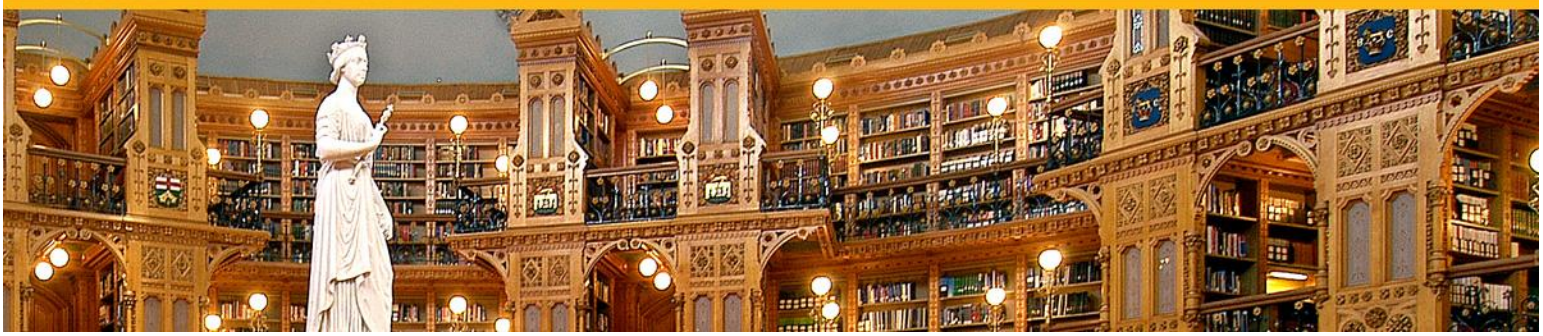
LIBRARY of PARLIAMENT
BIBLIOTHÈQUE du PARLEMENT

IN BRIEF



Current Issues in Mental Health in Canada: Directions in Federal Substance Abuse Policy

Publication No. 2014-06-E
28 January 2014

Wren Nasr
Karin Phillips

Legal and Social Affairs Division
Parliamentary Information and Research Service

Papers in the Library of Parliament's ***In Brief*** series are short briefings on current issues. At times, they may serve as overviews, referring readers to more substantive sources published on the same topic. They are prepared by the Parliamentary Information and Research Service, which carries out research for and provides information and analysis to parliamentarians and Senate and House of Commons committees and parliamentary associations in an objective, impartial manner.

Current Issues in Mental Health in Canada: Directions in Federal Substance Abuse Policy
(In Brief)

Publication No. 2014-06-E

Ce document est également publié en français.

CONTENTS

CURRENT ISSUES IN MENTAL HEALTH IN CANADA: DIRECTIONS IN FEDERAL SUBSTANCE ABUSE POLICY

1 INTRODUCTION

Substance abuse can be defined as a pattern of psychoactive substance use that results in mental, physical or social harm.[1] Total costs of substance abuse to the Canadian economy in 2002 (including costs for health care, losses in productivity and law enforcement) were estimated to be $39.8 billion.[2] Addressing substance abuse remains challenging, as decision makers must find policy responses that are proportional to the harms that the use and abuse of these substances may cause.[3] Furthermore, many individuals who are most at risk for substance abuse also experience wider mental health challenges.[4] Advances in neuroscience have changed our understanding of the impact of psychoactive substances on the brain, supporting new public health approaches in this area. It is within this context that this publication examines current and emerging issues shaping federal substance abuse policy today.

2 OVERVIEW OF SUBSTANCE ABUSE IN CANADA

2.1 UNDERSTANDING SUBSTANCE ABUSE AND ADDICTION

Psychoactive substances have the ability to alter the structure and functioning of the human brain.[5] These substances either mimic or produce "neurotransmitters," chemicals responsible for transmitting messages between neurons within the brain.[6] Psychoactive substances flood the limbic system – an interconnected series of structures that make up the brain's reward system – with dopamine, a neurotransmitter that stimulates feelings of pleasure; dopamine is also released in response to water, food, nurturing and sex.[7] The use of psychoactive substances also alters the function of the cerebral cortex, which is responsible for impulse control and judgment.[8] This results in the pursuit of the rewards of psychoactive substances without regard for possible adverse consequences.[9]

Yet the impact of psychoactive substances on the brain, on its own, does not explain addiction: many individuals experiment with these substances, but not all become addicted. The risk for the development of addiction is therefore also dependent upon individual differences in biology and on environmental factors that mediate the effects of different psychoactive substances.[10] Genetic factors account for between 40% and 60% of the likelihood that an individual will develop an addiction.[11] However, genetic factors alone will not cause an addiction. Rather, it is the interaction of an individual's genetic make-up with environmental factors, such as exposure to trauma and other stressors, disruption of social supports, and issues in interpersonal relationships, that will determine whether an addiction develops.[12]

This complex interaction of biological and environmental factors has led the American Society of Addiction Medicine to define addiction as "a primary, chronic disease of brain reward, motivation, memory and related circuitry."[13] This definition has also been adopted by the Canadian Society of Addiction Medicine.[14] The American Psychiatric Association's fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) does not include a definition of substance abuse or dependence, but instead has developed diagnostic criteria for substance-related disorders.[15] The DSM-5 places substance-use disorders on a continuum from mild to severe, depending upon the number of criteria exhibited.

2.2 Prevalence and Related Harms of Substance Use in Canada

Health Canada's Canadian Alcohol and Drug Use Monitoring Survey (CADUMS) is an annual general population survey of alcohol and illicit drug use among Canadians aged 15 years and older.[16]

The 2012 survey found that, overall, there were no significant changes in the rates of use of illicit drugs over the previous year among Canadians 15 years and older. However, the survey found that abuse of prescription psychoactive substances had increased over the previous year from 3.2% in 2011 to 6.5% in 2012. In addition, the survey revealed that 12.8% of consumers of alcohol were drinking at levels that put them at risk for negative acute effects, such as injuries and overdoses, and 19% were drinking at levels that put them at risk for chronic health effects, such as liver disease and certain cancers. The survey also found that 14.2% of Canadians had experienced harm as a result of someone else's alcohol use.

2.2.1 Population Groups Most at Risk

2.2.1.1 Youth

Youth is one of the population groups in Canada most at risk for substance abuse and addiction. The CADUMS results showed that substance use was significantly higher among youth aged 15 to 24 years than among people older than 24, particularly in relation to illicit drug use (20.3% versus 8.4% for cannabis and 6.3% versus 1.2% for other illicit drugs).[17] The survey also found that youth are more likely than people over 24 to experience harms associated with their use of alcohol and illicit drugs. This may, in part, be due to the fact that the brain is still maturing during adolescence, which makes youth more likely to participate in risk-taking behaviour.[18] Furthermore, the early onset of substance use can affect the development of the brain, creating the risk for increased use and addiction later in life.

2.2.1.2 Aboriginal Populations

Aboriginal populations, including First Nations, Inuit and Métis, have been identified as being at particular risk for substance abuse and addiction.[19] For example, results of the 2008–2010 First Nations Regional Health Survey found that 63.6% of First Nations adult consumers of alcohol engaged in binge drinking, defined as five drinks or more per sitting, a rate that is higher than that of the general population.[20] Problematic substance use in Aboriginal communities has been linked to the historic

impacts of colonization, including cultural discontinuity brought about by the residential school system and child welfare policies, as well as social indicators such as high rates of poverty, boredom, loss of self-respect, unemployment, family breakdown and poor social and economic structures.[21]

2.2.1.3 Individuals with Mental Health Disorders

Studies estimate that between one third and one half of individuals with a mental health disorder also have a substance-use problem.[22] The underlying causes behind the co-occurrence of these disorders are not yet fully understood. However, researchers have concluded that these high rates of co-occurrence suggest the need for greater integration of mental health and addiction services in Canada.[23]

2.2.1.4 Prisoners

Between 70% and 80% of individuals entering correctional systems in Canada have been identified as having problems with substance use.[24]

3 THE FEDERAL ROLE IN ADDRESSING SUBSTANCE ABUSE IN CANADA

3.1 Regulation of Psychoactive Substances

3.1.1 *Controlled Drugs and Substances Act*

The federal government regulates psychoactive substances and their precursors, with the exception of alcohol and tobacco, through the *Controlled Drugs and Substances Act*[25] (CDSA). The Act aims to protect public health and maintain public safety with respect to these substances[26] by establishing prohibitions for the production, trafficking, possession, export and import of these substances. However, section 55(1) of the Act also recognizes the potential health benefits of these substances and therefore, allows for the development of regulations granting access to these substances for medical, scientific, or industrial purposes, including their medical use when prescribed by a health practitioner. Section 56 also allows the Minister of Health to grant an exemption to the application of the CDSA, if it serves medical or scientific purposes under certain circumstances or is in the public interest.

The CDSA further fulfills Canada's obligations within the international drug control regime, which is based upon three United Nations (UN) treaties that collectively prohibit the cultivation, production and trade of cannabis, cocaine, heroin and psychoactive substances and their precursors.[27]

3.1.2 The Regulation of Alcohol and Tobacco

The federal government is responsible for authorizing the manufacturing, sale, labelling and promotion of alcohol in Canada under the *Food and Drugs Act*,[28] which does not contain any provisions aimed at limiting its use. The *Tobacco Act*[29] regulates the manufacturing, sale, labelling and promotion of tobacco in Canada. Its

provisions also aim to protect the Canadian public, and youth in particular, against the negative health effects of tobacco use, including addiction.[30]

3.2 The National Anti-Drug Strategy

In 2007, the federal government introduced the National Anti-Drug Strategy, which addresses illicit drug use in three main areas: prevention, treatment and enforcement.[31]

3.3 Federal Substance Use Treatment Programs for First Nations, Inuit and Other Federal Client Groups

Health Canada's First Nations and Inuit Health Branch (FNIHB) administers the National Native Alcohol and Drug Abuse Program (NNADAP) and the National Youth Solvent Abuse Program (NYSAP) for on-reserve First Nations and Inuit communities.[32] With a national network of 52 residential addiction treatment centres and over 550 community-based prevention and aftercare programs, NNADAP is intended to address the high levels of alcohol, drug and solvent abuse and addictions among First Nations and Inuit.[33] NYSAP complements NNADAP by providing prevention, treatment and recovery programs geared towards First Nations and Inuit youth through a network of 10 residential in-patient Youth Solvent Addictions Centres.[34] Both programs operate through contribution agreements with First Nations and Inuit communities and corporate operators of residential treatment centres.[35]

The federal government also either delivers or provides financial support for substance abuse treatment programs and services to other client groups for which it has responsibility, including active members of the military,[36] veterans,[37] and prisoners in federal penitentiaries.[38]

4 Current and Emerging Issues in Federal Substance Abuse Policy

4.1 Rise of Prescription Drug Abuse

As shown in the 2012 results of CADUMS, prescription drugs are increasingly used by Canadians for recreational or non-medical purposes. They are the third most commonly used substance in Canada after alcohol and marijuana, particularly among Canadian youth, of which 5% used prescription drugs for recreational purposes in 2010–2011.[39] The increasing rate of prescription drug abuse, which rose from 3.2% in 2011 to 6.5% in 2012, may be attributed to the increased availability of such drugs, as a result of their wider use in the treatment of chronic pain, the development of new slow-release formulations, and the public perception that they are safer than illicit drugs.[40]

To address this issue, federal, provincial and territorial governments established a Working Group on Prescription Drug Abuse in 2013 to promote collaboration in this area. In addition, the National Advisory Council on Prescription Drug Misuse, led by

the Canadian Centre on Substance Abuse, released a pan-Canadian strategy in May 2013 entitled *First Do No Harm: Responding to Canada's Prescription Drug Crisis*, which identifies areas of action to address prescription drug misuse in Canada.[41] Finally, the federal government has announced that it intends to expand the National Anti-Drug Strategy to include psychoactive prescription drugs.[42]

4.2 Review of Federal Substance Use Treatment Programs for First Nations and Inuit

In 2007, a comprehensive community-driven review of substance use services and supports was undertaken by FNIHB, the Assembly of First Nations, and the federal National Native Addictions Partnership Foundation, which was funded in part through the National Anti-Drug Strategy. As a result of this process, *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada* (the Framework) was developed.[43] Launched in 2011, the Framework is intended to guide changes to the NNADAP/NYSAP programs in order to better address key emerging substance-use issues facing First Nations and Inuit communities, including:

- the need for better coordination of services and supports across jurisdictions;
- the emergence of prescription drug abuse; and
- the unique treatment needs of certain populations (e.g., youth, women and people with mental health issues).[44]

The Framework articulates a vision for the renewal of the NNADAP/NYSAP system as a comprehensive continuum of services and supports that recognizes the connection between mental health and addiction issues. The Framework is currently being implemented at community, regional and national levels in partnership with First Nations.[45]

4.3 Access to Medical Marijuana

Through regulations made under the CDSA, the federal government grants access to marijuana for medical purposes for individuals who have grave and debilitating illnesses.[46] In June 2013, the federal government introduced new regulations to permit access to medical marijuana "in a controlled fashion in order to protect public safety."[47] Under the new *Marihuana for Medical Purposes Regulations*, Canadians have access to marijuana if a health care practitioner signs a medical document enabling a patient to purchase an amount appropriate for his or her medical condition from a licensed producer approved by Health Canada.[48]

Some groups have expressed support for the new regulations, since they increase the efficiency of the marijuana medical access program, as well as improve the quality of medical marijuana available to patients, and allow for the creation of a new profitable industry.[49] However, others, including health care practitioners, have expressed concern over these changes, because under the previous system, they were responsible only for confirming their patient's condition to Health Canada, not for authorizing access to marijuana.[50] This change is seen by some practitioners as

the transformation of medical marijuana into something akin to a prescription drug without its undergoing regulatory testing and approval processes to ascertain its effectiveness and possible side effects.[51] Meanwhile, some users have expressed concern that the changes will increase the costs of medical marijuana by putting it in the hands of commercial producers.[52]

5 FUTURE OUTLOOK

Advances in neurobiology have increased our knowledge about the impact of psychoactive substances on the brain, leading to an understanding of addiction as a complex chronic brain disorder caused by the interaction between genetic factors and environmental stressors. This understanding is shaping how substance abuse disorders are treated today, including addressing them as part of an integrated approach to mental health. Health experts hope that these insights will serve to address the stigma and discrimination experienced by individuals with substance-use disorders, confronting the widespread perception that these disorders reflect merely a failure of will, or the addictive properties of drugs alone.[53]

Both legal and illegal psychoactive substances will continue to pose challenges to policy-makers as they seek to find a balance between the medical benefits of these substances and their potential harms, as reflected in the cases of both medical marijuana and the rise of prescription drug abuse in Canada. In the future, it is likely that these issues will be increasingly influenced by international discussions surrounding drug policy reform. Indeed, some countries in Latin America have begun to question the effectiveness of the current international drug control regime, recognizing that efforts to control criminal activity in this area have led to violence and corruption with little impact on the demand for illicit substances.[54] As a result of these concerns, the UN General Assembly will hold a special debate in 2016 to examine alternative approaches to addressing the world's drug problems.[55] These international discussions could open the door to the reform of international drug laws, potentially shaping Canada's domestic debates in this area.

NOTES

1. For a discussion of the definition of "substance abuse," see World Health Organization [WHO], *Management of substance abuse*.
2. J. Rehm et al., *The Costs of Substance Abuse in Canada 2002: Highlights*, March 2006, p. 9.
3. WHO, *Neuroscience of psychoactive substance use and dependence*, 2004, p. 247.
4. Ibid., p. 248.
5. Ibid., p. 2.
6. National Institute on Drug Abuse, U.S. Department of Health and Human Services, *Drugs, Brains, and Behavior: The Science of Addiction*, August 2010.
7. Ibid.
8. Ibid.

9. American Society of Addiction Medicine, *Public Policy Statement: Definition of Addiction*, 12 April 2011.

10. WHO (2004).

11. National Institute on Drug Abuse (2010).

12. American Society of Addiction Medicine (2011).

13. Ibid.

14. Canadian Society of Addiction Medicine, *Policy Statements*, 5 October 2011.

15. Elizabeth Harney, "DSM 5 Criteria for Substance Use Disorders: The Symptoms Used for the Diagnosis of Substance Use Disorders," *Addictions*, 20 June 2013.

16. Health Canada, "Detailed Tables for 2012," *Canadian Alcohol and Drug Use Monitoring Survey (CADMUS)*, 2013; and Health Canada, "Summary of Results for 2012," *Canadian Alcohol and Drug Use Monitoring Survey (CADUMS)*, 2013.

17. Ibid.

18. WHO (2004).

19. National Framework For Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada, *Answering the Call*, 1st ed., Fall 2005, p. 6.

20. First Nations Information Governance Centre, "Smoking, Substance Misuse and Gambling," Chapter 8 in *First Nations Regional Health Survey (RHS) 2008/10: National Report on the Adult, Youth and Children Living in First Nations Communities*, 2012, p. 101.

21. Deborah Chansonneuve, "Addictive Behaviours and Residential School Abuse," Chapter 2 in *Addictive Behaviours Among Aboriginal People in Canada*, Prepared for the Aboriginal Healing Foundation, 2007, pp. 19–28; and Laurence J. Kirmayer, Gregory M. Brass and Caroline L. Tait, "In Review – The Mental Health of Aboriginal Peoples: Transformations of Identity and Community," *The Canadian Journal of Psychiatry*, Vol. 45, 2000.

22. Canadian Centre on Substance Abuse, *Concurrent Disorders: Substance Abuse in Canada*, December 2009, p. 9.

23. Ibid.

24. National Framework For Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada (2005), p. 6.

25. *Controlled Drugs and Substances Act*, S.C. 1996, c. 19.

26. *Canada (Attorney General) v. PHS Community Services Society*, [2011] 3 S.C.R. 134.

27. Laura Barnett et al., *Legislative Summary of Bill C-10: An Act to enact the Justice for Victims of Terrorism Act and to amend the State Immunity Act, the Criminal Code, the Controlled Drugs and Substances Act, the Corrections and Conditional Release Act, the Youth Criminal Justice Act, the Immigration and Refugee Protection Act and other Acts*, Publication no. 41-1-C10-E, Parliamentary Information and Research Service, Library of Parliament, Ottawa, 17 February 2012.

28. *Food and Drugs Act*, R.S.C., 1985, c. F-27, s. 1.

29. *Tobacco Act*, S.C. 1997, c. 13.

30. Ibid., s. 4(*b*).

31. Government of Canada, *National Anti-Drug Strategy*.

32. In addition to the National Native Alcohol and Drug Abuse Program [NNADAP] and the National Youth Solvent Abuse Program [NYSAP], the following federally funded national programs for First Nations and Inuit have solvent abuse treatment components: Building Healthy Communities; Brighter Futures; Indian Residential Schools Resolution Health Support Program; and the National Aboriginal Youth Suicide Prevention Strategy. For more information, see Health Canada, "Mental Health and Addictions Cluster Profile," Section 2.1 in *First Nations and Inuit Mental Health and Addictions – Cluster Evaluation 2005/06–2009/10*.

33. Health Canada, "National Native Alcohol and Drug Abuse Program," *First Nations and Inuit Health*.

34. Health Canada, "National Youth Solvent Abuse Program," *First Nations and Inuit Health*. Health Canada's First Nations and Inuit Health Branch maintains a NNADAP/NYSAP treatment centre directory on its website: Health Canada, "Treatment Centre Directory," *First Nations and Inuit Health*.

35. In the North, NNADAP funding is delivered mainly by transfer payments to territorial and First Nations' governments (see Health Canada, Assembly of First Nations and the National Native Addictions Partnership Foundation Inc., *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada*, 2011, p. 1). Up-to-date numbers on the total NNADAP funding envelope are not publicly available. NNADAP funding is not disaggregated from its parent spending category, "First Nations and Inuit Primary Health Care" (see Health Canada, *Health Canada 2013–14 Report on Plans and Priorities*).

36. National Defence and the Canadian Armed Forces, *CAF Mental Health Programs and Services – Understand, Educate, Care*.

37. Veterans Affairs Canada, "Other Services, Benefits and Supports," *Mental Health*.

38. Correctional Service Canada, *Health Services*.

39. Health Canada, "Summary of Results of the 2010–11 Youth Smoking Survey," *Health Concerns*.

40. College of Physicians and Surgeons of Ontario, *Avoiding Abuse, Achieving a Balance: Tackling the Opioid Public Health Crisis*, 8 September 2010.

41. National Advisory Council on Prescription Drug Misuse, *First Do No Harm: Responding to Canada's Prescription Drug Crisis*, March 2013.

42. Government of Canada, *Seizing Canada's Moment: Prosperity and Opportunity in an Uncertain World – Speech from the Throne*, 16 October 2013.

43. Health Canada, Assembly of First Nations and the National Native Addictions Partnership Foundation Inc. (2011). For an overview of the renewal process, see *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada*.

44. Health Canada, Assembly of First Nations and the National Native Addictions Partnership Foundation Inc. (2011), pp. 4–5.

45. Honouring Our Strengths: NNADAP Renewal, *Implementation Strategy*.

46. Health Canada, "About the Marihuana Medical Access Program," *Drugs and Health Products*.

47. Health Canada, "Harper Government Announces New Medical Marihuana Regulations," News release, 10 June 2013.

48. Ibid.

49. Isabel Teotonio, "2014 poised to go to pot," *Toronto Star*, 10 January 2014.

50. Laura Eggertson, "New medical marijuana regulations shift onus to doctors to prescribe," *Canadian Medical Association Journal*, Vol. 185, No. 12, 3 September 2013.

51. John Fletcher, "Marijuana is not a prescription medicine," *Canadian Medical Association Journal*, Vol. 185, No. 5, 19 March 2013.

52. "Medicinal pot 'free market' may force some users underground," *CBC News*, 2 October 2013.

53. WHO (2004), pp. 243–248.

54. Amira Armenta, Pen Metaal and Martin Jelsma, "A breakthrough in the making? Shifts in the Latin American drug policy debate," *Legislative Reform of Drug Policies*, No. 21 (Transnational Institute), June 2012, p. 2.

55. Connie I. Carter and Donald Macpherson, *Getting to Tomorrow: A Report on Canadian Drug Policy*, Canadian Drug Policy Coalition, 2013, p. 96.