended the forum. The forum participants acknowledged the existence of a drug problem in Kelowna, and recognized the need to develop an approach to the problem that would reflect the needs and realities of the community.

To that end a Task Force was struck, meeting for the first time on January 7th, 2004. Using the document **Framework for Action – A Four Pillar Approach to Drug Problems in Vancouver** as a working model, the Task Force established a Steering Committee and four working groups – Prevention, Treatment, Enforcement and Harm Reduction. Since then, these groups have been working steadily to consult with the community and to perform the external research needed to determine how best to realize the community’s primary goals:

1. **Greater Coordination and Cooperation:** Define and implement a coordinated response to problematic drug use, and to ensure the continued relevance of that response through ongoing research and consultation.
2. **Improved Public Health:** Address drug-related health and welfare issues through effective prevention, treatment and harm reduction activities.
3. **Enhanced Quality of Life:** Improve the social and economic quality of life for the community, by reducing the negative effects of problematic drug use.
4. **Restored Public Order:** Restore public order, by aggressively targeting drug-related threats to public safety and security in the Central Okanagan.

What is a Four Pillar Approach?

The Four Pillar approach is essentially one of balance – a balance between liberality and limitation, compassion and constraint, action and reaction. Experience has shown that one-dimensional approaches to complex issues seldom yield positive results; like one-legged tables, they collapse under load. By comparison, a community-based drug strategy that takes into consideration the four pillars of prevention, treatment, enforcement and harm reduction is a four-legged table – balanced, stable, comprehensive, and better able to respond to existing and emerging needs.

Problematic drug use is not limited to any one population group, and an effective drug strategy must recognize and address the varied needs of the entire community – non-users, non-addicted casual users, problematic or addicted users (including those not yet ready or able to seek treatment), their family and friends, and those drug-involved individuals who constitute a real or potential threat to public safety. The Four Pillars approach holds that the most effective means of doing so is through a balance of prevention, treatment, enforcement and harm reduction initiatives contained within a coordinated strategy. To succeed, such a strategy requires the support and participation of service providers, members of the public and all levels of government, and must reflect the community's specific needs.

We cannot ignore this issue [drug abuse]. We cannot incarcerate our way out of it and we cannot liberalize our way out of it. Rather, all levels of government must play their part in managing it. What we need is a balance of public health and public order.
(Former Vancouver Mayor Phillip Owen)

It is not always easy to determine which activities fall under which Pillar; depending on the needs and circumstances of the individual using the service, one person's harm reduction might be another's treatment. In general terms, though, the Pillars can be described as follows:

Prevention

Prevention involves educating people (non-users, non-addicted users, problematic and addicted users, and their friends and family) about the dangers of drug use, builds awareness about why people misuse drugs and tells what can be done to avoid drug use, addiction or worsened addiction. There are three main types of prevention:

1. Primary Prevention, which attempts to prevent substance use altogether or delay the onset of substance use;
2. Secondary Prevention, aimed at individuals in the early stages of substance use, before serious problems have developed; and,
3. Tertiary Prevention Interventions, which focus on preventing serious harm to individuals who have become addicted to drugs.

Prevention programs can take many forms, and are not limited to direct anti-drug education programs. Rather, they can and frequently do address the causal factors underlying drug and alcohol use – poverty, unemployment, homelessness and substandard housing, sexual exploitation of youth, mental health issues, flight of legitimate businesses from the downtown core, lack of economic opportunity for marginalized individuals, and NIMBYism¹, to name a few.

¹ NIMBY is an acronym for "Not In My Back Yard", a phenomenon where residents of an area resist or reject the establishment or continued existence of services or facilities they fear might have a negative impact on their property values or quality of life. NIMBYism is frequently a knee-jerk response based on faulty or incomplete knowledge and ingrained prejudices.

Treatment

Treatment consists of a continuum of interventions and support programs designed to help addicted individuals make healthier life decisions. While total abstinence from all illicit drugs is a desired outcome, it is not an integral component of all treatment programs – for example, some programs might accept a client who is trying to kick heroin, but who continues to use marijuana.

Treatment strategies are numerous and varied. Some examples are detoxification programs, outpatient treatment and counselling, residential treatment, and life skills training.

Enforcement

Enforcement is primarily concerned with the maintenance and enhancement of public order and safety. Examples of enforcement agencies include police, municipal bylaw enforcement bodies, the courts, corrections and probation services. Enforcement has long been society's default response to issues related to problematic drug use, and is a crucial element in any balanced and comprehensive community drug strategy; the success of Four Pillar initiatives worldwide shows, however, it should not be its only response. For the public to have confidence in a community drug strategy, it is essential that the crime and the general breakdown in public order that is a consequence of an active drug scene be addressed. This requires the co-operation of the police, courts, all levels of government, service providers, area merchants and the public at large in order to take place.

Effective enforcement strategies can include a wide range of initiatives, such as:

- Redeployment of committed manpower and additional resources;
- Efforts to target organized crime, drug houses and drug dealers;
- Changes or alternatives to existing sentencing guidelines;
- Improved court system support for enforcement activities;
- Amended Federal, Provincial or Municipal legislation;
- Improved co-ordination between enforcement agencies and service providers;
- Directing active users to available treatment programs; and,
- Increased public awareness and participation.

Harm Reduction

Harm reduction is a pragmatic approach that focuses on decreasing the negative consequences of drug use for individuals and communities alike. It recognizes that, while abstinence may be the best possible outcome of any treatment program, the presence of a street-entrenched open drug scene may make it an unrealistic goal for many drug users, particularly in the short term.

Harm reduction strategies lessen the impact of ongoing drug use through a hierarchy of achievable goals that protect both the interests of the community as a whole and those of active drug users. Some examples of successful harm reduction strategies are drop-in centres, public health outreach, emergency shelters, soup kitchens, food banks, supportive housing, employment services, needle exchanges, overdose prevention campaigns, needle drop boxes, prescription narcotics, and supervised drug consumption facilities.

Separate Responsibilities, Shared Accountability

In Canada, no one level of government bears sole, or even primary, responsibility for reducing the effects of problematic drug use. Jurisdiction is broadly distributed on an issue-by-issue basis, with the three levels of government often effectively sharing responsibility. The goals and actions that follow need the active co-operation of all levels of government if they are to succeed.

Federal Government

The federal government operates in numerous areas relevant to problematic drug use, including the criminal justice system, health promotion and research, employment and training, control of international and inter-provincial trade and transport, and immigration. Some areas of activity (and their related agencies) are:

Prevention

- Health promotion (*Health Canada*)
- Drug use research and education (*Canadian Centre on Substance Abuse*)
- Alleviation of homelessness (*National Homelessness Initiative*)
- Urban renewal and economic development (*Infrastructure Canada*)

Treatment

- Drug treatment research, clinical trials and evaluation (*Health Canada, Canadian Institute for Health Research, Canada's Drug Strategy*)
- Treatment facilities for Aboriginal people (*Health Canada, National Native Alcohol and Drug Abuse Program*)
- Employment and training (*Human Resources Skills Development Canada, Youth Employment Strategy*)
- Housing and shelter with services for drug users (*Human Resources Skills Development Canada, Supporting Community Partnership Initiative*)

Enforcement

- Domestic and international drug enforcement (*Royal Canadian Mounted Police, Canada's Drug Strategy*)
- Interdiction of cross-border drug traffic (*Canadian Border Service Agency*)
- Drug Treatment Courts, Community Courts, diversion programs (*Department of Justice Canada*)
- Offender rehabilitation (*Correctional Services Canada*)

Harm Reduction

- Development of innovative pilot projects (*Health Canada*)
- Pilot low-threshold support programs (*Health Canada*)

Numerous other Federal agencies could also make positive contributions. For example, Canada Mortgage and Housing Corporation has expertise in the development of low-income Single Room Occupancy (SRO) housing units, while the Social Sciences and Humanities Research Council of Canada supports the sort of innovative academic and community-based research into addictions and related social issues, that can track the effectiveness of our actions, and ensure future initiatives are based on solid, current data.

Provincial Government

The Province provides and regulates the provision of health services, education, law enforcement services, intra-provincial trade and transport, housing and social services to British Columbians. The participation of the Province of British Columbia and its various agencies is essential to the funding and implementation of the goals and actions contained in this report.

Prevention

- Education (*Ministry of Education, Interior Health*)
- Affordable housing (*BC Housing*)

Treatment

- Drug treatment (*Ministry of Health Services, Ministry of Children and Family Development, Interior Health*)
- Drug treatment research, clinical trials and evaluation (*Ministry of Health Services*)
- Employment and training (*Ministry of Human Resources*)
- Aboriginal, women's and seniors' services (*Ministry of Community, Aboriginal and Women's Services*)
- Income supports (*Ministry of Human Resources*)
- Local and regional government (*Ministry of Community, Aboriginal and Women's Services*)
- Drug-free housing (*Ministry of Health Services, BC Housing*)

Enforcement

- Alternative measures programs, diversion programs and restorative justice programs (*Ministry of Public Safety and Solicitor General, Ministry for Children and Family Development – Youth Justice*)
- Policing (*Ministry of Public Safety and Solicitor General*)
- Courts (*Ministry of Attorney General, Ministry for Children and Family Development – Youth Justice*)

Harm Reduction

- Substance misuse referral (*Ministry of Health Services, Ministry for Children and Family Development, Interior Health*)
- Needle exchange (*Ministry of Health Services, Interior Health*)
- Shelter options for drug users (*BC Housing*)

Municipal Governments

Relative to the two senior levels of government, municipalities have limited resources and few legislative tools with which to address the effects of problematic drug use; ironically, it is these same municipalities that suffer most directly from these effects. Municipalities in the Central Okanagan provide a range of services and amenities that contribute to community and individual well-being, and which are important elements in a Four Pillars strategy, including:

Prevention

- Parks and recreational facilities
- Grants-in-Aid
- Community information and forums

Treatment

- Grants-in-Aid
- Support for local service providers

Enforcement

- Bylaw enforcement
- RCMP funding

Harm Reduction

- Needle collection
- Community education and forums
- Community liaison
- Support for service providers

Non-Governmental Stakeholders

While the primary responsibility for providing leadership and acting on the goals and actions listed in this report clearly rests with the three levels of government, non-governmental stakeholders also have key roles to play. Service providers, the business community and private individuals all have a vested interest in reducing the negative effects of problematic drug use, and must be involved in the process if this issue is to be addressed successfully. Above all, non-governmental stakeholders have an obligation to ensure, to the best of their abilities, that the actions taken by governments and governmental agencies reflect the needs and the will of the community, and are carried out in an effective and timely manner. In short, they must put pressure on all three levels of government to ensure that this Framework is acted upon.

Service Providers

Service providers are at the “sharp end of the stick” when it comes to addressing problematic drug use and are critical to the success of any community drug strategy. Service providers of all stripes have an obligation to both their clients and the community at large to:

- Operate in a professional and ethical manner;
- Be consistent in the delivery of their services;
- Have a commitment to observing “Best Practices”
- Maintain collegial communications with other Service Providers; and
- Be open and forthcoming with the public on all matters relating to drug-related problems in the community

Business, Drug Users, Mental Health Consumers and the Public

Perhaps the most important, yet least well-defined area of responsibility is that owned by the business community, active drug users, mental health services consumers and members of the public at large. In order for a community drug strategy to be effective, it must engage the public and respond to its needs. However, for public input to be meaningful, it must also be informed. As such, every member of the public has an obligation to:

- Educate themselves as to the issues surrounding problematic drug use in the Central Okanagan;
- Share their information, opinions and ideas with each other, elected officials, and/or service providers; and,
- Be aware of, and provide ongoing comment on, the formulation and implementation of the community drug strategy.

Global, National and Regional Context

Most illegal drug users in Canada will never be regular users. It bears repeating that drug use is still, for the most part, a sporadic, recreational, exploratory activity. Most people are able to manage their drug use without any difficulty. Very few will become regular users, and even fewer will develop a drug addiction.

Illegal Drug Use in Canada & Crime
Senate Special Committee on Illegal Drugs, 3 October 2001

Drugs, whether we choose to admit it or not, are a part of our society. Over-the-counter patent medicines, prescription drugs, and legal psychoactives such as alcohol and tobacco are used by millions of Canadians daily. Generations of us have grown up in an environment where taking a pain reliever, tranquilizer or mood-altering substance is an accepted way of dealing with the stresses and demands of modern life. We are a society of substance users – and, in some cases, substance abusers as well.

The drug trade is a truly global industry. It respects no borders, no physical boundaries, and subjects itself to no external control or oversight. It takes full and immediate advantage of such developments as advances in secure communications technology, increases in cross-border transportation, new and sophisticated marketing opportunities and the ease with which funds can be transferred electronically. It does everything possible to increase drug consumption – and it is very good at it.

A case in point is the rising popularity of crystal methamphetamine and other amphetamine-type substances (ATS). The United Nations estimates the total number of ATS abusers worldwide at 34 million and rising – more than the total number of heroin abusers and cocaine abusers combined². In part, this is because coca plantations and opium poppy fields can be spotted by satellite and targeted by international enforcement efforts; the precursors for synthetic drugs are common chemicals that are legally produced and sold around the globe in huge quantities, and “recipes” are readily available on the Internet. As a result, organized crime is increasingly focussed on producing and distributing synthetic drugs rather than heroin and cocaine.

This is not to say they have abandoned these substances, however. Drug enforcement officials in Colombia recently reported discovering that a new strain of coca plant was under cultivation by the South American drug cartel. The plant, which can yield up to four times more high-grade cocaine than traditional coca plants, is the result of a crossbreeding and genetic engineering initiative estimated to have cost the cartel at least US\$60 million³.

Since 1989, Health Canada has funded three major national surveys on substance use – the National Alcohol and Other Drugs Survey (NADS, 1989), the Canadian Alcohol and Other Drugs Survey (CADS, 1994) and the Canadian Addiction Survey (CAS, 2004). Comparing these surveys shows that drug use in Canada has risen sharply; over the past 10 years, cocaine use has more than doubled, while the use of amphetamines, LSD and Heroin has nearly tripled.

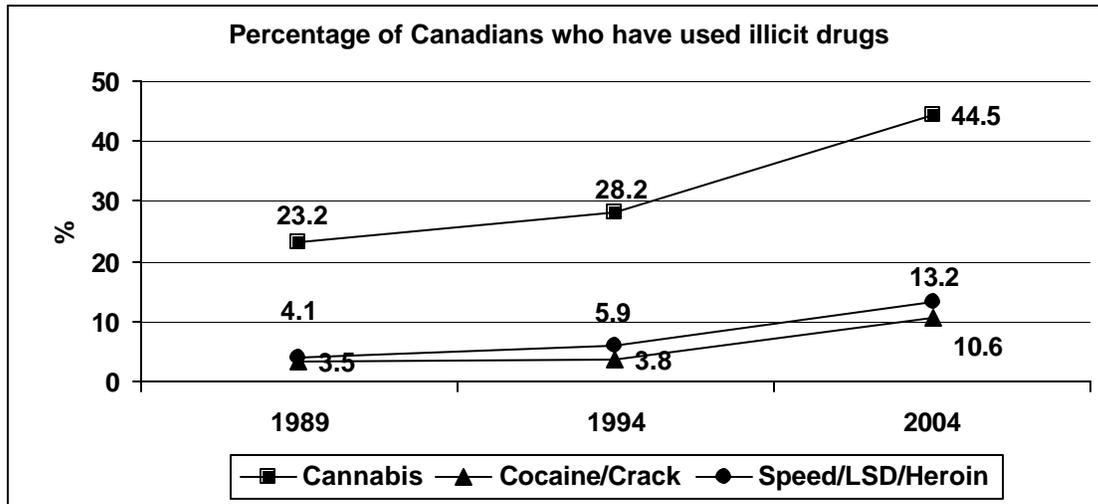
The problem is most acute in British Columbians, where more people use more drugs more often than anywhere else in Canada. BC reported the country’s highest lifetime rate of use for cannabis, cocaine, crack, Ecstasy and hallucinogens, and was second only to Quebec in methamphetamine use⁴. Overall, nearly 53% of BC residents surveyed reported having used some sort of illicit drug at some point in their lives, by far the highest rate in Canada.

²Howard LaFranci, “Global Scourge: Synthetic Drugs” Christian Science Monitor August 7, 2003

³Jeremy McDermott “New Strain of Coca Plant Stuns Anti-Drug Officials” The Scotsman, August 7 2004

⁴Canadian Centre on Substance Abuse “Canadian Addiction Survey” November 2004

Figure 1: Percentage of Canadians who have used illicit drugs

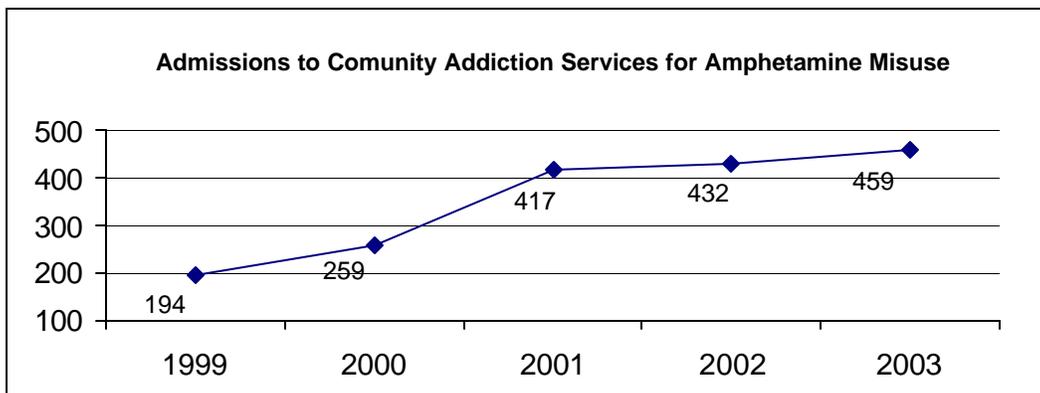


Source: Canadian Centre on Substance Abuse Canadian Addiction Survey, November 2004

Provincial drug crime and health statistics reflect this trend. From 2001 to 2002, cocaine-related drug crime in BC increased by 4% while heroin offences decreased by 23%; over the same period, however, offences related to opiate derivatives and ATS increased by 37%⁵. CMA is the drug of choice for 26% of Central Okanagan drug users, and admissions for amphetamine addictions have more than doubled in the Interior Health service area since 1999.

These statistics likely understate the pervasiveness of amphetamine use. Identifying a drug of choice does not imply exclusive use, and poly-drug use (the use of two or more drugs, interchangeably or in combination) is increasingly common, particularly among younger drug users. Moreover, analysis of seized drugs indicates that the majority of club drugs are “laced” with CMA, and that many of those who use Ecstasy or other substances are using amphetamines without being aware of it⁶.

Figure 2: Admissions to community addiction services for amphetamine misuse



Source: Government of BC, Crystal Meth and other Amphetamines: An Integrated BC Strategy

⁵ Ministry of Public Safety and Solicitor General “Drug Crime in BC – Summary Statistics 1993-2002”

⁶ Ken Tupper, BC Ministry of Health, comment at Interior Health forum on Crystal Methamphetamine use, September 2004

Drug use – Who, What and Why

The drug problem in the Central Okanagan is fuelled by its proximity to Vancouver. A major seaport and air transportation hub with hundreds of thousands of international arrivals and departures annually, Vancouver is “one of North America’s main points of entry for drugs⁷”. Located only 400 kilometres inland of Vancouver, and linked by regular air, rail and bus service and major highways, the Central Okanagan is easily supplied with drugs from around the world. In addition, the region’s proximity to the United States border and its location on the main route to Calgary, Edmonton, and points east makes it a key location for the transshipment of drugs between the Lower Mainland and other areas, and a convenient operating base for those involved in the manufacture, importation and distribution of those drugs.

Vancouver, it is estimated, is home to anywhere from 5,000⁸ to 10,000⁹ drug-addicted individuals; the numbers are lower in the Central Okanagan, but still significant. A recent Statistics Canada survey found that nearly 1% of Canadians aged 15 and older are dependent on illicit drugs¹⁰, suggesting the existence of more than 1200 addicted individuals in the Central Okanagan. While the survey notes that people who are single, separated or divorced, have low education and/or live in low-income households are at higher risk of becoming drug dependent, research clearly shows that drug use is common in all parts of society, regardless of age, gender, ethnicity, income and social standing.

While drug use is clearly a serious issue among homeless individuals, street-dwelling drug users represent only a fraction of the total drug-using population. Recent surveys estimate Kelowna’s homeless population at 420 people¹¹, up to 60% of whom (or about 250 people) were estimated to have substance abuse issues¹²; in other words, the street drug scene represents only about 20% of the community’s drug-addicted population. The remaining 80% of the estimated 1200 addicted persons in the Central Okanagan have homes of some description, and are far less visible as a result – less visible, but in no less need of attention and assistance.

Moreover, not all users are actually drug dependent; many more use drugs occasionally, recreationally, or in a manner that avoids actual addiction. Non-addicted drug users are as much (in some cases, more) at risk of overdose, inadvertent poisoning, HIV/AIDS, accidental injury or death, and other drug-related ailments as are addicted users, and their needs must also be addressed by a community drug strategy.

Why People Use Drugs

The reasons for illicit drug use are many and varied and can include poverty; substandard housing; homelessness; unemployment; physical injury; mental or emotional illness; familial breakdown; and personal tragedy. Confronted with one or more of these factors, some people turn to drugs as a form of refuge, where the user sees “the harm that they inflict upon themselves as the lesser of two – or perhaps several – evils¹³.” Some use drugs for pleasure, some to relieve physical or emotional pain, others still because they believe drugs enable them to function at a higher intellectual or physical level.

⁷Donald MacPherson “A Framework for Action – A Four-Pillar Approach to Drug Problems in Vancouver” City of Vancouver, 2001

⁸ Alan Podadowski, Vancouver Sun Monday March 15 2004

⁹Patrick Basham “Re-evaluating the War on Drugs”, Fraser Institute, 2001

¹⁰ Statistics Canada “Canadian Community Health Survey: Mental Health and Well-Being”, 2002.

¹¹ Kelowna Homelessness Networking Group “Census of Homeless Individuals” November 2004 (preliminary data)

¹² Kelowna Homelessness Networking Group, “Census of Homeless Individuals” Spring 2003, Fall 2003

¹³ Donald MacPherson “A Framework for Action – A Four-Pillar Approach to Drug Problems in Vancouver” City of Vancouver, 2001

Typically, these individuals find themselves marginalized, estranged from family and friends and isolated from the very health and support services they need in order to recover. A 2002 Statistics Canada survey found that more than 20% of substance abusers reported being unable to get help for their addiction in the previous 12 months, despite being aware they needed assistance¹⁴.

Although the Central Okanagan is a fairly prosperous region relative to the rest of the province¹⁵, not all residents share equally in its bounty. More than one-third of all area income tax returns filed in 2000 reported incomes of less than \$15,000. Nearly 5,900 Kelowna families, more than 17,000 individuals, subsist on inadequate incomes, and are substantially worse-off economically than their neighbours¹⁶. Of particular concern are low-income levels among the area's youth. 15-24 year-olds account for over 70% of the 4,980 individuals who reported having no income in 2001, and have median individual incomes that are less than one-third those of the region.

The region's tight housing market compounds the effects of low income. Throughout the area, vacancy rates are low and rents are rising, in part because construction of rental units has not kept pace with population growth. Between 1998 and 2002, the region's population increased by nearly 8%, while the number of rental units went up only 3%. Over the same period, the rental vacancy rate plummeted from 4.4% to 1.8%, while average rents increased by as much as 13%¹⁷.

Based on the region's median income and CMHC affordability benchmarks, a single individual in the Central Okanagan can afford gross rental costs of \$530 including utilities; in Kelowna, an average one-bedroom apartment rents for \$559 without utilities. There are, on average, fewer than 30 such units available in a given month, many of which have restrictions (e.g. no pets, no children, 55+, etc.) that make them unattainable for many individuals and forcing them to "take what they can get", even if it happens to be substandard or is in an unsafe area.

Housing statistics available from the City of Kelowna¹⁸ use Statistics Canada and Census information on household types, household income levels and low-income cut-offs to estimate the demand for low-income housing in Kelowna, then compare that to the available supply of publicly-funded low-income housing units. The results of the 1999/2000 study, shown in the table below, identify the need to establish 5,592 low-income housing units; given Kelowna's growth since 2000, the current low-income housing deficit is almost certainly much higher.

Figure 3: Low-Income Housing Deficit - Kelowna, 1999/2000

Low-income Population	Families	Existing Units	Units Needed
Female-led One-Parent Families	1976	620 units total for these 4 categories	3660 total family-oriented units
Male-led one-parent families	152		
Married, no kids	991		
Married, with kids	1161		
Elderly, living alone	2170	1204 (incl. multi-person units)	364
Non-elderly, living alone	1790	222	1568

¹⁴ Statistics Canada "Canadian Community Health Survey: Mental Health and Well-Being", 2002

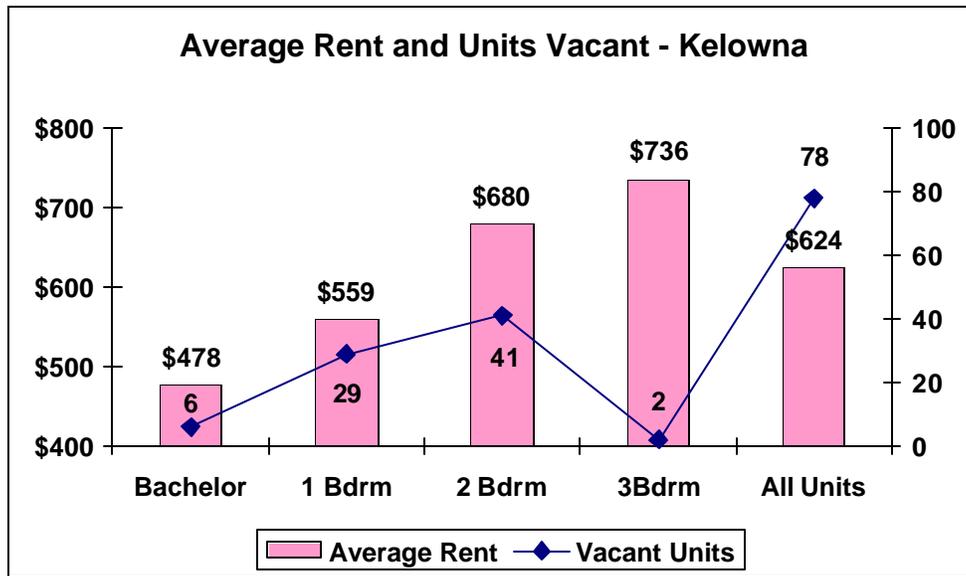
¹⁵ The region's annual per capita income is nearly \$1,000 above the provincial average. Kelowna's median individual income of \$21,191 is slightly below the provincial median, while its median family income of \$55,021 is slightly higher. (Source: BC Stats)

¹⁶ Based on StatsCan Low Income Cut-Off (LICO) statistics and City of Kelowna data. LICOs are not a true indicator of poverty, but do identify those who have inadequate incomes, and are facing economic hardship.

¹⁷ Based on CMHC data reported in City of Kelowna reports - Housing Resources Handbook 2002 and 1999-2000 Housing Study. CMHC data include only building with 3 or more rental units

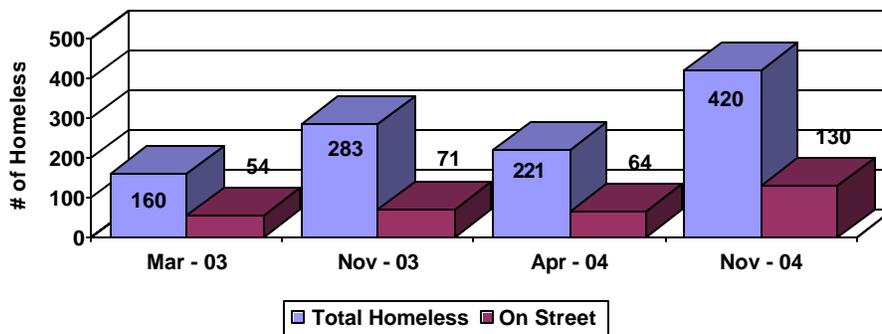
¹⁸ City of Kelowna Housing Needs Study 1999/2000

Figure 4: Average rents and units vacant by type - Kelowna



The relative lack of affordable rental accommodations is not the leading cause of homelessness, but it is a factor in what is acknowledged to be a growing problem. Recent censuses of homeless individuals in Kelowna hint at the extent of the problem throughout the region. In March 2003, 160 homeless individuals were enumerated, 54 of whom were dwelling on the streets; by November 2004, the total number of homeless in Kelowna had risen to 420, including 130 individuals living on the streets.

Figure 5: Number of Homeless in Kelowna - on street and in total



Earlier censuses have shown that youth are particularly at risk, accounting for nearly 16% of Kelowna's homeless population – over twice their representation in the general population. The vast majority of homeless teens were identified as having substance abuse problems. Three-quarters of the teens enumerated were female, and most of them identified the drug and/or sex trades as their primary source(s) of income¹⁹.

Youth and Drugs

In addition to income and housing factors, the low cost and easy availability of many drugs have also contributed to drug use among the region's youth. Statistics Canada estimates that 2.5% of those aged 15-24 are dependent on illicit drugs, nearly five times the rate of addiction for those aged 35 and older²⁰. Particularly at risk are relatively or absolutely homeless youth, who typically

¹⁹ Kelowna Homeless Networking Group "Census of Homeless Individuals in Kelowna" March 2003

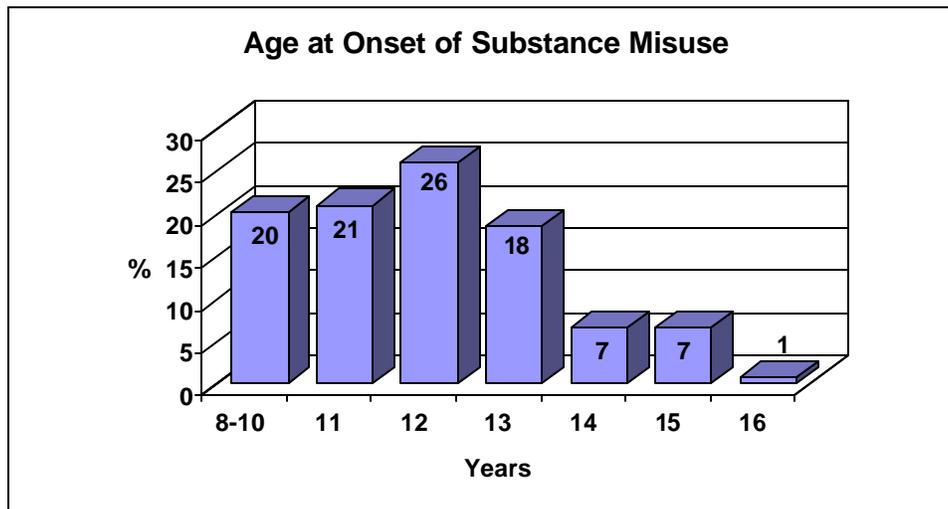
²⁰ Statistics Canada "Canadian Community Health Survey: Mental Health and Well-Being", 2002.

become drug-involved within six weeks of their arrival “as a means of survival²¹” – crystal methamphetamine (CMA) for example, can keep a street-involved user awake for days on end, reducing their risk of being attacked in their sleep.

So-called “club drugs”, such as ecstasy and CMA, are cheap, plentiful and very popular – it can cost as little as \$5/day to maintain a CMA habit²². CMA produces a high similar to that of cocaine, and can leave users feeling alert, euphoric and boundlessly energetic for up to 16 hours. The drug is highly addictive, with cumulative physical effects that are not naturally repaired once use ends²³. Appropriately enough, the street term for creating new CMA addicts is “making monsters”.

A 2002 survey of drug use among Lower Mainland youth found that 19% had used CMA at some point in their life, and that 7-8% had used it within the past 30 days. A recent survey of active drug users, conducted by Kelowna & Area Network of Drug Users (KANDU), showed CMA as the drug of choice for 26% of those interviewed, making it more popular than marijuana (23%) and alcohol (17%), and ranking second only to crack cocaine (29%)²⁴. The increased prevalence of CMA is of great concern, as its addictive qualities are difficult to overcome; up to 47% of youth who abandon or fail to complete treatment programs are CMA users. Area youth addiction service providers report that many of their clients became drug-involved at a very early age, with 20% misusing substances when they were between 8 and 10 years of age.

Figure 6: Age at onset of substance misuse



Source: ARC Programs, *Changes Program Performance Outcome Evaluation Report*

Addicted youths will frequently resort to crime and/or prostitution to support their addiction, with provincial studies estimating that up to 17% of street youth have traded sex for drugs. This portion of the population is most often female, aged 12 years and older, includes a disproportionately large number of Aboriginal youth, and is most likely to come from low-income, poorly functioning families²⁵. While the majority of street youth are not involved in prostitution, those who do are far more likely to become substance abusers – a study of female youths in Vancouver’s sex trade found that only about half identified “money for drugs” as reason for *becoming* involved in

²¹ Out from the Shadows, “Final Report Out from the Shadows International Summit of Sexually Exploited Youth”, May 1998

²² CCENDU “Methamphetamine Environmental Scan Summit – Final Report”, January 2003

²³ CCENDU “Methamphetamine Environmental Scan Summit – Final Report”, January 2003

²⁴ Kelowna Area Network of Drug Users “Survey of Active Drug Users” November 2004

²⁵ Assistant Deputy Ministers’ Committee on Prostitution and the Sexual Exploitation of Youth “Sexual Exploitation of Youth in British Columbia” Victoria: Ministries of the Attorney General, Health, Children and Families and Ministry Responsible for Seniors, 2000

prostitution, but all participants cited it as a reason to *remain* involved²⁶. As one report notes, drugs are “pervasive in the lives of many sexually-exploited children and youth”²⁷.

²⁶ S. Scott “Attractions and Aversions: Exploring Attitudes and Perceptions of Sexually Procured Youth in the Downtown Eastside”, Master’s Thesis, School of Social Work, University of British Columbia, 1998

²⁷ Out from the Shadows, “Final Report Out from the Shadows International Summit of Sexually Exploited Youth” May 1998

The Social Costs of Drugs

Just how much drugs and problematic drug use cost Canadian society is hard to quantify; it is possible to identify specific drug-related expenditures, but these amounts are only the tip of the cost iceberg. The federal government alone spends some \$500 million dollars annually on programs directly targeting illicit-drug use²⁸, but this does not reflect all drug-related costs. In enforcement, for example, drug possession is considered a drug-related crime – crimes (theft, prostitution, fraud, etc.) committed to support a drug habit are not. Similarly, hospital admissions for drug overdoses are considered drug-related healthcare expenditures, whereas admissions for injuries or illness arising from drug misuse generally are not. Nonetheless, it is possible to extrapolate some of the costs associated with problematic drug use in the Central Okanagan.

Enforcement Costs

British Columbia suffers the highest rate of drug-related crime in Canada, 544 offences per 100,000 population, significantly higher than the national rate of 295. Moreover, BC rates have been above national rates for each of the past 25 years. Uniform Crime Reporting Survey data indicates that 10% of all homicides are drug-related (26% of these involving gang activity), a national total of 684 from 1992-2002. 29% of these homicides occurred in BC, the highest rate in Canada; in addition, 58% of all heroin-related and 33% of all cocaine-related Canadian homicides occur in BC²⁹. As a result, over \$79 million is spent annually in British Columbia by all levels of government to address drug-related crime³⁰.

Many “non-drug” offences (property crime, assaults, sexual assaults, etc.) are also attributable to drug use. A 1994 report by BC’s Chief Coroner estimated that 60% of all crimes committed in the province were motivated by, but not directly linked to drugs³¹; Kelowna RCMP Superintendent Bill McKinnon recently estimated that percentage to be nearer to 70%³². Based on the lower of these estimates, the cost to police drug-related crime in the Central Okanagan is approximately \$8.6 million annually. This does not include the cost of related enforcement services (courts, corrections, Bylaw Enforcement, etc.), which make the total cost far higher.

Figure 7: Substance use history of inmates

Substance use by inmates in the 6 months prior to their arrest (*not mutually exclusive)		
Substance	Daily	Weekly
Alcohol	13.3%	44.4%
Drugs and Alcohol	5.7%	18.1%
All Drugs	19.1%	33.7%
Cannabis*	10.8%	24.5%
Cocaine*	9.0%	17.9%
Heroin*	2.7%	4.2%
Tranquilizers*	2.1%	6.4%

Source: *Forum on Corrections, January 2001*

Reducing drug-related crime would not, of course, reduce policing costs by \$8.6 million. The Central Okanagan is a large area with a rapidly growing population, and a reduction in police strength is simply not possible; in fact, the region would need to add nearly a dozen police officers just to meet the average ratio of police to population in the rest of the province. Reducing drug-related crime would, however, give the police and municipalities more latitude in determining

²⁸ Government of Canada Auditor General, “Report on Canada’s National Drug Strategy”, 2000

²⁹ Government of Canada, “Uniform Crime Reporting Survey 2 (UCR2)”, 2002

³⁰ Patrick Basham, “Revaluating the War on Drugs” Fraser Institute, 2001

³¹ JV Cain, “Report of the Task Force into Illicit Narcotic Overdose Deaths in British Columbia”, Ministry of the Attorney General 1994

³² Supt. Bill McKinnon, quote in R. Zacharias, “Opinions and Needles” Okanagan Life, September 2004

how best to utilize policing resources. Currently, many decisions about setting enforcement priorities are dictated by the need to respond to a large and active drug scene.

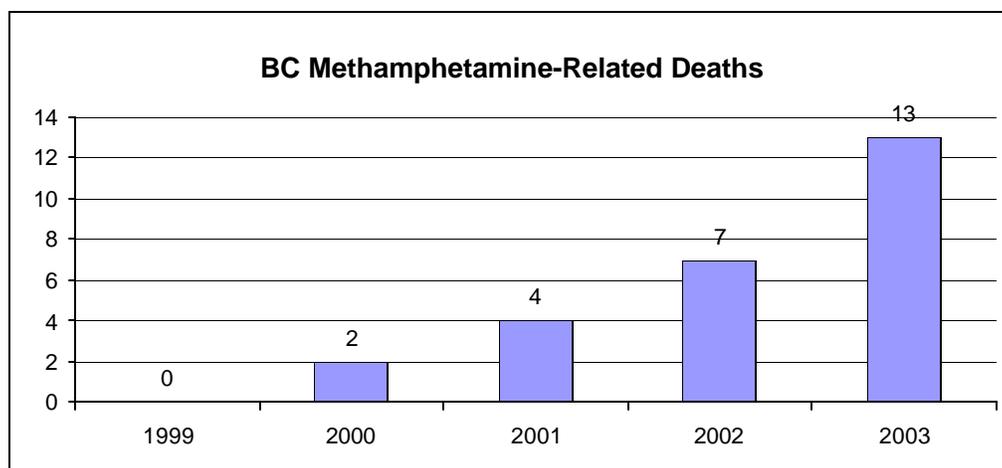
Healthcare Costs

Drug users, particularly injection drug users, are a huge burden on the healthcare system, and direct treatment costs represent only a portion of drug-related healthcare costs. For example, Interior Health (IH) estimates that 8% of all mental health admissions in the region (199 in 2001) stem from drug and/or alcohol dependency³³. Injuries sustained while under the influence of drugs or caused by another's use of drugs (e.g. an impaired driver), and illness contributed to by drug use are a major source of Emergency Room admissions. Statistics are not currently available from IH, but the Fraser Valley Health estimates that 85% of all Emergency Room admissions in that region are related to drug and/or alcohol use³⁴.

It has been estimated³⁵ that each untreated injection drug user costs the healthcare system \$7,432. If only half of the estimated 1200 drug-dependent individuals in the Central Okanagan are assumed to be injection drug users³⁶, the annual cost of providing healthcare services to these individuals would be nearly \$4.5 million. This estimate does not consider the cost to the system of treating non-addicted users, as there is no estimate of their numbers.

The BC Coroner Service reports that the number of deaths due to overdoses of illicit drugs has consistently declined over the past six years, from 417 deaths in 1998 to 173 in 2003, a drop of over 60%. The first six months of 2004 brought 49 illicit drug overdose deaths, suggesting that this downward trend will continue. The one exception to this trend has been methamphetamine-related deaths, which have nearly doubled in each year since 2000 (see chart, below). This might understate the actual extent of the problem – 68% of methamphetamine-related deaths from 2000-2004 were initially misclassified as accidental deaths³⁷.

Figure 8: BC methamphetamine-related deaths



Source: Government of BC, *Crystal Meth and other Amphetamines: An Integrated BC Strategy*

³³ Interior Health "Interior Health Population Health Profile", December 2002

³⁴ Ronwyn Grace, Executive Director, Crossroads Treatment Centre, in conversation with author.

³⁵ Donald MacPherson, "A Framework for Action" City of Vancouver, 2001. The 1992 Miller report, which forms part of the basis for the Vancouver Framework's cost estimates, estimates the total annual cost to government per untreated IDU at \$33,761, 18% of which (\$6,077) is healthcare related. I have adjusted this amount to reflect inflation, based on the Consumer Price Index for Canada 1992-2003.

³⁶ KANDU survey of active drug users, September 2004

³⁷ BC Coroners Service "Methamphetamine Deaths in BC", July, 2004

When overall drug-related deaths are considered, rather than just overdoses, the picture is somewhat bleaker. In the IH service region, age-standardized mortality rates have remained flat or declined since 1986 for all causes except alcohol- and drug-related deaths; in both of these categories, the rates have consistently increased³⁸. In 1995-96 alone, premature deaths related to drug use accounted for 4,033 potential years of life lost (PYLL) in the IH service region – and with them, 4,033 years of contributions, economic and social, to the community as a whole.

³⁸ IH “Interior Health Population Health Profile”, December 2003

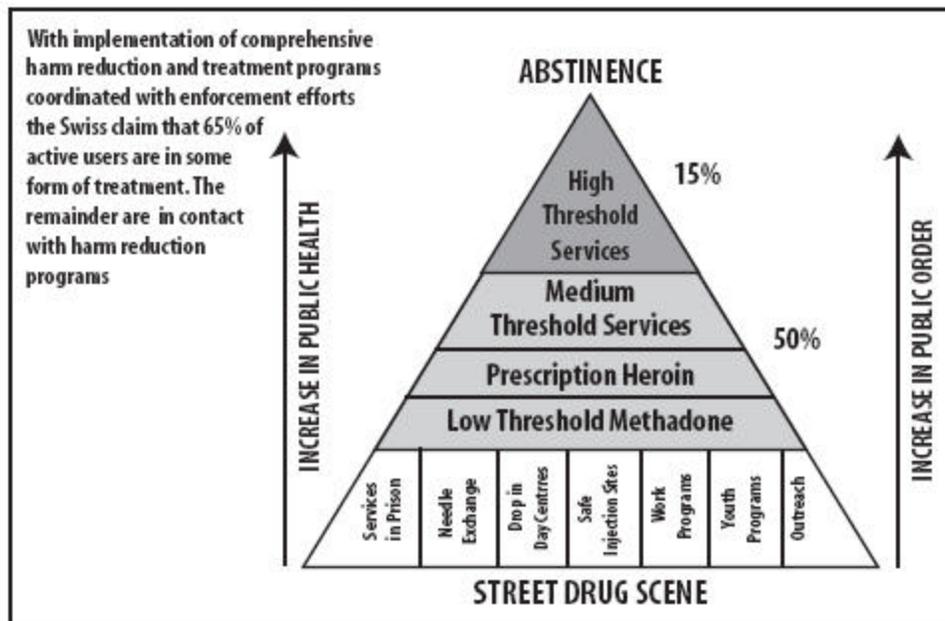
The Four Pillars Experience Elsewhere

The Four Pillars concept is not a new one – it has been around and in use in one form or another for decades in Europe, the United Kingdom, Australia and parts of the United States. In each case, the concept has been adapted to reflect the realities and goals of the specific area, with the result that no two Four Pillar approaches are the same. Despite differences in design and execution, however, there is one thing these initiatives have in common – they all work.

Europe

In the late 1980s, Switzerland experienced a dramatic increase in public drug consumption, resulting in the emergence of a large open drug scene in many cities. The Swiss re-examined their national drug strategy, and found that the medium-to-high threshold treatment model they adopted to that point was only allowing them to reach about 20% of active drug users. Over the following 15 years the Swiss developed and implemented a Four Pillar approach that balanced public health and public order imperatives, with the results that 50% of its estimated 30,000 drug users are in Methadone treatment programs, a further 15% are in abstinence-based programs, and drug-related criminal offences have been reduced by 60%³⁹.

Figure 9: Impact of harm reduction programs on street drug scene



Source: City of Vancouver, *A Framework for Action*, 2001

Around the same time, the German city of Frankfurt owned one of the worst drug scenes in Europe, with thousands of active users openly injecting drugs in public parks and alleys, a 25% rate of HIV infection among injection drug users, and large numbers of overdose deaths. In 1989, the city hired a Drug Policy Coordinator and adopted a Swiss-style drug strategy. The strategy combines treatment initiatives with a policing strategy that aggressively targets public drug consumption, and diverts users to crisis centres to access harm reduction and treatment programs. Since adopting the “help and suppression” strategy, the number of active addicts has dropped by 70%, the number of drug dealers by 72%, and property crimes by 36%⁴⁰.

³⁹ Donald MacPherson, “Framework for Action”, 2001

⁴⁰ Donald MacPherson, “Framework for Action”, 2001

The United States

While several US centres have implemented Four Pillar-type initiatives, perhaps the most successful of these lies just across the border, in Oregon. Faced with a dramatic increase in drug activity in the mid-1970s, particularly crack cocaine use among younger downtown residents, the City of Portland, local businesses and service providers combined to create the Burnside Consortium (now know as Central City Concern, or CCC) to create a setting where treatment providers from publicly funded agencies could discuss individual client's progress, coordinate services and improve the system as whole.

Over the following years, the group expanded into a range of health and recovery services, housing and residential services and employment services that reflected the needs of the community and the active users alike. The CCC now owns or manages more than 1,200 housing units in 22 buildings, and provides drug treatment services to over 13,000 individuals annually⁴¹. The initiative has been so succesful in addressing both homelessness and the street drug scene that, in 2003, residents of the City of Portland and Multnomah County voluntarily voted a 1.25% personal income tax surcharge to help fund its activities through to the end of 2005.

By contrast, in U.S. cities where more traditional approaches to drug use have been taken, the results are less positive. A case in point is San Diego, which has a population more than twice that of Portland and is home to over 10,000 homeless individuals, approximately two-thirds of whom have substance abuse issues. Since the 1950s, a series of faith-based and/or privately-operated facilities have emerged in San Diego to deal with the twin issues of homelessness and drug addiction, the most well-known of these being the St. Vincent de Paul Village. These facilities offer a wide range of essential services to several thousand homeless individuals annually, including soup kitchens, medical and dental clinics, and over 3500 emergency shelter beds and transitional housing units. While these facilities are important amenities, the majority of units are in high-threshold facilities, making them inaccessible to most intoxicated or drug-involved individuals. As a result, up to 73% of San Diego's homeless have no access to shelter.

The strong correlation between homelessness and drug use in the area means that these facilities not made a significant impact on the street drug scene either. The drug treatment programs offered by these facilities are almost exclusively abstinence-based, and do not meet the needs of the majority of drug users. According to the San Diego Regional Task Force on the Homeless, more than 76% of drug-involved homeless individuals cannot readily access treatment programs – interestingly, this is roughly the same percentage that continues to live without shelter, suggesting a strong positive correlation between following a comprehensive approach to drug addiction and reducing homelessness.

Vancouver

The success of the above initiatives (among others) moved the City of Vancouver to formulate and adopt a community drug strategy based on Four Pillar concepts. The project is still relatively new, but is already yielding noticeable results. For example, Vancouver's supervised injection facility, Insite, recently completed its first year of operation and is being viewed as a success. The facility has served over 3,000 individuals and provided treatment in more than 100 observed overdoses, preventing harm to the individuals and drastically reducing the need for drug-related ambulance responses and Emergency Room services⁴².

In addition to injection rooms, Insite offers a wide range of treatment and harm reduction programs. Clients have ready access to needle and equipment exchange, addiction counselling, primary health care, peer counselling, and referral to a wide range of community services, including withdrawal management, recovery programs, housing supports, and mental health

⁴¹ For more details, visit the Central City Concern web site (www.centralcityconcern.org)

⁴² BC Centre for Excellence in HIV/AIDS Evaluation of the Supervised Injection Site – Year One Summary, September 17, 2004

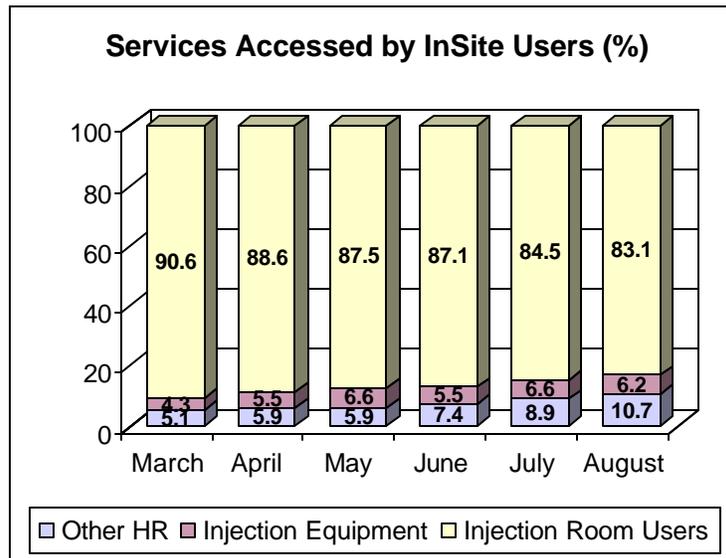
services⁴³. Since the facility opened, there has been a slow but steady decrease in the percentage of clients using the injection rooms, while the percentage of clients accessing other harm reduction/treatment initiatives has nearly doubled.

Not all of the aspects of Vancouver’s Four Pillar initiative have been positive, at least not in terms of their effect on other communities. Enhanced enforcement activities, in particular “Red Zoning” known or suspected drug dealers and troublesome addicts to prohibit their presence in the Downtown Eastside, has resulted in their relocating to other areas, including the Central Okanagan. Over the past six months, large numbers of these “criminal transients⁴⁴” have arrived, mostly in Kelowna, where the RCMP estimate that “the number of people who live off of crime downtown has doubled⁴⁵” since the spring of 2004.

The influx has contributed to the openness of the street drug scene and the general decline of the downtown core. Business owners in particular are feeling the impact, complaining that trash-strewn streets, visible drug activity, prostitution and increasing homelessness are driving customers away from their businesses⁴⁶. The situation is at its worst on the 200 block of Leon Avenue (arguably “ground zero” for Kelowna’s street drug scene), where all legitimate daytime businesses have now closed or relocated⁴⁷.

This example speaks to the importance of coordinated planning and implementation of activities. Vancouver’s recent enforcement blitz focused on displacing drug-involved individuals, without considering where they might eventually end up, and without attempting to refer red-zoned individuals to treatment facilities. As a result, the problem was not resolved, it was simply relocated, in part to the Central Okanagan. The lesson is a simple one – one cannot address a problem, simply by changing the problem’s address.

Figure 10: Service Accessed by InSite Users



⁴³ In addition to these services, European consumption rooms often provide emergency accommodations, laundry and/or shower facilities, and even cafés. As of December 2003, there were 62 authorized drug consumption rooms in Europe. Source: Dagmar Hedric “European Report on Drug Consumption Rooms” European Monitoring Centre for Drugs and Addiction February 2004

⁴⁴ RCMP Superintendent Bill McKinnon, speech to Kelowna Chamber of Commerce, November 2004

⁴⁵ Kevin Parnell “Downtown merchants fed up with trashed streets” Kelowna Capital News Sunday, January 23, 2005

⁴⁶ Kevin Parnell “Downtown merchants fed up with trashed streets” Kelowna Capital News Sunday, January 23, 2005

⁴⁷ Don Plant “Exodus on Leon” Kelowna Daily Courier, January 21, 2005

A Central Okanagan Framework for Action

The local effects of problematic drug use are unique to each community, and local residents often can best determine the most effective and appropriate responses to those problems. A logical and appropriate approach for Vancouver might not work in Kelowna, and might even do harm in Lake Country. Locally based responses are the most effective means of targeting local drug-related problems. These responses must, however, take into account the regional, national, and global realities that give rise to local problems.

The Central Okanagan Four Pillars Coalition, over a period of several months, has performed literature reviews and done extensive community-based research into problematic drug use and its effect on the Central Okanagan. Input was sought from the general public, area youth, active drug users and more than 80 area service providers in the areas of prevention, treatment, enforcement and harm reduction through a combination of public forums, online surveys, focus groups and one-on-one interviews. In all, 222 members of the general public, 67 area youth, 78 active drug users and 18 service providers furnished information and opinions⁴⁸. Many respondents advanced specific recommendations as to what needs to be done to address problematic drug use and related issues in the Central Okanagan – these suggestions are listed in appendices available from Living Positive Resource Centre (www.livingpositive.ca).

It is based on these responses and a series of targeted focus group interviews that the goals and actions in this framework are based. The four main goals of the Framework are:

1. **Greater Coordination and Cooperation:** Define and implement a coordinated response to problematic drug use, and to ensure the continued relevance of that response through ongoing research and consultation.
2. **Improved Public Health:** Address drug-related health and welfare issues through effective prevention, treatment and harm reduction activities.
3. **Enhanced Quality of Life:** Improve the social and economic quality of life for the community, by reducing the negative effects of problematic drug use.
4. **Restored Public Order:** Restore public order, by aggressively targeting drug-related threats to public safety and security in the Central Okanagan.

The goals have given rise to a series of 28 individual actions. For each identified action, potential lead and partner agencies are identified. In many cases, the identified agencies operate in related fields and/or offer similar or complementary services; some, particularly government ministries, bear legislative responsibility for some elements of the action. For the most part, however, these lead and partner agencies are included because they have expertise and/or resources that can help ensure its successful implementation, and/or because they are stakeholders in areas affected by the action.

Public Perceptions

It should come as no surprise that the vast majority of respondents⁴⁹ agreed that there is a drug problem in the Central Okanagan, with over 90% stating that the problem was increasing throughout the community. In fact, nearly two-thirds of respondents described the increase as either “significant”, “major” or “out of control”. 82% reported an increase in drug-related activity in their own neighbourhood, and slightly more than one-third felt that they had been personally

⁴⁸The region’s overall participation rate is roughly half that of Vancouver, which (with a total population roughly five times that of the Central Okanagan) had approximately 2,000 people participate in public discussions on its Framework for Action. Given that an open drug scene is a relatively recent development in the Central Okanagan, this response rate is quite encouraging.

⁴⁹ Not all respondents chose to answer every question, and the percentages quoted throughout this report refer only to the opinions of those who did. Where less than two-thirds of total survey respondents have answered a given question, the responses are excluded.

affected by drug-related activity in the community. Some of the more common themes expressed in the surveys include the need for:

- More effective prevention programs, including fact-based anti-drug education in schools, making use of recovering users where possible;
- Shorter wait times for entry into treatment programs;
- 24/7 availability of treatment and harm reduction services;
- Stable, long-term funding for anti-drug initiatives;
- More services for youth, women and Aboriginal persons;
- Greater police presence in the downtown cores;
- Enforcement focussing on dealers, rather than users; and,
- More stringent and consistent sentences for drug dealers.

Perhaps the most frequently expressed comments centred on the themes of cooperation and coordination. There were clearly stated desires for more-meaningful consultation among service providers, and for more community input into the design and delivery of services, as well as the need for professional coordination, implementation and oversight of drug-related initiatives in the future. Overall, there was an awareness that resolving the problems facing the Central Okanagan will require a comprehensive plan of action and ongoing coordination. It was noted that an effective drug strategy cannot be left entirely to volunteer committees, and that professional supervision was essential to any meaningful response to problematic drug use.

Action No. 1: Regional Drug Policy Coordinator

Establish and provide long-term support and funding for a Drug Policy Coordinator for the Regional District of Central Okanagan. The position would be maintained for a minimum of 10 years, with funding support from the Provincial government and Federal governments. The Coordinator would, at a minimum:

- *Ensure transparency and accountability in all stages and aspects of the Framework;*
- *Facilitate cooperation and coordination between service providers, in order to ensure the effective implementation of agreed upon strategies;*
- *Liaise with stakeholders, including government, service providers, researchers, local business owners, drug users and the public at large;*
- *Conduct additional research as required to assess the effectiveness of actions taken to date, and to help to determine the need for additional actions;*
- *Help identify real or potential challenges to anti-drug initiatives, such as funding issues and the emergence of new drugs or drug use patterns; and,*
- *Make regular progress reports to all parties and to the public at large.*

Potential Lead Agency: *Regional District of Central Okanagan*

Potential Partner Agencies: *Ministry of Communities, Aboriginal and Women's Services, Health Canada; Treatment Planning & Implementation Board (Action 11)*

Expected Outcome: *Greater coordination, communication and cooperation among stakeholders; increased public awareness and input*

Relates to: *Goal One (Coordination and Cooperation), Goal Two (Public Health), Goal Three (Quality of Life), Goal Four (Public Order)*

Prevention: Managing the Future

The value of effective prevention strategies is largely self-evident – the best way to resolve a crisis is to avoid it altogether. As noted above, prevention involves educating people about the dangers of drug use. It builds awareness about why people misuse drugs and tells what can be done to avoid drug use, addiction or worsened addiction. There are three main types of prevention:

1. Primary Prevention, which attempts to prevent substance use altogether or delay the onset of substance use;
2. Secondary Prevention, aimed at individuals in the early stages of substance use, before serious problems have developed; and,
3. Tertiary Prevention Interventions, which focus on preventing serious harm to individuals who have become addicted to drugs.

Prevention programs can take many forms, and are not limited to direct anti-drug education. They can and frequently do address the root causes of drug and alcohol use, such as:

- Poverty;
- Unemployment;
- Homelessness;
- Substandard housing;
- Sexual exploitation of youth;
- Mental health issues;
- Flight of legitimate businesses from the downtown core; and,
- Lack of economic opportunity for marginalized individuals.

As such, an integral part of prevention is community capacity building. Community capacity building stresses that a prevention strategy should not be merely a collection of programs, but rather a continuous process that creates healthy communities by building on existing resources and successes to strengthen the community, the sense of community and the level of civic engagement in community affairs. It is very much a grassroots process that focuses on encouraging a sense of personal investment in our neighbourhoods and our communities, fostering inclusion, and opportunities for meaningful participation. Schools (including student and parent associations), faith-based organizations, neighbourhood associations, community organizations, local businesses and governments all have roles to play in the process. Ongoing examining of existing community capacities and the development of strategies to enhance them will be critical to the success of all four pillars.

Prevention strategies must focus on more than just drug use among youth – other sectors of the population at risk of drug use and/or addiction must also be addressed, including seniors, persons with physical or mental handicaps, homeless individuals, mental health clients, single parents, and professionals in high-stress jobs, to name a few. Drug use can be found in every segment of the population, and effective prevention strategies must be able to reach at-risk individuals in each of those segments. In addition, the drug use prevention benefits created as a secondary benefit of educational, recreational, and cultural programs offered by such groups as the YM/YWCA, Boys and Girls Club, municipal recreation services, organized sporting teams, social organizations and cultural associations need to be recognized and supported.

Action No. 2: Community Capacity Building

Ongoing efforts must be made to identify, map and increase existing community capacities, and to enhance the abilities of service providers to provide effective prevention services. Area service providers should cooperate with community-based researchers to:

- *Increase public awareness of existing programs and identify opportunities for increasing program capacities;*
- *Facilitate ongoing research into existing community capacity;*

- Conduct workshops and education initiatives to increase awareness of current prevention research and “best practices” among prevention service providers;
- Design and implement valid, reliable and consistent longitudinal studies of the effectiveness of prevention initiatives;
- Assist the Regional Drug Policy Coordinator in the design and implementation of longitudinal studies on the effectiveness of treatment, enforcement and harm reduction initiatives; and,
- Create and help maintain linkages between prevention service providers.

Potential Lead Agency: University of British Columbia – Okanagan, prevention service providers

Potential Partner Agencies: Regional Drug Policy Coordinator (Action 1), School District #23,

Expected Outcome: Greater coordination, communication and cooperation among stakeholders; increased public awareness and input

Relates to: Goal One (Coordination and Cooperation)

Anti-Drug Education Strategies

Anti-drug education programs are a fundamental part of any prevention strategy, and the Central Okanagan not only has core prevention programs in place, including D.A.R.E., recreational programs offered by area municipalities, and numerous youth-focused programs and activities offered by area service groups. In addition, several of these are currently being expanded to increase their audience and impact. A case in point is D.A.R.E. During the 2003-2004 school year, D.A.R.E. was offered to 14 Grade Five classes in School District #23; in the 2004-2005 school year, the program is being offered in every one of the District's 74 Grade Five classes⁵⁰.

Research and observation both tell us, however, that more remains to be done. Even though 92% of Youth Survey respondents reported that they had attended school-based anti-drug programs such as D.A.R.E., 77% had gone on to use alcohol and/or drugs at some point in their lives anyway (24% alcohol only, 53% both alcohol and drugs). The advent of new drugs and changing portrayals of substance use in popular culture has increased the risk of substance use. While existing anti-drug education programs clearly work for some students, they need to be reviewed and, where necessary, changed or added to make them more effective and enable them to reach a larger audience more effectively. In many cases, the agencies providing these services are in the process of doing this.

The reason anti-smoking campaigns have been so successful is because they tell the blatant truth about the toxicity of cigarettes and [because] they start teaching kids about it at a young age...I knew all about cigarettes but absolutely nothing about Marijuana or any other drugs. When I asked the anti-smoking speaker questions in elementary school about cannabis all I was told is that "Pot is bad too, don't do it." That is not good enough.
Youth Survey Respondent

Members of the general public and service providers alike identified 13-19 year olds as the population most at risk of becoming drug-involved, and both groups cited peer pressure, social acceptance of drugs and a lack of support services as the problems to be overcome by prevention programs. However, where half of all respondents to the public survey felt that anti-drug education should be offered beginning in Grade Four, over 62% of service providers stated that it should be introduced as early as Preschool, arguing that, if 13-19 year olds are the population most at risk, it is necessary to begin to educate children about the dangers of drug use well before they reach that age.

Nearly 29% of Youth Survey respondents, and most service providers, expressed support for the D.A.R.E. program; however, D.A.R.E. training alone is not sufficient to prevent all youth from

⁵⁰ Kelowna RCMP Superintendent Bill McKinnon notes that this increase is in part due to efforts of the Four Pillars Coalition to increase awareness of the importance of Prevention programs.

using illicit drugs; rather, a continuum of prevention activities, targeting youths of all ages and embracing a wide range of innovative approaches is necessary.

Youth survey results clearly support this latter contention. When asked what a successful anti-drug program would look like, the youths overwhelmingly responded that fact-based programs would have the greatest impact. Several respondents expressed their frustration with programs that simply told them not to use drugs without giving them compelling reasons to make such a choice. To these respondents, shielding kids from the realities of drug use is patronizing and counterproductive, and “Just Say No” programs should be replaced with programs that tell the audience, honestly, factually and bluntly, what will happen if they say, “Yes”. Indeed, the majority of respondents stated that former users, preferably close in age to the audience, should deliver anti-drug education messages.

There is general agreement between youth respondents, the general public and service providers when asked what would be most effective in preventing substance abuse. The most popular responses were programs that enhanced the individual’s self-esteem; clear and factual information on the effects of drug use; and positive role models among both parents and peers. Service providers in particular emphasised the importance of mentors and positive role models in effective anti-drug education. At the same time, there was a sense that programs should recognize that some will use drugs regardless, and should therefore provide information about treatment and harm reduction.

Educators, the RCMP, parents’ groups, service providers and other stakeholders must co-operate to improve existing anti-drug education programs, and expand them into a continuum of prevention education programs covering all ages and grade levels.

Action 3: Expansion of D.A.R.E.

D.A.R.E. must build upon its successes and offer anti-drug to more students, more often. Specifically, the D.A.R.E. program should:

- *Continue to be offered in every Grade Five class in School District #23; and*
- *Be expanded over time to include every Grade Eight class in School District #23.*

Potential Lead Agency: RCMP, School District #23

Potential Partner Agencies: Ministry of Education, Parental Advisory Committees, Drug Policy Coordinator (Action 1)

Expected Outcomes: Improved drug education, reduced or delayed onset of drug use, greater student awareness of drug-related issues.

Relates to: Goal Two (Public Health)

Action 4: Enhanced Drug Education

Educators must work with area service providers to develop and offer an effective continuum of drug education programs to respond to the differing needs of students. Enhanced drug education programs should:

- *Be developed based on evidence and accepted research;*
- *Be offered to at every grade level, in a manner suited to the audience’s level of intellectual, social and emotional development;*
- *Engage the audience in an effective and compelling manner;*
- *Foster the development of social competency skills, self-esteem, peer resiliency and critical reasoning skills, and their inclusion into existing prevention programs;*
- *Be fact-based and honest in presentation and content;*
- *Prepare students for specific drug-related threats they might reasonably expect to face in their immediate future;*
- *Develop the individual’s interpersonal communication skills, problem solving ability, and their capacity to deal with stress and emotional upheaval;*
- *Incorporate the active participation of parents and members of the neighbourhoods in the school’s catchment area*

Potential Lead Agency: School District #23, Drug Policy Coordinator (Action 1)

Potential Partner Agencies: Ministry of Education, Ministry for Children and Family Development, University of British Columbia – Okanagan (Education, Nursing and Social Work Departments), Interior Health, Parental Advisory Committees, Boys and Girls Club, Kelowna Area Network of Drug Users, Kelowna Medical Society, NOW Canada, Elizabeth Fry Society, Living Positive Resource Centre, ARC Programs, Crossroads Treatment Centre, Health Canada

Expected Outcomes: Improved drug education, reduced or delayed onset of drug use, greater student awareness of drug-related issues; improved relations between youth and their community, increased parental understanding of drug-related issues.

Relates to: Goal Two (Public Health)

Action 5: Harm Reduction Education

Educators and parent must understand that some youths will choose to use drugs despite any and all drug education efforts, and must ensure that those youth are aware of Treatment and Harm Reduction programs available in the community, in order to facilitate their recovery. Programs should:

- Be offered to students in those age groups most at risk of becoming drug-involved;
- Incorporate honest, accurate portrayals of the effect of drug use;
- Be offered by actual Treatment and Harm Reduction service providers from the community;
- Incorporate, where appropriate, the participation of recovering users, particularly those close in age to the audience⁵¹;
- Incorporate the active participation of parents and members of the neighbourhoods in the school's catchment area

Potential Lead Agency: School District #23, Drug Policy Coordinator (Action 1)

Potential Partner Agencies: Ministry of Education, Ministry for Children and Family Development, Interior Health, Parental Advisory Committees, University of British Columbia – Okanagan (Education and Social Work Departments), Crossroads Treatment Centre, ARC Programs, Living Positive Resource Centre, Elizabeth Fry Society, NOW Canada, Kelowna Medical Society, Kelowna Area Network of Drug Users, Boys and Girls Club, Health Canada

Expected Outcomes: Reduced or delayed onset of drug use, greater student awareness of drug-related issues and of treatment options for themselves and peers; increased parental understanding of drug-related issues facing their children; improved youth access to treatment.

Relates to: Goal Two (Public Health), Goal Three (Quality of Life)

Alternatives to Drug Use

Over half (55%) of Youth Survey respondents who reported using drugs said that they first did so in order to be accepted by their peers; boredom and/or curiosity were the next most common reasons. Municipalities have made laudable efforts to provide parks, arenas and recreational, social, cultural and other activities that are an effective means of increasing self-esteem, making youth more resistant to peer pressure and less likely to become involved with drugs; however, the programs offered are not attractive to all, and user fees, equipment costs, childcare issues, transportation limitations, and other factors can make it difficult for many at-risk individuals to take advantage of these opportunities.

School budget cuts and curriculum changes have reduced the number and variety of school-based recreational and cultural activities. As a result, youth have less exposure to these sorts of activities, and are less inclined to adopt an active physical or social lifestyle. In addition, the emphasis placed on the development of athletic excellence over simple recreational enjoyment of sport (beginning in the pre-teen years and increasing thereafter) effectively excludes the majority of youth from participation in positive lifestyle activities, at the very moment they most need access to positive alternatives to drug use.

⁵¹ This was a frequently-requested change to existing prevention courses, but there is little research support for the concept; some service providers argue that showing youth someone who has “beaten” addiction makes drug use seem less harmful.

Action 6: Recreational, Social & Cultural Alternatives

Recreational, social and cultural activities offered in the Central Okanagan must be enhanced and expanded to increase long-term participation by youth and other at-risk populations. Programs should:

- *Be designed to improve the health, well-being, self-esteem and overall resilience of the participants;*
- *Encourage participation from an early age;*
- *Promote concepts of fair play and respect for others;*
- *Incorporate school-based activities, including expanded physical education classes, intra- and extra-mural sports, amateur theatrics and similar activities;*
- *Allow easy transition from school- to community-based activities;*
- *Emphasize the need for non-competitive sport “fun leagues” for all age groups;*
- *Promote lifelong involvement in leisure activities as a cornerstone of a healthy lifestyle;*
- *Incorporate the active participation of parents and members of the public as coaches, officials and mentors.*

Potential Lead Agency: *School District #23, Municipal Parks, Recreation and Leisure Services*

Potential Partner Agencies: *Ministry of Education, Parental Advisory Committees, Okanagan Families, Boys and Girls Club, Drug Policy Coordinator (Action 1)*

Expected Outcomes: *Reduced or delayed onset of drug use, greater student awareness of healthy lifestyle options, increased parental and community involvement in the lives of youth; greater youth self-esteem.*

Relates to: *Goal Two (Public Health)*

Program Awareness and Accessibility

Schools and extracurricular activities can provide valuable support systems, and do much to help youth make healthy choices. However, many of the drug-related challenges youths will face will occur outside of school and beyond regular office hours, when youth have limited access to support or assistance. Moreover, older individuals and youths who are not in the school system are also at risk of drug use, and need ready access to effective support and assistance systems. Information about prevention programs has to be made available to the community when and where they need it.

Action 7: Making Alternatives to Drug Use Accessible

Low-income individuals, single-parent families and other at-risk populations can experience difficulty accessing cultural and recreational activities offered as alternatives to drug involvement. Municipalities must move to reduce barriers to access, by:

- *Reducing or eliminating facility user fees and program registration fees;*
- *Establishing a used sports equipment pool for the benefit of lower income families and individuals;*
- *Scheduling and locating activities to make them more accessible to users of public transportation;*
- *Providing, where needed, childcare or child-minding services.*

Potential Lead Agency: *Municipalities (Parks, Recreation and Leisure Services)*

Potential Partner Agencies: *BC Transit, Drug Policy Coordinator (Action 1)*

Expected Outcomes: *Better access to activities for at-risk individuals.*

Relates to: *Goal Two (Public Health)*

Action 8: Drug-related Information Line

A public information telephone service should be established to help individuals access non-emergency social, health and government services. The service should:

- *Use an easy-to-remember, toll-free number (e.g. 211);*
- *Be available 24 hours a day, seven days a week throughout the Central Okanagan;*

- Be staffed by trained specialists capable of assessing the needs of the caller and linking them to the best available information and/or services;
- Be capable of dealing with any drug-related question or complaint; and
- Maintain a listing of all non-emergency governmental and non-governmental social services in the Central Okanagan.

Potential Lead Agency: Kelowna Community Resources, Drug Policy Coordinator (Action 1)

Potential Partner Agencies: Health Canada, Interior Health, Municipalities, Kelowna Medical Society, Living Positive Resource Centre, Canadian Radio & Telecommunications Commission, Okanagan Families, University of British Columbia – Okanagan (Education and Social Work Departments)

Expected Outcomes: Improved knowledge of services, better service delivery, increased public health and security

Relates to: Goal One (Coordination and Cooperation), Goal Two (Public Health), Goal Three (Quality of Life), Goal Four (Public Order)

Underlying Factors

Drug use does not evolve in a vacuum. Poverty, unemployment, racism, homelessness, substandard housing, sexual exploitation of youth, mental health issues and other events can and often do contribute, singly or in combination, to the onset and continuation of drug use among all age groups. Ultimately, an effective response to problematic drug use must include attempts to mitigate the effects of these and other underlying factors.

Action 9: Addressing Causal Factors

The social and economic factors that contribute to the onset and continuation of problematic drug use must be addressed in a comprehensive and ongoing manner. In particular:

- The number of emergency shelter beds must be increased to accommodate the growing number of homeless persons;
- Additional low-income and subsidized housing units, including Single Room Occupancy dwellings, must be developed in key urban areas;
- BC Benefits payment levels must be increased to reflect actual housing market prices;
- Employment opportunities (e.g. community works projects) should be offered to street-involved individuals as alternatives to panhandling and illegal activities;
- Preventive mental health services must be de-stigmatized, and made more accessible to individuals and families;
- Support services for at-risk, criminally-involved and/or sexually-exploited individuals must be increased, particularly services for youth;
- Support for families, including parent and family support networks, parenting education, and life skills training, must be made universally available.

Potential Lead Agency: Drug Policy Coordinator (Action 1), Ministry of Human Resources, Ministry for Children and Family Development, Interior Health

Potential Partner Agencies: BC Housing, Municipalities, Canada Mortgage and Housing Corporation, Health Canada, Human Resources Skills Development Canada, University of British Columbia – Okanagan (Education and Social Work Departments), Kelowna Community Resources, Kelowna Drop-In and Information Centre, Living Positive Resource Centre, John Howard Society, Elizabeth Fry Society, Kelowna Homelessness Steering Committee, NOW Canada, Ki-Low-Na Friendship Society, Westbank First Nation, Okanagan Nations Alliance, Okanagan Families, Boys and Girls Club, Downtown Kelowna Association, Chambers of Commerce

Expected Outcomes: Improved social cohesion, reduced homelessness, improved urban environment, early identification of mental health issues

Relates to: Goal Two (Public Health)

Community Environment

The relative lack of residential development in most downtown cores throughout the Central Okanagan, together with the flight of legitimate businesses from these and other areas where a visible drug scene exists, are serious issues. The resulting lack of legitimate residential foot traffic and growing numbers of empty storefronts, contribute to an overall air of urban decay, and help to create an atmosphere in which illicit activity can be pursued with relative impunity. Revitalization of the downtown cores is central to addressing the street drug scene and drug-related crime.

Action 10: Urban Renewal

Re-establishing the vitality, aesthetics, and economic competitiveness of downtown cores throughout the Central Okanagan must be an immediate priority. Possible initiatives include:

- *Property tax breaks, Development Cost Charge reductions and similar incentives to encourage development;*
- *Construction of public washrooms and similar amenities;*
- *Seasonal reduction of street parking fees to encourage holiday shopping;*
- *Converting select alleys into pedestrian malls;*
- *Expanding the number of open-air attractions, including outdoor cafés or seating areas and street vendors;*
- *Changing the timing of traffic lights and pedestrian crossing lights to facilitate pedestrian traffic;*
- *Enhanced public art, including murals;*
- *Ad campaigns in support of downtown businesses;*
- *Improved transit services, such as free “jump on, jump off” shuttle services for downtown shoppers; and,*
- *Street-level activities and entertainments (e.g. busking competitions, recreational and cultural exhibits, music festivals, etc.) that would draw attention to side streets as well as main thoroughfares.*

Potential Lead Agency: *Municipalities, Drug Policy Coordinator (Action 1)*

Potential Partner Agencies: *Infrastructure Canada, BC Housing, Ministry of Community, Aboriginal and Women’s Services, Tourism BC, Chambers of Commerce, Downtown Kelowna Association, BC Transit*

Expected Outcomes: *Improved social cohesion, reduced homelessness, improved urban environment, early identification of mental health issues*

Relates to: *Goal Two (Public Health), Goal Three (Quality of Life)*

Treatment: Building a Continuum

Addiction is a complex health and social issue – it is not a one-dimensional problem and will not yield to one-dimensional solutions. In the past, treatment programs have typically been high threshold (abstinence-based), a model that is still in evidence today. Over the past several decades, however, research into addictions and longitudinal studies of treatment outcomes have contributed to a shift in treatment philosophy. Increasingly, treatment is being offered on a harm reduction basis, with total abstinence being seen more as a desired ultimate outcome than an essential part of ongoing treatment.

This is not to suggest that abstinence-based treatment programs are of no value, or should be discounted; on the contrary, thousands have been successfully treated using this model, and it remains a valid treatment option for a many addicts. This Framework accepts abstinence-based treatment programs as a valid component of a comprehensive continuum of treatment services, and supports the activities of groups offering those programs. However, the undeniable fact remains that abstinence simply does not work for all drug users, with most research suggesting long-term recovery rates of about 15% for abstinence based programs. To serve the needs of the 85% for whom abstinence is not an immediately attainable condition, additional treatment models need to be introduced.

Treatment consists of a continuum of interventions and support programs that allows individuals to deal with addiction problems and to make healthier life decisions. Recovery is more sustainable when individuals have access to a managed progression of treatment services, designed to provide them with appropriate supports and resources at every stage of their recovery and with multiple points of access to services. A comprehensive continuum of care is essential if our community is to respond effectively to problematic drug use.

Treatment is not inexpensive. It is, however, one of the soundest economic investments a community can make. Treatment reclaims a human being, allowing them to improve their health and economic standing, increasing their capacity to contribute as productive members of society. Studies consistently show that treatment services more than pay for themselves. A recent Alberta Alcohol and Drug Abuse Commission report concluded that for each dollar invested in treatment, \$7.14 was saved in health and justice costs or returned to the economy through increased worker productivity, within a single year⁵². Clearly, the cost of providing effective treatment services is far outweighed by the social and economic costs of not doing so.

Treatment Coordination

The Central Okanagan has many, but by no means all of the key elements of a comprehensive system of care already in place. However, due to ever-increasing service demand, operational issues and gaps in the continuum of services, many of these community services are extended well beyond their capacity. Collaborative planning is essential if we are to meaningfully address treatment-related issues and effectively respond to the community's needs.

Action 11: Coordinated Planning and Implementation

Immediate action should be taken to establish a multilateral Treatment Planning and Implementation Board. The Board would:

- *Continue the review of existing treatment services;*
- *Explore new responses to problematic drug use;*
- *Conduct longitudinal studies to determine program effectiveness;*

⁵² Kaiser Youth Foundation "A Case for an Independent Substance Abuse and Addictions Commission", May 2000

- *Help determine how best to allocate current and future funding to improve the continuum of care in the region;*
- *Work to ensure the presence of long-term sustainable funding for anti-drug programs and initiatives in the community; and,*
- *Cooperate with the Regional Drug Strategy Coordinator to ensure the success of the overall Framework.*

Potential Lead Agency: *Interior Health, Drug Policy Coordinator (Action 1)*

Potential Partner Agencies: *Ministry of Health Services, Ministry for Children and Family Development, Ministry of Human Resources, University of British Columbia – Okanagan, Kelowna Medical Society, Municipalities, Crossroads Treatment Centre, ARC Programs, Kelowna Alcohol and Drug Services, Living Positive Resource Centre, Ki-Low-Na Friendship Society, Kelowna Area Network of Drug Users, Methadone Clinic, Okanagan Families, Boys and Girls Club, Downtown Kelowna Association, Chambers of Commerce,*

Outcome Expectations: *increased treatment capacity, improved needs assessment, improved treatment outcomes, reduced wait times for treatment services, improved public health and security*

Relates to: *Goal One (Coordination and Cooperation), Goal Two (Public Health)*

Treatment Capacity and Issues

Increased incidence of drug use and the emergence of new drugs and drug use patterns have placed serious strains on treatment service providers. Not only are more people demanding treatment services, they also increasingly demanding new types of treatment. Treatment service providers and mental health experts alike have recognized the links between addiction and mental health disorders, and have had to develop new services to respond the needs of the growing numbers of clients who struggle with both (concurrent disorders). Residential treatment service providers, for example, estimate that up to 85% of their clients have concurrent disorders.

The growing popularity of crystal methamphetamine and other synthetic drugs is seriously straining treatment system capacity, as are changing drug use patterns. Increasingly, individuals are using not just one, but several drugs at the same time (poly-drug use). Unlike heroin or cocaine addicts, poly-drug users often do not have a drug of choice and frequently end up addicted to multiple substances, greatly complicating treatment. Outpatient and day treatment programs are stretched beyond capacity, with the number of client referrals increasing dramatically with, at the same time, available resources dwindle. Changing drug use patterns compound matters, as clients entering the system require more intensive treatment over longer periods of time. Residential treatment programs are experiencing similar challenges, and are increasingly finding the standard 28-day treatment period too short to deal adequately with synthetic drug and poly-drug addictions⁵³.

The demand for more and different services has come, most unfortunately, during an era of fiscal restraint and uncertain funding for many service providers. Clients entering the system consume more resources for direct treatment than before, and those resources are increasingly being made available at the expense of other aspects of the treatment model. A case in point is counselling and support for families and friends of addicted individuals. Research and clinical experience clearly show that providing counselling and support to family and friends not only improves the addicts chances for long-term recovery, it also safeguards the children of addicts and prevents generational cycles of addiction. The sheer volume of demand for direct treatment services, however, means that counsellors are less able to offer these critical services comprehensively.

⁵³ Ronwyn Grace, Executive Director, Crossroads Treatment Centre, interview with author.

Action 12: Improving Treatment Capacity

Existing treatment programs must be adjusted as needed to ensure they are capable of dealing with the demands placed on the system by new drugs, changing drug use patterns and concurrent disorders. At a minimum, service providers must confirm, and governments must increase funding levels where necessary to ensure, that all programs:

- *Include clear treatment plans and outcome expectations for each client, both at each stage of treatment and cumulative;*
- *Are sufficiently flexible to adapt to the individual needs of the client, including extended treatment periods as needed;*
- *Contain an appropriate Mental Health component and/or linkages to Mental Health services;*
- *Provide ongoing client support once initial treatment has been completed; and,*
- *Include or provide access to appropriate family and peer counselling and support services.*

Potential Lead Agency: *Treatment Planning & Implementation Board (Action 11), Interior Health*

Potential Partner Agencies: *Ministry of Health Services, Ministry for Children and Family Development, Drug Policy Coordinator (Action 1), relevant treatment service providers*

Outcome Expectations: *increased capacity, improved outcomes, reduced wait times, improved public health*

Relates to: *Goal One (Coordination and Cooperation), Goal Two (Public Health)*

Youth Addiction Services

Notable shortcomings exist in youth addiction services, creating gaps that seriously reduce community capacity to care for youth with substance abuse and addiction issues. For example:

- Youth Outpatient and Day Treatment services have experienced record high demand, and remain under stress despite efforts to develop new community services.
- The current Youth Detox facility was funded through a one-time federal grant, and continues to seek long-term sustainable funding.
- There is no Youth Residential Treatment Facility in the community, and youth must travel to other parts of the province if they require that level of service, effectively cutting them off from familial and other support structures and negatively affecting their recovery.

Funding uncertainties are of particular concern, often threatening the viability of successful programs and needlessly placing drug-involved individuals at further risk. A case in point is the youth detox facility, a proven effective means of addressing addictive behaviours among area youth. Between August 2002 and January 2005, the facility treated 103 drug-involved youths who were either homeless or at risk of becoming so, successfully detoxified them, placed them into residential or outpatient treatment programs and ensured that they had appropriate housing. Significantly more youths could have been cared for, had the facility not been forced to close for six months due to a lack of long-term government funding. Sufficient funding was eventually restored to allow the facility to re-open – however, there is still no long-term guaranteed funding, and the facility may well have to close again in the near future.

Provincial ministry structures further complicate the provision of youth addiction services. As mentioned above, concurrent disorders are increasingly prevalent among problematic drug users. However, funding responsibility for afflicted youth is divided between Interior Health (for youth addiction) and the Ministry for Children and Family Development (for youth mental health and youth justice). School District #23 currently funds or coordinates early prevention/intervention programs and alcohol and drug use reduction programs. Effective coordination between funding agencies is necessary if youth with concurrent disorders are to be properly served, including long-term collaboration on the development and implementation of service delivery models, outcome expectations, etc.

Action 13: Increasing Youth Addiction Services Capacity

Immediate steps must be taken to improve the stability and capacity of Youth Addiction Services in the community, including:

- *Providing stable, long-term funding for Youth Outpatient and Day Treatment services;*
- *Sufficiently increasing funding levels to ensure the capacity to meet growing service demands;*
- *Guaranteeing long-term funding for Youth Detox facilities;*
- *Establishing a Youth Residential Treatment facility;*
- *Increasing access to counselling and support services for families and peers of addicted youth.*

Potential Lead Agency: *Treatment Planning & Implementation Board (Action 11), Interior Health*

Potential Partner Agencies: *School District #23, Ministry of Health Services, Ministry for Children and Family Development, Drug Policy Coordinator (Action 1), relevant youth treatment service providers*

Outcome Expectations: *increased capacity, improved outcomes, reduced wait times, improved public health*

Relates to: *Goal Two (Public Health)*

Adult Addiction Services

Adult addiction services face many of the same challenges as do youth addiction services, and for many of the same reasons – newer and more addictive drugs, being used in newer and more harmful manners. Outpatient and day treatment programs are under extreme stress, and counsellor caseloads are almost overwhelmingly large. To date, proactive case management techniques have allowed service providers to avoid waitlists for walk-in services; unfortunately, the result is that counsellors are less able to offer comprehensive support and services to the family and friends of addicted individuals.

Action 14: Increasing Adult Addiction Services Capacity

Immediate steps must be taken to improve the capacity of Adult Addiction Services in the community, including:

- *Providing adequate long-term funding for Adult Outpatient and Day Treatment services;*
- *Sufficiently increasing funding levels to ensure the capacity to meet growing service demands;*
- *Increase service provider capacity to provide comprehensive counselling and support for families and peers of addicted adults.*

Potential Lead Agency: *Treatment Planning & Implementation Board (Action 11), Interior Health*

Potential Partner Agencies: *Ministry of Health Services, Ministry for Human Resources, Drug Policy Coordinator (Action 1), relevant treatment service providers*

Outcome Expectations: *increased capacity, improved outcomes, improved familial cohesion, improved public health*

Relates to: *Goal Two (Public Health)*

For residential treatment service providers, increased demand has resulted in significant waitlists at all stages of treatment. Clients typically wait up to four weeks to access detox, by which time up to 90% of those who sought entry can no longer be found. The waitlist to enter residential treatment can be as long as four months (depending on gender), most clients leaving residential treatment will never see the inside of a subsidized supportive recovery housing unit, and there is no second stage long-term supportive housing available in the community. As a result, lasting recovery from addiction is more difficult and relapse more common.

The community currently has eight adult detox beds (for males or females), 43 residential recovery beds (28 for males, 15 for females, of which only eight are funded by IH) and 24 supportive recovery beds (for males only). The average detox stay is six-eight days, after which most clients will enter a residential treatment program for a 28-day period; research into treatment issues surrounding poly-drug use and concurrent disorders, however, suggests that that period is

too brief, and that some clients might need to remain in residential treatment for up to three months. After residential treatment, many clients spend up to one year in supportive recovery housing to help them develop the life skills necessary to support their long-term recovery.

Figure 11: Existing Adult Treatment Capacity

Unit Type	Beds – Male	Beds Female	Average Stay	Waitlist
Detox	8 beds total (male or female)		6 days	4 Weeks
Residential Treatment	28	15	28 days	Up to 4 months
Supportive Recovery	24	0	1 year	Up to 1 year

While not every client leaving detox will need to enter residential treatment in this community, there still needs to be sufficient capacity to ensure that every client can access the facilities and services necessary to support the next stage of their recovery. The problem is one of capacity. If only half of the clients leaving detox need to enter residential treatment in the community, and half of those individuals later need to access supportive recovery housing, then for every detox bed there needs to be a minimum of two residential treatment beds and approximately 24 supportive recovery beds. If treatment periods are extended to address the effects of poly-drug use and concurrent disorders, proportionately more residential treatment units would be needed to avoid significant increases in waitlists for clients leaving detox.

Action 15: Adult Residential Treatment Capacity

Immediate action must be taken to increase the capacity of Adult Residential Treatment facilities in the community, including:

- *Establishing, and providing stable funding for a minimum of 12 additional detox beds, in order to reduce waitlists;*
- *Creating 30 additional residential treatment beds for men;*
- *Providing funding for seven existing (but currently unfunded) residential treatment beds for women;*
- *Creating an additional 10 residential treatment beds for women.*

Potential Lead Agency: *Treatment Planning & Implementation Board (Action 11), Interior Health*

Potential Partner Agencies: *Ministry of Health Services, Ministry for Human Resources, Drug Policy Coordinator (Action 1), relevant treatment service providers*

Outcome Expectations: *increased treatment capacity, improved treatment outcomes, including reduced incidence of relapse*

Relates to: *Goal Two (Public Health)*

In addition, there is a lack of provincially-funded supportive recovery houses, meaning clients leaving residential treatment are frequently referred to privately-funded (generally faith-based) recovery facilities. This is not always a successful move, as residential treatment is offered on a harm reduction basis, while many private recovery facilities operate on an abstinence basis. The resulting conflict contributes to relapse and can make lasting recovery difficult to achieve.

Action 16: Funding Supportive Recovery Housing

Immediate action must be taken to increase the availability of provincially-funded Supportive Recovery Housing, including:

- *Creating a minimum of 40 additional supportive recovery housing beds for men;*
- *Creating a minimum of 20 supportive recovery housing beds for women; and,*
- *Requiring privately-funded recovery programs to meet provincial licensing standards and Alcohol and Drug service standards.*

Potential Lead Agency: *Treatment Planning & Implementation Board (Action 11), Interior Health, BC Housing*

Potential Partner Agencies: *Ministry of Health Services, Ministry for Human Resources, Drug Policy Coordinator (Action 1), relevant treatment service providers*

Outcome Expectations: *improved treatment outcomes, reduced incidence of relapse*

Relates to: *Goal Two (Public Health)*

Finally, there are significant limitations on the offering of withdrawal management service in the community. Methadone treatment is an effective means of managing the negative effects of heroin withdrawal, and is proven to contribute to lasting recovery. Methadone clients are less likely to suffer relapse, and more likely to become contributing members of society. Unfortunately, the service is offered on a limited basis only – four hours Tuesday and Wednesday, and eight hours on Thursday. Despite this, the program remains popular, with more than 75 current clients and more being added weekly.

Action 17: Supporting Methadone Treatment Programs

Methadone treatment programs in the community must be expanded. At a minimum, long-term funding must be provided to allow:

- *Methadone clinic hours to be expanded to five days per week, with no more than one day off between clinic days;*
- *On-site attendance by a certified Methadone doctor no less than three days per week;*
- *Expanded counselling capacity, to ensure effective individual case management.*

Potential Lead Agency: *Treatment Planning & Implementation Board (Action 11), Methadone Clinic*

Potential Partner Agencies: *Ministry of Health Services, Interior Health, Drug Policy Coordinator (Action 1), relevant treatment service providers*

Outcome Expectations: *improved treatment outcomes, reduced incidence of relapse, improved public health*

Relates to: *Goal Two (Public Health), Goal Three (Quality of Life)*

Aboriginal Services

Aboriginal drug users must contend with, in addition to the issues noted above, a range of unique challenges when attempting to access treatment, including racism, inadequate and under-staffed on-reserve addiction services, limited addiction services for the urban Aboriginal population, a lack of aboriginal-specific addiction programs in surrounding communities, and the stigma attached to admitting one's addictions within the Aboriginal community. Compounding matters are jurisdictional and funding conflicts between Federal and Provincial programs that can effectively prevent status natives living on reserve land from accessing Provincial treatment programs or facilities, unless they leave the reserve for the city, apply for BC Benefits and, once the waiting period has passed, try to get referred to a Provincially-funded facility. Unfortunately, most find themselves effectively homeless during the process, and many never make it to treatment.

Action 18: Improved Aboriginal Addiction Services

Aboriginal individuals must be afforded greater access to addiction treatment services. Minimum actions include:

- *Changing existing funding guidelines to allow status Natives greater access to available treatment services;*
- *Adding Aboriginal components to Provincially-funded programs;*
- *Improving the range and capacity of front-line addiction services available on First Nation lands; and,*
- *Improve the resources and capacity of front-line addiction services for the urban Aboriginal population.*

Potential Lead Agency: *Westbank First Nation, Ki-Low-Na Friendship Society, Treatment Planning & Implementation Board (Action 11)*

Potential Partner Agencies: *Health Canada, Ministry of Health Services, Okanagan Nation Alliance, Drug Policy Coordinator (Action 1), Interior Health*

Outcome Expectations: *improved access to treatment and improved outcomes, reduced homelessness, improved public health*

Relates to: *Goal Two (Public Health)*

Enforcement: Ensuring Public Security

Enforcement has long been society's default response to drug issues. Historically, Canadians in general have tended to see problematic illicit drug use as an entirely criminal issue, rather than a health issue with criminal overtones, and past approaches have reflected this underlying attitude. It has become apparent, however, that enforcement activities alone cannot stop drug use and drug related problems. Billions of dollars are spent annually in Canada on enforcement, yet drug-related crime continues to grow.

Enforcement remains an essential part of addressing issues related to problematic drug use, however. The manufacture, importation, distribution and sale of illicit drugs provide the financial basis for criminal activities ranging from counterfeiting and smuggling to trafficking in human cargo and terrorism, while the crimes committed by drug-involved individuals to support their habits impact on all members of society. For the public to have confidence in a community drug strategy, it is essential that the crime and the general breakdown in public order that is a consequence of an active drug scene be addressed.

Managing the Load

The Kelowna RCMP detachment is the third busiest in BC, and one of the busiest *per capita* in Canada. Its 170 members responded to 70,000 calls in the past year, an increase of 20,000 over the past five years, in large part due to high levels of drug crime and drug-related crime. In the first nine months of 2004, drug crimes (possession, cultivation, trafficking, etc) increased by 42% over the same period in 2003, including a 148% increase in cocaine possession. Drug-related crime (robbery, break and enter, prostitution, counterfeiting, and other crimes committed to support a drug habit or drug activities) absorbs about 70% of the current police budget – more than nine million dollars in 2003 alone⁵⁴.

The prevention, treatment and harm reduction priorities identified in this document will all help to reduce problematic drug use and its effects; however, these are long-term initiatives, evolutionary and incremental in nature, and some could take years to establish and to realize results. Enforcement, on the other hand, addresses the maintenance and enhancement of public order and safety in a more immediate manner, and is thus crucial to any balanced and comprehensive community drug strategy. Enforcement activities can “buy time” for the other pillars' initiatives to be put into place and take effect – to do so, however, enforcement agencies need to improve their capacity to deal with the rising tide of drug-related crime.

An example of how this can be done, quickly and effectively, can be found in the recently established RCMP Special Projects Team, which targets drug dealers at the street level, and follows their criminal drug activity up through the drug culture hierarchy. The Team consists of four members (eight during the summer months) under direction of a senior Non-Commissioned Officer in Command (NCOIC), draws upon resources of the RCMP dog and drug squads as needed, and coordinates its activities with such other enforcement agencies as City of Kelowna Bylaw Enforcement and the Downtown Kelowna Patrol. The establishment of the team was made possible through the actions of the City of Kelowna; its recent decision to hire 10 additional RCMP members ensured that essential police services would not be removed from other areas of the City to respond to emerging situations in the downtown core.

Action No. 19: RCMP Special Projects Team

The operations of the RCMP Special Projects Team should be continued, and expanded as needed to address drug crime and drug related crime in the Central Okanagan. At a minimum, the Team should:

- *Continue to focus on drug enforcement and the reduction of related offences such as prostitution, through the even-handed and consistent application of appropriate*

⁵⁴ Kelowna RCMP Superintendent Bill McKinnon, speech to Kelowna Chamber of Commerce.

legislative tools such as the Criminal Code of Canada, Provincial Acts and Statutes (including the Safe Streets Act and Trespass Act) and relevant municipal bylaws;

- *Aggressively target drug dealers at the street level and follow criminal drug activity up through the drug culture hierarchy; and*
- *Through the Non-Commissioned Officer in Command (NCOIC), cooperate with the Regional Drug Policy Coordinator to establish a communication strategy that will ensure public awareness of and education about enforcement initiatives and other drug-related issues in the Central Okanagan.*

Potential Lead Agency: RCMP, Municipalities

Potential Partner Agencies: Ministry of Attorney General, Ministry of Public Safety and Solicitor General, Drug Policy Coordinator (Action 1)

Outcome Expectations: *reduction in drug activity, improved public order, increased public awareness, generation of statistical data*

Relates to: *Goal One (Coordination and Cooperation), Goal Four (Public Order)*

Criminal Justice

While most respondents felt that the police were dealing fairly well with drug-related issues overall, the rest of the criminal justice system did not fare as well. Many respondents blamed the court system for the extent of the drug problem, complaining that lenient and/or inconsistent sentencing, together with overly liberal probation and parole provisions made drug enforcement “a joke” and “tied the hands of the police”. Over 70% of the general public felt that, once offenders entered the court system, the sentences handed out were inadequate; service providers echoed this, with 80% calling for more severe sentences for drug dealers and producers.

The call for harsher sentences did not, generally, extend to drug users, however. Most respondents expressed the belief that addiction needed to be treated as a healthcare issue rather than a criminal matter. Respondents generally called for more-flexible sentences for addicted persons, including restorative justice approaches and mandated treatment. Overall, there was an awareness that enforcement had to be offered in concert with treatment in order to be effective.

Several respondents suggested that decriminalizing marijuana would free up valuable police and court resources, and allow for greater attention to be paid to more-pernicious drugs. Others argued for the outright legalization of marijuana, arguing that doing so would make illegal cultivation unprofitable, thus eliminating grow-ops and ending the involvement of criminal elements in marijuana production. However, the majority of marijuana grown in BC is exported to the United States, where it is frequently exchanged kilo for kilo in the US for cocaine or for illegal firearms, both of which are then smuggled back into BC to further the activities of criminal organizations⁵⁵. The likelihood is that criminal elements will remain involved in marijuana grow operations, and that any enforcement benefits realized by legalizing marijuana would be offset by increased incidence of cocaine use and gun-related crime.

Action No. 20: Effective Application of Legislation

Local governments, service providers, local businesses and area residents should cooperate with senior levels of government to ensure that the criminal justice system deals with drug crime and drug-related crime in an appropriate, effective and consistent manner. Possible initiative include:

- *Seizure of the proceeds of crime and property used by drug dealers, including real estate on which a “grow-op” is discovered (e.g. through municipal bylaws such as those in place in Surrey and Chilliwack);*
- *Re-examination of sentencing guidelines for drug dealers and producers;*
- *Establishment, by the RCMP, of a Court Watch or similar program to ensure effective and consistent application of sentencing guidelines by increasing public awareness and understanding of, and involvement in, the judicial process and; and,*

⁵⁵ Solicitor General Rich Coleman, speech to the BC Legislature, February 13, 2003 (source: Legislative Assembly of British Columbia Official Report of the Debates of the Legislative Assembly (Hansard) Thursday February 13, 2003 Victoria: Queen’s Printer, 2003)

- *Increased use of alternative sentencing options (e.g. diversions programs, restorative justice initiatives, addictions and mental health treatment options, etc.) for first-time or low-risk addicted offenders.*

Potential Lead Agency: *Drug Policy Coordinator (Action 1), Regional District of Central Okanagan*

Potential Partner Agencies: *Solicitor General for Canada, Correctional Services Canada, Crown Prosecutors Office, Ministry of Attorney General, Ministry of Public Safety and Solicitor General, Department of Justice, RCMP, Chambers of Commerce, Downtown Kelowna Association, John Howard Society, Elizabeth Fry Society, Municipalities*

Outcome Expectations: *reduction in drug activity, improved public order, increased public confidence in justice system*

Relates to: *Goal Four (Public Order)*

Policing the Community

A majority of both public and service provider respondents held that police enforcement priorities should change, with generally less emphasis being placed on strict enforcement of the letter of the law and more attention paid to prevention by helping to educate the public about the dangers of drug use. Numerous respondents stressed the importance of greater communication and cooperation between enforcement agencies and service providers, noting that each has access to knowledge, capabilities and resources that can aid the other. In particular, police and service providers need to become more aware of each other's aims and activities, and of the realities under which each party operates.

At the same time, however, several service providers and some respondents to the general public and youth surveys warned of the dangers of asking either police or service providers to step too far outside of their area of training and expertise. Police are primarily concerned with law enforcement and service providers with the provision of needed services; there is a limit to which one can be involved with the other before the services offered by both begin to suffer. For example, it was suggested that police should spend at least half of their time on Prevention; as desirable as this might be in the abstract, the reality is that demand for core police services already stretches available resources to the limit. Having police spend half their time on prevention activities would detract from their ability to perform essential police services – much as requiring service providers to spend half their time responding to 911 calls would negatively affect their ability to serve their core clients.

The degree to which enforcement agencies can act as social service providers is also, to some extent, limited by changing drug use patterns. The advent of new and stronger drugs has led to increased incidents of paranoid aggression and violent behaviour among users; in addition, users remain under the drug's influence for significantly longer periods of time. Drug-intoxicated individuals are often a danger to themselves and others, yet there is little police can do unless the individual actually commits a crime. Even then, jail might not be a safe or appropriate place to hold them; however, there are few existing alternatives.

Arrested individuals can be taken for psychiatric evaluation, but current procedure requires the arresting officer to remain with them until the evaluation has been completed. Some arresting officers have spent up to eight hours "babysitting" detainees awaiting evaluation – eight hours in which they are off the street and out of the law enforcement business.

Action No. 21: Protective Detention

A medically-supervised "sobering station" should be established in the community. The station would:

- *Provide safe and secure facilities for two to four individuals apprehended under the influence of illicit substances;*
- *Allow police to "drop off" intoxicated individuals, rather than having to accompany them through the evaluation and treatment process;*

- *Detain, where medically advisable, intoxicated individuals for a sufficient period to allow them to reach a level of sobriety where they no longer pose a risk to themselves or others (LEGISLATIVE CHANGES REQUIRED); and,*
- *Present drug-involved persons with treatment opportunities.*

Potential Lead Agency: RCMP, Interior Health

Potential Partner Agencies: Solicitor General for Canada, Ministry of Attorney General, Ministry of Public Safety and Solicitor General, Drug Policy Coordinator (Action 1), Municipalities

Outcome Expectations: *increased referrals to treatment services, improved public order, reduced risk to individuals and the public at large*

Relates to: *Goal Two (Public Health), Goal Three (Quality of Life), Goal Four (Public Order)*

Communications and Relations

A number of respondents have noted the need for ongoing communication and cooperation between enforcement agencies and area social service providers. In the past, poor communication has occasionally contributed to a lack of understanding and stressful relationships.

Action No. 22: Professional Courtesy and Interaction

Enforcement agencies and service providers should meet on a regular (at least monthly) basis to facilitate communication and cooperation. The meetings would serve to:

- *Increase understanding between parties;*
- *Provide networking opportunities and facilitate the development of mutually-beneficial professional relationships;*
- *Help assess the effect of ongoing enforcement and social service activities;*
- *Facilitate information sharing;*
- *Identify cross-training needs and opportunities;*
- *Enhance the security of service providers, their clients and staff;*
- *Increase public awareness of enforcement initiatives; and,*
- *Encourage a co-operative approach to enforcement issues relating to problematic drug use.*

Potential Lead Agency: Drug Policy Coordinator (Action 1)

Potential Partner Agencies: RCMP, Bylaw Enforcement, Crown Prosecutors Office, Boys and Girls Club, Methadone Clinic, Kelowna Area Network of Drug Users, Ki-Low-Na Friendship Society, NOW Canada, Kelowna Gospel Mission, Kelowna Homelessness Steering Committee, Elizabeth Fry Society, John Howard Society, Living Positive Resource Centre, Kelowna Drop-In and Information Centre, ARC Programs, Kelowna Alcohol and Drug Services, Crossroads Treatment Centre, Okanagan Families, University of British Columbia – Okanagan (Nursing and Social Work Departments)

Outcome Expectations: *increased referrals to treatment services, improved public order, reduced risk to individuals and the public at large*

Relates to: *Goal One (Coordination and Cooperation), Goal Four (Public Order)*

Harm Reduction: Taking the Next Steps

Education and treatment are the two strategies that come to mind in the discourse about reducing drug-related harms. But, the literature suggests that educational approaches are relatively ineffective in reducing rates of drug use. Treatment of drug problems does show some positive effects but treatment is relatively ineffective in reducing the overall rates of drug-related problems in the population. Education and treatment are good things for a society and a government to be doing about drug problems, but they do not constitute in themselves a public-health policy on drugs.”

Robin Room

Psychoactive Substances in Canada: Levels of Harm and Means of Reduction.

Probably the least understood (and consequently the most controversial) of the Four Pillars, harm reduction is a pragmatic approach that focuses on decreasing the negative consequences of drug use for individuals and communities alike. It recognizes that, while abstinence may be the best possible outcome of any treatment program, the presence of a street-entrenched open drug scene may make it an unrealistic goal for many drug users, particularly in the short term.

Harm reduction strategies employ a hierarchy of achievable goals that protect the interests of both active drug users and the community as a whole. Some examples of successful harm reduction strategies are drop-in centres, public health outreach, emergency shelters, soup kitchens, food banks, needle exchanges, overdose prevention campaigns, needle drop boxes, prescription narcotics, and supervised consumption sites.

These strategies serve the larger public interest in a number of ways. They lessen the negative impact of an open drug scene on local business, improve the climates for tourism and economic development, and lower law enforcement costs. In addition, they can significantly reduce drug-related healthcare costs by reducing the number of overdoses and the incidence of needle-borne illnesses such as HIV/AIDS and hepatitis C, and by lessening drug-related demands on hospital emergency rooms, ambulances and other healthcare services. Certain strategies (e.g. food banks, shelters, public health outreach, etc.) also benefit other disadvantaged populations, such as the homeless and the working poor.

Popular Misconceptions

Resistance to harm reduction initiatives is somewhat puzzling, given the concept has been used in other areas of our lives for years – seatbelts are a form of harm reduction, as are ashtrays and bicycle helmets. Like drug-related harm reduction strategies, these initiatives reduce the negative effects of individual behaviour on the entire community. Needle exchanges, for example, help prevent the spread of HIV, hepatitis C and other illnesses, and in doing so reduce the burden on the healthcare system and taxpayers' wallets.

Taken out of context, harm reduction initiatives could seem to condone or even facilitate drug use; they do not. Many harm reduction initiatives are modeled after similar programs that have helped to mitigate the negative effects and reduce consumption of legal substances such as tobacco and alcohol. Needle drop boxes, for example, give injection drug users a safe way to dispose of used needles, much as public ashtrays give smokers a safe way to dispose of their cigarette butts. Both force users to acknowledge that they have a personal responsibility to dispose of their waste in a responsible manner.

Much of the fear surrounding harm reduction seems to come from the mistaken belief that harm reduction means drug consumption sites. It does not; accepting the concept of harm reduction does mean accepting its every expression. Drug consumption sites are not a default part of a community harm reduction strategy, and are generally considered only if an area regularly experiences large numbers of street overdose deaths. Of the six drug overdose deaths recorded

in the IH service region in 2003, only one did not occur in the user's home⁵⁶, suggesting there is little need for a drug consumption site. Even active users, when asked about consumption sites, responded that they were not necessary and that fundamental harm reduction measures were more of a priority⁵⁷.

Shelter Needs – Emergency and Longer Term

The provision of basic shelter facilities is an essential harm reduction activity. In addition to the obvious health benefits of putting people into a warm, dry bed rather than a cold wet alley, shelters can bring homeless and drug-involved individuals into close contact with needed health and social services, and are often an addicts first exposure to treatment services.

The Central Okanagan's homeless population has grown steadily over the past several years, particularly in Kelowna. The April 2004 homeless census reported finding 221 individuals, 64 of whom were living on the street; data from previous censuses suggests that up to 60% of these individuals might be drug-addicted. Estimates from Kelowna RCMP and downtown service providers suggest that, since the summer of 2004, as many as 100 additional homeless have arrived in the Central Okanagan. Available shelters are operating at or near capacity and, despite the efforts of several area churches, insufficient new spaces have been created to accommodate this influx.

Providing emergency shelter for homeless and drug-addicted individuals addresses only part of the problem, however. Lasting recovery requires stable long-term housing that provides the things that most of us take for granted – a place to stay during the day; somewhere to store your belongings, do laundry, prepare meals, etc. Having stable accommodations improves health, reduces dependency on social services and makes finding gainful employment a more realistic possibility. Moreover, removing homeless and drug-addicted individuals from the streets protects the interests of property owners, improves the aesthetics of the downtown core, helps restore public order, and improves the general business, social and cultural environment of the community.

Action No. 23: Short-term shelter pilot project

A low-threshold short-term shelter pilot project must be established immediately in the downtown Kelowna core. The project would:

- *Provide emergency shelter to those in need, regardless of age, gender, personal circumstances, or physical condition;*
- *Offer support and referral services outside of normal business hours (in the hours when such services are most needed);*
- *Serve as a place for police to direct individuals who are homeless and/or misuse substances;*
- *Feature a qualified multi-disciplinary staff trained in crisis intervention, counselling and harm-reduction strategies;*
- *Offer effective street-level services for at-risk individuals, including weekend and evening access to counsellors, outreach workers and detox facilities;*
- *Provide health outreach and related Harm Reduction services to homeless and/or drug-involved individuals;*
- *Make referrals to detoxification, treatment and other services as needed; and*
- *Facilitate cooperation with service providers and enable drug-involved individuals to make healthier lifestyle choices.*

Potential Lead Agency: *City of Kelowna, Kelowna Homelessness Steering Committee*

⁵⁶ Pat Townsley, Manager, Addiction Services, Okanagan Health Services Area, interview with author, August 2004.

⁵⁷ KANDU report, December 2004

Potential Partner Agencies: Interior Health, BC Housing, Ministry of Human Resources, Infrastructure Canada, National Homelessness Initiative, Drug Policy Coordinator (Action 1), Treatment Planning & Implementation Board (Action 11), University of British Columbia – Okanagan (Nursing and Social Work Departments), Kelowna Drop-In and Information Centre, Living Positive Resource Centre, Kelowna Gospel Mission, NOW Canada, Ki-Low-Na Friendship Society, Kelowna Area Network of Drug Users

Outcome Expectations: reduction in open street drug scene, increased referrals to treatment services, improved public order, reduced risk to individuals and the public at large, enhanced public safety and security

Relates to: Goal Two (Public Health), Goal Three (Quality of Life), Goal Four (Public Order)

Action No. 24: Youth shelter and drop-in facility

A low-threshold emergency/short-term shelter and drop-in centre for youth (those aged 19 and under) must be established immediately in the downtown Kelowna core. The project would:

- Provide emergency shelter to homeless, drug-involved or street-involved youth regardless of gender, personal circumstance, or physical condition;
- Offer support and referral services outside of normal business hours (in the hours when such services are most needed);
- Serve as a place for police to direct youth who are homeless and/or misuse substances;
- Feature a qualified multi-disciplinary staff trained in crisis intervention, counselling and harm-reduction strategies;
- Offer effective street-level services for at-risk youth, including weekend and evening access to counsellors, outreach workers and detox facilities;
- Provide health outreach and related Harm Reduction services;
- Make referrals to detoxification, treatment and other services as needed; and
- Facilitate cooperation with service providers and enable drug-involved individuals to make healthier lifestyle choices.

Potential Lead Agency: City of Kelowna, Boys and Girls Club, Kelowna Homelessness Steering Committee

Potential Partner Agencies: Interior Health, BC Housing, Ministry of Human Resources, Infrastructure Canada, National Homelessness Initiative, Drug Policy Coordinator (Action 1), Treatment Planning & Implementation Board (Action 11), University of British Columbia – Okanagan (Nursing and Social Work Departments), Kelowna Drop-In and Information Centre, Living Positive Resource Centre, Kelowna Gospel Mission, NOW Canada, Ki-Low-Na Friendship Society, Kelowna Area Network of Drug Users

Outcome Expectations: reduction in open street drug scene, increased referrals to treatment services, improved public order, reduced risk to individuals and the public at large, enhanced public safety and security

Relates to: Goal Two (Public Health), Goal Three (Quality of Life), Goal Four (Public Order)

Action No. 25: Low-income Housing Projects

The establishment of low-income and/or subsidized housing must become an urban development priority. Housing units should:

- Be affordable to individuals and families with incomes below the Statistics Canada Low Income Cut-off level;
- Be distributed throughout the community, so as to avoid the emergence of depressed areas or socio-economic ghettos;
- Include common-area facilities that will encourage cultural and recreational activities for residents (Action 6);
- Allow for on-site delivery of essential social services (life-skills training, basic health care, employment counselling, etc.);
- Have ready access to public transportation;
- Encourage resident participation in the management and maintenance, so as to foster pride of place and self-esteem.

Potential Lead Agency: Municipalities, BC Housing

Potential Partner Agencies: Ministry of Human Resources, Canada Mortgage and Housing Corporation, Infrastructure Canada, National Homelessness Initiative, Drug Policy Coordinator (Action 1), Treatment Planning & Implementation Board (Action 11).

Outcome Expectations: reduction in open street drug scene, increased referrals to treatment services, improved public order, reduced risk to individuals and the public at large, reduced homelessness

Relates to: Goal Two (Public Health), Goal Three (Quality of Life)

Preventing Harm to Others

While it is difficult to estimate exactly how many intravenous drug users (IDU) there are in the Central Okanagan, it is clear that the numbers are sufficient to create a significant problem. The number of needles used by an addict in a single day varies depending on the drug of choice. The effects of heroin injection might last several hours, and most users inject one-three times daily. Cocaine injection, on the other hand, provides an intense but short-lived high, often as short as 5-10 minutes, and heavy users might inject 30 or more times daily.

With needle use comes the risk of infection from HIV, hepatitis C and other blood-borne pathogens, risks that increase dramatically the more often a needle is used or shared. From a public health and disease prevention standpoint, it is preferable that a new needle be used for each injection. As each new case of HIV costs the healthcare system over \$145,000 in lifetime treatment costs, it is preferable from an economic standpoint as well.

Improper disposal of these needles, however, merely transfers the risk from one section of the populace to another, and is one of the most serious public health issues arising from intravenous drug use. A discarded needle can expose an unwary individual to drugs, as well as to HIV, hepatitis C and other blood-borne pathogens. While there are several agencies that will collect discarded needles, not all of these have accurate statistics available, and it is not possible to estimate the number of needles collected annually. Moreover, some of the sources for needles (e.g. area pharmacies) do not record the numbers of needles distributed, there are no reliable estimates of how many needles are in circulation at a given time.

Needle drop boxes are designed to prevent the spread of disease and improve health and can help users access treatment and other support services. They are safe and effective, a proven means of protecting the public from potentially life-threatening injuries. In Calgary, drop boxes have been in use since the 1990s, and taken over 125,000 needles per year from city streets.

Action No. 26: Improved Needle Drop Box Services

Existing Needle Drop Box services must be expanded. Boxes should be:

- *Placed in consultation with area intravenous drug users;*
- *Designed to ensure public safety and minimize any potential impact on tourism or commerce; and*
- *Used to advertise treatment and support services to users, increasing the chance that they might begin to make healthier lifestyle choices.*

Potential Lead Agency: Municipalities, Drug Policy Coordinator (Action 1)

Potential Partner Agencies: Interior Health, Health Canada, Treatment Planning and Implementation Board (Action 11), Kelowna Drop-In and Information Centre, Living Positive Resource Centre, Kelowna Gospel Mission, NOW Canada, Kelowna Medical Society, Ki-Low-Na Friendship Society, Kelowna Area Network of Drug Users, Downtown Kelowna Association, Chambers of Commerce, Boys and Girls Club

Outcome Expectations: lessened risk to public health, increased referrals to treatment services, improved public order, improved climate for business and tourism

Relates to: Goal Two (Public Health), Goal Three (Quality of Life)

Public Education

As mentioned above, harm reduction is a contentious issue, and not all survey respondents were convinced that it was an effective, or even advisable activity. Although 68% of general respondents claimed at least a working knowledge of harm reduction strategies, support for this pillar was, at best, tentative, with 28% reporting that they were at least somewhat concerned that harm reduction programs would encourage drug use in the community. Many of those who recognized the value of harm reduction programs more as an adjunct to programs offered by the other pillars rather than as freestanding entities. One respondent opined that harm reduction programs offer no incentive to addicts to quit using, and that mandatory treatment would be more effective.

Service providers were generally more supportive of harm reduction; however, that support was tempered by the understanding that the community might be unwilling to accept it. For example, 83% of service providers identified needle exchanges as necessary, while at the same time, 33% acknowledged that they would probably be unacceptable to the public. Awareness campaigns, needle drop boxes and income supports were seen as the most needed initiatives.

The benefits of harm reduction initiatives are increasingly accepted, and the concept itself is a central part of most drug strategies. However, the ultimate effectiveness of these initiatives depends on public acceptance of them.

Action No. 27: Public Education

The community (including elected officials, business groups and the public at large) must be educated as to the nature, extent and benefit of existing and proposed harm reduction initiatives. Educational materials should:

- *Provide accurate and factual information about Harm Reduction and Harm Reduction activities;*
- *Be easily accessible and understandable;*
- *Be widely distributed (e.g. in conjunction with municipal utility bills);*
- *Provide opportunities for meaningful feedback.*

Potential Lead Agency: Municipalities, Drug Policy Coordinator (Action 1)

Potential Partner Agencies: Interior Health, School District #23, Health Canada, Methadone Clinic, Kelowna Area Network of Drug Users, Kelowna Medical Society, Living Positive Resource Centre, Kelowna Alcohol and Drug Services, Crossroads Treatment Centre

Outcome Expectations: *increased knowledge and understanding of drug-related issues, lessened risk to public health, more treatment services referrals, improved public order*

Relates to: Goal One (Coordination and Cooperation), Goal Two (Public Health), Goal Three (Quality of Life)

Public Health

The provision of enhanced street-level health care is an integral part of this Framework. Unsurprisingly, drug-involved individuals, particularly those living on the street, are often in relatively poor health. Moreover, many face barriers to accessing proper health care, including lack of transportation, no money for prescriptions, and a lack of physicians accepting new patients, to name a few. While street-level health care is available in the community, inadequate funding limits both hours of operation and program effectiveness. Outreach Health, Kelowna's main provider of street-level nursing services, can afford to remain open for only four half-days per week, despite extremely high demand for its services – on average, the clinic serves about 70 people in a 3.5 hour shift⁵⁸. When the clinic is closed, those clients generally rely on hospital Emergency Rooms for even minor medical care, at great expense to the healthcare system. As mentioned above, up to 85% of all Emergency Room visits are drug-related; most of these could be dealt with more quickly, and at far less expense to the public purse, through properly funded street-level nursing programs.

⁵⁸ Connie Zol, Outreach Health, interview with author

Action No. 28: Public Health Outreach

Immediate action should be taken to expand street-level nursing services throughout the community. Services should have sufficient support and funding to allow them to:

- *Remain open at least 40 hours per week (based on demand);*
- *Offer a full range of basic healthcare services;*
- *Provide effective prevention and harm reduction programs;*
- *Have a medical doctor on site a minimum of three days per week*

Potential Lead Agency: *Interior Health, Boys & Girls Club, Drug Policy Coordinator (Action 1),*

Potential Partner Agencies: *Health Canada, Kelowna Medical Society, , Treatment Planning and Implementation Board (Action 11), Kelowna Drop-In and Information Centre, Living Positive Resource Centre, Kelowna Medical Society, Kelowna Area Network of Drug Users, Westbank First Nation,*

Outcome Expectations: *reduced healthcare costs, improved public health, lessened load on hospital Emergency Room*

Relates to: *Goal Two (Public Health), Goal Three (Quality of Life)*

Conclusion

Problematic drug use is a complex issue that reaches into all aspects of life in our community and, in doing so, affects us all. It has no single cause, presents no single profile and cannot be successfully addressed by any single approach. Its root causes are numerous, and there are as many different paths to problematic drug use as there are people to travel them.

For most people, becoming a problematic drug user was not a conscious choice. An individual who elects to try a drug for the first time is not consciously choosing to become addicted, any more than someone having their first beer is volunteering to become an alcoholic. Problematic drug use is usually the unfortunate and unanticipated end result of a series of unfortunate decisions, often combined with personal trauma such as an undiagnosed mental illness, familial breakdown, sudden unemployment, and childhood physical or sexual abuse. For many, drugs are a means of surviving personal tragedy, of coping with the reality of a life that is, to them, often unbearable. As long as the conditions that give rise to problematic drug use persist, we will never be able to completely eliminate the phenomenon from our community.

We *can* make a difference, however, by working together as a community, and responding to issues related to problematic drug use in a balanced and coordinated manner. In this way, we *can* prevent drug use among our youth. We *can* improve public health, and repair the damage done by drugs to our social and economic quality of life. We *can* restore public order, and make our community safer and more inviting for all residents.

It will not be easy. The more one learns about drugs and drug-related issues in our community, the more it becomes apparent that we have only just scratched the surface of the problem. The actions outlined in this Framework are but the first steps in a long and challenging journey. Problematic drug use in our community will continue to evolve and adapt over time, and so must our responses to it. Properly implemented, the actions outlined in this report will help ensure that those responses are the right responses.

Bibliography

- Adam, L. *et al* Profile of Substance Abuse Treatment and Rehabilitation in Canada Ottawa: Office of Alcohol, Drugs and Dependency Issues, Health Canada 1999
- Advisory Council on the Misuse of Drugs UK Drug Strategies United Kingdom: North Ireland and Great Britain, 2001
- Assistant Deputy Ministers' Committee on Prostitution and the Sexual Exploitation of Youth Sexual Exploitation of Youth in British Columbia Victoria: Ministries of Attorney General, of Children and Families, of Health, and Responsible for Seniors, 2000
- Basham, Patrick Re-evaluating the War on Drugs Vancouver: Fraser Institute, 2001
- BC Centre for Disease Control Communicable Disease Control Needle Exchange Programs February 2003
- BC Coroners Service Methamphetamine Deaths in BC Victoria: Government of British Columbia April 2004
- Illicit Drug Deaths – 1996 to 2003, Victoria: Government of British Columbia August 2004
- Birmingham, John Ottawa Green-Lights Free Heroin Program The Province, August 19, 2004
- Blakeslee, Sandra Amphetamine Use Shrinks Brains New York Times, July 20, 2004
- Bohl, Kelly Report of the "Caught in the Web" 2004 BCPOA Conference Vancouver: BC Probation Officers Association, 2004
- Brochu, Serge, *et al* Drugs Alcohol, and Criminal Behaviour: A Profile of Inmates in Canadian Federal Institutions Ottawa: Correctional Services Canada Forum on Corrections Research Focusing on Alcohol and Drugs January 2001 vol. 13 no. 3
- Butterfield, Fox Most Efforts to Stop Crime Fall Short, Study Finds New York Times, Wednesday May 5, 2004
- Buxton, Jane Vancouver Drug Use Epidemiology July 2003 Vancouver: Canadian Community Epidemiology Network on Drug Use, 2003
- Cain, JV Report of the Task Force into Illicit Narcotic Overdose Deaths in British Columbia, Ministry of the Attorney General, 1994
- Canadian Centre on Substance Abuse Canadian Addiction Survey Ottawa: Canadian Centre on Substance Abuse, 2004
- Envisioning a National Framework for Action on Substance Use and Abuse Ottawa: Canadian Centre on Substance Abuse, 2004
- Canadian Community Epidemiology Network on Drug Use Methamphetamine Environmental Scan Summit – Final Report, Vancouver: Canadian Community Epidemiology Network on Drug Use January 2003
- Canadian Press B.C. Safe Injection Site Worries U.N. March 3 2004
- Caputo, Tullio FCM Municipal Drug Strategy Phase III Report – A summary Evaluation of Pilot Projects Canadian Federation of Municipalities, 2003
- Caranci, Julia Highest Meth Abuse in BC Surrey Leader, August 6, 2004
- Casavant, Lyne and Chantel Collin Illegal Drug Use and Crime: A Complex Relationship Ottawa: Senate Special Committee on Illegal Drugs October 2001
- City of Kelowna, Housing Needs Study 1999/2000 Kelowna: City of Kelowna, 2001

- City of Vancouver Supervised Injections Sites (SISs) – Frequently Asked Questions Vancouver: City of Vancouver 2004
- Central City Concern Homeless, Alcohol and Drug Intervention Network – Interagency Linkage Agreement Portland: Central City Concern, 2003
- Curtis, Malcolm Health Officer Endorses Safe Drug Site for Victoria Victoria Times Colonist, March 27, 2004
- Dandurand, Ching and Associates Lower Mainland Crime and Drug Misuse Prevention Strategy – Regional Action Plan to Reduce the Harmful Effects of Alcohol and Drug Misuse Abbotsford: Lower Mainland Municipal Association, 2001
- Dell, Colleen Canadian Community Epidemiology Network on Drug Use (CCENDU): 2002 National Report Ottawa: Canadian Centre on Substance Abuse, 2003
- Derfel, Aaron Addicts to Get Free Heroin Montreal Gazette Tuesday, October 21 2003
- Drug Reform Coordination Network UN Drug Report Criticizes Safe Injection Sites <http://stopthedrugwar.org/chronicle/327/incbreport.shtml>
- Russia's New Drug Law in Effect: No Jail for Drug Users, Greater Penalties for Drug Traffickers March 12, 2004
- Interview with Mayor Larry Campbell November 21, 2003
- Government of Canada Proceedings of the Special Committee on Illegal Drugs May 13, 2002 Ottawa: Queen's Printer, 2002
- , Uniform Crime Reporting Survey 2 (UCR2), 2002
- Government of Canada Auditor General, Report on Canada's National Drug Strategy, Ottawa: Auditor General, 2000
- Handschuh, Darren Overdose of Reality: BC Bud Appears to be Giving Way to More Deadly Narcotics in the Okanagan Kelowna Daily Courier, January 23, 2004
- Cocaine Crackdown Kelowna Daily Courier, November 21, 2003
- Mom at wits end as daughter falls into world of drugs Kelowna Daily Courier, January 21, 2004
- Teens tell tales of life on streets Kelowna Daily Courier, March 10, 2004
- Clinic Brings Care to the Street Kelowna Daily Courier, November 27, 2004
- Harding, John What's Killing Us? Kelowna Daily Courier, November 21, 2003
- Health Canada Best Practices: Treatment and Rehabilitation for Youth with Substance Use Problems 2001
- Health Canada, Reducing the Harm Associated with Injection Drug Use in Canada Ottawa: Ministers of Health Meeting, September 2001
- Hedric, Dagmar European Report on Drug Consumption Rooms European Monitoring Centre for Drugs and Drug Addiction, 2004
- Hill, Melissa Evaluative Report of the PERSON Project Kelowna: AIDS Resource Centre, 2003
- HIV/AIDS Strategy Advisory Committee British Columbia's Framework for Action on HIV/AIDS Victoria: Ministry of Health and Ministry Responsible for Seniors, 1998
- Hlady, Jerry Kelowna's Homeless Kelowna: Downtown Kelowna Association, 2004
- Howell, Mike Mayor Says Legal Crack Smoking Room is no Pipe Dream Vancouver Courier, August 30, 2004
- Interior Health Interior Health Population Health Profile, Kelowna: Interior Health, December 2002

- James, C. Alberta – Social and Health Indicators of Addiction Alberta: Alberta Alcohol and Drug Abuse Commission, 1999
- James, D, Sakwa, E Drug Treatment Courts Canadian Journal of Policy Research, Vol.3 no. 1, Spring 2002
- James, Robert Kelowna – A Closer Look Kelowna: United Way of the Central and South Okanagan May 2004
- Homelessness and Problematic Drug Use in Kelowna – A Primer Kelowna: Central Okanagan Four Pillars Coalition, 2004
- Johnson, Sara L. Impact of Institutional Methadone treatment on Release Outcome Ottawa: Correctional Services Canada Forum on Corrections Research Focusing on Alcohol and Drugs January 2001 vol. 13 no. 3
- Jurgens, R. The Impact of Canada's Drug Laws on the Spread of HIV. A Joint Submission to the Standing Senate Committee on Legal and Constitutional Affairs Montreal: Canadian HIV/AIDS Legal Network and the Canadian AIDS Society, 1996
- Kaiser Youth Foundation A Case for an Independent Substance Abuse and Addictions Commission, May 2000
- Kelowna Area Network of Drug Users Survey of Active Drug Users Kelowna: Okanagan Aboriginal AIDS Society November 2004
- Kelowna Homelessness Networking Group Report on the Census of Homeless Individuals in Kelowna – March 2003
- Report on the Census of Homeless Individuals in Kelowna – November 2003
- Report on the Census of Homeless Individuals in Kelowna – April 2004
- Report on the Census of Homeless Individuals in Kelowna – November 2004 (preliminary data)
- Kelowna Steering Committee on Homelessness Community Plan: Reducing Homelessness in Kelowna, BC July 2003, June 2006 Kelowna: Kelowna Steering Committee on Homelessness
- Kerr, Thomas, Darlene Palmer, Ralf Jurgens Time to Find New Ways to Fight Drugs Montreal Gazette, Tuesday November 18, 2003
- LaFranci, Howard Global Scourge: Synthetic Drugs Christian Science Monitor, August 7, 2003
- Laude, Carolyn The Regina and Area Drug Strategy Report Regina: Drug Strategy Reference Committee, June 2003
- Legislative Assembly of British Columbia Official Report of the Debates of the Legislative Assembly (Hansard) Thursday February 13, 2003 Victoria: Queen's Printer, 2003
- Linton, David Our Prairie Future – Toward Child and Youth Centred Communities Centre of Excellence Ottawa: Health Canada, 2003
- MacPherson, Donald A Framework for Action, A Four Pillar Approach to Drug Problems in Vancouver Vancouver: City of Vancouver, 2001
- Mangham, C. Harm Reduction and Illegal Drugs: The True Debate – A Paper Prepared for the Special Committee on Illegal Drugs, 36th Parliament – 2nd Session, 2000 Dalhousie: Prevention Source BC, 2000
- McDermott, Jeremy New Strain of Coca Plant Stuns Anti-Drug Officials The Scotsman, August 27, 2004
- McKinnon, Supt. W. "Speech to the Kelowna Chamber of Commerce" November 2004

- Millar, John HIV, Hepatitis, and Injection Drug Use in British Columbia – Pay Now or Pay Later? Victoria: Ministry of Health, 1998
- Milne, Celia Club Drugs Causing Fewer Emergency Room Visits: Ecstasy is out, but Cocaine is on the rise Medical Post, August 17, 2004
- Ministry for Children and Family Development Interior Child, Youth and Family Service Delivery Plan Victoria: Queen's Printer, 2003
- Ministry for Health Services Crystal Meth and other Amphetamines: An Integrated BC Strategy Victoria: Queen's Printer, 2004
- Policy for British Columbia Needle Exchange Agencies Receiving Free Supplies Victoria: Queen's Printer, 2003
- Ministry of Public Safety and Solicitor General Quarterly Crime Report 1st Quarter 2004 Victoria: Queen's Printer, 2004
- Drug Crime in BC – Summary Statistics 1993-2002 Victoria: Queen's Printer, 2003
- Minkoff, Kenneth Co-occurring Psychiatric and Substance Disorders – An Integrated Treatment Model and Comprehensive System of Care Vancouver: Fraser Valley Health Authority November 2002
- Motiuk, Larry and Ben Voung Profiling the Drug Offender Population in Canadian Federal Corrections Ottawa: Correctional Services Canada Forum on Corrections Research Focusing on Alcohol and Drugs January 2001 vol. 13 no. 3
- Murphy, Emily J. The Black Candle Totonto: Thomas Allen, 1922
<http://www.freeworldnews.com/frontmatter.html>
- Ottawa Citizen Police on Grow Ops – Don't You Believe It March 2, 2004
- Out From the Shadows Final Report Out from the Shadows International Summit of Sexually Exploited Youth, May 1998
- Parnell, Kevin "Downtown merchants fed up with trashed streets" Kelowna Capital News Sunday, January 23, 2005
- Picken, Shane Changes Program Performance Outcome Evaluation Report: April 2003 Kelowna: ARC Programs, March 2004
- Plant, Don "Exodus on Leon" Kelowna Daily Courier, January 21, 2005
- Podsadowski, Alan 30 Years on, We've Made Little Progress in Treating Drugs Vancouver Sun, Monday March 15 2004
- Prime Minister's Caucus Task Force on Urban Issues Canada's Urban Strategy – A Vision for the 21st Century Ottawa: Queen's Printer, 2002
- Regional Task Force on Homelessness,
- Roy, Michel The National Drug Strategy of the Correctional Service of Canada Ottawa: Correctional Services Canada Forum on Corrections Research Focusing on Alcohol and Drugs January 2001 vol. 13 no. 3
- Scott, S. Attractions and Aversions: Exploring Attitudes and Perceptions of Sexually Procured Youth in the Downtown Eastside, Master's Thesis, School of Social Work, University of British Columbia, 1998
- Simpson, A. Closing the Revolving Door: The Toronto Drug Treatment Court Ottawa: Caledon Institute of Social Policy, 2001
- Single E, *et al* The Costs of Substance Abuse in Canada Ottawa: Canadian Centre on Substance Abuse, 1996

- Statistics Canada Alcohol and Drug Use in Early Adolescence The Daily, May 18, 2004
- Adult Criminal Court Survey Tables Ottawa: Canadian Community Epidemiology Network on Drug Use (CCENDU) 2001
- Canadian Community Health Survey – Mental Health and Well-being 2002
- Canadian Community Health Survey – Mental Health and Well-being 2004
- Trends in Drug Offences and The Role of Alcohol and Drugs in Crime, 2002
- Ubelacker, Sheryl Street Youth More Likely to Die of Suicide, Drug Overdoes: Montreal Study Canadian Press, August 7, 2004
- Vancouver Board of Trade Property Crime in Vancouver Vancouver: Vancouver Board of Trade, 2003
- Vasudev, Navin A Study of the Perceptions on Sales of Needles and Syringes by Pharmacies in Kelowna Kelowna: AIDS Resource Centre, 2003
- Watts, Richard FAS/FAE Creates Issues for Criminal Justice System Victoria Times Colonist, Tuesday March 9, 2004
- Weeks, John Needle Exchange Programs – FAQs Ottawa: Canadian Centre on Substance Abuse, 2004
- Zacharias, Rand “Opinions and Needles” Okanagan Life, September 2004

APPENDIX ONE: SUMMARY OF GOALS AND ACTIONS

Goal #1 Coordination and Cooperation

Define and implement a coordinated response to problematic drug use, and to ensure its continued relevance through ongoing research and consultation.

Action No. 1: Regional Drug Policy Coordinator

Establish and provide long-term support and funding for a Drug Policy Coordinator for the Regional District of Central Okanagan. The position would be maintained for a minimum of 10 years, with funding support from the Provincial government and Federal governments. The Coordinator would, at a minimum:

- *Ensure transparency and accountability in all stages and aspects of the Framework;*
- *Facilitate cooperation and coordination between service providers, in order to ensure the effective implementation of agreed upon strategies;*
- *Liaise with stakeholders, including government, service providers, researchers, local business owners, drug users and the public at large;*
- *Conduct additional research as required to assess the effectiveness of actions taken to date, and to help to determine the need for additional actions;*
- *Help identify real or potential challenges to anti-drug initiatives, such as funding issues and the emergence of new drugs or drug use patterns; and,*
- *Make regular progress reports to all parties and to the public at large.*

Potential Lead Agency: Regional District of Central Okanagan

Potential Partner Agencies: Ministry of Communities, Aboriginal and Women's Services, Health Canada; Treatment Planning & Implementation Board (Action 11)

Expected Outcome: Greater coordination, communication and cooperation among stakeholders; increased public awareness and input

Action No. 2: Community Capacity Building

Ongoing efforts must be made to identify, map and increase existing community capacities, and to enhance the abilities of service providers to provide effective prevention services. Area service providers should cooperate with community-based researchers to:

- *Increase public awareness of existing programs and identify opportunities for increasing program capacities;*
- *Facilitate ongoing research into existing community capacity;*
- *Conduct workshops and education initiatives to increase awareness of current prevention research and "best practices" among prevention service providers;*
- *Design and implement valid, reliable and consistent longitudinal studies of the effectiveness of prevention initiatives;*
- *Assist the Regional Drug Policy Coordinator in the design and implementation of longitudinal studies on the effectiveness of treatment, enforcement and harm reduction initiatives; and,*
- *Create and help maintain linkages between prevention service providers.*

Potential Lead Agency: University of British Columbia – Okanagan, prevention service providers

Potential Partner Agencies: Regional Drug Policy Coordinator (Action 1), School District #23,

Expected Outcome: Greater coordination, communication and cooperation among stakeholders; increased public awareness and input

Action 8: Drug-related Information Line

A public information telephone service should be established to help individuals access non-emergency social, health and government services. The service should:

- *Use an easy-to-remember, toll-free number (e.g. 211);*
- *Be available 24 hours a day, seven days a week throughout the Central Okanagan;*
- *Be staffed by trained specialists capable of assessing the needs of the caller and linking them to the best available information and/or services;*

- Be capable of dealing with any drug-related question or complaint; and
- Maintain a listing of all non-emergency governmental and non-governmental social services in the Central Okanagan.

Potential Lead Agency: Kelowna Community Resources, Drug Policy Coordinator (Action 1)

Potential Partner Agencies: Health Canada, Interior Health, Municipalities, Kelowna Medical Society, Living Positive Resource Centre, Canadian Radio & Telecommunications Commission, Okanagan Families, University of British Columbia – Okanagan (Education and Social Work Departments)

Expected Outcomes: Improved knowledge of services, better service delivery, increased public health and security

Action 11: Coordinated Planning and Implementation

Immediate action should be taken to establish a multilateral Treatment Planning and Implementation Board. The Board would:

- Continue the review of existing treatment services;
- Explore new responses to problematic drug use;
- Conduct longitudinal studies to determine program effectiveness;
- Help determine how best to allocate current and future funding to improve the continuum of care in the region;
- Work to ensure the presence of long-term sustainable funding for anti-drug programs and initiatives in the community; and,
- Cooperate with the Regional Drug Strategy Coordinator to ensure the success of the overall Framework.

Potential Lead Agency: Interior Health, Drug Policy Coordinator (Action 1)

Potential Partner Agencies: Ministry of Health Services, Ministry for Children and Family Development, Ministry of Human Resources, University of British Columbia – Okanagan, Kelowna Medical Society, Municipalities, Crossroads Treatment Centre, ARC Programs, Kelowna Alcohol and Drug Services, Living Positive Resource Centre, Ki-Low-Na Friendship Society, Kelowna Area Network of Drug Users, Methadone Clinic, Okanagan Families, Boys and Girls Club, Downtown Kelowna Association, Chambers of Commerce,

Outcome Expectations: increased treatment capacity, improved needs assessment, improved treatment outcomes, reduced wait times for treatment services, improved public health and security

Action No. 19: RCMP Special Projects Team

The operations of the RCMP Special Projects Team should be continued, and expanded as needed to address drug crime and drug related crime in the Central Okanagan. At a minimum, the Team should:

- Continue to focus on drug enforcement and the reduction of related offences such as prostitution, through the even-handed and consistent application of appropriate legislative tools such as the Criminal Code of Canada, Provincial Acts and Statutes (including the Safe Streets Act and Trespass Act) and relevant municipal bylaws;
- Aggressively target drug dealers at the street level and follow criminal drug activity up through the drug culture hierarchy; and
- Through the Non-Commissioned Officer in Command (NCOIC), cooperate with the Regional Drug Policy Coordinator to establish a communication strategy that will ensure public awareness of and education about enforcement initiatives and other drug-related issues in the Central Okanagan.

Potential Lead Agency: RCMP, Municipalities

Potential Partner Agencies: Ministry of Attorney General, Ministry of Public Safety and Solicitor General, Drug Policy Coordinator (Action 1)

Outcome Expectations: reduction in drug activity, improved public order, increased public awareness, generation of statistical data

Action No. 22: Professional Courtesy and Interaction

Enforcement agencies and service providers should meet on a regular (at least monthly) basis to facilitate communication and cooperation. The meetings would serve to:

- Increase understanding between parties;
- Provide networking opportunities and facilitate the development of mutually-beneficial professional relationships;
- Help assess the effect of ongoing enforcement and social service activities;

- Facilitate information sharing;
- Identify cross-training needs and opportunities;
- Enhance the security of service providers, their clients and staff;
- Increase public awareness of enforcement initiatives; and,
- Encourage a co-operative approach to enforcement issues relating to problematic drug use.

Potential Lead Agency: Drug Policy Coordinator (Action 1)

Potential Partner Agencies: RCMP, Bylaw Enforcement, Crown Prosecutors Office, Boys and Girls Club, Methadone Clinic, Kelowna Area Network of Drug Users, Ki-Low-Na Friendship Society, NOW Canada, Kelowna Gospel Mission, Kelowna Homelessness Steering Committee, Elizabeth Fry Society, John Howard Society, Living Positive Resource Centre, Kelowna Drop-In and Information Centre, ARC Programs, Kelowna Alcohol and Drug Services, Crossroads Treatment Centre, Okanagan Families, University of British Columbia – Okanagan (Nursing and Social Work Departments)

Outcome Expectations: increased referrals to treatment services, improved public order, reduced risk to individuals and the public at large

Action No. 27: Public Education

The community (including elected officials, business groups and the public at large) must be educated as to the nature, extent and benefit of existing and proposed harm reduction initiatives. Educational materials should:

- Provide accurate and factual information about Harm Reduction and Harm Reduction activities;
- Be easily accessible and understandable;
- Be widely distributed (e.g. in conjunction with municipal utility bills);
- Provide opportunities for meaningful feedback.

Potential Lead Agency: Municipalities, Drug Policy Coordinator (Action 1)

Potential Partner Agencies: Interior Health, School District #23, Health Canada, Methadone Clinic, Kelowna Area Network of Drug Users, Kelowna Medical Society, Living Positive Resource Centre, Kelowna Alcohol and Drug Services, Crossroads Treatment Centre

Outcome Expectations: increased knowledge and understanding of drug-related issues, lessened risk to public health, more treatment services referrals, improved public order

Goal #2 Public Health:

Address drug-related health and welfare issues through effective prevention, treatment and harm reduction activities.

Action No. 1: Regional Drug Policy Coordinator

Establish and provide long-term support and funding for a Drug Policy Coordinator for the Regional District of Central Okanagan. The position would be maintained for a minimum of 10 years, with funding support from the Provincial government and Federal governments. The Coordinator would, at a minimum:

- Ensure transparency and accountability in all stages and aspects of the Framework;
- Facilitate cooperation and coordination between service providers, in order to ensure the effective implementation of agreed upon strategies;
- Liaise with stakeholders, including government, service providers, researchers, local business owners, drug users and the public at large;
- Conduct additional research as required to assess the effectiveness of actions taken to date, and to help to determine the need for additional actions;
- Help identify real or potential challenges to anti-drug initiatives, such as funding issues and the emergence of new drugs or drug use patterns; and,
- Make regular progress reports to all parties and to the public at large.

Potential Lead Agency: Regional District of Central Okanagan

Potential Partner Agencies: Ministry of Communities, Aboriginal and Women's Services, Health Canada; Treatment Planning & Implementation Board (Action 11)

Expected Outcome: Greater coordination, communication and cooperation among stakeholders; increased public awareness and input

Action 3: Expansion of D.A.R.E.

D.A.R.E. must build upon its successes and offer anti-drug to more students, more often. Specifically, the D.A.R.E. program should:

- *Continue to be offered in every Grade Five class in School District #23; and*
- *Be expanded over time to include every Grade Eight class in School District #23.*

Potential Lead Agency: RCMP, School District #23

Potential Partner Agencies: Ministry of Education, Parental Advisory Committees, Drug Policy Coordinator (Action 1)

Expected Outcomes: Improved drug education, reduced or delayed onset of drug use, greater student awareness of drug-related issues.

Action 4: Enhanced Drug Education

Educators must work with area service providers to develop and offer an effective continuum of drug education programs to respond to the differing needs of students. Enhanced drug education programs should:

- *Be developed based on evidence and accepted research;*
- *Be offered to at every grade level, in a manner suited to the audience's level of intellectual, social and emotional development;*
- *Engage the audience in an effective and compelling manner;*
- *Foster the development of social competency skills, self-esteem, peer resiliency and critical reasoning skills, and their inclusion into existing prevention programs;*
- *Be fact-based and honest in presentation and content;*
- *Prepare students for specific drug-related threats they might reasonably expect to face in their immediate future;*
- *Develop the individual's interpersonal communication skills, problem solving ability, and their capacity to deal with stress and emotional upheaval;*
- *Incorporate the active participation of parents and members of the neighbourhoods in the school's catchment area*

Potential Lead Agency: School District #23, Drug Policy Coordinator (Action 1)

Potential Partner Agencies: Ministry of Education, Ministry for Children and Family Development, University of British Columbia – Okanagan (Education, Nursing and Social Work Departments), Interior Health, Parental Advisory Committees, Boys and Girls Club, Kelowna Area Network of Drug Users, Kelowna Medical Society, NOW Canada, Elizabeth Fry Society, Living Positive Resource Centre, ARC Programs, Crossroads Treatment Centre, Health Canada

Expected Outcomes: Improved drug education, reduced or delayed onset of drug use, greater student awareness of drug-related issues; improved relations between youth and their community, increased parental understanding of drug-related issues.

Action 5: Harm Reduction Education

Educators and parent must understand that some youths will choose to use drugs despite any and all drug education efforts, and must ensure that those youth are aware of Treatment and Harm Reduction programs available in the community, in order to facilitate their recovery. Programs should:

- *Be offered to students in those age groups most at risk of becoming drug-involved;*
- *Incorporate honest, accurate portrayals of the effect of drug use;*
- *Be offered by actual Treatment and Harm Reduction service providers from the community;*
- *Incorporate, where appropriate, the participation of recovering users, particularly those close in age to the audience⁵⁹;*
- *Incorporate the active participation of parents and members of the neighbourhoods in the school's catchment area*

Potential Lead Agency: School District #23, Drug Policy Coordinator (Action 1)

Potential Partner Agencies: Ministry of Education, Ministry for Children and Family Development, Interior Health, Parental Advisory Committees, University of British Columbia – Okanagan (Education and Social

⁵⁹ This was a frequently-requested change to existing prevention courses, but there is little research support for the concept; some service providers argue that showing youth someone who has "beaten" addiction makes drug use seem less harmful.

Work Departments), Crossroads Treatment Centre, ARC Programs, Living Positive Resource Centre, Elizabeth Fry Society, NOW Canada, Kelowna Medical Society, Kelowna Area Network of Drug Users, Boys and Girls Club, Health Canada

Expected Outcomes: Reduced or delayed onset of drug use, greater student awareness of drug-related issues and of treatment options for themselves and peers; increased parental understanding of drug-related issues facing their children; improved youth access to treatment.

Action 6: Recreational, Social & Cultural Alternatives

Recreational, social and cultural activities offered in the Central Okanagan must be enhanced and expanded to increase long-term participation by youth and other at-risk populations. Programs should:

- Be designed to improve the health, well-being, self-esteem and overall resilience of the participants;
- Encourage participation from an early age;
- Promote concepts of fair play and respect for others;
- Incorporate school-based activities, including expanded physical education classes, intra- and extra-mural sports, amateur theatrics and similar activities;
- Allow easy transition from school- to community-based activities;
- Emphasize the need for non-competitive sport “fun leagues” for all age groups;
- Promote lifelong involvement in leisure activities as a cornerstone of a healthy lifestyle;
- Incorporate the active participation of parents and members of the public as coaches, officials and mentors.

Potential Lead Agency: School District #23, Municipal Parks, Recreation and Leisure Services

Potential Partner Agencies: Ministry of Education, Parental Advisory Committees, Okanagan Families, Boys and Girls Club, Drug Policy Coordinator (Action 1)

Expected Outcomes: Reduced or delayed onset of drug use, greater student awareness of healthy lifestyle options, increased parental and community involvement in the lives of youth; greater youth self-esteem.

Action 7: Making Alternatives to Drug Use Accessible

Low-income individuals, single-parent families and other at-risk populations can experience difficulty accessing cultural and recreational activities offered as alternatives to drug involvement. Municipalities must move to reduce barriers to access, by:

- Reducing or eliminating facility user fees and program registration fees;
- Establishing a used sports equipment pool for the benefit of lower income families and individuals;
- Scheduling and locating activities to make them more accessible to users of public transportation;
- Providing, where needed, childcare or child-minding services.

Potential Lead Agency: Municipalities (Parks, Recreation and Leisure Services)

Potential Partner Agencies: BC Transit, Drug Policy Coordinator (Action 1)

Expected Outcomes: Better access to activities for at-risk individuals.

Action 8: Drug-related Information Line

A public information telephone service should be established to help individuals access non-emergency social, health and government services. The service should:

- Use an easy-to-remember, toll-free number (e.g. 211);
- Be available 24 hours a day, seven days a week throughout the Central Okanagan;
- Be staffed by trained specialists capable of assessing the needs of the caller and linking them to the best available information and/or services;
- Be capable of dealing with any drug-related question or complaint; and
- Maintain a listing of all non-emergency governmental and non-governmental social services in the Central Okanagan.

Potential Lead Agency: Kelowna Community Resources, Drug Policy Coordinator (Action 1)

Potential Partner Agencies: Health Canada, Interior Health, Municipalities, Kelowna Medical Society, Living Positive Resource Centre, Canadian Radio & Telecommunications Commission, Okanagan Families, University of British Columbia – Okanagan (Education and Social Work Departments)

Expected Outcomes: Improved knowledge of services, better service delivery, increased public health and security

Action 9: Addressing Causal Factors

The social and economic factors that contribute to the onset and continuation of problematic drug use must be addressed in a comprehensive and ongoing manner. In particular:

- The number of emergency shelter beds must be increased to accommodate the growing number of homeless persons;
- Additional low-income and subsidized housing units, including Single Room Occupancy dwellings, must be developed in key urban areas;
- BC Benefits payment levels must be increased to reflect actual housing market prices;
- Employment opportunities (e.g. community works projects) should be offered to street-involved individuals as alternatives to panhandling and illegal activities;
- Preventive mental health services must be de-stigmatized, and made more accessible to individuals and families;
- Support services for at-risk, criminally-involved and/or sexually-exploited individuals must be increased, particularly services for youth;
- Support for families, including parent and family support networks, parenting education, and life skills training, must be made universally available.

Potential Lead Agency: Drug Policy Coordinator (Action 1), Ministry of Human Resources, Ministry for Children and Family Development, Interior Health

Potential Partner Agencies: BC Housing, Municipalities, Canada Mortgage and Housing Corporation, Health Canada, Human Resources Skills Development Canada, University of British Columbia – Okanagan (Education and Social Work Departments), Kelowna Community Resources, Kelowna Drop-In and Information Centre, Living Positive Resource Centre, John Howard Society, Elizabeth Fry Society, Kelowna Homelessness Steering Committee, NOW Canada, Ki-Low-Na Friendship Society, Westbank First Nation, Okanagan Nations Alliance, Okanagan Families, Boys and Girls Club, Downtown Kelowna Association, Chambers of Commerce

Expected Outcomes: Improved social cohesion, reduced homelessness, improved urban environment, early identification of mental health issues

Action 10: Urban Renewal

Re-establishing the vitality, aesthetics, and economic competitiveness of downtown cores throughout the Central Okanagan must be an immediate priority. Possible initiatives include:

- Property tax breaks, Development Cost Charge reductions and similar incentives to encourage development;
- Construction of public washrooms and similar amenities;
- Seasonal reduction of street parking fees to encourage holiday shopping;
- Converting select alleys into pedestrian malls;
- Expanding the number of open-air attractions, including outdoor cafés or seating areas and street vendors;
- Changing the timing of traffic lights and pedestrian crossing lights to facilitate pedestrian traffic;
- Enhanced public art, including murals;
- Ad campaigns in support of downtown businesses;
- Improved transit services, such as free “jump on, jump off” shuttle services for downtown shoppers; and,
- Street-level activities and entertainments (e.g. busking competitions, recreational and cultural exhibits, music festivals, etc.) that would draw attention to side streets as well as main thoroughfares.

Potential Lead Agency: Municipalities, Drug Policy Coordinator (Action 1)

Potential Partner Agencies: Infrastructure Canada, BC Housing, Ministry of Community, Aboriginal and Women’s Services, Tourism BC, Chambers of Commerce, Downtown Kelowna Association, BC Transit

Expected Outcomes: Improved social cohesion, reduced homelessness, improved urban environment, early identification of mental health issues

Action 11: Coordinated Planning and Implementation

Immediate action should be taken to establish a multilateral Treatment Planning and Implementation Board. The Board would:

- Continue the review of existing treatment services;
- Explore new responses to problematic drug use;
- Conduct longitudinal studies to determine program effectiveness;
- Help determine how best to allocate current and future funding to improve the continuum of care in the region;
- Work to ensure the presence of long-term sustainable funding for anti-drug programs and initiatives in the community; and,
- Cooperate with the Regional Drug Strategy Coordinator to ensure the success of the overall Framework.

Potential Lead Agency: Interior Health, Drug Policy Coordinator (Action 1)

Potential Partner Agencies: Ministry of Health Services, Ministry for Children and Family Development, Ministry of Human Resources, University of British Columbia – Okanagan, Kelowna Medical Society, Municipalities, Crossroads Treatment Centre, ARC Programs, Kelowna Alcohol and Drug Services, Living Positive Resource Centre, Ki-Low-Na Friendship Society, Kelowna Area Network of Drug Users, Methadone Clinic, Okanagan Families, Boys and Girls Club, Downtown Kelowna Association, Chambers of Commerce, **Outcome Expectations:** increased treatment capacity, improved needs assessment, improved treatment outcomes, reduced wait times for treatment services, improved public health and security

Action 12: Improving Treatment Capacity

Existing treatment programs must be adjusted as needed to ensure they are capable of dealing with the demands placed on the system by new drugs, changing drug use patterns and concurrent disorders. At a minimum, service providers must confirm, and governments must increase funding levels where necessary to ensure, that all programs:

- Include clear treatment plans and outcome expectations for each client, both at each stage of treatment and cumulative;
- Are sufficiently flexible to adapt to the individual needs of the client, including extended treatment periods as needed;
- Contain an appropriate Mental Health component and/or linkages to Mental Health services;
- Provide ongoing client support once initial treatment has been completed; and,
- Include or provide access to appropriate family and peer counselling and support services.

Potential Lead Agency: Treatment Planning & Implementation Board (Action 11), Interior Health

Potential Partner Agencies: Ministry of Health Services, Ministry for Children and Family Development, Drug Policy Coordinator (Action 1), relevant treatment service providers

Outcome Expectations: increased capacity, improved outcomes, reduced wait times, improved public health

Action 13: Increasing Youth Addiction Services Capacity

Immediate steps must be taken to improve the stability and capacity of Youth Addiction Services in the community, including:

- Providing stable, long-term funding for Youth Outpatient and Day Treatment services;
- Sufficiently increasing funding levels to ensure the capacity to meet growing service demands;
- Guaranteeing long-term funding for Youth Detox facilities;
- Establishing a Youth Residential Treatment facility;
- Increasing access to counselling and support services for families and peers of addicted youth.

Potential Lead Agency: Treatment Planning & Implementation Board (Action 11), Interior Health

Potential Partner Agencies: School District #23, Ministry of Health Services, Ministry for Children and Family Development, Drug Policy Coordinator (Action 1), relevant youth treatment service providers

Outcome Expectations: increased capacity, improved outcomes, reduced wait times, improved public health

Action 14: Increasing Adult Addiction Services Capacity

Immediate steps must be taken to improve the capacity of Adult Addiction Services in the community, including:

- Providing adequate long-term funding for Adult Outpatient and Day Treatment services;

- Sufficiently increasing funding levels to ensure the capacity to meet growing service demands;
- Increase service provider capacity to provide comprehensive counselling and support for families and peers of addicted adults.

Potential Lead Agency: Treatment Planning & Implementation Board (Action 11), Interior Health

Potential Partner Agencies: Ministry of Health Services, Ministry for Human Resources, Drug Policy Coordinator (Action 1), relevant treatment service providers

Outcome Expectations: increased capacity, improved outcomes, improved familial cohesion, improved public health

Action 15: Adult Residential Treatment Capacity

Immediate action must be taken to increase the capacity of Adult Residential Treatment facilities in the community, including:

- Establishing, and providing stable funding for a minimum of 12 additional detox beds, in order to reduce waitlists;
- Creating 30 additional residential treatment beds for men;
- Providing funding for seven existing (but currently unfunded) residential treatment beds for women;
- Creating an additional 10 residential treatment beds for women.

Potential Lead Agency: Treatment Planning & Implementation Board (Action 11), Interior Health

Potential Partner Agencies: Ministry of Health Services, Ministry for Human Resources, Drug Policy Coordinator (Action 1), relevant treatment service providers

Outcome Expectations: increased treatment capacity, improved treatment outcomes, including reduced incidence of relapse

Action 16: Funding Supportive Recovery Housing

Immediate action must be taken to increase the availability of provincially-funded Supportive Recovery Housing, including:

- Creating a minimum of 40 additional supportive recovery housing beds for men;
- Creating a minimum of 20 supportive recovery housing beds for women; and,
- Requiring privately-funded recovery programs to meet provincial licensing standards and Alcohol and Drug service standards.

Potential Lead Agency: Treatment Planning & Implementation Board (Action 11), Interior Health, BC Housing

Potential Partner Agencies: Ministry of Health Services, Ministry for Human Resources, Drug Policy Coordinator (Action 1), relevant treatment service providers

Outcome Expectations: improved treatment outcomes, reduced incidence of relapse

Action 17: Supporting Methadone Treatment Programs

Methadone treatment programs in the community must be expanded. At a minimum, long-term funding must be provided to allow:

- Methadone clinic hours to be expanded to five days per week, with no more than one day off between clinic days;
- On-site attendance by a certified Methadone doctor no less than three days per week;
- Expanded counselling capacity, to ensure effective individual case management.

Potential Lead Agency: Treatment Planning & Implementation Board (Action 11), Methadone Clinic

Potential Partner Agencies: Ministry of Health Services, Interior Health, Drug Policy Coordinator (Action 1), relevant treatment service providers

Outcome Expectations: improved treatment outcomes, reduced incidence of relapse, improved public health

Action 18: Improved Aboriginal Addiction Services

Aboriginal individuals must be afforded greater access to addiction treatment services. Minimum actions include:

- Changing existing funding guidelines to allow status Natives greater access to available treatment services;

- Adding Aboriginal components to Provincially-funded programs;
- Improving the range and capacity of front-line addiction services available on First Nation lands; and,
- Improve the resources and capacity of front-line addiction services for the urban Aboriginal population.

Potential Lead Agency: Westbank First Nation, Ki-Low-Na Friendship Society, Treatment Planning & Implementation Board (Action 11)

Potential Partner Agencies: Health Canada, Ministry of Health Services, Okanagan Nation Alliance, Drug Policy Coordinator (Action 1), Interior Health

Outcome Expectations: improved access to treatment and improved outcomes, reduced homelessness, improved public health

Action No. 21: Protective Detention

A medically-supervised “sobering station” should be established in the community. The station would:

- Provide safe and secure facilities for two to four individuals apprehended under the influence of illicit substances;
- Allow police to “drop off” intoxicated individuals, rather than having to accompany them through the evaluation and treatment process;
- Detain, where medically advisable, intoxicated individuals for a sufficient period to allow them to reach a level of sobriety where they no longer pose a risk to themselves or others (LEGISLATIVE CHANGES REQUIRED); and,
- Present drug-involved persons with treatment opportunities.

Potential Lead Agency: RCMP, Interior Health

Potential Partner Agencies: Solicitor General for Canada, Ministry of Attorney General, Ministry of Public Safety and Solicitor General, Drug Policy Coordinator (Action 1), Municipalities

Outcome Expectations: increased referrals to treatment services, improved public order, reduced risk to individuals and the public at large

Action No. 23: Short-term shelter pilot project

A low-threshold short-term shelter pilot project must be established immediately in the downtown Kelowna core. The project would:

- Provide emergency shelter to those in need, regardless of age, gender, personal circumstances, or physical condition;
- Offer support and referral services outside of normal business hours (in the hours when such services are most needed);
- Serve as a place for police to direct individuals who are homeless and/or misuse substances;
- Feature a qualified multi-disciplinary staff trained in crisis intervention, counselling and harm-reduction strategies;
- Offer effective street-level services for at-risk individuals, including weekend and evening access to counsellors, outreach workers and detox facilities;
- Provide health outreach and related Harm Reduction services to homeless and/or drug-involved individuals;
- Make referrals to detoxification, treatment and other services as needed; and
- Facilitate cooperation with service providers and enable drug-involved individuals to make healthier lifestyle choices.

Potential Lead Agency: City of Kelowna, Kelowna Homelessness Steering Committee

Potential Partner Agencies: Interior Health, BC Housing, Ministry of Human Resources, Infrastructure Canada, National Homelessness Initiative, Drug Policy Coordinator (Action 1), Treatment Planning & Implementation Board (Action 11), University of British Columbia – Okanagan (Nursing and Social Work Departments), Kelowna Drop-In and Information Centre, Living Positive Resource Centre, Kelowna Gospel Mission, NOW Canada, Ki-Low-Na Friendship Society, Kelowna Area Network of Drug Users

Outcome Expectations: reduction in open street drug scene, increased referrals to treatment services, improved public order, reduced risk to individuals and the public at large, enhanced public safety and security

Action No. 24: Youth shelter and drop-in facility

A low-threshold emergency/short-term shelter and drop-in centre for youth (those aged 19 and under) must be established immediately in the downtown Kelowna core. The project would:

- *Provide emergency shelter to homeless, drug-involved or street-involved youth regardless of gender, personal circumstance, or physical condition;*
- *Offer support and referral services outside of normal business hours (in the hours when such services are most needed);*
- *Serve as a place for police to direct youth who are homeless and/or misuse substances;*
- *Feature a qualified multi-disciplinary staff trained in crisis intervention, counselling and harm-reduction strategies;*
- *Offer effective street-level services for at-risk youth, including weekend and evening access to counsellors, outreach workers and detox facilities;*
- *Provide health outreach and related Harm Reduction services;*
- *Make referrals to detoxification, treatment and other services as needed; and*
- *Facilitate cooperation with service providers and enable drug-involved individuals to make healthier lifestyle choices.*

Potential Lead Agency: *City of Kelowna, Boys and Girls Club, Kelowna Homelessness Steering Committee*

Potential Partner Agencies: *Interior Health, BC Housing, Ministry of Human Resources, Infrastructure Canada, National Homelessness Initiative, Drug Policy Coordinator (Action 1), Treatment Planning & Implementation Board (Action 11), University of British Columbia – Okanagan (Nursing and Social Work Departments), Kelowna Drop-In and Information Centre, Living Positive Resource Centre, Kelowna Gospel Mission, NOW Canada, Ki-Low-Na Friendship Society, Kelowna Area Network of Drug Users*

Outcome Expectations: *reduction in open street drug scene, increased referrals to treatment services, improved public order, reduced risk to individuals and the public at large, enhanced public safety and security*

Action No. 25: Low-income Housing Projects

The establishment of low-income and/or subsidized housing must become an urban development priority. Housing units should:

- *Be affordable to individuals and families with incomes below the Statistics Canada Low Income Cut-off level;*
- *Be distributed throughout the community, so as to avoid the emergence of depressed areas or socio-economic ghettos;*
- *Include common-area facilities that will encourage cultural and recreational activities for residents (Action 6);*
- *Allow for on-site delivery of essential social services (life-skills training, basic health care, employment counselling, etc.);*
- *Have ready access to public transportation;*
- *Encourage resident participation in the management and maintenance, so as to foster pride of place and self-esteem.*

Potential Lead Agency: *Municipalities, BC Housing*

Potential Partner Agencies: *Ministry of Human Resources, Canada Mortgage and Housing Corporation, Infrastructure Canada, National Homelessness Initiative, Drug Policy Coordinator (Action 1), Treatment Planning & Implementation Board (Action 11).*

Outcome Expectations: *reduction in open street drug scene, increased referrals to treatment services, improved public order, reduced risk to individuals and the public at large, reduced homelessness*

Action No. 26: Improved Needle Drop Box Services

Existing Needle Drop Box services must be expanded. Boxes should be:

- *Placed in consultation with area intravenous drug users;*
- *Designed to ensure public safety and minimize any potential impact on tourism or commerce;*
and
- *Used to advertise treatment and support services to users, increasing the chance that they might begin to make healthier lifestyle choices.*

Potential Lead Agency: *Municipalities, Drug Policy Coordinator (Action 1)*

Potential Partner Agencies: *Interior Health, Health Canada, Treatment Planning and Implementation Board (Action 11), Kelowna Drop-In and Information Centre, Living Positive Resource Centre, Kelowna*

Gospel Mission, NOW Canada, Kelowna Medical Society, Ki-Low-Na Friendship Society, Kelowna Area Network of Drug Users, Downtown Kelowna Association, Chambers of Commerce, Boys and Girls Club
Outcome Expectations: lessened risk to public health, increased referrals to treatment services, improved public order, improved climate for business and tourism

Action No. 27: Public Education

The community (including elected officials, business groups and the public at large) must be educated as to the nature, extent and benefit of existing and proposed harm reduction initiatives. Educational materials should:

- Provide accurate and factual information about Harm Reduction and Harm Reduction activities;
- Be easily accessible and understandable;
- Be widely distributed (e.g. in conjunction with municipal utility bills);
- Provide opportunities for meaningful feedback.

Potential Lead Agency: Municipalities, Drug Policy Coordinator (Action 1)

Potential Partner Agencies: Interior Health, School District #23, Health Canada, Methadone Clinic, Kelowna Area Network of Drug Users, Kelowna Medical Society, Living Positive Resource Centre, Kelowna Alcohol and Drug Services, Crossroads Treatment Centre

Outcome Expectations: increased knowledge and understanding of drug-related issues, lessened risk to public health, more treatment services referrals, improved public order

Action No. 28: Public Health Outreach

Immediate action should be taken to expand street-level nursing services throughout the community. Services should have sufficient support and funding to allow them to:

- Remain open at least 40 hours per week (based on demand);
- Offer a full range of basic healthcare services;
- Provide effective prevention and harm reduction programs;
- Have a medical doctor on site a minimum of three days per week

Potential Lead Agency: Interior Health, Boys & Girls Club, Drug Policy Coordinator (Action 1),

Potential Partner Agencies: Health Canada, Kelowna Medical Society, , Treatment Planning and Implementation Board (Action 11), Kelowna Drop-In and Information Centre, Living Positive Resource Centre, Kelowna Medical Society, Kelowna Area Network of Drug Users, Westbank First Nation,

Outcome Expectations: reduced healthcare costs, improved public health, lessened load on hospital Emergency Room

Goal #3 Quality of Life:

Improve the social and economic quality of life for the community, by reducing the negative effects of problematic drug use.

Action No. 1: Regional Drug Policy Coordinator

Establish and provide long-term support and funding for a Drug Policy Coordinator for the Regional District of Central Okanagan. The position would be maintained for a minimum of 10 years, with funding support from the Provincial government and Federal governments. The Coordinator would, at a minimum:

- Ensure transparency and accountability in all stages and aspects of the Framework;
- Facilitate cooperation and coordination between service providers, in order to ensure the effective implementation of agreed upon strategies;
- Liaise with stakeholders, including government, service providers, researchers, local business owners, drug users and the public at large;
- Conduct additional research as required to assess the effectiveness of actions taken to date, and to help to determine the need for additional actions;
- Help identify real or potential challenges to anti-drug initiatives, such as funding issues and the emergence of new drugs or drug use patterns; and,
- Make regular progress reports to all parties and to the public at large.

Potential Lead Agency: Regional District of Central Okanagan

Potential Partner Agencies: Ministry of Communities, Aboriginal and Women's Services, Health Canada; Treatment Planning & Implementation Board (Action 11)

Expected Outcome: Greater coordination, communication and cooperation among stakeholders; increased public awareness and input

Action 5: Harm Reduction Education

Educators and parent must understand that some youths will choose to use drugs despite any and all drug education efforts, and must ensure that those youth are aware of Treatment and Harm Reduction programs available in the community, in order to facilitate their recovery. Programs should:

- Be offered to students in those age groups most at risk of becoming drug-involved;
- Incorporate honest, accurate portrayals of the effect of drug use;
- Be offered by actual Treatment and Harm Reduction service providers from the community;
- Incorporate, where appropriate, the participation of recovering users, particularly those close in age to the audience⁶⁰;
- Incorporate the active participation of parents and members of the neighbourhoods in the school's catchment area

Potential Lead Agency: School District #23, Drug Policy Coordinator (Action 1)

Potential Partner Agencies: Ministry of Education, Ministry for Children and Family Development, Interior Health, Parental Advisory Committees, University of British Columbia – Okanagan (Education and Social Work Departments), Crossroads Treatment Centre, ARC Programs, Living Positive Resource Centre, Elizabeth Fry Society, NOW Canada, Kelowna Medical Society, Kelowna Area Network of Drug Users, Boys and Girls Club, Health Canada

Expected Outcomes: Reduced or delayed onset of drug use, greater student awareness of drug-related issues and of treatment options for themselves and peers; increased parental understanding of drug-related issues facing their children; improved youth access to treatment.

Action 8: Drug-related Information Line

A public information telephone service should be established to help individuals access non-emergency social, health and government services. The service should:

- Use an easy-to-remember, toll-free number (e.g. 211);
- Be available 24 hours a day, seven days a week throughout the Central Okanagan;
- Be staffed by trained specialists capable of assessing the needs of the caller and linking them to the best available information and/or services;
- Be capable of dealing with any drug-related question or complaint; and
- Maintain a listing of all non-emergency governmental and non-governmental social services in the Central Okanagan.

Potential Lead Agency: Kelowna Community Resources, Drug Policy Coordinator (Action 1)

Potential Partner Agencies: Health Canada, Interior Health, Municipalities, Kelowna Medical Society, Living Positive Resource Centre, Canadian Radio & Telecommunications Commission, Okanagan Families, University of British Columbia – Okanagan (Education and Social Work Departments)

Expected Outcomes: Improved knowledge of services, better service delivery, increased public health and security

Action 10: Urban Renewal

Re-establishing the vitality, aesthetics, and economic competitiveness of downtown cores throughout the Central Okanagan must be an immediate priority. Possible initiatives include:

- Property tax breaks, Development Cost Charge reductions and similar incentives to encourage development;
- Construction of public washrooms and similar amenities;
- Seasonal reduction of street parking fees to encourage holiday shopping;
- Converting select alleys into pedestrian malls;
- Expanding the number of open-air attractions, including outdoor cafés or seating areas and street vendors;
- Changing the timing of traffic lights and pedestrian crossing lights to facilitate pedestrian traffic;

⁶⁰ This was a frequently-requested change to existing prevention courses, but there is little research support for the concept; some service providers argue that showing youth someone who has “beaten” addiction makes drug use seem less harmful.

- *Enhanced public art, including murals;*
- *Ad campaigns in support of downtown businesses;*
- *Improved transit services, such as free “jump on, jump off” shuttle services for downtown shoppers; and,*
- *Street-level activities and entertainments (e.g. busking competitions, recreational and cultural exhibits, music festivals, etc.) that would draw attention to side streets as well as main thoroughfares.*

Potential Lead Agency: Municipalities, Drug Policy Coordinator (Action 1)

Potential Partner Agencies: Infrastructure Canada, BC Housing, Ministry of Community, Aboriginal and Women’s Services, Tourism BC, Chambers of Commerce, Downtown Kelowna Association, BC Transit

Expected Outcomes: Improved social cohesion, reduced homelessness, improved urban environment, early identification of mental health issues

Action 17: Supporting Methadone Treatment Programs

Methadone treatment programs in the community must be expanded. At a minimum, long-term funding must be provided to allow:

- *Methadone clinic hours to be expanded to five days per week, with no more than one day off between clinic days;*
- *On-site attendance by a certified Methadone doctor no less than three days per week;*
- *Expanded counselling capacity, to ensure effective individual case management.*

Potential Lead Agency: Treatment Planning & Implementation Board (Action 11), Methadone Clinic

Potential Partner Agencies: Ministry of Health Services, Interior Health, Drug Policy Coordinator (Action 1), relevant treatment service providers

Outcome Expectations: improved treatment outcomes, reduced incidence of relapse, improved public health

Action No. 21: Protective Detention

A medically-supervised “sobering station” should be established in the community. The station would:

- *Provide safe and secure facilities for two to four individuals apprehended under the influence of illicit substances;*
- *Allow police to “drop off” intoxicated individuals, rather than having to accompany them through the evaluation and treatment process;*
- *Detain, where medically advisable, intoxicated individuals for a sufficient period to allow them to reach a level of sobriety where they no longer pose a risk to themselves or others (LEGISLATIVE CHANGES REQUIRED); and,*
- *Present drug-involved persons with treatment opportunities.*

Potential Lead Agency: RCMP, Interior Health

Potential Partner Agencies: Solicitor General for Canada, Ministry of Attorney General, Ministry of Public Safety and Solicitor General, Drug Policy Coordinator (Action 1), Municipalities

Outcome Expectations: increased referrals to treatment services, improved public order, reduced risk to individuals and the public at large

Action No. 23: Short-term shelter pilot project

A low-threshold short-term shelter pilot project must be established immediately in the downtown Kelowna core. The project would:

- *Provide emergency shelter to those in need, regardless of age, gender, personal circumstances, or physical condition;*
- *Offer support and referral services outside of normal business hours (in the hours when such services are most needed);*
- *Serve as a place for police to direct individuals who are homeless and/or misuse substances;*
- *Feature a qualified multi-disciplinary staff trained in crisis intervention, counselling and harm-reduction strategies;*
- *Offer effective street-level services for at-risk individuals, including weekend and evening access to counsellors, outreach workers and detox facilities;*
- *Provide health outreach and related Harm Reduction services to homeless and/or drug-involved individuals;*

- Make referrals to detoxification, treatment and other services as needed; and
- Facilitate cooperation with service providers and enable drug-involved individuals to make healthier lifestyle choices.

Potential Lead Agency: City of Kelowna, Kelowna Homelessness Steering Committee

Potential Partner Agencies: Interior Health, BC Housing, Ministry of Human Resources, Infrastructure Canada, National Homelessness Initiative, Drug Policy Coordinator (Action 1), Treatment Planning & Implementation Board (Action 11), University of British Columbia – Okanagan (Nursing and Social Work Departments), Kelowna Drop-In and Information Centre, Living Positive Resource Centre, Kelowna Gospel Mission, NOW Canada, Ki-Low-Na Friendship Society, Kelowna Area Network of Drug Users

Outcome Expectations: reduction in open street drug scene, increased referrals to treatment services, improved public order, reduced risk to individuals and the public at large, enhanced public safety and security

Action No. 24: Youth shelter and drop-in facility

A low-threshold emergency/short-term shelter and drop-in centre for youth (those aged 19 and under) must be established immediately in the downtown Kelowna core. The project would:

- Provide emergency shelter to homeless, drug-involved or street-involved youth regardless of gender, personal circumstance, or physical condition;
- Offer support and referral services outside of normal business hours (in the hours when such services are most needed);
- Serve as a place for police to direct youth who are homeless and/or misuse substances;
- Feature a qualified multi-disciplinary staff trained in crisis intervention, counselling and harm-reduction strategies;
- Offer effective street-level services for at-risk youth, including weekend and evening access to counsellors, outreach workers and detox facilities;
- Provide health outreach and related Harm Reduction services;
- Make referrals to detoxification, treatment and other services as needed; and
- Facilitate cooperation with service providers and enable drug-involved individuals to make healthier lifestyle choices.

Potential Lead Agency: City of Kelowna, Boys and Girls Club, Kelowna Homelessness Steering Committee

Potential Partner Agencies: Interior Health, BC Housing, Ministry of Human Resources, Infrastructure Canada, National Homelessness Initiative, Drug Policy Coordinator (Action 1), Treatment Planning & Implementation Board (Action 11), University of British Columbia – Okanagan (Nursing and Social Work Departments), Kelowna Drop-In and Information Centre, Living Positive Resource Centre, Kelowna Gospel Mission, NOW Canada, Ki-Low-Na Friendship Society, Kelowna Area Network of Drug Users

Outcome Expectations: reduction in open street drug scene, increased referrals to treatment services, improved public order, reduced risk to individuals and the public at large, enhanced public safety and security

Action No. 25: Low-income Housing Projects

The establishment of low-income and/or subsidized housing must become an urban development priority. Housing units should:

- Be affordable to individuals and families with incomes below the Statistics Canada Low Income Cut-off level;
- Be distributed throughout the community, so as to avoid the emergence of depressed areas or socio-economic ghettos;
- Include common-area facilities that will encourage cultural and recreational activities for residents (Action 6);
- Allow for on-site delivery of essential social services (life-skills training, basic health care, employment counselling, etc.);
- Have ready access to public transportation;
- Encourage resident participation in the management and maintenance, so as to foster pride of place and self-esteem.

Potential Lead Agency: Municipalities, BC Housing

Potential Partner Agencies: Ministry of Human Resources, Canada Mortgage and Housing Corporation, Infrastructure Canada, National Homelessness Initiative, Drug Policy Coordinator (Action 1), Treatment Planning & Implementation Board (Action 11).

Outcome Expectations: reduction in open street drug scene, increased referrals to treatment services, improved public order, reduced risk to individuals and the public at large, reduced homelessness

Action No. 26: Improved Needle Drop Box Services

Existing Needle Drop Box services must be expanded. Boxes should be:

- Placed in consultation with area intravenous drug users;
- Designed to ensure public safety and minimize any potential impact on tourism or commerce; and
- Used to advertise treatment and support services to users, increasing the chance that they might begin to make healthier lifestyle choices.

Potential Lead Agency: Municipalities, Drug Policy Coordinator (Action 1)

Potential Partner Agencies: Interior Health, Health Canada, Treatment Planning and Implementation Board (Action 11), Kelowna Drop-In and Information Centre, Living Positive Resource Centre, Kelowna Gospel Mission, NOW Canada, Kelowna Medical Society, Ki-Low-Na Friendship Society, Kelowna Area Network of Drug Users, Downtown Kelowna Association, Chambers of Commerce, Boys and Girls Club

Outcome Expectations: lessened risk to public health, increased referrals to treatment services, improved public order, improved climate for business and tourism

Action No. 27: Public Education

The community (including elected officials, business groups and the public at large) must be educated as to the nature, extent and benefit of existing and proposed harm reduction initiatives. Educational materials should:

- Provide accurate and factual information about Harm Reduction and Harm Reduction activities;
- Be easily accessible and understandable;
- Be widely distributed (e.g. in conjunction with municipal utility bills);
- Provide opportunities for meaningful feedback.

Potential Lead Agency: Municipalities, Drug Policy Coordinator (Action 1)

Potential Partner Agencies: Interior Health, School District #23, Health Canada, Methadone Clinic, Kelowna Area Network of Drug Users, Kelowna Medical Society, Living Positive Resource Centre, Kelowna Alcohol and Drug Services, Crossroads Treatment Centre

Outcome Expectations: increased knowledge and understanding of drug-related issues, lessened risk to public health, more treatment services referrals, improved public order

Action No. 28: Public Health Outreach

Immediate action should be taken to expand street-level nursing services throughout the community. Services should have sufficient support and funding to allow them to:

- Remain open at least 40 hours per week (based on demand);
- Offer a full range of basic healthcare services;
- Provide effective prevention and harm reduction programs;
- Have a medical doctor on site a minimum of three days per week

Potential Lead Agency: Interior Health, Boys & Girls Club, Drug Policy Coordinator (Action 1),

Potential Partner Agencies: Health Canada, Kelowna Medical Society, , Treatment Planning and Implementation Board (Action 11), Kelowna Drop-In and Information Centre, Living Positive Resource Centre, Kelowna Medical Society, Kelowna Area Network of Drug Users, Westbank First Nation,

Outcome Expectations: reduced healthcare costs, improved public health, lessened load on hospital Emergency Room

Goal # 4 Public Order:

Restore public order, by aggressively targeting drug-related threats to public safety and security in the Central Okanagan.

Action No. 1: Regional Drug Policy Coordinator

Establish and provide long-term support and funding for a Drug Policy Coordinator for the Regional District of Central Okanagan. The position would be maintained for a minimum of 10 years, with funding support from the Provincial government and Federal governments. The Coordinator would, at a minimum:

- *Ensure transparency and accountability in all stages and aspects of the Framework;*
- *Facilitate cooperation and coordination between service providers, in order to ensure the effective implementation of agreed upon strategies;*
- *Liaise with stakeholders, including government, service providers, researchers, local business owners, drug users and the public at large;*
- *Conduct additional research as required to assess the effectiveness of actions taken to date, and to help to determine the need for additional actions;*
- *Help identify real or potential challenges to anti-drug initiatives, such as funding issues and the emergence of new drugs or drug use patterns; and,*
- *Make regular progress reports to all parties and to the public at large.*

Potential Lead Agency: *Regional District of Central Okanagan*

Potential Partner Agencies: *Ministry of Communities, Aboriginal and Women's Services, Health Canada; Treatment Planning & Implementation Board (Action 11)*

Expected Outcome: *Greater coordination, communication and cooperation among stakeholders; increased public awareness and input*

Action 8: Drug-related Information Line

A public information telephone service should be established to help individuals access non-emergency social, health and government services. The service should:

- *Use an easy-to-remember, toll-free number (e.g. 211);*
- *Be available 24 hours a day, seven days a week throughout the Central Okanagan;*
- *Be staffed by trained specialists capable of assessing the needs of the caller and linking them to the best available information and/or services;*
- *Be capable of dealing with any drug-related question or complaint; and*
- *Maintain a listing of all non-emergency governmental and non-governmental social services in the Central Okanagan.*

Potential Lead Agency: *Kelowna Community Resources, Drug Policy Coordinator (Action 1)*

Potential Partner Agencies: *Health Canada, Interior Health, Municipalities, Kelowna Medical Society, Living Positive Resource Centre, Canadian Radio & Telecommunications Commission, Okanagan Families, University of British Columbia – Okanagan (Education and Social Work Departments)*

Expected Outcomes: *Improved knowledge of services, better service delivery, increased public health and security*

Action No. 19: RCMP Special Projects Team

The operations of the RCMP Special Projects Team should be continued, and expanded as needed to address drug crime and drug related crime in the Central Okanagan. At a minimum, the Team should:

- *Continue to focus on drug enforcement and the reduction of related offences such as prostitution, through the even-handed and consistent application of appropriate legislative tools such as the Criminal Code of Canada, Provincial Acts and Statutes (including the Safe Streets Act and Trespass Act) and relevant municipal bylaws;*

- Aggressively target drug dealers at the street level and follow criminal drug activity up through the drug culture hierarchy; and
- Through the Non-Commissioned Officer in Command (NCOIC), cooperate with the Regional Drug Policy Coordinator to establish a communication strategy that will ensure public awareness of and education about enforcement initiatives and other drug-related issues in the Central Okanagan.

Potential Lead Agency: RCMP, Municipalities

Potential Partner Agencies: Ministry of Attorney General, Ministry of Public Safety and Solicitor General, Drug Policy Coordinator (Action 1)

Outcome Expectations: reduction in drug activity, improved public order, increased public awareness, generation of statistical data

Action No. 20: Effective Application of Legislation

Local governments, service providers, local businesses and area residents should cooperate with senior levels of government to ensure that the criminal justice system deals with drug crime and drug-related crime in an appropriate, effective and consistent manner. Possible initiative include:

- Seizure of the proceeds of crime and property used by drug dealers, including real estate on which a “grow-op” is discovered (e.g. through municipal bylaws such as those in place in Surrey and Chilliwack);
- Re-examination of sentencing guidelines for drug dealers and producers;
- Establishment, by the RCMP, of a Court Watch or similar program to ensure effective and consistent application of sentencing guidelines by increasing public awareness and understanding of, and involvement in, the judicial process and; and,
- Increased use of alternative sentencing options (e.g. diversions programs, restorative justice initiatives, addictions and mental health treatment options, etc.) for first-time or low-risk addicted offenders.

Potential Lead Agency: Drug Policy Coordinator (Action 1), Regional District of Central Okanagan

Potential Partner Agencies: Solicitor General for Canada, Correctional Services Canada, Crown Prosecutors Office, Ministry of Attorney General, Ministry of Public Safety and Solicitor General, Department of Justice, RCMP, Chambers of Commerce, Downtown Kelowna Association, John Howard Society, Elizabeth Fry Society, Municipalities

Outcome Expectations: reduction in drug activity, improved public order, increased public confidence in justice system

Action No. 21: Protective Detention

A medically-supervised “sobering station” should be established in the community. The station would:

- Provide safe and secure facilities for two to four individuals apprehended under the influence of illicit substances;
- Allow police to “drop off” intoxicated individuals, rather than having to accompany them through the evaluation and treatment process;
- Detain, where medically advisable, intoxicated individuals for a sufficient period to allow them to reach a level of sobriety where they no longer pose a risk to themselves or others (LEGISLATIVE CHANGES REQUIRED); and,
- Present drug-involved persons with treatment opportunities.

Potential Lead Agency: RCMP, Interior Health

Potential Partner Agencies: Solicitor General for Canada, Ministry of Attorney General, Ministry of Public Safety and Solicitor General, Drug Policy Coordinator (Action 1), Municipalities

Outcome Expectations: increased referrals to treatment services, improved public order, reduced risk to individuals and the public at large

Action No. 22: Professional Courtesy and Interaction

Enforcement agencies and service providers should meet on a regular (at least monthly) basis to facilitate communication and cooperation. The meetings would serve to:

- Increase understanding between parties;

- Provide networking opportunities and facilitate the development of mutually-beneficial professional relationships;
- Help assess the effect of ongoing enforcement and social service activities;
- Facilitate information sharing;
- Identify cross-training needs and opportunities;
- Enhance the security of service providers, their clients and staff;
- Increase public awareness of enforcement initiatives; and,
- Encourage a co-operative approach to enforcement issues relating to problematic drug use.

Potential Lead Agency: Drug Policy Coordinator (Action 1)

Potential Partner Agencies: RCMP, Bylaw Enforcement, Crown Prosecutors Office, Boys and Girls Club, Methadone Clinic, Kelowna Area Network of Drug Users, Ki-Low-Na Friendship Society, NOW Canada, Kelowna Gospel Mission, Kelowna Homelessness Steering Committee, Elizabeth Fry Society, John Howard Society, Living Positive Resource Centre, Kelowna Drop-In and Information Centre, ARC Programs, Kelowna Alcohol and Drug Services, Crossroads Treatment Centre, Okanagan Families, University of British Columbia – Okanagan (Nursing and Social Work Departments)

Outcome Expectations: increased referrals to treatment services, improved public order, reduced risk to individuals and the public at large

Action No. 23: Short-term shelter pilot project

A low-threshold short-term shelter pilot project must be established immediately in the downtown Kelowna core. The project would:

- Provide emergency shelter to those in need, regardless of age, gender, personal circumstances, or physical condition;
- Offer support and referral services outside of normal business hours (in the hours when such services are most needed);
- Serve as a place for police to direct individuals who are homeless and/or misuse substances;
- Feature a qualified multi-disciplinary staff trained in crisis intervention, counselling and harm-reduction strategies;
- Offer effective street-level services for at-risk individuals, including weekend and evening access to counsellors, outreach workers and detox facilities;
- Provide health outreach and related Harm Reduction services to homeless and/or drug-involved individuals;
- Make referrals to detoxification, treatment and other services as needed; and
- Facilitate cooperation with service providers and enable drug-involved individuals to make healthier lifestyle choices.

Potential Lead Agency: City of Kelowna, Kelowna Homelessness Steering Committee

Potential Partner Agencies: Interior Health, BC Housing, Ministry of Human Resources, Infrastructure Canada, National Homelessness Initiative, Drug Policy Coordinator (Action 1), Treatment Planning & Implementation Board (Action 11), University of British Columbia – Okanagan (Nursing and Social Work Departments), Kelowna Drop-In and Information Centre, Living Positive Resource Centre, Kelowna Gospel Mission, NOW Canada, Ki-Low-Na Friendship Society, Kelowna Area Network of Drug Users

Outcome Expectations: reduction in open street drug scene, increased referrals to treatment services, improved public order, reduced risk to individuals and the public at large, enhanced public safety and security

Action No. 24: Youth shelter and drop-in facility

A low-threshold emergency/short-term shelter and drop-in centre for youth (those aged 19 and under) must be established immediately in the downtown Kelowna core. The project would:

- Provide emergency shelter to homeless, drug-involved or street-involved youth regardless of gender, personal circumstance, or physical condition;
- Offer support and referral services outside of normal business hours (in the hours when such services are most needed);
- Serve as a place for police to direct youth who are homeless and/or misuse substances;

- *Feature a qualified multi-disciplinary staff trained in crisis intervention, counselling and harm-reduction strategies;*
- *Offer effective street-level services for at-risk youth, including weekend and evening access to counsellors, outreach workers and detox facilities;*
- *Provide health outreach and related Harm Reduction services;*
- *Make referrals to detoxification, treatment and other services as needed; and*
- *Facilitate cooperation with service providers and enable drug-involved individuals to make healthier lifestyle choices.*

Potential Lead Agency: *City of Kelowna, Boys and Girls Club, Kelowna Homelessness Steering Committee*

Potential Partner Agencies: *Interior Health, BC Housing, Ministry of Human Resources, Infrastructure Canada, National Homelessness Initiative, Drug Policy Coordinator (Action 1), Treatment Planning & Implementation Board (Action 11), University of British Columbia – Okanagan (Nursing and Social Work Departments), Kelowna Drop-In and Information Centre, Living Positive Resource Centre, Kelowna Gospel Mission, NOW Canada, Ki-Low-Na Friendship Society, Kelowna Area Network of Drug Users*

Outcome Expectations: *reduction in open street drug scene, increased referrals to treatment services, improved public order, reduced risk to individuals and the public at large, enhanced public safety and security*

APPENDIX TWO: KANDU REPORT

From the outset, the Steering Committee made a decision that in order to address problematic drug use at the street level, we needed to be able to find out from the street involved population what their needs and priorities for action are. Partnering with Okanagan University College (OUC) School of Nursing, three undergraduate students stepped forward to assist the Coalition with conducting needs assessments with the street involved population, for which they receive credits towards their degree. The information in this report reflects the priorities for action of the most visible drug users in the Central Okanagan, albeit they represent the considerable minority of all drug users in the Central Okanagan

K.A.N.D.U. (Kelowna & Area Network of Drug Users)

KANDU is a project based on a harm reduction program established in Vancouver called VANDU (Vancouver & Area Network of Drug Users). Three OUC Nursing students (“Project Coordinators”) began this project in January 2004 in response to interest expressed by several members of Kelowna’s drug-using population. KANDU joined forces with The Four Pillars Coalition in Kelowna to help address the city’s drug problem. The KANDU Project Coordinators, consisting of street interviews, one-on-one interviews and focus group meetings, began a needs assessment in the summer of ‘04. Our areas of concern addressed all four pillars (harm reduction, enforcement, treatment and prevention) and the results of the data collected offers insight and ideas from the drug users themselves. Initial interviews during the summer focused on the harm reduction pillar. This report is based upon data gathered since September 2004 and gives a more expansive and in-depth view of the drug user’s concerns and needs regarding all four pillars.

Demographics (based on interviews with 47 individuals):

74%	Male
26%	Female
69%	Long-term residents of Kelowna (>1 year)
46%	Homeless by choice

Drug of choice (based on data gathered from 35 individuals):

29%	Crack Cocaine
26%	Crystal Methamphetamine
23%	Marijuana
17%	Alcohol
4%	Other

Prevention Priority for Action: Reality-Based Education for Youth

The majority of individuals we interviewed spoke of “reality-based” education for youth as being the most effective method for addiction prevention and education. We spoke with several ex-users who are interested in speaking in schools about the consequences of using drugs. This would enable the drug users to give back to society and would benefit those who are subjected to the users presentation. Showing youth what will happen if they say “yes” to drugs has been stated by the majority of users spoken to as the most effective form of prevention. Many users said that this form of education would have helped them to choose a different path.

Treatment Priority for Action: Greater Number of Treatment Facilities with Improved Services

The drug users we interviewed repeatedly expressed the need for immediate help when they wanted to “get clean”. Waiting is not an option when an addicted individual has decided to seek

treatment. There is a need for a greater number of treatment facilities in Kelowna that offer immediate assistance instead of the usual two-week wait.

Another concern that was repeatedly mentioned was the issue of non-regulation of recovery homes. Many individuals complained of unscrupulous practices relating to costs, length of stay and non-reimbursement of funds if one has to leave before the prescribed amount of time. It was suggested that ex-addicts are more easily able to establish rapport with those in recovery, and that training should be provided to recovered users to enable them to work as staff in recovery homes.

Effective treatment needs to be long-term, and must approach the individual in a holistic way (including family/friends). Current treatment facilities are short-term, and the individual leaves treatment lacking basic life skills necessary for long-term recovery.

Enforcement Priorities for Action: Increased Enforcement/Improved Communication

It was suggested by numerous interviewees that police should be more visible in the downtown area. Many of the users interviewed felt that there are not enough officers at the street level. Though many expressed resentment towards the Kelowna RCMP and even went as far as to describe them as harassing, they still stated there needs to be more RCMP on the street.

The majority of those interviewed also expressed the need for RCMP to communicate with them in a “friendly and non-threatening” way. More police at the street level would allow for time to be spent getting to know some of the users and enable the officers to gain an understanding of the street level mentality. Specific problem areas such as The Gospel Mission (crack and crystal methamphetamine use) and the rose garden area of City Park (where the majority of hard drugs are sold) need constant surveillance. Crystal meth has been cited as the cause of violent behaviour, and individuals on crystal methamphetamine are committing the majority of crimes in the downtown area, and also crack dealers (and “crack houses”) need to be identified and dealt with by the police.

Dealers often cut drugs with other substances (i.e. heroin) to ensure that the buyer becomes easily addicted, thus ensuring a steady supply of new customers. Most drug-related crimes are being committed in the daytime in Kelowna, and there is a need for increased enforcement during daylight hours to address this issue.

Harm Reduction Priorities for Action: Shelters/24-Hour Drop-In Centre

The majority of those interviewed expressed concern regarding a lack of short-term shelter, particularly in the winter months. Without shelter, users were more susceptible to illness and violence, as well as easily procured drugs to ease the pain of living on the street. Combined with a lack of basic items such as blankets, these factors all contribute to a lessened capacity to deal with addiction. The cycle of homelessness and drug abuse continues unchecked when the individual’s mental and physical health is compromised.

There was an expressed need for co-ed shelters and shelters that accommodate pets. Pets can provide companionship, something to care for, and protection to an individual who suffers from drug addiction and homelessness. Co-op housing may be an option for those who are further along in the recovery process. Basing rent payments on the amount of wages earned would provide an incentive to work. There is an urgent need for housing specifically for women. Women living alone on the streets are easy targets for violence. They are often forced into prostitution, or are sought after by dealers who offer “protection” for their company.

A drop-in centre (enforced with security) that is open 24 hours/7 days a week was mentioned repeatedly during our interviews. Such a facility could provide services such as referral to medical services, counselling and treatment facilities and needle-exchange drop-off boxes.

APPENDIX THREE: EXISTING HARM REDUCTION STRATEGIES

Virtually anything that limits or reduces the impact of drug use on the community or on an individual could be considered Harm Reduction. This Appendix lists programs or services primarily aimed at those individuals who are active drug users, including those who are not yet ready or able to access Treatment programs. It is not an exhaustive list, and contains information about only those agencies that provided data prior to the publication deadline.

Programs offered by Outreach Health Services:

- Confidential needle exchange program (Mon, Thurs, Fri 13:00-16:30, Tues 13:00-18:00; Mobile services Friday 16:30-21:00, On-call Mon-Thurs 10:00-16:30)
- Walk-in health services, including:
 - Free condoms, STD education, testing, and treatment, as well as sex education and contraception assistance
 - HIV/AIDS testing
 - Hepatitis testing, medical support, and referral
 - Immunization for hepatitis A + B, Flu, Tetanus, TB skin test.
 - Substance misuse counselling and/or referral from a harm reduction perspective.
 - Health education presentations
 - Provide free donuts and juice on Tuesdays (donated by the Food Bank), and hand out sandwiches and juice on Friday nights (donated by local churches)
 - Non-judgemental environment and staff
 - No medical coverage necessary, anonymity assured
 - Volunteer doctor available on most Tuesdays from 16:30-18:30
 - Provide free personal hygiene items, vitamins, antibiotics, and Tylenol and Ibuprofen when available.

Programs offered by Kelowna Alcohol and Drug Services:

- Services include Individual, Group and Family Counselling as well as drop in services
- Assessments designed to provide treatment options, which could include withdrawal management, residential treatment and outpatient counselling services.
- Referrals to various treatment facilities throughout the province.
- Outreach services available at the Kelowna Drop-in Centre, Outreach Health Services, Kelowna General Hospital and Crossroads Treatment Centre

Programs offered by Campus Health

- Non-judgmental counselling
- Client-centred health services
- Health information and healthy-lifestyle promotion
- Information on the risks of drug use, including STDs, HIV/AIDS, hepatitis A, B & C and other blood-borne pathogens

Programs offered by the City of Kelowna

- Daily examination of beaches for needles, razors and other sharps (through volunteer efforts of local metal detector club).
- Records kept on the amount of needles collected in our Parks and public areas.
- Needle display board, providing information to staff and volunteers on the hazardous waste that we come across in public areas.

- C.P.T.E.D (Crime Prevention Through Environmental Design) – cleaning of site lines for public areas, lifting of lower branches, and addition of high density lighting to enhance public safety.
- Cleaning up of homeless shelters, after they have been abandoned, including storage of abandoned effects for 30 days. (maid service)
- Public information (approximately 50 publications) about a wide range of issues, including how to access emergency shelters, where to get food, service directories, housing guides, etc.

Programs offered by Crossroads Treatment Centre

- Detoxification Unit
 - Educate clients on reduced and safer drug use, to reduce risk of accidental overdose following initial detoxification.
 - Educate clients on all health issues (i.e. medication, nutrition, hepatitis, HIV, needle use/exchange, safer sex, etc.)
 - Referrals to supports within the community (i.e. Alcohol and drug clinic, 12 step meeting locations and times).
 - Work with the client on a discharge plan for when detox is complete.
 - Have beds immediately available for treatment centre clients and supportive living clients who have relapsed and require medical detoxification.
- Crossroads residential treatment program
 - Formerly, Crossroads would screen out individuals who did not commit to the philosophy of the 12 step model. Presently, all individuals with a chemical dependency are being accepted.
 - Individualized comprehensive assessments of client's personal goal for safer use or abstinence.
 - Individualized client assessment, including issues besides the immediate chemical dependency (i.e. unresolved issues, mental health issues, sexual abuse, trauma, coping strategies, social skills, etc.).
 - Aftercare program for clients.
 - Confidential and effective feedback system.
 - Outcome evaluation system that measures reduced harm caused by use and minimisation of risk.
- Crossroads Tarbet House Supportive Living and Employment program
 - Harm Reduction model, not an abstinence model.
 - Staff trained in the harm reduction philosophy and motivational interviewing skills.
 - Relapse intervention protocol established utilizing the detox unit for medical detoxification.
 - Educate clients on reduced and safer drug use.
 - Educate clients on all health issues (i.e. medication, nutrition, hepatitis, HIV, needle use/exchange, safer sex, etc.)
 - Teaching life skills (i.e. Grocery shopping, house cleaning, budgeting, etc.).
 - Provide clients assistance to help them access supports within the community (i.e. Alcohol and drug clinic, 12 step meeting locations and times, methadone clinic, physicians, dentists, etc.)
 - Referrals to various community employment services and programs.
 - Work in conjunction with the client to have a discharge plan in place prior to leaving the supportive living program.
 - Community job search /job finding club for any individuals with addictions issues within the community to utilize.

Programs offered by Kelowna Drop-In & Information Centre

- Washrooms and Showers
- Laundry facilities
- Lockers
- Phone, Fax, Internet computer access
- Mailing address
- Coffee, breakfast and lunch
- Third Party Administration for MHR office (Income assistance)
- Drug and alcohol counsellor on site Thursday mornings
- Outreach Health nurses drop by Thursday mornings
- Needle drop boxes in washrooms
- Advocacy services (Help for homeless people to access Income assistance, Housing, Medical, Transportation, Legal, Mental Health, Drug and Alcohol, Detox, etc.)
- Beauty Night
- Art Workshops

Program offered by Okanagan Independent Living Society:

- Outreach services for individuals with concurrent disorders following a harm reduction model of 'meeting individuals where they are at'

APPENDIX FOUR – EXISTING TREATMENT PROGRAMS

PROGRAM	PROVIDER
YOUTH TREATMENT PROGRAMS	
Changes Program (Outpatient Treatment)	ARC Programs
Youth Alcohol & Drug Detox Program	Okanagan Families Society
YOUTH & ADULT TREATMENT PROGRAMS	
Outpatient Counselling	Kelowna Alcohol & Drug Services
Chemical Dependency Unit	Kelowna General Hospital
Detoxification Unit	Crossroads Treatment Centre
Methadone Clinic	
Outreach Health Clinic	Boys & Girls Club/Interior Health
Outpatient Counselling	Westbank First Nation
Outpatient Counselling (Aboriginal)	Ki-Low-Na Friendship Society
ADULT RESIDENTIAL TREATMENT PROGRAMS	
Residential Treatment Program	Crossroads Treatment Centre
Tarbet House Supportive Recovery	Crossroads Treatment Centre
Harmony House	Harmony House
CAPS Program	Cannon Addictions Place Society
Madson House	
Supportive Recovery Housing (3 Houses)	Freedom's Door

APPENDIX FIVE – ADS CONTINUUM OF CARE

The following matrix of services represents an accepted BC Alcohol and Drug Services continuum of addiction services, which are represented across the province, but not necessarily in every region

Prevention Services

- School-based prevention workers
- Public awareness campaigns
- Smoking cessation programs
- Dry-grad programs
- D.A.R.E. program
- Parent drug and alcohol awareness/education program
- Seniors' outreach/education programs

Early Intervention Services

- Youth addictions outreach services
- School-based outreach/education programs
- Co-dependent counselling/groups
- Outpatient services for children and youth (early-stage substance use)

ADS Outpatient Clinics

- Individual addiction treatment, case management with the ADS System of Care
- May be youth-specific (best practice), adult-specific, or adult/youth combined
- Usually provide fairly brief intervention
- May provide various group-based services (support-recovery, co-dependent, life skills, drop-in groups, etc.)
- Core services within the ADS System of Care, provided in most BC communities

Withdrawal Management Services

- “Detox” programs
- Larger communities may have a continuum of withdrawal management services: outpatient, outreach support, day stabilization, medically-supervised or non-medical/social residential facilities)
- Youth and/or adult-specific residential treatment programs
- Residential facilities licensed under the Community Care Facilities Act

Intensive Day Treatment

- Intensive addiction treatment programs, usually combining individual and group-based services
- Population-specific programs
- Standardized psycho-educational program modules
- Standardized cycles of services (3-5 hours per day, 3-5 days per week, 3-12 weeks in duration)
- Closed intake (clients admitted at beginning of cycle, admissions then closed until next cycle intake)

Concurrent Disorder Services

- Serve dual-diagnosis (addiction/mental health) populations
- Usually outpatient, may be residential-based
- Clinicians may be cross-trained or the program may have both addictions counsellors and mental health clinicians

- Psychiatric services involved (on-site or consulting)

Residential Treatment Services

- Health/ADS funded programs, some privately-funded facilities
- Intensive treatment services, usually targeting specific populations
- Similar to day treatment, but more intensive, with benefit of residential setting (removes client from living situation and associated relapse risks during treatment)
- Licensed facilities under Community Care Facilities Act

Harm Reduction Services

- Intended to reduce harm associated with substance use
- Do not require commitment to abstinence or reduced usage
- Could address health/social issues other than substance abuse
- Legitimate short-term goal in treatment process
- Generally target health-related issues associated with substance use (often IV drug use)
- Can include needle exchanges, outreach nursing, methadone, prescribed-heroin dispensing clinics, etc.

Support-Recovery Residential Programs

- Health/ADS funded services
- Provide supportive housing in residential facilities (usually 12-16 weeks)
- Clients referred following residential treatment, usually by outpatient clinics
- Provide group-based services (12-step support group programs, life skills, employment preparation, etc.)
- Linked to ADS System of Care
- Licensed facilities under Community Care Facility Act

Supportive Housing Programs

- Privately operated housing programs, usually funded through room-and-board fees from clients (and/or Income Assistance) or faith-based, church-supported facilities.
- Recent new facilities developed through HRSDC funding
- Usually boarding house or communal style setting
- Usually provide group-based services (12-step support groups, life skills)
- Usually population-specific
- Rarely licensed facilities – operate as rooming houses

Self-Help Programs

- AA/NA, 12 step group programs
- Co-dependent support group programs
- Parent support groups
- Teen support groups
- After-care support groups

APPENDIX SIX: GROUPS AND AGENCIES CONSULTED

- Adventist Community Services
- Alanon/Alateen
- Alertline Emergency Response Society
- ARC Programs
- BC Ambulance Service
- BC Schizophrenia Society
- Big Brothers & Sisters
- Boys and Girls Club
- Canadian Association of Retired Persons
- Canadian Red Cross
- Cannon Addictions Place Society
- Centre Culturel Francais de l' Okanagan
- Citizens Against Sexual Exploitation of Youth
- City of Kelowna
- Community Corrections – Adult Probation
- Community Futures Development Corporation
- Crossroads Treatment Centre
- Crown Prosecutors' Office
- Correctional Services Canada
- Downtown Kelowna Association
- Downtown Patrol
- Elizabeth Fry Society
- Freedom's Door
- Harmony House
- Interior Health Authority
- John Howard Society
- Kalano Club
- Kelowna Area Network of Drug Users
- Kelowna Alcohol & Drug Services
- Kelowna Chamber of Commerce
- Kelowna Community Food Bank
- Kelowna Community Resources
- Kelowna Drop-In & Information Centre
- Kelowna Family Centre
- Kelowna Family Justice Services
- Kelowna Foetal Alcohol Syndrome Community Resource Team
- Kelowna General Hospital
- Kelowna General Hospital Chemical Dependency Unit
- Kelowna Gospel Mission
- Kelowna Health Centre
- Kelowna Medical Society
- Kelowna Métis Family Services
- Kelowna Poverty Task Force
- Kelowna Women's Resource Centre
- Kelowna Women's Shelter
- Kelowna Youth & Family Services
- Ki-Low-Na Friendship Society
- Legal Aid/Legal Services Society
- Living Positive Resource Centre
- Madson House
- Methadone Clinic
- Ministry for Children and Family Development – Youth Services
- Ministry of Human Resources
- Mothers Against Drunk Driving
- Municipality of Lake Country
- Narcotics Anonymous
- New Opportunities for Women Canada
- Okanagan Aboriginal AIDS Society
- Okanagan Advocacy & Resource Society
- Okanagan Families Society
- Okanagan Halfway House Society
- Okanagan Independent Living Society
- Okanagan University College
- Outreach Health Services
- Pat's Place
- Project New Start
- RCMP
- RCMP Community Policing
- Reachout Youth Counselling Centre
- Rutland Health Centre
- Salvation Army
- School District #23
- Seniors' Outreach Services
- Society of Hope
- United Way of the Central Okanagan
- Westbank First Nation
- Western Canada Soc for Access to Justice
- Wolf's Den
- Women In Need Getting Support
- Youth Probation Services

APPENDIX SEVEN: STEERING COMMITTEE & SUBCOMMITTEES

Steering Committee

City of Kelowna
RCMP
School District #23
Okanagan Aboriginal AIDS Society
John Howard Society
Okanagan University College
North End Residents' Association
Kelowna Alcohol and Drug Services
NOW Canada
Okanagan Independent Living Society
Okanagan Boys and Girls Club
Okanagan Families Society
Crossroads Treatment Centre
Ki Low Na Friendship Society

Westbank First Nation
John Weisbeck, MLA, Constituency Office
Living Positive Resource Centre
Nursing Students
CEO Management
ARC Programs
Dencar Consulting Inc
Kelowna Drop-In Centre
The Write People
Concerned Citizens
Alcoholics Anonymous
Narcotics Anonymous
Chamber of Commerce
Downtown Kelowna Association

Prevention Sub-Committee

Colleen Evans (Okanagan Advocacy & Resource)
Theresa Eichler (City of Kelowna)
Doug Gibson (Resident)
Judy Gillespie (Okanagan University College)
Heather Klotz (Resident)
Angus Leslie (Resident)
Sylvia Loewen (Resident)
Mari MacIntosh (North End Residence Assn)
Lloyd McBeth (Living Positive Resource Centre)
Craig Monley (Boys and Girls Club)
Gail Scanlan (School District #23)
Kerry Solinski (DARE Coordinator)
Dawn Turner (Resident)

Enforcement Sub-Committee

Rand Zacharias (The Write People) - CHAIR
Connie Lenza (Amici's Salon)
Bill McKinnon (RCMP)
Daryle Roberts (Living Positive Resource Centre)
Catherine Williams-Jones (NOW Canada)

Treatment Working Group

Shelley Cook (John Howard Society) - CHAIR
Shannon Bender (Okanagan Families Society)
Downtown Kelowna Association
Crissi E (Resident)
Paula Farrell (Resident)
Garth Homer (Okanagan University College)
Carol Lust (Alexandra Gardner Centre)
Lester M. (Resident)
Shane Picken (ARC Programs)
Ira Roness (Kelowna Alcohol and Drug Services)
Frank Shannon (Resident)
Leora Splett (St. Michael's Anglican Church)

Harm Reduction Sub-Committee

Carmen Lenihan (Okanagan Independent Living Society) - CHAIR
Rebecca Aaron (Mental Health-OHS)
Leah Dawe (Student)
Liz Gibson (NOW Canada)
Paula Grosse (City of Kelowna Parks)
Dennis Lenihan (Dencar Consulting Inc)
Melanie McArthur (Resident)
Bonnie Ross (KGH-Chemical Dependency Unit)
Monica Turner (Crossroads Treatment Centre)
Connie Zol (Outreach Health Services)

APPENDIX EIGHT: SUMMARY OF TREATMENT SERVICE PROVIDER FOCUS GROUP INPUT

In October 2004, area treatment service providers gathered together for a one-day focus group session on treatment service and programs in the Central Okanagan. Participants responded to a series of questions designed to help determine the current state of treatment in the community, determine existing service gaps or stress points, and identify emerging trends and issues. To facilitate a frank and open exchange of views, comments were recorded, but not attributed to specific agencies or individuals. The responses and comments are summarized below.

1) How do you classify your services and/or your clientele (per ADS Continuum of Care)?

- Three-bed non-medical youth detoxification program. Clients are self-referred, or referred by family, Ministry for Children and Family Development (MCFD), area service providers, and healthcare service providers. Clients stay from four to 14 days (eight on average), and are not discharged until they can be placed in a suitable environment for ongoing treatment.
- Eight adult non-medical detoxification beds (for males or females); clients are referred by ADS, probation services, or (increasingly) self-referred, and stay for an average of eight days. Following detox, clients are referred to area outpatient services, Mental Health service providers, residential treatment programs, or other programs as needed.
- 43-bed (28 male, 15 female) residential intensive treatment program, 28 days in duration. Majority of clients are self-referred, and are released, on completion of program, to supportive recovery housing facilities (in or out of community) or to outpatient programs.
- 24-bed supportive recovery program (male only). Clients remain for one year, and receive ongoing support and treatment, supportive employment program and life skills training. Clients generally referred by residential treatment provider.
- Youth-specific (ages 13-18) outpatient treatment programs, occasional early intervention activities in concert with schools and street nurses, group-based services offered according to demand. Programs cover area from Peachland to Oyama, with clients being self-referred or referred by Youth Justice, Youth Probation, family, healthcare providers or community service providers. Outplacement of clients to youth residential treatment facilities (out of region), area outpatient addiction services and collateral agencies.
- Individual, group and family outpatient counselling, with five adult counsellors, one youth-specific counsellor and on concurrent disorders worker (half-time). Outreach services offered area service providers. 75% of clients are self-referred, most of the remainder are linked to outreach services. Clients are referred to detoxification, residential treatment facilities, and other area and out-of-area service providers as required. After-care services provided to encourage clients to return for follow-up sessions.
- Counselling services for Aboriginal clients on reserve land. Minimal level of services (generally offered on a walk-in basis), including referral to other area and out-of-area services. No facilities for follow-up. No supportive care or residential treatment facilities. Limited support for counselling activities by Band Council and reserve community.

2) Please provide demographic and statistical information regarding your client population.

- Youth-oriented (ages 12-18) intensive treatment services, offered to a maximum of 3 youth at a time. 40 youths were served in 2003, most between the ages of 12 and 17. Adolescent females are more likely to present and seek treatment; females tend to support their drug habit through more visible means (e.g. prostitution) and are therefore more likely to be apprehended and referred for treatment than are males.

- Intensive residential treatment services for adult males and females. On average, 900 clients are served per year. While services are geared to those 19 and older, the emerging trend is toward younger, poly-drug users.
- Youth outpatient services only. 144 total outpatients in 2003-04, plus 12 youth justice groups and 45 clients accessed through School District #23. 80% of clients have a history of abuse and/or sexual violence. There are three to four counsellors with average caseloads of 60 clients (summer) to 80 clients (winter) – warmer weather brings decreased willingness to be indoors, hence lower caseloads.
- Services to First Nation clients. Mostly male, mostly adult – very few youths present for counselling. Male clients are generally older and generally have problems primarily with alcohol. Females generally younger and, together with youth clients, tend to abuse both alcohol and drugs.

3) What are the primary drugs and drug use patterns in your client population? Have drug use patterns among your clients changed recently?

- Among youth, virtually 100% use marijuana, 90%+ use alcohol, 50% (combined) use cocaine and/or Ecstasy, 31% use methamphetamine, and 10% use opiates. While there is a trend toward poly-drug use and increased heroin, cocaine and methamphetamine use, the incidence of intravenous drug use is relatively low compared to that among adults. From 2002-03 to 2003-04 operating year, methamphetamine use increased from 18% to 31% of clients.
- Adult clientele only. Steady increase in poly-drug use. Cocaine and alcohol use predominates, but methamphetamine use is climbing rapidly. Injection drug use prevalent
- Primarily adult, but some youth clients. 25% abuse alcohol, 13% cocaine, 12% methamphetamine, Ketamine, Ecstasy, etc. 50% indicate no specific drug of choice, and are generally poly-drug users.
- Among Aboriginal clients, alcohol has been the drug of choice, but cocaine and crack cocaine are increasing in popularity, and are often injected. Methamphetamine use is becoming more noticeable, particularly among youth.

4) What are the critical issues arising from the changes in drug use patterns among your clients?

- Youth service providers noted that the youth population is less stable overall, increasingly disengaged from family and natural support systems, and harder to engage. Youth are unwilling to leave the area to access residential treatment facilities, Increasing incidence of concurrent mental health disorders, including drug-induced schizophrenia. Poly-drug use mandates longer detox period and more intensive treatment programs.
- Adult service providers noted increases in concurrent disorders, particularly related to methamphetamine use.
- Aboriginal client treatment issues complicated by prevalence of family violence, sexual abuse and generational addiction issues.

5) What other presenting issues are most critical in the client group? (mental health, housing, employment, domestic violence, etc.)

- All service providers noted the increase in mental health issues relating to drug use – approximately 50% of youth clients and up to 85% of adult clients present with concurrent disorders. 80% of youths had history of sexual abuse, 86% had a violent or traumatic personal history, including incest, sexual assault and substance abuse within the home; adult statistics, while not specified, were reported to be quite similar.

6) Are there services (treatment or non-treatment) that are not currently in place that would compliment your services?

- Harm reduction education needs to be a priority. The public is largely ignorant of the need for harm reduction and the rationale for providing such services.
- Long- and short-term supportive housing
- Ability to extend treatment periods to respond to new drugs and changing drug use patterns.
- Stable housing is key to post-treatment support, and needs to be considered a part of a continuum of care.
- Multilateral treatment planning and program implementation body needed.
- Programs require stable long-term funding, not one-time cash injections.
- There needs to be coordination of the activities of all service providers (prevention, treatment, enforcement and harm reduction).
- Homelessness must be addressed.
- Immediate access to detox programs.
- Subsidized housing developments.
- Youth residential treatment facilities needed.
- 24/7 youth drop-in services and detoxification programs.

7) Is there a waitlist for your services? If so, how many are on it and how long do they generally wait? What are the attrition rates for waitlisted individuals?

- Youth outpatient services experience no waitlists due to treatment model. Clients are triaged based on first assessment (initial walk-in) and given immediate counselling – a permanent caseworker is assigned, usually within a week. There is never a waitlist for high-risk/high-needs clients.
- Youth treatment facilities experience occasional waitlists, with an average wait of 4.5 days.
- Adult residential treatment facilities experience significant waitlists at all stages of treatment (three weeks or longer). This results in huge attrition rates (80-90%).
- Adult outpatient programs are case-managed to avoid waitlists. There is no waitlist for drop-in or group services; clients may wait two to six weeks to be assigned an individual counsellor, but have access to drop-in services in the interim.
- Aboriginal counselling services have no official waitlist, and are offered on a drop-in basis. Low staffing levels mean that, in the event of a crisis, other clients cannot access services.

8) What barriers exist around access to your services, and how could they be removed or reduced?

- All service providers commented on a general lack of awareness of the services available as a key barrier to access. In addition, days and hours of operation are often limited, with little availability evenings and weekends.
- Admission thresholds have been lowered to improve access to adult treatment facilities.
- The statutory need to tuberculosis testing prior to admission to residential treatment is troublesome, as testing is available only once per week; health outreach could resolve this issue.

- Lack of staff resources is key.
- Exogenous factors (lack of stable housing, mental health issues, childcare and transportation needs, etc.) form barriers to access.
- Lack of coordination between federal and provincial funding bodies a key concern for Aboriginal service providers.

9) What would improve services to your client group in this community?

- Increased availability of mental health services (delivered in conjunction with addiction services)
- Foster-home style “respite” care options
- The ability to offer “treatment in place” where applicable.
- Sustainable youth detox services
- Youth residential treatment facilities
- Supportive recovery housing
- More school-based prevention programs, including early intervention services, particularly at the middle school grades
- Semi-independent low rent supportive housing for youth
- More transitional housing
- Youth small scale group housing
- More concurrent treatment residences, with lower admission/retention thresholds
- Ability for Aboriginals to access provincially funded services
- Cross-training and information exchange between service providers
- Time release must be funded to allow alcohol and drug service providers to meet and exchange information on a regular basis

APPENDIX NINE: PUBLIC INPUT

Prevention-Related Comments and Suggestions

Point made by many respondents

Point made by several respondents

Point made by one respondent

- **Prevention is the key to addressing drug abuse**
- **Educate the public about Harm Reduction as well as Prevention; tell them what to do if they find a needle, etc. Accurate and honest information has to be available.**
- **Fact-based anti-drug education for students at all stages of their education, incorporating outside expertise and experience**
- **An alcohol and/or drug prevention program should have people teaching it that have used and abused drugs and alcohol in the past and have seen what it does. A person who has been on drugs and has gotten over them can help other people not go on drugs or help them get off drugs if they have had the experience of being on them. That way they know the real feeling of the effects of the drug and/or alcohol and they can give better advice. The people the person is talking to will also then believe the person talking more because it's not just a load of crap.**
- *We need expanded mentoring programs like Big Brothers Big Sisters for young kids so they stay positive before they get involved with drugs.*
- *Media outlets have to be involved in prevention and the other Pillars*
- *Families and peers have to participate in the Prevention process.*
- *We all need more awareness of the overall situation*
- *We need to address the root causes, such as mental health issues*
- *Begin prevention education earlier in schools*
- *There's no one program that would work for everyone.*
- *Every grade should have a CAPP class that explains what drugs are and how they can affect you. Also how to avoid peer pressure.*
- *The lack of affordable housing in the region contributes to drug use*
- DARE program works because it reaches the children before the majority of them are addicted.
- Peer2Peer education programs need to be provided for all ages and socio-economic groups because a lawyer can relate best to another lawyer, a teen can relate to another teen, an Aboriginal can relate to another Aboriginal, and so on.
- There is a lack of affordable alternatives for teens - cocaine can be purchased for \$8 - \$10 to give a person 8 hours of 'fun'. A ticket to a Rockets hockey game is \$12 + \$5 parking for 2 hours entertainment. There is more 'value' in purchasing cocaine
- Put \$250,000 into prevention
- SD#23 is unwilling to fund or provide a continuum of appropriate drug abuse prevention and education programs starting at the Kindergarten level and throughout the entire school system. It appears that SD#23 is taking direction from non-secular interests without taking into consideration input from the youth or service providers.

- I think that every school in school district 23 should have a group of kids, teachers, and volunteers from the community help make schools a drug free zone and makes kids feel better about going to school. If these groups were put into action then our school district would become a much happier and safer environment for kids learn in.
- I depend on my family, they are role-models for me, I have a image to uphold and wouldn't want to tarnish it, and I know no good comes from using.
- I've been offered drugs and alcohol quite often as a teenager. I always keep it simple and don't make up stupid excuses or give them an opportunity to continue pressuring me. I simply shake my head no and if they persist I'll leave the group entirely. Most of my friends know well enough that while I hang out with them, drugs just aren't my scene.
- By better understanding addiction, people may be more willing to donate funds/ goods to treatment programs, and volunteer their time to compensate for the lack of government funding to these programs.
- School drug lectures don't work and fear-based programs – they omit relevant facts and treat the kids like they have no intelligence
- The general public needs to be educated about the street people, told the truth, not the bleeding heart approach.
- Inform the public not to give panhandlers money, as it just encourages drug use. If they feel necessary to give, create tokens for food or showers – businesses can give to customers free, customers can give to panhandlers.
- We don't need trained, skilled police officers doing education, not their role.
- Community needs to be educated re: the four pillars. Citizens must realize that this is a community problem and will need a continuum of services to be effective. Citizens must further realize that they have a responsibility to support existing services by remaining informed about the issues surrounding addictions in the Kelowna area.
- Educate teens before they try drugs.
- Harm reduction needs to be a significant component of prevention education (e.g. Intermediate levels).
- An effective prevention program should look like it explores all aspects of life that influence our decision making when it comes to drugs and alcohol. I think someone who is looked up to and trusted should run the program. Also, someone already well known in the community especially to the younger age groups so that we feel comfortable with that person when we have questions.
- Educational programs and training for teachers and counsellors in the public education system are necessary
- After school programs - giving children/youth an alternative to the streets or negative peer groups.
- We need to make young people more aware of the affects of drugs.....a captive audience such as in school where they are forced to hear and listen. Perhaps some of the young people who have had their lives destroyed by substance abuse either directly or indirectly could speak to them on their level. It has helped with the alcohol and driving area...why not with the drug scene???
- The four pillars group needs to do a more effective job of explaining the four pillars concept to the public and convincing them of its worth
- Our community together with the law makers need to make changes such as all those involved in community volunteer for drug testing.

- Destigmatize accessing mental health care - it should be as automatic and accepted as visiting a family doctor.
- Provide free general counselling (not specific to drugs and alcohol) in order to address underlying causes of addiction.
- I think the only prevention that might work is allowing it to seem a natural thing, not forbidding, by which making it all the more tempting.
- All City and Community agencies, as well as volunteers, need to work together
- Have a youth team talk to other youth about drugs. Youth don't want to hear 'don't do drugs' It's over used. Understand why kids are using it first. Most likely it starts with problems at home or school.
- Education, education, education starting at a very early age; all services readily available in one major locale with a community of 'drop-in' centres in each area, i.e. Kelowna, Westbank, Winfield, etc.
- Long term prevention is needed by reducing poverty, unemployment, giving people hope. In the short term we need to have a secure(security guards, etc.) drug clinic in the downtown area where addicts can go when they can't get what they need anywhere else, kind of like a combination of a methadone clinic with a safe injection site.

Treatment-Related Comments and Suggestions

Point made by many respondents

Point made by several respondents

Point made by one respondent

- **There needs to be better coordination, cooperation and information sharing among service providers, and less duplication of services**
- **There is a lack of information and public awareness about treatment services in the Central Okanagan**
- **There is no visible, known central location for everyone to go to get treatment.**
- **There are not enough services**
- **We need homes or facilities to house mentally ill and drug addicted persons**
- **Wait times for services are too long**
- **There is a lack of immediate access detox beds**
- **The whole continuum of services needs to be available 24/7.**
- **There are not enough treatment facilities even in crisis situations.**
- **There is a lack of room in treatment facilities.**
- **Lack of post-treatment care and support.**
- **There is a general lack of government financial support due to cutbacks, and too much red tape surrounding access to treatment**
- **There is a lack of treatment services for drug-addicted youth (detox, residential treatment, outpatient, etc.) in our area.**
- **There are not enough treatment opportunities for women, including supportive recovery housing**

- **Too many people with mental illness are left to their own resources, making them vulnerable to abuse and compounding the treatment issues.**
- **The stigma of drug addiction is a barrier to accessing treatment**
- **Prevention is the cheapest form of treatment.**
- **Resources and funding are being cut for programs that are working**
- **The family of the addict needs answers / information; needs to know when their addict has reached bottom / needs help - families need to know what to do / who to contact when they discover they have an addict**
- **Use a harm reduction philosophy vs. the Minnesota model of abstinence.**
- **Treatment resources and mandatory 'safe-care' for street-involved youth at risk**
- *There needs to be mandatory substance abuse treatment for anyone convicted of a criminal offence resulting from substance abuse.*
- *Emergency food and shelter provision needs to be made contingent on the recipient's agreeing to getting help*
- *Parenting classes should be made available to the general community at a reduced rate.*
- *Need a place where youth can go to receive treatment, learn job search and job training skills, free daily access to computers, practice personal hygiene (i.e. showers, haircuts, dental and so on) and help to find a 'fixed address' so that they can become more independent and productive.*
- *We need inclusive programs for dealing with psychological and self-esteem issues and life skills courses and life coaching after treatment.*
- *There need to be gender segregated Residential Treatment Facilities*
- *Longer term treatment centres; treatment cannot be 28 days, addicts need 6 to 8 months treatment to get cured like in Germany There's an all or nothing attitude. Very hard to get treatment until you are off drugs, which seems to defeat the purpose.*
- *There seems to be a Christian approach to some of the programs, which may discourage members of other religions, atheists or agnostics from obtaining the service, and support they need. Too many faith-based organizations with political agendas to fill.*
- *There should be more walk in centres for people, and like Vancouver needle exchanges.*
- *We need more street social workers, not have them sitting in offices.*
- *Too few outreach workers are working 9pm - 5am (vs. 9am - 5pm)*
- *We need a facility where someone can sign themselves in, or family members can when they are incapable, due to substance use, where they will remain throughout detox and support phase, and then can move to longer term housing, complete with support, counselling, groups, work placement, education, etc.*
- *Secondary housing components should be away from the environment that encourages drug use, so people can recover and move ahead with their life without the influences that will likely throw them back into using. they need to be away for a long enough time to move ahead and rebuild their lives.*
- *Develop resources that will allow for harm reduction instead of pure abstinence*
- *Encourage the development of secular treatment programs*
- *Many services have unrealistic expectations and restrictions*

- “211” or similar number providing gateway information about drug treatment and rehab.
- Lack of transportation and childcare are barriers to accessing treatment
- The literature states that on the average it takes numerous attempts to become completely clean, however many of the current standards of care in this community evict anyone suspected of drug use. This only serves to enhance, particularly youth's opinion that there is no real help available.
- The biggest barrier in my opinion is that of looking at addiction as a moral and character deficit, rather than looking at it as an illness to which many professionals assert that it is.
- Too few A&D counsellors for too many clients resulting in insufficient time to treat the whole client in conjunction with other service providers in a variety of fields.
- Lack of 'wet' houses - where users can reside while reducing their dependence on substances via counselling efforts
- Residential programs do not provide long term care.
- Everyone is too afraid of doing anything positive. They are too busy taking notes as this is such a litigious society that the motto should be protect your behind in lieu of doing something that works. This will lead to a vigilante society if something isn't done en masse.
- Seems we try to reform these people, teach them food safe, comp fund, etc. [with] a couple non-related useless courses that will not make a street person addicted to drugs get a job.
- Rather than enabling [drug users] with needle exchange why not sentence [them] to rehab centres [or] mental facilities (when necessary).
- Need halfway houses to reintegrate recovering addicts into mainstream society
- Lack of adequate counsellors for traditional Aboriginal clients
- If we are going to medicate with methadone, there needs to be care, a person hooked on drugs needs constant monitoring.
- Let's open [treatment] facilities to house [drug users] and close [the] résumé writing centres.
- Provide detox 'on-demand', followed by a 40 week (not 40 day) behaviour modification treatment program, followed by a two year residential program wherein the recovering addict can be reintegrated into sober society.
- Lack of cohesion in addiction services, especially the severance of Aboriginal services from non-aboriginal services, is a barrier to effective Treatment.
- Joining Mental Health and Addiction Services leads to preference of a medical model of treatment over a counselling model. There is increasing conflict between MH workers and addiction services providers.
- Parenting support, respite for parents needing it, for free. These services would prevent many of the issues leading to substance misuse.
- We desperately need to start treating persons with mental and other illnesses with respect, paying them a liveable income.
- The disability [benefit] rates must rise significantly, to the same [levels] as pensioners get.
- There should be HRDSC “maternity-leave” style support programs to address the needs of working addicts
- Unequal treatment (males vs. females) and a lack of availability of medical services

- Lack of Treatment for youth [and] cutting Youth Programs when youth substance use is skyrocketing [is a problem]
- Intolerance among some segments of the community
- Mentor recovering addicts in the community
- Lack of holistic approach to address gender, culture, medical issues
- Some programs are only implemented after the fact so if there isn't a major incident or crisis some people fall thru the cracks and may not qualify if they don't meet certain criteria. i.e. must be on probation, must have a mental health diagnosis. etc.
- A mobile clinic would help
- The problem has to be really obvious and causing a problem for society before help is available and by then it is too late.
- Treatment is available for minorities, single mothers and those on assistance but if you are middle class and working poor you are on your own.
- There needs to be greater access to psychiatrists, counsellors, and paediatricians for early intervention, education on mental illness etc.
- Hospitals have no time/patience with addicts (even when the person is suicidal).
- In middle schools punishment is used instead of help, teaching and access to programs. For example expelled for having paraphernalia, then at home with nothing to do for 10 days. Eventually permanent expulsion and this is at the age of 14-15 years. No mental health help through the schools and only able to get any help once involved in the legal system and then further into the addiction spiral.
- [There are] no barriers [to treatment] if the users are informed of outreach groups
- Lack of funding, political pissing matches between agencies and limited resources are all barriers to accessing treatment.
- The warm and fuzzy [services] take all the cash, despite the fact that for the most part, they are ineffective, and many of them [have been] for years.
- Local newspaper could consult with community agencies and publish a one page spread listing the treatment programs/services available to everyone in the community.
- Safe injection sites are needed
- There is not enough help out there for the homeless and low income earners.
- We need residential/live-in treatment service that is of a professional standard, not treatment houses run by ex-addicts
- Treatment services needs to be considered at the place of residence. Most go to get a Holiday Inn getaway. There is also no accountability such as how many times can you go for treatment. Most being served are the repeaters, which are the persons, considered homeless.
- Seniors are being ignored or lumped in with 'kids'
- Services are needed on the Westside
- Nobody is being served well because of the emphasis and waste of resources on law enforcement.
- Reality based education is needed in schools

- More community based treatment services based on where people are at in their use not where treatment services think they should be
- Have one main treatment organization like the 4 pillars and then branch off into the different -treatment-enforcement-harm reduction, etc.
- Mandatory life skills training and grief counselling.
- More in school services to identify students at risk for drug use. The education system is now set up to deal only with those who do well in school. Kids who are not doing well end up quitting do to poor self esteem and wind up on the streets and on drugs. Many times their education needs are not identified and the kids find it easier to quit than stick it out.
- Lack of one on one professional treatment services. Many avoid group counselling sessions, hence refusing treatment
- A facility where they can be admitted high/drunk, and then followed by mandatory treatment (3 months), with no off premises privileges, strictly disciplined.
- Mental health services for teens woefully lacking. Counselling services are very expensive and anything free is say once a week when more intense services probably required.
- Single moms are in need of specific and relevant service.
- Better prescription abuse strategies targeting seniors
- Stop trying to solve the problem ,and correct the serious issues such as homelessness, a lack of proper funds for assistance, a lack of affordable housing, better job training, etc., which are the direct causes of most drug and alcohol problems.
- Services almost need a degree of Lawful Oversight to insure ongoing cooperation etc.
- Quarantine anyone who uses addictive substances and force them to undergo treatment. Don't release them until they are clean.
- Close the bars earlier than 4AM
- Leave Youth counselling for A&D counsellors with a proven track record (Arc Programs Ltd.-Changes) rather than transferring Youth to programs/clinics designed by and for ADULTS which has a proven track record for not being successful for Youth
- see above Also combining the best elements of professional treatment with the best elements of community development, i.e. building networks of formal to informal supports for those in treatment
- legalize marijuana to be sold cheaply to the citizen, taking the crime element out of the picture and use the money from the taxes generated to offset the rehab costs
- Do not open so many beer and wine stores, and cut off the off-sales at bars. Go back to regular liquor stores. That would cut down on people getting a case when leaving the bar.
- Make replacement drugs for cocaine more available over the counter just like the morning after pill.
- An ombudsperson for those 'caught in the system'.

Enforcement-Related Comments and Suggestions

Point made by many respondents

Point made by several respondents

Point made by one respondent

- **Convicted offenders should be mandated to attend treatment, or no release.**
- **Police need more funding to increase presence on the streets**
- **Go after those who deal and/or supply**
- **More severe sentences for dealers and producers**
- **The police could do their job if the court system backed them up, stopped sending offenders home to watch movies, and get a gym pass.**
- **Get rid of conditional sentences for dealers, don't give choice re participating in treatment, retraining, etc. No one is free and clear until they have changed life course. They gave up their choice when they broke the law.**
- *Change to city police from RCMP as recommended by previous reports and surveys.*
- *Leave personal use users alone. Go after the scum bags who make money on innocent/unsuspecting people*
- *Laws on drug use are a creation of the 20th century. It is the laws themselves that create the problem.*
- *Get the dealers off the streets and don't allow the 'big crime' leaders to get a foot hold on our youth*
- *Legalize small amounts of marijuana for possession and also small, discreet gardens for one's personal use only and tax it. Before long it won't be worth trying to grow and sell large amounts.*
- *This is more of a public health issue and enforcement is a waste of time, energy, money.*
- *Sentencing of an addict is totally ridiculous considering it is just as easy if not easier to get drugs in the penal system. There should be more programs to assist the addict not prison time.*
- *Stricter enforcement of Crystal Meth, e.g. :ingredients should not be readily available in large quantities.*
- RCMP members should work closely with service providers, to be aware of the resources in the community, and so that both parties can share their perspective and concerns, and build a positive relationship recognizing both are on the same side.
- Follow up on complaints by informing the complainant (resident) so that the community knows what is going on.
- Make it illegal to sleep out of doors anywhere in the City.
- Send homeless to a permanent camp, like those used in the oil patch.
- Community newsletters would be great.
- Dealers should be incarcerated in labour camps, learn how to work for a living, and not be allowed to re enter society until they have proven to be capable of earning a living gainfully.
- Work with parents to scare the hell out of drug-involved kids

- Habitual drug offenders need stricter penalties, as incarceration keeps users cleaner than if they are out on the streets.
- Restorative Justice needed, they should give related services back to the community to make up for the crime, including picking up drug paraphernalia ,distributing clothing and food, and so on.
- Offenders need to be educated about empowering things in prison. No TV or anything that reinforces the drug lifestyle.
- Change the laws to force judges to 'make the punishment fit the crime'. One grow op can bring in millions of dollars, but are given a \$5,000 fine - growers see this as a cost of doing business. Make mandatory minimum sentencing 12 years (they can be out in four) and fine them based on the size of the operation (\$5,000 per plant with a minimum of \$50,000 fine). Same goes for Crystal meth Labs, coke dealers, etc.
- Arrest with probation conditions, counselling, rehab etc
- Enforcement needs to be consistent and round the clock. Drug related crime accounts for a high degree of all crime in the area. Police should concentrate on enforcement and leave education to other community agencies.
- What is needed is for the public and law enforcement, and other agencies to fully team in a nationwide effort to bring down the kingpins feeding off the miseries of those addicted and, in the process, elevating crime rates across Canada. Hit the biker gangs and nattily-attired crime bosses hard. Namely, destroy them. Saves a few dollars and countless lives.
- I think it's a step by step process. Right now, drugs are rampant, at least among youth, and it's imperative we get that under control. We need to clamp down on the dealers of course, but we need to start educating the rest so the cycle eventually ends...hopefully.
- Harm reduction should be a mandatory part of the prison system.
- Police need to deal with Hells angels in Kelowna. They are the major dealers and the top of the food chain.
- Police should maintain enforcement efforts and increase cooperation with existing youth programs to further educated/prevent at risk youth.
- Offences involving minors should be dealt with on an immediate basis.
- Make it illegal to have a shopping cart and seize the property of anyone caught with one.
- More strict attention to drug use in schools and in the community.
- Parents need to be held responsible for the actions of their minor children.
- Users should have access to community treatment programs and perform community service when caught.
- Police need to be visible in the community, they need to regularly liaise with schools and neighbourhoods to hear concerns and they need to respond to these not with strict enforcement but with clear consequences for those that are impacting public well being.
- Police are not and should not be social workers. It is important that they be part of the justice system and perceived as the enforcement end of the spectrum. If they are not perceived as a definite deterrent system, what becomes part of the motivation to cease and desist in the illegal activity? You cannot be both the counsellor and enforcement entity. The two entities are a conflict of philosophy, whether real or perceived. Each side must have a distinct identity, you cannot be both and have the system start working.

- Users require treatment for their illness, but dealers, particularly those who target youth, are the dregs of society and must be dealt with harshly and immediately. Dealers are predators, no less destructive and dangerous to our society than Clifford Olsen or Paul Bernardo, and every attempt must be made to rid us of them.
- Canada Customs and Revenue must be enlisted to attack dealers. The penalties for tax evasion are in many cases more severe than those for trafficking; dealers should automatically be prosecuted for tax evasion and be sentenced to consecutive, not concurrent, jail terms.
- The police need to issue picture ID of the drug users and fingerprint to allow for a data base to catch re-offenders
- More serious charges for first time offenders and mandated drug counselling at that level.
- Perhaps an alert could go out for an immediate radius when someone is found distributing drugs so families can be on alert
- Unless we are willing individually to risk being involved, reporting observances, seeking change, nothing is going to change. Many would rather deny there's a problem until their homes or lives are being personally disrupted.
- Neighbourhood and park security programs could be better implemented - citywide.
- Hydroponics stores cater to grow ops and need to be controlled.
- Landlords should be aware of what tenants are doing and should do regular inspections.
- They should arrest the users immediately, put them into a rehab program and not wait for court orders. Drug dealers, no second chances, throw the book at them. Straight into a cell, no slaps on the wrist.
- Zero tolerance for dealers and users who commit criminal acts to sustain their habits
- The problem with youth going to jail is that they are then educated and surrounded with an even more negative influence and a worse peer group. I think the answers lie more in treatment, prevention and ongoing treatment and support in the community.
- How about police responding to calls of abuse, relating to drug usage and sales. After many calls in one evening, the tenant was beating his wife, he sells drugs at the door all day and night, the police never came but did drive by the next morning. Where is our once proud Mountie, sitting in his car safely eating doughnuts and drinking coffee. Having worked for the LCB and placing many calls for help the RMCP with no response, I have lost faith in our MOUNTIE of old. It is time to get the dealers, users, and the riffraff off of the street. This will set an example for our children and young adults. They, the RCMP, are more interested in giving tickets for the revenue, rather than the no revenue of drug enforcement. Time to make our homes, parks, streets, and neighbourhoods safe. Then we can talk about treatment. Pretty sad when our residents are afraid to venture out at night, to call the police, due to reprisal from the dealers.
- Implementation of a drug court, whereby consequences to users involve mandated treatment before jail time.
- Seize property and through the sale of drug assets, move those funds to programs in the community.
- Focus on the pimps and johns of youth in the sex trade as opposed to the girls involved; implement a john school
- Drug inflow has to be nipped at the bud, somehow. More traffic stops, etc.
- We need to end the demand because it will be impossible to cut off the supply, education is necessary.

Harm Reduction-Related Comments and Suggestions

Point made by many respondents

Point made by several respondents

Point made by one respondent

- *Harm reduction should be available to all of the major communities in the Okanagan valley and interior of BC*
- *Harm reduction is a waste if there are no programs available to catch people before they turn to these avenues. Really, we are again putting the cart before the horse. Either we get serious or we will continue spending money with no significant improvement.*
- *Harm reduction is wrongly seen as facilitating drug use. The public MUST come to realise that it is not only harm to the users that is being reduced, but harm to the rest of society as well. Pragmatism is not surrender.*
- *Install as many needle drop boxes as necessary wherever the active users indicate that they would be used*
- The only way to reduce harm is to make sure that people have access to affordable housing, food and employment opportunities, so that the problem need not arise.
- Harm reduction continuum strategies have been proven to save lives, save families, and allow addicts to move to recovery at a greater rate than ignoring the continuum and preaching only abstinence.
- I know with the youth it is important to work out a harm reduction plan but more important to have the support of the counsellors/workers to help them work through it and continue down a healthy path.
- I have not seen any evidence that this pillar is strongly supported by the city officials. We need to be more proactive in this area, and help the public realize that harm reduction is sometimes the first step towards helping someone realize there is another way to live.
- Public information on details of harm reduction, and benefits of harm reduction needed
- Harm Reduction will only work when the illegal drug market no longer exists. This will only happen when there is a regulated legal market for adult drug use. The first step is to legalize marijuana for adults, and regulate that market.
- I can see the logic to the program and hope that by having a needle exchange as well as services in place that can help the street person get of the drugs, will overall be helping everybody in the community.
- It is a respect for other human beings to present them with harm reduction by providing safe injection sites etc. We have to get beyond the attitude that we aren't responsible for each other
- Mandatory treatment would likely be the best form of harm reduction--providing safe injection sites simply offers no incentive to addicts to kick their habit
- Hope harm reduction gets off the ground faster and with fewer time-wasting studies than the new bridge.
- I strongly support both prevention and harm reduction. I know we can not cure this problem in a short time so the harm needs to be reduced both to the addict and to those that surround him/her. We need supports at all levels for all clients no matter what level.
- Needle exchange and methadone programs are clear examples of the failure of this approach, but it does employ a lot of people.